



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in December
2013 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 in the segregation unit of HMP Leeds in December 2013. He was 37 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer reviewed the clinical care the man received in prison. HMP Leeds cooperated fully with the investigation.

The man had been on remand at HMP Leeds since 28 August 2013. He had a long history of substance issue problems and had served a number of short sentences in prison before. When he arrived at the prison, there was little to indicate that he was at risk of suicide or self-harm. He was dependent on heroin so began a drug treatment programme and seemed to be making good progress.

In early December, the man told his cell mate that he was in debt to another prisoner and, to pay off the debt, was being coerced into helping get illicit items into the gaol. He seemed very distressed but neither of them told prison staff. On 30 December, he and another prisoner were found with a long strip of cloth which they were suspected of using to bring items over the wall. They were taken to the segregation unit and shortly afterwards the man self-harmed by cutting his arm. Staff began suicide and self-harm prevention procedures and resorted very quickly to the extreme measures of removing all the furniture from his cell and his clothes, which they replaced with a special tear-resistant tunic. These measures should have led to him being monitored at least five times an hour, but instead he was checked only every half an hour. He had obscured the observation panel into his cell yet little was done about this and we are not satisfied that the checks were as thorough as they should have been. About half an hour after the last recorded check an officer found the man hanging from a ligature made of a tear-resistant blanket. Despite prompt emergency assistance, resuscitation was unsuccessful and he was pronounced dead.

Prison Service instructions say that prisoners subject to suicide and self-harm prevention procedures should be held in segregation units only in exceptional circumstances and I am very concerned that this was the second death of a prisoner identified as such a risk, in the segregation unit at Leeds in five months. Both cases share disturbing similarities, particularly in relation to inadequate level of observations. In this man's case there appeared to be little understanding that the actions taken were usually those of last resort and it is particularly worrying that not only were mandatory actions designed to safeguard vulnerable prisoners not followed, but the managers and staff responsible for the safe custody of prisoners did not know what those required actions were.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man had a long history of offending and substance use problems and had served a number of short prison sentences. In 2008, he disclosed that he had tried to hang himself when he was in prison in 2004, after his father had died. He had spent several previous short periods at Leeds and staff regarded him as a pleasant and cooperative person.
2. The man was remanded to HMP Leeds on 28 August 2013, charged with dangerous driving and assaulting police officers. He was withdrawing from heroin and began a methadone detoxification programme, gradually reducing his dose.
3. In early December, he told his cell mate that he was in debt to another prisoner. As payment, the prisoner was pressuring him into throwing lines of material over the prison wall to bring contraband items into the prison. Neither the man nor his cell mate told staff about this. On the afternoon of 30 December 2013, prison officers found him and another prisoner in an interview room on B wing. There was a line hanging from the window and the man tried to conceal another one in his trousers.
4. The staff who discovered them said that the man seemed very frightened and was shaking. Both prisoners were taken to the segregation unit but there is no record that the officers told the segregation staff that he had appeared very distressed when he was caught and no one made a record of it in his case notes.
5. The man protested that he should not be in the segregation unit and he objected to the cell he was given, which he said smelled of faeces. He began banging and kicking his cell door. When officers unlocked his cell for a nurse to carry out an initial segregation health screen, they found that he had cut his left wrist with a plastic knife. At 6.30pm the nurse opened an ACCT document. (ACCT is the Prison Service process for managing those at risk of suicide and self-harm.)
6. The man said he would smash up his cell and hurt or kill himself. Because of this, the supervising officer in charge of the segregation unit decided to remove the non-fixed furniture from the cell and take away his clothes and standard bedding and give him tear-resistant clothing and a blanket. This was retrospectively authorised by the duty governor.
7. Prison Service instructions require an enhanced case review to be held immediately when alternative clothing is used, but the duty governor, who was the prison's Head of Safety, and the unit supervising officer both admitted at interview that they were not aware of this. The nurse left the ACCT document in the segregation unit but no one completed an immediate action plan, which should have been done within an hour, to set the level of required observations and other actions needed to support the man. The staff appeared to believe that observations were required twice an hour, although

instructions require prisoners in special accommodation to be checked at least five times an hour.

