

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in July 2013,
while a prisoner at HMP Leeds**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, a prisoner at HMP Leeds, who died in July 2013 at hospital. He had been found hanging in his cell. He was 36 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received in prison was undertaken. HMP Leeds cooperated fully with the investigation.

The man arrived at HMP Leeds on 15 July 2013. He had been recalled for breaching his licence conditions after a previous prison sentence and was facing further charges. He had a history of mental health problems and was on medication for attention deficit hyperactive disorder (ADHD). He had attempted suicide several times in the past. These risks were noted on his escort record and seen by reception staff at Leeds. Because of his severe mental health problems he was managed under the NHS Care Programme Approach.

A prison doctor prescribed a much lower dosage of ADHD medication than indicated in the man's community GP records until he could be seen by the consultant psychiatrist. This was never subsequently reviewed or adjusted, despite his protestations that he was not on the right dose. Eight days later, he was transferred to HMP Everthorpe before he had seen anyone from the mental health in-reach team at Leeds or the consultant psychiatrist whose care he was under. He protested when he arrived at Everthorpe and was taken back to Leeds the next day as Everthorpe did not have the expertise to manage his condition. At Leeds he spent the next three days in the segregation unit, still waiting for a mental health assessment and medication review. Late on the evening on 25 July, he self-harmed by cutting his arm. Staff began to monitor him as at risk of suicide and self-harm, but he was only observed hourly, rather than five times an hour as the prison's local policy required. The next morning he refused to engage with healthcare staff in the segregation unit, as his medication had still not been reviewed. An hour later, an officer went to check him and found him hanging in his cell. He was taken to hospital but never recovered and died a few days later.

I am concerned that when the man was recalled to prison, reception staff did not assess his numerous known risk factors adequately and ensure he had an urgent mental health assessment. Changes in his mood and erratic actions were not recognised as potential signs of mental distress and an indication of the need to review his medication as he suggested, but instead were treated as poor behaviour. I do not consider that he should have been transferred to Everthorpe before he had a full mental health assessment and medication review. After he self-harmed on 25 July, prison staff did not monitor him at the frequency required by their local procedures, nor were exceptional circumstances identified for keeping him in segregation while on suicide and self-harm monitoring. Finally, I am concerned that local emergency arrangements at Leeds were out of step with national requirements and this led to a delay in calling an ambulance.

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**

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SUMMARY

1. The man was arrested and recalled to prison on 13 July 2013. He had a history of self-harm and had attempted suicide several times. He had been diagnosed with schizo-affective disorder, attention deficit hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD) and depression. When he was arrested, he had not taken the medication prescribed for his ADHD for two months, as he had been evading arrest and was homeless.
2. The man arrived at HMP Leeds on 15 July. His mental health conditions and history of self-harm were recorded during his reception health screen. He was referred to the mental health in-reach team and the in-reach consultant psychiatrist who had also been responsible for his care in the ADHD clinic in the community. The psychiatrist was not working in the prison specifically as an ADHD specialist, although did have specialist training in ADHD. A custodial manager who saw him to assess his risk for sharing a cell described him as appearing "chaotic". The prison doctor who saw him that evening prescribed a low dosage of ADHD medication. He was assessed as a risk to others if he shared a cell. He was not considered at risk of self-harm or suicide.
3. On 23 July, the man was transferred to HMP Everthorpe. The Person Escort Record completed at Leeds did not record his mental health issues or his history of suicide and self-harm. When he arrived at Everthorpe, he refused to leave the escort vehicle. He was angry and aggressive towards staff and began smearing excrement over his body. He was removed from the vehicle by force and taken to the segregation unit. He continued to act aggressively towards staff, who were unable to fully assess his health needs. Everthorpe healthcare team reviewed his electronic medical record and noted that he had been transferred before being assessed by the mental health in-reach team and the in-reach consultant psychiatrist at Leeds and he had no medication. Everthorpe had no ADHD specialist and were reluctant to try to manage his medication. They agreed with Leeds that because of his complex medical needs, he would return to Leeds the next day.
4. When he returned to Leeds on 24 July, the man was taken straight to the segregation unit. A segregation safety assessment concluded that there was no health reason to prevent him being segregated. He told staff that he needed an increased dose of his ADHD medication and was advised that he should discuss this with the consultant at an appointment scheduled for 26 July. The next morning, 25 July, during the segregation healthcare rounds, he told the nurse that his poor behaviour was a result of not having the correct medication.
5. That evening, at around 8.00pm, the man made superficial cuts to his arm and was reported to be angry and abusive towards staff. Staff began suicide and self-harm prevention procedures and specified hourly checks. This was the standard level of observation for prisoners in the segregation unit and not in line with the prison's local policy which requires prisoners in the segregation

unit subject to suicide and self-harm monitoring to be checked at least five times an hour until a full assessment is completed.

6. When checked at around 9.00pm staff could not see the man and he did not initially respond. He was hiding underneath his bed but eventually an officer coaxed him out and discussed his concerns with him for about an hour. He said he had not been treated well. He was keen to see the mental health team and his in-reach consultant who had managed his ADHD previously. The duty governor was informed of his self-harm and authorised his continued stay in the segregation unit, but did not indicate there were any exceptional reasons for holding a prisoner regarded as a risk of suicide and self-harm in the segregation unit.
7. The next morning, the man was reported to be angry and aggressive. He continually shouted at staff and refused to engage in conversation. He also refused to take his medication. When an officer checked him at 9.36am, he found him hanging in his cell. Prison and healthcare staff attempted resuscitation until the paramedics arrived and found a pulse. He was then taken to hospital where, sadly, he died a few days later.
8. The man had a number of mental health issues as well as a history of self-harm. When he arrived at Leeds, staff did not take account of his many risk factors when assessing his risk of suicide and self-harm or consider making an urgent referral for a mental health assessment. He was transferred to a prison that could not offer the continuity of care that he needed and when he returned to Leeds, his behaviour was treated as a discipline problem rather than a sign of mental distress. No reasons were given to justify holding a man regarded as at risk of suicide and self-harm in the segregation unit. When he was found hanging, resuscitation procedures were prompt but, contrary to national guidelines, staff delayed calling an ambulance until a member of healthcare staff had attended.
9. We consider the man's risk of suicide and self-harm should have been more proactively addressed at the outset. When he harmed himself there should have been a greater degree of urgency in seeking a mental health assessment and a check on his medication. We make 10 recommendations.

THE INVESTIGATION PROCESS

10. Notices were issued to staff and prisoners at HMP Leeds, informing them of the investigation and inviting anyone who had relevant information to contact the investigator. No one responded.
11. West Yorkshire Police conducted a criminal investigation into the circumstances of the man's death. In accordance with the Ombudsman's terms of reference, our investigation was suspended while the police conducted their enquiries. We resumed our investigation in October 2013 and the police shared key documents with the investigator, including witness statements.
12. The investigator visited HMP Leeds three times and interviewed 17 members of staff and one prisoner. Three prisoners and one member of staff (who was no longer employed at Leeds), indentified by the man's family solicitor, declined to be interviewed. The investigator gave the deputy governor initial feedback about the preliminary findings of the investigation and followed this up in writing. The investigator obtained copies of his medical records and all relevant prison records.
13. NHS England appointed a clinical reviewer to review the man's clinical care at HMP Leeds.
14. The investigator informed HM Coroner for HM Coroner West Yorkshire Eastern District of the investigation and we have sent a copy of this report the Coroner.
15. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation and invite his family to identify any relevant issues that they wished the investigation to consider. They had the following questions and concerns:
 - The circumstances of his arrest.
 - Was he given appropriate treatment and mental health support given his history of self-harm, drug issues and ADHD? His family were concerned that his medication for ADHD had been withheld and believed that not receiving the correct medication would have greatly affected him.
 - As he was subject to suicide and self-harm monitoring and in the segregation unit, how was he able to hang himself and what did he use as a ligature?
 - Was he allowed to use the telephone in the segregation unit?
 - Why was he taken to HMP Everthorpe?
 - The circumstances of his death.

16. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP LEEDS

17. HMP Leeds, in West Yorkshire, is a local prison holding up to 1,120 male sentenced and remand prisoners. Leeds Community Healthcare Trust provides primary healthcare services. Leeds and York Partnership Trust provides mental health in-reach services for prisoners with more severe and enduring mental health problems.

HM Inspectorate of Prisons

18. HM Chief Inspector of Prisons carried out a full announced inspection of HMP Leeds in January 2013. The Inspectorate found that levels of self-harm were low and the care given to those most vulnerable to self-harm was good, but self-harm monitoring procedures needed improvement. An integrated mental health in-reach team supported prisoners with severe and enduring mental health conditions and inspectors noted good integration between the mental health teams and healthcare and prison staff. Local ADHD services were available. Inspectors found that relationships between staff and prisoners in the segregation unit were good and that, while wing conditions were reasonable, some cells were grubby.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of volunteers from the community who help ensure that prisoners are treated fairly and decently. In its most recent report, for the year ending December 2012, the IMB said that prisoners were positive about the standard of care and treatment they received. The IMB noted that the mental health team ran regular programmes to support prisoners, including counselling and psychological support.

Assessment, care in custody and teamwork (ACCT) procedures

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held.

Previous deaths at Leeds

21. Since 2009, we have investigated 18 deaths at Leeds, including that of the man's. After the self-inflicted deaths of two men in January 2009 and January 2010, this office made recommendations about sharing information received from community GPs with the prison GP and ensuring that all relevant risk information is transferred to Person Escort Records. These issues arise again in this investigation.

KEY EVENTS

22. The man was first convicted in 1991, when he was 13 years old. He had numerous convictions and had spent much of his adult life in prison.
23. The man had a history of self-harm, depression and substance misuse in the community and in prison. He also had several health conditions, including post-traumatic stress disorder (PTSD), schizo-affective disorder and he had been diagnosed with several traits of adult ADHD including mood fluctuations, lack of attention to detail, failure to follow instructions, fidgeting, restlessness, stress intolerance and engaging in risk-taking activities. When he was in prison, he was under the care of various mental health in-reach teams (MHIRT). In January 2011, a psychologist concluded:

“He remains highly vulnerable to continued mental health problems such as depression, anxiety and sleep disturbance: he is likely to need medication at various points in the future to help manage these problems and help him calm down. He is also vulnerable to potentially more serious deterioration in his mental state and to further episodes of self-harm should he encounter significant life stresses and especially if he returns to drug use. He remains highly vulnerable to relapsing into drug use as his general coping skills are limited.”
24. In September 2011, the man was arrested and remanded to HMP Leeds, charged with possession of drugs, burglary and theft. He was sentenced to 18 months imprisonment on 6 March 2012 and, after transferring to several prisons, he moved to HMP Wealstun in June 2012.
25. At Wealstun, the man was under the care of a consultant psychiatrist at the adult ADHD assessment clinic in Leeds, who also ran clinics at the prison. In November 2012, it was decided that after his release he would have a single point of access in the community and the psychiatrist would manage his mental health conditions under the care programme approach (CPA). This is a system of delivering community mental health services to individuals diagnosed with a mental illness. Health and social services assess the needs of the individual, provide a written care plan that outlines any risks, including details of what should happen in an emergency or crisis. A care coordinator is allocated and there are regular reviews of the plan with key stakeholders. His care coordinator was the psychiatrist.
26. On 9 January 2013, the psychiatrist noted that the man had stopped his medication due to ‘prison regime factors’. Prison records show that he had been unhappy about having to collect his medication during lunchtime. He had refused alternative times offered by the prison pharmacy and stopped taking his medication. This had affected his sleep and concentration, but he felt it would be better to re-start the medication after his release from prison in February and he could manage his symptoms until then.
27. The man was released on licence from Wealstun 8 February 2013 and, as part of his licence conditions, he was required to live at Probation Service

approved premises in Leeds. He continued to attend the psychiatrist's ADHD clinic in Leeds and, at an appointment on 2 May, the psychiatrist noted that he was taking concerta¹ XL 54mg daily. He was positive about the benefits of the medication. He said he had been able to manage his frustrations and had not been involved in any conflict since his release from prison. At this consultation, the psychiatrist increased the concerta XL to 72mg, gave him a 28-day prescription and planned to review him in a month.

28. On 14 May, the man was arrested on suspicion of criminal damage and was released the next day, without charge. When he returned to the approved premises, probation staff told him that he was to be recalled to prison as there had been increasing evidence of him abusing alcohol and an allegation of assault against another resident. He left the premises and did not return. His licence was revoked and a warrant issued for his arrest.
29. On 13 July, the man was arrested for burglary and breaching his licence conditions. He had been homeless for two months. In his police custody risk assessment, the police recorded his mental health conditions and that he had not taken his ADHD medication for two months. They also noted a history of violence, self-harm and attempted suicide, which included attempted hanging in 1997 and 2006 and taking an overdose of tablets in 2009. The police nurse assessed him and raised no concerns, noting that he was fit to be detained in custody. He said he was not dependent on drugs or alcohol and had no thoughts of self-harm.

The man's arrival at HMP Leeds

30. On 15 July 2013, the man was taken to HMP Leeds. The police gave the escort contractor, Geo Amey, a Person Escort Record² (PER), a copy of his police custody medical notes and his licence recall notice giving the reason for his recall to prison. The PER noted that he had been recalled to prison and his risks included PTSD, ADHD, schizophrenia disorder and violence towards the police. It also noted a history of self-harm, with suicide attempts in 1997, 2006 and 2009.
31. At Leeds, an officer reviewed the information on the PER and recorded his risks for a cell sharing risk assessment³ (CSRA) as PTSD, ADHD, schizophrenia disorder, arson, violence to police and manslaughter. The officer told the investigator that he did not record details of the man's history of self-harm and suicide attempts as the CSRA assesses the risk a prisoner poses to another prisoner rather than to himself.

¹ Concerta is used to treat attention deficit disorder and attention deficit hyperactivity disorder (ADHD). It is a central nervous system stimulant. It affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control.

² The Person Escort Record is a form that accompanies prisoners on all journeys to communicate risk factors.

³ The CSRA assesses the risks posed by an individual to other prisoners, which includes taking into account the situational context of any previous violence or mental health issues.

