Investigation into the circumstances surrounding the death of a male prisoner at HMP Leeds in May 2006

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the circumstances surrounding the death of a man who was a prisoner at HMP Leeds. His death occurred in May 2006. Shortly after 7.10am one morning, the man at the centre of this report was found hanging in his cell. Following a conviction 22 years earlier, he had been released on life licence in 2005. He was recalled to prison two months before his death. A post mortem examination conducted in May 2006 confirmed that death was caused by hanging.

The investigation was carried out by my two of my colleagues. They met with members of the man's family and I much appreciate the family's willingness to discuss his death so soon after their bereavement. I do not underestimate how difficult this must have been for them. I offer the man's family and friends my sincere condolences for their loss.

I also commissioned a clinical review of the management of the man's health needs while he was in custody, and I am most grateful for the clinician's assistance in doing this. I must also thank the Governor, Deputy Governor, and staff at Leeds for their ready help and co-operation during the investigation.

Over recent years, the number of prisoners on licence who are recalled to prison has grown rapidly. Indeed, I understand that during the last five years there has been a 350 per cent increase in the number of offenders recalled for apparent breach of their licence conditions. So-called 'secondary imprisonment' is an important explanation for the current record size of the prison population as a whole. From a number of my death in custody investigations, it has also become clear that those recalled to prison are particularly at risk of suicide. Although I make no criticism of the decision to recall the man, both prison and probation staff need to be aware of the extent to which recall is a risk factor in relation to self harm/suicide.

My report includes five recommendations. One of these reflects my concerns about communication between probation officers inside and outside the prison and is addressed to the West Yorkshire Probation Area. One is concerned with awareness of ACCT procedures in all parts of the criminal justice system and is addressed to the NOMS Safer Custody Group. I am pleased to say that all these recommendations have been accepted.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2007**

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SUMMARY

In August 1983, the man at the centre of this report was sentenced to life imprisonment for murder. Although originally set a tariff of 15 years, he eventually spent 22 years in 12 different establishments. He was released on life licence from HMP Leyhill on 5 May 2005 to a hostel in Bradford. He had previously stayed there three times as part of his resettlement plan. Soon afterwards he went to live with his wife, but their relationship broke down and he later moved in with a new partner.

On 1 March 2006, the man was questioned by the police regarding threats to kill and given police bail. During the same week, his probation officer was informed that the police were also investigating allegations of sexual abuse/indecent assault. As a result, his licence was revoked on 17 March 2006 and he was arrested. He spent the night in police custody, before being transferred to HMP Leeds. He was not charged, but the police continued to make further enquiries. On arrival at Leeds, the man underwent the normal prison reception interviews and an induction programme. No concerns were raised in his health screening or cell sharing risk assessment.

The man was assigned a personal officer and was soon described as settling back well into prison regime. Staff spoke to him about his recall, and offered support and advice. He subsequently submitted an appeal against the recall. He was visited by his probation officer, whom he had known for many years, and who completed a report as part of the appeal process. The report was based on an interview with the man some four weeks before he took his life. It refers to him not coping in prison and thinking about harming himself. The information was included in the probation service computerised case record and the recall appeal report. However, it had not been read by anyone by the time the man at the centre of this report had hanged himself.

On that day he had been taken into police custody for questioning. Again he was not charged, but was told that the Crown Prosecution Service (CPS) were to consider whether any charges would be brought against him. On returning to HMP Leeds later that day, staff thought that the man seemed fine, as did another prisoner who spoke to him. He made three telephone calls to his partner after returning to prison.

On the morning of 10 May, although the roll check was considered completed, the landing which contained the man's cell appears not to have been checked until an hour later when the cells were unlocked. He was then discovered by staff around 7.20am. He was hanging by a ligature in his cell. Officers, healthcare staff and paramedics attempted cardio pulmonary resuscitation (CPR), but sadly were unable to revive him.

My investigation into the man's death started on 12 May. As part of my investigation, I have looked into the concerns of his family about what might have led to him taking his own life and whether more could have been done to prevent it.

I make five recommendations.

THE INVESTIGATION PROCESS

1. The investigation at Leeds began on Friday 12 May 2006 when the investigation team met the Governor, Deputy Governor, a representative of the local branch of the Prison Officers' Association (POA), and the Healthcare Manager. The lead investigator explained the nature and scope of the investigation, and the report handling process. He also spoke on the telephone with the Chair of the prison's Independent Monitoring Board (IMB).

2. On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone with concerns or information relating to the man at the centre of this report's death, to make themselves known to the investigation team. Only one prisoner came forward. The investigation team interviewed 18 members of staff who had contact with the man during his time in prison. They also interviewed the man's home probation officer.

