PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Leeds in February 2012

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

This is the report of the investigation into the death of a man at HMP Leeds in February 2012. He was 31 years old when he was found hanging in his cell during a routine check early in the morning. He had been dead for some time. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to review the clinical care the man received in prison. Staff at Leeds fully co-operated with this investigation.

The man had been at Leeds for less than 48 hours when he died. He suffered from depression and misused alcohol and drugs. He was prescribed anti-depressant medication and methadone in the community and both prescriptions were continued in prison. He had been in prison before but was apparently worried that he might receive a longer sentence as a result of the new charges he was facing. However, he consistently denied having any thoughts of suicide or self harm and officers and healthcare staff did not think that he needed to be closely monitored.

Assessing the risk a prisoner poses to himself is not an exact science and involves balancing the prisoner's demeanour and behaviour against known risk factors. The man clearly had some risk factors but at no time had he given any indication to staff or fellow prisoners that he intended to take his own life. Overall, I am satisfied that he received appropriate care at Leeds and that his actions could not reasonably have been foreseen or prevented.

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 **August 2012**

CONTENTS

SUMMARY

1. The man was born in June 1980. He lived with his parents, had a partner and two children, and was unemployed. He had a history of depression and drug and alcohol abuse. He had previously served custodial sentences, with the last ending in July 2011, when he was released on licence.

2. On Saturday 18 February 2012, the man was recalled to prison after being charged with new offences and was next due to appear in court on 24 February. He was taken to HMP Leeds where healthcare staff assessed him. They placed him on a methadone maintenance programme for his drug dependency as well as prescribing medication for his depression. He also had an assessment by a member of the mental health team. At no time did he say that he had thoughts of harming himself or taking his own life and staff had no concerns about his risk to himself. He was not monitored under suicide prevention measures.

3. A few days later staff found the man hanging in his cell and called for emergency medical assistance. Healthcare staff examined him but found no signs of life and, as it was evident that he had been dead for some time, resuscitation was not attempted. Paramedics arrived and confirmed that he had died.

4. In the days that followed, the prison family liaison officer maintained contact with the man's family and offered support and financial assistance towards the funeral expenses.

5. Although the man had some risk factors which increased the risk of self harm and suicide, we conclude that these were not sufficient to indicate that he needed to be more closely monitored. We are satisfied that his assessment and treatment was timely and equivalent to what he could have expected in the community. We do not think that staff could have predicted or prevented his death and we make no recommendations.

THE INVESTIGATION PROCESS

6. The investigation was opened on 20 February 2012, when the investigator issued notices announcing the investigation to staff and prisoners and inviting anyone with any information relevant to the investigation to contact him. No one came forward as a result.

7. The investigator visited HMP Leeds on 23 February 2012. During his visit he was given copies of all documentation relating to the man and was shown his cell.

8. The investigator returned to Leeds on 15 March and interviewed five members of staff and one prisoner. Written feedback on the progress of the investigation was sent to the Governor on 30 May.

9. The local PCT appointed a clinical reviewer to review the clinical care the man received at Leeds. He reviewed the man's medical records and was given copies of the transcripts of interviews conducted by the investigator. The investigator and the clinical reviewer discussed aspects of his treatment.

10. HM Coroner for Leeds was informed of the investigation and provided a copy of the post mortem report. This investigation report will be sent to the Coroner to assist his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers contacted the man's father to inform him about the investigation and invite him to ask any questions or raise any concerns. He asked the following questions:

    - Why was his son in a cell on his own?
    - Whether any checks were conducted during the night?
    - Why was he not being monitored under suicide prevention measures?
    - What time was he found and at what time his death was pronounced?

    We hope that this report helps to answer their questions.

HMP LEEDS

12. HMP Leeds is a category B local prison. The prison serves Magistrates' and Crown Courts in the West Yorkshire area taking adult male prisoners on remand until trial and for short periods after sentence. Currently the prison can hold up to 1,120 prisoners who are housed on one of the six residential wings or in the 20-bed healthcare inpatient unit.

13. Nursing staff are available 24 hours a day and during the day, there is also a doctor in the prison. Primary health services at Leeds prison are commissioned and provided by the local Primary Care Trust.