32. A nurse carried out a health screen and noted no concerns about the man's physical health. He told the nurse that he had been diagnosed with ADHD and was under the care of the psychiatrist. He said he had not taken his ADHD medication for two months as he had been "on the run". He said he had no thoughts of suicide or self-harm and gave the contact details for his community GP.
33. A mental health nurse conducted a further general health screen in reception, (in which it was mistakenly noted that he was not a licence recall prisoner). In addition to the information recorded earlier about the man's medical conditions and self-harm, she noted that he had been previously prescribed concerta for ADHD. During the assessment, he was relaxed, his speech was rapid and his eye contact was intermittent. He said he had no thoughts of suicide or self-harm. She recorded "Increased Risk" on his CSRA, stating that he needed his medication. She indicated that he should be given a single cell and reviewed after receiving his medication that evening. She also made a routine referral to the mental health in-reach team, requesting the psychiatrist, a member of the in-reach team, to see him.
34. As the man's CSRA had been classified as "increased risk", a custodial manager reviewed the CSRA and interviewed him. He told the investigator he was not aware of his history of self-harm as it had not been noted on the CSRA. He described his presentation as "chaotic" and he had disclosed that he was on medication for ADHD. He recorded that he needed help to stabilise his erratic behaviour and that he was "high risk", for cell-sharing, but he did not consider him to be at risk of self-harm. He was then taken to the prison's First Night Centre
35. A doctor examined the man at around 7.28pm. He recorded that he was agitated and angry and he recognised signs of thought disorder when speaking to him. He recorded his core symptoms as ADHD and that he needed to be seen by the psychiatrist. Until he could see the psychiatrist, the GP prescribed a small dose of concerta (18mg for 14days) and zopiclone (7.5mg for two nights) to aid his sleeping.
36. Concerta is a controlled drug and had not been available when the man arrived. To ensure that he would receive the medication the next day, the pharmacy technician recorded in the prescription, "Please make sure he gets Concerta today! 16.7.13". She also noted that he should be seen by the psychiatrist on 17 July, at the doctor's request. (The psychiatrist only held clinics on Monday and Friday mornings, and 17 July was a Wednesday so the next clinic with him would have been Friday 19 July.) Healthcare staff recorded on his medication chart that he had received Concerta from 16 July to 23 July inclusive.
37. On Tuesday 16 July, healthcare staff sent a fax to the man's community GP, requesting details of his medical history. A nurse conducted his secondary health screen and identified no specific concerns. A custodial manager completed the next CSRA check. Information from the police national computer had indicated that an offence of arson, which had been listed as

one of his risk factors on the CSRA, had been committed in 1991. The custodial manager therefore reduced his CSRA risk to standard.

38. The man's GP faxed confirmation of his medical history to Leeds on 17 July. It showed that he had been prescribed concerta in May 2013, at a level of 54mg, which was subsequently increased to 72mg. (The GP's fax had been scanned onto his electronic medical records, but there is no evidence that any of the healthcare team reviewed his medication as a result.)
39. An offender supervisor introduced himself to the man on 17 July and they discussed his recall to prison. He noted in his electronic prison record that he had been reluctant to get out of bed, had been very vocal about being recalled to prison and disagreed with the decision. He advised him to wait until he had received the full recall pack containing the reasons, when all the facts would be clearer and he could then contact his solicitor if he was still unhappy. He noted that he got increasingly "worked up" during the conversation and he agreed to see him again once the recall procedure was complete.
40. On Thursday 18 July, the healthcare communication team (comprising the primary healthcare and mental health in-reach teams) referred the man to the mental health in-reach team. The referral was discussed at the in-reach team's weekly referral meeting the next day. Attendees included the psychiatrist and mental health nurses, mental health in-reach team manager and a nurse. They allocated him to the nurse and made an appointment for him to see the psychiatrist on Friday 26 July. (The nurse was on leave on Monday 22 July and was subsequently on long-term sick leave, so had no contact with him.)
41. The man was due to be transferred to HMP Everthorpe, a category C prison in East Yorkshire, on Tuesday 23 July. That morning, a nurse, one of the primary mental health team at Leeds, telephoned the mental health in-reach team and spoke to the in-reach team manager to find out whether there was any reason why he could not be transferred. At 11.09am, a nurse noted on his medical record that he was fit to be transferred. No concerns about the risk of suicide or self-harm had been recorded during this initial period at Leeds.
42. At interview, the in-reach team manager said that a nurse had raised no concerns about his welfare, therefore he was not aware of any reason why the man should not be transferred. He had telephoned Everthorpe healthcare team to inform them that he would be arriving, but no one had answered the call, so he had left a voicemail message confirming this. In the message, he explained that he had been under the care of the mental health in-reach team at Leeds.

The man's transfer to HMP Everthorpe

43. The PER for the man's journey to Everthorpe stated no known medical or mental health risks. In the section to identify risks of self-harm and suicide, it was recorded that, "ACCT Docs closed 2009". No mention was made of his specific previous history of self-harm or suicide. It was also noted that his prescribed medication had been given to the escort staff. The PER completed the next day said that the medication had not been sent by Leeds.
44. There is no record that the man's raised any concerns about the move before he left Leeds. However, when he arrived at Everthorpe, at around 11.00am, he refused to leave the escort vehicle. Geo-Amey escort staff noted on the PER that they had tried to talk to him but he refused to let them speak, was very angry and would not calm down. He was adamant that he would not leave the vehicle voluntarily without physical force. He subsequently took off his shirt, smeared excrement over his body and became physically aggressive. He told the staff that he was a danger to society and would smash up the prison. He threatened staff and would not listen or comply with their instructions to leave the vehicle. He said he did not want be at Everthorpe as he had arranged visits at Leeds from solicitors and others.
45. At 12.40pm, prison staff removed the man from the escort vehicle by force using Prison Service approved control and restraint procedures. He was then put in special accommodation in the segregation unit and charged with a disciplinary offence under Prison Rules.
46. The nurse was present while staff moved the man to the segregation unit. She recorded that he was non-compliant, violent and aggressive towards them. He received no visible physical injuries while being restrained and continued to smear excrement in his cell. He refused to engage with her, so she was unable to assess him properly. She recorded that he would be assessed when he was compliant and willing to engage with healthcare staff. She reviewed his electronic medical record and noted his mental health history. She saw that he had been referred to the mental health in-reach team at Leeds and that he was waiting to be assessed by the psychiatrist.
47. A doctor went to the segregation unit at 1.55pm, to assess the man. He saw through the cell observation panel that he was upset and ranting but did not go into the cell as he refused to speak to him. The doctor noted that, although he looked physically fit, he was unable to assess his mental health. He instructed that staff should continue to monitor him and that he should take his medication. (However, he had no medication.)
48. At around 2.00pm, the man told staff that he was willing to comply with their instructions and stop his 'dirty protest'. He was allowed to shower and was given a different cell in the segregation unit. Afterwards (3.00pm) a custodial manager spoke to him and did not have any concerns about him. At 4.35pm, it was recorded in the segregation observation book that he has made threats to stab anyone who came to his door.

49. At 4.43pm, a nurse at HMP Leeds noted in the man's medical record that a member of the healthcare team at Everthorpe had telephoned, expressing concern that he had transferred to them before the psychiatrist had seen him and that he was on a low dose of Concerta in comparison to his previous prescription. They had received no communication about him and he had been transferred to them without any medication. They said that they did not have a GP who specialised in ADHD or was willing to manage or change his medication. The duty manager at Leeds therefore authorised that he should return to Leeds. The nurse noted that the primary mental health team would see him when he returned and would discuss his care plan with the mental health in-reach team.
50. A manager recorded in Everthorpe's senior duty manager report log that the man would return to Leeds because of his "complicated medical needs". When he was told that he would transfer the next morning, he appeared happy with this decision.