8. The man covered up his observation panel with tissue. Although he removed it briefly when an officer asked him to, he covered it again and it remained that way making observations very difficult. Despite this, none of the other staff challenged him about this or made any attempt to remove the tissue.
9. The officer who took over responsibility for the segregation unit just after 8.00pm said he checked the man by peering through the gaps between the cell door and the door frame. CCTV footage shows him at 8.28pm walking up the landing and glancing towards the cell door before walking back. He does not appear to have looked in. He wrote in the ACCT record that the man was lying on his bed staring at the ceiling.
10. At 8.56pm, the officer went to check on the man and found the glass was still obscured. He pressed his face against the glass and realised that he was hanging from a ligature at the other end of the cell. He radioed an alarm and, although he did not use the expected emergency medical code, the emergency response was quick. Prison staff and paramedics were unable to resuscitate him, and just after 9.32pm, the paramedics declared him dead.
11. The prison did not inform the man's sister, his next of kin, of his death until the next day at midday.
12. The investigation found that staff did not follow the correct procedures when opening an ACCT. No one set the required level of observations which should have been at least five an hour. There was no awareness of the need to hold an enhanced ACCT case review, and a lack of understanding about segregation procedures including the use of special accommodation when furniture is removed from a cell and about the use of protective clothing. The man's distress in the segregation unit seems to have been interpreted solely as aggression and a behavioural problem rather than one of vulnerability. We are concerned that managers and staff did not follow mandatory instructions designed to protect prisoners and recommend a disciplinary investigation into some of their actions on that day. We also recommend that the Deputy Director for Custody for Yorkshire and Humberside satisfies herself about the safe operation of the segregation unit at the prison. We make seven other recommendations.

THE INVESTIGATION PROCESS

13. Notices were issued at Leeds, announcing the investigation to staff and prisoners and inviting anyone with relevant information to contact the investigator. No one responded.
14. The investigator met the Governor and obtained copies of the man's medical records and all relevant prison records. She interviewed 19 members of staff and four prisoners at the prison during the course of the investigation and wrote to the Governor outlining the preliminary findings of the investigation.
15. NHS England appointed a clinical reviewer to review the man's clinical care at HMP Leeds.
16. We informed HM Coroner for West Yorkshire Eastern District of the investigation and we have sent a copy of this report to the Coroner.
17. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation and invite her to identify any specific issues she wanted the investigation to consider. His sister said that the manner of his death was out of character and unexpected but that she accepted that he had taken his own life. His sister received a copy of the draft report. The solicitor representing her wrote to us pointing out some factual inaccuracies and omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of the report. We have provided clarification by way of separate correspondence to the solicitor.
18. West Yorkshire police conducted a preliminary investigation into the circumstances of the man's death. In accordance with the Ombudsman's memorandum of understanding, the police shared documents with the investigator including witness statements and CCTV footage of the segregation unit. However, as the system hard drive was removed before the police were able to calibrate, the CCTV timings cannot be confirmed.

HMP LEEDS

19. HMP Leeds is a local prison holding up to 1212 men. Leeds Community Healthcare Trust provides primary healthcare services including an integrated drug treatment service for prisoners with substance misuse problems. Leeds and York Partnership Trust provides mental health in-reach services.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons last inspected Leeds in January 2013. The Inspectorate found that the prison worked hard to reduce the supply and demand for drugs and alcohol. There were good treatment programmes run by well-trained staff. Levels of self-harm were low and the care given to those most vulnerable to self-harm was good, but ACCT procedures needed improvement. Prisoners' perception of their safety was better than at comparable prisons. Inspectors found that relationships between staff and prisoners in the prison including the segregation unit, were good but some cells were grubby and toilets dirty.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of volunteers from the community who help ensure that prisoners are treated fairly and decently. In its most recent report, for the year ending 2012, the IMB said that prisoners were positive about their care and treatment. The IMB noted an increase in the numbers of prisoners held in the segregation unit but were satisfied about their conditions, regime and treatment there.

