PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in May 2014 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 who was found hanging in his cell at HMP Leeds on 12 May 2014. The man was 25 years old. I offer my condolences to all who knew him.

An investigator carried out the investigation. A clinical reviewer reviewed the man's clinical care at Leeds.

The man arrived at Leeds on 15 April 2014. He spoke limited English, and the reception nurse used an interpreter service for an initial health assessment. On 22 April, the man cut himself and prison staff began suicide and self-harm prevention procedures. Later that evening, officers took the man to the segregation unit after he bit his cellmate and set fire to a bin. The next day, staff stopped monitoring the man as a risk of suicide, as they considered that his actions had largely been attempts to get tobacco.

The day before the man hanged himself, a custodial manager discovered that he had plaited a sheet into a rope. This was treated as a security issue rather than an indication that the man intended to harm himself. The next morning, at around 10.40am, an officer found the man hanging from a ligature made from a sheet.

The investigation found that the man did not have a full health assessment after he arrived at the prison and the subsequent mental health assessments were inadequate. Despite the man's poor English, too little use was made of interpreters so it is difficult to see how an informed decision could have been reached about his state of mind. I agree with the clinical reviewer's conclusion that the clinical care the man received at Leeds was not equivalent to that he could have expected in the community.

The investigation also identified a number of concerns about the management of the suicide and self-harm prevention procedures and the use of segregation shortly after the man was assessed as at risk of suicide and self-harm. After staff found the man hanging, there was a delay in requesting an ambulance. We do not know whether this affected the outcome for the man, but it is essential that staff call an ambulance immediately in life-threatening emergencies.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2015**

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SUMMARY

1. The man was a Sudanese national. The immigration authorities had previously detained him at an immigration detention centre, but released him on bail in August 2013. He reported to the immigration authorities weekly until November 2013, when he went missing. On 14 April 2014, the police arrested the man for robbery and he was remanded to HMP Leeds. The reception nurse used a telephone interpreting service, to interview him during an initial healthcare assessment. However, she did not explore the man's comments that he had nightmares and he did not have a secondary health assessment. No other staff used interpreting services to speak to the man during the rest of his time at the prison.

2. On the evening of 22 April, the man cut his forearms and said it was because he was frustrated and anxious as he had no tobacco. Prison staff began suicide and self-harm prevention procedures, known as ACCT, although they believed his actions were manipulative. The man then bit his cellmate, when he tried to stop him from harming himself. Officers moved his cellmate and the man set fire to a bin. Staff moved the man to the segregation unit that night, but did not note any exceptional circumstances why this was necessary for a prisoner on an ACCT. The next day, a supervising officer closed the ACCT, without involving any other staff. The man went back to C wing on 28 April.

3. On 11 May, a custodial manager found that the man had plaited a sheet into a rope and tied it around his waist, hidden underneath his sweatshirt. Officers removed it and reported the incident as a security issue. No one considered whether he had intended to harm himself.

4. The next morning, 12 May, officers were late unlocking prisoners on C wing because there was a shortage of supervising officers. At approximately 10.40am, an officer unlocked the man and found him hanging from the window bars. She called for help, but did not have a radio and neither did the first few staff who responded. Officers and healthcare staff attempted cardiopulmonary resuscitation until paramedics arrived at the cell at 10.59am. The paramedics took over emergency treatment but pronounced the man dead at 11.34am.

5. There is no evidence that the man received a mandatory full health review after he arrived at Leeds and subsequent mental health assessments were not thorough. In spite of his limited English, only one member of staff used interpreting services and most relied on superficial indications that he was all right. The man's brief period on an ACCT plan was poorly managed and a single officer closed the ACCT without any healthcare input – a mandatory requirement for first ACCT reviews. ACCT documentation was poorly completed. After officers found the man hanging, there was a delay in communicating the emergency to the control room and calling an ambulance. The clinical reviewer judged that the care the man received was not comparable to what he could have expected in the community. We make seven recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Leeds, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner, who had been released from Leeds, telephoned her to speak about the man's treatment in prison.

7. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

8. The investigator visited Leeds on 13 May. She and the clinical reviewer interviewed staff at the prison in June and July.

9. We informed HM Coroner for the County of West Yorkshire of the investigation. We have sent a copy of our investigation report to the Coroner.

10. The prison, the police and the Coroner were unable to find any of the man's family.

11. The prison commented that paragraph 63 of the draft report inaccurately reflected that the man had not had a second health screen and the Head of Healthcare confirmed this had taken place. There is no other evidence of this.

