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 at HMP Leeds on 25 January 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 hanging in his cell at HMP Leeds on 25 January 2014. The man was 27 years old. I offer my condolences to his family and friends.

An investigator was appointed. Two clinical reviewers reviewed the man's clinical care at Leeds. Staff at Leeds co-operated fully with the investigation.

The man arrived at Leeds on 14 November 2013. He had been recalled to prison just three weeks after he had been released on licence from another prison. On 2 November, he had taken a large overdose of diazepam which and had been admitted to hospital. He informed staff at reception about this during health screens, but he was not identified as at risk of suicide and self-harm.

The man's two months at Leeds were largely uneventful and he was viewed by prison staff as a model prisoner. However, friends told us that he was often stressed about his relationship with his partner and, on 20 January 2014, this led him to punch his cell mate and, subsequently, be moved to a different cell. There is no evidence that staff investigated the reasons for this or knew about his relationship difficulties. While this would not necessarily have led to staff opening suicide and self-harm prevention procedures, this was a missed opportunity to identify the man's potential vulnerabilities.

The man had some difficult telephone conversations with his partner that week, the last of which was on the morning of 25 January. That afternoon, his cell mate found him hanging in his cell.

I am concerned that when the man first arrived at Leeds, reception staff did not adequately assess his known risk factors including his recall to prison, which should have resulted in him being managed under suicide and self–harm prevention procedures. Not enough emphasis was placed on his recent overdose and, instead, staff relied on the man's physical presentation and his statement that he had no intention to harm himself. However, I recognise that, subsequently, the man appeared to settle well at the prison and it would have been difficult for staff to identify that he was at risk. The investigation found that emergency procedures at Leeds are not in line with national requirements and it is important that this is rectified.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2014**

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SUMMARY

1. The man was released on licence from HMP Forest Bank on 23 October 2013. On 2 November, he took a large diazepam overdose and was admitted to hospital. After his probation officer received several pieces of intelligence about his activities, the man was recalled to prison and went to HMP Leeds on 14 November. Suicide and self-harm prevention procedures were not initiated when he arrived at the prison, as we believe they should have been, taking into account the man's recent overdose and other risk factors. He was not referred to the mental health inreach team, as should have happened.

2. The man appeared to settle well at Leeds. He trained to work as a mentor on his wing and prison staff who knew him described him as a positive, polite man who did not cause any problems. He was nominated for trusted positions. Prisoners he was friends with said that the man was often "stressed" about his relationship, which led to him moving cells on 20 January 2014, after falling out with his cell mate who alleged that the man had punched him. None of the wing staff we spoke to, including the wing manager, were aware of the background to the man's altercation with his cell mate and therefore the opportunity to identify an area of vulnerability was lost.

3. The man's partner was concerned that he did not understand why he had been recalled to custody and was not given the appropriate documents. We found that he was informed, both orally and in writing, of the reasons for his recall. His offender manager was satisfied that the man understood why he had been recalled, even though he did not accept the reasons.

4. The man had two difficult telephone conversations with his partner on 23 January. On the morning of 25 January, he spoke to his partner on a mobile telephone illicitly obtained by another prisoner. That afternoon, when his cell mate returned from spending some time in the open air, he found the man hanging from the bed frame. Prison staff and paramedics attempted cardiopulmonary resuscitation, but this was unsuccessful and the man was pronounced dead.

5. We consider that the man's risk of suicide and self-harm should have been more proactively addressed when he first arrived at Leeds and he should have been referred to the prison's mental health inreach team. The reasons for his cell move should have been recorded and appropriately followed up. We are also concerned that the prison's local protocol for medical emergencies is not in line with national guidelines, an issue we have raised previously at this prison. We also found that some aspects of liaison with the man's family could have been better. We make five recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.

7. The investigator visited Leeds on 31 January 2014 and saw the man's cell and spoke to two prisoners who knew him. He met the deputy governor and the prison's family liaison officer and obtained a copy of the man's prison records. The investigator wrote to the man's cell mate, who had been released, to invite him to participate in the investigation but he did not reply. However, West Yorkshire police gave the investigator a statement he had made to them, as well as other relevant documents.