3. My office also contacted the Coroner for West Yorkshire (Eastern), and the investigating police representative. A copy of this report will be sent to the Coroner to assist him with his enquiries.

4. On 20 June, my investigator and one of my Family Liaison Officers, visited members of the man's family. The family raised the following matters which are addressed in the report:

   The man's niece said she had telephoned both the police station and the prison to express concerns that the man might harm himself. Was any information passed from the police to the prison about the man's level of risk to himself, and if so, why the prison did not put him on any sort of suicide or self harm watch?

   Was the man aware of all the allegations made against him at the time of his death?

   After visiting the cell, they thought the bars were very prominent and an obvious ligature point.

   Could it be determined how long the man had been dead when he was found?

   Had a disagreement with his partner occurred shortly before his death? The family believe the man had phoned her on the night before his death. They have also seen a drawing in a puzzle book within his possessions that gives rise to concern.

   As he was a life sentence prisoner, were the usual precautions to look after new prisoners ignored, and was he expected to be able to settle in and cope?

   Did the man tell his probation officer who saw him in prison that the prison was "doing his head in", and that he was suicidal? If this was said, it is a major concern and the family wish to know what was done with the information.

HMP LEEDS

5. HMP Leeds is a category B local prison, dating from 1847. It accepts adult male prisoners from courts in West Yorkshire and has 680 cells, plus rooms and wards for 26 in the Healthcare Centre. A new gate complex opened in September 2002, providing staff facilities and an improved entry point for all visitors and staff. Leeds has an operational capacity (maximum crowded capacity) of 1,150 prisoners, and always functions at or near this figure. It expanded from four to six wings in 1994. Leeds was last visited by HM Chief Inspector of Prisons in August 2005. She identified that the prison faced a number of difficult challenges because of chronic overcrowding and a high turnover of prisoners.

6. There have been five apparently self-inflicted deaths at Leeds between March and July 2006. Four of the prisoners who died had been recalled to prison.

Life sentence prisoners

7. Prisoners who are serving life sentences often have the option of a single cell. Life sentence prisoners are also assigned a lifer manager, who keeps in regular contact with them and deals with their sentence management for the duration of their period in custody.

Recall process

8. A life sentence prisoner who is released has to abide by licence conditions. Should there be a breach of any of these conditions, they are liable to be recalled to prison. Leeds receives an estimated 120 licence recalls (including life licence recalls) per year.

Personal Officer Scheme

9. All prisoners are assigned a personal officer. Their role is to meet with the individual on a regular basis and to discuss any issues or concerns the prisoner may have.

Roll check procedures

10. The roll check is the physical count of the number of prisoners within a prison. Roll checks occur on a number of occasions during the day. Night Staff conduct roll checks at the start of their duty and again at 6.30am. A running roll is maintained by the prison. At each roll check, the Assistant Orderly Officer (Oscar 2) reconciles the roll by confirming the running roll at the Centre with that at the Gate. The local instructions at Leeds for the conduct of roll checks state that:

> "The first morning Roll Check is conducted at 6.30am by the night staff on that wing/area; this is normally done in conjunction with the 'early start' day staff. At 7am a full roll check is conducted with the roll being reported to the Senior Officer (Oscar 2) in the 'Centre Office'."

Acct

11. Leeds has implemented the Assessment, Care in Custody and Teamwork (ACCT) approach to helping and monitoring prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, to identify prisoners' individual needs, and to offer individualised care and support before, during and after a crisis.

Safer Cells

12. Leeds has a number of "safer cells". These are specially designed to contain as few ligature points as possible.

Probation Officer Contact

13. West Yorkshire Probation Area employs probation officers both within the prison and outside in the community. All use the same computerised record of their contact with offenders. If a concern is raised, the database can be accessed for further information

KEY EVENTS

Between 1 March 2006 and 17 March 2006

14. On 1 March 2006, the man at the centre of this report was questioned by the police regarding allegations of threats to kill. He was not charged with any offence as the police were continuing with their enquiries. During the same week, his probation officer was informed that the police were also investigating allegations of sexual abuse/indecent assault, alleged to have taken place the previous month. A report was completed by the West Yorkshire Probation Area and submitted to the Home Office's Early Release and Recall Section. The report recommended that, given the allegations and apparent increased risk, it was appropriate for the man to be recalled to prison. His life licence was revoked on 17 March. He was arrested and taken to Bradford Bridewell police station.

