Investigation into the circumstances surrounding the death of a man at HMP Leicester in February 2011

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This report considers the circumstances surrounding the death of a man at HMP Leicester in February 2011. He was found hanging in his cell shortly before 9.00am. He was 34 years old at the time of his death and had been on remand for almost a year. I offer my sincere condolences to his family and all those who knew him

The investigation was conducted by a senior investigator. The Governor of Leicester and her staff co-operated fully with the investigation. A review of the man's clinical care was provided by a clinical reviewer on behalf of the local PCT. I apologise that the report has been delayed.

The man was first remanded to Leicester on 31 March 2010. Prison staff often found his behaviour difficult to manage. He flooded cells, destroyed property, and on one occasion set a fire inside his cell. He spent a good deal of his time in the prison's segregation unit. On three separate occasions while at Leicester, he was subject to self-harm monitoring procedures. In January 2011, he was transferred to HMP Lincoln. At Lincoln he was again subject to self-harm monitoring after making cuts to his hands and wrists. On 14 February, he returned to Leicester and the monitoring continued until 24 February. He died several days later.

The investigation identifies weaknesses in self-harm prevention measures and makes recommendations accordingly. It is also clear that clinical diagnoses regarding the man's mental health differed and that continuity of care between prisons was poor and, again, improvement is called for. However, it is not possible to say that these issues affected the outcome in this sad case. Recommendations are also made regarding electronic record keeping and access to smoking cessation treatment. Finally, the report concludes that HMP Leicester was less supportive than we would expect to his family and recommends an apology and better family liaison arrangements in future.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2012**

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SUMMARY

1. The man was remanded to HMP Leicester on 31 March 2010 after being arrested for a number of alleged offences. There were no immediate concerns about his mental health or about suicide and self-harm. Around a week after his arrival at Leicester, he flooded his cell and was removed to the prison's segregation unit. He said he was having trouble sleeping and a doctor prescribed sleeping tablets. He was released on bail and then remanded to HMP Hewell, before returning to Leicester on 19 April 2010.

2. The man was taken to the segregation unit on 24 April after smashing the television in his cell. The same day, he was subject to self-harm monitoring after banging his head against the wall of his cell. Four days later, he flooded his cell in the segregation unit. On 30 April, he assaulted a prison officer. A number of officers described him as a difficult individual who displayed destructive and sometimes aggressive behaviour.

3. On 3 May, the man was again subject to self-harm monitoring after he said he felt suicidal. During the rest of May, he saw mental health nurses and doctors, and had regular reviews with members of staff about his risk of harming himself. The self-harm monitoring ended on 29 May.

4. The man continued to display challenging behaviour during May and June. He smashed a television and barricaded his cell to refuse members of staff access. As a result, he spent much of his time in the prison's segregation unit.

5. Prison officers began to notice the man behaving in an unusual and paranoid way. He claimed that he was being watched and that people were communicating with him through the television. He repeated this to a mental health nurse on 10 August. Later that month, he set fire to clothing on his bed and stacked furniture against his cell door to prevent staff entering.

6. On 29 August, the man saw a mental health nurse who did not consider that he was suffering from a mental illness and concluded that he did not require ongoing mental health support. A different mental health nurse reached the same conclusion the next day.

7. During September, there were only minor concerns about the man's behaviour. In early October, he was involved in a fight with another prisoner. Although he spent much of October to mid-December in the segregation unit, there were no major concerns about him, and he saw members of healthcare staff regularly.

8. On 14 December, the man was convicted of one offence but remained on remand for others. The next day, he made a small cut to his left wrist. He was made subject to self-harm monitoring. An assessment was completed and he saw a mental health nurse, but the self-harm monitoring ended the same day.

9. Between late December 2010 and 8 January 2011, the man was seen regularly by healthcare staff and did not report any issues. On 10 January, he was transferred to HMP Lincoln.

10. On 4 February, while at Lincoln, the man saw a consultant forensic psychiatrist who completed a report for the court. The psychiatrist concluded that he seemed to be suffering from either a delusional disorder or paranoid schizophrenia. He suggested that he might need to be hospitalised rather than serving a prison sentence, and recommended follow-up with the prison's regular psychiatrist.

11. After meetings with a mental health nurse on 7 and 10 February, the man was referred for an appointment with Lincoln's psychiatrist. On 12 February, he made cuts to his hands and wrists using a razor. He was again made subject to self-harm monitoring and saw a mental health nurse. An appointment was arranged for him to see a psychiatrist on 14 February, but he was scheduled to appear in court on the same day and so was unable to attend the appointment. After court, he returned to HMP Leicester rather than Lincoln and no alternative appointment was made.

12. When he arrived at Leicester, the man said he felt unsafe in the prison and requested segregation for his own protection. This was agreed, but the dedicated vulnerable prisoner unit was full and he was located in an annex to the first night centre.

13. Between 14 and 24 February, three self-harm monitoring reviews were held. Mental health nurses were present at two of these reviews, but it is not apparent that the nurses took into account the information from his medical records when he was at Lincoln. He was not seen by a psychiatrist. The self-harm monitoring ended on 24 February and the case manager wrote on the review form that he seemed much more settled and said he had no intention of harming himself.

14. One morning several days later, the man was found hanging in his cell. The emergency response was swift. Several officers and nurses entered the cell almost immediately, and a resuscitation attempt began. Paramedics arrived at the prison within a few minutes. The resuscitation attempt was ultimately unsuccessful and he was pronounced dead at 9.11am.

15. The investigation has looked into the self-harm monitoring process, the mental health intervention that the man received, provision of smoking cessation treatment, the emergency response, record keeping, and issues raised by his family. We make five recommendations and endorse one more made by the clinical reviewer. The recommendations about information sharing and the consideration of all available information during self-harm monitoring are of particular importance.

THE INVESTIGATION PROCESS

16. An investigator was appointed to conduct the investigation. Notices of the investigation were sent to the prison for distribution and display, giving staff and prisoners the opportunity to contact him with any relevant information. Nobody came forward in response.

17. The investigator visited HMP Leicester to open the investigation on 4 March 2011. He met the prison's liaison officer and a number of other staff members. The liaison officer provided copies of documents relating to the man's time in custody. The investigator visited the prison's main wing, and the first night centre and its annex.

18. Further documentation was provided about the man's short stay at HMP Lincoln during early 2011.

19. As part of the investigation, the investigator interviewed 12 members of staff at HMP Leicester. The interviews were recorded.

20. A nurse saw the man on several occasions at Leicester because of concerns about his mental health. She was not interviewed as she had retired and moved away from the area.

21. One of our family liaison officers (FLOs) contacted the man's wife, from whom he was separated, to explain the purpose of the investigation and provide his family with an opportunity to raise any questions about the care that he received in prison. When speaking to the FLO, she said she found it hard to understand his actions because of his Catholicism and strong belief that suicide was a sin. She said that his parents and brother had suffered from schizophrenia, and she thought he might also be schizophrenic. She told the FLO that, when she went to visit him, he was often paranoid and erratic and believed that people were coming out of the television and that there were spies in the prison watching him. She also said that he was concerned about taking medication as he had not liked the way it had affected his brother.

22. In terms of the man's time in custody, his wife was concerned about:

- The mental health intervention that he had received in prison and its appropriateness.
- The medication that he was prescribed for mental health issues.
- Bruising to his face and body when she saw him in the chapel of rest.
- His clothing being destroyed despite assurances from the prison that it would be returned to her.
- Delays in the return of some of his property.
- The possibility that some items of his property were not returned to her.
- A letter that she received from him, in which he explained that he had revealed some personal information to other prisoners at HMP Lincoln, but regretted disclosing the information because the prisoners were making his life difficult.

23. We have done our best to answer the family's questions in the report, which we hope will help them understand better the circumstances of the man's death.

24. The local PCT appointed a clinical reviewer to conduct a clinical review into the man's care in custody. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be of an equivalent standard to what might have been expected in the community. The clinical reviewer had access to the man's medical records and to the transcripts of the interviews conducted by the investigator. The final version of the clinical review was provided to the investigator in February 2012. The findings are summarised in this report. We apologise for the resultant delay in the issue of this report.

Responses to the draft report

25. As part of the consultation period, a draft version of this report was considered by the man's family, and by the National Offender Management Service (NOMS) and HMP Leicester and HMP Lincoln.

26. The man's wife said she thought it was very clear from his letters that he had problems with mental health, and questioned why this was not picked up by the prison. She also said that she told members of staff at HMP Leicester about him being unwell and about the family's history of schizophrenia, but felt that nobody was prepared to listen.

27. She felt that there was a clear failure in information sharing between Lincoln and Leicester which contributed to what she referred to as unsatisfactory monitoring at Leicester.

28. The family remained concerned about what happened to a large number of letters that the man's daughter sent to him. As mentioned in the report, a relatively small number of possessions were listed on the cell clearance certificate after his death. Therefore, it is not possible to explore this issue further.

29. The man's wife wanted to express in the report her dissatisfaction with the way in which HMP Leicester handled the issue of a letter that he left in his cell. She said that the prison told her there was no letter, and she only learned of its existence when reading the draft version of this report. She felt that she should have been made aware of this much sooner, particularly as the letter was addressed to his daughter. She said this issue had prolonged the grieving process for his daughter.

30. She said an apology from the prison would mean very little to the family, particularly as it would be done only in response to a recommendation in this report, rather than out of a genuine sense of regret.

31. HMP Leicester, via NOMS, pointed out a number of factual inaccuracies in the draft version of this report. These were corrected and additional information

was provided where necessary to clarify particular points. All of the recommendations were accepted or partially accepted and the responses to them can be found at the end of the report.

32. There was fundamental disagreement between the man's family and HMP Leicester about certain aspects of the family liaison, particularly in terms of his clothing and rosary beads. The man's wife said the prison told her that they had destroyed some of his clothing. The prison said that this was not the case, and that all the clothing from his cell was returned to the family, along with his property. With regard to the rosary beads, the prison said that after attempting unsuccessfully to retrieve them from Leicestershire Police, the family liaison officer tried to suggest alternatives, such as having a new set blessed by the prison chaplain.

33. With such conflicting accounts, it is unfortunate that we are not able to resolve these remaining issues.

HMP LEICESTER

34. HMP Leicester is a mostly Victorian prison about half a mile from Leicester city centre. It operates as a local prison for adult males, meaning that it accepts new prisoners from the local courts. The main residential wing is a long rectangular cell block with four landings. Other areas, such as a vulnerable prisoner unit, segregation unit, and first night centre, are separate from the main residential area but housed in the same building. The prison has the capacity for 392 prisoners.