8. The investigator interviewed nine members of staff at Leeds in March and April and spoke to several members of F wing staff who had known the man. The investigator gave the Governor feedback about the preliminary findings of the investigation and followed this up in writing. The investigator interviewed the man's offender manager and an investigator from the Professional Standards Branch of Greater Manchester Police, by telephone.

9. NHS England commissioned two clinical reviewers to review the man's clinical care in prison. They joined the investigator for interviews with clinical staff.

10. We informed HM Coroner for West Yorkshire of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted the man's partner and father on 18 February. They raised the following issues that they wanted the investigation to address:

- The man had taken a large overdose a few days before his recall to prison. His family asked if the prison knew about this, as the Governor had initially told them that they did not. They wanted to know if appropriate monitoring and support had been in place.

- The man did not understand why he had been recalled and had not been given his recall paperwork. When his solicitor tried to visit him, he was told that the man had cancelled the visit, which his partner said was not true. They believed that the man was uncertain about his future as he was serving an indeterminate sentence.

- The news of the man's death was broken to his partner by another prisoner on a mobile telephone. The man's partner said that when she telephoned the prison to enquire further, she was spoken to unprofessionally.

- The man's partner said she had agreed to the prison sending a wreath to his funeral on the condition that it did not mention the prison. She was upset to find a card attached clearly stating it was from HMP Leeds.

- The man had, through his prison account, ordered a gift for his partner shortly before his death, which was delivered around three weeks later. His partner said this was a shock to her and she thought that the prison should have intercepted this and had it delivered more sensitively.

12. The man's partner and family received copies of the draft report. His partner pointed out some omissions. This report has been amended accordingly. The man's partner and family also 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

13. HMP Leeds is a local prison holding up to 1,212 men. Leeds Community Healthcare Trust provides primary healthcare services. Leeds and York Partnership Trust provides mental health inreach services for prisoners with severe and enduring mental health problems.

HM Inspectorate of Prisons

14. HM Chief Inspector of Prisons carried out a full announced inspection of HMP Leeds in January 2013. Inspectors 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. They also reported on the very good staff-prisoner relationships and that reception processes were positive with staff aware of new prisoners' potential risks.

Independent Monitoring Board

15. 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 published annual report, for the year ending December 2012, the IMB said that reception staff provided an efficient service in difficult working conditions. They noted that prisoners who self-harmed were closely monitored and guidance was given to staff where improvements were needed.

Previous deaths at HMP Leeds

16. We investigated two self-inflicted deaths at HMP Leeds in the year before the man died. In one investigation we found that prison staff took insufficient account of the man's risk factors and should have opened an ACCT document when he arrived at the prison. We also found that local emergency arrangements were not in line with national requirements. Both issues are repeated in this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

17. 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 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 be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map 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 of the actions on the care map have been completed.

KEY EVENTS

18. In September 2006, the man was sentenced to an indeterminate sentence for public protection (IPP) with a minimum period to serve of 21 months before he could be considered for release. He had previously served a 15 month sentence from which he had been released in August 2005.

19. The man was released on licence in April 2011, but was recalled to custody a year later. He was released again in November 2012, before being recalled for a second time on 4 June 2013. The man spent the next four months at HMP Forest Bank before being released on licence again on 23 October. He was not identified as at risk of suicide and self-harm at any time during this or any of his previous periods in custody.

20. On 2 November, shortly after he had been released, the man was admitted to hospital after taking an overdose of diazepam (a sedative). (He later told prison staff that he had taken 1,000 tablets, although this has not been verified.) The man was discharged from hospital on 3 November.

21. On 8 November, the man's licence was formally revoked and his recall to prison authorised on 8 November. His offender manager told us that the reason for the man's recall was intelligence-led and was based on a combination of several different pieces of information. The full reasons for recall were as follows:

    - The man was in possession of a knife when paramedics and police officers attended his flat after his overdose. He had to be restrained before being taken to hospital.

    - One of his licence conditions was that he would live alone. He was found to be living at an address registered to his partner.

    - The man was one of two men stopped by police on 8 November after a cash-in-transit van driver reported that he was being watched by them.

    - Drugs paraphernalia was discovered in the car in which the man was stopped and it was suspected that the car was stolen. (The offender manager told us that the police subsequently withdrew the information about drugs paraphernalia and the car was found to be rented rather than stolen.)

