PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in June 2011 at hospital while in the custody of HMP Leicester

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This report considers the circumstances surrounding the death of a man at hospital in June 2011. He was found hanging in his cell. He was only 22 years old at the time of his death and had been on remand at HMP Leicester for less than four days. I offer my condolences to his family and all those who knew him.

The investigation was conducted by an investigator. Staff at HMP Leicester co-operated fully with the investigation. A review of his clinical care was provided by a clinical reviewer on behalf of the local Primary Care Trust. I apologise that the report has been delayed.

The man had been released on licence from HMP Onley on 27 May 2011 but was arrested for new offences on 19 June. While in police and court custody, concerns were raised about his risk of self-harm by his solicitor and his employer. He was remanded to HMP Leicester on 20 June where these issues were not initially picked up. The next morning, after staff became aware of the content of a troubling telephone call, he was made subject to self-harm monitoring. On 24 June, when a member of staff unlocked his cell for a review of his care, he was found hanging from the window bars. A sustained and coordinated resuscitation effort obtained a pulse. He was taken to hospital but, sadly, he died several days later.

The investigation raises a particular concern that information about the man's risk of self-harm, which accompanied him to HMP Leicester, was not apparently noticed and acted on by reception staff. In the event, this failing was mitigated by his state of mind being identified the next day and self-harm prevention arrangements were put in place, although it is surprising that his risk was assessed as low. On the evidence available, greater weight should have been given to his static risk factors, including his previous attempt to hang himself on the anniversary of his mother's suicide, the fact that he was a recalled prisoner facing a possible indeterminate sentence and that he had had mental health problems. Overall, too much reliance appears to have been placed on his presentation and recommendations are made that staff should review all relevant documentation and take appropriate action when there are any identified concerns. Scope to improve recording and better support for staff after traumatic incidents is also identified.

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 **January 2013**

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SUMMARY

1. On 15 November 2010, the man was convicted of committing grievous bodily harm and sentenced to eight months' imprisonment. He had committed previous offences and, at the time, was subject to a suspended sentence order. The custodial element of this was activated and added to his sentence, meaning that his total sentence was for 12 months. He was initially taken to HMP Leicester and, shortly afterwards, transferred to HMYOI Onley.

2. During a reception health screening, the man said he suffered from bipolar disorder (a condition often characterised by episodes of elevated mood and periods of depression). As a result, he was referred to the mental health team. Between November 2010 and May 2011, he attended four appointments with mental health nurses. During each appointment, he appeared stable and positive in mood. He used his time at Onley constructively and received positive reports from members of staff before his release on 27 May.

3. The man was arrested on 19 June for offences of assault and criminal damage. He telephoned his friend and employer, saying he was going to kill himself. She then reported her concerns to the police. The next day, when he attended court, his employer and his solicitor also informed the escort contractors of the risks he might present to himself. A suicide/self-harm warning form was completed to alert those coming into contact with him of the potential risk. He was remanded in custody and taken to HMP Leicester on 20 June. It does not appear that this warning was noted when he arrived at Leicester.

4. On the evening of 20 June, the man made a telephone call to his partner. During the call, he made a number of remarks that intimated self-harm or suicide. He said he was not "going to stick around too long" and made other similar statements. He also asked his partner to call his father. An officer from the security department listened to the call the following morning, 21 June and, out of concern, went to see him. He indicated he was particularly concerned about the prospect of receiving an indeterminate custodial sentence for his new offences. (An indeterminate sentence requires a prisoner to serve a minimum term with subsequent release dependent on satisfying the Parole Board that he is no longer a risk to the public.) As a result of the meeting the officer initiated self-harm monitoring to provide more frequent observations by and interaction with members of staff. A further review was scheduled for 24 June.

5. The man also saw a careers advisor on 21 June and made a second telephone call to his partner. He did not make any of the same intimations as during the initial call. The next day, he saw a mental health nurse, who reported that he appeared calm and settled. There were no concerns about his mental health, and avenues of support within the prison were discussed. He saw the careers advisor again and enrolled on two courses. On 23 June, he moved from the prison's first night centre to a different cell, sharing with a different prisoner than he had on arrival.

