Investigation into the circumstances surrounding the death of a man at HMP Leeds on 27 October 2009

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is the report of an investigation into the death of a male prisoner at HMP Leeds. The man died on 27 October 2009, having been discovered in his cell with a ligature around his neck. The post mortem concluded that the man had died as a result of hanging. I offer my sincere sympathy and condolences to his family and friends.

The investigation was carried out by my colleague, Investigator A assisted by Investigator B. An independent review of the man's medical care in custody was carried out by a clinical reviewer on behalf of Leeds Primary Care Trust. I am most grateful to him for his assistance.

I would also like to thank the Governor and staff of Leeds for their full and ready co-operation during the course of the investigation. I am especially obliged to a member of staff for her help in liaising with the investigators.

The man had been on remand at Leeds since July 2009 for assaulting his mother. He was assessed as at risk of suicide as soon as he arrived at the prison and was appropriately monitored as a result. Following his mother's death five days later, he was placed on constant supervision for a week. The intensity of the monitoring was gradually decreased until suicide prevention measures were no longer assessed as necessary on 17 August. This seems to have been an informed and reasonable decision and I formally recognise the good practice involved by a number of members of staff. More than two months elapsed between the end of the monitoring and the man's death.

One of the man's main concerns, aside from the offence with which he had been charged, was that he was in danger of being attacked by other prisoners. I found no evidence to substantiate these claims. Staff, including a psychiatrist and mental health nurses, worked with him to rationalise his fears. There was no indication of any worsening in his mental state in the weeks leading up to his death. In fact some staff believed he had started to make progress in the prison.

I make eight recommendations. Many on healthcare issues, including recording on System One (the healthcare computerised case record), the prescribing process, the referral system between healthcare teams and ensuring that communication between these teams is robust. I also focus on how well the support officer scheme is functioning at Leeds and the repercussions this has for recording key information about a prisoner on the National Offender Management Information System (NOMIS). Lastly, in relation to the emergency response, I consider whether more information could be given during the call to the emergency services and the viability of all staff receiving basic first aid training.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

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SUMMARY

The man was remanded to HMP Leeds on 8 July 2009, following his arrest two days earlier for wounding with intent to commit grievous bodily harm on his mother. He took an overdose at the time of the offence, and was immediately made subject to suicide prevention measures. He had been in prison before. Following the death of his mother five days later, the man was made subject to constant supervision. On 16 July, the charge against him was changed to that of murder. He remained on constant supervision until 20 July, when a multi-disciplinary panel decided observations and interactions could be gradually reduced.

Throughout his time at Leeds he remained in fear of his life, believing that other prisoners would attack him once he was placed on normal location, due to the offence with which he had been charged. He therefore remained on the first night centre longer than usual but was eventually moved to A wing (the vulnerable prisoners' wing) on 4 August. Following his refusal to eat or drink after the move, he was admitted to the healthcare centre the next day. The man had various mental health assessments while he was in healthcare, including weekly appointments with a psychiatrist. All the staff involved assessed that he did not have a severe and enduring mental illness, but that he was suffering from anxiety.

Following a gradual reduction in his supervision, he was removed from suicide prevention measures on 17 August and the appropriate post-closure review was held a week later. All the staff involved told the investigators that they did not believe the man was a risk to himself, rather that he was fixated on the risk he perceived from other prisoners. I have found no evidence to substantiate his fears. Furthermore, many of the prisoners on A wing would have been charged with or convicted of offences which other prisoners might disapprove of. The use of the suicide prevention measures seems entirely appropriate in this man's care.

At the end of August, he was prescribed olanzapine by a psychiatrist to treat his anxiety. After a week, the psychiatrist did not believe the medication was having any effect. The man had also been encouraged to work with psychiatric nurses to rationalise his fear and manage his anxieties. However, he did not want to do this, since he was of the opinion that staff could not help him. The psychiatrist made the decision, in consultation with the rest of the team, to discharge him from healthcare on 3 September and he went back to A wing. A different doctor prescribed olanzapine for a further 28 days following this discharge, but it is not clear whether the man was actually offered or accepted this medication. I make a recommendation in this regard.

Throughout this period, staff from the different wings, in particular from safer custody and his support officer, made considerable attempts to help him to settle at Leeds. Many of their efforts went unrecorded and were revealed when they spoke to the Ombudsman's investigators. It is therefore unfortunate that, around two weeks after the man moved to A wing, he was left without a support officer or any mental health follow-up due to a missed referral. (The support or personal officer scheme was introduced so that prisoners are given a named officer that they can approach for advice or to resolve complaints.) This was exacerbated by the lack of entries on

NOMIS and by sporadic use of System One by some mental health services. I consider these issues further in this report.

On 13 October, the charge against the man was lessened to that of assault occasioning actual bodily harm and his case was adjourned until the week commencing 26 October for the production of medical reports.

However, on 27 October, he was discovered hanging in his cell after lunch. Staff and paramedics unsuccessfully attempted to revive him and his death was pronounced at 2.37pm. At the time of the emergency, the emergency bag, including the defibrillator, was in the pharmacy being restocked and was therefore not immediately available to staff. This issue has now been resolved. I have given consideration to whether the prison can amend their protocol with the Leeds Ambulance Service so that any member of staff can request an ambulance, rather than having to wait for healthcare to attend the emergency. I make a recommendation in this regard, along with a suggestion that more information is given to emergency services when the initial call is made for an ambulance.

THE INVESTIGATION PROCESS

1. The investigation was opened on 30 October 2009, when investigator A, visited HMP Leeds and issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. One prisoner wrote to Investigator A in Arabic and he then agreed to be interviewed in English on 1 December, since his spoken English was of a high standard. Whilst opening the investigation, Investigator A also interviewed seven other prisoners and met with the Independent Monitoring Board (IMB) and the Prison Officer's Association (POA).

2. Investigator A was given access to the man's prison files, including the medical record. She later returned to Leeds with another investigator, Investigator B on 30 November and 1 December and conducted interviews with twelve members of staff and two prisoners. Investigator A returned to Leeds on 3 February 2010 and carried out a further six interviews with members of staff. She also conducted interviews with three members of staff over the telephone.

3. A clinical review of the man's health needs whilst he was in custody was carried out by a clinical reviewer on behalf of Leeds Primary Care Trust (PCT).

4. One of the Ombudsman's family liaison officers, wrote to the man's sister-in-law on 4 December 2009, to inform her of the investigation and invite her to raise any issues she wished the investigation to address. In February 2010, the man's niece came forward as his next of kin and the family liaison officer spoke to her. Neither family member has raised any issues. I hope that this report helps the man's family to better understand what happened in the time leading to his death.

HMP LEEDS

5. HMP Leeds is a category B local prison dating from 1847, serving the courts in West Yorkshire. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

6. Leeds accepts adult male prisoners from West Yorkshire and has an operating capacity of 1,154 across six wings. They are: A wing (vulnerable person's wing), B wing (currently closed for refurbishment), C wing (normal location), D wing (induction unit and first night centre) and E and F Wings (voluntary drug testing units). Prisoners are located on A wing if they are considered to be vulnerable or at risk from other prisoners if placed on normal location. For example, if they had accumulated debts to other prisoners or had committed an offence which other prisoners would disapprove of.

7. HM Chief Inspector of Prisons, last inspected Leeds in December 2007. She found that, although Leeds was not performing sufficiently well in any of the key areas, there had been progress in all aspects of the prison as managers sought to introduce improvements.

8. In relation to A wing, HM Chief Inspector of Prisons said there were no restrictions on the prisoners' regime. She said that, although the wing was shared between sex offenders and others (such as those in debt), most prisoners felt relatively safe on A Wing. She also found that there was a written support officer policy but the scheme was not operating effectively, with considerable gaps in entries in some of the records.

9. Although half the prisoners surveyed by HM Chief Inspector of Prisons said that the healthcare services were either good or very good, her report made a number of recommendations. She also commented that not all staff had had resuscitation training in the last 12 months, and recommended that this should be rectified.

10. An Independent Monitoring Board (IMB) is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the National Offender Management Service (NOMS) and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State, highlighting good practice and areas of concern.

11. In their 2009 annual report on Leeds, the IMB also expressed its concern that the support officer scheme was not working well. However, the Board added that, "within the constraints of budgets and staff selection and recruitment, HMP Leeds is providing a generally safe environment for prisoners and slowly improving the respect shown to them by staff".

12. The National Offender Management Service (NOMS) is responsible for the management of prisons in England and Wales. Every three months it

publishes an assessment of an individual prison's performance against 34 measures. Prisons can gain a rating of between one (serious concerns) and four (exceptional performance). Leeds scored three (good performance) for the first quarter of 2009-2010 and for the three quarters before this scored two (requiring development).

13. Leeds had six deaths in custody in 2009, of which three were self-inflicted (including that of the man). In the two years before, there had been ten deaths at Leeds, of which five were self inflicted.