22. The man was arrested and arrived at HMP Leeds on 14 November. He had not been in Leeds before. The Person Escort Record (PER, a form that accompanies prisoners on all journeys to communicate information including about risk factors) indicated that the man had been recalled to prison, had previously been convicted of a violent offence and had escaped from custody in 2002. There was no reference to his recent overdose and the section in which any risk of suicide or self-harm should be detailed was blank.

23. A healthcare assistant carried out a routine health screen when the man arrived. The man told her that he had taken an overdose of Valium (a brand name for diazepam) a week previously. The healthcare assistant did not ask anything about the nature or circumstances of the overdose and the man told her he had no current thoughts of harming himself or of suicide. The healthcare assistant did not identify the man's recall to custody as a factor to suggest increased risk. The healthcare assistant told us that she did not consider the man was a risk to himself and did not therefore open an ACCT document. She noted that she had told the man how to contact the prison's mental health inreach team if he needed further support.

24. A prison nurse then carried out a secondary health assessment. (Secondary health screens now take place on the prisoner's second day in custody.) The man told her that he had taken an overdose of 1,000 Valium tablets the previous week. At interview, the nurse told us that the man said he had taken the overdose because he had been recalled, although she did not record this at the time. (The man's recall was authorised several days after the overdose.) The nurse did not open an ACCT document. She explained that this was because the man appeared cheerful and stable and he did not appear vulnerable when she saw him. No other member of staff in reception considered that the man was at risk of suicide and self-harm.

25. The nurse explained to the man how to refer himself to the inreach team. She said that she had been told to ask prisoners to self-refer rather than making a referral to the inreach team herself. The prison's head of healthcare told us that this was not correct and the process had always been for an immediate referral to the inreach team if there was any concern about mental health issues during a reception screen.

26. The man was taken to the prison's first night centre before moving to F wing the next day. On 19 November, he met his prison offender supervisor. They discussed his recall and the offender supervisor recorded that he was quite vague about some of the reasons. (The offender supervisor told us that she was unaware of the reasons herself at this point, and only discovered them the next week when the man's offender manager visited.) The man also told her about his recent overdose but said that this was out of character for him and he had no current intention to harm himself.

27. On 28 November, the offender manager visited the prison for a meeting with the man and the offender supervisor to explain the reasons for recall to the man and to complete a supervision plan. The offender manager told us that the man completely understood the reasons for his recall although he did not necessarily agree with them. The offender supervisor agreed that the man had understood the reasons given.

28. On 12 December, the man spoke to a member of the prison's Counselling Assessment Referral Advice Throughcare team. (CARATs - which provides interventions and services for prisoners with drug and alcohol problems.) The man had referred himself to the service because of his recent overdose. He told the CARAT worker that the overdose was a reaction to being recalled to

prison but this was a one off and he no longer considered it a problem. (As previously, we note that the man's recall was not authorised until several days after his overdose) The man asked to attend the prison's Narcotics Anonymous group and was put on their waiting list.

29. The man started attending a mentoring class on 2 January 2014. He received very positive reports from the course instructor and shortly afterwards began to work as a mentor, advising other prisoners on F wing about aspects of prison life.

30. The offender supervisor visited the man on F wing on 7 January. She gave him his recall dossier, which contained written details of the specific incidents that had led to his licence being revoked and his recall to prison. The offender supervisor told us that the man was jovial and pleasant at the meeting.

31. On 14 January, the man attended his first Narcotics Anonymous group. The CARAT worker noted that he engaged well and that no issues were raised from the group.

32. The man's solicitor was scheduled to visit on 15 January. The solicitor told us that the man telephoned him 40 minutes before the scheduled visit and the solicitor told him he was waiting outside the prison at the time. When he went into the prison, the solicitor said he was told that the man did not want to see him. The man's partner told our family liaison officer that the man had told her that the prison had cancelled the visit.

33. A prisoner, who shared a cell with the man at the time, told us that on 20 January the man had punched him because he was stressed about his relationship. The man's cellmate said that he had refused to go back in the cell with the man and the man was therefore moved to another cell. The wing manager on duty that day, a Supervising Officer (SO), told us that he had no recollection of the cell move or the reasons for it. We spoke to several members of F wing staff, but none were aware that the man had moved cells that day or the reasons why. The man's prison records contain only a factual note of the move on his cell history page. There is no record of the move or reasons for it in his case notes or in the wing observation book, which is used to convey information to officers on the wing. The man's new cell mate told the police that he had understood that the move was because the man had fallen out with his former cell mate.