6. At 9.00am on 24 June, the man's cell was unlocked and he was asked if he wanted to take exercise. He declined. At 9.50am, an officer unlocked his cell

so that he could attend a review of his self-harm monitoring. He was discovered suspended from a ligature that was made from bedding and attached to the cell's window bars. He was initially unresponsive; he was not breathing and had no pulse. A sustained and coordinated resuscitation effort commenced, and a pulse was eventually found. He was taken to hospital but his death was pronounced several days later, when scans showed no brain activity.

7. The investigation has covered the issue of whether the risks were identified in a timely fashion, the use of the suicide and self-harm monitoring procedures, and support for members of prison staff. We make four recommendations, the most important of these relating to consideration of warning forms that arrive with prisoners and considering all the known risk factors when making assessments of risk.

THE INVESTIGATION PROCESS

8. An investigator conducted 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.

9. He visited HMP Leicester to open the investigation on 11 July 2011 and visited the areas of the prison where the man had spent time, and also collected records relating to his time in custody. This included documents not only about his time at Leicester, but also at HMYOI Onley.

10. The investigator returned to Leicester to conduct interviews with nine members of staff on 30 and 31 August, and 31 October. An Assistant Ombudsman also attended two of the interviews on 30 August. On 1 November, the investigator interviewed a friend, employee and support worker who the man had known for a number of years. On 2 November, he interviewed three members of staff at HMYOI Onley. The interviews were recorded. He also spoke by telephone to the man's solicitor.

11. One of the Ombudsman's family liaison officers (FLOs) spoke to the man's father to explain the purpose of the investigation and provide him with an opportunity to raise any issues or questions about the care that his son received in prison. He said he wanted to be reassured that prison staff did everything in their power to prevent his son's death. He added, however, that he was realistic about how far members of staff could go to prevent someone from taking their own life if that was their intention. He also spoke about the professional and compassionate support that he and his family had received following his son's death.

12. The local Primary Care Trust appointed a clinical reviewer to conduct a review of the man's care whilst in custody. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be an equivalent standard to what might have been expected in the community. The clinical reviewer consulted the man's medical records to inform his review. He attended the interviews with members of staff at HMYOI Onley on 2 November and had access to the transcripts of the interviews that the investigator conducted. His findings are summarised within this report. The final version of the clinical review was sent to the Ombudsman's office in March 2012. This report has unfortunately been delayed as a result.

Responses to the draft report

13. As part of the consultation process, a draft version of this report was sent to the man's father, and to the National Offender Management Service (NOMS) and HMP Leicester.

14. The man's did not make any comments about the draft version of this report. His initial concerns are outlined above and addressed in the report.

15. The governor of HMP Leicester, via NOMS, disagreed with the conclusion drawn in this report that there was no evidence of a suicide and self-harm

warning form completed at court being considered as part of the reception health screening, and that the screening did not take account of known risk factors. The governor wrote:

> "During interview, [the nurse] knew about the man's history of self-harm, reported diagnosed bipolar disorder and his mother's suicide. She states 'he stated when he saw me that there was no intention of self harm or suicide and he showed no signs of that, he made good eye contact, he was calm, there was no signs of anxiety, he was chatty'. All the risk factors highlighted by the investigator had been fully considered by [the nurse]."

16. The Assistant Ombudsman wrote to NOMS on 18 July, addressing this matter as follows:

> "The conclusion reached was based on the interview with [the nurse] as well as documents relating to the man's first night in prison. [The nurse] told the investigator that concerns she had about his self-harm were historic (she said at interview that "issues that he had with self-harm in the past were in 2008, 2009/2008, and obviously we're in 2011 now"), and that she had no reason to think he was a risk to himself at the time of the assessment. This in itself suggests that she did not see the warning form that had been completed at court (the alternative explanation being that she saw the document and did not consider the information to be relevant). There was no mention of the form on the CSRA or during the record of the first night interview. Nothing was recorded on the computerised clinical record or P-NOMIS to suggest that such a document had been seen or taken into account. There is, therefore, no indication that it was considered as part of the reception process."

17. All of the recommendations were accepted. The Assistant Ombudsman raised concerns in his letter that the response to the recommendations was to issue reminders to staff rather than to implement any substantive change in policy or practice, and questioned whether this approach was sufficiently robust. At the time of issuing the final version of the report, no reply to the letter had been received.