The man's return to HMP Leeds

51. The next day, Wednesday 24 July, the man arrived at Leeds at around 11.23am. This time the section on the PER to identify medical or mental health risks noted, "increased risk known to Leeds". It noted that he was on medication, but Leeds had not sent it with him the previous day. He was immediately taken to the segregation unit. The segregation was authorised by the deputy governor and the reason given was "Segregated following an incident at Everthorpe".
52. An officer completed another Cell Sharing Risk Assessment. He noted his medical conditions and the events of the previous day and recommended that the man should have a standard single cell. A custodial manager endorsed it and assessed him as high risk for sharing a cell.
53. Shortly afterwards a nurse completed a segregation safety algorithm. This is a flow chart to assess whether it was appropriate for the man to be held in the segregation unit. She told the investigator that, throughout the assessment, he was calm and appropriate and she had no concerns about him being segregated. He asked for his dose of concerta to be increased and a nurse advised him to discuss this at his appointment with the psychiatrist on 26 July. The mental health in-reach team was informed of his return and he was allocated to the mental health nurse who was still on sick leave.
54. An officer gave the man the documents relating to his disciplinary charge at 4.30pm and told him that his hearing would be held at 9.00am the next morning, 25 July 2012. The charge was refusing a direct order to leave the escort vehicle and enter reception at Everthorpe.
55. An officer arrived for night duty on the segregation unit around 7.30pm and began a roll check (count of prisoners). He told the investigator that, when he opened the man's observation panel, he said he wanted to talk to him, so he returned to speak to him after he had completed the check. The officer said

that he was initially a “little bit agitated” but he later calmed down. He spoke about his transfer to Everthorpe, his girlfriend and child, his licence recall and wanting his medication. The officer said their conversation lasted around ten minutes and he then went to bed. As was the routine, the officer checked the prisoners in the segregation unit hourly during the night and raised no concerns about him.

Thursday 25 July 2013

56. At 8.24am on 25 July the man collected his breakfast pack. Applications are made at this time for exercise, to take a shower and use the telephone. He made no telephone calls during his time in the segregation unit.
57. At 9.38am a nurse noted that during the healthcare round of the segregation unit, the man told her that he was not happy to be in Leeds. He attributed his behaviour to not having the correct medication. She told him that the psychiatrist would review it the next day and noted no other issues.
58. The deputy governor held the man’s disciplinary hearing at around 10.00am. He told the investigator that he appeared to be wound up. He became verbally abusive and threatened staff. The hearing was adjourned and he was charged with a further disciplinary offence because of his behaviour. He was told he would remain in segregation unit because of this outburst and another hearing was scheduled for Saturday 27 July. He said that no one had raised any concerns with him about the man’s health before the hearing.
59. During the course of the day, no further concerns were noted about the man. He accepted his medication (concerta XL 18mg) at 11.47am and had his lunch shortly afterwards. He had a shower, exercise and his evening meal. He and a member of the chaplaincy visit during the day and raised no concerns about him. In his police statement, another prisoner who was in the cell opposite said he spoke to him (by shouting through their cell doors). The man told him that he had only been given 18mg of his medication and not 72mg, which he had been prescribed in the community.
60. A nurse said that she distributed the evening medication to prisoners at around 5.00pm. Although the man was not on the evening medication list, he had called her to his door and asked her to sort out his medication. She said he became loud and demanding. An officer who was nearby intervened and told him that a nurse would see him during the healthcare round the next morning.
61. Shortly after an officer arrived for duty at around 7.30pm; he looked through the observation panel of the man’s cell to check on him. The man came up to the door, lifted up his arm and showed the officer apparently superficial cuts. The officer said he asked, “what are you going to do now?”. He said he had cut himself because the prison was treating him poorly, by not allowing him to have his medication or contact his solicitor. He did not show the officer what he had used to cut his arm, but it was later believed to be a plastic knife.

62. The officer radioed for the duty manager and someone from the healthcare team. A custodial manager went to the segregation unit immediately, closely followed by a healthcare assistant and an agency nurse. The custodial manager said that as soon as he opened the cell observation panel, he became verbally abusive by swearing and ranting at him. He said he was unable to interrupt or stop him. The man said that he did not know why he had been placed in the segregation unit and was now on hunger strike. He added that he had not been allowed to make a telephone call and had not been given a toothbrush or toothpaste – although he subsequently threw his toothbrush and toothpaste at the cell door that were issued to him that evening.
63. In his police statement, the custodial manager said he could not see the extent of the man's cuts but offered treatment by the nurses. He repeatedly refused treatment and for around ten minutes, continued to verbally abuse the staff outside his cell and bang on the cell door. In view of his violent and aggressive behaviour, the custodial manager believed that it would be unsafe for any member of staff to go into his cell.
64. By around 8.00pm, the man had gone to the back of his cell. He appeared to have calmed down slightly, but still refused treatment for his cuts. The custodial manager and the two nurses then had to attend another urgent incident. As he had self-harmed, the custodial manager told an officer to open the ACCT procedures so that staff could support him more closely. He suggested that he be observed hourly, which was the segregation unit routine in any event.
65. At the end of the man's shift, he handed over to the night custodial manager and updated her on the position with the man. She was new to night duties and told the investigator that she had been warned that staff should be cautious if they had to go into his cell during the night, as he might have a weapon with which he had cut himself. She had not been told that he had any particular health issues and knew she would have to return to the segregation unit within the hour to complete the ACCT paperwork.
66. An officer completed the ACCT Concern and Keep Safe document at 8.00pm, in which he recorded key details of the man's self-harm, behaviour and concerns. At 8.25pm, (although this appears to be incorrectly recorded in the ACCT log as 9.25pm) the officer asked the healthcare team for information about him. He was told that he had had his daily medication and was due to see the doctor and the mental health team the next day.
67. The night custodial manager went to the segregation unit at around 8.30pm and completed the ACCT Immediate Action Plan. She recorded that the man had spoken to staff at length and was now calmer. She agreed that he should be observed hourly. She said that after his death she had learnt that the local policy was that ACCT observations should have been increased to five times an hour at least until the ACCT assessment was completed. She had not been notified of any health concerns.

68. The officer checked the man at 8.57pm and noted that he was moving around in the toilet area of his cell. At 10.00pm, he could not see him when he looked through the observation panel and he did not respond when he called his name. The toilet area has a separate observation panel but he still could not see the man. He therefore radioed the night custodial manager, who arrived shortly afterwards. The man was not visible and did not respond when called. His blanket was draped over the edge of his bed and they believed he was hiding underneath, out of view.
69. The night custodial manager telephoned the duty governor at his home to discuss what to do. She had reservations about going into his cell without a further risk assessment. She was also concerned about whether it was appropriate for him to remain in the segregation unit when he was regarded as a risk of suicide and self-harm. They discussed the staff resources available and he decided to ask the officer, a trained negotiator, who was on duty in another part of the prison, to go and speak to him.
70. The officer swapped duties temporarily with another officer and went to the segregation unit at around 10.45pm. Within a minute, the man started to speak to him, although he remained underneath his bed. The night custodial manager, who was nearby, said he was shouting in an aggressive and loud tone. She left the segregation unit and telephoned to update the duty governor.
71. The officer told the investigator that he talked to the man for over an hour and he eventually came out from under his bed. He said that he appeared upset and angry and spoke at a fast pace, quickly jumping from one issue to the next. However, as he started to get his concerns off his chest, he calmed down. He did not show him what he had used to cut himself with, but said he could have killed himself and would kill himself. He quickly moved on to talk about other topics, including his concern that he was not getting the correct medication and the reasons why he was being held in the segregation unit. He said he was unhappy about some of his family relationships and wanted to make a telephone call. He did not feel that the staff had treated him well, but his main concern was to see the psychiatrist. The officer told him that he would pass on his concerns and they would be dealt with in the morning. He appeared content with this response and said he intended to go to bed. After their conversation, he fully briefed the night custodial manager.
72. The night custodial manager said she had asked a member of staff to telephone the healthcare team to check the man's medical history. She was told that he had an appointment with the psychiatrist the next day.
73. After a further update, the duty governor authorised that the man should continue to stay in the segregation unit until the morning, when a further review would take place. He did not give any exceptional reasons for this or state what alternatives had been considered. He said that the staff were satisfied that he had no intention to harm himself again and it was therefore unnecessary for them to go into his cell to retrieve the instrument he had used to cut his arm. He was also concerned about the safety of staff going into the

cell. He asked the night custodial manager to contact him immediately if his demeanour or behaviour changed in any way. No further concerns were recorded in the night.

