A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Leeds in September 2014

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 hanged in his cell at HMP Leeds in September 2014. He was 28 years old. I offer my condolences to his family and friends.

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

The man was charged with serious sexual offences against his partner and was remanded to Leeds prison in July 2014. He had harmed himself when he was in police custody and said that he wanted to die. The police completed a warning form and a court officer spoke to the prison to alert them to his risk of suicide. Despite this, no one identified him as at risk of suicide and self-harm when he arrived at the prison. The next day, a nurse was concerned about his state of mind and referred him for a mental health assessment, but another nurse cancelled the referral. In September, police charged him with additional serious sexual offences and he reacted very badly. Again, no one at the prison acted on the police's warning about his demeanour and no one assessed him when he came back to the prison. Later that evening, his cellmate found him hanged in their cell

It is very difficult to understand how the prison did not identify the man as at risk of suicide and put in place procedures to support him. The alleged offences alone should have alerted them to his raised risk without the additional warnings from the police, which were discounted and ignored. I am very concerned that a mental health referral was cancelled without any proper reason and that the prison does not appear to have an adequate process for reassessing prisoners when they have been out of the prison for questioning by the police and other circumstances that might increase their risk of suicide and self-harm. Overall, reception procedures were very poor in his case and the Governor needs to ensure that the prison improves its arrangements so that all staff are aware of their responsibilities.

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 **May 2015**

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SUMMARY

1. On 9 July 2014, the man was charged with serious sexual offences against his partner and remanded to HMP Leeds. At the police station, he became very upset and threatened to kill himself. He cut his arms, banged his head, and needed hospital treatment. The police completed a suicide and self-harm warning form, which they passed to the court. Escort staff gave the warning form to reception staff at Leeds when he arrived.

2. A reception officer signed to confirm he had received the warning form and passed it to a supervising officer. There is no evidence that either of them assessed the man's risk of suicide or self-harm. A mental health nurse completed his reception health screen. He told her that he had harmed himself at the police station, because he had been shocked about the charges. He said he had no thoughts of suicide or self-harm. The nurse accepted this and did not start suicide prevention measures.

3. The next day, 10 July, the man was upset and tearful and another nurse was concerned about him. She asked the mental health nurse to assess him again. Once more, the mental health nurse closed the referral without seeing him.

4. In September, the man was taken to a police station and charged with further serious sexual offences. He was very distressed and became aggressive. The police telephoned the prison to warn them about how he had reacted and that six police officers would escort him back to the prison because they thought he might become violent. A reception officer said he was very shocked that he had been charged with more offences but very quiet. Officers did not assess his risk of suicide or self-harm and a nurse did not assess him in reception. An officer took him back to his cell at about 4.00pm.

5. At about 6.30pm, the man's cellmate came back from a court appearance and an officer let him into the cell but did not check the man. When his cellmate went to use the toilet, he found him behind the privacy curtain, hanging from the window bars. He alerted staff and officers, and nurses tried to resuscitate him. Paramedics arrived and took over emergency treatment. Just after 7.00pm, a doctor confirmed that he had died.

6. We are very concerned that the prison did not recognise the man's raised risk of suicide, when he first arrived, or after he was charged with further offences. Poor reception procedures meant that officers did not consider key information about him. The reception nurse relied too much on what he told her, rather than his known risk factors. The referral for a mental health assessment, the day after he arrived, should not have been cancelled. Staff should have assessed his risk of suicide and self-harm when he was charged with further offences in September. We make three recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Leeds about the investigation, inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison and medical records. She interviewed 11 members of staff and one prisoner at Leeds and informed the prison about the initial findings of the investigation.

9. NHS England appointed a clinical reviewer to review the man's clinical care at HMP Leeds.

10. We informed the Coroner for the County of West Yorkshire of our investigation, who provided a copy of the post-mortem report. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted the man's parents and explained the investigation process. They had no questions for the investigation to consider and had no comments on the draft report.

HMP LEEDS

12. HMP Leeds is a local prison holding up to 1,120 men. Leeds Community Healthcare Trust runs 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. They were positive about reception processes and noted that staff were aware of the potential risks to new prisoners.

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 2013 annual report, the IMB noted that the prison were doing an excellent job protecting prisoners, although the IMB was concerned about the quality of ACCT documents. The IMB noted that prison staff were concerned about the lack of properly trained reception staff, which slowed down the admissions process.

Previous deaths at Leeds

15. There were two other self-inflicted deaths at Leeds in 2014. In these investigations, we found that prison staff took insufficient account of the prisoners' risk factors and should have started suicide prevention monitoring when they arrived at the prison. We have found the same failings in this investigation.

Assessment, Care in Custody and Teamwork

16. ACCT - assessment, care in custody and teamwork - is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. On 27 June 2014, the man received a 14-day prison sentence for breach of a domestic violence protection order. He served his sentence at HMP Leeds and was released on 3 July. Staff did not identify any problems during his short time at the prison.