HMP LEEDS

12. HMP Leeds is a local prison holding up to 1,120 men. Leeds Community Healthcare Trust run primary healthcare services and Leeds and York Partnership Trust provides mental health in-reach services for prisoners with severe and enduring mental health problems.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons last inspected 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 generally needed improvement. Few reviews were attended by multidisciplinary teams and inspectors found examples where cases had been inappropriately closed by a senior officer acting alone. Interpreters were not always used at ACCT reviews for prisoners with limited English. They noted good relationships between staff and prisoners. Reception processes were positive and staff were aware of the potential risks to new prisoners. There was no check of whether prisoners had received a full induction and only 46% of prisoners inspectors surveyed, said that they had had a full induction programme. Inspectors noted that while foreign national prisoners received some good support, staff needed to use telephone translation services more frequently for prisoners who spoke little English, particularly for sensitive or complex discussions.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its latest annual report, from January 2013 to December 2013, the IMB was concerned about the quality of the completion of ACCT documents.

Previous deaths at HMP Leeds

15. We investigated three self-inflicted deaths at HMP Leeds in 2013 and another in 2014. In two of these investigations, we found that prison staff took insufficient account of the prisoners' risk factors and should have opened an ACCT document when they arrived at the prison. We also found that local emergency arrangements were not in line with national requirements. We repeat both issues in this investigation.

ACCT

16. 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 staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular 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. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. The man was a Sudanese national, who had lodged a judicial review against a decision to deport him to Italy. He had been held in detention at Campsfield House Immigration Removal Centre, but was released on bail on 15 August 2013. He reported to the immigration authorities weekly, as required, until November 2013, when he stopped and went missing.

April 2014

18. On 14 April, the police arrested the man and charged him with robbery. On 15 April 2014, Leeds Magistrates' Court remanded the man to HMP Leeds. The Person Escort Record, which accompanied him from the court to prison recorded that he was alert, orientated and answered all questions. It did not note that the man was a foreign national prisoner and a possible deportee. At the police station, staff had observed him hourly and the recommended observation level was 'general'.

19. West Yorkshire Police had completed a risk assessment, which they attached to the escort record. It noted that the man was fit and well, calm and compliant. The man had said that he sometimes felt down, but he had no thoughts of harming himself. The report also noted that this was the man's first time in custody and he needed an Arabic interpreter, preferably able to speak the Sudanese dialect.

20. A nurse assessed the man for an initial health screen when he arrived at the prison. The nurse noted that the man's voice was clear, but he seemed very shy and spoke very little English so she used Language Line, a telephone interpreting service, to speak to him. Although the man had poor eye contact, she recorded that his mood and mental state appeared stable and he said he had no thoughts or history of suicide and self-harm. The man said he smoked ten cigarettes a day, but did not want help with stopping smoking. He told the nurse that he suffered from nightmares, but she did not follow this up by asking for more information.

21. An officer completed a cell sharing risk assessment. He noted no concerns and assessed the man as a low risk of violence to others. The man went to the first night centre that night, and then moved to a shared cell on C wing the next day.

22. The man gave his brother's name, address and telephone number as his next of kin details. (These details later turned out to be incorrect.) Staff noted that the man was not very literate, but they did not record whether he needed an interpreter.

23. Another officer briefly met the man on the wing. The officer said that the man spoke limited English and used hand gestures to communicate. However, the officer believed that he understood enough to pick up the basics of living on the wing. He recalled that the man was a loner and did not come out of his cell much. There is no record that the man attended an induction programme.

24. On 22 April at 8.40pm, the man cut both his forearms superficially. The nurse examined him, but, apart from cleaning, the cuts did not require any treatment. The man had also banged his head on the cell door and had a small lump on his forehead, but his skin was not broken. The man said he had harmed himself because he was frustrated at not having any tobacco.

25. Because of the man's self-harm, the custodial manager in charge of the prison that night, began ACCT procedures and noted that staff should observe the man at least once an hour. The Concern and Keep Safe section of the document noted that the man had harmed himself because he had no tobacco and had said that he had no next of kin. No one signed the page or entered the time and date.

26. The custody manager completed the Immediate Action Plan and noted that The man should share a cell. She repeated the need for hourly observations and said that a nurse should assess him. She recorded that she had "reminded" him of the services of the Listeners (prisoners trained by the Samaritans to support other prisoners in distress) and the Samaritans if required, but did not note his evident language difficulties.

27. At 9.30pm, a nurse responded to another emergency call after the man had bitten his cellmate on his right shoulder. The man's cellmate was then moved to another cell. The man's cellmate told the investigator that they had shared a cell for a week and there had been no problems initially. He said the man was a very quiet man, who was a heavy smoker. He had got tobacco from another prisoner to give to the man three or four times and had asked him to try to make it last. The man's cellmate said that the man had bitten him because he had tried to stop him harming himself with a plastic fork.