14. Following the investigations of the deaths between 2004 and 2007, the Ombudsman made recommendations surrounding the need for contemporaneous and detailed medical records. In the last year, Leeds has acquired System One, a clinical database and I hope that this will assist such record keeping. I make a recommendation in this respect.

15. Relevant to this investigation, after two deaths in 2007, the Ombudsman recommended that the Governor ensured the support officer scheme was working effectively and officers were making regular entries on wing history sheets. It is disappointing that, despite some committed work by individual officers, I reiterate this recommendation in this report.

16. Lastly, following deaths in 2007 and 2008, the Ombudsman recommended that the Governor ensures that Assessment, Care in Custody and Teamwork (ACCT) observations and potential triggers to self-harm are recorded properly. (ACCT is the suicide prevention system used by prisons to identify and support prisoners who are thought to be at risk of self-harm and/or suicide.) While the overall use of the ACCT process was appropriate in this man's case, there were similar gaps in the documentation.

KEY FINDINGS

6 July - 4 August (first night centre)

17. The man had a history of offending dating back to the 1960s and had been in prison on a number of previous occasions. He was arrested on 6 July 2009 for wounding with intent to commit grievous bodily harm. The victim was his elderly mother, for whom he was the primary carer. When arrested, he told the police that he had tried to cut his wrists a month earlier. He also told the police doctor that he had taken an overdose of 100 co-codamol (a painkiller) on 5 July. The police therefore took the man to hospital, where he refused treatment. He was subsequently put under constant supervision at the police station, as he was assessed as a high risk of self-harm or suicide. Having seen another police doctor the following day, the man's observations were reduced to twice an hour.

18. On 8 July, the man was taken from his local Police Station to the local Magistrates' Court, where he was placed in a cell with a camera. (The camera can be watched by staff to ensure that the prisoner remains safe.) Having appeared in court, he was remanded into custody at HMP Leeds. He arrived at 3.00pm and was immediately seen by a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.)

19. Thirty-five minutes after the man's arrival at Leeds, a Senior Officer (SO) completed a concern and keep safe form. (This form can be opened by any member of staff and is the first step in the ACCT process.) The man said that he could not see himself serving a long prison sentence and would attempt suicide. The immediate action plan indicated that, although he had said he would prefer to be in his own cell, ideally he should share a cell and would be observed twice every hour.

20. The duty governor was located in the first night centre to deal with any operational issues arising with new arrivals and complete cell sharing risk assessments (CSRA) when the man arrived at Leeds. (The CSRA assesses the risk of harm a prisoner presents to others.) The Governor said an officer initially interviewed the man to make an assessment. They assessed him as being a high risk due to potential mental health issues, as he said he could not remember committing the alleged offence.

21. A nurse completed the second section of the form and assessed him as a medium risk, meaning that there was no immediate risk but the situation would need to be reviewed regularly. She was, however, concerned that he could be targeted by other prisoners due to the nature of his offence.

22. The Governor explained that the forms for prisoners assessed as medium or high risk would then be passed to a senior officer, to make an action plan as to how they are going to manage the prisoner. The form would then be passed to a governor, in this case himself, to review. The Governor agreed

with the nurse's assessment that the man presented a medium risk and could share a cell with a suitable cellmate. The CSRA shows that he was subsequently put in a single cell due to the threat of attack he perceived from other prisoners. The Governor considered this an entirely reasonable decision while he settled in. He added that sometimes it took weeks to find a suitable cellmate for a prisoner to share with. A Listener was also located with the man overnight.

23. A doctor assessed the man later that evening. The doctor noted that he was shaking considerably and prescribed five days supply of diazepam to alleviate some of his anxiety and help him sleep.

24. The man subsequently asked to be designated a vulnerable prisoner, as he was concerned that he would be targeted by other prisoners because his mother was the victim of his offence. This meant that the man would be located on A wing, the vulnerable prisoners' wing, for his own safety. (Prisoners can ask to be segregated as a vulnerable prisoner if they feel their safety is threatened by others. A vulnerable prisoners unit or wing only allows such prisoners to mix with each other.) Senior Officer A told the investigators that A wing functions more as a self-contained unit than other wings since, due to the prisoners' vulnerability, they cannot associate with the general prison population. She said a number of factors are taken into consideration when locating someone on A wing, including their own wishes, but ultimately it is the Governor's decision as to where they would most safely be located.

25. The following morning, 9 July, an officer completed the man's ACCT assessment (this must be completed within 24 hours of the concern and keep safe form). The man said that he would receive a life sentence, since he had been told that his mother would die. He felt guilty about the alleged crime, could not live with his mother's death on his conscience and had nothing to live for. He was fearful that other prisoners would find out what he had done and attack him. He said he would not tell anyone if he made plans to kill himself. After the assessment, the officer left a voicemail message for Nurse A, from mental health and safer custody, asking her to assess the man.

26. Observations as part of the suicide prevention measures continued at half hourly intervals until 2.30pm, when there was a gap in recorded observations until 8.30pm. The investigators queried this with Senior Officer B who said that it is the responsibility of her team or an ACCT assessor to check all the open ACCTs weekly. The duty governor also checks ten per cent of open ACCTs and the wing manager should check them each day. If a manager notices gaps in observations, they should raise it with the member of staff concerned. If a governor or someone from the safer custody team notices the error, they too would take it up with staff involved. In Senior Officer B's experience, missed observations were generally not a problem at Leeds and she was surprised that there were several in the man's case.

27. The man continued to voice similar concerns later that evening when the ACCT action following assessment was completed. The triggers identified as increasing the man's risk of suicide or self-harm were recorded as the

deterioration of the victim and court appearances. The list of triggers does not appear to have been updated on the front page of the ACCT documentation when different triggers became apparent.

28. Nurse B (RMN) first met the man on 10 July, two days after he came into prison, following a referral from Doctor A in reception. Nurse B works for the primary care team who are responsible for making an initial assessment of the mental or physical health of a prisoner. If they identify severe mental health problems or that the prisoner requires the input of a psychiatrist, they will refer them to the mental health in-reach team (MHIRT), also known as secondary care. If the issue is less severe, the primary care team will work with the prisoner themselves, for example by providing anxiety management sessions. In addition, if the prisoner needs closer monitoring they will be admitted to healthcare, which includes an automatic referral to the MHIRT to see the psychiatrist.

29. Nurse B assessed that the man was in shock and traumatised by the alleged offence. She did not consider him mentally ill but, to gain a more thorough assessment, she referred him to a psychiatrist, Doctor B, via the MHIRT. Doctor B works at the prison up to two days a week. He mainly assesses prisoners during his weekly ward round in the healthcare centre but also holds a weekly clinic for those on other wings to attend and, in unusual cases, will see prisoners on the wing at the request of staff.

30. Twice hourly ACCT observations continued, although again none are recorded between 11.00am to 1.30pm and 1.30pm to 5.15pm.

31. The man's mother died on 12 July and the local police asked the prison to inform the man. They also told the prison that he would not be allowed to attend the funeral due to the ongoing investigation into the offence and in accordance with the family's wishes.

32. The prison chaplain broke the news to the man the following morning. He was immediately placed on constant supervision, meaning that he was placed in a cell with a gate formed by bars and staff worked in shifts to constantly watch and interact with him. He said that there was nothing the prison could do to stop him killing himself.

33. At midday, the first review of the ACCT took place, as scheduled with the man, a Governor, two SOs and Nurse B. The man said that he was shocked by his mother's death, could not see a future for himself and believed he would not get out of prison alive. As a result of this review, Nurse B asked the doctor for some night time sedation for the man and zopliclone was prescribed for three nights.

34. The second and third ACCT reviews took place over the following two days, with a similar mix of staff disciplines and the man present. He remained on constant supervision. It is apparent from the ongoing ACCT record that staff made concerted efforts to talk to the man and encourage him to come out of his cell to associate with other prisoners, which he did on a couple of

occasions. Senior Officer B recalled that every effort was made in this regard and staff would encourage him to help the cleaners or speak to Listeners.

35. On 16 July, the man appeared at a local Crown Court, when the charge against him was changed to murder. He remained on constant supervision throughout this time, returning to Leeds by lunchtime, when he saw a Listener.

36. Later that day, as a result of Nurse B's referral to a psychiatrist, Nurse C (Registered Mental Nurse), in the MHIRT, assessed the man. Nurse C's role was to determine whether he had a severe and enduring mental illness or whether he could be referred back to primary care. He believed the man to be highly anxious and would ordinarily have spoken to Doctor B about these concerns. However, he did not have the opportunity to speak to the doctor before he went on annual leave. The nurse felt that the man was being adequately managed and monitored by the ACCT process, along with his appointments with Nurse B. Therefore he waited for Doctor B to return from annual leave to get a psychiatrist's opinion.

37. The fourth ACCT review took place later that day and the fifth the following day. There was no change in the man's mental state and constant supervision continued, with staff making efforts to engage him in conversation with themselves or other prisoners, including Listeners on the wing. Increasingly, the man talked to staff about his fear of moving outside of the first night centre, due to his belief that other prisoners would assault him. He told staff that he had been attacked on A wing while serving a previous sentence at Leeds several years before. Staff tried to alleviate his fears and engage him in more constructive conversation. The staff interviewed by the investigators said it was very difficult to do this and he remained in fear. The man talked about ending his life on several occasions.