HM Inspectorate of Prisons (HMIP)

14. HMIP last conducted an unannounced full follow-up inspection of the prison between 3-12 March 2010. The inspection report noted that there were good support services and first night procedures for new prisoners. The first night centre had a relaxed and supportive atmosphere. Generally, procedures to identify and support prisoners at risk of suicide and self harm were sound. Following a recommendation made at the last inspection, night staff on the first night centre received a handover sheet identifying prisoners who might need additional support, such as those new to custody or recalled to prison.

Independent Monitoring Board (IMB)

15. Each prison is monitored by an Independent Monitoring Board of unpaid volunteers from the local community. Board members monitor all aspects of prison life to ensure that proper care and decency are maintained. The most recent IMB annual report for Leeds covers the period to December 2011. In their report the IMB made the following comments:

> "Board members report that the First Night Centre exhibits a caring atmosphere and is run efficiently under difficult conditions with variances in expected arrival times. No complaints were received from the First Night Centre during 2011.
>
> "The Board has met substance use managers and attended drugs strategy committees on a regular basis and is pleased to record that the intensified recovery programmes, extensive use of community agencies, peer group and officer support, coupled with a Deter and Reward Strategy are resulting in a fairer and humane approach to this serious issue."

Reception

16. New prisoners are received by reception staff, who gather information about them. Reception staff do not routinely have access to a prisoner's past records, so the prisoner is the main source of information. However, all prisoners will also have a Person Escort Record (PER). This document is completed by staff responsible for escorting individuals between prisons, courts, and police

stations. It includes pertinent information, such as a prisoner's risk to others or themselves.

17. The initial healthcare screen is completed on the prisoner's arrival and concentrates on their immediate physical and mental health needs, risk of self harm or suicide, and any drug or alcohol withdrawal or detoxification issues.

Suicide and self-harm monitoring

18. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs) and Prison Service Instructions. PSO 2700 – 'Suicide prevention and self-harm management' (Now replaced by PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others - Safer Custody' with effect from 1 April 2012) details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm.

19. Any member of staff can start the ACCT process, by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training. Once placed on an ACCT plan, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

Integrated Drug Treatment System (IDTS)

20. IDTS is a Prison Service scheme which aims to increase the amount and quality of substance misuse treatment available to prisoners, with particular emphasis on the early days in custody. It is intended to improve the links between clinical and non-clinical services and reinforce continuity of care from the community into prison, between prisons, and on release into the community. As part of the IDTS programme, prisoners can be prescribed substitute substances to aid detoxification along with integrated clinical and psychological treatments in prison and the community.

Previous deaths at Leeds

21. The man is the fourth prisoner apparently to take his own life at Leeds since 2010. The last self inflicted death was in 2011. There are no similarities between these deaths and that of his.

KEY EVENTS

22. The man was born in June 1980. He had a partner and two children but lived with his parents in the Barnsley area. He had a history of depression, drug and alcohol abuse. He had a number of criminal convictions and had previously served custodial sentences, being released on licence from HMP Doncaster on 7 July 2011. (When a prisoner is released on licence, they must adhere to certain conditions. If they break any of the conditions of their licence, they can be recalled to prison.)

23. On Saturday 18 February 2012, the man appeared at Magistrates Court charged with burglary and assault, after being arrested the previous evening. He was regarded as having breached the conditions of his licence by his conduct so his licence was revoked and he was returned to custody to await his trial, which was due to begin on 24 February. From court he was taken to HMP Doncaster, but as the prison was full, went to HMP Leeds instead.

24. The documentation that accompanied the man from the court to Leeds included the Person Escort Form (PER) which was completed by the police and custodial transfer staff. There is room on the PER to record details of potential risk such as self harm, mental or physical ill health, drug or alcohol issues. Staff completing the form did not identify him as being at risk of self harm or suicide but noted that he was a methadone user and suffered from depression.

25. In reception, a cell sharing risk assessment (CSRA which considers the risk posed to others by the individual) was completed. A governor assessed the man as posing a high risk to others because previous prison records indicated that he had a history of violence and racist tendencies. The governor recorded that the assessment should be reviewed once Leeds had received his custodial records from Doncaster. He was given cell D1-22 on the first night centre (FNC), which was a double cell that he occupied on his own. The observation panel in the cell door has both metal and glass sliding panels so that staff can easily observe the prisoner and any medications can be given without needing to open the cell door.