74. The night custodial manager sent set an e-mail to the duty governor at 1.25am, highlighting the concerns that the man had raised. These were:
- He was not aware of why he was being held in segregation.
 - He had not been allowed to use the telephone.
 - He had no toiletries and so was unable to shower/wash.
 - He wanted to see the psychiatrist.
 - He wanted to see the mental health team.
 - He had not received his property.

Events leading up to the incident

75. At 6.30am the officer handed over to another officer in the segregation unit. Staff were told to be extra vigilant when opening the man's cell in the morning as he might be volatile. When the roll check was completed at 7.00am, he was still sleeping.
76. The duty governor arrived for duty at 7.30am and went immediately to the segregation unit to check on the situation with the man. He noted that the psychiatrist, mental health and property and toiletry issues were to be considered but he did not see him.
77. Two officers unlocked the man's cell at 8.00am. He jumped off his bed and shouted that he intended to go on hunger strike and refused his breakfast. In view of his aggression, staff shut his cell door immediately.
78. Around 8.34am, a doctor started to review prisoners in the segregation unit and a nurse arrived at the same time for the medication round. Due to the man's earlier aggressive behaviour, a Supervising Officer and two officers accompanied them to his cell. When they opened the cell door and told him that the nurse had his medication and the doctor was there to see him, he responded aggressively. He was abusive and refused to engage with the doctor or nurse. He refused his medication and said that he was on hunger strike. An officer told the investigator that he had never seen anybody behave like that before. He was volatile and angry every time they went to see him and he would not listen when they tried to talk to him. The doctor said that it was difficult to assess him because the officers were standing in front of him but he was extremely agitated. He said he was shouting non-stop and waving his hands in the air. He was abusive towards the staff and would not listen to them or let them speak.
79. A member of the prison chaplaincy visited the segregation unit at 8.50am. She said that she had attempted to speak to the man through the cell observation panel. She asked him how he was but he ranted and raved incessantly in a loud, aggressive and angry tone. The chaplain said she was unable to get a "word in edgeways". He complained about staff and not being

treated well. He said he was not getting his medication, although had refused to accept his morning medication that morning. He was unhappy with his adjudication and said he felt unsupported.

80. At 9.36am, an officer looked through the cell observation panel to conduct the man's ACCT check. He saw him hanging from a bed sheet tied to the window bar. He shouted for help, went into the cell and radioed a code blue.
81. An officer and a SO arrived immediately and helped to support the man's body while the officer cut the ligature. His feet were suspended above the floor. His body was limp and he was unresponsive. Two officers then arrived and placed him onto the bed. The SO removed the ligature from around his neck. There was no breathing movement from his chest, but an officer and the SO Garbutt both checked for signs of life and felt a faint pulse.
82. Two nurses arrived at the cell at 9.37am, with medical emergency bags. The nurses saw the man in the recovery position lying on bed and ligature marks were visible on his neck. They examined him and found no signs of life so they then placed him on the floor and started cardiopulmonary resuscitation (CPR). One nurse maintained his airway, while the other gave chest compressions. They used a defibrillator, which instructed that CPR should continue. (A defibrillator is a life-saving device that analyses heart rhythm and automatically delivers electric shocks to victims of cardiac arrest when it determines there is a rhythm that is likely to respond.) Further nursing assistance was requested and an ambulance. The control room logged the time of the call for the ambulance as 9.39am.
83. Two more nurses arrived at the man's cell at 9.49am with additional medical equipment. They continued to use the defibrillator intermittently to assess his condition. The paramedics also arrived at 9.49am, just after the two nurses. They continued CPR and, around 10.05am, they detected a pulse. They took him to hospital at 10.21am, with a copy of his prison medical record, escorted by two officers. No restraints were used.
84. As the man's condition was very serious and he had been placed in an induced coma on a life support machine, an operational manager began the prison's death in custody contingency plan. She chaired a debrief meeting at 10.35am. Staff involved were given the opportunity to discuss the events of the morning and were offered the support of the prison care team.
85. Two officers were appointed as the prison's family liaison officers. Shortly after 11.00pm, one officer telephoned a relative of the man's, who she originally believed was his brother and next of kin, but was later confirmed as his cousin. He said he would attend the hospital as soon as possible and inform other family members. One officer went to the hospital at 12.20pm to meet the family
86. Over several days, an officer went to the hospital daily, where she met several members of the man's family and offered them support. The hospital

consultant told the family that his condition had deteriorated and his life support would be withdrawn. That evening, with his family present, he died.

87. The officer continued to support the man's family and offered financial assistance with the funeral costs, in line with Prison Service guidance. The funeral was held on 9 August, attended by prison staff and three prisoners who were relatives of his. His family subsequently visited the prison. The prison chaplain held a remembrance service at the prison.

Letter found in the man's cell

88. After the man was taken to hospital, the police searched his cell and found a lengthy letter he had written, torn into pieces and discarded down the toilet. They reconstructed the letter, which had been addressed to another prisoner. In the letter he had complained of being in the segregation unit, not getting his medication despite repeatedly asking for it to keep him calm and that the staff would not listen to his concerns. As he had very little money for phone calls, he asked the prisoner to contact whom we believe to be a firm of solicitors specialising in prison law and a local MP to tell them about his situation. He wanted the psychiatrist and his probation supervisor to be aware and stated, *"if owt should happen to me I want my kids compensating because of what the prison service drove their dad to doing"*. He went on to say that his only option was to continue his hunger strike and he wanted his family told of his situation. He said, *"if I am still alive tomoz mate I will be either in a hospital bed or back from hospital in a strip cell on 24/7 watch"*. (The prisoner declined to speak to the investigator.)

Post-mortem

89. The post-mortem report concluded that the cause of the man's death was, irreversible hypoxic brain injury, caused by hanging.

ISSUES

Clinical care

90. The clinical reviewer notes that the man had an extensive psychiatric history with several mental health conditions. He had spent 18 of the previous 23 years in prison and had been seen by numerous mental health professionals. He had a history of substance misuse and self-harm and had previously tried to hang himself in prison. She has made a number of recommendations for improvements in healthcare.

Reception procedures at HMP Leeds

Assessment of the man's risk of self-harm

91. When he arrived at Leeds on 15 July 2013, the man's PER identified that he had been diagnosed with PTSD, ADHD, schizophrenia disorder and had a history of self-harm. He had made two attempts to hang himself in 1997 and 2007 and had taken an overdose in 2009. He had been recalled to prison after breaching his licence, but it was noted in error at the reception health screen that he was not a licence recall prisoner.
92. Healthcare staff were aware that the man had a history of self-harm, but during an assessment of his mental state he told them he had no thoughts of harming himself. They were concerned about his presentation and behaviour, describing him as chaotic and noting that he needed his ADHD medication to stabilise him. However, they do not appear to have considered whether this or any other factors, such as his recall to prison had increased his risk of suicide or self-harm. Although the prison doctor recorded that he was angry, neither he nor officers raised any concerns about his wellbeing or risk of self-harm.
93. Prison Service Instruction (PSI) 64/2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 74/2011 – Early days in Custody, both list a number of risk factors for suicide and self-harm. PSI 74/2011 states that all staff should be alert to the increased risk of suicide/self-harm posed by prisoners during their early days in custody and act appropriately to address any concerns. The man had a number of factors that were significant indicators of risk, including, a history of deliberate self-harm, licence recall, irrational behaviour, mental illness, childhood adversity, depression and early days in custody.
94. We are concerned that, initially, staff took insufficient account of all the man's risk factors and we have considered whether they should have started, or at least considered opening an ACCT when he first arrived at Leeds in July 2013. It seems that in assessing his risk of self-harm, staff relied heavily on his statement that he had no such thoughts. Staff judgement is fundamental to assessing risk and relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. All risk factors must be recorded, collated and considered to ensure that a prisoner's level of risk is

holistically judged. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk.