38. On 20 July, he was reviewed by Nurse C, but he did not engage and said he had not slept much lately. The sixth ACCT review, held later that day, indicated that the man was still considering suicide but had not made any plans in this regard. They discussed him moving from the first night centre to a location on a residential wing. This worried him greatly. Those present decided that constant supervision should cease and be replaced by four observations per hour, recorded on an hourly basis and three interactions (that is, meaningful conversations) daily, spread across the morning, afternoon and evening.

39. Two days later, Senior Officer B led the seventh ACCT case review which noted that the man continued to shake, was terrified about his future and the impending court case. He was also concerned about moving to A wing. Following the review, Senior Officer B escorted the man personally to A wing to introduce him to staff there in an effort to try and allay some of his fears.

40. Whilst on A wing, the man met Listeners and Officer A who had known him from a previous prison sentence. Since he seemed to find it easy to talk to

Officer A, Senior Officer B asked him to be the man's support officer, to which he agreed.

41. Officer A told the investigators that the man acted very differently during this time in prison compared to previous sentences. The officer believed this was due to the different nature of his current offence. Officer A considered that he had a good relationship with the man and they could talk openly. Over the following few days, either Officer A or Senior Officer B would go to the first night centre to take the man to association in A wing to try and gradually integrate him there. (Association is the time that prisoners are out of their cells and make telephone calls, take part in other wing based activities and talk to each other.) This was included as part of his ACCT care plan, with the aim of moving him there permanently on 4 August when his CSRA would also be reviewed.

42. The man remained in a single cell whilst he was in the first night centre, apart from a brief period when he shared with another prisoner. (Prisoner A) The investigators spoke to Prisoner A who said that the man had told him he wanted to kill himself. Prisoner A had told officers about this and also asked to be moved to another cell as he found it difficult to cope with the man's obvious distress.

43. On 27 July, another ACCT review was held as scheduled. The man told those present that he no longer had any plans to kill himself but he felt he deserved to die. Observations were to continue at the same level. There were occasions when entries were missing for a couple of hours and, on 29 July, no observations were recorded for nearly 12 hours between 10.30am and 9.00pm.

44. Staff noted in an ACCT review on 30 July that the man had interacted well during his visits to A wing but remained scared of moving there. His observations were reduced to twice hourly.

45. Officer B, who works on A wing, told the investigators that he was appointed as a second support officer on 1 August, although this is not documented in any paperwork. He said that he also spent time with the man when he was brought over from the first night centre. As with other staff on A wing, Officer B thought that there was no substance to the man's fears about other prisoners attacking him. He also said that he did not think the man was suitable to share a cell with another prisoner due to his fears.

46. As scheduled, on 4 August, the man moved to A wing, escorted by Officers A and B. He remained scared about his safety and commented that he felt Officer A was his only friend. He declined association later that day. A CSRA review was completed which concurred with the original assessment that the man was a medium risk and could share with an appropriate cellmate.

5 August – 2 September (healthcare)

47. The following day, 5 August, another ACCT review was held and the man was offered support from the MHIRT and chaplaincy. He declined both, saying he had seen them before and it had not helped him.

48. A doctor assessed the man on the wing as he was agitated and had not eaten or drunk anything for 24 hours. The man denied any suicidal thoughts and did not want to discuss his concerns with the doctor. The doctor offered him a prescription of anti-depressants which he also declined.

49. Later that day, as he had refused food and drink, the man was admitted to the healthcare centre. This was authorised by both a doctor and nurse. Senior Officer B took the man from A wing to healthcare on that occasion. Her impression was that the man was scared of being located anywhere in the prison, not just A wing. On the way there, he told her that he believed prisoners in the healthcare centre were going to kill him. After he moved, the man told staff he had not had any food or drink as he was not hungry and that there was no other motivation for his actions.

50. Senior Officer C, who works in the healthcare centre, explained that a maximum of 14 prisoners can be accommodated in the centre, with around five staff on duty at any time. As a result, there is much more scope for staff to spend time with prisoners than when they are located anywhere else in the prison. Senior Officer C said that staff continually tried to encourage the man out of his cell, with only intermittent success. He tried to reassure the man that he could only be discharged back to the wing at Doctor B's request.

51. With regards to the management of the ACCT, Senior Officer C said that staff regularly came from A wing to the reviews to assist the man's eventual settlement on that wing. He also agreed with Senior Officer B view that the man was scared of other prisoners regardless of where he was located in the prison, rather than this being specific to A wing.

52. All the cells in the healthcare centre are single, so despite Senior Officer C reviewing the man's CSRA and the assessment remaining at medium risk, it was not possible to locate him with a cellmate. In any event, Senior Officer C did not believe that it would be appropriate for the man to share a cell due to his mental state and fears about other prisoners.

53. Nurse D, RMN, first met the man the day after he was admitted to the healthcare centre, on 6 August. She assessed him as suffering from anxiety and discussed with him how this could best be managed. Nurse D also referred the man to the psychiatrist. She said that she made an effort to talk to him whenever she was on duty and tried to allay his fears that he was going to be killed on A wing. Nurse D found no substance to the man's fear but worked with him by attempting talking therapies and anxiety management. She said that staff in healthcare also tried to determine the cause of his shaking.

54. On 10 August, another ACCT review was held in the healthcare centre. The man again voiced his belief that he was not safe on A wing but was evasive about what help he would accept. He refused to answer when asked whether he would harm himself. Observations were reduced to hourly. Senior Officer B said she felt the man's risk to himself had reduced at this point. She considered that his location within healthcare and the intervention of the mental health team made it easier to monitor his mood.

55. Later that day, Nurse D assessed the man. She spent a significant amount of time talking to him, noting that he was highly anxious and that he would be assessed by the psychiatrist, Doctor B, on 12 August.

56. On 11 August, the man was discussed at the monthly multi-disciplinary safer custody meeting. It was agreed that he would be referred to the safer custody programme by a Nurse. This is a four week programme which includes groupwork, access to a gym, tai chi and yoga. The Nurse told the investigator that the referral did not take place as it was subsequently felt that the man was already receiving sufficient input from Nurse D and Nurse B. The investigators did not see documentary evidence that the decision was reversed.

57. The mental health and well-being team co-ordinator is responsible for the safer custody programme. He said that the safer custody programme takes referrals from any member of staff or self-referral from prisoners, with the exception of those from A wing, the vulnerable person's wing. He told the investigators that, since this wing has a much more static population, there are insufficient numbers of prisoners suitable for the programme to keep running them exclusively for A wing.

58. The Mental Health Team Co-coordinator explained that, whilst not ideal, A wing prisoners could be worked with individually by primary care staff. Furthermore some of his team led weekly group classes, such as relaxation techniques, on A wing. Therefore there would have been no point in the man being referred to the safer custody programme since he was due to move back to A wing when he was discharged from healthcare.

59. The man's appointment with Doctor B on 12 August was cancelled as the prison was on patrol state at lunchtime. (Patrol state is when all prisoners are locked in their cells, with a single officer in charge of a landing.) Nurse D said that, due to the number of people Doctor B had to see, his appointments sometimes ran over into lunchtime. It is not possible for a prisoner to see Doctor B during patrol state. (Neither Doctor B nor Nurse D were aware that cancellation of psychiatrists' appointments was a general problem.)

60. On 17 August, an ACCT review was led by Senior Officer C. The man remained shaky and concerned for his safety on A wing, but said he felt better in the healthcare centre. He said he had no more thoughts of suicide or self-harm. The meeting decided to close the ACCT support and monitoring, with the routine post-closure review meeting arranged for 24 August. Officer A said that the man did not say he was going to harm himself during any of their

conversations. The man had told him that there was no point him being subject to ACCT procedures since he would not harm himself. He had not told Nurse D that he was thinking about self-harm or of killing himself either.

61. Senior Officer C and Nurse D said that gradually the man started eating, associating with other prisoners more and also attending education classes. Whilst located in healthcare, he had not voiced any thoughts of self-harm or suicide to Senior Officer C.

62. On 19 August, the man was assessed for the first time by Doctor B, who noted the man's fears about being at danger from other prisoners remained consistent. He diagnosed acute anxiety but did not believe that there were severe and enduring mental health issues, which would normally be treated in the healthcare centre by the MHIRT. He decided that the man should stay in the healthcare centre at least another week.

63. Doctor B tried to rationalise the man's fears by highlighting that others on the vulnerable prisoners' wing were also likely to have committed offences which some prisoners might disapprove of. He encouraged him to engage in psychological techniques such as relaxation exercises and recording his thoughts. However, the man showed a limited willingness to engage as he did not believe any psychological help would increase his ability to cope.