18. The final version of the report was initially issued in October 2012, when no reply to the Assistant Ombudsman's letter had been received. Following the issue of the final report, we received a letter from the Acting Deputy Governor at Leicester. In this letter, he said that he had decided to look at the issues raised in this investigation again, to ensure that robust systems are in place and to look at whether any audit trails or management checks could be introduced to give assurances on compliance. We are pleased that Leicester have decided to re-examine their procedures and have agreed to reflect this in the final report.

19. Since the issuing of the first final report, the inquest into the man's death has been held. The jury returned a verdict of death by misadventure.

20. The response to the recommendations is included.

HMP LEICESTER

21. HMP Leicester is a mostly Victorian prison about half a mile from Leicester city centre. It is 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.

22. Healthcare at the prison is provided by a private company.

Her Majesty's Inspectorate of Prisons

23. 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. Inspectors reported that while some improvements had been made to the first night centre it remained grim with little natural light. Overall, the prison was performing reasonably well against the Inspectorate's tests.

24. With regard to supporting prisoners at risk of self-harm and suicide, the Inspectorate reported that monitoring documents demonstrated a high quality of care, although reviews were not always multi-disciplinary.

Independent Monitoring Board

25. All prisons have an Independent Monitoring Board (IMB) made up of unpaid members of the local community. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Secretary of State for Justice annually. The most recent published report covered the period February 2010 to January 2011. The IMB reported that purposeful activity for vulnerable prisoners had increased but was concerned about the number of prisoners at Leicester suffering from mental health problems. The Board spoke highly about the support staff gave to men at risk of suicide and self-harm.

Previous deaths at HMP Leicester

26. This office has been responsible for investigating deaths in prison custody since April 2004. Before the man's death, we have investigated 14 self-inflicted deaths at Leicester. Two of these occurred in 2004, two in 2005, one in 2006, four in 2007, one in 2008, two in 2009 and two in 2011. Following a death in 2009, our investigation made a recommendation about using all sources of information for information about a prisoner's risk of suicide or self-harm. Regrettably, we draw attention to a similar matter in this report.

KEY EVENTS

Background

27. The man had been involved in the criminal justice system since 2005. Between then and 2010, he served a number of sentences in young offender institutions.

28. Around 2006 or 2007, he became involved with a social enterprise run by a mentor. Initially, he attended a music project. She explained to the investigator that she had developed a close friendship with him, and spoken to him almost every day for several years. He also took up a paid mentoring position with her social enterprise. Due to concerns about his mental health, she acted as his appropriate adult during police interviews.

HMP Onley

29. On 15 November 2010, the man was convicted of offences and sentenced to eight months' imprisonment. He had committed previous offences and, at the time, was subject to a suspended sentence order. The custodial element of this was activated and added to his sentence, meaning that his total sentence was for 12 months. He was initially taken to HMP Leicester and, four days later, transferred to HMP Onley.

30. A nurse conducted a routine reception health screening for the man when he arrived at Onley. She told the investigator that he said he suffered from bipolar disorder (a condition often characterised by episodes of elevated mood and periods of depression). She asked one of the mental health nurses on duty at the time to see him for further assessment. As a result of this, an agreement was reached that he would be seen regularly by a nurse from the mental health team.

31. Following the referral at reception, the man was seen by another nurse on 25 November. She explained to the investigator that he said he had been diagnosed with bipolar disorder. He also gave her information about his background and family relationships, saying his mother also suffered from bipolar disorder and had taken her own life in 2008. She wrote in the clinical record that he was pleasant and polite, and appeared relaxed with no evidence of thought disorder or cognitive impairment.

32. The nurse recalled that he said he had been prescribed medication for his bipolar disorder but had only taken it a few times, and had not taken it at all for several months. He was not taking any medication at the time of the review and did not feel that he needed any. After the appointment, she spoke to one of the prison psychiatrists, who advised her to try and obtain his medical notes from his psychiatrist in the community.

33. On 31 December, the nurse again saw the man. She had no concerns about him at that time, and noted in the clinical record that the stability in his mood had been maintained. There was no evidence of mood disorder or psychotic symptoms. He was engaging in activities within the prison and appeared to be using his time in custody constructively. Despite two requests by this

point, she had not received the information she required from the community psychiatrist.

