

**Circumstances surrounding the death on 17 May 2005 of a man
after he attempted to hang himself on 12 May at HMP Leicester**

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

August 2006

This is the report of an investigation into the death of a man who died at a local hospital on 17 May 2005. He had been taken there from HMP Leicester after attempting to hang himself in his cell on 12 May. The man was convicted but awaiting sentence at the time of his death.

This investigation was conducted by two of my Investigators. I would like to extend my thanks to the former Governor and his staff at Leicester for their help and co-operation during this investigation.

The Eastern Leicester Primary Care Trust was asked to carry out a Clinical Review into the medical care that the man received.

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Summary

1. The man who is the subject of this report was remanded into custody at HMP Leicester on 4 May 2005 by Loughborough Magistrates' Court. It was noted on the reception documentation that he stated that he was anxious and depressed and had stomach problems. He denied any thoughts of harming himself.
2. The nurse who completed the First Reception Health Screen ticked the box on the form for the man to be assessed by the in reach mental health team. That assessment was never completed. The man was assessed as suitable to share a cell on the First Night Centre (FNC).
3. On 9 May, the man was seen by a doctor. He complained of diarrhoea, and a stool sample was taken and sent for analysis at the local hospital. It was again noted that he was feeling anxious and depressed.
4. The man returned to Loughborough Magistrates' Court on 11 May, where he was convicted and remanded to Crown Court for sentencing. He was worried about the effect that might have on his mother and the fact that his wife and children wanted nothing more to do with him. That night, he sat up talking with his cell mate. The cell mate listened but thought the man would feel better in the morning.
5. The following morning, both the man and his cell mate went to Healthcare. The man saw the practice nurse and complained of anxiety caused by diarrhoea and its implications in prison. The consultation was cut short when the man said that he needed to use the toilet.
6. About 9.30 am, the man was returned to the wing where he may have had a shower before being locked back in his cell. At 10 am, when his cell mate returned to the cell and asked a member of staff to open the cell door, they saw the man hanging from the cell window bars behind a makeshift curtain.
7. The alarm was raised and other officers responded swiftly. The bed sheet he had used as a ligature was undone and he was moved into the corridor where Cardio Pulmonary Resuscitation (CPR) was started. Paramedics arrived at 10.20 am and took control of his medical care. At 10.37 am, the man was transferred to the local hospital. He died at 8.30 pm on 17 May 2005.

Investigation methodology

8. The investigation was opened at HMP Leicester on 19 May 2005. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation. A number of prison staff were formally interviewed. A serving prisoner was also interviewed, as was the man's cell mate who had been released from custody.
9. My investigators also met with the investigating officer from Leicester Police to discuss the case.
10. The Eastern Leicester Primary Care Trust was contacted. In line with Department of Health requirements, they agreed to carry out a Clinical Review of the medical care that the man received whilst he was in custody.
11. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
12. One of my family liaison officers contacted the man's wife and his mother. Neither wanted a personal visit from the FLO or the investigators at that time, but both raised their concern about his death over the telephone. They both felt that the prison had not done enough to support the man's depression.

The subject of this report

13. The man was born in 1957. He was married with two children and lived in Leicester until the time of his death.
14. He was first convicted of a criminal offence in the early 1970's, subsequently appearing at court and being convicted on a further three occasions. He had never received a custodial sentence, his offences having been dealt with by way of Community Rehabilitation Orders and other non-custodial penalties. The man had been in prison on remand on one previous occasion.
15. The man was convicted of a sexual offence in May 2005 and was awaiting sentence at Crown Court when he attempted to hang himself. He was 47 years old when he died.

HMP Leicester

16. HMP Leicester is an early Victorian prison. The main living accommodation is a long rectangular cell block with four landings. Most cells have two occupants although some have been converted into dormitories. In cell electricity is currently being installed in all living units. Whilst this investigation was taking place, some alteration work and rewiring, including the installation of in-cell electricity, was taking place in the First Night Centre.
17. The prison was last inspected by Her Majesty's Chief Inspector of Prisons in July 2003 when it was noted that Leicester was three months into a five year action plan.
18. Since April 2004, there has been six deaths at Leicester: four self inflicted, one from natural causes and one homicide. Action plans drawn up as the result of the investigations into two of the deaths have not yet been completed. Insufficient healthcare staff was cited as the main reason for the delay in implementation.
19. In the latest Prison Performance Ratings for the first quarter 2005/6, Leicester rated level 3 of 4. That level is defined as 'Meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime'.