18 March 2006

15. The man was not formally charged but spent the night in police custody. He was transferred to HMP Leeds the following day, arriving around 11.28am. My investigators were unable to trace the prison escort record (PER) relating to the transfer from police custody to prison, and it has apparently been misplaced. It is not known whether it included a reference to information about concerns for the man's safety, as reported by his family.

16. On arrival at Leeds, he was interviewed by staff as part of the prison's reception process. As he had been in prison previously, he was offered the choice of either the full prison induction programme or the shorter version. He opted for the short induction. This included a talk by a prison chaplain, and one on race relations, as well as being seen by a Counselling, Advice, Referral and Throughcare (CARAT) worker. A cell sharing risk assessment was completed which recorded "no problems or risks" and noted that the man was a lifer recall prisoner. The first reception healthcare screening, which also assessed any suicide risk factors, was conducted by a nurse. No concerns were noted.

Between 19 March and 8 May 2006

17. The man completed his prison induction on 19 March. The next day he was moved from the induction wing to B Wing, where he chose to occupy a single cell. His cell was in reasonable condition and furnished with a bed, chair, cupboards, table, television, sink and toilet. The man was assigned a personal officer. She had an initial one to one meeting with the man to discuss his first day on the wing. He said he was unhappy to have been recalled. He denied both allegations against him (the first was that he had threatened to kill; the second was of a sexual nature, which the man said he knew nothing about and was upset by). He was positive that neither allegation would be proved. His personal officer said that she was aware that the man was subsequently visited by his solicitor and probation officer, but did not know the content of discussions between them.

18. About two days later, the man received a letter from the Home Office Release and Recall Section which explained the reason for the recall and the process

should he wish to appeal. On 23 March, the prison's Lifer Manager and the internal prison probation officer interviewed him. (This was a routine interview for lifer prisoners, known as an immediate needs assessment interview.) The internal probation officer told my investigators that the purpose of the meeting was to discuss the circumstances of the recall and for the man to be able to raise any other concerns. She said that he was aware of the reasons for his recall, which he seemed relaxed about and was confident that the allegations were untrue. He said that he knew nothing of the second allegation, and was upset that such an accusation could be made about him. The internal probation officer said she was not involved in the recall appeal process, and was unaware of a report subsequently written by his field probation officer. She also said that probation officers within the prison share the same computer system as those who work in the community. She was unaware of the field probation officer's record of contact with the man and had no reason to access it.

19. The lifer manager told my investigators he knew the man, but only interviewed him on the one occasion with the internal probation officer. Any further contact would usually be instigated by the prisoner. The lifer manager said that the man was informed of all sources of support in the prison. He also confirmed that the man was aware of the allegations which led to his recall, and was angry that this had happened to him. The lifer manager said that he too was unaware of the field probation officer's later report and had no reason to be informed of its content. He said that reports include information gathered for the appeal and are not usually reviewed until the hearing.

20. The man's personal officer spoke with him again about his recall on 24 March. Throughout March and April, all her meetings with him were recorded with comments such as "no problems" in respect of his behaviour. They also show that he got on well with other prisoners and staff, had settled back into the prison regime and had soon applied for various jobs.

21. On 13 April, the field probation officer visited the man. The information he gathered from their conversation was later recorded in the computerised case record and included in a report to be used as part of the man's appeal against recall. The report included a section headed "Conduct in Prison" and made the following comment about his wellbeing since being recalled:

> "Since coming back into custody the man is unhappy and emotionally negative to such an extent that he had contemplated self-harm/suicide".

22. The field probation officer said that he was not concerned that the man was currently at risk of harming himself, but did say that this was the only time he had ever referred to self harming. Having built up a professional relationship with him over the years, the field probation officer did not believe that the man's suggestion of self harm was a genuine statement of intent. He felt it was something he had said off the top of his head and, indeed, during the course of their conversation his mood changed. Based on his knowledge of the man, the field probation officer did not draw the statement about contemplating self harm or suicide to anyone else's attention. The field probation officer said that the man's

mood lifted in the course of their meeting, and he had no anxieties about him when he left.

23. My investigators asked the field probation officer if he was aware of the ACCT procedures within prisons which help with the management and care of 'at risk' prisoners. He said he was unaware of them and that, had he known about the procedures, he would have brought the reference to self harm to the attention of prison staff.

24. On 19 April, the man's personal officer told him that the oral hearing for his appeal against recall was scheduled for 19 May. On 21 April, the field probation officer submitted his report to the Lifer Release and Recall Section of the Home Office. The report constituted a release risk assessment of the man and included the information the field probation officer had gained from their meeting a week earlier.

25. On 24 April, the man's wing history sheet showed that his personal officer had telephoned the prison's police liaison officer to come and speak with him about his recall. There were no records to show whether this actually took place.