34. After the appointment on 31 December, the nurse, in preparation for a period of leave, arranged for another nurse to take over the man's appointments. The nurse first saw him on 18 February 2011. Recalling her impression of him, she said:

> "I thought he was an incredibly mature young man. He would stay focused at that time on what he wanted, where he could see himself going. There was no evidence at that time of any symptoms of mental illness. He was doing very well at work; he worked in the market gardens at the time. The staff there had incredibly high regard for him. As I say he just struck me as … a very mature young man."

35. As with the previous appointments, there were no concerns about the man's mental health at that time. The nurse recorded in the clinical record that there was no evidence that medication was required.

36. Before the appointment on 18 February, the nurse had received records from his psychiatrist in the community. She told the investigator that the psychiatrist had not made a conclusive diagnosis of bipolar disorder.

37. The nurse saw him again on 20 May, more than three months after the last appointment. She explained that it was not easy to see him because he was attending a number of courses and was occupied for most of the time. However, when she did see him, she did not find any cause for concern. He presented in the same way as during the previous appointments, was using his time constructively, and did not have any mental health issues.

38. The man was released from Onley on licence on 27 May. The reports from prison staff at the time of his release were very positive. He had made the most of his time in prison and was reported to have excelled himself.

39. He lived in Market Harborough and according to his mentor he reacquainted himself with old friends whom she did not consider a positive influence. She told the investigator that he was not in a constructive environment following his release from Onley.

Arrest and remand to HMP Leicester

40. On 19 June, the man was arrested. A healthcare professional completed a medical form at Wigston police station at 8.45am. The form reads:

> "Bipolar disorder. Past history of suicidal attempts but states he sought aid for these himself and now has got things to live for. Regrets these attempts. Anniversary of mother's death but feel okay and states that he does not feel at risk of [self-harm]/suicidal ideation. States he has poor memories of time periods when his mood is 'up' or 'down'. Mood appropriate at present. Past history of asthma with occasional current use of blue inhaler."

41. The mentor attended the man's police interviews as his appropriate adult. She told the investigator that, later that day, she received a telephone call from him, who was very upset and said he was going to kill himself. She said she telephoned the police station to inform the officers there that he presented a risk to himself.

42. The next day, the man attended Magistrates' Court and his case was committed to the Crown Court. Because his licence to remain in the community had been revoked, he was remanded in custody.

43. The mentor told the investigator that she asked the man's solicitor to make the escort contractors aware of his mental health issues and risk of suicide. When the investigator spoke to the solicitor, she confirmed that she had spoken to G4S, the private company responsible for the transport of prisoners, about the issues. A suicide/self-harm warning form was completed, noting the mentor's warning that he was at risk of suicide or self-harm. This formed part of the person escort record (PER). (This is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort.)

44. The man arrived at HMP Leicester at 1.45pm. The suicide/self-harm warning form was signed by a member of the reception staff, as were the other escort papers.

45. A nurse completed his reception health screening. During interview with the investigator, she said he talked about previous attempts at self-harm, and also his mother's death. She recalled that he was calm, chatty and did not appear anxious. She did not have any concerns about him in terms of suicide or self-harm. She told the investigator that she usually saw the PER for arriving prisoners, but did not give any indication that she had seen his suicide/self-harm warning form.

46. The nurse referred the man to the prison's mental health team when he told her that he had been diagnosed with bipolar disorder but had not taken medication for more than six months.

47. As part of the reception process, a cell sharing risk assessment (CSRA) was also completed. The primary purpose of such an assessment is to identify any risks that prisoners might pose to others, or risks that they might be exposed to, when sharing a cell. No such risks were identified for the man. He did not have any objection to sharing a cell, but asked to share with a prisoner of a similar age who was clean and tidy, and drug-free.

48. Following the reception process, he was allocated to cell L1-04, which he shared with another prisoner. There was a record of a first night centre interview with an officer, though there was no suggestion that this officer had seen the information contained in the PER or considered him a risk of suicide or self-harm. The interview appeared to be more a check of understanding of prison procedures rather than a review of whether risk factors had been identified and assessed appropriately.