Events prior to the man being found hanging

20. The subject of this report arrived at HMP Leicester on 4 May 2005 having been remanded into custody by Loughborough Magistrates' Court. The Prisoner Escort Record (PER) form, which was initiated at Loughborough Police Station, listed under medical risks: headache, stomach problems and depression. Nothing was ticked in the Security or Other sections, nor was there any mention of risk of self harm or suicide.
21. The man's First Reception Health Screen form was completed by a nurse on 4 May. She noted on the form that he suffered from depression and anxiety and required a mental health assessment. The man told the nurse that he had received treatment for depression and had been an in-patient in 1985. He said that he had never received any medication for mental health problems. He claimed never to have harmed or tried to harm himself and denied any thoughts of suicide or self harm. The details of the man's GP were recorded, as was the fact that he suffered from asthma and was allergic to penicillin. At the end of the form the nurse ticked the box 'Refer to GP' and signed the form.
22. During her interview, the nurse told my investigators that she believed that, as she had ticked the box on page two of the form indicating that a mental health assessment was required, the doctor would then complete a referral form. In fact, on 4 May, the procedure according to the deputy healthcare manager was that the nurse should have completed the referral form or if the forms were completed late at night the healthcare assistant should go through the forms the following day and action any referrals. The man never had a mental health assessment.
23. A reception officer completed the Cell Sharing Risk Assessment form. In section one, he ticked that he had received the PER form, the Warrant and the man's previous convictions. During interview, the officer admitted that he was not in possession of those documents at that time. In section two of the form, a yes/no answer is required to the question: Does the prisoner have any previous convictions (including attempted) for the following ...? A list of offences follows, two of which the man had convictions for, yet the no box was ticked. The third question in that section asks if the current offence is one of the offences on the list. The man's current offence was on the list but again the no box was ticked. Alongside these and other questions on the form are boxes marked 'Source'. The intention is that the completing officer enters the source of the information into the box: either D for documents, I for inmate/prisoner

or S if staff are asked. None of the Source boxes on the form is completed.

24. The officer said during his interview that all of the information came from the man but he forgot to complete the source boxes. When he asked the man what his alleged offence was, he replied, "Oh, I can't remember." That interaction appears typical of the whole interview. The officer asked the questions and accepted at face value whatever the man replied. When the officer later discovered that the current offence was on the list of offences, he did not alter the form. The man was assessed as a low risk and suitable for cell sharing using the Cell Sharing Risk Assessment.
25. The man was put into a cell on the First Night Centre (FNC). The FNC is a group of cells set aside to house new prisoners when they first enter Leicester. The new prisoners then undergo an induction process before moving on to other parts of the prison. The stay in the First Night Centre can often extend to over a week due to the lack of accommodation elsewhere in the prison.
26. As part of the induction process, the man was seen the following day by a healthcare assistant. She completed the Second Reception Health Screen form and noted that the man was fit only for light duties and unfit for sport. She also referred him to the GP's morning surgery on Monday 9 May regarding blurred vision, depression, itchy hands and scalp, constant headaches and loose stools. There is no record of the man being given any medication, although the doctor who saw the man during the reception process, said in interview that he made sure he was given some loperamide for his diarrhoea. There is no documentary evidence to show this ever having been prescribed or issued.
27. On 5 May, the man was also seen by the Chaplain, had a resettlement interview and a probation remand interview as part of the induction procedure. Later that afternoon, the man telephoned his wife. She promised to send some money for him but refused to visit.
28. The man was seen by a doctor at morning surgery on 9 May. During her interview the doctor said that he presented with a number of problems all relating to anxiety. She prescribed a shampoo for his itchy scalp, Paracetamol for his tension headaches, Propanadol, a beta-blocker, to help calm him, and Zolpidem to help him sleep. She arranged for a stool sample to be taken and sent to the local hospital for analysis. The doctor also noted that she did not have the man's medical records from his own GP. She wrote a letter requesting the medical notes which was faxed to the GP that day. The GP replied by fax that he needed the man's consent before he could release them to the prison. During interview, the prison doctor agreed that the GP was correct and that the healthcare assistant

should also have faxed a copy of the man's consent which he signed on 4 May. The man's medical notes were never obtained from his GP.