64. One of the prison doctors assessed the man on 21 August. (Doctor D) At interview, he said that he found the man to be, "very obsessed with his own guilt, self-punishing and generally not particularly accepting of assistance or support. He felt that he deserved to be punished for the alleged offence." Doctor D also believed that the man was at risk of suicide since he was not accepting help, was over 60 years old and was overwhelmed by feelings of guilt. However, the doctor did not have sufficient concerns to consider re-opening the ACCT.

65. The ACCT post-closure review was held on 24 August. The man said he was getting by day to day, although he found it hard due to the nature of his offence. He had found it useful speaking to staff while subject to ACCT monitoring. However he believed that he would die in prison, either naturally due to the length of sentence he expected to receive, or due to other prisoners attacking him. It was noted that the man would need a support plan when he was discharged from healthcare back to the wing. Senior Officer C said there had been no other indications that the man would harm himself since the ACCT was closed. All those present agreed that it was appropriate for the ACCT to remain closed. Senior Officer B said that the ACCT documents were then returned to her team for quality checking.

66. Doctor B reviewed the man again on 25 August. He felt a bit better but wanted to stay in healthcare as he remained fearful for his life on A wing. The following day, Doctor B prescribed olanzapine (an anti-psychotic drug) for his anxiety and shaking. The man refused to take it, saying he did not know what it was for. Nurse D gave him more information and a leaflet about olanzapine. He was also advised that if he did not accept treatment, he might be

discharged from the healthcare centre. The intention was to persuade the man to cooperate and thereby increase his self-confidence before he returned to A wing. He accepted his medication two days later. Staff continued to attempt to involve him in anxiety management but he refused to participate.

67. On 2 September, Doctor B carried out a further assessment of the man. He told him that, since the olanzapine was not having any effect on his anxiety and he was not willing to participate with anxiety management from staff, he would be transferred to A Wing. Both Doctor B and Nurse D confirmed that this was a team decision, involving the psychiatric nurses, Doctor B and healthcare officers.

68. Doctor B also told the man that support from the MHIRT would be available to him on A wing, as would counselling should he require it. Throughout the man's admission to healthcare, Doctor B said he had no concerns about his risk of self-harm or suicide. In his assessment, the man remained fixated about the risk of harm he perceived from others but did not have a severe mental illness

3 September – 26 October (A wing)

69. On 3 September, the man was discharged from healthcare and taken to A wing. Senior Officer B said that, within seven days of discharge from healthcare, prisoners should receive a follow up appointment with MHIRT on the wing. The man remained assigned to Nurse C. The nurse would aim to see prisoners each week but this would depend on their need and the available resources. At the time the man was discharged from the healthcare centre Nurse C was on annual leave.

70. Officer A collected the man and took him to A wing. According to Nurse D, this was unheard of and she said it was testament to the additional support which officers offered him.

71. Nurse D completed a tick list discharge summary. The clinical reviewer, noted that it did not refer to any follow-up appointments with the MHIRT. The nurse noted on the form that letters to the wing nurses and staff were issued, but neither the investigator nor the clinical reviewer had access to these since they were not in the medical record and could not be traced. Nurse D said that the letters would have included aims such as "continue to monitor for anxiety symptoms, offer support and to be seen on outpatients' call-up clinic". However, since the man was still automatically under the care of the MHIRT it would be for them to decide how to continue the work regarding his mental health.

72. Senior Officer C said that the man's support plan for his transfer to A wing, mentioned in the ACCT closure review, was a verbal agreement between himself and Senior Officer D. He acknowledged that this could have been recorded on NOMIS for other staff to refer to. He said the main part of the support plan was to try to allay the man's concerns about being attacked and involve him in the regime on A Wing. It also included practical things such as

Officer A escorting him to collect his meals if he was too scared, to ensure that he had adequate food. Senior Officer D explained that this plan included access to Listeners and staff observing him more closely than other prisoners.

73. Following the man's discharge, he was prescribed 28 days supply of olanzapine by Doctor C, who said this was at the request of Doctor B. However, Doctor B told the investigators that since the olanzapine was not having any effect on the man he would not have re-prescribed the drug or asked anyone else to do so. It is therefore unclear as to who authorised this repeat prescription.

74. Furthermore, whilst there is a prescription for olanzapine in the man's medical record, there is no evidence that the medication was given to him. Both Doctor C and Doctor B said this could either be because he was not offered the medication, or he refused it. However, neither doctor could draw any conclusions from the details in the medical record in which they would have expected this to be recorded.

75. Senior Officer B thought the man settled well after he moved to A wing and used the support available to him. She tried to arrange some cognitive behavioural therapy (a therapy based on examining the link between thoughts, feelings and behaviours) and counselling, but he refused to do either. Following the ACCT post-closure review, the man did not say anything that gave Senior Officer B cause for concern with regards to his risk of self-harm or suicide.

76. Senior Officer D concurred with Senior Officer B's view. Following, the man's move to A wing, the Senior Officer believed he appeared to become a little more outgoing, collected his meals all the time, moved further away from his cell during association periods, speaking to other prisoners and a particular Listener. Senior Officer D considered that, "he seemed to be making slow and steady progress to actually integrate himself, albeit to a limited extent into the wing regime". However, he continued to have no outside visitors, apart from his solicitor.

77. Senior Officer A, also said that she noticed a marked improvement in the man when he returned to the wing. She said his general appearance improved, he came out of his cell more and was less shaky. He talked to other prisoners more as well.

78. After returning to A wing, the man remained alone in his own cell, apart from a period of around eight hours near the beginning of September when he shared with another prisoner. (Prisoner B) The investigator spoke to Prisoner B, who said that he had discussed the man's background, acquaintances and current offence with him. He had told him that he wanted to kill himself. He believed that the man would carry out this intention and it was just a matter of time before he did so. Prisoner B did not discuss the man's threats with any members of staff as he felt that some were not trustworthy. He told the investigators that he was in prison to complete his sentence, not talk to staff. This meant that the staff were unaware of the man's continued feelings of

suicide. Prisoner B also said that the man had been very worried about other prisoners killing him. The prisoner said he had never heard any threats being made against the man or other prisoners talking about him.

79. After around eight hours, Prisoner B could no longer cope with being in a cell with the man due to his paranoia about being attacked and so he was moved to a different cell, at his own request.

80. The investigators interviewed seven other prisoners on A wing, all located in the cells adjacent to the man's. After he moved cells, Prisoner B shared with a fellow prisoner (Prisoner C). Prisoner C told the investigators that Prisoner B had told him about the man's suicidal thoughts. He had never spoken to the man but, if he was concerned for a prisoner's welfare, he would report it to staff.

81. Prisoner D, who briefly shared a cell with the man on D wing, said that he often went to see him when he returned to A wing. The man remained distrustful of everyone but, as far as Prisoner D was concerned, he had never heard any threats or rumours being spread about the man. The other five prisoners interviewed supported the view already expressed: that they were unaware of any threat against the man and his alleged offence was common knowledge. They all had limited or no interactions with the man since he spent most of the time in his cell.

82. Senior Officer D and Senior Officer A said that, if they discussed the possibility of another prisoner sharing his cell with the man, he would become defensive and ask to be left on his own because he would not feel safe otherwise. They agreed to this on the basis that it seemed to make him feel more comfortable and there was no pressure on bed spaces on the wing at the time. The man was asked to tell them if he met a prisoner he thought he could share his cell with.

83. On 9 September, Nurse E from the MHIRT assessed the man on A wing as Nurse C was on annual leave. Nurse E's notes show that he attempted to talk to the man about using coping strategies, but he refused to engage. Nurse E made a note that he would not review the man again but would wait for Nurse C to return from annual leave on 20 September. Nurse C told the investigators that he felt this was a reasonable decision given that no medical staff had assessed the man as having a severe and enduring mental illness.

84. The following day, Officer A unexpectedly went on long-term sick leave, and did not return to work before the man's death. Officer B said that he was then the man's only support officer. He did not expect to be given a back-up and made sure that he spoke to the man every time he was at work on the wing.

85. However, on 20 September, Officer B moved to work in another area of the prison. Before moving, he spoke to the man about this, as he was still very concerned about other prisoners attacking him and had heard shouting at him during the night. Officer B asked the night staff about this, who said they had never heard anyone shouting at the man. Following Officer B's move, he had

no further contact with the man. This effectively left him without a support officer, as a replacement was not appointed by a wing SO.

86. On 21 September, the day after he returned from annual leave, Nurse C assessed the man on A wing. The nurse spent a long time trying to discuss the man's fear of other prisoners and his understanding of how prison had changed over the years. However, the man refused to engage with Nurse C, stating that nobody could help him and he did not want any intervention from the MHIRT. Nurse C made a note on the medical record that he would discharge the man from his caseload and refer him back to primary care.

87. Nurse C said he would have normally typed his referral and put it in the internal post for the attention of Nurse B. He realised after the man's death that he had forgotten to complete the referral. The mental health and well-being team co-ordinator said a referral back to primary care would have enabled the man to be seen by a mental heath nurse within 24 hours if there were urgent concerns, or otherwise within a few days. They would have provided ongoing care as appropriate. The man had no further contact with the mental health service.