28. At 11.00pm, the man made a small fire in his cell bin and pressed his cell bell. Officers put out the fire and moved him to the segregation unit. On the way there, he struggled and lashed out at the staff escorting him and they restrained him.

29. The custody manager completed an 'Authority to segregate a prisoner on an open ACCT' form. She wrote that the man had made superficial cuts to his arms to get tobacco. When he did not get any, he had bitten his cellmate and set fire to his bin. The custody manager said that she thought his actions were solely to try to obtain tobacco and noted that he had no history of self-harm. No exceptional reasons to hold him in the segregation unit were recorded on his ACCT plan.

30. The custody manager said there were no safer cells (with reduced ligature points) or cells with CCTV coverage available in the segregation unit, but because she felt that the man had not deliberately attempted suicide, she allocated him a standard cell and expected staff to check him five times an hour. The segregation unit manager, countersigned the decision to segregate the man under Prison Rule 45 (Good order or discipline).

31. A nurse completed the initial segregation safety screen algorithm that night, to assess whether the man was fit for segregation. The nurse concluded that the man's actions were caused by frustration rather than a genuine attempt to harm himself. The cuts to his arms were superficial and had not required treatment. The nurse thought that the man was able to communicate very well. She did not consider that his mental health would deteriorate if he remained in the segregation unit, or that he would not be able to cope.

32. On 23 April, a member of the safer custody team, interviewed the man in the segregation unit, for an ACCT assessment. He said that, when he asked the man more detailed questions, the man said that he did not understand. The officer recorded that the man said that he was fine and felt good, but he kept asking for tobacco, although staff had given him some. The man said he would not harm himself again and had never done so before. The officer said he had not considered using the telephone interpreting service, as he believed the man had understood most of what he said. Staff continued to observe the man five times an hour.

33. The man was later charged with a disciplinary offence under Rule 51 paragraph 15 - 'intentionally or recklessly sets fire to any part of a prison … or any other property, whether or not his own.' Staff did not charge him with assault, for biting his cellmate.

34. Twenty minutes after the ACCT assessment, the wing manager, Supervising Officer (SO) held the first ACCT case review with the man. Although the officer's name is also on the document, he told the investigator that he had not attended the review, but had spoken to the SO beforehand and that the document should have reflected this. The man repeated that he felt fine and had no thoughts of harming himself again. He said his actions were in response to having no tobacco. The SO did not seek input from the mental health team and there was no member of healthcare staff present, which is a mandatory requirement for first ACCT case reviews. The officer assessed the man's risk of further self-harm as low and closed the ACCT. He scheduled a post-closure review for 30 April.

35. Another SO supervised the segregation unit at Leeds. He recalled that the man was able to communicate with him and that he continually asked for tobacco. His impression was that the man did not want to engage, just wanted to stay in bed and spent most of his time asleep.

36. The daily segregation record showed that an operational manager and a chaplain had visited the segregation unit on 23 April, but there was no record that a doctor or nurse had attended. No one raised issues about the man.

37. On 24 April, the man had a disciplinary hearing about lighting a fire in his cell. The hearing was adjourned for seven days for the man to get legal advice. There was no further record of what happened or any information about the outcome.

38. During his daily round of the segregation unit on 25 April, the doctor noted that the man seemed to be coping well. Later that day, the duty operational manager, reviewed the man in the segregation unit. The duty manager was concerned about the man's demeanour and thought he might not be fit to stay in the segregation unit, so he asked the nurse to conduct a full mental health assessment. The nurse asked another nurse to assess the man, as she was busy elsewhere.

39. The nurse recorded the assessment in the man's medical record at 3.23pm. She considered that the man understood her and that they had communicated effectively. The man told her that he had had, "head problems" but felt all right now. He said he had no problem being in the segregation unit and knew he had to stay there for two weeks. When they discussed the incident on the wing, the man said that he had set fire to the bin because he did not have any cigarettes and nobody would give him any tobacco. This had made him very angry and he had harmed himself as he had not got what he wanted. He said he did not want to cut himself again, or end his life.

40. The man told the nurse that he had a wife and three children abroad, had few friends and did not work. He said that he was eating well but was having difficulty sleeping. He declined her offer of sleeping tablets.

41. The nurse noted that he appeared tired, closed his eyes at times, held his head down and hands together, and spoke quietly and slowly. He was pleasant and polite to her throughout and sometimes smiled. The nurse concluded he was overtired. She asked segregation staff to monitor his sleep for the next three days and she would return to see him.

42. The nurse completed another segregation safety assessment. She noted that she had no concerns about the man at that time and the manager countersigned the form. The manager also completed another 'Segregation under Rule 45 Reason for Initial Segregation' form which gave the same reasons for segregation as the original form. He noted that healthcare staff had not raised any concerns about the man staying in the unit and he was due to remain there until 28 April.