26. The field probation officer visited the man again on 27 April in order to prepare for the recall appeal hearing. On this occasion, no reference was made to the man not coping with prison life or of harming himself. The same day, the man's personal officer also interviewed him for the Post-Recall Induction Interview. The man told her that he was devastated at being recalled as he had started a new life with a new partner and her children. His partner visited him on 6 May. (This was not the first time she had visited him.)

9 May 2006

27. At around 9.20am on 9 May, the man was taken from the prison to Bradford Central police station. The police wanted to question him about the allegations which had led to his recall to prison. The accompanying escort form did not refer to any problems, and recorded that the man was of "no known risk". However the police custody records indicate that he was assessed as having a "mental condition or illness". The officer who made the assessment described him in the following words: "detained prisoner states he feels a little depressed at this time, no med." The man was questioned about the allegations made against him, but was not charged. He was returned to prison at around 2.00pm that afternoon. Again, the accompanying escort form did not refer to any problems. My investigators found no documentation to suggest the man was interviewed in prison reception on his return.

28. On returning to B wing, the man was allocated a new personal officer, who introduced himself the same day. At interview, the new personal officer said that although he had worked on B Wing previously he had had minimal contact with the man up until this point. He could not recall their introductory conversation, but said that he appeared fine, raised no concerns and did not mention his interview with the police.

29. The man made a number of telephone calls to his partner whilst in prison. In particular, three calls were made on 9 May after he returned from the police interview. The first call was at 2.26pm, the second at 2.48pm and the last at 7.30pm. The content of the telephone calls has been established from transcripts of the recorded conversations, as they were not contemporaneously monitored by prison staff. The conversations centred on the man's police interviews. Although he had not been charged, he was unhappy about the allegations against him. He had been told that his case was to be referred to the CPS to decide whether or not the matter was to be pursued. During the telephone conversations, the man's partner said that they might have to stop being partners, and just become friends as it was possible that he might not be released very soon. On two occasions within the conversations, he refers to his head as "choker, really really choker".

30. The man's friend occupied the cell next door to him. He told the investigation team that he had known the man since his recall. On 9 May, the night before the man died, he said they spoke briefly on the landing during association at around 7.20pm. The man had told him about his interview by the police, but they did not discuss the detail. The man's friend described him as being "OK" during their conversations.

31. During the same evening, a wing landing officer said that she also had a general chat with the man as he passed her on the landing during association at around 7.40pm. She described him as "fine, calm and in good spirits". He mentioned being interviewed by the police. The landing officer said that there was no apparent worry in his voice. He also spoke about his partner and her children, saying that he was happy and loved them. He said he was expecting and looking forward to a visit from his partner the next morning. Their conversation lasted around ten minutes and ended by the man saying that he would see the officer the next day. The officer's duty ended at 8.30pm that evening.

32. The evening roll checks of landings two, three and four on B wing were carried out at around 8.00pm by the night duty officer when he began his night duty shift. He checked that all prisoners were in their cells, that the exterior cell door bolts were in place and made himself aware of the prisoners subject to an open ACCT. During the night, the night duty officer assisted with an incident on A wing. The man's friend said that he was awake throughout parts of the night of 9 -10 May and heard no sounds coming from the man's cell next door.

Wednesday 10 May 2006

The morning roll check

33. Staff told the investigation team that the normal daily wing routine begins with an officer conducting the morning roll check at approximately 6.00am. Each cell on the landing is checked by an officer who looks through the cell door flap and puts the cell night light on to physically check on prisoners. Staff coming on duty in the morning, normally around 6.00am on contracted hours (also known as overtime hours), would conduct the official roll checks and would then sign the wing sheet records to this effect. The man's friend (in the cell next door to the man) said that

he did not recall the morning roll check being done on his cell. He said it was normally carried out between 6.00am and 6.30am.

34. The night duty officer said that he believed that the morning roll check completed by night staff was an un-audited roll check. As such, night staff were not expected to sign the wing roll check. He said that he did his own check for his own peace of mind at the end of his night shift, and thought that the official check was done by staff arriving in the morning. At around 5.00am, he started his morning roll check of the wing. He only completed the third landing, and did not unlock the exterior bolts. (At the time he was unaware of the responsibility. He was new to the establishment and, since starting night duties, no one had informed him that unlocking the bolts was part of his duty.)