35. Healthcare at the prison is provided by a private company. An integrated team provides both primary and secondary mental health intervention. The primary mental health team addresses issues that arise unexpectedly, as well as treating problems such as depression, anxiety or general low mood. The secondary mental health team, sometimes called the in-reach team, works with those who have a more serious or enduring mental illness and those with specific, more onerous needs. When working with the secondary team, prisoners will usually be part of a caseload and seen at regular intervals.

Her Majesty's Inspectorate of Prisons

36. The most recent inspection of HMP Leicester was conducted in October 2010. This was an unannounced follow-up to a full inspection that had taken place in June 2008. The Chief Inspector of Prisons wrote in his introduction to the report that the prison was generally safe, and that there were good relationships between prisoners and staff. He noted that Leicester was a small, complex local prison which had to address the many risks and needs posed by a transient population in an ageing and inadequate physical environment, and was performing reasonably well against the Inspectorate's tests.

37. The inspection noted that while some vulnerable prisoners were held in the first night centre and could join those on the dedicated vulnerable prisoner unit for association and exercise, association only every other day, and work opportunities were very limited. Vulnerable prisoners were one of the groups most likely to lose out when there were staff shortages.

38. The Inspectorate reported that the documents used to monitor prisoners believed to be at risk of self-harm demonstrated good care, but few reviews were multi-disciplinary. Mental health services had improved from previously.

Independent Monitoring Board

39. All prisons have an Independent Monitoring Board (IMB) made up of volunteers from the local community. IMBs must satisfy themselves as to the humane and just treatment of people in custody, and they report to the Secretary of State for Justice annually. In the report that covered February 2010 to January 2011 the IMB reported that purposeful activity for vulnerable prisoners had increased. The Board was concerned about the number of

prisoners at Leicester suffering from mental health problems but spoke highly of the support staff gave to men at risk of suicide and self-harm.

Previous deaths at HMP Leicester

40. This office has been responsible for investigating deaths in prison custody since April 2004. Before the man's death, we have investigated 12 self-inflicted deaths at Leicester. Two of these occurred in 2004, two in 2005, one in 2006, four in 2007, one in 2008, and two in 2009. After deaths in 2008 and 2010, we made recommendations about the proper and effective use of computerised clinical records. It is disappointing that we have to refer to similar issues in this report.

KEY EVENTS

41. The man was remanded to HMP Leicester on 31 March 2010 after being arrested for a number of alleged offences. It was his first time in prison custody. A short medical assessment for all new prisoners, known as a reception health screening was carried out by a nurse, who recorded on the electronic clinical record that the man did not report any major health issues. He was physically well and suitable for work and for location in a normal cell. He said he had previously been prescribed diazepam (a medication used primarily for treating anxiety). He did not have any thoughts of self-harm or suicide.

42. As part of the reception process a cell sharing risk assessment (CSRA) is carried out to identify any potential dangers with prisoners sharing cells. The man was assessed as a low risk for sharing.

43. On 7 April, the man appeared at Court through a video link from the prison. On the same day, he was removed to the prison's segregation unit after flooding his cell. He was seen by a nurse, who recorded in the clinical record that he was fit for cellular confinement.

44. The man was briefly released on bail, but was again remanded in to custody on 16 April, this time to HMP Hewell. The reception health screening was completed by a nurse, who recorded no major issues. He said that although he had no thoughts of suicide or self-harm, he had been seen by the mental health crisis team in the community, in January the same year. He had been discharged the following day and prescribed diazepam.

45. On 17 April, the day after his arrival at Hewell, he saw a nurse for a mental health assessment. She recorded that he was "very much full of his own self-importance". She found no evidence of psychosis or problems with his mood. He had previously been prescribed citalopram (an anti-depressant) and zopiclone (a medication to help sleeping) as well as diazepam, but had stopped taking them because he did not feel any benefit. She concluded that no further action was necessary and that he was aware of how to contact mental health services in prison should he need to do so.

46. The same day, the man saw a prison GP. He said he wanted help sleeping. He said he was "in a mess" because of problems in his personal life. The doctor prescribed 7.5mg of zopiclone daily.

47. On 19 April, an officer recorded in the man's adjudication record that on the same day, he disobeyed the rules by climbing across the safety netting to reach the other side of the wing.

48. The man attended Magistrates' Court on the same day, and was again remanded in custody. While at court, he told his solicitor that going to prison would kill him as he would be unable to smoke or get the medication he needed. These concerns were noted in the person escort record (PER). A note was also made that he did not make explicit threats to harm himself and,

when asked about his remarks, laughed and said he did not know why he made them.

49. Instead of returning to Hewell, the man went to HMP Leicester. A nurse noted on the 'information of special importance' card that he had arrived from court with a self-harm warning, and that he had been passed to another nurse.

50. A reception health screening was carried out by a nurse. Although there were no major concerns, the man said he felt quite low in mood. He told the officer completing his CSRA that he had a lot on his mind, did not sleep well, and became angry and frustrated. It was noted that he had previously flooded his cell. He was assessed as a high risk for sharing a cell sharing and was allocated a single cell.

51. Between 20 and 23 April, there were various discussions about his medication. On 20 April, he told a nurse that he had been prescribed zopiclone and this was confirmed by his GP in the community. However, the next day another nurse told him that it was not a repeat prescription, and that he would have to see the doctor. He saw a doctor on 23 April and was prescribed medication to help him sleep.

52. In the early hours of 24 April, the man was recorded as being verbally abusive to three different prison officers. At 5.20am, he smashed his television and the wardrobes in his cell. He was subsequently taken to the segregation unit. There was no further information in the records to suggest why he was abusive or why he caused damage to his cell.

53. At 9.00am on 24 April, he deliberately banged his head against the wall of his cell in the segregation unit, causing a superficial graze to his forehead. He told a nurse that he was "alright", and she decided that no medical treatment was required, but as he was continuously banging his head against his cell door an Assessment, Care in Custody and Teamwork (ACCT) document was opened. The ACCT process is used for prisoners who are at risk of self-harm or suicide and aims to provide additional monitoring and support in accordance with their needs during any perceived period of crisis.

54. An 'immediate action plan' was then formed. This is intended to cover the initial period of the ACCT (up to 24 hours), between the process being started and the prisoner being assessed by a trained member of staff. A Senior Officer (SO) wrote that the man was in a single cell, and was to be observed by members of staff five times every hour. He was also aware of means of support, such as using a telephone to contact the Samaritans, and seeing a Listener (a prisoner trained by the Samaritans to offer confidential peer support).

55. At 10.05am the same morning, a nurse saw him to conduct his assessment interview. He told the nurse that his alleged offences were "going round and round" in his head and that this was causing problems. He said that this was the reason he had smashed his television. He said that banging his head on the cell door was not an attempt at suicide but he had felt that the pressure

was building up inside him. The nurse noted that he appeared unsettled. When asked about any thoughts of suicide, he said he would not kill himself as it was against his religion. He said he had many reasons for living, including his step-daughter and his business. He also said he would feel better if he was allowed a radio and some tobacco.

56. An initial ACCT review was carried out at 11.15 the same morning. It was agreed at the review that although the man appeared to have anger management problems and was frustrated with his situation, he did not intend to harm himself. He was assessed as a low risk and the ACCT was closed, although he was referred urgently to the prison's mental health team.

57. At 4.13pm, a doctor saw him on the wing. He said he had lots of problems to think about and could not sleep. The doctor told him that his problems could not be solved by the prescription of sleeping tablets, and he agreed. He asked to be referred for smoking cessation treatment and the doctor agreed to add his name to the list.

58. The next day, a nurse saw the man during her visit to the segregation unit. She wrote in the clinical record that he was in a good mood and listening to music. On 26 April, a doctor saw him and prescribed zopiclone for two days.

59. On 27 April, a nurse saw him and did not report any medical concerns. On the same afternoon, a member of the healthcare team made enquiries about his mental health referral. He discovered that he had previously been referred by his GP, and that he was not considered suitable for intervention from the community mental health team. He was therefore added to the waiting list for mental health input from the prison's primary mental health team.

60. At 9.30pm on the same day, the man flooded his segregation unit cell, causing water to run on to the landing and into other cells. An officer, who recorded the incident on the electronic case notes (P-NOMIS), wrote that he seemed to think his actions were funny.

61. The next evening, he was seen by a doctor in the segregation unit. He said he was sleeping poorly, and would much prefer tobacco to night-time sedation. The doctor noted that because of his behaviour, location in the segregation unit and punishment including loss of canteen (the shop from which prisoners can order various items including tobacco) he was unlikely to be able to get tobacco for a while. She also noted that long-term prescription of night sedation was not an option.

62. On 30 April, a post-closure review of the man's ACCT took place. The purpose of a post-closure review is to examine the decision that was taken to close the ACCT, and to check whether the risk of self-harm has changed. The review was conducted by SO, with an officer and the man present but no healthcare representative. The review concluded that there was no reason to re-open the ACCT. He was said to be coping okay and in a positive mood, although he remained frustrated with his situation.

63. The same afternoon, the man assaulted an officer by “placing his hands aggressively on his shoulders”. He was restrained in his cell by officers until he became calm. A nurse attended but he declined a medical check. It was reported that he had two small bumps to his forehead and small scratches under his eyelid. It was not clear whether or not these injuries were sustained during the restraint. He was advised to inform officers if he felt unwell.

64. An officer who witnessed the assault against his colleague, told the investigator that the man behaved in a difficult and refractory manner from almost the beginning of his time at Leicester. He said he could be intimidating and aggressive and made threats to staff.

65. Another officer recalled the man in a similar way and said as he would not fit in with the prison regime he spent most of his time in the segregation unit. He described him as very demanding and constantly pressing his cell call bell for non-emergency matters.

66. The next day, a nurse saw him as part of her routine segregation unit rounds and reported no issues. On 2 May, he complained of neck pain. He said his neck had been in an awkward position the previous evening. He was given ibuprofen for pain relief.

67. Shortly after 10.30am on 3 May, a doctor saw the man as part of a routine visit to the segregation unit. He was outside on the exercise yard and trying to find tobacco from discarded cigarette ends. The doctor explained to him that she could not do anything about his tobacco problem because his canteen privileges had been withdrawn.

68. At 3.30pm the same afternoon the ACCT process was opened again as an officer wrote that the man “stated he feels suicidal … [and] that the reasons for these feelings are no visits, lack of tobacco, also lack of money”.

69. An ACCT assessment interview was carried out immediately by a nurse. She wrote that the man was tense and frustrated about complex issues around his offences, his family and his business. He said he found it difficult to sleep due to ruminating about his situation, and because he had no tobacco. He agreed that he was “doing things the hard way” but then angrily said he would continue to do so.