43. On 26 April, an operational manager, chaplain and IMB member visited the segregation unit, but there was no record of a doctor or nurse attending that day or the next.

44. A doctor saw the man in the segregation unit on 28 April and noted that he appeared to be coping well. The same day, the manager authorised the man's segregation under Rule 45. He noted that a segregation health screen had been completed which had assessed him as suitable to remain in the segregation unit and that the man was waiting for a post-closure ACCT review.

45. The man went back to C wing later that day, 28 April. The nurse reviewed him in his cell and noted that he was reading Arabic magazines and had an English television guide. He asked for a shower and for some cigarettes. The

nurse told him he would need to order cigarettes from the prison shop. The man said he had slept better over the weekend and felt better in himself, but just wanted cigarettes. The nurse told him to discuss this with wing staff. She noted that the man spoke coherently, and seemed bright and alert. She considered that he needed no further mental health input at the time.

May 2014

46. On 2 May, an SO held an ACCT post-closure review, initially scheduled for 30 April. (The SO said he had, by chance, found a pile of ACCT documents that were due for post-closure reviews.) The SO said he had no difficulty communicating with the man who told him that the problems that had led to his self-harm had been resolved and he had support from his family. (Although his ACCT document clearly stated that he said he had no next of kin.) The SO was satisfied that the ACCT should remain closed. He could not remember reading that the man had no next of kin.

47. An operational support grade (OSG), began duty as a night patrol officer on 8 May. In a statement, the OSG said that during her handover, the day staff told her that the man had rung his cell bell during the evening to ask for cigarettes.

48. During the night of 9/10 May, the man pressed his cell bell again and asked the OSG for cigarettes. She told him that he needed to wait for his order from the prison shop to arrive. The man pressed his cell bell a further three times with the same request. The OSG said that the third time, after explaining that he could not have cigarettes, he asked her to go into his cell for sex. She told him that he could not speak to women in that way and if he did so again she would issue him a formal warning about his behaviour. Shortly afterwards, the man pressed his cell bell again and repeated his request for sex. The OSG gave him a negative behaviour warning and recorded this in his case notes. She explained to the man that she had done this and she said he nodded in response. He did not press his cell bell again that night.

49. As a result of him constantly ringing the cell bell and his behaviour towards the OSG, the SO reviewed his level on the prison's incentives and earned privileges scheme later that day. He demoted the man to the basic regime, with reduced privileges, with a further review in 21 days.

50. At around midday on 11 May, a custodial manager, noted an altercation between the man and prison officers about the man rummaging through bins on the wing. He took the man back to his cell. On their way back, the man tried to go into another prisoner's cell to ask for some tobacco. The custodial manager put out his hand to stop him and felt something around his waist. He asked the man to lift up his sweatshirt and saw that he had tied a rope made from plaited sheets around his waist. The custodial manager took it off him and handed it to an officer. The custodial manager said he asked the man why he had the rope, but as the man's English was very poor, he was unable to explain. The custodial manager said that, despite his limited English, he had indicated to him that he was okay.

51. The custodial manager searched the man's cell and found that he had some extra sheets, which he removed. His main concern was that the man might use the rope to climb onto the bars of the staircase on the wing, as they had experienced a similar incident a few days before. The officer took the rope to the security department and reported the incident.

52. The custodial manager told the investigator that he did not think that the man had made the rope to harm himself (a view he had shared with other staff he spoke to that day). He suggested to wing staff that the man should receive his meal in his cell that afternoon, as he was concerned that he might climb onto the staircase. The man stayed in his cell and no one reported any further concerns that day. Staff conducted roll checks (to make sure that all prisoners are present) at 9.30pm and 5.30am, but no one noted any concerns about the man and there is no record that he pressed his cell bell that night.

12 May 2014

53. On the morning of Monday 12 May, there was no supervising officer on the wing to oversee officers unlocking prisoners. The officer telephoned a custodial manager and said that the prisoners were still in their cells. At 8.00am, the officer called again and The manager instructed the officers to unlock prisoners waiting for medication (The man was not on any medication.) At 8.15am, the manager arrived on C wing and told the officers to begin unlocking prisoners for work and those on landings two and three for a period of association (when prisoners can carry out domestic tasks, make telephone calls, take showers and socialise with each other). Just after 10.30am, the prisoners who had been unlocked for the association period went back to their cells.

54. At 10.40am, an officer began to unlock prisoners on landing four for association. She reached the man's cell, C4-08, a few minutes later. The officer said she unlocked the door and looked into cell, which was dark. He was not sitting at the desk, as he usually was when she unlocked his cell, and she noticed his bed was empty. She then saw the man suspended by a sheet around his neck, attached to the window bars.