88. The man appeared at a local Crown Court on 13 October, when the charge against him was reduced to assault occasioning actual bodily harm. His case was adjourned to the week commencing 26 October 2009.

89. When completing a management check in NOMIS on 16 October, a senior officer noted that there were no support officer entries for the man. However, he does not seem to have realised that the man did not have a support officer at that stage or taken any steps to rectify the omission.

90. A week later, on 22 October (a month after the man's support officer left the wing), Officer C was assigned as his new support officer. During interview, Officer C explained that this was because of a new arrangement for allocating support officers, rather than any realisation that the man was without one. Previously prisoners had been assigned to a particular officer on a wing and stayed with them regardless of which cell they were located in. Officers were to be allocated particular cells and be the support officers for the prisoners in those cells.

91. Officer C was on annual leave from 19 to 25 October. He therefore did not have the opportunity to meet the man in his capacity as support officer. With regards to the support officer scheme, Officer C understood that he would be expected to make two entries on NOMIS each month. However, he said these entries would often not be made, although he frequently saw the prisoner.

27 October

92. Officer D unlocked the man's cell at around 8.30am, along with the rest of the prisoners on the landing. This was due to a new open door policy allowing more time for prisoners to associate with each other. Officer D had a brief

conversation with the man who asked why he had opened the door so early. The officer thought that the man seemed his usual self and remained in his cell as usual.

93. Officer E saw the man later when he collected his lunch from the servery shortly before midday. Since Officer E was responsible for overseeing lunch, it was a busy time and so he did not have a chance to speak to the man. However, he noticed nothing out of the ordinary in his demeanour.

94. Staff on the wing could not remember who locked the man back in his cell for lunch. However, they confirmed that two officers would have been responsible for securing all the cells on the floor of the wing where the man was located. The prison was on patrol state between 12.30pm and 1.30pm. When he returned from his lunch break, Officer D first unlocked the prisoners who were due to go to the workshops. He then began unlocking the rest of the prisoners on the landing.

95. At 2.07pm, Officer D looked through the observation flap of the man's cell before unlocking the door. As he could not see the man, he assumed he was in the bathroom which cannot be viewed through the observation flap. Officer D went into the cell where he saw the man hanging from the bathroom window bars, having used part of a sheet as a ligature.

96. Officer D immediately came out of the cell and shouted "staff". (He was not carrying a radio on him that day.) Officers F and G who were on the same landing rushed to the man's cell, arriving within seconds. Both Officer D and Officer F had completed basic first aid training years previously, whereas Officer G's training was up to date and she had attended regular refresher training. Officer D supported the man's body while Officer F cut the ligature using his anti-ligature knife. They placed the man on the floor and Officer F cut the ligature from his neck. Officer F and Officer D both checked for a pulse but could not find one. Officer D remembered that the man was warm to the touch. Officer F tried to get a response from him by shouting his name and gently slapping his face. Senior Officer D immediately began locking other prisoners back into their cells.

97. Officer G radioed the control room stating that there had been a "code blue" emergency and requested emergency medical assistance. (A code blue indicates a medical emergency when someone has stopped or is having difficulty breathing.) The officer then attempted to resuscitate the man by starting chest compressions. Officer F remained by the man's head checking for signs of life. He said he did not assist with resuscitation attempts as he felt that Officer G was more qualified. He would feel confident to carry out cardio pulmonary resuscitation (CPR) if required to do so, although he was unaware of the current correct ratio of compressions to breaths.

98. Nurse F was carrying the 'Hotel 3' radio that day. This indicates that she was the healthcare first responder in case of an emergency. When she heard the emergency call over the radio, she was standing next to Nurse G in the reception area of the prison. Both nurses immediately rushed to the man's

cell, arriving within a minute. Nurse F tried to find a pulse. Nurse G recalled that the man looked blue at this stage.

99. Nurse G said that Nurse F immediately confirmed that an ambulance had been called and was told this had been done. Both nurses took over the resuscitation efforts, with Nurse G completing compressions and Nurse F giving the breaths. Senior Officer E arrived at this time and assisted with resuscitation efforts, so that they could rotate and avoid becoming tired. Officer D, Officer F and Officer G all left the cell.

100. Nurse H was carrying radio Hotel 5. He said that Hotel 5 does not have any specific responsibilities assigned to it, but it is part of the healthcare group of radios. He had been standing near Nurse F and overheard the emergency call on her radio. He immediately went to the central treatment room to collect the emergency bag and, as it was not there, assumed it had already been taken to the emergency. When he arrived at the cell, he noticed that the bag was not there. He therefore left the cell to get a defibrillator from the medical reception about 150 metres away, through four locked doors. When he returned to the cell, he attached the defibrillator to the man. This indicated that no shock should be given, meaning that cardio pulmonary resuscitation should continue.

101. The incident log, completed at the time of the emergency, noted that an ambulance was requested by radio to the control room at 2.13pm. The control room asked for the ambulance at 2.16pm, according to the ambulance report. The description given in the ambulance paperwork is “cardiac arrest”.

102. Nurse H was not sure when he asked for the ambulance, but believed he was mistaken in his statement which says he asked for it before he got to the man’s cell. He thought he had radioed control shortly after he reached the scene, saying that there had been a “cardiac arrest” and an ambulance was needed. It is not clear whether this was the first request to control for an ambulance or whether one had been made prior to Nurse G and Nurse F arriving. Unfortunately, Leeds has been unable to provide the investigator with the control room log for 27 October to clarify this issue.

103. Following a telephone call to the pharmacy, the pharmacist brought the emergency bag to the cell. While the three officers continued resuscitation attempts, Nurse H attached a bag valve mask to the man to give him high flow oxygen. Nurse H remembered concentrating on the man’s airway whilst the three officers continued rotating in their resuscitation attempts. Vomit came from the man’s mouth at one stage, but Nurse H managed to keep the airway clear with a suction pump.

104. At 14.22pm, the ambulance technician arrived and asked the staff to move the man to the main area of his cell. This was done while the resuscitation attempts continued. The technician applied their defibrillator to the man, on which the cardiac monitor indicated there was no cardiac electrical activity and an electric shock should not be administered to the man.

105. Resuscitation attempts continued and the paramedics arrived at 2.31pm. Nurse H said at this point healthcare prison staff left the cell and the paramedics took over resuscitation attempts. They asked Officer E, who was standing outside the cell, what had happened, as they had apparently been unaware the man had been found hanging. They indicated that this was crucial information for them to know and would be filing a complaint in this regard.

106. Three minutes later, a doctor arrived at the scene and, at 2.37pm, he certified that the man had died. The cell was secured and 16 of the staff involved attended a hot debrief straight afterwards. The healthcare manager, said that both officers and healthcare staff thought it had been a good team effort in responding to the emergency.

107. Healthcare staff also had their own debrief and wrote their statements. Nurse H said that, in retrospect, he had written his statement too quickly. He realised during the interview with the Ombudsman's investigators that there were some factual errors such as when he had called the ambulance.

108. Later that afternoon, Senior Officer A and Officer H reviewed the 15 prisoners with open or recently closed ACCTs on A wing and interviewed each prisoner.

109. An officer was appointed as the family liaison officer. The man's records had not been updated since his mother's death and she was still named as his next of kin. At 3.15pm, the Family Liaison Officer called the police officer, who had been involved with the family since the man's remand into custody, in order to obtain the details of other members of the family. The police officer expressed the view that she thought the family would receive the news better from her, since she had built up a rapport with them. She informed the man's sister-in-law straight away who said she would pass on the news to the rest of the family.

110. The police officer also told the Family Liaison Officer that the funeral for the man's mother was the following day. However, it is unclear whether he was aware of this when he took his life since he had not received any visitors, apart from his solicitor, nor made any telephone calls. (The investigator understands that the funeral was arranged at fairly short notice and, in any event, the family had said the man would not be welcome.)

111. All the staff who the investigators spoke to said they had been told of the man's death sensitively and would know where to access support should they need it. They expressed surprise at the man's death as most felt he had made some progress settling in the prison in the last weeks.

After the man's death

112. Due to the Family Liaison Officer other commitments, Officer H was reassigned as the family liaison officer on 28 October. He telephoned the man's sister-in-law the following day to introduce himself and said he would contact them again on 3 November. He told them that the prison would cover

up to £3,000 towards funeral costs and he could organise the funeral if necessary. The man's sister-in-law said she would make a list of things she wanted to discuss. Officer H also offered to visit the family, but they declined and asked for contact to be made by telephone.

113. Officer H spoke to the family as promised on 3 November. They asked that he organise the funeral and expressed a wish for the man to be cremated. Officer H complied with their wishes and the funeral was held on 20 November. He attended, along with the original family liaison officer and a governor. The prison chaplain, conducted the service, which three family members attended. Officer H kept in contact with the family about returning the man's property and money in his prison account.