35. As he had some outstanding paperwork to conclude, the night duty officer went downstairs to the movements office, leaving the second and fourth landing unchecked. Two wing officers arrived soon after to start their morning shift. The night duty officer said he briefed both officers on the night's events, and the first wing officer went to count the second landing. Other officers also started to arrive for the beginning of their shifts. When the night duty officer went onto the landing, he said he saw the senior officer checking the third landing and called to tell her that he had already checked it. Before finishing his shift around 6.45am, the night duty officer said he had heard a female member of staff shout "the numbers are correct".

36. The senior officer told my investigators that, being on contracted hours duty, she started at 6.00am and her first task was to complete the B wing roll check. She began her checks on the third landing. While in the midst of doing so, the night duty officer called to say that he had already checked the cells on the wing. The senior officer replied that he had not thrown the exterior bolts open, to which he said he was unaware that he had to do this. She continued to unlock the bolts on the doors on the rest of the landings, but did not look through any more observation panels as she believed that they had all been checked.

37. The night duty officer only counted the third wing landing, and said that he informed the senior officer of this. However, the senior officer believed that the night duty officer had checked all the cells. This misunderstanding meant that the roll check was incomplete when it was later signed off by a third wing officer. The third wing officer also started his duty at 6.00am. He told my investigators that he signed the roll check sheet to say that the count was correct although he had not carried out the check himself. He could not recall which officer or officers had actually carried out the roll count. When asked whether it was normal practice for the roll check to be signed by an officer who had not carried it out, he said it was customary for staff to undertake checks on behalf of others and for someone else to sign the record.

After the morning roll check

38. Once the wing roll check is complete, staff begin unlocking the prisoners attending workshops and court. The cell of the man's friend was one of the first to be unlocked at around 7.15am by a fourth wing officer, who then proceeded to

the man's cell next door. When the officer opened the man's cell door, he found him hanging off the back wall. He stood in shock and then immediately shouted for staff whilst running into the cell to lift the man up. The man's friend said that he heard a shout for "staff", and ran out to the landing to see what was happening. No one was in sight. When he walked down the wing past the man's cell, he looked in and saw him hanging from the window bars at the back of the cell. He was facing the back wall and the fourth officer was supporting his body at the waist.

39. The man's friend said that he stood startled, looking into the cell and the officer shouted to him for help to support the man's body. He ran into the cell to assist the officer and, whilst doing so, the man's body turned round and he saw a sock in his mouth and quickly pulled it out. By now other officers had come to assist and cut the ligature from the window bars.

40. A further officer who assisted came on duty at around 7.05am. At around 7.20am he was on the B Wing fourth landing when he heard a shout. This assisting officer quickly made his way in the direction that he saw other staff running. When he arrived at the man's cell, he saw the fourth officer supporting the man hanging by ligature from the cell window bars. He assisted the officer until a second assisting officer entered the cell and cut the ligature from the window bar. The senior officer arrived and relieved first assisting officer who left the cell. The first assisting officer said that other staff were present now, but he also noticed the man's friend who was standing at the back of the cell.

41. At around 7.10am, the second assisting officer, in his role as B Wing third floor landing officer, began to turn on the lights in each cell on his landing for prisoners scheduled to attend the workshops. At 7.20am, he heard a shout coming from the landing above him, ran upstairs, and was directed to the man's cell by a prisoner on the landing. On entering the cell he saw the fourth officer supporting the man's body with his arms around him. The man's friend was also in the cell and assisting the fourth officer. The second assisting officer said he stood on a chair and cut the ligature so that the man could be placed on the floor. Other staff had by now arrived and commenced cardio pulmonary resuscitation (CPR).

42. The senior officer told the investigation team that she was on the third landing at around 7.20am when she heard a call for assistance from the fourth officer on the landing above. She ran up to the landing and, on arriving at the cell, saw the fourth officer and the second assisting officer with the man's friend bring the man's body down from the cell window bars to lay him on the floor. She noticed the ligature around the man's neck, and checked for a pulse but found none. The man's body was also very cold and stiff. She told staff to start CPR, but she found it difficult to get air into his mouth because his jaw was so stiff. A further officer, temporary senior officer, who was now also in the cell, commenced chest compressions. The senior officer said that she cut the ligature from around the man's neck and then left the cell.

43. The wing landing officer from the previous evening returned to duty at 7.00am. After being on duty for a very short time, she heard a shout for staff and made her way in the direction of the shouting. She hit the general alarm button at some

point between hearing the shout for assistance and arriving at the man's cell. The alarm button was recorded as being activated at 7.22am. On arriving at the man's cell, she looked in to see him hanging. The fourth officer was supporting him from the top of the waist, and the man's friend was assisting him.