29. The doctor noted on the medical record that the man should have an In Reach (mental health) referral. She said that it is usual for prisoners at Leicester to be seen within seven to ten days of the request. The doctor said that she was not sufficiently concerned about the man's mental health to open a F2052SH self-harm booklet.
30. The man returned to Loughborough Magistrates' Court on 11 May where he was convicted and remanded into custody to await sentencing at Leicester Crown Court on 8 June. His change of status was not notified to healthcare and, as stated in the clinical review, there is no consistent mechanism for communicating such information. The man's cell mate said that the man was very 'down' when he came back as he was hoping to be released on bail. The cell mate said that either that night or possibly the night before, the man asked a member of staff if he might see a Listener. (A Listener is a prisoner who has volunteered to be trained by the Samaritans and is then available to other prisoners in time of crisis.) The cell mate said that the officer said he would see what he could do.
31. There were three Listeners available on those nights, so there was no reason why the man's request to speak with a Listener, if indeed he did ask, could not have been arranged. My investigators have spoken to the officers on duty, of whom the request could have been made, but none of them recalls such a request.
32. The man's cell mate also said that, during the evening of 11 May, the man said, *'You know what, do me a favour. When I'm asleep if you kill me'* (sic). The cell mate said that he knew that the man was feeling very down about the court case, but felt that by the morning he would be alright again. He also thought that the man was too worried about his health to really think about killing himself.
33. On the morning of 12 May, both the man and his cell mate went to healthcare. The man saw the practice nurse at about 9.30 am. She noted that he was pale and anxious about his diarrhoea. She explained to him that they needed to await the results of the stool analysis before a proper diagnosis could be made. The man then said that he needed to go to the toilet and the nurse told him that he could come back if he so wished. She did not see him again. The nurse noted the fax from the man's GP regarding consent, and during interview said that it was her intention to discuss the matter with the prison doctor.
34. A healthcare officer took the man back to the wing and, as is usual practice, let him onto the Centre and called out to notify the staff that a

prisoner had returned. He did not put him back into his cell. The healthcare officer did not notice anything unusual about the man's behaviour as they walked back.

35. The Centre cleaner saw the man shortly after he arrived back, at around 10 am, and the man asked him for some soap so that he could have a shower. The man walked with the cleaner to where the soap was kept, and the last the cleaner saw of him was the man walking back towards his cell. It has not been possible to confirm if he took a shower or not.

Events surrounding the man's hanging

36. About 10 am, the man's cell mate returned to the First Night Centre and looked into the cell. He noticed that the television was on but the cell light was off. He did not see the man, but saw that the sheet, which had been placed on the window as a makeshift curtain by a previous occupant, was down so as to cover the window and that there was a shadow behind it. The cell mate asked a wing officer to let him into the cell. The cell mate went to the back of the cell and pulled the curtain aside. He saw the man hanging from the window bars by a bed sheet and shouted for staff.
37. An officer came to the cell door and shouted for more staff to attend. An officer entered the cell and took hold of the man and held him up so as to relieve pressure on his neck. The cleaner and another officer entered the cell. The cleaner helped to hold the man up while the officer attempted to cut through the twisted sheet with a 'fish knife'. Upon hearing the general alarm on the radio, the control room asked for Hotel 4 (Healthcare emergency response) to attend the scene. The Senior Officer (SO) arrived in the cell and told the cleaner to leave. He also tried to cut the sheet without success. Eventually, they managed to untie the knot nearest the man's neck and he was placed onto the cell floor.
38. At 10.06 am, three nurses were at the cell.
39. One of the nurses and the SO began Cardio Pulmonary Resuscitation (CPR). At 10.08 am, an ambulance and the attendance of the Senior Medical Officer (SMO), were requested. After a short time, they moved the man out into the corridor and screens were placed around. CPR was continued until the SMO arrived at 10.13 am. He examined the man and could not detect a pulse or signs of breathing. CPR then continued with the Healthcare Manager taking over the chest compressions from the SO.
40. The paramedics arrived at 10.20 am and connected the man to a cardiac monitor. The SMO obtained an intravenous access and administered a dose of adrenaline. A saline solution was administered followed by another dose of adrenaline. About 10.27 am, cardiac output was shown on the monitor and chest compressions were stopped. Assisted breathing was continued and the man was then transferred by ambulance to the local hospital. The man was unconscious and escort handcuffs were not used either en route to the hospital or at any time whilst he was there.

41. Two notes written by the man were found in the cell. They contained a list of things that he would no longer be able to do and expressed his feelings of isolation and despair.
42. The man had placed a healthcare request to see the Triage Nurse dated 5 May into the applications box. The application boxes should be emptied every night by the night staff. The man's note was found at the bottom of the box at 10.50 am on 12 May. It is not possible to say with certainty when the request was put into the box.
43. A hot-debrief was held at the prison to give the staff involved the chance to talk through what had occurred. They were also offered the services of the care team. Prisoners who were on open F2052SH booklets and the prisoners on the First Night Centre were spoken to in order to gauge any reaction to the man's apparent suicide attempt.
44. The man's family were notified of his condition and were able to visit him whilst he was at the hospital.
45. The man did not recover consciousness and was pronounced dead by at the local hospital at 8.30 pm on 17 May 2005.
46. My investigators spoke to the solicitor who had represented the man at court on 4 and 11 May. She said that the Judge had expressed concern in open court that the man was at risk. My investigator contacted the Judge but he does not recall considering the man to be at risk. He said that on 4 May there was a discussion which took place regarding the change in sentencing arrangements from 1 April 2005, the man's previous convictions and the potential length of the sentence he would receive if convicted. The sentencing would be heard at Crown Court and the sentence could potentially be indeterminate. The Judge believed that the man would have been aware of this conversation and the possible ramifications. The man's solicitor did not pass on any concerns about his safety to either the court or prison staff.