26. Later that afternoon, the man saw a nurse who conducted an initial healthcare screen. He told the nurse that he was prescribed mirtazapine (an anti-depressant) for depression. He also told the nurse that he smoked 20 cigarettes a day and had a history of drug and alcohol abuse. The nurse recorded that he had a bruised left ear and a slight graze to his left cheek which he said he happened when he was restrained by the police. The nurse asked him if he had any thoughts of harming himself or taking his own life and he said no. The nurse referred him to the prison doctor.

27. A prison doctor saw the man shortly afterwards. The doctor recorded that he had a history of depression and had been prescribed mirtazapine. He told the doctor that he was prescribed methadone but also injected heroin every day and drank eight cans of super strength lager a day, though he had not had any alcohol for two days. He said that he had no thoughts of self harm or suicide. On examining him, the doctor recorded that there were no signs of alcohol

withdrawal and decided that he did not need to be placed on an alcohol detoxification programme (where the individual is prescribed a decreasing dose of medication to treat the dangerous symptoms of withdrawal). However, the doctor requested that IDTS nursing staff observe him for 24 hours for any signs of withdrawal. The doctor prescribed 20ml methadone (a heroin substitute) twice a day for the first two days, increasing to 40ml once a day thereafter. The doctor also prescribed 30mg mirtazapine tablets, which he could keep in his cell and take one each evening. The pharmacy technician gave him that day's dose of methadone and recorded no concerns.

28. In interview, the doctor said that the man described himself as relaxed about being at Leeds and did not seem distressed. The doctor said that he showed no signs of being a suicide risk.

29. The same afternoon, an officer explained how the man could contact friends and family while at Leeds. He had £4.00 of telephone calling credit but did not make any calls during his time at Leeds.

30. At approximately 7.00pm, after all prisoners had been locked in their cells for the night, a roll check of the FNC was conducted. The check is done by an officer looking through the observation hatch of each cell door to see that the prisoners are present. The purpose of the roll check is to ensure that all prisoners have been accounted for, rather than to check on the prisoners' well being. However, if the officers have any concerns, they must be reported. The officer on duty in the FNC carried out the roll check. The officer raised no concerns about the man.

31. A nurse checked the man at 9.40pm when she gave him the prescribed mirtazapine, and again at 12.45am, 3.25am and 5.20am. On each occasion the nurse recorded that there were no concerns regarding his health and welfare.

32. During the night the prison is in night patrol state. All prisoners remain in their cells and there is a restricted number of staff on duty. Each cell has an alarm bell that a prisoner can press to summon assistance from a member of staff. The timing of each call made on the cell bells, and the time of the response, is logged, and the records showed that the man did not use his cell bell at any time

33. During the morning of Sunday 19 February, a nurse saw the man to assess his withdrawal symptoms and to see if he had any other concerns. He told the nurse that his legs ached and he felt sick but had not vomited. The nurse examined him and found no other signs of withdrawal such as a pounding heart, stomach cramps, diarrhoea, feeling cold or yawning.

34. A mental health nurse saw the man that afternoon to conduct a mental health assessment because of his history of depression. In interview, she said that she spent about 15 minutes with him. He told her that he had been prescribed mirtazapine by his community doctor and the prison doctor and that this helped his sleep pattern. He said he was "fine". He told the nurse he was due back in

court in a couple of days and said that he thought he might receive a five to six year custodial sentence. She asked him if he had any thoughts or intentions of harming himself. He said that he had two children whom he loved very much and that he wanted to be involved in their lives. He denied any thoughts of self harm. She said that he was open, relaxed, made good eye contact and was pleasant throughout the interview. She said that he gave her no reason to worry. The nurse noted that there was no evidence of low mood at that time but advised him to contact the mental health team straight away if there was any deterioration in his mood.

35. A pharmacy technician gave the man his prescribed methadone and mirtazapine and had no concerns about him.

36. The investigator interviewed the man's long time friend and a fellow prisoner. He explained that, between 17 and 18 February, they had been held at the same police station, appeared at the same court and travelled in the same custody transport. He said that the man seemed his normal self apart from being concerned about the possible length of sentence that he might be given. The man told him that he had made a mistake and had let down his parents and family. The last time he spoke to the man was on Sunday evening, 19 February, when he gave him a tea bag, sugar and an orange. At that time he said that he appeared fine.