114. A critical incident debrief was also held for staff on 30 November.

ISSUES

Assessment, Care in Custody and Teamwork

115. As soon as the man arrived at Leeds on 8 July, the ACCT suicide and self harm monitoring arrangements were put in place as he had made a recent suicide attempt and continued to think about taking his own life. Intermittent observations and regular reviews took place. They were sufficient until 13 July, when he was placed under constant supervision after the death of his mother. Following several multi-disciplinary reviews this level of supervision was gradually decreased until the ACCT was eventually closed on 17 August. A week later, the decision to close the ACCT was confirmed at the post-closure review.

116. Staff identified that he was concerned that he would be attacked by other prisoners due to his alleged offence. They also told the investigators that he found it difficult to come to terms with the offence and his mother's death. However, by the time the ACCT was closed, all those involved agreed that they no longer thought the man would harm himself.

117. Much good practice is apparent within the ACCT documentation. Staff made considerable efforts to engage the man in conversation and distract him from his concerns, for example by playing chess. The reviews were held within a multi-disciplinary context, with a good range of staff of differing grades and departments. It was clear from interviews with staff that they all had a good grasp of the issues facing the man and were realistic in their discussions with him. They also worked well as a team across departments, for example by collecting him from healthcare to take him to A wing to try and allay his fears about moving there.

118. I have found nothing to suggest that staff could reasonably have assessed the man as a risk of harm to himself after the ACCT was closed. In fact, many staff believed he was making slow, but steady progress on A wing during the last two months of his life. Furthermore, he had told staff early on in his remand period that he would not tell anyone if he made plans to kill himself.

119. In summary, I agree with the Clinical Reviewer's conclusion:

> "The clinicians and officers at HMP Leeds appear to have used the ACCT process appropriately and skilfully in this case. There was no hesitation in placing the prisoner on constant observations when he was most vulnerable. He remained on the ACCT for five weeks and it was monitored and reviewed appropriately. It was closed on the 17th August after careful evaluation, more than two months prior to the man's death."

The ACCT procedure was used effectively, within a multidisciplinary setting, with sensible levels of observations and conversations and reasoned assessments regarding reviews and closure.

120. However, there are gaps in the ACCT arrangements. There are several days when the man's observations were not fully documented. For example, on 9 July between 2.30pm and 8.00pm and on 29 July between 10.30am and 9.00pm. It is disappointing that management checks did not rectify the omissions. In addition, the triggers page of the ACCT has not been kept up to date to include information such as his mother's death and his fears about moving location in the prison.

121. The man remained safe whilst he was on ACCT and two months elapsed between its closure and his death. Given the overall high standard of assessment, review and decision making involved in the man's ACCT documentation I do not make a formal recommendation in this regard. However, I have previously made recommendations on this subject following deaths in 2007 and 2008. I would therefore advise the Governor to satisfy himself that ACCT observations are being carried out consistently and any triggers to suicide or self-harm are noted on the front page of the ACCT for easy reference.

The man's location in a cell on his own

122. Aside from very short periods of time, the man was located in a cell on his own. This was not due to the risk he presented to other prisoners, but at his own request. He was extremely concerned that he would be attacked by other prisoners and he therefore felt safer located on his own.

123. Several officers spoke to him about this and indeed, they even tried locating him with another prisoner on two occasions. However, both these prisoners found it hard to share a cell with the man due to his level of anxiety and distress and asked to be moved. Given the circumstances and the man's mental state, I therefore find the decision to locate him on his own understandable.

Support officer scheme

124. The Leeds support officers' policy states that:

> "Through daily interaction with prisoners positive relationships are established that can challenge, coach and support prisoners to ensure we prepare them for their release to the outside community … All residential officers at Leeds, as part of their role, will act as Support Officers, ensuring that prisoners are fully supported throughout their time in custody."

125. The scheme is based around ten principles, including:

- prisoners having easy access to their support officer
- support officers being aware of the individual needs of a prisoner and having an effective relationship with them
- support officers maintaining a diary of their contact with prisoners
- support officers to provide input and advice and

- support officers to ensure family ties are maintained

126. The guidance notes that the benefits of the support officer scheme include help for prisoners who struggle to cope in the prison environment, reduction in the stress of the prison environment and the risk of suicide and self-harm.

127. It is widely recognised that it is more difficult to successfully run such schemes in overcrowded prisons or where there is a high turnover of prisoners, as there is at Leeds. However, the public inquiry into the murder of a man at Feltham Young Offender Institution in March 2000 concluded that it was not an impossible task. With an investment of a small amount of time, effective relationships could be built up between prisoners and personal officers. Furthermore, several staff told the investigators that A wing, where the man was located after he was discharged from healthcare, had a more stable prison population than other wings due to the type of prisoners generally located there.

128. The man was verbally assigned Officer A as a support officer on 22 July. This was recorded on NOMIS on 3 September. Officer B was verbally appointed as a back up officer on 1 August, although this was not documented.

129. Officer A and Officer B demonstrated a high level of commitment to their role as support officers and the man clearly seems to have trusted Officer A particularly, remarking he was his "friend". A number of staff told the investigators how much effort they felt these officers and others had put into trying to alleviate the man's fears and help him settle in the prison.

130. Unfortunately, on 10 September, Officer A unexpectedly went on sick leave and did not return before the man died. On 20 September, Officer B moved to another area of the prison and was not replaced on A wing. Although Officer C was appointed on 22 October as the man's support officer, he was on annual leave at the time and never had the chance to meet him in this capacity.

131. It is regrettable that for the first two weeks the man was in prison and the last seven weeks of his life, he did not have access to a support officer. As will be discussed further in this report, the latter period coincided with a time when healthcare services also overlooked him. Much work had been done to support the man by Officer A and Officer B, such that to a certain degree he trusted them. The man seems to have been a prisoner who required this extra level of support before he would talk to or trust staff.

132. Until he was interviewed as part of the investigation, Senior Officer D was unaware that the man did not have a support officer for the last seven weeks of his life. He said that usually, when an officer is moved from A wing to another part of the prison, a replacement is provided. On this occasion it did not happen and there was no system to ensure he was allocated an alternative officer. Senior Officer D admitted during interview that the lack of a support officer for the man was an oversight.

133. Both HM Chief Inspector of Prisons and the IMB found that, although there was a written support officer scheme at Leeds, it was not operating effectively. Furthermore, following self-inflicted deaths at Leeds in June and September 2007, the Ombudsman recommended that the Governor review the support officer scheme to ensure support officers are able to perform their duty fully and to ensure that contact is made with prisoners at least monthly and that this is recorded. Leeds accepted these recommendations and, as of May 2009, indicated they had been implemented, adding that the support officer scheme now required weekly contact with prisoners. I again make the following recommendation:

The Governor should again satisfy himself that the support officer scheme is operating effectively and in accordance with the local protocol.

Record keeping

134. Aside from the gap in allocating the man a support officer, there are only three entries on NOMIS for the entire time he was at Leeds. One of these notes his ACCT had been closed, another is from the MHIRT and the third was entered by a Senior Officer stating that no personal officer entries had been completed. It was not recognised at the time that the man did not have a support officer.

135. The support officer policy at Leeds requires those undertaking the role to make an entry in NOMIS at least once a fortnight, but also when there are any significant events. It is the responsibility of senior officers to conduct regular checks that the entries are being made and principal officers should also make monthly checks. There should be a monthly meeting between the residential governor and principal officers to ensure the scheme is running effectively, which should also be recorded on NOMIS. Aside from one management check, there is no evidence that this was completed in the man's case.

136. All of the senior officers interviewed recognised that, since computerised entries on NOMIS had replaced handwritten wing history sheets, it had been more difficult for staff to make regular entries about a prisoner. This was for a number of reasons.

137. There was a shortage of computer terminals on A wing, with three available. However, officers explained that one was mainly used by the senior officers and another was used for movements. It was therefore often difficult to gain access to a terminal and staff would have to wait. Senior Officer D said that A wing in particular had fewer computer terminals than the rest of the prison. He did not know why this was the case. Such a situation is clearly not conducive to keeping contemporaneous records on prisoners.

138. Some staff also said that they did not think there had been adequate training on NOMIS, with officers having to learn as they used the system. This is clearly more difficult for staff who are not computer literate. Senior Officer D

said that personal officer duties were often the first duty to be removed when staffing levels are short. This, in turn, would impact on the number of support officer entries logged onto NOMIS.

139. Senior Officer C said that realistically, the man was likely to be one of around 60 prisoners on a landing and therefore every piece of work which was done with him could not be documented. Senior Officer C indicated that managers are expected to check ten per cent of support officer entries in healthcare. He also said there would be more opportunity for staff in healthcare to access NOMIS, since there are more terminals per staff member and fewer prisoners to supervise. However, this is not reflected in any increase in entries while the man was located in healthcare.

140. Officer A said he had made efforts to log onto the system but had been unsuccessful. He recognised that he had therefore not added any entries to the system. The officer said when the man was subject to ACCT procedures he would record information in the handwritten observation sheets. However, when it was closed, he seems to have stopped recording information about his interactions with the man.