34. During the afternoon of 22 January, the man made ten telephone calls to his partner. (All prisoners' telephone calls are recorded and we obtained recordings of the man's calls. A sample of telephone calls are monitored by prison staff, but the man's calls were not among those.) Their conversations were positive and they spoke of plans for the future.

35. The next afternoon, 23 January, the man telephoned the Bolton probation office to speak to his offender manager. She was not available and instead he spoke to her manager and discussed his recall. The manager told the man

that a Parole Board hearing, at which his recall would either be confirmed or he would be released, had been set for March.

36. The man then made five telephone calls to his partner, totalling around 42 minutes. The last two conversations were difficult and the man's partner said she was sick of him being in and out of prison and that he needed to change his ways. The man was tearful during these calls, which ended when his telephone credit expired. His partner described these calls to our family liaison officer as their "usual arguments, ups and downs".

37. An investigator in the Professional Standards Branch of Greater Manchester Police interviewed the man on 24 January in relation to a complaint he had made about being assaulted by the police officers who had attended his flat after his overdose in November. The police investigator told the investigator that the man had seemed upbeat, although he was not happy about being in prison. The man did not mention having any problems in his relationship and said he was looking forward to seeing his partner on a visit the next week. The police investigator said that the complaint was still under investigation and he gave the man no indication of what the outcome might be.

38. On the morning of Saturday 25 January, the man telephoned his partner on a mobile telephone that another prisoner had illicitly obtained. The man's partner told us that he had made plans for a friend to bring a mobile telephone into the prison for him but that he told her he no longer needed this. The man's partner also said that he was very persistent in trying to establish her whereabouts later that day. She added that the call ended amicably and the man said he would try to call her later in the day.

39. The investigator spoke to two F wing officers who remembered speaking to the man during the morning association period. An officer said that he had spoken to the man several times that morning and he seemed to be his normal self. Another officer said he spoke to the man about becoming a wing cleaner, a job he offered to the man because he was viewed as a model prisoner who would be suitable. The officer said that the man had seemed his usual jovial self.

40. At around 3.30pm, the prisoners were unlocked to allow them a period of time in the open air. The man's new cell mate told the police that the man did not leave the cell because he said he had a headache and felt sick. The man's new cell mate went out to the exercise yard. He told the police that, although it was unusual for the man not to go out, he had had no concerns about his safety.

41. Another prisoner told the police that he thought he saw the man's call light on during the afternoon, indicating that he had pressed his cell bell to request assistance from an officer. The investigator spoke to all of the officers who worked on F wing that afternoon, none of whom recalled going to the man's cell to answer the cell bell. Leeds does not have an electronic system which records when cell bells are pressed and answered and there is no CCTV coverage of the wing so this could not be checked further.

42. At around 4.40pm, an officer took the man's new cell mate back to his cell. The man's cell mate found the man hanging from a ligature made from shoelaces which was tied to the frame of the bunk bed. The man's cell mate called to the officer to come back to the cell. The officer who was not carrying a radio, shouted to colleagues for assistance, went into the cell and cut the shoelaces using his anti-ligature knife. The man was not breathing, so the officer began cardiopulmonary resuscitation (CPR).

43. At 4.42pm, the wing manager radioed the prison's communications room to request medical assistance, but did not use an emergency code. A message was then transmitted over the prison's radio network. A nurse who responded to the call, said that the words "ligature" and "swinging" were used to describe the nature of the incident so she had understood a prisoner had been found hanging. She and a healthcare assistant were the first healthcare responders to arrive at the man's cell, followed by a colleague who had collected an emergency bag and a defibrillator. The nurse requested that an ambulance be called and, with her colleagues, took over administering CPR. The radio call to request an ambulance was recorded at 4.46pm.

44. A team of paramedics was already in the prison dealing with a separate incident. Prison staff contacted them and one of the team went to the man's cell to help and arrived several minutes before the ambulance crew arrived. The paramedics took over CPR but were unable to resuscitate the man and, at 5.16pm, his death was confirmed.