37. The officer on duty on the night of the incident had no concerns about the man at the 7.00pm roll check. He was lying on his bed and watching television. He did not use his cell bell to summon assistance from staff during the night.

38. At approximately 5.30am, the officer conducted the early morning roll check. When he got to the man's cell, he saw that fabric had been placed over the observation glass panel. He unlocked the glass panel and tried unsuccessfully to pull the obstruction away. He realised that something was wrong and immediately summoned assistance over the radio. The officer did not use a code system to alert staff to the nature of the problem. (Code systems are in use in most prisons and inform staff of the nature of the emergency. The use of code system helps healthcare staff to bring the right medical equipment to the scene.)

39. A Senior Officer (SO) was on the landing immediately above the FNC and came down the stairs to the officer, who was getting the cell key out of his sealed pouch. (At night, officers on the wings have a cell key in a sealed pouch. If they need to unlock a cell in an emergency, they must break the seal. This means that cell entry is monitored and accounted for.) Two nurses also heard the call for assistance and went to the cell in case they were required. The nurses arrived at the cell at the same time as the SO, along with another officer who had also responded.

40. The SO and officer tried to open the cell door but realised that the man had hanged himself from a pipe leading to the ceiling light fitting, which was just in front of the cell door. The weight of his body was preventing the door from opening, and the SO had to force the door open. Having done so, he

supported the body while both officers cut the knotted bed sheet he had used to hang himself with, using an anti-ligature knife (a specially designed knife carried by all officers) and lowered him to the floor.

41. On hearing that the man had been found hanging, Nurse A immediately went to collect the emergency resuscitation equipment. At 5.32am, an emergency ambulance was requested. Nurse B examined him and found no signs of life and rigor mortis (the stiffening of the body that occurs naturally and normally several hours after death) was very evident.

42. Nurse B knew that the man rwin had been dead for quite some time and that to commence rescusitation would be inappropriate. The fast response paramedic arrived at 5.40am and, at 6.05am, after assessing him, confirmed that he had died.

43. After his death, the cell was searched and a letter he had written to his parents was found. In the first part of the letter, marked "Saturday Tea", he said he was sorry for letting the family down and said that he might receive a five or six year prison sentence this time. He said that he could not believe what he had done and "could not get his head around it". He asked his parents to visit and send him some money and family photographs. On the following page, marked "Sunday", he apologised to his parents and children.

Contact with the man's family

44. At approximately 9.00am that morning, the Governor and family liaison officer visited the man's parents to break the news of their son's death and offer support. In the days that followed, Leeds maintained contact with them to provide support and financial assistance towards the funeral expenses.

Support for staff and prisoners

45. At 8.00am on 20 February, a hot debrief was held for all staff involved in the emergency response and support was made available from the local care team and the national Employee Support Service. (Hot debriefs should be led by a senior member of prison staff and are intended to offer staff involved reassurance, information and support.) Following the man's death prisoners were offered support from the chaplaincy, IMB or the Samaritans. All prisoners being monitored on ACCT plans were reviewed.

ISSUES

Assessment of risk

46. As the man was in prison for less than 48 hours before his death, an important part of this investigation has been to consider whether staff missed any signs that he posed a risk to himself. He had been in prison before and his prison computer records did not show that he had previously harmed himself. Although it seems that he was monitored on an ACCT plan in 2006, the reasons are unknown. He suffered with depression and was prescribed antidepressants. He also had a history of drug and alcohol abuse.

47. When questioned about thoughts of suicide or self harm on his arrival at Leeds, he said he had never had any such thoughts. Neither the CSRA nor the first night assessment identified any concerns about suicide and self harm. All those who met him described him as seeming calm and relaxed, and he said he was "fine".

48. His mental state and risk of self harm or suicide was assessed by three healthcare staff on his arrival at Leeds. None thought that he showed any signs of vulnerability. On 19 February, he saw a member of the mental health team. He denied any thoughts of self harm or suicide and talked of his wish to be involved in his children's lives. He gave the nurse no reason to worry about him.