44. The temporary senior officer had arrived on duty around 7.00am and carried out staff checks. At around 7.20am, she was on B Wing second landing and heard a shout for "staff", coming from the fourth landing. She ran to the cell and saw the fourth officer and the second assisting officer supporting the man. The man's friend was at the back of the cell. The temporary senior officer said that she quickly removed the fourth officer's knife from his belt and passed it to the second assisting officer who cut the ligature from the bars. The temporary senior officer assisted the fourth officer to support the man's weight as he was laid down on to the cell floor. The fourth officer and the second assisting officer left the cell and a third assisting officer arrived. The senior officer had commenced mouth to mouth resuscitation, and the temporary senior officer began chest compressions until the third assisting officer took over. Nursing staff also arrived and, on the instruction of one of them, the temporary senior officer removed the man's socks. Any signs of life were checked for whilst CPR continued, but none was apparent. The temporary senior officer then left the cell.

45. The principal officer was the orderly officer for the day, which meant that he was responsible for the routine management of the prison. His duty began at around 5.45am when he started to deploy staff to various roles. As there had been an incident the night before, he also had to debrief a group of staff. The principal officer told my investigators that he heard a loud scream at around 7.10am whilst on B wing. He made his way in the direction of the scream and saw the man's friend standing outside the man's cell. He saw staff inside carrying out CPR and nursing staff just arriving. The principal officer said that he immediately used his radio to contact the control room and call an ambulance. He arranged for security screens and sealed the cell area. The paramedics arrived after approximately ten minutes.

46. The first nurse arriving at the man's cell came on duty at 6.30am. At around 7.15am, she heard an officer shout "blue call". She told my investigators that she ran to the cell where the shout had come from, taking her around a minute to get there. The emergency equipment bag had been brought to the cell, and she saw two female officers carrying out CPR. The nurse checked the man's pupils and observed that there were no signs of life, before taking over mouth to mouth resuscitation from the senior officer. The nurse said that the senior officer used her knife to remove the ligature from around the man's neck. Despite its removal, the nurse said it looked as if the breaths of air were not passing beyond the point of his neck where the ligature had been situated. She also tried to enter an airway into his mouth, but his jaw was locked and it proved impossible. CPR continued for approximately ten minutes. A second nurse was now also present.

47. The paramedics arrived soon afterwards and confirmed that the man was dead. Their report stated that the man was already dead when they arrived at the cell. The paramedics recorded that the nursing staff had been attempting CPR, and

that rigor mortis had set in, the man's pupils were fixed and dilated, and staff were unable to open an airway.

Other events

48. The duty governor began to implement the 'death in custody' contingency plans. The Independent Monitoring Board was informed at 7.40am, as were the Samaritans. A protective screen was put around the man's cell door, and the cell was sealed at around 7.55am. The police were also called. The first police officers arrived at the prison at 9.45am followed by others throughout the day. The coroner's officer arrived around 8.15am.

49. The man's partner was due to visit him that day. He had left a note for staff, asking them to contact her before she left home. Unfortunately, she had already left home by the time he was found, and she arrived at the prison at 9.30am. It was therefore decided to meet her at the visitors centre to break the news of his death. This was done jointly by the duty governor, a further governor and the prison's family liaison officer. The man's partner told them that the only thing on his mind which she was aware of concerned his recall to prison. She did not believe these issues were serious enough for him to actually try to harm himself or take his own life.

50. The man had named his sister as his next of kin, and the news of his death was broken to her in person by prison staff at around 9.30am. The family were invited to visit the cell, and did so at a later date using the opportunity to take flowers. The prison offered assistance with the funeral costs.

51. All prisoners within the wing on open ACCTs were interviewed. A hot de-brief meeting was held straight afterwards and staff talked through events of the morning. A further de-brief was held some days later, although few staff attended. The majority of staff were content with the level of support available, although one of the senior members of staff felt that, because of their rank, they were often expected to cope and not offered the same level of support as those more junior. The man's friend was offered support by way of a counsellor and the prison's GP.

ISSUES CONSIDERED IN THE INVESTIGATION

The family's information about the police and prison

52. The man's niece said she telephoned both the police station and the prison to express concerns that he might harm himself. He had told her that, if he ever went back into prison, he would kill himself. She was reassured by the police that he was being held in a camera cell. She could not recall whom she spoke to at the prison and did not receive a call back to say if any action had been taken. The family wanted to know if any information was passed from the police to the prison expressing concerns about the man's level of risk to himself, and if so why the prison did not put him on suicide or self harm watch.