55. The officer was not carrying a radio, so she immediately shouted to other wing staff that she had a 'code blue', (an emergency where a prisoner is unresponsive or might not be breathing. Two other officers responded. One officer had earlier given the main radio for the wing to the manager, so he pressed the general alarm bell.

56. One officer supported the man's weight, while the other officer used an anti-ligature knife to try to cut through the sheet. She was unable to do this easily because of the height of the window, so she pulled a chair over, climbed on it, and again tried to cut through the ligature. She still had difficulty because of the thickness of the sheet and the officer tried to cut through it from the other side, while the officer unravelled the sheet. They eventually released the ligature.

57. The officers lowered the man to the floor. One officer checked for signs of life, but found none. However, he felt warm and there was no sign of rigor mortis. He immediately began chest compressions. The officer tried to open the man's airway by tilting his head, but did not attempt rescue breaths.

58. The officer continued chest compressions until a nurse arrived. The nurse also attended. No one could recall who had brought the emergency bag, which contained a defibrillator and oxygen, as well as other items (An emergency bag is kept in a treatment room on every wing.) At 10.45am, the nurse established that no one had called a code blue. A SO radioed the control room, but the control room staff said that the ambulance controller would want the man's details, including his date of birth, before they would despatch an ambulance. The officer went to the wing office to get his file. (The Ambulance Service received a call for an ambulance at 10.51am.)

59. Two nurses attached the defibrillator to the man but it did not advise any shock. A nurse took over chest compressions. The other nurse inserted an airway, helped by the nurse. Another nurse arrived to help. One nurse maintained the airway while the other nurses carried out chest compressions. The nurse said the man had not felt cold, but his pupils were fixed and dilated. Another nurse had also heard the emergency call and went to C wing to assist.

60. Paramedics arrived at the prison at 10.57am and reached the man's cell two minutes later. They assessed him and continued emergency treatment, but pronounced the man dead at 11.34am.

61. An operational manager, held a debrief at 3.00pm, for the staff involved in the emergency response and offered the support of the prison's care team. The staff raised a number of issues, including the lack of radios and earpieces, muffled radio transmission and the delay calling an ambulance because of the additional information the ambulance service required.

62. Staff advised prisoners of the services of Listeners, Samaritans and the chaplaincy to support them and informed them that they should speak to staff if they felt affected by the man's death. All prisoners who were subject to ACCT monitoring were reviewed.

63. The prison, the Coroner and the police were unable to locate any of the man's family or friends. Therefore, the prison arranged his funeral. His belongings remain at the prison.

ISSUES

Clinical care

64. When the man arrived at Leeds, a nurse carried out an initial health screen, using the Language Line telephone interpreting service. The man told her he had no thoughts of suicide or self-harm and the nurse concluded he was mentally stable. The clinical reviewer noted that the man had told the nurse he suffered from nightmares, but she did not explore this further with him or consider whether it impacted on his overall mental health. We recognise that initial health assessments on reception can be limited in scope, but there is no record that the man had a secondary health assessment at which health issues could have been explored in more depth.

65. Prison Service Order (PSO) 3050, *Continuity of healthcare,* states:

> "In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community. Such assessments are not standardised, however the general health assessment should act as an opportunity for:
>
> - gathering further medical information
> - checking how the prisoner is settling in
> - health education
> - providing information
> - health promotion.

66. The lack of a second health assessment was a missed opportunity to assess him further and discuss in more depth some of the issues he had raised at his initial reception health screen. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff offer all new prisoners a secondary health screen, and that this is recorded.

67. On 25 April, the operational manager, asked healthcare staff to carry out a full mental health assessment because he was concerned about the man's demeanour and behaviour. A nurse assessed him that day and reviewed him three days later. The clinical reviewer considered that, although the nurse asked some questions which would have been found in a structured self assessment such as PHQ9 (Patient Health Questionnaire-9, a tool specifically designed to score the symptoms of depression), these assessments were not methodical and did not amount to a full mental health assessment. She was also concerned that the nurse completed them without the use of an interpreter, despite the man's limited English. (We discuss the use of interpreting services below.) Because of the lack of a full health and mental health assessment and the failure to use interpreting services, the clinical reviewer concludes that the man's care at Leeds was not comparable to that expected in the community, and we agree. We make the following recommendation:

The Head of Healthcare should ensure that there is an agreed protocol for conducting mental health assessments and that such assessments are thorough and accurate.

Assessment of risk and management of ACCT procedures

Case review

68. Prison Service Instruction (PSI) 64/2011 – *Safer Custody* outlines the purpose of an ACCT, which includes identifying the prisoner's most pressing needs and how to address them, the level of risk, considering and recording progress against the initial caremap and considering whether the prisoner exhibits any additional needs that might require staff to update the caremap.