Clinical review

47. The Eastern Leicester Primary Care Trust (PCT) is responsible for commissioning the provision of healthcare at HMP Leicester. On 25 May, my investigator told the PCT of the man's death, and they conducted a Clinical Review into the medical care that he had received whilst at Leicester and the local hospital in accordance with the agreement between the Home Office and the Department of Health. The PCT is required to conduct a significant untoward incident report under its own internal procedures.
48. The Clinical Review concludes that in the main the man's healthcare management at Leicester was appropriate. The report states that there is no evidence that different actions by healthcare staff would have resulted in a significantly different outcome.
49. The report has made a number of recommendations and two observations of good practice in his report.

Findings and conclusions

50. The subject of this report arrived at Leicester on Wednesday 4 May, complaining of a number of medical conditions. He was seen briefly by a doctor as part of the reception process. The doctor says that he ensured the man was given medication for his upset stomach, but my investigators have not found documentary evidence to support this. The following day, the man was booked in to see a doctor at the morning surgery on Monday 9 May.
51. The request to obtain the man's medical notes from his GP was declined because a signed consent form had not been faxed to the GP's office. No further attempt was made to obtain the notes, although it is likely that practice nurse would have done so later on 12 May.
52. A nurse completed the First Reception Health Screen when the man arrived. She ticked the box requesting a mental health assessment but mistakenly believed that the doctor would note the box and arrange the referral. The procedure for referral for a mental health assessment is not clear and needs to be properly documented and training given. All officers involved in the reception process should be aware of the correct procedures to be followed.
53. The reception officer completed the Cell Sharing Risk Assessment (CSRA) form for the man on 4 May. The completion of the form and the information obtained was not of the standard to be expected. Whilst the poor completion of the form had no detrimental effect in this case, the CSRA form is an important document designed to protect prisoners and create a safer prison environment. Officers completing such documentation should be diligent in their questioning and recording.
54. As previously noted, the man's change in status from a remanded to a convicted prisoner was not notified to healthcare staff. If it had been, any change in his mood might have been picked up. However, it should be remembered that the man was not on a F2052SH and there is no record of it being noted in Reception that the man was 'low' or depressed when he arrived back at Leicester.
55. Overall, my investigators found Leicester to be a well run establishment with a good number of dedicated and caring staff. The officers involved when the man was found hanging responded quickly and professionally. I have no doubt their efforts gave the hospital doctors the best chance of saving his life.

56. Although I am critical of some record-keeping, and the fact that the mental health assessment had not been completed before his death, I have no evidence that his attempted hanging could have been foreseen or, for that reason, prevented.
57. Contrary to information given to my investigators whilst carrying out the investigation, the healthcare manager, states in the prison's response to my report that there was no formal procedure for referral for a mental health assessment in place at the time and that subsequent actions to be taken are open to interpretation. As can be seen from the preceding pages the reception nurse clearly believed a procedure existed. This confusion should be addressed as a matter of urgency.

Recommendations

Operational

Records & record keeping

58. Staff should be reminded of the importance of accurate record keeping to ensure a holistic multi-disciplinary approach to prisoner care and support.
59. Service Response: ACCEPTED – *Staff Information Notice to be published reminding staff of requirement to keep accurate records, and maintain high quality Cell Sharing Risk Assessment documents. Target date for completion 28/2/06.*

Health

59. The Governor and PCT should ensure that health staff involved in the reception process by completing the First Reception Health Screens, understand the referral process for obtaining specialist support and advice, and work as part of the multi-disciplinary team.
60. Service Response: ACCEPTED - *Appropriate training for Health staff in reception procedures, screening and referrals, to be integral part of the HMP Leicester Healthcare specification submitted to the PCT for commissioning. Target date for completion 28/2/06*
61. The Governor and the PCT should ensure that robust procedures are put in place with regard to the referral process for obtaining specialist support and advice, and that all staff are aware of those procedures.
62. Service Response: ACCEPTED – *Referral forms to be made available to all HCC staff in Reception. 2nd Screening to pick up any further referrals on First Night Centre. Procedures in place where referral forms go direct to mental health nurses. Target date for completion 31 July 2006*
63. The Governor and PCT should ensure that there is a clear protocol for any change in a prisoner's status as the result of a Court appearance to be communicated to Healthcare staff during the Reception process.
64. Service Response: ACCEPTED - *Governor's Order to be published, stating that prisoners are not to leave Reception until they have been seen by Healthcare staff and for Reception staff to be made aware of need to*

inform Healthcare of any change in a prisoner's status. Target date for completion 28/2/06.

65. All items on the prison action plan are now completed.