53. The investigation team contacted the prison's police liaison officer to obtain a copy of the custody record for the man on the day that he was arrested. They also tried to obtain a copy of the escort records, which should have been completed for the journey between the police station and prison. Neither record could be located. My investigators were also unable to locate any prison procedures for recording concerns raised by relatives via the telephone system. As a result, I have not been able to answer this point for the man's family. From the information available there was no reason to put him on special monitoring for self harm.

    The Governor should implement a system to record any family concerns received at the prison and the action taken to address them.

Was the man aware of all the allegations against him?

54. The man's family said that the police interviewed him and he was apparently fine during the interview. They enquired whether, at the time of his death, he was aware of the allegations made against him. It was apparent from my investigation that he told staff he was aware of all the allegations. There may have been further details passed to him during his interview with the police. Some were mentioned in the last telephone calls to his partner on 9 May, including that his case was being referred to the CPS for a decision on whether he would be charged.

Was there a disagreement with his partner?

55. The family wondered whether there had been a disagreement between the man and his partner shortly before his death. They believe he telephoned her the night before he died, and that the contents of the call might be relevant. They have also seen a drawing in a puzzle book in his possessions. This includes a picture of him and his partner on the beach, then with her figure crossed out. It said "I can't do it, I'm dead."

56. My investigators have not seen the puzzle book, but have read the transcripts and listened to the telephone calls which have been referred to earlier in this report. The man was concerned about being recalled to prison, and being interviewed by the police. He refers to his head as being "choker". Although I

cannot categorically determine the meaning of the expression, it appears to have been used in the sense that he was feeling stressed or perhaps confused about events. Coupled with his partner's concern that their relationship would have to change if he was facing a further long period of custody, this may indicate something of the man's state of mind.

Clinical review

57. The clinical review was carried out by the Director of Public Health for Leeds West Primary Care Trust. The review was compiled from the prison medical record, security records and discussion with the Head of Healthcare. The report makes no recommendations and considers that the man's care was appropriate.

58. From the limited information available, the clinical reviewer says there was nothing of note recorded during the man's reception screening. The suicide risk assessment score was two (a score of 10 or above would have indicated the need for clinical intervention). He had little interaction with the healthcare team whilst in Leeds.

59. When the man was found, the nursing staff arrived promptly and took over the resuscitation and acted appropriately. (I defer to the clinical reviewer's view, but given the state of the man's body when he was found it might be argued that he was already beyond resuscitation. It is not respectful either to staff or to the deceased person to conduct CPR when rigor mortis has already set in.)

Ligature points

60. Having visited the man's cell, his family commented that the window bars were very prominent and an obvious ligature point. As he was not thought to be at risk of self harm, he was in a normal prison cell rather than a special cell with reduced ligature points. He was also not monitored in the same way a prisoner known to be at risk of self harm would be.

Time of death

61. The man's family wondered whether it could be determined how long he had been dead when he was found. My investigators explained that they would try to determine when the man was last seen alive, and when he was discovered. However, between these times they could not estimate a time of death which would be a matter for a pathologist. My investigators found that the man was last seen alive when his cell was locked on the evening of 9 May. He spoke to staff and another prisoner during association but gave no indication of what he intended to do.

Arrangements for life sentence prisoners

62. The man's family wondered if, because he was a lifer, the usual precautions to look after new people arriving in prison were ignored as he would be expected to settle in and cope. However, all prisoners, whether it is their first time in custody or not, go through a prison induction and health reception on the day of arrival.

He had the option to complete a long or short induction programme. Having previously spent a long period in prison, he opted for the short induction programme which was completed. In addition, and like other Leeds prisoners, he was assigned a personal officer and had the opportunity to raise any concerns. In fact, as a life sentence prisoner, it is arguable that more safeguards were in place for the man, as he was also interviewed by the Lifer Manager and probation officer. By all accounts, the man appeared to have settled back into the prison regime without giving any cause for concern.

Comments to the probation officer

63. The family believe the man told his field probation officer that prison was "doing his head in" and that he was suicidal. They have asked what happened with the information, whether it was passed to the prison and, if so, what action was taken. My investigation confirmed that the man had known his probation officer for many years, and that this was the only occasion that any reference was made to thoughts of self harm. By the end of the conversation, which took place more than a month before he took his life, the field probation officer was satisfied that his mood had lifted. He recorded the conversation in the probation computerised log, and referred to it in his report for the recall appeal hearing. However, he did not draw the conversation to the attention of the prison, nor to his fellow probation officer in the prison. The field probation officer was unaware of the prison's ACCT arrangements and said that, had he known of them, he would have been more inclined to inform prison staff. The probation officer also said that he did not know what action to take about other issues arising from his contact with prisoners.