95. Healthcare staff and officers accepted the man's assurances that he had no thoughts of suicide and self-harm. In previous cases, we have been critical of prison staff placing too much reliance on what the prisoner tells them and ignoring the weight of other risk-related information. He had a number of risk factors which should have been considered carefully in the context of suicide and self-harm, but it is not apparent what weight, if any, was given to them by reception staff. We are concerned that insufficient weight was given to his serious known risk factors. We make the following recommendation:

The Governor and Head of Healthcare should ensure that reception staff take into account and record all known potential risks and triggers when assessing a prisoner's risk of suicide or self-harm.

Mental health referral

96. After his diagnosis of enduring mental health problems, the man had been under the care of a psychiatrist for approximately two years as part of the care programme approach (CPA). The clinical reviewer notes that, in spite of the CPA, primary care nurses assessed him when he initially arrived at Leeds and on his return to Leeds from Everthorpe. There was no mechanism for him to be seen or assessed directly by a member of the mental health in-reach team, pending his appointment with the psychiatrist.
97. At interview, healthcare staff confirmed there was no direct pathway for an immediate assessment by the mental health in-reach team unless the man's presentation was considered to be acute. However, the fact that a patient is being managed under the care programme approach is in itself an acknowledgment that the person has heightened mental health risks. The GP had prescribed a low dose of his Concerta medication until he could be seen by a psychiatrist. We accept that it was appropriate for the GP to take a conservative approach to prescribing Concerta, but at the time he believed that the psychiatrist would be able to see him on 17 July, two days later. The lack of any direct access to the mental health in-reach team and thus to his consultant, the psychiatrist meant that his mental health and his medication were not reviewed with sufficient urgency.
98. Although HM Inspectorate of Prisons had found the services were well integrated at the last inspection in January 2013, the clinical reviewer was concerned about the working relationship between the mental health in-reach and the primary care mental health teams, who have different management structures, follow different policies and use different clinical systems as they are employed by different NHS Trusts.
99. We agree with the clinical reviewer's view that an immediate assessment might have indicated problems with the man's medication regime, based on

the CPA already in place. It would have ensured better continuity of his healthcare. We make the following recommendation:

The Head of Healthcare should ensure that prisoners subject to the Care Programme Approach are immediately referred to the mental health in-reach team for an urgent assessment when they arrive in prison.

Obtaining and reviewing GP records

100. Prison Service Order (PSO) 3050 requires that efforts should be made to retrieve information from a prisoner's GP or other relevant service to inform his clinical care in custody. Two days after the man's arrival at Leeds (17 July), the healthcare team received details of his health history and medication from his community GP. It indicated that his Concerta medication was last prescribed at a dosage of 72mg. This contrasted significantly to the 18mg prescribed when he arrived at Leeds, yet this obvious anomaly did not appear to trigger any concern and no action was taken to review his medication or escalate the need for a mental health assessment in the light of the disparity.
101. While the man's community records were obtained quickly, there is no evidence from the records that healthcare staff compared notes or reviewed his prescription or current risk or brought this to the attention of the GP who had prescribed a much lower dose two days earlier. We made a previous recommendation to Leeds about this issue in October 2011. This case would suggest that that recommendation had not been implemented. We repeat the recommendation:

The Head of Healthcare should implement an auditable process to ensure that healthcare staff review correspondence from a patient's community GP and take appropriate action, where necessary.

The man's transfer to HMP Everthorpe

102. We are concerned that the man was transferred to Everthorpe before he had seen the consultant psychiatrist who was responsible for his care both in prison and the community and before his medication had been reviewed. PSO 3050 (Continuity of healthcare for prisoners) gives guidance on the reception and transfer of prisoners, with ongoing health needs. It stipulates that staff should identify physical and mental health problems and communicate information on continuity of care, as well as providing a supply of relevant medication until a GP at the receiving prison can prescribe a further supply.
103. At the time of his transfer to Everthorpe, the man was waiting for a mental health assessment by a member of the Leeds mental health in-reach team and had yet to be seen by the psychiatrist who was responsible for his care. Despite being managed under the Care Programme Approach, he was transferred without any recorded communication to Everthorpe or a care plan to manage his mental health or medication regime. The in-reach team

manager said he had attempted to contact Everthorpe to tell them of his impending arrival, but was unable to speak to anyone so he left a message. We regard that as inadequate notice and preparation.

104. The man had been prescribed a significantly lower dosage of his ADHD medication when he arrived at Leeds on 15 July 2013 than his previous prescription in May 2013. As this was a controlled drug, it could not be transferred with him to another prison. Yet no one at Leeds checked that the medication would be available at Everthorpe and, apparently gave no consideration to the absence of an ADHD specialist at Everthorpe to review the medication and ensure appropriate continuity of healthcare. We consider that he should not have been transferred until he had seen his consultant psychiatrist, had a full mental health assessment and had his medication confirmed. A transfer to Everthorpe should not have been considered until Leeds could be sure about his existing health issues and that Everthorpe was able to meet them. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners with specialist health needs are not transferred until required assessments have been completed and staff confirm that the receiving prison is able to provide appropriate treatment and care.

105. We are also concerned that the PER for the man's transfer to Everthorpe was inadequate. The PER completed for his journey to Leeds on 15 July, noted multiple health risks as well as offences of arson, violence to police and manslaughter. Yet eight days later on 23 July, the PER completed at Leeds for his transfer to Everthorpe, identified "no known risks", medical or related to his mental health. It was recorded that: "ACCT Docs closed 2009", but there was no explicit reference to his previous history of self-harm or suicide and no details of his medication.
106. There is no record of the man's views about the transfer when he left Leeds. However, when he arrived at Everthorpe, he was noted to be violent, aggressive and distressed so it does not appear he was willing to be transferred.
107. The PER is the key tool to help ensure that information about the risks posed by prisoners moving between prisons or transferred within the criminal justice system is always available to those responsible for their safe custody. In the man's case, staff at Leeds failed to include in the PER form any risk details in relation to his extensive mental health and suicide and self-harm history or the controlled medication he had been prescribed. Escort staff and staff at Everthorpe therefore had little information about him.
108. PSO 1025 sets out the arrangements for communicating risks during escort or transfer. In particular, it notes that it is essential that known risks including those of suicide and self-harm are communicated to others into whose custody the prisoner is passed. The quality of information on PERs was identified as a concern during the investigation of the death of a prisoner at Leeds in January 2009. We make the following recommendation:

The Governor and Head of Healthcare should ensure that person escort records are completed fully and accurately and that all mental health issues, risks and triggers for self-harm are recorded to alert the receiving prison of any concerns.