18. On 7 July, police arrested the man and charged him with two counts of rape against his partner. He reacted badly to the allegations and cut his fingers and arm. He said he wanted to die. The police took him to hospital for treatment. He returned to the police station where he was constantly supervised.

19. At approximately 4.45pm on 8 July, the man became upset and violent at the police station. He banged his head against the wall and seemed to be having a panic attack. The police took him to hospital for more treatment, and he returned to the police station at about 8.00pm.

20. On 9 July, the man appeared at court and was remanded into custody. The police completed a suicide and self-harm warning form, noting that he had reacted badly to the charges, had banged his head on the cell walls, cut himself, and said that he wanted to die. When he arrived at court, court staff noted his risk and checked him frequently. Court staff spoke to an officer at HMP Leeds about his risk to himself and noted this on his Person Escort Record (PER), a document that accompanies all prisoners when they move between police stations, courts and prisons. He also noted this on the suicide and self-harm warning form. (The officer told the investigator that he did not remember the conversation about the man's risk of suicide and self-harm and made no note of it.)

21. When the man arrived at the prison, an officer signed the suicide and self-harm warning form to confirm he had received it. The officer did not consider whether he should open an ACCT document to begin Prison Service suicide and self-harm prevention procedures and there is no evidence that any other officer in reception considered his risk of suicide and self-harm. The officer told the investigator that he would tell a supervising officer if a prisoner arrived with a suicide and self-harm warning form, but he would not assess a prisoner's risk himself. The officer was acting as a supervising officer in reception that day. He recorded the man's personal details in his prison record, and told the investigator that he would usually note in the prisoner's case history if there were any concerns. There is no record that the officer assessed his risk of suicide and self-harm.

22. A mental health nurse completed the man's first reception health screen. She recorded in his medical record exactly what was written on the suicide and self-harm warning form; that he had banged his head on the cell wall, cut himself and said that he wanted to die. She did not sign the form to confirm that she had seen it. He told her that he did not intend to harm himself, and his actions at the police station had been because he had upset about his partner's accusations. She recorded that he was frustrated and shook when

he talked about the circumstances of his arrest. The nurse told the investigator that she did not consider him at risk of suicide or self-harm. She therefore did not open an ACCT. He asked for help to sleep. She recommended, and the doctor prescribed, sleeping tablets for two nights.

23. The next morning, a nurse saw the man for a second health assessment. He was tearful and told her that he was upset because his partner had falsely accused him of sexual offences against her. He said that he had no thoughts of harming himself. She noted that a mental health nurse had assessed him the day before, but she was concerned about him and referred him to the mental health team. She picked up the referral and responded asking another nurse to read the notes of her reception health screen. This nurse replied that she had read the reception health screen, but considered that he needed more input from the mental health team. The mental health nurse closed the referral on 11 July without seeing him, or arranging a mental health assessment.

24. The man was offered the opportunity to apply for vulnerable prisoner status for his own protection, because of the nature of charges against him, but he declined. There was no evidence to suggest that he felt unsafe or had any problems with other prisoners during his time at the prison.

25. The man worked in the prison's clothing and exchange store (CES) and officers noted that he did the job well. On 9 September, he began to share a cell with another prisoner. The cellmate said the man never mentioned any thoughts of suicide or self-harm to him, during the week they shared the cell. He said that the man received some post on 15 September, which he spent the evening reading and seemed angry. (The man's solicitor told the investigator that he had sent case papers to him on 10 September, with statements from his partner.) He told his cellmate that his partner had said some unpleasant things about him. He did not eat his evening meal and stayed awake reading the documents into the early hours, while his cellmate watched television.

Day of the incident

26. The police arranged to question the man about further allegations against him and an officer completed a person escort record in reception before he left, but did not refer to his self-harm in July. A Detective Constable (DC) took him to the police station and charged him with four more counts of rape and a sexual assault against another woman. He was extremely upset and the DC thought that he might assault him. When he was due to go back to the prison, a police officer telephoned to let the prison know that he was on his way back, with a police escort because of his aggressive behaviour.

27. An officer signed the man's escort record when he returned, but did not remember speaking to him. An officer who was working in the prison's reception that day, had been warned that he was coming back escorted by six police officers as he might be violent. In fact, when he got back, the officer said that he was quiet and looked shocked and blank. He searched him, who

then waited in a holding cell in reception to be taken back to his wing. The officer said that there is no formal reception assessment for prisoners coming back to the prison. He told the investigator that there were no healthcare staff on duty in reception at that time, so a nurse would not have seen him.

28. At approximately 4.00pm, the officer took the man back to his wing, about a minute's walk from reception. He said he could not remember him saying anything and he still appeared shocked. He said that he believed he would have told a wing officer that the man was facing extra charges, but he could not remember who he spoke to or what he said. There was no note in his records or in the wing observation book about this.