141. It is not only support officer entries which are missing from NOMIS. There is also virtually no information regarding significant events and assessments in the man's record. For example, he was due to attend court the week commencing 26 October, an event that was likely to be of concern to the man and potentially relevant to his subsequent death.

142. When shown the NOMIS entries for A wing, Senior Officer D commented that they were inadequate. Senior Officer C acknowledged that he could have documented the man's support plan on NOMIS as well as the conversations he had with Senior Officer D regarding his transfer back to A wing. Officer B said that, whilst he was aware of a support plan to integrate the man from healthcare to A wing, he had not been told the details. However, he said he knew Officer A had been given the information and, had he wanted to, he could have found the details. He also acknowledged that both he and the SOs involved could have been more proactive in sharing this information. However, he said he thought staff use and knowledge of the system were improving all the time.

143. I therefore make the following recommendation:

The Governor should ensure that staff have received adequate training on NOMIS, are allocated adequate time to make entries regarding a prisoner, that sufficient computer terminals are available on each wing to facilitate this and that the required management checks and reviews are completed.

The man's mental health reviews

144. He was originally assessed by Nurse B on 10 July, two days after his reception into prison. She referred him for a review with a psychiatrist. As a result of this referral, the man had an appointment with Nurse C of the MHIRT nearly a week later. Since Doctor B was on annual leave at the time, Nurse C made the decision that the man did not urgently need to see the covering psychiatrist and that the care he was receiving as a result of being subject to ACCT procedures was sufficient at the time.

145. The man was subsequently admitted to healthcare on 5 August. He did not see Doctor B as part of his ward round on 12 August due to the prison being on patrol state over lunchtime and therefore the first input a psychiatrist had into the man's care was on 19 August, six weeks after his reception into custody. Doctor B concluded that, "I don't believe this delay contributed to the man's death, however it was a missed opportunity to engage with him promptly." It also seems that this delay was considered and had the man been assessed as a priority, this psychiatric assessment would have occurred sooner.

146. Doctor B comments that:

> "Throughout the early stages of his imprisonment the man received a high standard of care at HMP Leeds. The nurses and doctors including the psychiatrist made thorough assessments of his condition and constructed a sensible care plan. Their use of medication was judicious and appropriate. The opportunity to formally assess his mental state in the prison hospital was sympathetic and caring. Doctor B the psychiatrist was able to see him on three occasions and form a sensible reasoned opinion that he was suffering from an acute stress disorder and that he was not suffering from a formal mental illness such as a psychosis, depression or organic brain disorder."

However, Doctor B also believes that a formal depression assessment could have been completed, as could an assessment of personality disorder.

147. Furthermore, Doctor B says:

> "There is also clear evidence that communication between the primary care and prison in-reach mental health teams was of an insufficient standard. Planned meetings when cases should have been reviewed had fallen by the wayside and as such opportunities to discuss the man's case and his disabling anxiety were missed."

148. I therefore endorse Doctor B's recommendation that:

The head of healthcare ensures there is improved continuity care provision by the in-reach team and better communication with the primary care team. This may be facilitated by a regular minuted meeting for case reviews attended by nurses, doctors, chaplaincy, psychology and wing officers where appropriate.

Prescription of olanzapine

149. The man had been prescribed olanzapine while in healthcare. Following his discharge and transfer to A wing, Doctor C prescribed a further 28 days of medication. Doctor C said this was at the request of Doctor B, which Doctor B denied was the case. Furthermore, it seems, from the prescription chart, that the man never took this medication. There is no record as to whether this was because it had not been offered to him, or if he had declined to take it.

150. On this occasion, there seems to be a lack of clarity in communication between the two doctors. It is also apparent that recording of whether a prisoner takes their medication or has at least been offered it needs to improve. I therefore make the following recommendation:

The head of healthcare ensures that if a doctor prescribes at the request of another, they ensure that the prescribing doctor's signs the original prescription. In addition, it should be recorded on the prescription if the prisoner does not receive or refuses their medication.

Referral back to primary care

151. Following the man's discharge from healthcare and return to A wing, he remained on the MHIRT's caseload. On 21 September, Nurse C indicated that due to the man's lack of engagement, he discharged him from his caseload and intended to refer him back to primary care. Due to an oversight on Nurse C's part, this referral did not take place. As a result, the man received no further psychiatric care or mental health support up until his death five weeks later.

152. This referral process has been reviewed by the Mental Health Team Co-ordinator since the man's death. He said that if Nurse C had completed the referral correctly, he would have expected to receive a referral letter himself via the internal mail. He would then have acknowledged this by placing an entry on System One.

153. A weekly single point referral meeting was set up three years ago which included primary care, MHIRT, a counsellor, a chaplain, probation and CARAT. This meeting had not been utilised as intended and referrals often bypassed the meeting, either being sent through the internal post (as would have been the case for the man) or directly between prison officers to the MHIRT.

154. All prisoners initially see primary care, who make their assessment and either continue to see the prisoner or refer them on to another service. If referring the prisoner, this would happen at the single point referral meeting. Similarly if a prisoner is being referred between services or back to primary care this should occur through the parties present at the meeting. This allows for all referrals to be documented through both meeting minutes and the template used for referrals at the meeting and should avoid any referrals being omitted. Since the man's death the importance of all referrals occurring via meeting has been re-emphasised.

155. However, even after the re-introduction of this system, some staff, including Nurse C, were not aware of the necessity of using this single point referral meeting. I therefore make the following recommendation:

The head of healthcare should ensure all staff are aware of and utilise the single point of contact meeting for referrals to medical and mental health services.

Use of System One and medical record keeping

156. Some of the man's medical notes were recorded electronically on System One. This had been installed at Leeds shortly before he arrived. However, not all of the man's interactions with healthcare professionals are recorded on System One. For example, the first assessment of the man by the MHIRT on 16 July is contained within the ACCT observations record. Nurse C also told the investigator this would have been recorded in the mental health file, although the investigator did not have access to this.

157. Other notes, such as those of the psychiatrist, Doctor B, are also handwritten and kept separately in the healthcare department. Although other records while the man was in healthcare are also handwritten, the majority (but not all) of these are also summarised on System One.

158. The Clinical Reviewer commented:

> "The overall standard of hand written notes in the IMR appears to be high. The various prison teams ie primary care, in-reach and security appear to be far less comfortable with the electronic note keeping systems. The health care teams had recently started using System One which had replaced Egton Medical Information System (EMIS) whilst the security team had recently started using NOMIS. Many of the staff interviewed acknowledged their difficulty in using these new systems and hence their reluctance to keep them contemporaneously and accurately up-dated. As such, key information regarding internal prison referrals for the man and relevant stressful life events such as his mother's funeral may not have been recorded in the detail which they would have been using the previous systems. This may have contributed to the man essentially being lost to follow-up for over a month."

159. The Mental Health Team Co-ordinator said staff's use of System One was not satisfactory. The system enables users to double check any referrals as they appear in a type of inbox in the form of tasks. This provides an auditable trail for all referrals and forces users to acknowledge all tasks received. Ultimately, he was aiming for a paper free system including the use of System One in meetings to avoid duplication of work. Additional training was provided for staff in January 2010 to improve their knowledge and confidence with the system.

160. Both Doctor C and Doctor B felt that use of System One had improved since the man's death. Doctor B commented that he now enters a summary of his assessments on the system, as well as keeping his handwritten notes. Doctor C told the investigators that prison healthcare is now monitoring its performance by the quality and outcomes framework which is used in the community. This has also shown an improvement in healthcare and staff having increased confidence in using System One.

161. I have made recommendations following previous deaths at Leeds regarding the need for centralised and contemporaneous medical record keeping. I again make the following recommendation:

The Governor and head of healthcare should ensure that all medical staff are using System One to record their assessments, interactions and referrals for prisoners.

The location of the emergency bag and defibrillator

162. It took 14 minutes from when the man was discovered for staff to get the defibrillator to his cell. Nurse H had looked in the cupboard where the emergency equipment is usually kept on his way to the man's cell. Since it was not there, he assumed the equipment was already at the scene. As indicated, this was not the case and the emergency bag was being restocked in the pharmacy. Nurse H therefore went back to get a defibrillator from another wing. He told the investigators that he discussed this with the Health Care Manager the next day, since he felt it was unacceptable that there was no easily accessible defibrillator and emergency bag.

163. The Health Care Manager told the investigators that the emergency bag was normally located in a treatment room central to wings A, B, C and D. When the bag needed restocking, or the seal was broken it was taken to the pharmacy. During the weekly check on the morning of 27 October, the bag's seal was found to have been broken and it was therefore taken to the pharmacy to be resealed. Therefore when the emergency with the man occurred, the bag was not in the central treatment room and staff could only take very basic equipment with them to the emergency. A member of staff called the pharmacy who brought the emergency bag to the scene as quickly as they could.

164. The Health Care Manager, who began working at Leeds in June 2009, said that before the man's death she had been in the process of reviewing the

contents and use of the emergency bag, as well as all emergency procedures. As a result of the man's death, she immediately revised the process for restocking the bag so that it now never leaves the central treatment room and is restocked and resealed there. Therefore the emergency bag should now always be available and accessible.