64. It seems that there was little communication between the prison and home probation officers. Although the computerised log is shared, it was not clear when one probation officer would become aware of the work of another. In the man's case, this appears to have resulted in them working in a disjointed manner which did not encourage the sharing of important information. Although the man's reference to harming himself might not have appeared as a genuine statement of intention, it should still have been passed to prison staff so that they could decide what action was appropriate. An entry was made on the computer case record, but it was not picked up because it was not drawn to the attention of the prison probation officer who only checks the record if she is involved in the case. Her work with the man had been completed before he met the field probation officer and thus she had no occasion to access the record.

65. My investigators also contacted the Home Office Lifer Release and Recall Section. They were told that comments such as those in the man's report are unfortunately quite common. The Lifer Release and Recall Section receives a large number of reports. All are read, but staff do not routinely flag up issues within them.

66. It would appear that the prison's Lifer Clerk and the Parole Board itself are also unlikely to draw specific attention to comments about self harm in a recall appeal report.

The Governor should liaise with the West Yorkshire Probation Area regarding the procedures in place to respond to prisoners at risk of harming themselves.

West Yorkshire Probation Area to remind staff of the importance of adhering to its procedures for sharing important information with prison staff.

The NOMS Safer Custody Group should consider the implications of paragraphs 63-65 above with a view to improving awareness of ACCT procedures elsewhere in the criminal justice system.

Roll check procedures

67. The local instructions for the conduct of roll checks state that the first morning roll check is conducted at 6.30am by the night staff, and is normally done in conjunction with the first day staff coming on duty. At 7.00am, a full roll check is conducted, with the roll being reported to the Senior Officer (Oscar 2) in the Centre Office.

68. The night duty officer was unable to do a full roll check at 7.00am, as per the instruction, as his duty finished around 6.30am. The night of 9 May 2006 was the first occasion he worked a night at Leeds. His night duties at his previous prison differed from those at Leeds, but he was unaware of the difference until the end of his shift. His instructions did not include all the necessary information, and the senior officer that morning was not aware of this. The outcome was that the roll check was only partially completed when it was signed off.

69. Although in interview all staff confirmed their awareness of their responsibilities for roll checks, there were problems on this occasion. It appears to be the custom that staff sign for tasks which they have not personally carried out. On 10 May, the record was signed without anyone realising that the check had not actually been completed. I cannot say whether the man had already taken his life when the roll check should have been conducted. However, had the procedures been carried out correctly, he would have been found earlier and an attempt at resuscitation would have been made sooner.

The Governor should urgently review the roll check procedures and remind staff of their responsibility to follow the local instruction.

70. In the event, staff responded well and professionally when the man was found. I also commend the actions of the man's friend and would be grateful if the Governor could arrange for those sentiments to be shared both with him and the staff.

71. I also judge that the prison managed its family liaison responsibilities sensitively and well.

CONCLUSIONS

72. It is impossible to know what exactly was in the man's mind on the night of 9-10 May. His niece says that he had told her that if he ever went back to prison he would kill himself. The man had also told his field probation officer four weeks earlier that he was not coping well since being recalled and found himself thinking about ways to harm himself. However, he had given no other indication of such intentions – either to staff or to fellow prisoners.

73. I cannot entirely explain what the man meant when he said during his last telephone call that his "head was choker". It was quite possible that he found it difficult to accept the allegations made against him, and knew that they could result in him remaining in prison. His partner did not report what he had said to the prison, who remained unaware of the conversation until the calls were transcribed for this investigation. To those around him, he seemed his usual self the night before he died and appeared to be looking forward to a visit the following morning.

74. Nevertheless, there was some information about the man's risk of suicide or self-harm sitting in a recall appeal report and in the Probation Service's computerised case record. His death therefore raises issues about awareness elsewhere in the criminal justice system of the Prison Service's policies to prevent suicide and self-harm.

RECOMMENDATIONS

HMP Leeds

1. **The Governor should implement a system to record any family concerns received at the prison and the action taken to address them.**

2. **The Governor should liaise with the West Yorkshire Probation Area regarding the procedures in place to respond to prisoners at risk of harming themselves.**

3. **The Governor should review the roll check procedures and remind staff of their responsibility to follow the local instruction.**

West Yorkshire Probation Area

4. **West Yorkshire Probation Area to remind staff of the importance of adhering to its procedures for sharing important information with prison staff.**

   (This recommendation had been amended in light of consultation with the West Yorkshire Probation Area)

NOMS

5. **The NOMS Safer Custody Group should consider the implications of paragraphs 63-65 above with a view to improving awareness of ACCT procedures elsewhere in the criminal justice system.**