45. A note was found in the man's cell, addressed to his partner, in which he apologised for how he had treated her and said that he had struggled to come to terms with how he had hurt her in the past.

46. At 5.58pm, the duty governor telephoned the prison's family liaison officer and told her about the man's death. The family liaison officer agreed to come to the prison to prepare to visit the man's partner, his listed next of kin, to break the news. However, at 6.28pm, the man's partner telephoned the prison and said another prisoner had contacted her using a mobile telephone and had told that the man had died. The duty governor asked the operator to take the man's partner's details so he could confirm her identity and phone her back. He returned the call shortly afterwards and confirmed the details of the man's death. The family liaison officer arrived at the prison at around 7.00pm and, after a handover from the duty governor, telephoned the man's partner at 7.30pm. She also spoke to several members of the man's family that night. The next morning, she and the Governor visited the man's partner and family to offer condolences and give them more information about what had happened.

47. The man's new cell mate moved into a cell with a Listener before his release on 27 January. Prison and healthcare staff who were involved in the events of 25 January said that they received appropriate support from managers.

48. The man's funeral took place on 14 February and the prison contributed towards the costs, in line with national guidance. A post-mortem examination established the cause of death as hanging.

ISSUES

The man's risk of suicide and self-harm

49. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". A list of risk factors for suicide includes previous deliberate self-harm, mental illness and early days in custody. Licence recall is also listed as a trigger.

50. Twelve days before he arrived at Leeds, the man had taken a large overdose which required overnight hospital treatment. He was open about this at the reception and secondary health screens that took place in his first hours at the prison. However, the healthcare assistant and nurse who completed these screens did not satisfactorily explore the nature and circumstances of the overdose. Instead they relied, firstly, on the man's statement that he had no further thoughts of suicide or self-harm and, secondly, on their view that his physical presentation suggested no additional risk. No other member of staff in reception appears to have considered the man's risk.

51. 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. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to the man's presentation. The overdose described by the man indicated a significant, recent attempt to take his own life and we believe that this and other indicators of risk such as the fact that the man had been recalled to prison should have been given much greater weight. Our view is that an ACCT document should have been opened for the man when he first arrived at Leeds.

52. In the investigation into the death of another prisoner at Leeds in July 2013, we were critical that prison staff placed too much reliance on what the prisoner told them rather than balancing this against other information about risk. It is important that all staff in reception are vigilant about the risks of newly arrived prisoners. We make the following recommendation:

The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**

- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

53. It is not possible to know whether the initial support of ACCT procedures would have altered the outcome for the man. He appeared to settle well at Leeds and it seems likely that even if an ACCT had been opened when he first arrived, he would not have been managed under suicide and self-harm prevention procedures for long unless he disclosed further vulnerabilities. There was little to bring him to the attention of prison staff who described him as a "model prisoner", a polite man who did not cause any problems and who recommended him for trusted positions on the wing. None of the prison staff we spoke to knew of any issues that were troubling the man.

54. Prisoners who knew the man said he had no problems in the prison, such as bullying or debt, but said he was often stressed about his relationship and was also worried about his upcoming parole hearing. Two friends of the man's said that, a few weeks before his death, he had made a noose and had also said that he was going to cut his wrists. They did not think he was serious and so did not report this to prison staff. The man's cell mate told the police that the man never spoke of any issues or concerns to him. The man's partner and family told us that he was concerned about his future as a prisoner serving an indeterminate sentence.

55. The man spent a lot of time on the telephone to his partner. The last two recorded conversations, two days before he died, were difficult. The note left by the man indicated that he was finding it difficult to come to terms with relationship issues. None of the members of staff we spoke to said they had noticed anything untoward or saw anything that concerned them. This meant that they had no reason to consider whether he needed additional support.

Cell move

56. The man moved cells on 20 January 2014, five days before his death. There is no record of the move or the reason behind it in his prison records or the wing observation book. His former cell mate said that the man had punched him because he was stressed about his relationship. His former cell mate said that prison staff did nothing other than arrange the cell move. He did not know the names of the staff involved. He said that no one asked him or the man what had led to the altercation. The man was not charged with any offence against prison discipline which would have led to further enquiries. No formal violence reduction procedures were used.