69. Case reviews should be multi-disciplinary. It states that the first case review should comprise:

> 'the Residential Manager or equivalent and/or the Case Manager (if different), the Assessor, whenever possible, a member of staff who knows the prisoner, e.g. wing officer, the person who raised the initial concern, healthcare staff and any other member of staff who has or will have contact with the at risk prisoner and who can contribute to their support and care.'

70. On 22 April, the man cut himself and staff began ACCT procedures. The next day, the SO held the only ACCT case review, on his own. There was no healthcare representative, which is a mandatory requirement of PSI 64/2011. The SO had spoken to a wing officer and gave the impression on the ACCT record that the officer had attended the review, but the officer told the investigator that this was not the case. The SO considered the man's risk was low and singlehandedly closed the ACCT. ACCT reviews should not be held by just one person and it is very poor practice to close an ACCT without the appropriate input of others to help assess risk.

Post-closure review of the ACCT

71. The man had previously said that he had no next of kin but he told the SO who saw the man for an ACCT post-closure review on 2 May that he had the support of family and friends. The SO said that he had briefly read the ACCT document before carrying out the post-closure review, but he did not remember checking that piece of important information and did not notice the note on the ACCT, which stated that the man had no next of kin. He said that he had relied on what the man had told him. We consider that this significant discrepancy should have led the supervising officer to question the man further. Managers did not complete a quality assurance document to assess whether staff had completed the ACCT correctly. The review was also two days late, and had only come to the officer's attention when he found a pile of ACCT documents in the wing office.

Discovery of a rope around the man's waist

72. On 11 May, a custodial manager, found that the man had hidden a makeshift rope of plaited bed sheets under his sweat-shirt. He thought the man might have had a plan to create disorder by tying himself to the bars of the wing staircase, as another prisoner had done a few days earlier. He did not consider that this was an indicator of the man's risk of suicide and self-harm and treated it as a security issue. He asked staff to keep the man locked up for the rest of the day, without any further assessment.

73. It is concerning that the custodial manager or the other staff did not consider the possibility that the man had intended to harm himself. In the light of the man's previous actions and, the fact that he had recently been monitored as at risk of suicide and self-harm, we believe that the discovery of the plaited sheet was significant enough to indicate that staff should have started ACCT procedures. The next day, the man hanged himself with a similar ligature, made from bed sheets. This suggests that he had made the previous rope with the intention of harming himself.

74. We consider that the management of the ACCT process was poor. In particular, we are concerned that a single member of staff conducted the case review and closed the ACCT, without convening a multidisciplinary team or consulting healthcare staff. There was a delay in conducting the post-closure review and staff did not begin ACCT procedures again when they found a rope around his waist the day before he died. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Holding multidisciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care;**
- **Carrying out post-closure reviews promptly on the due date; and**
- **Opening an ACCT plan if staff observe changes in a prisoner's behaviour or circumstances which indicates an increase in the risk they pose to themselves.**

The decision to segregate the man

75. The effect of segregation on the state of mind of someone who is already vulnerable can be significant. PSO 1700 (Segregation) sets out an expectation that staff should focus on helping prisoners manage their behaviour and problems rather than simply on punishment.

76. Healthcare staff should conduct an initial segregation health screen within two hours of arrival in the segregation unit. This is not a full mental/medical health assessment but a safety assessment, which assists staff to check the suitability of a prisoner for segregation. There are only two possible

outcomes. The first is that there are no health concerns at the time; the second is that there are healthcare reasons why a prisoner should not be segregated. An operational manager then endorses and countersigns the form.

77. PSO 1700 states that a prisoner on an ACCT plan should not be kept in segregation unless there are exceptional circumstances, they are such a risk to others that no other suitable location is appropriate and where other options have been tried or considered inappropriate. PSI 64/2011 (Safer Custody) says the reasons for segregation must be clearly documented in the ACCT plan and include other options that were considered but discounted. The healthcare or mental health team should undertake a mental health assessment of all prisoners on an ACCT document held in the segregation unit, within 24 hours. This is reiterated in the prison's local policy. This did not happen, apparently because the ACCT was closed within 24 hours.

78. Prison staff concluded that the man's self-harm and subsequent setting fire to his cell had been acts of manipulation, rather than an indication of his risk. They annotated the form to indicate that were no safer cells or cells with CCTV coverage available in the segregation unit, but there is no clear evidence why staff considered the segregation unit was an appropriate location for the man, who was at risk of suicide or self-harm. Neither did they indicate whether other options or locations had been considered. We make the following recommendation:

The Governor should ensure that prisoners assessed as at risk of suicide or self-harm 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.

Use of translation services

79. PSI 64/2011 states:

> 'All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process.'