70. The nurse noted that he had not made previous suicide attempts, but during the interview made statements saying he wanted to be dead. She thought these feelings were a direct response to his frustration and ongoing issues. Despite the statements, he vehemently denied any intention to kill himself, again citing his religion. Although he claimed to be ill, she said there was no evidence of depression or low mood. She said that “he is tense, frustrated, worried and tends towards paranoid thinking which may or may not be rooted in fact”.

71. The nurse further wrote:

> "Generally discussed that his life in prison would improve if he could get out of segregation and stay out. He accepts that his behaviour has led to this but then became angry, pushed the chair and left."

72. An initial review of the ACCT was carried out at 6.00pm by several staff and the man. A SO wrote that the man said he was feeling more settled, and was writing a letter to his wife. He also said he had suffered a nervous breakdown the previous April. He went on to say that he was not coping well in the segregation unit. He was assessed as a raised risk of harm, and the ACCT remained open. A further urgent referral to the mental health team was made, and a further ACCT review arranged for the next day.

73. A nurse summarised the ACCT assessment and review in the clinical record, and wrote:

> "Presented initially as calm, almost charming. Said he would like to die but will not kill himself as he is Catholic. Gives reasons as having lost everything. His story does not hang together well. It is difficult to tell what is accurate. During interview he often stared at me intently and appeared to be 'weighing me up', for what is not clear. Tried some charm but quickly lapsed into agitation and frustration. Bottom line is he wants [sleeping tablets] and tobacco. Says he simply cannot cope without tobacco, he became angry, left the room, pushing the chair out of the way. ACCT remains open. No signs of mental illness – not low mood or depressed but rather irritated and tense, no sign or complaint of perceptual disturbance. Speech and thought content has definite paranoid flavour but not seemingly to a psychotic level."

74. The CAREMAP, part of the ACCT process, identifies issues, goals and action that is required. The SO identified a number of issues, including maintaining religious links and family contact, addressing possible mental health issues, reducing dependency on tobacco, and reducing in-cell boredom. Various actions were taken, including referring the man to the mental health team and for smoking cessation treatment.

75. A nurse saw him in the segregation unit the next day on the morning of 4 May. He did not voice any healthcare issues. The same afternoon, a doctor noted in the clinical record that sleep monitoring had been conducted for the previous three nights. On the first night, he had been awake from midnight to 6.00am. On the other two nights, he had only woken once during the night. Therefore, no medication was prescribed.

76. At 4.30pm, an ACCT review was conducted. This involved a SO, officer, the duty governor and the man. The SO wrote that the man said he was still low in mood. He wanted sleeping tablets and tobacco but understood they could not be facilitated. He said he would not hurt himself or attempt suicide due to his religious beliefs. He was assessed as a raised risk of harm. The ACCT remained open with a review arranged for 11 May.

77. On 5 May, the duty governor saw the man, who continued to be agitated about his health issues and the lack of tobacco. He was kicking his cell door and so his trainers had been removed. She spoke to the healthcare unit about smoking cessation. On the same day, a doctor said she would make him a priority for smoking cessation but was not convinced that he actually wanted to quit. Two days later, he told the doctor that he was sleeping slightly better. The doctor reassured him that he was a priority for smoking cessation but she was not sure when the next clinic was being run.

78. The man told a nurse on 8 May that he could not sleep during the day or night due to anxiety. Two days later, he told a doctor that sleeping tablets had been prescribed for the previous three nights. There was nothing in the clinical record to suggest that this was actually the case. The doctor did not prescribe any medication.

79. On 11 May, a further ACCT review took place. This was again conducted by a SO. The man and a nurse were also present. An officer from the unit was consulted before the review. The SO wrote that he said he had no intention of harming himself but sometimes felt anxious. He had received visits from family members, and had a radio in his cell. In general, he was keeping himself occupied but felt frustrated. He was assessed as raised risk, with the ACCT remaining open and a review arranged for 19 May.

80. The next day, the man appeared at Magistrates' Court using a video link from the prison. He was remanded in custody until 30 June and his case was committed to Crown Court for trial. A doctor saw him on the same day. He told her he expected to get tobacco later that day, and said sleep would not be an issue if he had tobacco.

81. On 14 May, he moved from the segregation unit back to normal wing accommodation. In the early hours of 17 May, he placed an obstruction against his door and refused to remove it. At 6.30am, a nurse was contacted by the night orderly officer (the person in charge of the prison overnight) after he asked for sleeping tablets and became irate.

82. At 3.57pm, the next afternoon a doctor wrote in the clinical record: "I see that the man was added to my clinic as an urgent [referral]. There is no point in this man seeing me to discuss sleeping tablets – we have discussed this many times before".

83. On 19 May, the man received a behaviour warning for the misuse of his emergency cell bell. This triggered a review of his privilege level in accordance with the Incentives and Earned Privileges (IEP) system. This system has three levels: basic, standard and enhanced. The default level for new prisoners is standard, and they can be promoted or demoted, gaining or losing privileges, according to their behaviour. As part of the review, an officer noted that he had been subject to four behaviour warnings, as well as numerous guilty adjudications for breaking the prison rules. Another officer added that he had no intention of following the landing regime, was aggressive and abusive to members of staff, had numerous negative entries

in his wing file, as well as behaviour warnings and adjudications. It was proposed that he would be demoted from the standard to the basic regime. There was no reference to the fact that he was subject to an open ACCT document.

84. The ACCT review that was scheduled for the same day was postponed because of other events in the prison. The review was carried out on 20 May and involved a SO, officer, nurse and the man. He said he continued to feel suicidal and had issues with his mental health and lack of tobacco. He explained that he barricaded his cell door because he felt frustrated. The ACCT remained open, with his risk level maintained at raised, and a review was arranged for 29 May. There was no evidence of any discussion around him being demoted to the basic regime and the implications that this might have for the management of his ACCT.

85. A nurse saw the man shortly after 1.15pm the next day, 21 May. He said he was depressed and that lots of things were wrong in his life. She wrote in the clinical record that he had again been referred to the mental health team, but he insisted he needed to see the doctor to request sleeping tablets.

86. On 23 May, the security department added comments to the IEP review form that had been started four days earlier. On 26 May, a decision was made that he would remain on the standard regime, but that he would be demoted to the basic regime if there were any further behaviour warnings in the following few weeks. (An additional comment was added to the document that trying to help him had not worked, and that after several further adjudications and behaviour warnings he would now be reduced to the basic regime. It is not clear when this comment was added.)

87. The man saw a doctor on 27 May. The doctor wrote that she was able to spend more time with him and hear his story now that he could attend an appointment in the outpatient clinic rather than the segregation unit. She noted that he had problems at home but was still able to smile and laugh appropriately. He said he had emergency tobacco arriving the next day, and would finally be able to buy tobacco in the next few weeks as he had started to attend education classes and would be paid. She agreed to prescribe zolpiderm (a sleeping tablet) for three nights, and would try to arrange a prescription for a nicotine inhaler. She noted that he still had not been given a smoking cessation appointment. The pharmacy technician checked with her that he could have the medication in his possession, given that he was subject to an open ACCT. She confirmed that she thought this was suitable.

88. On 29 May, a further ACCT review was completed. A SO, officer, nurse and the man were present. The SO wrote that the man was feeling much more positive, and had been able to order tobacco using his wages from education classes. He said he had no intention of harming himself. Strategies to help him cope when stressed were discussed. His risk level was recorded as low, and the ACCT was closed. A post-closure review meeting was scheduled for 12 June.

89. A nurse wrote an entry in the man's clinical record, confirming that the ACCT had been closed. She said he denied any thoughts of harming himself but said he sometimes had impulsive feelings about killing other people. She noted that his behaviour appeared a little paranoid at times, and that he had been referred to the primary mental health team.

90. At 5.45pm the same day, he smashed the television in his cell. In response, despite the decision the previous day to close the ACCT, the SO held a further review at 8.15am on 30 May. She wrote that he had smashed the television in frustration because tobacco had been stolen from his cell. He said he did this to relieve his annoyance and that it was in no way an attempt at self-harm. The situation was no different from the previous day when the ACCT was closed. As such, it remained closed with the post-closure review scheduled for 12 June.

91. Almost two hours after the ACCT review, the man barricaded himself in his cell by pushing a locker across the door. When members of staff gained access to the cell, he was taken to the segregation unit. A nurse wrote in the clinical record that he had banged his head on the cell doorway, but there were no marks on his head and he told her that he was fine.

92. A doctor saw him as part of her segregation unit rounds on 31 May. He said he was physically well and explained that he had smashed his television after someone stole his tobacco. He said it was "better to trash a TV than a person".

93. The next day, he was demoted to the basic regime and an agreement was drawn up about the required standards of behaviour. It included him refraining from using his cell bell for non-emergency situations, being respectful to members of staff, other prisoners and visitors, and keeping himself and his cell clean and tidy at all times. He was limited to a private account of £22 per week, one association period per week, and three visits of one hour. He was not allowed a television. He refused to sign the agreement.

94. The same evening, a doctor wrote in the clinical record that she had not requested nicotine inhalers for him as he was back in the segregation unit and, given the restrictions on private purchases that this entailed, his lack of tobacco was not going to be a short-term problem. The next day, she saw him as part of her segregation unit rounds. He did not report any major issues and presented with a pleasant demeanour.

95. The man was seen regularly by various members of healthcare staff completing segregation unit rounds between 3 June and 25 June. He did not report any major complaints or issues during these visits.

96. On 14 June, he had an IEP regime review after two weeks on the basic regime. This was conducted by a SO and two officers. He was upgraded to 'stage 2 basic', an interim level between basic and standard, due to some positive improvements in his behaviour. He was allowed a television as a

reward for continued improvement in his behaviour but four days later he smashed the television after staff refused to give him tobacco. On 18 June, he received a warning for misusing his cell bell.

97. No entries were made in the man's clinical record by members of staff at Leicester between 25 June and 10 August.

98. He appeared at Crown Court by video link on 30 June. He was remanded in custody until 11 August.

99. By 1 July, he had moved from the segregation unit to a normal residential cell. On 1 July, 2 July and 16 July, he was issued with behaviour warnings for misusing his cell bell. On each occasion, he asked members of staff for tobacco.

100. A review of the man's need for a single cell was carried out on 7 August by a SO, officer and the man. The SO noted that he acted "very bizarrely" and would not give direct answers to questions. The officer said that members of the wing staff had concerns about his mental health, and would refer him to the in-reach team. A mental health assessment was noted as a specific need. He remained a high risk for cell sharing.

101. An officer was one of the members of staff with concerns about the man's mental health. He told the investigator that he presented as paranoid, and said he used to talk about nameless people speaking to him through the television. In his discussions with him about religion and the Bible he also detected an element of paranoia. The officer said that while he was articulate and coherent he felt there were underlying issues with his mental health.