57. None of the F wing staff we spoke to were aware that the man had moved cells or the reason for the move. This included the wing manager on the day of the cell move. The wing manager told us that the reason for a cell move will not necessarily be recorded unless it is significant.

58. Good communication in a prison is important and good 'dynamic' security, indicated by positive relationships between staff and prisoners, helps to identify risks and vulnerabilities - to the safety of the whole prison as well as to individuals. It is evident that other prisoners were aware that the man was stressed by his situation and his relationship difficulties yet none of the staff knew about this. We noted earlier that all F wing staff we spoke to considered the man to be a "model" prisoner yet none of them appeared to regard the apparently out of character incident as potentially indicating an underlying problem. No one appears to have spoken to him about his reasons for falling out with his cell mate. While this would not necessarily have led to additional support under ACCT procedures, this was a missed opportunity to identify any underlying issues that might have been causing the man to be stressed. We consider that the reasons behind the alleged assault and subsequent cell move should have been discussed with the man. We make the following recommendation:

The Governor should ensure that the reasons for non-routine cell moves are recorded in wing observation books and the prisoners' records. When a move is the result of violence or other significant incident, wing staff should discuss the incident with those involved, record their findings and consider whether further action or additional support is required.

Mental health referrals

59. The nurse who completed the secondary health screen told us that she did not refer the man to the mental health inreach team as her understanding was that managers expected nurses in reception to explain to prisoners how to self-refer rather than referring them directly. The head of healthcare told us that this was not correct and the process had always been for an immediate referral if there were any concerns about a prisoner's mental health during a reception screen.

60. The clinical reviewers considered that, because of his recent overdose, the man should have been referred to the inreach team for a mental health assessment at his first night health screen. It is clearly important that prisoners who arrive with significant mental health problems are not expected to refer themselves to mental health services and it is concerning that there was some confusion about the referral process. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff, particularly those working in reception, understand when and how to refer prisoners to the mental health inreach team.

The man's recall to custody

61. The man's partner said he did not understand why he had been recalled to prison and had not been given his recall paperwork. When his solicitor visited

him to discuss his recall and upcoming parole hearing he was told that the man had cancelled the visit, which his partner said was not true.

62. The man's offender manager and his offender supervisor met the man on 28 November 2013. The offender manager told us that this meeting was, partly, to explain the reasons for recall. Both the offender manager and the offender supervisor told us that their view was that the man completely understood the reasons for his recall but did not necessarily agree with them. The offender supervisor gave the man his formal recall dossier on 7 January 2014 which set out the reasons in writing. We are satisfied that the man was informed, both verbally and in writing, of the reasons for his recall.

63. The man's solicitor was scheduled to visit him on 15 January 2014. He told us that when he arrived at the prison staff told him that the man did not want to see him. The man's partner said this was not true and that the man had told her that the prison had cancelled the visit. There is no note in the man's prison record to indicate that he refused this visit, but there is also no indication that he complained about this incident. In his visits record the event was marked as 'non-attendance'. The solicitor told us that this was not the case and that the man had telephoned him around 40 minutes before the scheduled start time and gave no indication that he would not be attending. (There is no record of this call on the man's prison phone records, but it is possible he used an illicit mobile phone.) The man telephoned the offender manager that afternoon who told him that his partner had telephoned her earlier and said that she been called by his solicitor, who said that the man had refused the visit. The man told the offender manager that he had not known about the visit and so was not on the visits list. He then telephoned his partner and, during the conversation, said that the fault was with the visits system at the prison.

64. It has not been possible to establish what happened that morning which prevented the visit from taking place. However, it is clear that the man had a legal visit scheduled and, for an unknown reason, this did not happen, even though his solicitor came to the prison for the visit. Legal visits are important for prisoners, especially those such as the man who have been recalled and have upcoming parole hearings and it is essential that, where possible, they take place as scheduled. We make the following recommendation:

The Governor should ensure that prisoners are able to attend pre-booked legal visits and that reasons are fully recorded and explained if the visit does not take place.

Emergency response

65. 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 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.

66. A request for medical assistance was made quickly by the wing manager but he did not use the emergency code blue in line with the national and local policy. The wing manager told us that he thought he asked for an ambulance at the same time, although this request was not recorded or actioned in the control room. An ambulance was not requested until four minutes later when a nurse asked for one to be called when she arrived at the man's cell.