80. It was evident that the man spoke and understood little English and the police had noted on his escort record that he needed an interpreter. At Leeds, accounts of the man's proficiency in English varied. The reception nurse, was the only member of staff who used an interpreter when speaking to him. The nurse who assessed the man's fitness to remain in the segregation unit, believed that the Language Line telephone translation service was only available to staff in reception. Notably, when a custodial manager found the man with a makeshift rope the day before his death, the custodial manager said that the man did not really explain anything as his English was 'very, very broken.'

81. The clinical reviewer, concluded that, although the nurse felt she had sufficient personal experience to enable her to communicate with the man, their communication had been basic. She was concerned that the nurse and the man did not share sufficient mutual understanding of the questions and responses, to carry out an effective assessment of his psychiatric wellbeing and mental state. The clinical reviewer had similar concerns about the nurse's review of the man three days later. All other staff interviewed said they felt it was unnecessary to use a translator, as the man appeared to understand what they had said. However, no one had assessed his comprehension. We make the following recommendation:

The Governor and Head of Healthcare should ensure that professional interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, particularly in health assessments and when assessing prisoners at risk of suicide and self-harm.

Emergency response

82. Prison Service Instruction (PSI) 03/2013 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 effectively communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and there are no delays in calling an ambulance. It stipulates that if someone calls an emergency code over the radio, then the control room must call an ambulance immediately and a member of the healthcare team or a manager does not have to attend the scene before this is done.

83. As the officer did not have a radio, she shouted a code blue to colleagues. None of the first members of staff to respond held a radio either, and did not raise a code blue with the control room until a nurse arrived and queried whether this had been done. Staff should have called a code blue immediately after the officer found the man. This meant that staff attending the incident were not aware of the nature of the emergency.

84. The SO told the investigator that even if a member of staff calls a code blue, the control room staff will not call an ambulance until they have the prisoner's full details, including name and date of birth. The SO said he thought this was to enable the paramedics to have an idea of the emergency they are attending. The manager said that the ambulance control room had requested more details from the prison and this was an ongoing problem. The manager said he had spoken to the Head of Healthcare about this and he understood that she would liaise with the ambulance service about this.

85. HMP Leeds and Yorkshire Ambulance Service NHS Trust issued agreed guidance on 10 December 2013, which states that when there is a code blue emergency an ambulance will be called immediately. Appendix 1, 11.2, of the document stares that the Yorkshire Ambulance Service will ask the prison six questions when the prison requests an ambulance. These are:

- What is the chief complaint?
- What is the approximate age of the patient?
- Is the patient conscious?
- Is the patient breathing?
- Does the patient have chest pain?
- Is there any serious bleeding?

86. If the answer to any of the above questions is unknown, then the prison can say so. The prison can inform the ambulance service later but this should not lead to a delay in calling one. The instructions are very clear and show that there is no need for prison staff at the incident to get any additional information, as they can answer the questions immediately and give an approximate age if the actual age is not known. There is no reason why obtaining these details should cause any delay or prevent staff calling a code blue immediately. We make the following recommendation:

The Governor should ensure that all prison staff are aware of and understand PSI 03/2013, local instructions 46/2013 and 29/2013 and their responsibilities during medical emergencies, including efficiently communicating the nature of a medical emergency and ensuring there are no delays in calling an emergency ambulance.

Availability of radios

87. There is a local policy which stipulates who should carry a radio. Not every member of staff carries a radio but each SO or officer in charge of the wing has one. It is unfortunate that on the morning of the 12 May, none of the officers who initially attended the man held a radio. The manager told the investigator that there are always plenty of radios available for staff if they want one. Radios are a quick and efficient way of communicating emergencies or other important information. We make the following recommendation:

The Governor should ensure that sufficient staff carry a radio in every part of the prison to enable them to call an emergency quickly.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff offer all new prisoners a secondary health screen, and that this is recorded.

2. The Head of Healthcare should ensure that there is an agreed protocol for conducting full mental health assessments and that such assessments are thorough and accurate.

3. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

   - Holding multi-disciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care;
   - Carrying out post-closure reviews promptly on the due date; and
   - Opening an ACCT plan if staff observe changes in a prisoner's behaviour or circumstances which indicates an increase in the risk they pose to themselves.

4. The Governor should ensure that prisoners assessed as at risk of suicide or self-harm 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.

5. The Governor and Head of Healthcare should ensure that professional interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, particularly in health assessments and when assessing prisoners at risk of suicide and self-harm.

6. The Governor should ensure that all prison staff are aware of and understand PSI 03/2013, local instructions 46/2013 and 29/2013 and their responsibilities during medical emergencies, including efficiently communicating the nature of a medical emergency and ensuring there are no delays in calling an emergency ambulance.