Segregation

109. The effect of segregation on the state of mind of someone who is already vulnerable can be severe. PSO 1700 (Segregation) sets out an expectation that staff should focus on helping prisoners manage their behaviour and problems rather than simply on punishment.
110. Healthcare staff should conduct an initial segregation health screen within two hours of arrival in the segregation unit. This is not a full medical/mental health screen but a standard safety algorithm which assists staff to assess the suitability of a prisoner to be segregated. There are only two possible outcomes. The first is that there is 'no health care intervention at this time' and the second is 'there are healthcare reasons not to segregate at this time,' 'discuss with health team'. This form is then endorsed by the person who carried out the screening and countersigned by the duty governor.
111. Despite the lack of information on the PER, it had been clearly documented in the man's record that he had a history of self-harm, mental health problems and was taking medication for ADHD. Healthcare staff at Everthorpe described his behaviour as non-compliant and said that he had complicated medication needs. He had clearly been in a distressed state when he arrived there yet went straight to the segregation unit. Nevertheless, because of his behaviour and demeanour at the time he arrived at Everthorpe we accept that segregation at that point was likely to have been a reasonable course of action.
112. When he returned to Leeds, the man was automatically sent to the segregation unit on the basis that he had been in the segregation unit at Everthorpe. None of the prison staff appear to have questioned this, although he had not been segregated at Leeds before his transfer the day before and appeared to have been no control problem at Everthorpe once it was agreed that he would return to Leeds. The deputy governor authorised the segregation with little apparent recorded justification except that he had come from the segregation unit at Everthorpe.
113. Healthcare staff appear to have made no effort to explore the depth of his mental health issues. The primary mental health nurse who completed the segregation safety algorithm on 24 July does not appear to have considered whether the man's poor behaviour was a consequence of his mental health issues and lack of medication. He was insistent that his medication regime was not right and wanted an increase in his dosage, but was told that the psychiatrist would discuss his medication with him on 26 July. No consideration seems to have been given to the adverse effect the lack of medication might have had.

114. As the man was being managed under the CPA, we would have expected his mental health and medication regime to have been assessed immediately he returned to Leeds as we have noted above. (See recommendation at paragraph 97.) Instead, he was sent straight to the segregation unit, without a discussion as to whether segregation was the appropriate or correct location and advised to await the outcome of a routine referral to his psychiatrist. The deputy governor authorised the segregation with very little information on which to justify it. Although we accept that his behaviour had been difficult at Everthorpe, he was noted to be “calm and appropriate” when he arrived back at Leeds. We do not consider that the incident at Everthorpe in itself provided sufficient grounds for believing that his behaviour was likely to be so disruptive that locating him on a standard wing would have been unsafe, particularly when it was acknowledged that his mental health problems had not been addressed. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners are not segregated for reasons of Good Order or Discipline unless there are reasonable grounds for believing that the prisoner’s behaviour is likely to be so disruptive that keeping him elsewhere is unsafe, and that healthcare staff take full account of all the information available about the prisoner and his needs.

115. PSO 1700 (Segregation) states that a prisoner on an open ACCT plan must only be kept in segregation under exceptional circumstances, if they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate. PSI 64/2011 (Safer Custody) says the reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted. The healthcare or mental health in-reach team should undertake a mental health assessment of all prisoners on an open ACCT who are placed in a segregation unit, within 24 hours. This is reiterated in the prison’s local policy.
116. An ACCT plan was opened after the man self-harmed by cutting himself in the segregation unit on the evening of 25 July. Two nurses attended to treat his cuts, but he refused treatment, behaved aggressively and was reported to be shouting and swearing. He eventually calmed down and went to sleep. Given his behaviour and the time of day, it is perhaps understandable that it was decided that he should remain in the segregation unit at that time. However, we are concerned that there is no evidence that any alternative was considered or that this decision was reconsidered the next day. There is no written explanation to justify the exceptional use of segregation for a prisoner on an open ACCT. We make the following recommendation:

The Governor should ensure that prisoners on open ACCT plans are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.

Opening the ACCT and managing the man's risk

117. PSI 64/2011 stipulates that it is the responsibility of the Residential Manager, Daily Operational Manager or Night Operational Manager to request any relevant information from healthcare staff which will contribute to the assessment and subsequent risk management of the prisoner who is assessed as at risk of suicide and self-harm.
118. Prison staff followed this guidance when the man's ACCT was opened and contacted healthcare staff. They were told only that he had taken his daily medication and had appointments with the mental health team and the psychiatrist the next day. No information appeared to be given to the officers about his extensive mental health problems and history of self-harm. We believe that information in his medical record could have been used to contribute to a more thorough and holistic risk assessment by the staff responsible for managing him after he had self-harmed. It is important that relevant healthcare issues and concerns are shared with officers who have regular contact with prisoners so they can make informed decisions about their care.

The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams share all relevant information to enable accurate ACCT assessments and subsequent risk management of prisoners regarded as at risk of suicide and self-harm.

119. Leeds' local policy states that when a prisoner on an open ACCT is held in the segregation unit in "exceptional circumstances" then ACCT observations should be five times per hour. However, the night Custodial Manager set the initial ACCT observations at hourly. She told the investigator that her understanding of the segregation procedure was limited at the time because she was new to the unit and she had therefore maintained the man's observation level at hourly.
120. All prisoners in the segregation unit are routinely checked hourly, whether or not they are subject to suicide and self-harm prevention procedures and irrespective of Leeds' local policy about the level of observations, we are concerned that after the man cut himself, the staff decided that he did not require a level of monitoring above the routine for all prisoners in the segregation unit.
121. The staff did not investigate what the man had used to cut himself or make any effort to remove it from the cell or move him to safer accommodation. The duty governor told the investigator that after the man self-harmed in the segregation unit, he did not send staff into the cell to retrieve the item he had used to cut himself as he was concerned about their safety, given his earlier volatile and aggressive behaviour. He was satisfied by his reassurances that he would not harm himself again. Although he had calmed down, if his mood had changed again he would still have had the means to harm himself. Once the decision had been made to leave him in the cell with the object he had

used to self-harm we would have expected the risk to have been mitigated by observations more frequent than hourly.

122. Had the ACCT observation level been set at five times per hour, the level prescribed in the local policy, this would have reduced the man's opportunity for further self-harm the next morning. It would also have meant that it was much more likely that he would have been discovered sooner after he hanged himself, which would have improved the possibility of successful resuscitation. We make the following recommendation:

The Governor should ensure that prisoners on open ACCTs, held in the segregation unit in exceptional circumstances, are monitored at the required frequency to ensure their safety.

The emergency response and calling an ambulance

123. Prison Service Instruction (PSI) 3/2013 *Medical Emergency Response Codes*, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.
124. We are concerned that the local procedures at Leeds (086/2013 Medical Emergency Codes) deviate from the national instruction that an ambulance should be called automatically. The local policy says:

“... The need to call an ambulance immediately in all cases may not be necessary and we may be diverting resources away from the community by automatically calling for an ambulance. We will continue to assess each situation on its merits and deal with any situation safely and with appropriate medical care. Any staff member feeling an ambulance should be called upon coming across a red or blue code situation ...can however continue to request one via the control room.”