67. In the investigation into the death of a prisoner at Leeds in July 2013, we found that the prison's local policy (086/2013 Medical Emergency Codes) was not in line with the national requirements as it stated that a specific additional request for an ambulance must be made, in addition to an emergency code. It is a concern that at the time of the man's death, almost a year after the issue of the national instruction the prison had still not implemented a medical emergency code protocol which is in line with the national instruction. In this case, the delay was mitigated as other paramedics were already in the prison attending another incident and one went to the man's cell. However, in other circumstances even a short delay could have a significant impact on a person's chances of survival in a life threatening situation.

68. We are also very concerned about the language used to communicate the nature of the emergency to the response nurses. It is wholly inappropriate to use phrases such as "swinging" over the radio network. We repeat our previous 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.**

Family liaison

Breaking the news of the man's death

69. The man's partner learnt of his death from another prisoner using an illicit mobile telephone. His partner told us that when she telephoned the prison to enquire further, the switchboard operator was not very understanding and said that someone would call her back "whenever they were free". The man's partner said she had been very distressed at the time and thought that this should have been handled more sensitively. .

70. The man died on a Saturday and there was no trained family liaison officer in the prison at the time. The duty governor telephoned the prison's lead family liaison officer at around 6.00pm (around 45 minutes after the man's death had been confirmed) to inform her. The family liaison officer arrived at the prison at around 7.00pm to prepare to visit the man's partner to break the news. In the meantime, at around 6.30pm, the man's partner telephoned the prison.

71. PSI 64/2011, Chapter 13, about family engagement after a death in a prison, states that time is of the essence in breaking the news of a death to the next of kin to try to ensure that they do not find out from another source. Unfortunately, another prisoner contacted the man's partner by phone very soon after his death before the family liaison officer could visit her to inform her in person.

72. We are satisfied that the duty governor acted correctly in asking the operator to take the man's partner's details before he called her back, so that he could confirm from the man's records that he was talking to the appropriate person and that he could ensure he had the relevant details to answer any questions. The duty governor acknowledged that these were difficult telephone calls and it is unfortunate that the man's partner thought that the operator spoke to her inappropriately. We are unable to judge whether this was the case as we do not know what was said, but the man's partner must have been in great distress at the time and these events should act as a reminder to all prison staff dealing with bereaved families to act professionally at all times.

Information provided to the family about the man's overdose

73. The man's partner said that when the Governor visited her on 26 January, she told them that the prison had not been aware that the man had taken an overdose shortly before he had been recalled to prison. The man's partner said she was later told that the prison had known, but it had not been considered that he needed additional support. (There is no record of when this was clarified.)

74. Grieving families will understandably be very distressed after the death of a loved one and we appreciate that at an early stage it may be very difficult for prisons to provide all the answers to their questions. Some questions might need to wait for the PPO investigation and then the inquest process before they are answered. Even when prisons have the answers, bereaved families might find them difficult to accept, so good communication is essential.

75. PSI 64/2011 emphasises that 'it is vital that accurate information about the prisoner's death is given to the next of kin' and notes that 'inaccurate information at this stage can cause unnecessary distress and suspicion and undermines the prison's ability to build a relationship with the family.' We consider that it is important that any member of staff meeting a bereaved family should know the relevant details and be able to answer straightforward questions about the circumstances of the death.

76. It is unfortunate that, when the Governor and the prison's family liaison officer met the man's family the morning after his death, they appear to have been unaware that he had taken an overdose in the community before he had been recalled to prison. However, while we would have expected them to be able to answer questions about the immediate circumstances of his death, we consider it would be unrealistic to expect prison staff, the morning after a death in the prison, to be aware of all the events that led up to it. It appears that the Governor was genuinely unaware at the time that the man had taken an overdose at the beginning of November and, when she discovered otherwise sought, to correct this.

Provision of a wreath at the man's funeral

77. The man's partner told us that she had agreed to the prison sending a wreath to his funeral as long as it did not mention the prison and was upset to find a wreath with a card stating it was from HMP Leeds. The family liaison officer said that the man's father had a different view. He had told her that he was paying for the funeral on behalf of his family (in addition to the prison's contribution), most of the people who would be attending were relatives and he was adamant that his family wanted a wreath that was visibly from the prison. The family liaison officer acknowledged that it was difficult to decide what to do but she concluded that the prison should send a wreath with a card.