102. Another officer expressed similar concerns about the man's mental health and told the investigator that he made bizarre references to being observed by the light fittings on the exercise yard. He said that the man believed he was being targeted and monitored by powers beyond the local police such as MI5 and the security services. He also referred to him watching television with a towel draped over it which he said made it 'easier'.

103. On 10 August, a nurse saw him as part of routine men's health rounds. He told her that he felt stressed and depressed, and was isolated with no support group in the prison. He believed he was being bullied and not being allowed to exercise with other prisoners. During the time that she was talking to him, he was offered exercise by an officer. He told her that his television was talking to him and that he was talking back. He acknowledged that he was paranoid and said he wanted to go to the healthcare unit. He also said he had submitted a number of complaints about his perceived bad treatment but believed that members of staff were removing his forms from the complaints box. She described him as eloquent, clean, appropriately dressed, and maintaining good eye contact. He mentioned smoking cessation and said his name had been on the list for some time. She said his name was not on the list and added it. She wrote that she would refer him to mental health services.

104. On the same day, the man submitted an application to be considered for enhanced status under the IEP regime. The form makes it clear that enhanced status will be approved only for prisoners who have displayed consistently good behaviour and contribute positively to the prison regime. A section of the form asks how the prisoner is using his time productively in prison. He wrote "fighting for prisoners' rights" on that section of the form.

105. The next day, 11 August, a wing officer completed a section of the man's application for enhanced status, saying that he had lots of negative entries and displayed bizarre behaviour. (The application was subsequently rejected on 24 August.)

106. On 18 August, a nurse, the senior in-reach mental health nurse, wrote in the clinical record that concerns about his mental health had been raised by staff on his unit. There was no further information given, other than that the concerns were forwarded to another nurse for consideration.

107. At 10.05am on 23 August, the man set fire to clothing on his bed, causing substantial damage to the cell. He also stacked furniture against the door, preventing staff access. A nurse was called to the cell and wrote in the clinical record that he was seen standing at the back of the cell near the window while members of staff tried to get in. He was eventually taken to the segregation unit. She wrote in the clinical record that there was no sign of smoke inhalation.

108. The next day, another nurse saw him in the segregation unit as part of her rounds. No health issues were identified.

109. On 25 August, the man was demoted to the basic regime. A SO wrote:

> "Landing staff have stated that you show no respect for landing rules or the regime and display a very poor attitude. As well as negative comments … you have been charged for barricading your cell and setting a fire."

110. The man again refused to sign the behaviour agreement for the basic regime.

111. Daily notes were made in his basic regime monitoring log. On 25 August, he behaved "to an acceptable standard", but the next day he spent the afternoon misusing his cell bell. On 27 August, he appeared in person at Crown Court and remained on remand. When he returned to the prison, he threw food around his cell.

112. A nurse wrote in his clinical record on 28 August as a result of his referral to the mental health team. She noted that she had seen him in May and found no evidence of mental illness, although he was somewhat paranoid. She wrote that he continued to be a demanding prisoner with regular discipline problems, but that members of the unit staff had no concerns about him presenting with unusual behaviour or speech content. This is inconsistent

with the accounts given by prison officers to the investigator during interview. He said he spoke to his television, and admitted he felt isolated. She thought there was no evidence of psychosis. He asked for admission to the healthcare unit. She did not pursue a referral for ongoing mental health intervention because there were no major changes in his presentation and he had "other agendas", namely relocation to the healthcare unit. She noted that she would see him immediately if there were any changes in presentation or serious concerns, and also noted that he denied suffering from any mental illness. He was removed from the mental health team waiting list.

113. On the same day, notes in the man's basic regime monitoring log suggest that he asked to see a governor, was shouting in his cell about not having any tobacco and, when visited by the duty governor, said he was starting a hunger strike because of his various issues. During the evening, he told a nurse that he had refused food for three days. She wrote in the clinical record that there were no signs of dehydration, his skin integrity was good, he had been seen by a doctor and no concerns had been raised.

114. The next morning, 29 August, a nurse saw him after a request from the duty governor. She wrote in the clinical record that she had discovered part of a psychiatrist's report suggesting that he might be suffering from a "delusional disorder". She said that he presented as "rational and almost charming initially" and that she felt he was trying to decide what use she could be to him. He showed her a second psychiatrist's report which concluded that he was not suffering from a mental illness. She wrote in the clinical record that he smiled and said he had told unit staff that the television was talking to him. She wrote:

> "Whilst this can be a symptom of a psychotic illness it does not present in isolation and people who have this symptom do not sit calmly, with a smile and state it. It is always accompanied by [related symptoms]. His current issue, once again, is lack of tobacco. He is unable to accept responsibility for this, and that his behaviour results in losses on adjudication. He spoke flippantly about setting fire to his cell the other day and also about how he will likely lose it and really hurt someone. When saying this he fixed me with a penetrative stare, presumably to intimidate."

115. The nurse remained of the opinion that he did not need ongoing mental health services and was not suffering from a mental illness.

116. The monitoring log suggested that the man had a good day on 29 August, with no concerns or issues to report. The next day, a nurse saw him during her segregation unit rounds. He said he felt his imprisonment was putting a lot of stress on his body, and again asked to be considered for smoking cessation. He was advised to put in an application about this, although he had previously been told some months before that his name was on the list. The duty governor also saw him and asked a nurse to see him, because members of staff on the unit were concerned about his mental state.

117. A nurse saw him on the same afternoon. He wrote in the clinical record that the man talked about the fire he had set, and said he did it because he wanted to be removed from the wing due to bullying. He refused to expand on the point. During the interview, he did not mention the issues that had concerned members of staff on the unit – hearing voices, displaying paranoid behaviour – but he did ask about an item of equipment in the office and suggested that 'they' would be watching. The nurse wrote:

> "During our conversation he was clear and to the point, eye contact during most questioning was appropriate, his body language appeared relaxed, he engaged from what I could see very well, even though at times he appeared a bit on edge, generally he did not appear delusional. But in saying all of this, I got an impression that he was being quite guarded over certain issues out on the wing. He did say to me that he has no mental health issues and cannot understand why I was called to see him."

118. According to the monitoring log, the man was quiet and compliant during that day. No major concerns were raised the next day, and there was a suggestion that he had settled down in terms of behaviour. No concerns were raised during 1-3 September, and no further entries were made for four days.

119. On 8 September, he asked an officer for a television and was described as verbally abusive. He was seen by a nurse as part of her segregation unit rounds, and no concerns were raised. On the same day, he was moved to normal residential location, but was reported to be constantly misusing his cell bell and "jamming the whole cell bell system". He was returned to the segregation unit.

120. The next day, an officer spoke to him at length about his behaviour. While he was apologetic, he refused to take any responsibility. He said he was happy to be segregated. There were no recorded behavioural issues that day.

121. The man attended Crown Court on 10 September and was remanded back to the prison. On the same day, a review of his cell sharing risk status was completed. He remained high risk and required a single cell.

122. During 11 and 12 September, it was noted that he shouted demands through his cell door and misused his cell bell, but these were described as minor infractions. He saw a doctor on 13 September, and said he was not getting enough food and was losing weight. The doctor wrote in the clinical record that there was no objective sign of this. He was generally well behaved on 14 and 15 September. There were some minor concerns on the morning of 16 September.

123. A review of the man's suitability for the basic regime took place on 17 September. He denied most of the behaviour described above, and then "started ranting about staff lying about him". A decision was taken for him to remain on the basic regime for at least a further two weeks, when he would be reviewed again.

124. His behaviour for the rest of September remained a mixed picture. On 29 September, he left the segregation and returned to a normal residential cell. He was encouraged to comply with the prison rules and attain the standard regime.

125. On 6 October, two nurses attended the segregation unit to provide medical assistance to the man, who had been in a fight with another prisoner and had been removed from wing. One nurse wrote in the clinical record that he had sustained a cut to the bridge of his nose and grazes on his forehead. He did not report any dizziness, nausea or headache. He was taken to hospital for treatment and arrived back at the prison the same evening. A nurse saw him the next day and reported that his nose remained swollen and bruised, and he had a graze to his forehead. He did not complain of headache or discomfort. On 8 October, the nurse wrote that the swelling had reduced.

126. A cell sharing risk review took place on 11 October. A SO wrote that other prisoners would quickly become intolerant of the man's unorthodox behaviour. He was located in a single cell on the overflow to the first night centre, was a high risk in terms of cell sharing, and would require a single cell.

127. The same day, a nurse saw him and reported that there was no swelling to his nose but grazes remained visible.

128. On 21 October, a nurse saw him, who said he had no healthcare issues but had recently lost 21 pounds in weight. She wrote that he did not appear emaciated but asked him to mention it to the doctor. He said he was eating but the prison was not providing enough food. The next day, he refused to attend a follow-up appointment (relating to the injuries sustained in the fight) at hospital.

129. Between 22 October and 19 November, he was seen regularly by medical staff and reported no issues.

130. The man saw a doctor on 22 November. (The entry in the electronic clinical record was made under another member of staff's login details.) He asked for sleeping tablets and talked about his family issues, saying he had lost everything. He was prescribed flupentixol, an anti-psychotic and anti-depressant medication, for two weeks and referred to the mental health team. On 2 December, he told a nurse that he no longer wished to take the medication as it was not effective. The next day, he told another nurse that he wanted to see a doctor to discuss changing his medication. Although there is no evidence of such an appointment taking place, he was seen regularly by other healthcare staff between 4 December and 14 December and reported no major issues,

131. On 14 December, the man appeared at Crown Court. He was convicted of one offence but a number of others remained outstanding. He was remanded back to the prison.

132. The next day at 9.15am, an ACCT was opened as he had cut his left hand with a razor blade and said he needed a radio as he could not cope with the television.

133. The man was subject to observations by staff every half an hour. A nurse wrote in the clinical record that he had made a superficial scratch to his left inner wrist, with no apparent bleeding and no treatment required.

134. An officer assessed him for the ACCT document and he said he was annoyed about his court appearance, wanted tobacco, and had cut himself in order to obtain some. He said he just wanted a radio and some tobacco, but also said he "would like to be dead but has 'no bottle' to do it". The same afternoon, a nurse spoke to him at length. She wrote in the clinical record:

> "Again concerns have been raised about this prisoner's mental health and so I saw and spoke to him at length with a SO who was reviewing the ACCT following his extremely minor self-harm incident. He presented as relaxed, polite, no irritation, often smile on his face. He had spoken to the SO about the TV talking to him. He has said this before but usually with a smirk on his face and no [related] signs. Today he gave a little more detail [and] said it dates to pre-prison. First noticed when he was watching a chat line type programme and the girl referred to him. Says he feels he is the subject of some kind of experiment and there are cameras around. Has asked for TV to be taken away and replaced by a radio. Has manipulated the self-harm procedures to achieve this and admits as much."