49. Around 6.30pm the same day, the man made a telephone call to his partner. All prisoners at Leicester are allowed to make a three-minute call on the evening of their arrival. All of these first night calls are monitored by members of staff working in the prison's security department, so that issues about security and keeping prisoners safe during their early days in custody can be addressed. Although the calls are monitored, this is not necessarily done at the time they are made.

50. During the telephone call, he made a number of statements that intimated self-harm or suicide. He said he was not "going to stick around too long" and made similar statements. He also asked his partner to call his father.

51. An officer from the prison's security department listened to the telephone call on the morning of 21 June. She told the investigator that, when she heard the content of the call, she became immediately concerned about the man's well-being. She went to the wing and asked members of staff if any concerns had been raised about him overnight. Other than him perhaps being somewhat quiet overnight, no issues had arisen. She decided to speak to him with a colleague, and they went to see him in his cell at around 8.00am. He was alone because his cellmate was attending court.

52. The officer told the investigator that he seemed shocked and taken aback that members of staff at the prison cared about him. She explained to him why she was concerned about him, and he said he was worried about the prospect of an indeterminate prison sentence.

53. As a result of her initial conversation with the man, the officer decided to open an Assessment, Care in Custody and Teamwork (ACCT) document. ACCT is used by all prisons in England and Wales to provide additional support and monitoring for prisoners thought to be at risk of suicide or self-harm. The first stage of the ACCT process is a 'concern and keep safe' form. She wrote on the form that she had concerns about self-injury or statement of intent to self-harm, explaining that he had said during a telephone call that he would not cope if he received an indeterminate sentence.

54. Ordinarily, there is a delay of up to 24 hours between an ACCT being opened and a detailed assessment interview being conducted by a trained ACCT assessor. An immediate action plan is formed to help keep the prisoner safe in the meantime. The officer was a trained ACCT assessor and so decided to conduct the assessment interview immediately. There was, therefore, no need for the interim action plan.

55. The officer recalled that during the interview the man was quite reserved. He engaged in conversation and, although he was forthcoming with answers, the information that he offered was limited. He told her that he had attempted to hang himself the previous June around the anniversary of his mother's death. He also said he was going to hang himself the previous night (20 June) but did not feel strong enough. He was worried about the prospect of an indeterminate prison sentence and the fact that he had been remanded in custody until September. She explained the support mechanisms in place from staff and other prisoners and from Listeners (prisoners trained by the Samaritans to offer confidential peer support to other prisoners), and also spoke about bereavement counselling and purposeful activity.

56. Following the assessment interview, the first review of the ACCT took place. This involved a Senior Officer (SO), the officer and the man. The SO told the investigator that he thought a mental health nurse was also present, though this was not recorded on the form. He wrote on the review form that the man said he would be fine, but was concerned about his offences and subsequent sentencing. The officer had suggested to the SO McGilway that he was allowed to make a further free telephone call, both for support and to monitor whether he said anything that would raise concern for his safety. He said he planned to make a telephone call to his partner later that day. The SO wrote on the form that he collected his lunch and, although he was somewhat low in mood, there were no major concerns about him. His level of risk was recorded as low. The ACCT remained open and a further review was scheduled for 24 June.

57. Prisoners on the ACCT process are expected to be monitored more frequently than would normally be the case. Members of wing staff were required to have at least two conversations with the man during the day, and to observe him once in the morning, afternoon and evening, and three times during the night. Another part of the ACCT process is the Caremap. This details issues specific to an individual prisoner, along with goals and how they can be achieved. Two items were recorded on his Caremap. The first related to medication for bipolar disorder. The SO wrote that he was awaiting an appointment with the doctor. The other item referred to contact with his partner. As discussed during the review, a telephone call was arranged. There was nothing on the Caremap about his concerns that he would receive an indeterminate sentence for the new offences.

58. On the same day, the man saw a careers advisor working in the prison. This initially arose as a result of mistaken identity; she had sought to find a prisoner of the same name and had located him instead in the prison's gym. They had a short talk and he expressed an interest in training to be a Listener. Also on 21 June, he attended key skills assessments to test his level of literacy, numeracy and information technology.