49. We have considered whether staff should have opened an ACCT plan on the man's arrival in custody. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. It is not an exact science.

50. The clinical reviewer considered whether an ACCT plan should have been opened and made the following comment:

> "The assessments of his physical and mental health were sufficiently comprehensive and were well documented. There was no reason to open an ACCT that I can determine had been overlooked or ignored."

He writes that the man's mental health was appropriately assessed by the healthcare staff who saw him.

51. We find that the man had some relevant risk factors indicating that he might be at risk of suicide or self harm, such as his history of depression and use of alcohol and drugs, for which he had been prescribed anti-depressants and methadone. While he reported using a high level of alcohol, he was closely monitored for any sign of withdrawal. He had been recalled to prison, a known risk factor, and it seems that he might have been facing a long sentence in relation to the new charges. However, we conclude that, on balance, the risk factors were not sufficient to indicate that an ACCT plan should have been

opened. He consistently denied any thoughts of self harm or suicide when asked directly about this and his behaviour and demeanour gave no indications otherwise.

Clinical Care

52. On his arrival at Leeds, the man told healthcare staff of his history of depression, alcohol and drug misuse. He was promptly prescribed anti-depressant medication and methadone. Assessments revealed no signs that he was experiencing alcohol withdrawal symptoms and so the doctor concluded that he did not need to be placed on an alcohol withdrawal programme. However, for the first 24 hours, IDTS nursing staff monitored him for any emerging signs of withdrawal. The clinical reviewer has carefully considered the overall clinical care given to him and concludes:

> "With regard to healthcare in the prison setting then it is in my considered opinion that I do not think that he could have been treated any differently or in a way that would have led to a different outcome. This applies to both his drug misuse problem and his depression.
>
> "From my assessment of the medical notes, the statements given at interview and my knowledge of assessment procedures then it is my opinion that he was received into HMP Leeds as well as could be expected and usual protocols and procedures were followed ... I do not think, therefore, that his death could have been prevented."

53. He makes no recommendations in his review. In our opinion, the care that the man received at Leeds was both appropriate and equivalent to the care he would have received in the community.

Emergency response

54. The officer realised that something was wrong when he found fabric covering the observation panel in the man's cell door. He immediately used his radio to call for assistance, but he did not use an emergency code because he was not certain of the situation. The nurses who responded to the call did not bring any medical equipment and, when staff confirmed that he had hanged himself, one of them had returned to the treatment room to collect it. In fact, the cell was only yards from the treatment room and so this did not unduly delay the response. It was also clear that he had been dead for some time and so resuscitation was not attempted. We have considered whether the officer should have used the code system when raising the alarm. We conclude that, because he could not be sure what had happened, it was reasonable for him not to have done.

55. National guidance directs that resuscitation should be attempted unless rigor mortis is present. The clinical reviewer commented on the decision not to attempt resuscitation as follows:

> “All the staff and the two nurses were of the opinion that death had occurred some time ago as there were significant changes of rigor mortis which were immediately noticeable at this time. Resuscitation was not attempted.”

56. The paramedics who arrived agreed that resuscitation should not be attempted and confirmed the man’s death.

CONCLUSION

57. The man was at Leeds for less than 48 hours before taking his life. He had been in prison before but thought he might be facing a longer sentence as a result of new charges. He also suffered with depression and had a history of alcohol and drug misuse. On his arrival at the prison, he was prescribed anti-depressants and methadone. On several occasions, he was asked directly whether he had any thoughts of suicide or self harm and consistently said that he did not. He apparently gave neither staff nor his friend reason to worry about him.

58. Although he had some risk factors which heightened the risk he posed to himself, we conclude that these were not sufficient to suggest that he needed to be more closely monitored. The care that he received was equivalent to that he could have expected in the community. We make no recommendations as a result of the investigation.

    The man's father received a copy of the draft report as part of the consultation process and provided written representations in response to the findings of the investigation. He was particularly concerned as to why his son was in a cell on his own while taking the drug Ritalin, as he understands there are side effects associated with this medication, which he considers pertinent to his son's death.

    He raised further concerns over the safety of the cell and the ligature point used by his son and also wished to refute comments in the report that his son was racist. We are grateful to the family for the time they have taken to consider the report and for their comments.