135. The nurse went on to say that his two court reports did not agree about a mental illness, and that his solicitor had suggested a third report but he was not interested. She felt that although his speech had the "flavour of psychosis" there were no other symptoms present.

136. The SO wrote on the ACCT review form:

> "He was very open and honest during the review. He explained how he had manipulated the staff into receiving a smoker's pack by 'cutting' his arm (skin not broken). He assured us he had no intention of harming himself again and was apologetic for wasting people's time. All agreed the document should be closed."

137. The ACCT was closed and a post-closure review meeting was arranged for 22 December. This took place as planned, and the SO thought there was no reason to re-open the ACCT.

138. Between 31 December 2010 and 8 January 2011, the man was seen regularly by healthcare staff and did not report any issues. On 10 January, he was transferred to HMP Lincoln due to overcrowding at Leicester. When he arrived at Lincoln, a cell sharing risk assessment (CSRA) was completed. Despite the mention of his paranoia, trouble sleeping and high risk status at Leicester, he was assessed as a medium risk.

139. A nurse completed a reception health screening. She noted that he suffered from paranoia and offered to refer him to the mental health team, but he declined. He said he had no thoughts of harming himself.

140. The man was seen by a consultant forensic psychiatrist on 4 February who was preparing a psychiatric report for the court. He dictated notes about his meeting with him, which were transcribed and entered in the clinical record. He said of the man:

> "He describes a complex delusional system whereby he believes that he is the subject of some kind of government led experiment. He describes being watched through the television and believing that some of the things on the television are communicating directly with him. He also believes that his dead parents and brother were murdered as part of this conspiracy. He says he became aware of being watched about two years ago and of being communicated with through the TV for the last few months whilst in custody. He denies auditory hallucinations and passivity type experiences."

141. The psychiatrist went on to say that the man gave "a strong impression of suffering from either a delusional disorder or that he has an emerging picture of paranoid schizophrenia". He recommended that he was seen by the mental health in-reach team and the prison's visiting psychiatrist, and that consideration was given to the prescription of anti-psychotic medication. He also said that it "seems likely that he will need admission to hospital". He acknowledged that another psychiatrist had seen him and found no evidence of mental illness, but thought "the clinical picture is now much clearer and he may benefit from a reassessment".

142. On 7 February, he saw a nurse from the prison's mental health team. The nurse wrote a detailed entry in the clinical record about the man's belief of an elaborate and wide-reaching conspiracy against him. He also expressed concerns that the conversation was being recorded and said he thought most rooms in the prison were fitted with recording equipment. He described in detail a theory he had developed about a member of his family and a link between a high-profile news story. He declined the offer of medication, and the nurse agreed to follow up the appointment.

143. The next day, the man saw another nurse. He told her that he felt sick, had not slept all night and that he was anxious about his mental state. She informed the mental health nurse, who planned to see him.

144. The man saw the mental health nurse again on 10 February. The nurse wrote in the clinical record that he saw him at his cell door. He had decided that he wanted to consider medication and had experienced some symptoms of distress about the matters they had previously discussed. The nurse wrote that he was agreeable to him arranging an appointment with the consultant psychiatrist to discuss medication options, but that this might take around a

week to arrange. He noted that he denied any thoughts of harming himself or others.

145. On 12 February at 3.00am, another ACCT was opened as the man had harmed himself and was also displaying 'unusual behaviour or talk'. An officer wrote:

> "He self-harmed by cutting his arms/wrists and hand. He stated that he will be killed anyway so may as well kill himself. Stated that he is going to be killed and the TV is telling him this. Stated he isn't going to cut again but will use a different method next time."

146. A nurse wrote in the clinical record that she was called to see the man. She wrote:

> "Once the cell was opened it was covered in various parts with blood, and [the man] was telling me he had lost lots of blood and [asking if he would] recover. He was pacing up and down. He was taken to the treatment room on E wing to have the wound cleaned. The [two] wounds are approximately one inch long, already clotted, these were steri-stripped and dressing applied over. Asked him if he had done this before and he replied no, not like this. Asked why and he just says he has had enough and wants to be dead because that's what's going to happen to him sooner rather than later. When asked why, he says because he has heard this and that the TV is telling him this, when asked if the TV is telling him anything else he says the TV is not talking to him. Very bizarre behaviour. Keeps contradicting himself. Says no one can help him, only God. Says not on any medication and when asked if he had seen anyone from the mental health team he said no, then said he is going to see someone soon but could not say who. Open ACCT on half-hourly observations for review in morning. To inform mental health again. He has been moved to another cell overnight due to the mess."

147. The immediate action plan was completed by an officer and a nurse. The officer wrote on the form that the man would be checked every half-hour, and that he was aware of access to the Samaritans and Listeners should he want to speak to someone.

148. The officer completed the ACCT assessment interview shortly after 10.30am. A nurse also attended. The officer wrote on the assessment form that the man said he could not cope with life in prison, had no support outside, and that talking about his problems made things worse. Although he had said in the early hours of the morning that he wanted to be dead, he was now unsure. He said he was sleeping okay, but had lost his appetite a few days earlier. He felt down but was not on any medication. The officer noted that he kept changing his mind when answering questions. He said he did not have thoughts of suicide or self-harm at the time of the interview, and again mentioned his religion.

149. The nurse wrote in the clinical record that the man was quite guarded and somewhat reluctant to talk openly, and she arranged to see him later that day.

150. Another nurse saw him at around 2.30pm to check his wounds. The nurse who attended the ACCT review saw him around 3.30pm to talk to him in more detail before the first ACCT review. She wrote in the clinical record:

> "Talked more openly than this morning. States no one can help him as his problems are much bigger than 'this place'. Information passed on from officers that he had suggested that he was being watched by someone, but not able to say who. The conversation I had with him would support this, as he referred to an outside organisation who was observing him. He made reference to 'them' and stated that 'they' were watching him and would punish him if he divulged too much. He stated that he did not want to die, but felt that this was the only way out of his situation. He described a belief that he had been watched all his life, but only in the last year being aware of it. He described his religion as Catholic, and stated that this may prevent him from taking his own life, but in the next sentence said that he did not think of this when he had self-harmed the night before."

151. The man told a nurse that he had not had previous contact with mental health teams. She referred to the doctor's assessment from eight days earlier, and made an urgent referral for him to see the visiting psychiatrist.

152. The same afternoon, a SO conducted the first ACCT review. A nurse, two officers and the man were present. The SO wrote on the form:

> "The man attended for his case review unshaven and low in mood. He talked politely with staff and indicated that he had nothing to live for. He recognises that he has mental health issues and is aware that he will be seeing the resident psychiatrist on Monday morning (14 February). He stated that he currently had fleeting thoughts of self-harm. He is having trouble finding reasons to carry on, but he has no immediate plans of harming himself. Has been made aware of all support mechanisms available."

153. The risk of harm was indicated as 'raised', and a further review was arranged for two days later, 14 February. No-one at Lincoln seems to have checked the man's record which would have indicated that he was due in court in Leicester that day. As a result a psychiatrist's appointment and an ACCT review were arranged neither of which he would be able to attend, at least not at Lincoln.

154. At 4.15pm, a SO wrote in the ACCT ongoing record that he had spoken to the man, who had said he felt a bit better now that he had some tobacco. The SO gave him some paper and pencils for in-cell activity, for which he was grateful. He also reminded him to collect his evening meal, which he then did. At 8.00pm, he asked an officer for two cigarettes, but he was not given them.

155. The next morning, 13 February, a nurse saw the man shortly after 9.00am at the request of officers on the unit. He complained of feeling unwell and dizzy. He said he had not been sleeping well, and had lost his appetite but would be having Sunday dinner. The nurse changed his wound dressing. He commented that the wounds were feeling sore and that he "won't be doing that again". He was advised to contact healthcare staff if he continued to feel unwell.

156. That afternoon, he attended Roman Catholic Mass. He then left his cell for the association period and seemed relaxed and happy, giving members of staff no cause for concern. Later, he was observed in his cell rolling a cigarette as another prisoner had given him some tobacco. He said this had cheered him up.

157. The man attended Crown Court on 14 February. He continued to be remanded in custody, and was taken to HMP Leicester rather than returning to Lincoln. (It is not unusual for prisoners to be taken to a different prison after a court appearance as part of general population management. Leicester would have been the more usual prison for prisoners from Crown Court subject to there being spaces there.) A nurse at Lincoln wrote in his clinical record that he had not attended his appointment with the psychiatrist, and discovered belatedly that this was due to the court appearance. She spoke to the psychiatrist, who noted that there was disagreement between medical professionals about whether he was suffering from a mental illness, and whether he was fit to plead in court.

158. He was assessed as unsuitable for cell sharing at Leicester. The open ACCT was mentioned, as was his propensity for anger, agitation and paranoia, as well as previous fire setting.

159. At 6.55pm, an ACCT review took place. A SO, officer and the man attended; there was no healthcare presence. The SO wrote on the review form that the man had arrived from Lincoln via the court, and that he was a little quiet and subdued but able to articulate his feelings. He had asked for a radio, and the SO indicated that one could be provided. There was no reference to the fact that he had missed an urgent appointment with the psychiatrist that day. The ACCT remained open, with a further review arranged for 17 February. His level of risk was unchanged at 'raised'. The SO also sent an email to a nurse from the mental health team, informing her that the man was back at Leicester.

160. An operational manager wrote in the ACCT ongoing record at 7.30pm that the man had requested vulnerable prisoner status under Prison Rule 45, which allows governors to remove prisoners from normal association with others, either to maintain the good order and discipline of the prison, or for the protection of the prisoner. He wrote that the man's request was because he had previously been assaulted at Leicester. This related to the incident in October 2010, which had previously been described as a fight. He said he felt unsafe in a normal residential location. His request was allowed and he was allocated to the first night centre annex.

161. Several officers told the investigator during interview that the landing for vulnerable prisoners at Leicester was often full, with more prisoners requesting segregation from the normal population than could be accommodated on the landing. As a result, prisoners were accommodated in other areas of the prison, such as an annex of cells close to the first night centre. A SO explained that the annex was used when the VPU was full and prisoners moved from the annex to the VPU in order of arrival as spaces became available.

162. A nurse noted in the clinical record that the man had returned to Leicester, had harmed himself, and was known to the mental health team. The clinical records at both Leicester and Lincoln use the same electronic system, and so clinical members of staff at Leicester would have been able to access entries made by staff at Lincoln.