165. In addition, the Health Care Manager said that she and the Primary Care Team Co-ordinator, were in the process of revising the emergency procedure folder. This includes handouts for trainees, details of the equipment, checking procedures and the list of trained staff. Their aim is to put together one standardised folder which can be distributed so that all relevant staff are aware of the emergency procedures.

166. Both members of staff were also revising the contents of the emergency bags since each one weighed 12kg which they believed was too heavy to carry to an emergency. They are considering having a lighter first response bag, containing only critical equipment, with a secondary bag available to be taken to the scene of an emergency.

167. There also seemed to be a lack of clarity amongst staff about who would bring the bag to the scene of an emergency. The Primary Care Team Co-ordinator, said that he believed Hotel 3, the first responder, should pick up the bag on the way to the scene. However, the Health Care Manager believed that Hotel 3 should get to the scene as quickly as possible and those following should get the emergency bag. Nurse H did not believe there was a prescriptive instruction to say that if a code blue was called over the radio that the emergency bag would automatically be taken by any member of staff. As a result of the man's death and our investigation, the Health Care Manager said that this would be clarified and communicated to staff.

168. Given the recent changes which have been made by the Health Care Manager and the healthcare team with regard to the location of the emergency bag and the review she is currently completing of the responsibilities of those responding to an emergency, I do not make a formal recommendation in this regard.

Request for an ambulance

169. It has been a requirement since September 2004 that each governing Governor ensures their prison has a protocol in place with their local ambulance service. A letter from the Department of Health to Prison Service Governing Governors, dated 22 March 2004 noted:

> "internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the healthcare team to attend the scene before emergency services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 cal has been made, a member of the

healthcare team arrive with the patient and deem that an emergency ambulance response is not required."

170. The protocol which Leeds has in place with West Yorkshire Ambulance Trust makes reference to the above direction. However, it says that it is healthcare staff rather than those first on scene who should make the decision about whether an ambulance is called. The protocol also states that the details which should be provided to the ambulance service are the age of the patient, their state of consciousness, details of their breathing and whether they have undergone a cardiac arrest.

171. The Health Care Manager said that Leeds followed what she believed to be NOMS' policy, that an ambulance could only be requested by a member of healthcare. Other staff, including those responding to the emergency with the man also expressed the same view. However, Senior Officer D agreed that, while he would normally expect this to be a healthcare decision, he would allow discipline staff to make the request if they had the necessary expertise.

172. The Health Care Manager told the investigators that she was in the process of reviewing who could call an ambulance with Leeds' senior management to find out, if the need for an ambulance is obvious, whether this request could be made by staff other than healthcare. The Health Care Manager believed that a clear call should be made to control as quickly as possible with the relevant details. Clearly the above instruction from the Department of Health indicates that this should be the case.

173. On this occasion, the Health Care Manager thought that Nurse F had asked whether an ambulance had been called and then Nurse H also checked and put another call over the radio to ensure that it had. Nurse H confirmed that he had radioed for an ambulance. It is unclear whether this was the second request for an ambulance as Leeds were unable to provide the control log for 27 October. In any event, the incident log shows that it took six minutes from the discovery of the man for an ambulance to be requested by the control room. It seems reasonable that those officers first attending the scene could have made this request immediately, once they had quickly determined there had been a hanging and the man was not breathing. The Clinical Reviewer is in agreement with this opinion.

174. Nurse H said that in his request for an ambulance, he had not told the control room a hanging had taken place. If paramedics had known, they would have brought spinal boards to the scene. It was clear to the investigators that Nurse H had clearly reflected on his own role in the emergency and how he could improve his part in responding in the future. He commented that he would need to be clearer with the information communicated to control. Healthcare managers are also reviewing the information given to the emergency services when an ambulance is requested. I therefore make the following recommendation:

The Governor and Head of Healthcare should review the existing protocol with West Yorkshire Ambulance Trust to ensure it complies

with the Department of Health's guidelines regarding requesting an ambulance and is clear about information which should be given to the emergency services.

First Aid training

175. I am satisfied that the handling of the resuscitation attempts in the man's case were appropriate and in line with current guidelines issued by the Resuscitation Council. Staff should be commended for their concerted and professional efforts to revive the man.

176. Officers who had been present at the emergency but not involved in the attempted resuscitation said they would have felt confident to help if required. These officers had been trained when they first joined the Prison Service but had not received any refresher training since and did not know the current recommended compression to breaths ratio of 30 to 2.

177. The Health Care Manager said that healthcare staff cannot train all prison staff in first aid and resuscitation, since the numbers are too great. She provides CPR training for the PCT staff. I therefore make the following recommendation, which is also endorsed by the Clinical Reviewer:

The Governor should consider ensuring that all prison staff receive CPR training, such as Heartstart, on an annual basis

CONCLUSION

178. The man was on remand in Leeds prison for over three months for allegedly assaulting his mother who subsequently died. He had made an attempt on his life at the time of the offence and was subject to suicide prevention measures for over a month after he arrived at Leeds. He was assessed by several mental health professionals, including a psychiatrist, who all believed he was suffering from anxiety rather than a severe mental illness.

179. The man did not cope well in the prison environment, rarely coming out of his cell and remaining fearful throughout that he would be attacked by other prisoners. He was also struggling to come to terms with the offence with which he had been charged and felt he would die in prison either due to the length of sentence he received or at the hands of other prisoners. Staff admirably tried to lessen the man's fears and rationalise his anxieties but he did not believe anyone could help him. They found no substance to his claims that he would be attacked by other prisoners.

180. This report makes recommendations for potential improvements in record keeping and the effect that this can have on the continuity of care a prisoner receives. It is of particular regret that for the last month of his life, through separate oversights by the MHIRT and senior officers on A wing, the man had neither a support officer nor any mental health intervention. Despite this, staff on the wing and in safer custody believed he had started to show small signs that he was settling at the prison during his final weeks. However, in the week that he was due to appear back at court he was found hanging in his cell.

RECOMMENDATIONS

1. The Governor should satisfy himself that the support officer scheme is operating effectively and in accordance with the local protocol.

   This recommendation was accepted. Terms of Reference for a review of the support officer scheme have been drafted. A member of the senior management team is being assigned to complete the review. Head of Residence to follow up recommendation from the review.

2. The Governor should ensure that staff have received adequate training on NOMIS, are allocated adequate time to make entries regarding a prisoner, that sufficient computer terminals are available on each wing to facilitate this and that the required management checks and reviews are completed.

   This recommendation was accepted. Staff were trained on CNOMIS as part of the implementation process. A review of CNOMIS training to be carried out to identify any staff who have not received this training. A review is held on a quarterly basis to identify the needs of the establishment, recalling and relocating as appropriate to the need. Management checks are carried out on CNOMIS case notes.

3. The head of healthcare ensures there is improved continuity care provision by the in-reach team and better communication with the primary care team. This may be facilitated by a regular minuted meeting for case reviews attended by nurses, doctors, chaplaincy, psychology and wing officers where appropriate.

   This recommendation was accepted. Weekly single point referral meeting. Open to all staff but regularly MHIRT, Primary Care Mental health, Counsellor, CARATs and Probation. Notes taken and available.

4. The head of healthcare ensures that if a doctor prescribes at the request of another, they ensure that the prescribing doctor's signs the original prescription. In addition, it should be recorded on the prescription if the prisoner does not receive or refuses their medication.

   This recommendation was accepted. All prescription medications are entered on system 1. Notes are made in the patient's medical record by staff if medications are not received or if the patient refuses. On refusal of medication a disclaimer is completed by the patient for his record.

5. The head of healthcare should ensure all staff are aware of and utilise the single point of contact meeting for referrals to medical and mental health services.

   This recommendation was accepted. Most referrals are tasked from system 1. Primary Care Mental Health assess and if necessary will then take forward to a single point.

6. The Governor and head of healthcare should ensure that all medical staff are using System One to record their assessments, interactions and referrals for prisoners.

   This recommendation was accepted. System one is now sited in all clinical areas and all staff are trained. There has been an increase in referrals using the system and individuals identified through audits as poor record keepers will be sign posted to record keeping training.

7. The Governor and Head of Healthcare should review the existing protocol with West Yorkshire Ambulance Trust to ensure it complies with the Department of Health's guidelines regarding requesting an ambulance and is clear about information which should be given to the emergency services.

   This recommendation was accepted. This is currently under review between the Prison, Healthcare and West Yorkshire ambulance service.

8. The Governor should consider ensuring that all prison staff receive CPR training, such as Heartstart, on an annual basis.

   This recommendation was not accepted. HMP Leeds fully complies with the Health and Safety (First Aid) Regulations 1981 meeting. ACOP ratio of 1 trained first aider to every 50 workers during the main core day. It operates a nominated person scheme during the night. PCT provide 24 hour nursing cover

FAMILY RESPONSE

The man's relative received the draft report and did not offer any comment prior to the publication of the final report.