59. The man made a second telephone call to his partner on the same day. He did not make any of the same intimations as during the initial call, and talked about his partner visiting in six days' time.

60. On the morning of 22 June, he saw a nurse as a result of the referral that was made during the reception health screening. The nurse told the investigator that the man appeared calm and settled and that he did not have any concerns about his mental health. He noted in the clinical record that he had not been taking medication for more than six months, including his time at Onley. There was no indication that a discussion had taken place regarding any resumption of treatment. He made him aware of the various avenues of support within the prison, in terms of the mental health team and also more informal forms of support. He told the investigator that when the man left the appointment, he did not have any reason to be worried or concerned about his well-being. He was aware that he was subject to the ACCT process but did not make a note of their appointment in the ongoing record section of the document.

61. Later the same day, the man again saw the careers adviser. This was to record his qualifications, to talk about the results of the key skills assessment, and to develop goals for his time in prison. He talked about his mentor's social enterprise, and said he felt sure he would be able to return to it when he was released. Although he did not have any formal educational qualifications, there no issues with his literacy, numeracy and IT skills. He signed up for the Listeners course and a food safety course. She said he was polite and compliant but also seemed somewhat preoccupied. She was aware that he was subject to the ACCT process, but did not make a note of their appointment.

62. On 23 June, he moved from the first night centre to cell L4-15 to share with a different prisoner. There was little else of note recorded in his records for that day, though the ACCT remained open.

The emergency response

63. At 9.00am on 24 June, an officer opened cell doors on L3 landing to ask prisoners if they wanted to take exercise. The man was alone in his cell, because his cellmate had gone to court. He told the officer that he did not want exercise. The officer explained to the investigator that this was not unusual and that it would not in itself be a cause for concern.

64. SO 1 recalled that, around 9.45am, he wanted to conduct the man's ACCT review. He had already spoken to a nurse by telephone to obtain some information about how he had presented from a mental health perspective. The SO approached Officer A to ask where the man was. The officer then went to his cell to unlock him. The SO followed him.

65. Officer A told the investigator that when he opened the observational panel and looked into the cell, he could only see the man's right arm at the back of the cell. This was because the privacy curtain had been pulled all the way across, and the officer assumed that he was smoking at the back of the cell. He opened the cell door, went inside, and called out to him to ask if he was okay. The SO followed the officer into the cell.

66. The officer described pulling back the privacy curtain and seeing the man with a ligature, made from the bed covers, around his neck. The other end was attached to the cell's window bars, and he was suspended a few centimetres from the floor. He recalled shouting for assistance from other members of staff.

67. The SO explained to the investigator that he had followed the officer into the cell, and so saw the man hanging when the officer pulled back the privacy curtain. The SO used his anti-ligature tool to cut the ligature. The officer attempted to support the man's weight, but he slumped to the floor. The SO made an emergency 'code blue' call over the radio. ('Code blue' indicates an emergency involving breathing difficulties.) The prison's control room logged the time of the message as 9.50am. The SO positioned the man on his back and, after checking for signs of life, began to perform chest compressions.

68. SO 2 was in the centre of the prison when she heard the emergency radio call. She immediately made her way to the cell and found SO 1 performing

chest compressions. She felt that the officer was in shock, and she instructed him to leave the cell. She relayed a further radio message to the control room, confirming the cell location and requesting an ambulance. This message was logged at 9.51am. She then began to administer rescue breaths to the man.

69. A nurse was in the prison's first night centre, on L1, three floors below the man's cell, when he heard the emergency radio call. He made his way to L4 landing, first stopping at L2 landing to collect a 'grab bag' containing emergency equipment. He estimated that he arrived at the cell less than two minutes after the radio call. He recalled that both SOs were performing cardio-pulmonary resuscitation (CPR). He took over the rescue breaths, using a mask and oxygen. Other members of staff had begun to arrive, and he asked one of them to set up the defibrillator. (This is a piece of medical equipment that monitors a patient's heart rhythm and delivers an electric shock if required.)

70. The CPR effort continued. As other members of staff, such as two more officers arrived. The nurse asked them to assist with the chest compressions so that people did not become too tired to continue. The defibrillator indicated that a shock was not required.