163. On the morning of 16 February, an officer wrote in the ACCT ongoing record. The name of the officer was not legible, but the entry referred to him being in a sombre mood and asking the officer to pray for him.

164. A further ACCT review took place on the morning of 17 February. This involved two SOs, a nurse from the mental health team and the man. One SO was handing the responsibility of the ACCT to the other SO, who would be the case manager from that point onwards. The case manager wrote on the review form that the man was not very engaging and said he was worried about being attacked by other prisoners. He was reassured that, as he was segregated under Prison Rule 45, this was unlikely to happen. He had been given a radio to try and keep him occupied.

165. He told the investigator that the man was a very quiet prisoner anyway and did not say much at the review. He had been bothered about being assaulted and he tried to reassure him he was safe.

166. The nurse wrote in the clinical record that at the ACCT review the man showed no signs of mental illness, said he felt okay and did not want to harm himself, but did not maintain conversation and appeared to be concentrating intently. Again, there was no reference to the missed psychiatric appointment three days earlier. Her recollection of the meeting, when talking to the investigator, was similar to that of the case manager.

167. The ACCT remained open, but the man's level of risk was reduced to low. A further review was arranged for 24 February.

168. Two entries of note were made in the ACCT ongoing record that day , 17 February, although the names of the officers making the entries were not legible. They read as follows:

> "The man doesn't look very well, quite fatigued and fed up. I spoke some encouraging words during the … exercise but he's generally down."

> "He appeared agitated when unlocked for tea. He was pacing up and down in his cell. He said he thought something bad was going to happen. He doesn't look well and his mood is very low."

169. Between 17 February and 23 February, the man was seen daily by a member of the healthcare team. No issues were noted.

170. An officer told the investigator that the man behaved differently when he returned to Leicester from Lincoln. He said he was very quiet and he and other officers asked him how he was feeling each day at unlock but he was very subdued.

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171. On the morning of 24 February, was still assessed as requiring a single cell. The same day, a review of the ACCT took place. The case manager, a nurse and the man were present. An officer was asked for information before the review, but was not present when it took place. He told the investigator that he had had no concerns about him at that time. There was no mention of the outstanding psychiatric appointment.

172. The case manager wrote on the review form:

> "The man a lot more talkative and seems to have settled back down. He stated that he has no intention to self-harm but admits to having ongoing 'thoughts' in his head. This mainly revolves around his forthcoming trial and him worrying. He was reminded that Listeners and [the] Samaritans phone is available should be need to talk."

173. Recalling the review, he said during interview:

> "The man was a lot more positive about things, a lot more chatty. There was good eye contact, good communication. He spoke about his self-harm and said that it was a stupid thing to do and he said he didn't know why he did it and he said he was alright now."

174. The man was assessed as low risk, and the case manager and nurse agreed that there was no longer a need for the ACCT to be open. A post-closure review was arranged for 3 March.

Events leading up to the incident

175. A full roll check took place around 7.00am. A roll check involves officers looking in every cell to confirm that the prisoners are present and that nothing is obviously wrong. Although officers look in every cell and physically count the prisoners, they are not required to speak to them. The man's ACCT had been closed three days earlier, and so he was not subject to any additional monitoring or observation. The alarm was not raised at 7.00am, and nothing untoward was recorded during the roll check.

176. Shortly before 9.00am, an officer began to unlock the cells of vulnerable prisoners who were due to attend a service in the chapel. She explained to

the investigator that she always opened the observation panel in a cell door, before unlocking the door itself. When she opened the man's observation panel she said she did not immediately register what she had seen, and closed the panel momentarily before opening it again. She said she saw the silhouette of him at the back of the cell against the window. She could see that his feet were suspended from the floor. She then shouted for help from other members of staff, and put her key in the cell door's lock while she waited for help to arrive.

177. A SO and several officers were in the segregation unit when they heard the officer shout for help. The officers told the investigator during interview that they immediately made their way to the first night centre annex. The SO described the distance as "probably no more than 10 metres" and the officers said they arrived at the cell within seconds. The officer recalled that when she saw the other officers arriving, she unlocked the cell door and went inside. She was followed almost immediately by other officers.

178. The five officers were consistent in their recollection of the man's condition. They said that one end of a bed sheet was tied to the cell's window bars and the other end was around his neck. He was suspended from the floor by a few centimetres. The officers recalled that his skin looked grey. Two officers said their initial impression was that he was dead, and another said he did not think resuscitation was viable.

179. The SO told the investigator that he used his radio to alert other members of staff to a 'code blue' situation. This is a radio call sign that indicates an emergency situation involving someone not breathing or struggling to breathe. The prison's control room noted that the radio message was transmitted at 8.55am, and that an ambulance was called two minutes later.

180. The officer who found the man left the cell almost immediately. She told the investigator that she was very shocked. One officer stood on a chair and used his anti-ligature knife (a tool with a safety blade carried by all operational prison staff) to cut the ligature. He told the investigator that this was quite difficult due to the thickness of the bed sheet. He, the SO and two officers then lowered him to the floor of the cell and placed him on his back. One officer recalled that his body was very stiff.

181. The SO began to perform chest compressions, part of cardio-pulmonary resuscitation (CPR). He asked an officer to check for any signs of life. The officer said he could not find a pulse, and recalled that the man felt very cold to the touch. He said the SO asked him to begin rescue breaths, but that a nurse arrived before he could begin.

182. A nurse told the investigator that he was on the main wing, dispensing medication to prisoners from a treatment hatch, when he was made aware of the emergency situation. He could not recall whether he was alerted by the shout from an officer or the 'code blue' message over the radio. He secured the treatment room and made his way to the cell, estimating that this took no longer than 90 seconds. When he arrived his colleague was already at the

cell and had begun to administer oxygen to the man using a face mask. The SO was continuing with chest compressions. The nurse and the officers mentioned that his colleague attempted to insert a tube to facilitate better the oxygen delivery to him, but she was unable to open his mouth to do so.

183. Like the officers, the nurse believed that the man was dead. Nevertheless, he attached the automated external defibrillator (AED) to him. (An AED is a piece of medical equipment that assesses a patient by checking for electrical activity in the heart. If there is abnormal heart activity in a particular rhythm, known as ventricular fibrillation, the machine can administer an electric shock which is intended to force the heart into a normal rhythm. However, if no electrical activity is detected, the AED will not administer a shock and will advise that manual CPR should continue.)

184. The SO and nurse alternated in performing chest compressions. The AED did not indicate a need to deliver a shock. The other nurse continued to administer oxygen.

185. A SO was the orderly officer that morning. This means that she was the most senior person in the prison other than the duty governor. She told the investigator that she was working in an office just off the main wing when she heard the radio message. She immediately made her way to the cell, and estimated that this took no longer than two minutes. She did not go into the cell. The duty governor was already on the landing, and he informed her of the situation. She then took on a management role, ensuring that a log keeper (to record the names of people entering and leaving the cell) was appointed, that ambulance personnel could access the prison, and that other members of staff such as the governor in charge were informed. She was not involved in the CPR effort.

186. The control room recorded that an ambulance arrived at the prison at 9.01am. The log keeper recorded that paramedics entered the cell at 9.05am. The officers left the cell at 9.08am while the paramedics and nurses continued to administer CPR. This was, however, unsuccessful, and the man's death was pronounced at 9.11am.

Events after the emergency response

187. At 10.30am, the members of staff who had been involved in the emergency response attended a 'hot debrief' chaired by the prison's senior management. The purpose of the debrief was to talk about the circumstances of the emergency, the response to it, and to identify any support that was needed for members of staff.

188. The orderly officer told the investigator that all prisoners with open ACCTs, and those in the post-closure stage, were reviewed by senior officers to check their well-being and enquire whether any additional support was required.

189. Notices to staff and prisoners were produced on the same day to inform them of the man's death.

Informing the man's family members

190. Two members of staff from the prison visited the man's wife the same day to inform her that he had died. She raised with our office some issues around the ongoing liaison with the prison, which are covered in the next section of this report.

191. The funeral took place on 14 March. The Governor and the prison's family liaison officer attended.

Letter found in the man's cell

192. An un-posted letter was found in the man's cell. In it, he does not specifically refer to an intention to take his own life, although he does mention "a half-attempted go at committing suicide" and talks about how he cut his wrists and lost some blood. He also advises the intended recipient to "get on with your life" but says he would like to see her "one last time". While there is not a clear reference to suicidal intent, he makes several mentions of being "finished", having "blown it", and says "whatever happens, remember I always loved you".

ISSUES

Assessment, Care in Custody and Teamwork (ACCT)

193. During his time in custody, the man was subject to the ACCT process on four separate occasions. Two of these ACCTs were open for less than a day, while the others (the first and last ones) were open for longer periods of time.

194. On each occasion, the proper procedures appear to have been followed. After the initial concern was raised, an immediate action plan was formed and an assessment interview was completed. A review then took place to decide what would happen next.

195. On the two occasions where the ACCT remained open, reviews were scheduled and carried out. When the ACCTs were closed, the reasons for doing so were recorded on the review form by the case manager. Although most reviews were multi-disciplinary, this was not always the case. The CAREMAPS generally contained a number of issues and goals, and the steps taken to address the issues were recorded.

196. On 4 February while at HMP Lincoln, the man saw a psychiatrist for a psychiatric report. The psychiatrist thought he was suffering from either a delusional disorder or had an emerging picture of paranoid schizophrenia. Eight days later, 12 February, an ACCT was opened when he harmed himself. The review that took place the same day mentioned the assessment that the psychiatrist had carried out, and he was referred for an urgent appointment with another psychiatrist. No-one realised that this was scheduled for the same day as a court appearance, and so he was unable to attend. After court, he was taken to HMP Leicester rather than returning to Lincoln, and so the appointment with the psychiatrist did not take place.

197. The clinical reviewer wrote:

> "It appears that the level of concern expressed at HMP Lincoln was not picked up at HMP Leicester. This may be related to the knowledge that staff at HMP Leicester had about the man's behaviour earlier during his imprisonment and there is no evidence that an urgent assessment by a psychiatrist was considered."

198. There is further discussion about the different opinions of the man's mental health below. Mental health nurses attended his ACCT reviews on 17 and 24 February but not on 14 February, the date on which his psychiatric appointment was scheduled. He had attended court on 14 February and the ACCT review took place at 6.55pm, after he returned to the prison and when no mental health nurses were on duty. His appointment with the psychiatrist was detailed in the electronic clinical record, as was a further appointment with a mental health nurse at Lincoln, and the urgent referral to another psychiatrist. This was also recorded in the ACCT review that took place on 12 February while he was at Lincoln. However, there is no mention of these events in the ACCT reviews from 14, 17 or 24 February, or in the

corresponding entries in the clinical record, following his transfer to Leicester. It is unclear whether the nurses who attended his ACCT reviews on 17 and 24 February had familiarised themselves with his recent medical history, particularly the events of the previous few days and weeks.