125. An officer called a code blue emergency code at 9.36am. However, an ambulance was not called until a nurse arrived at the cell and requested one three minutes later at 9.39am. Even such a short delay can have a significant impact on a person's chance of survival in a life threatening situation. We are not satisfied that Leeds' protocol is fully compliant with PSI 03/2013 and it is apparent that staff at Leeds are not fully aware of the expectations to immediately call an ambulance in these circumstances. We make the following recommendation:

The Governor should ensure that all staff are made aware of PSI 03/2013 and understand their responsibilities during medical emergencies and that Leeds has a local medical emergency response protocol which:

- **Efficiently communicates the nature of the emergency; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that reception staff take into account and record all known potential risks and triggers when assessing a prisoner's risk of suicide or self-harm.
2. The Head of Healthcare should ensure that prisoners subject to the Care Programme Approach are immediately referred to the mental health in-reach team for an urgent assessment when they arrive in prison.
3. The Head of Healthcare should implement an auditable process to ensure that healthcare staff review correspondence from a patient's community GP and take appropriate action, where necessary.
4. The Governor and Head of Healthcare should ensure that prisoners with specialist health needs are not transferred until required assessments have been completed and staff confirm that the receiving prison is able to provide appropriate treatment and care.
5. The Governor and Head of Healthcare should ensure that person escort records are completed fully and accurately and that all mental health issues, risks and triggers for self-harm are recorded to alert the receiving prison of any concerns.
6. The Governor and Head of Healthcare should ensure that prisoners are not segregated for reasons of Good Order or Discipline unless there are reasonable grounds for believing that the prisoner's behaviour is likely to be so disruptive that keeping him elsewhere is unsafe, and that healthcare staff take full account of all the information available about the prisoner and his needs.
7. The Governor should ensure that prisoners on open ACCT plans are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
8. The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams share all relevant information to enable accurate ACCT assessments and subsequent risk management of prisoners regarded as at risk of suicide and self-harm.
9. The Governor should ensure that prisoners on open ACCTs, held in the segregation unit in exceptional circumstances, are monitored at the required frequency to ensure their safety.
10. The Governor should ensure that all staff are made aware of PSI 03/2013 and understand their responsibilities during medical emergencies and that Leeds has a local medical emergency response protocol which:

- Efficiently communicates the nature of the emergency; and
- Ensures there are no delays in calling, directing or discharging ambulances.

PRISON SERVICE ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that reception staff take into account and record all known potential risks and triggers when assessing a prisoner's risk of suicide or self-harm.	Accepted	All reception and first night centre staff will receive additional ACCT assessor training to ensure they understand the need to take into account all relevant risk factors when considering an individual's risk of suicide and self-harm. Medical reception staff will be reminded of the need to record all known potential risks and triggers in the patient record and ensure that informed decisions are made on the balance of these factors and not just the patient's presentation.	Head of Safety 31 May 2015	
2	The Head of Healthcare should ensure that	Accepted	The Leeds Community Health SOP ensures that prisoners who are known to be subject to	Head of Healthcare	

	<p>prisoners subject to the Care Programme Approach are immediately referred to the mental health in-reach team for an urgent assessment when they arrive in prison.</p>		<p>the Care Programme Approach are immediately referred to the mental health in-reach team for an urgent assessment when they arrive in prison. Staff will be reminded of the need to follow this procedure.</p>	<p>30 April 2014</p>	
3	<p>The Head of Healthcare should implement an auditable process to ensure that healthcare staff review correspondence from a patient's community GP and take appropriate action, where necessary.</p>	<p>Accepted</p>	<p>A Standard Operating Procedure is in place which provides an auditable process to ensure that healthcare staff review correspondence from a patient's community GP and take appropriate action, where necessary. Staff will be reminded of the need to follow this procedure.</p>	<p>Head of Healthcare 30 April 2014</p>	
4	<p>The Governor and Head of Healthcare should ensure that prisoners</p>	<p>Accepted</p>	<p>A standard operating procedure is now in place to ensure that prisoners who require specialist health assessments are not</p>	<p>Completed</p>	

	with specialist health needs are not transferred until required assessments have been completed and staff confirm that the receiving prison is able to provide appropriate treatment and care.		transferred until those assessments are completed and staff are able to confirm that appropriate treatment and care is available at any receiving establishment.		
5	The Governor and Head of Healthcare should ensure that person escort records are completed fully and accurately and that all mental health issues, risks and triggers for self-harm are recorded to alert the receiving prison of any concerns.	Accepted	<p>Governor: Person escort records (PER) will be completed fully and accurately to ensure that all known issues, risks and triggers for self harm are recorded to alert the receiving prison of any concerns.</p> <p>Head of Healthcare: Person escort records (PER) will be completed fully and accurately to ensure that all known mental health issues, risks and triggers for self-harm are recorded to alert the receiving prison of any concerns.</p>	<p>Head of Safety 30 April 2014</p> <p>Head of Healthcare 30 April 2014</p>	

6	<p>The Governor and Head of Healthcare should ensure that prisoners are not segregated for reasons of Good Order or Discipline unless there are reasonable grounds for believing that the prisoner's behaviour is likely to be so disruptive that keeping him elsewhere is unsafe, and that healthcare staff take full account of all the information available about the prisoner and his needs.</p>	Accepted	<p>Governor: Prisoners will only be segregated for reasons of Good Order or Discipline when there are reasonable grounds for believing that the prisoner's behaviour is so disruptive that keeping him elsewhere is unsafe or it will have a detrimental effect on maintaining Good Order or Discipline within the prison.</p> <p>Head of Healthcare: Healthcare staff will be reminded of the need to take full account of all available information about the prisoner and his needs when completing the safety algorithm and assessing if being placed in segregation will have a detrimental impact on the prisoner.</p>	<p>Head of Safety 30 April 2014</p> <p>Head of Healthcare 30 April 2014</p>	<p>24.04.14 – All duty governors reminded of advice contained within PSO 1700 and need to only segregate prisoners on GOOD when there are reasonable grounds for believing that the prisoners behaviour is so disruptive that keeping him elsewhere is unsafe or it will have a detrimental effect on maintaining Good Order or Discipline within the prison.</p>
7	<p>The Governor should ensure that prisoners on open ACCT plans are not held in the</p>	Accepted	<p>Prisoners on open ACCT plans will only be held in the segregation unit in exceptional circumstances and where all other options have been considered and excluded.</p>	Completed	

	segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.		When this occurs the decision will be fully documented using the 'Authority to segregate a prisoner on an open ACCT' form which has been updated to support this.		
8	The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams share all relevant information to enable accurate ACCT assessments and subsequent risk management of prisoners regarded as at risk of suicide and self-harm.	Accepted	Prison, healthcare and mental health teams will be reminded of the need to share all relevant information to enable accurate ACCT assessments and subsequent risk management of prisoners regarded as at risk of suicide and self-harm. Individuals with particularly complex needs will be subject to multi disciplinary care planning meetings.	Head of Safety 30 June 2014	
9	The Governor should	Accepted	All staff working in the segregation unit will be	Head of	

	ensure that prisoners on open ACCTs, held in the segregation unit in exceptional circumstances, are monitored at the required frequency to ensure their safety.		reminded of the need to monitor and record ACCT observations/interactions in line with the specified frequency and a daily management check of all ACCT's held in the segregation unit is now in place.	Safety 30 April 2014	
10	The Governor should ensure that all staff are made aware of PSI 03/2013 and understand their responsibilities during medical emergencies and that Leeds has a local medical emergency response protocol which: a) Efficiently communicates the nature of the emergency; and	Accepted	Staff Information Notice 86/2013 which outlines the responsibilities of staff under PSI 03/2013 to: a) Efficiently communicate the nature of the emergency; and b) Ensure there are no delays in calling, directing or discharging ambulances. This will be immediately revised and re-published and then again on an annual basis.	Head of Safety 30 April 2014	

	b) Ensures there are no delays in calling, directing or discharging ambulances				
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