71. The first ambulance arrived at 9.57am. A second ambulance arrived three minutes later. The nurse recalled that the paramedics were content for the prison staff to continue to administer CPR while they set up their equipment. The chest compressions continued, as did the delivery of oxygen. The paramedics administered adrenaline intravenously.

72. During the resuscitation effort, the paramedics' monitoring equipment indicated that the man had a heartbeat. As a result, chest compressions ceased but the delivery of oxygen continued. He was moved to a spinal board and carried by the paramedics, SO 2, two officers and the nurse to the waiting ambulance. During the journey through the prison, the nurse continued to administer oxygen. The ambulance left the prison at 10.35am and he was taken to hospital.

Events after the emergency response

73. The duty governor informed the man's father of what had happened, and agreed to meet him at the hospital.

74. A 'hot debrief' took place very shortly after the man left the prison. This was chaired by two senior managers, involved representatives from the care team and Independent Monitoring Board, and was attended by those members of staff involved in the emergency response. There was consensus that the response was swift and that the CPR was very well coordinated. Reviews took place for all prisoners subject to the ACCT process, to ensure that additional support and monitoring was being offered as needed.

The man's death

75. The man remained in hospital for several days. Although he spent time breathing unaided, he did not regain consciousness and there were concerns

about brain injury. At 2.00pm on 27 June, a test showed that there was no brain activity. The test was repeated at 5.00pm with the same results. His death was therefore confirmed as the earlier time of 2.00pm.

76. Members of staff from HMP Leicester were present throughout the man's time at the hospital, though no restraints were used. Notices to staff and prisoners were issued to inform them of his death.

Ongoing liaison with the man's family

77. The man's father told the Ombudsman's family liaison officer that he was very appreciative of the ongoing support that he received from the prison. In accordance with national policy, the prison returned his property and assisted with the costs of the funeral.

ISSUES

Identifying the risk of self-harm

78. After the man appeared in court on 20 June, his solicitor and mentor/appropriate adult made the escort contractors aware that he might be at risk of self-harm. The previous evening, his mentor had also made the police aware of the same issue after she received a worrying telephone call from him. Although the escort contractors did not add anything obvious to the front page of his person escort record (PER), they did complete a suicide/self-harm warning form which was placed inside the PER booklet and accompanied him to HMP Leicester.

79. There is no indication that this form was considered as part of the reception processes. It seems that the reception health screening, cell sharing risk assessment (CSRA) and other first night procedures were mostly based on the man's personal presentation rather than an objective assessment of the known risk factors. While there is often a reliance on information from newly arrived prisoners, there should also be an acute awareness that the PER can and often does contain important information about the risks posed. Had the PER been fully considered it is very likely that he would have been placed on an ACCT as soon as he arrived. Even without the PER it is surprising that a newly arrived prisoner who had been recalled to prison, now possibly facing an indeterminate sentence, with a history of self-harm, a reported diagnosis of bipolar disorder and a mother with that condition who had killed herself almost exactly three years previously was not identified as a risk of suicide and self-harm at that stage.

80. Although it seems that there was no consideration of the suicide/self-harm warning form on the man's first night in prison, or that sufficient attention was given to his other risk factors, concerns were raised the following morning after his telephone call to his partner had been monitored. The ACCT process was started at this time, and he remained subject to additional monitoring until the time of his death, although it is a concern that his risk was assessed as low. Nevertheless, as he was placed on an ACCT, it seems unlikely that the failure to consider the form on the evening of 20 June or to consider fully all the known factors which heightened his risks would have made any difference to the ultimate outcome. On another occasion, however, the timely use of this important knowledge and full consideration of all the risk factors could be crucial to ensuring a prisoner's safety. We therefore make the following recommendations:

The Governor and Head of Healthcare should ensure that members of staff working in reception thoroughly check the person escort record for all relevant information about prisoners being received.

The Governor should ensure that members of staff identify and fully take into account all known indicators of risk when assessing a prisoner's risk of self-harm.

Assessment, Care in Custody and Teamwork (ACCT)

81. Once the risk was identified, on 21 June, an officer opened an ACCT and immediately completed the assessment interview. It appears that the ACCT review that followed was not multi-disciplinary. The SO thought a nurse was present, although his name was not on the review form. The nurse did not recall attending the review. It is also concerning that the man was assessed as low risk after the initial review, given the known risk factors and the content of the telephone call.