199. The clinical reviewer recommended a review of the information available to nurses attending the ACCT review. In terms of improving future practice, we believe that all members of staff should access appropriate documents in advance of ACCT reviews, and we therefore make the following recommendation.

The Governor and the Head of Healthcare at HMP Leicester should ensure that members of staff at Assessment, Care in Custody and Teamwork (ACCT) reviews familiarise themselves with information that might be useful to the review process before attending.

200. A decision to close the ACCT was taken after the man had been at Leicester for ten days. He presented as talkative at the review on 24 February, told the members of staff present that he had no intention of harming himself, and was reminded of the methods of support that were available to him. Although the decision to close the ACCT might seem reasonable based on the information that was considered during the review, it is worrying that relevant information from Lincoln was not taken into account at any point during the reviews. The prior knowledge that members of staff had about him was, of course, valuable, as was his presentation on the day of the reviews. But this formed only part of the overall picture. His recent assessment by a psychiatrist, as well as an urgent follow-up referral, should have been considered. This information was contained in the clinical record and should have been taken into account as part of the ACCT process.

The Governor of HMP Leicester should ensure staff take into account all indicators of risk when assessing the risk of self-harm and before closing an ACCT document.

Mental health intervention

201. It is clear that there were differences of opinion about the man's mental health. His wife told our family liaison officer (FLO) that she thought he had suffered from schizophrenia, and that there was a family history of the condition. Members of staff at Leicester and Lincoln were unaware of this, and it does not appear that he mentioned it during his appointments.

202. He was first seen by a nurse on 3 May 2010, after an ACCT was opened. At this time, she believed that there was no sign of mental illness and that he was trying to obtain sleeping tablets and tobacco. She found no sign of depression but noted some indications of paranoia.

203. The nurse was asked to see him again on 29 August 2010 after wing staff reported that he had been behaving unusually. After seeing him, her opinion remained the same, that he was not suffering from a mental illness. She had

found part of a psychiatric report that suggested he might be suffering from a delusional disorder, but a second psychiatric report said there was no sign of mental illness. The next day, another nurse saw him, again after concern from the wing staff. The nurse found no evidence of mental illness and noted that he did not appear delusional.

204. On 15 December, after the man had harmed himself, a nurse saw him again. At this appointment, he gave more details about his symptoms, saying he thought he was the subject of some kind of experiment, was being watched, and that the TV was talking to him. She noted that although his speech content had the flavour of psychosis, he did not experience other related symptoms. She again recorded in the clinical record that she thought his dysfunctional behaviour in the prison was carried out with the aim of obtaining tobacco.

205. A number of officers who were working on the wings expressed concerns about his mental health during interview with the investigator. One officer said:

> "We were certainly seeing … on a number of occasions he'd be watching his telly with a towel over it and when spoken to about that as part of his ACCT management you would sort of say to him well, why are you watching your telly through a towel - well, I just find it easier – which then started to raise again our concerns with regard to his mental health."

206. When asked if he thought the man was attempting to manipulate people in order to gain tobacco, the officer said:

> "I think their opinion was that he was attempting to manipulate the mental health issue and use that to his advantage if you like, but again having read the report in full and it tying in with my own opinion of it, I was more of the belief that there was some underlying mental health problem. The issue with him a lot of the time was when the nurses came to speak to him he did have a knack of being able to just laugh everything off and make a joke out of it and … he was perhaps a proud [man] who didn't wish to admit to having any mental health issues and he obviously [presented] them with an issue of how do they … assess him … from the way he's presenting."

207. The officer was, of course, merely stating his observations as a prison officer rather than someone qualified in mental health assessment. He did, however, have the benefit of observing the man's behaviour over a significant period of time. The nurse remained of the opinion that he was not suffering from mental health problems.

208. On 4 February 2011, after the man had been transferred to HMP Lincoln, a very different conclusion was reached by a consultant psychiatrist. He thought he was suffering from either a delusional disorder or possibly paranoid schizophrenia. He went so far as to suggest that he might need to be hospitalised rather than serving a prison sentence. Four days later, during

an appointment with a nurse, he gave a bizarre and impossible account of his family being linked with a major news event. He was unable to account for obvious inconsistencies and contradictions in his story when they were pointed out to him.

209. After he harmed himself by making cuts to his wrists and hands on 12 February, he was seen by a nurse and again suggested he was being watched by an outside organisation. The nurse referred him to the visiting psychiatrist for HMP Lincoln, but unaccountably the appointment was made for 14 February, the same day that he was due to appear in court at Leicester, so he was unable to attend. He did not return to Lincoln from the court but instead went to HMP Leicester.

210. It is not clear how much information was passed on directly from HMP Lincoln to HMP Leicester on the man's transfer. The information about his appointments with the psychiatrist and nurses were contained in the electronic clinical record and so should have been available to healthcare staff at Leicester when he arrived. The planned appointment with the visiting psychiatrist should also have been recorded. In addition to the clinical record, the ACCT review document from 12 February also made reference to his referral to see the visiting psychiatrist.

211. When the man arrived at Leicester, a nurse concluded that he was known to the mental health team and made a referral to them. A SO emailed two nurses to inform them that he had returned to the prison. Although mental health nurses attended the ACCT reviews on 17 and 24 February, there was no other intervention by mental health staff at Leicester, and no input from a psychiatrist despite the urgent referral outstanding from 12 February.

212. In his clinical review, the clinical reviewer wrote:

> "During his stay in prison the man appears to have developed possible paranoid ideation and delusional beliefs. These may be indicative of psychosis but the diagnosis of psychotic illness can be extremely difficult. The diagnosis is often made over a period of time as symptoms develop. In his case the difficulties were increased by his use of symptomatology to try to obtain medication, tobacco or transfers between different parts of the prison, behaviours which he is recorded as having admitted.
>
> "The incidence of completed suicide is somewhat higher in people with psychotic illness (treated or untreated) than in people without such illness. Nevertheless, the vast majority of people with psychotic illness (treated or untreated) do not commit suicide. It is unclear whether his suicide was related to any psychotic illness which he may have been developing or whether it was an impulsive act.
>
> "It is, however, clear from the medical record that health professionals at HMP Lincoln were concerned that he may be developing a psychotic illness and that these concerns were heightened by the entry made in his records by the psychiatrist. He was due to be assessed by a consultant

psychiatrist, who would have been in a position to offer him treatment if this was deemed appropriate, on the day that he went to court and was subsequently transferred back to HMP Leicester. It appears that the level of concern expressed at HMP Lincoln was not picked up at HMP Leicester. This may be related to the knowledge that staff at HMP Leicester had about his behaviour earlier during his imprisonment and there is no evidence that an urgent assessment by a psychiatrist was considered. I am unable to give an opinion on whether his suicide might have been prevented if he had seen a psychiatrist between 14 and 27 February 2011."

213. Regarding the management of the man's mental health, the clinical reviewer made two recommendations about communicating medical and mental health information between prisons. We combine these into the recommendation below.

The Heads of Healthcare at HMP Leicester and HMP Lincoln should ensure that prisoners transferred in or out of the prisons have their clinical record reviewed for relevant information.

214. Regarding a particular nurse, the clinical reviewer made a recommendation about supervision and support. However, given that that nurse has retired from the prison and we did not speak to her directly, we have been unable to reach a conclusive judgement about her involvement with the man.

Smoking cessation

215. It is clear from the man's prison and clinical records that he often wanted more tobacco than he was able to obtain. This was particularly apparent when he was in the segregation unit at Leicester and, due to poor behaviour, had restrictions on what he could buy from the canteen.

216. He first asked to be considered for smoking cessation treatment on 24 April 2010, and his name was added to the list. On 5 May, a nurse asked the psychiatrist about whether any progress had been made in this area, and she agreed to prioritise him for treatment. The psychiatrist wrote in the clinical record on 27 May that the man had still not been given an appointment for smoking cessation treatment.

217. On 10 August, the man saw a nurse and mentioned that his name had been on the list for smoking cessation for some time. She observed that his name was not on the list, and added it. He asked about the issue again on 30 November, and was advised to put in an application to request the treatment.

218. It is not clear why he was not offered smoking cessation treatment over a period of seven months, why his name was apparently removed from the waiting list despite him being made a priority, or why he was not prescribed any sort of nicotine replacement therapy. This is particularly troubling when considered alongside the assessments by a nurse, which state that his unusual and damaging behaviour was an attempt to obtain tobacco.

The Head of Healthcare at HMP Leicester should review the referral and waiting list processes for smoking cessation treatment, and ensure that treatment is offered in a timely fashion.

The emergency response

219. When the officer raised the alarm shortly before 9.00am on the morning of the incident, the response from other members of staff was swift. Four other officers arrived at the cell within seconds and, after cutting the ligature, placed the man on his back and began CPR. Two nurses arrived with emergency equipment in less than 90 seconds. Ambulance personnel arrived at the prison six minutes after the emergency 'code blue' message over the radio.

220. The clinical reviewer wrote the following in his clinical review:

> "The medical records and the interviews suggest that in the man's case, the resuscitation attempt was properly and efficiently performed. Nevertheless, the descriptions of him as being blue, cold and stiff when he was found suggest that the heart had stopped beating some significant time before he was found and that there was no possibility of resuscitation being successful."

221. He went on to observe that:

> "Attempted resuscitation, or prolongation of resuscitation attempts in such circumstances could be perceived as affording a lack of dignity to a deceased person and may be distressing for staff involved."

222. Prison Service Order (PSO) 2700, the relevant instruction at the time, entitled 'Suicide and Self-Harm', gives instructions to members of staff on how to deal with responding to, amongst other matters, suicide attempts. Annex C is entitled 'Action following self-harm - emergency procedures'. In the sub-section entitled 'Hanging', the PSO gives the following instruction:

> "If not breathing and/or no pulse is present, clear airway and attempt resuscitation, using a face mask with non-return valve, unless rigor mortis has clearly set in. (Rigor mortis is a condition of extreme stiffness, affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows or knees.)"

223. The descriptions about the man that members of staff gave to the investigator indicate that rigor mortis might well have set in. Although we recognise that members of staff acted with the best of intentions, the guidance suggests that attempting CPR might not have been strictly necessary.

Record keeping

224. The clinical reviewer noted in his clinical review that, on several occasions, entries were made in the clinical record by members of staff other than the

one logged into the system. It therefore appeared that a different person had made the entries or had seen the man. He made the following recommendation, which we have made before and endorse.