78. The family liaison officer was clearly in a difficult position and tried to encourage dialogue between the man's family and his partner to resolve the issue. Unfortunately, families do not always agree about funeral arrangements. As the man's parents were arranging the funeral we consider it is understandable that the family liaison officer complied with their wishes but it would have been helpful to have explained this to the man's partner in advance.

Gift ordered by the man before his death

79. The man's partner was shocked to receive a present he had ordered for her about three weeks after his death. The family liaison officer said that the man had bought the gift through a scheme that gave prisoners the opportunity to buy a present for their partner for Valentine's Day. She said that the man's prison account should have been frozen after his death, but incorrect coding on the prison's computer system led to his account remaining active. The family liaison officer said that this issue had now been addressed.

80. It is understandable that the man's partner was upset by the arrival of this unexpected gift. It is unfortunate that this happened, but we note that the prison has acknowledged that a mistake was made and has taken steps to ensure that this does not happen again in a future case.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

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

2. The Governor should ensure that the reasons for non-routine cell moves are recorded in wing observation books and the prisoners' records. When a move is the result of violence or other significant incident, wing staff should discuss the incident with those involved, record their findings and consider whether further action or additional support is required.

3. The Head of Healthcare should ensure that healthcare staff, particularly those working in reception, understand when and how to refer prisoners to the mental health inreach team.

4. The Governor should ensure that prisoners are able to attend pre-booked legal visits and that reasons are fully recorded and explained if the visit does not take place.

5. 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.

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff: • Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.	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 individuals risk of suicide and self harm. Healthcare staff on reception will be reminded of the need to record and share knowledge of 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 patients presentation. Head of Healthcare is commissioning mental health training on suicide and self harm for all healthcare staff and officers who have been identified on each wing as mental health liaison officers. This will provide a consistent understanding of risk.	Head of Safety 31 March 2015 Head of Healthcare 31 July 2014 Head of Healthcare 31 December 2014	

	• Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.		Local guidance will be produced to highlight risk factors and the available mechanisms to provide support for those identified as being at risk. Local guidance will be produced which will include the need to ensure that where prisoners are identified as having recently self-harmed or expressed suicidal intent an ACCT will be opened.	Head of Safety 31 August 2014 Head of Safety 31 August 2014	
2	The Governor should ensure that the reasons for non-routine cell moves are recorded in wing observation books and the prisoners' records. When a move is the result of violence or other significant incident, wing staff should discuss the incident with those involved, record their findings and consider whether further action or additional support is required.		A Staff Information Notice will be published highlighting the procedures to be taken for all non-routine cell moves. This will include the requirement to record all such moves and the reasons for them on NOMIS and within wing observation books. The violence reduction policy will be reviewed and updated to ensure that all violent incidents are fully investigated and discussed with those involved. Any findings, sanctions and/or support mechanisms will also be fully documented within the investigation report.	Head of Residence 31 July 2014 Head of Safety 31 August 2014	
3	The Head of Healthcare should ensure that healthcare staff, particularly those working in reception, understand when and how to refer prisoners to the mental health in-reach team.	Accepted	The reception Standard Operating Procedure provides a clear process of how to refer into mental health services (which is always primary mental health in the first instance and these patients are always seen the next morning). If primary care feel there is a need for an in reach referral they will immediately refer the patient. This process has been reviewed again and there will be a teaching session in place to disseminate to staff as a reminder.	Completed Head of Healthcare 16 July 2014	

4	The Governor should ensure that prisoners are able to attend pre-booked legal visits and that reasons are fully recorded and explained if the visit does not take place.	Accepted	A 'Declined Visit' slip will be introduced to enable prisoners to formally decline a visit and sign to that effect which will then be passed to the visitor/s. The decision to decline the visit and any reasons given will also be recorded on NOMIS by visits staff.	Head of Operations 31 August 2014	
5	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.	Accepted	Staff Information Notice 86/2014 was published on 15th May 2014 and provides updated requirements for staff dealing with a medical emergency in line with PSI 03/2013. The notice includes guidelines on the use of 'code red' or 'code blue' and that when these are used over the radio net an ambulance **must be automatically called**.	Completed	