82. When the careers adviser and nurse saw him, both were aware that he was subject to the ACCT process. However, neither of them recorded in the ongoing record section of the ACCT document that they had seen him. It is good practice for ACCT documents to accompany prisoners to appointments with other members of staff, and for those members of staff to record their interactions. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all members of staff update ACCT documents after interacting with prisoners.

Clinical issues

83. The review into the man's medical care was completed by a clinical reviewer. He concluded that "the quality of medical care in prison can be equal to and indeed in this case was better than that which could be expected outside the custodial setting".

84. He raised no issues of concern and made no recommendations.

Support for members of staff

85. Two members of staff – one prison officer and one nurse – felt that they were not adequately supported following the emergency response and the man being taken to hospital. Both members of staff said there was an expectation that they would immediately return to work without any kind of meaningful break.

86. In addition, one member of staff said that she was told of the man's death in passing by a senior manager. Those who work in prisons often have to deal with difficult or upsetting situations, but it is important that they are given proper support. We make the following recommendation:

The Governor and Head of Healthcare should ensure that members of staff are adequately supported following potentially traumatic incidents.

CONCLUSION

79. The man had been in the community on licence for just over three weeks when he was arrested for new offences on 19 June 2011. He telephoned his friend and employer from police custody and said he was going to kill himself. The next day at court, his friend and his solicitor informed the escort contractors of the possible risk of suicide and self-harm. The escort contractors completed a warning form that was sent to the prison.

80. It seems that the warning form was not considered when he first arrived at HMP Leicester on 20 June. However, the ACCT process was started the next morning, in response to the concerning tone and content of a telephone call that he had made to his partner. During an interview with a member of staff, he said he was particularly concerned about the possibility of an indeterminate sentence of imprisonment.

81. He remained subject to suicide prevention monitoring. No immediate concerns were raised about him in the two days that followed. On the morning of 24 June, when members of staff unlocked his cell for a review of his ACCT, they found him suspended from a ligature. Cardio-pulmonary resuscitation (CPR) was administered by prison staff and paramedics, and a heartbeat was eventually restored. He was then taken to hospital, but died there several days later.

82. We make recommendations about the administration of the ACCT, and support for members of staff following traumatic incidents. However, the most pressing issue relates to the recognition of risk when prisoners arrive. It is not clear whether the suicide/self-harm warning form was noticed by reception staff when he arrived at Leicester, and it does not appear that factors known to increase the risk of suicide and self-harm were taken into account. It is vital that staff use all the information open to them to keep prisoners safe when they arrive and, accordingly, we make a recommendations about these matters.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that members of staff working in reception thoroughly check the person escort record for all relevant information about prisoners being received.

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

   "A reminder has been issued to all staff members working in Healthcare about the importance of comprehensively checking the PER for all relevant information about prisoners being received in to the prison during the reception screening process. Additionally, a permanent notice has been posted in the Reception Healthcare Screening Room to reinforce this important matter."

2. The Governor should ensure that members of staff identify and fully take into account all known indicators of risk when assessing a prisoner's risk of self-harm.

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

   "All staff will be reminded of the need to identify and fully take into account all known indicators of risk when assessing a prisoner's risk of self-harm."

3. The Governor and Head of Healthcare should ensure that all members of staff update ACCT documents after interacting with prisoners.

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

   "A reminder has been issued to all staff members working in Healthcare about their responsibilities in relation to the completion of the relevant sections of the ACCT document. In particular, the importance of updating the ongoing record section of the document. All Registered Nurses have also been issued with a personal copy of the Nursing & Midwifery Council (NMC) document "Record Keeping: Guidance for nurses and midwives" in order to remind them of their professional accountabilities. This document is also issued as standard to all new members of nursing staff who join the department as a part of their induction process. Notice to staff to be issued reminding all staff of the importance of updating the on going record with all interactions with the prisoner."

4. The Governor and Head of Healthcare should ensure that members of staff are adequately supported following potentially traumatic incidents.

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

   "We will ensure that all staff are reminded of the support available to them following potentially traumatic incidents. In the event of a future potentially

traumatic incident we will ensure individuals are contacted and offered support."