The Head of Healthcare at HMP Leicester should ensure that members of healthcare staff who need to make entries into the clinical record are able to log on to the computerised system.

225. On at least two occasions entries were made in the man's clinical record, which appear to relate to other prisoners. It seems that these entries have been made in error, and should have been made in the clinical records of other prisoners. While on this occasion, the other prisoners could not be identified from the information given, there are clear implications in terms of data protection, information security, and potentially a person's medical treatment and safety.

The Head of Healthcare at HMP Leicester should ensure that entries in clinical records relate to the correct prisoners, and that healthcare staff are diligent about this issue.

Issues raised by the man's family

226. The man's wife raised a number of concerns. Issues around mental health and medical intervention have been covered in the sections above. The remaining issues are covered here.

227. She said that, when she saw her husband's body in the chapel of rest, he had a black eye and bruising to his left hand. She was concerned that he had been bullied or in a fight, but was assured by prison staff that this was not the case. It was suggested that the injuries might have occurred during the emergency response.

228. A post-mortem examination of the man's body was conducted on 28 February. The pathologist observed what were described as "fresh marks and changes" as follows:

> "There was generalised congestion with marked petechiae [tiny burst blood vessels] to the whole face above the level of the ligature, including the inner eyelids, the whites of the eyes, behind the ears and the gum mucosa [inside of the gums].
>
> "There was blue bruising and swelling to the right lower eyelid.
>
> "There were two groups of abrasions to the back of the right lower arm, immediately below the bend of the elbow. The larger of these groups (medial) measured 2.8cm x 0.2cm and the smaller of these groups (lateral) measured 0.7cm x 0.2cm.
>
> "There were three fresh abrasions, over an area measuring 4cm x 1cm, to the middle of the front of the left lower leg.

> "There were widespread petechial haemorrhages [tiny burst blood vessels] over the whole of both legs and feet.
>
> "There was a purple bruise, measuring 0.7cm x 0.2cm, to the nail bed of the left third toe."

229. When commenting at the end of the report, he wrote:

> "The external examination identified … six single or groups of recent injuries which have neither caused nor contributed to death. The finding of a fresh black eye on the right is in keeping with a recent impact to this region of the face. However, there is no indication that the deceased suffered an assault or was restrained prior to death."

230. Some of the injuries observed during the post-mortem report, such as congestion and petechial haemorrhaging, can be attributed to the effects of being suspended by a ligature. However, the same cannot be said for injuries such as a black eye and abrasions to the arms.

231. It is worth noting that, on 10 August 2010, the man told a nurse that he was being bullied. There was no evidence to substantiate this claim and he did not make a formal complaint. On 6 October, he was involved in a fight with another prisoner. When he returned to Leicester from Lincoln on 14 February, he asked to be treated as a vulnerable prisoner.

232. Nothing in the statements provided by members of staff or during their interviews suggested that the man was injured during the emergency response on 27 February 2011. Furthermore, there was no indication that he was in a fight or assaulted shortly before his death, either at HMP Lincoln or Leicester. We are, therefore, unfortunately unable to provide an explanation for the injuries that his wife observed and none has been provided by the prison. We are also unable to substantiate the information that he gave in a letter to his wife about disclosing personal information to prisoners at Lincoln who then made his life difficult. There was nothing in computerised records or wing observation books to corroborate this information.

233. The man's wife told our family liaison officer that her relationship with the prison had been damaged by the action they had taken regarding his clothes. She asked for the prison to return the clothes that he was wearing when he was found. She understood that they might be soiled or torn but wanted them to be returned in the same condition. After being directed to the funeral directors, coroner, police and back to the prison without any clear answer, she was eventually told that the prison had destroyed the clothes because of their condition. She felt that she was lied to from the start. A similar issue arose regarding the return of his rosary beads. They were eventually returned to her by the police, after the prison failed to respond to her requests.

234. Prison Service guidance makes it clear that prison family liaison officers should consult family members about how they would like the property returned to them. It mentions clothing specifically, and states:

> "Some families like to have clothes laundered, others will want them just as they are. In either event, pack them neatly in a suitable bag or container, not a black sack or a bag recognisable as prison issue."

235. The failure of HMP Leicester to follow this guidance affected the man's wife's view of the support provided and led her to be suspicious of the prison's motives. We therefore make the following recommendation.

The Governor of HMP Leicester should apologise to the man's wife for the failure to handle her husband's property in accordance with her wishes and ensure in future that an appointed member of staff efficiently relays accurate information to family members, and that property is returned in a timely fashion.

236. The man's wife said that there did not seem to be much property returned to her, and wondered whether items such as letters and photographs might have been left at Lincoln. The investigator confirmed with Lincoln that all of his items of property travelled with him from Lincoln to the court, and then on to Leicester. The cell clearance certificate, completed when property was removed from his cell after his death, listed a relatively small number of personal possessions.

CONCLUSION

237. The man spent almost a year on remand in prison custody prior to his death in February 2011. He spent most of this time at HMP Leicester. From early in the remand period prison staff found his behaviour difficult to manage, and he spent much of his time in Leicester's segregation unit.

238. Prison officers had concerns about his unusual and sometimes bizarre behaviour and his mental health. However, the mental health nurse thought he was not suffering from a mental illness, and suggested that he was attempting to manipulate members of staff for his own gain. It was accepted, however, that he appeared paranoid. Prison staff appear to have been unaware of his family history of schizophrenia which is a significant risk factor for the illness.

239. During 2010, the man was subject to self-harm monitoring on three separate occasions. This was due to him harming himself and saying he felt suicidal.

240. The man was transferred to HMP Lincoln in January 2011. On 4 February he saw a forensic psychiatrist who was preparing a report for the court. The psychiatrist thought he was suffering from either a delusional disorder or paranoid schizophrenia. Follow-up with another psychiatrist was recommended.

241. On 12 February, the man cut his hands and arms with a razor. Self-harm monitoring began and an urgent referral was made for him to see the prison's psychiatrist on 14 February. However, he had to attend court on this date and instead of returning to Lincoln, he went back to HMP Leicester from court.

242. The man did not see a psychiatrist at Leicester and no arrangements were made for him to do so despite the outstanding appointment from Lincoln. There was no indication that members of staff at Leicester read the notes in his medical records that their counterparts at Lincoln had made. He remained subject to self-harm monitoring until 24 February.

243. A few days later he was found hanging in his cell by a prison officer. Other officers and nurses arrived quickly and a resuscitation effort began, but this was unsuccessful. Descriptions of him suggest that he had been dead for some time.

244. There are clear issues around the continuity of medical care for prisoners who transfer between establishments, and whether available information is lost along the way. In this case, it seems that information about the man's mental health and the assessment that was undertaken by the psychiatrist at Lincoln was not considered by anyone at Leicester. Whether this would have made a difference to the ultimate outcome is not known, but further consideration of his mental health issues might have led to him remaining on ACCT monitoring on 24 February rather than the ACCT document being closed.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare at HMP Leicester should ensure that members of staff at Assessment, Care in Custody and Teamwork (ACCT) reviews familiarise themselves with information that might be useful to the review process before attending.

   The recommendation was accepted. HMP Leicester's response was as follows:

   "Members of the Healthcare team have been issued with email reminders regarding their professional responsibilities in familiarising themselves with patients and their health / behavioural issues before engaging in pre-planned activities.

   "Additionally, all Registered Nurses have been re-issued with a copy of the Nursing & Midwifery Council's Code of Professional Conduct, Performance and Ethics in order to further reinforce their professional obligations.

   "A notice will be issued to all staff informing them that they must familiarise themselves with information that might be useful to a review process before attending."

2. The Governor of HMP Leicester should ensure staff take into account all indicators of risk when assessing the risk of self-harm and before closing an ACCT document.

   The recommendation was accepted. HMP Leicester's response was as follows:

   "A notice will be issued to all staff informing them they must take into account all known indicators of risk when assessing the risk of self-harm and before closing an ACCT document."

3. The Heads of Healthcare at HMP Leicester and HMP Lincoln should ensure that prisoners transferred in or out of the prisons have their clinical record reviewed for relevant information.

   The recommendation was accepted. The response from HMP Leicester was as follows:

   "Members of the Healthcare team have been issued with email reminders regarding their professional responsibilities in familiarising themselves with patients and their health/behavioural issues before engaging in pre-planned activities.

   "Additionally, all Registered Nurses have been re-issued with a copy of the Nursing & Midwifery Council's Code of Professional Conduct, Performance and Ethics in order to further reinforce their professional obligations."

The response from HMP Lincoln was as follows:

"As soon as the healthcare department are informed of a pending outward transfer the clinical notes are reviewed and all relevant information placed in a discharge summary which accompanies the prisoner to their new establishment. If transfer takes places without knowledge of healthcare, the department will contact the receiving establishment's healthcare team to appraise them of any relevant issues.

"All electronic clinical records are maintained up to date.

"The physical healthcare team carry out first night safety screens with all arriving prisoners whether they are new to prison or transferring. All prisoners are asked if they have any existing health issues and the electronic records will be checked to see if there is any relevant information, where necessary the team will contact the transferring establishments healthcare team for information."

4. The Head of Healthcare at HMP Leicester should review the referral and waiting list processes for smoking cessation treatment, and ensure that treatment is offered in a timely fashion.

The recommendation was partially accepted. The response from HMP Leicester was as follows:

"Smoking cessation services at HMP Leicester are directly commissioned and funded by the local PCT, therefore the Governor and Head of Healthcare at HMP Leicester have limited influence over how treatment is offered.

"However, waiting lists for all clinical services are managed much more effectively in terms of the receipt and processing of applications than they were previously. All applications are recorded electronically, including information on their date of receipt, processing and appointment allocation. Appointments are allocated according to the patient's position on the waiting list.

"Additionally, the Smoking Cessation Co-ordinator now has the ability to draw a set of keys, allowing her the freedom to visit prisoners on main location instead of waiting for prisoners to be escorted to her clinic, as was previously the case."

5. The Head of Healthcare at HMP Leicester should ensure that members of healthcare staff who need to make entries into the clinical record are able to log on to the computerised system.

The recommendation was accepted. The response from HMP Leicester was as follows:

"All healthcare staff and other clinicians are allocated a personal log in username and password. This includes locum and visiting clinicians."

6. The Governor of HMP Leicester should apologise to the man's wife for the failure to handle her husband's property in accordance with her wishes and ensure in future that an appointed member of staff efficiently relays accurate information to family members, and that property is returned in a timely fashion.

The recommendation was partially accepted. The response from HMP Leicester was as follows:

"A letter of apology will be sent to her for any distress caused. All family liaison officers will be advised of the importance of the family's wishes to be observed.

"The property not returned was not destroyed by the prison. It was held by the police or coroner, not HMP Leicester."