7. The Governor should ensure that sufficient staff carry a radio in every part of the prison to enable them to call an emergency quickly.

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Head of Healthcare should ensure that healthcare staff offer all new prisoners a secondary health screen, and that this is recorded	Accepted	The secondary health screen will be undertaken the next morning prior to prisoners moving off the first night centre. This will be recorded on SystmOne and quality checked by a manager on a monthly basis.	Completed	
2	The Head of Healthcare should ensure that there is an agreed protocol for conducting full mental health assessments and that such assessments are thorough and accurate	Accepted	A stepped care pathway approach to mental health assessment has been implemented. A primary care mental health nurse undertakes a triage, and where appropriate a referral is made to the secondary mental health provider for a full mental health assessment. This process is managed by the mental health governance steering group which includes representatives from the prison, the healthcare providers (Leeds Community Health and Leeds and York Partnership Trust) and NHS England commissioners. Annual patient safety and documentation audits are in place to ensure compliance. All staff receive clinical supervision, and are subject to performance management interventions if it becomes apparent that	Completed	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
			thorough and accurate assessments are not being delivered.		
3	The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: • Holding multi-disciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care; • Carrying out post-closure reviews promptly on the due date; and • Opening an ACCT plan if staff observe changes in a prisoner's behaviour or circumstances which indicates an increase in the risk they pose to themselves.	Accepted	A full review of the Safer Custody department has been undertaken. A comprehensive action agreed with the Governor, the Regional Lead for Safer Custody and the Regional Deputy Director of Custody. This was completed in September 2014 and is currently being implemented. It will be progressed and managed via the Safer Custody meetings. This action plan includes the development of the full staff group at HMP Leeds starting with a Safety themed training shut down morning. This training programme now includes ACCT foundation. This is delivered to multi-disciplinary staff such as Leeds Community Healthcare and Manchester College. This includes anyone noticing changes to behaviour that cause concern can open and ACCT. A robust quality checking process has now been introduced, and when deficiencies in procedures are identified notices are served to residential managers for immediate action. Support and management plans are in place for all staff and managers who	Head of Safety Target completion date for staff training September 2015	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
			consistently fail to deliver care in line with national guidance. ACCT reviews have been added to the daily briefing sheet which is sent out to all managers and discussed each morning at the morning meeting. The Safer Custody Manager and the Mental Health Manager have agreed an additional safeguard procedure to ensure that reviews are multidisciplinary and that the right people are in attendance. If, in exceptional circumstances, the identified relevant person cannot attend they must submit a report prior to the scheduled review in accordance with PSI 64/2011. A database has been initiated in the Safer Custody Department showing when post closure reviews are due. In addition those out of scope have been escalated to the Head of Residence and the staff concerned challenged on their performance. A training package for all Band 4s has been developed and is in the process of being rolled out. It includes a 'Safety' day incorporating ACCT Management.		

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
4	The Governor should ensure that prisoners assessed as at risk of suicide or self-harm 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	Accepted	A checklist has been introduced for Duty Governors to complete in the event of the need to consider segregating a prisoner on an open ACCT or of an ACCT being opened on a segregated prisoner. It ensures that all possible alternative locations are explored, and that if the decision is nonetheless taken to segregate the prisoner, the exceptional circumstances that apply in the case are fully documented. Completed forms are monitored by the Regional Safer Custody Lead.	Completed	
5	The Governor and Head of Healthcare should ensure that professional interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, particularly in health assessments and when assessing prisoners at risk of suicide and self-harm.	Accepted	Comprehensive Language Line training has been provided to healthcare staff and first night centre staff. Further sessions are also booked for healthcare and admission group. Additional handsets have been purchased and issued to give better access. (Leeds Community Health). The establishment has re-issued guidance on the use of Language Line to all staff and partner agencies. The Equalities Department have taken lead on this and put new notices up in all key areas.	Commenced	
6	The Governor should ensure that all prison staff are aware of	Accepted	A Notice to Staff has been issued to remind staff of the requirements of PSI 03/2013.	Completed	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	and understand PSI 03/2013, local instructions 46/2013 and 29/2013 and their responsibilities during medical emergencies, including efficiently communicating the nature of a medical emergency and ensuring there are no delays in calling an emergency ambulance		Contingency plan exercises will be developed to include involvement from Control Room operatives to ensure that the ambulance protocol is fully understood. The Safer Custody and Operations departments will audit all medical emergency calls to ensure compliance.	February 2015	
7	The Governor should ensure that sufficient staff carry a radio in every part of the prison to enable them to call an emergency quickly.	Accepted	Additional radios have been issued and are in use.	Head of Operations Head of Safety February 2015 Reviewed annually	