29. The man's cellmate came back to the wing from a court appearance, at approximately 6.25pm. An officer took him back to the wing and let him into his cell. He did not check before opening it, as there was no cell card and he assumed there was no other occupant. The officer then went to the wing office to let staff know that he was leaving.

30. In his police statement, the cellmate said that he noticed a tray of food on the table and that the man had made his bed, which was unusual. He knew that the man had been taken to the police station that day, so he was not surprised that he did not appear to be in the cell. He started to flick through the television channels, and then went to use the toilet. He pulled the privacy curtain back and found him with a bed sheet around his neck with one end tied to a window bar. He felt his arm, which was cold. He pressed the cell bell and banged on the door to alert staff.

31. An officer went to the cell and another officer, who had not yet left the wing, waited to see if he needed help. The officer looked through the door observation panel and shouted that there was a code blue emergency as a prisoner was hanging and went into the cell immediately. The other officer did not have a radio so he telephoned the control room and told his colleague that there was a code blue emergency, a prisoner had hanged himself and that they needed an ambulance immediately. This was at 6.35pm. She broadcast a code blue emergency over the radio network and then called an ambulance. The ambulance service operator began to ask for additional information, but she impressed upon them the urgency of the situation and they agreed to despatch an ambulance immediately. At 6.38pm, she noted in the log that she had called ambulance and included a reference number for the call.

32. An officer had been bringing prisoners from the gym to the wing when he heard banging and shouting. He said he saw an officer run to a cell and shout for help. The officer ran to the cell, which his colleague had already opened and supported the man's weight while an officer cut the sheet. They lowered him to the floor. An officer checked him for a pulse but found none and he was not breathing. At this point, nurses arrived. Officers took the cellmate away from the cell and tried to console him, as he was upset.

33. At 6.35pm, the designated emergency response nurse heard the code blue call over the radio. Within a minute, he and a colleague, who had also heard

the call, reached the man's cell. The response nurse checked him but could find no signs of life and his colleague started chest compressions.

34. Another nurse brought the emergency bag and arrived at the cell at approximately 6.37pm. The response nurse took an ambubag and mask from the bag. He began to administer rescue breaths, while his colleague continued with chest compressions. Another nurse then took over chest compressions. A defibrillator was attached (a life-saving device that can re-start the heart by giving an electric shock in some cases of cardiac arrest) but found no shockable heart rhythm. The man's pupils were fixed and his face appeared blue. The nurses continued cardiopulmonary resuscitation.

35. Paramedics arrived at 6.45pm and assessed the man. They took over the resuscitation attempt and administered adrenalin. At 6.58pm, a doctor arrived and examined him. At 7.01pm, the doctor pronounced him dead.

36. Staff found a note that the man had left in his cell, addressed to his parents. He said he was sorry but was angry with the women who had made allegations against him and said that he intended to kill himself.

Family Liaison

37. A prison's family liaison officer was appointed. The Governor and the family liaison officer visited the man's parents at 10.45pm to break the news of his death. The prison contributed to the cost of the funeral in line with national policy.

Support for staff and prisoners

38. The cellmate was badly affected by the man's death. Officers moved him to a cell with Listeners (prisoners who are trained by the Samaritans to support prisoners in distress) and referred him to the mental health team. Staff offered prisoners the support of Listeners, the Samaritans and the chaplaincy. Staff reviewed prisoners on ACCTs in case they had been affected by the death.

39. The next day, a governor debriefed the staff who had been involved in the emergency response. The staff said they found it helpful and that the prison's staff care and welfare team had given them good support.

ISSUES

Assessing risk of suicide and self-harm on arrival

40. The police had recorded on the man's suicide and self-harm warning form on 9 July that he had harmed himself in police custody and said that he wanted to die because of the charges against him. An officer signed the suicide and self-harm warning form to confirm its receipt, but did not assess his risk of suicide or self-harm or open an ACCT. The officer said he would have passed it to the acting supervising officer that day, but the acting supervising officer did not remember seeing a warning form and he did not assess the man. It appears that the mental health nurse must have seen the suicide and self-harm warning form, although she did not sign it, because she copied the exact details into his medical record. Despite the information on the warning form, she did not consider him at risk of suicide or self-harm and did not start ACCT suicide and self-harm prevention procedures. She told the investigator that she could not remember why she did not open an ACCT.

41. Prison Service Instruction (PSI) 74/2011, about early days in custody, sets out mandatory reception procedures and says 'The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRA assessments, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others'. As there is no evidence that reception officers acted on the suicide and self-harm warning form highlighting the man's risks, we do not consider that the prison complied with this instruction.

42. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 74/2011, both list a number of risk factors and potential triggers for suicide and self-harm. The man had a number of these risks. He was in the early days of custody, was a young man, had previously (and recently) self-harmed and had been charged with serious sexual offences against his partner. PSI 74/2011 requires staff to interview new prisoners in reception to assess the risk of suicide and self-harm and expects all staff to be alert to the increased risk and to act appropriately to address any concerns. This includes opening an ACCT. Yet no reception officer assessed his risk of suicide or self-harm. Only the nurse considered his risk, yet it does not appear that she took into account his known risk factors. Instead, despite his recent self-harm, his declaration the day before that he wanted to kill himself, and the charges he was facing, she relied on his assertion that he did not intend to harm himself.

43. Staff judgement is fundamental to the ACCT system. It relies on staff to use their experience and skills, as well as local and national assessment tools, to determine risk. This must include the prisoner's known risk factors and their presentation. Prison Instruction (PSI) 64/2011 states that 'all staff who have contact with prisoners must be aware o the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action'. Despite the man's numerous risk factors, neither the reception officer nor the reception nurse opened an ACCT. The deficiencies in assessing his risk suggest a need for improved procedures, which all staff understand and follow. We

have criticised reception staff's assessment of risk at Leeds in two other investigations in 2014. We make the following recommendation:

The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk.**
- **Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records.**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.**

Assessment of risk after a change of circumstance

44. On 16 September, the man was charged with four more counts of rape. The police warned reception officers that a number of police officers would escort him back to the prison as he had reacted badly to the additional charges. Despite this, nobody from reception asked a nurse to see him when he returned and none of the officers considered his risk of suicide and self-harm after being questioned by the police.

45. Prison Service Order 3050 (PSO) about Continuity of Healthcare indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase someone's risk of suicide and self-harm. Prisons are requires to have protocols to screen prisoners passing through reception for any potential healthcare or suicide/self-harm issues. Staff said that there was no routine re-assessment of prisoners when they came through reception. We are concerned that Leeds does not follow the mandatory procedures of PSO 3050 and missed a further opportunity to assess the man's risk a very short time before his death. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health problems and risk of suicide and self-harm after all court appearances, police questioning and other events that might increase their risk.

Mental Health care

46. The mental health nurse said she had no concerns about the man during his assessment in reception, and that he had told her he did not intend to harm himself. The next day, a nurse was concerned about him and asked for a mental health assessment. The mental health nurse ignored the concerns of her colleague and cancelled the referral without seeing him again.

47. The mental health nurse could not explain her actions and why she did not allow her colleague's request for a mental health assessment to proceed. We cannot know whether a mental health assessment would have changed the outcome for the man, although it might have given him access to mental health support if he needed it. It is a serious concern that the referral was cancelled without anyone seeing him. We make the following recommendation:

    The Head of Healthcare should ensure that mental health assessments are carried out promptly after a referral is received.

RECOMMENDATIONS

1. The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

    - Have a clear understanding of their responsibilities and the need to record relevant information about risk.
    - Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records.
    - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.

2. The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health problems and risk of suicide and self-harm after all court appearances, police questioning and other events that might increase their risk.

3. The Head of Healthcare should ensure that mental health assessments are carried out promptly whenever a referral is received.

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should: ▪ Have a clear understanding of their responsibilities and the need to record relevant information about risk. ▪ Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records. ▪ Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.	Accepted	PSI 2015/07 Early days in custody discussed at Safety / Admissions meeting. Details shared with all staff via SIN and posters produced for display in reception area. The BD007 Suicide/Self Harm Warning Forms are used by escorting staff. They will complete if they have any concerns about a prisoner or want to alert us to any at risk information. This does not initiate an ACCT being opened but Reception staff and Healthcare staff must sign the form to evidence that they are aware of the warnings raised. A copy is then filed in the prisoner's core record. BD007s have been discussed with the admissions staff and managers and all are now aware of importance of this handover of information. As a matter of course ACCT documents are routinely considered for opening in Reception. All discussed and highlighted risks are routinely noted on PNOMIS as are reasons for non-opening of ACCT's in light of BD007 information. All those entering the establishment through Reception as a new reception and/or change of circumstance are routinely seen by a member of healthcare. This is covered within the Don Grubin Screening/Reception Tool, which ensures that healthcare staff carry out a secondary screening. This is done in two parts; one on the first evening when arriving in to custody and a follow up screening on the following morning both of these are recorded. The Don Grubin is a nationally utilised health screening assessment utilised across the UK for prisoners entering reception. There is a separate suicide risk assessment within the tool validated for use in prison to identify patients at risk and those scoring a high level, which requires the opening of an ACCT. The second aspect of the health screen is implemented the next morning prior to prisoners moving off the first night centre into the prison.	Head of Admissions Head of Safety 24.04.2015 Head of Admissions Immediately actioned Head of Healthcare Completed	