Assessment, Care in Custody and Teamwork (ACCT) Procedures

22. Assessment Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT process is to try to determine the level of risk posed, the steps needed to reduce this and the extent to which staff need to monitor and supervise the prisoner. After an ACCT is opened and immediate action plan should be agreed within an hour. Checks should not be carried out at predictable intervals. Part of the ACCT process involves assessing immediate needs and 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.

Previous deaths at Leeds

23. Since 2010, we have investigated seven apparently self-inflicted deaths at Leeds, including that of this man. There have been four deaths in the segregation unit including one five months before this man's death. That

prisoner was also being managed under suicide and self-harm prevention procedures. We have only recently completed that investigation which was suspended pending a police investigation. Both cases share some worrying similarities including deficiencies in carrying out ACCT procedures, setting appropriate levels in frequency of observation and treating potential signs of mental distress as poor behaviour.

KEY EVENTS

24. The man was first convicted of a criminal offence in 1988 when he was 12 years old. He first spent time in custody when he was 15 and subsequently served a number of short prison sentences.
25. In 2008, he told a nurse at HMP Hull that he had deliberately driven into a wall in 1997 as he was upset with the way his life was going. He said that he had attempted to hang himself in prison in 2004, after his father's death but that harming himself was no longer an issue.
26. In May 2013, the man received a community sentence with a requirement for drug rehabilitation and on 14 August he was remanded to HMP Leeds for breaching the terms of his community sentence. At an initial health screen he said that he had never tried to harm himself before. He had been on a methadone maintenance programme in the community to treat heroin addiction and was prescribed methadone when he arrived. The next day he was released by the court.
27. On 28 August, the man was remanded to HMP Leeds again, this time charged with dangerous driving and assaulting two police officers. A police risk assessment noted that he was withdrawing from heroin and was known to be violent to officers. He had told the police that he had never tried to harm himself before and they assessed him as a low risk of harm to himself.
28. When he arrived at the prison, he told a healthcare assistant who carried out his initial health screen, that he had no thoughts of self-harm. He said that he had used heroin two days previously and usually spent £30 a day on heroin and also smoked 10 cigarettes a day. He said he had dog bites on his right leg and left arm inflicted by police dogs when he had been arrested. A nurse then examined him and he told her he had never tried to harm himself inside or outside prison. His answers to a standard set of questions indicated that he was at relatively low risk of self-harm. The nurse referred him to the substance misuse service as his urine tested positive for cocaine, amphetamines and opiates. He gave his sister as his next of kin and the nurse recorded her name and address in his medical record.
29. A prison doctor then saw the man, who told him that he was experiencing aching legs, back pain and shivers due to withdrawing from heroin. He described the man's symptoms on examination as sniffles and the dog bites as superficial skin abrasion. He prescribed antibiotics and a 10 mg dose of methadone followed by 21 day methadone detoxification programme.
30. The man did not call anyone on the telephone when he arrived or throughout his stay at the prison. A cell sharing risk assessment to determine whether he was a risk of violence to other prisoners indicated that he was suitable to share a cell.
31. Healthcare staff monitored the man's withdrawal symptoms and at a review with a drug worker on 2 September, he decided to remain on a maintenance

dose of methadone until he was released, which he optimistically hoped would be at the end of October.

32. The man remained in prison throughout October and on 1 November, he agreed with his drug recovery worker that he would begin a self-detoxification programme, which meant that he would be able to choose the pace of methadone dose reduction within certain limits. Over the next four weeks, he gradually reduced his daily dose of methadone. On 28 November, a urine test confirmed that he was taking only the amount of methadone prescribed. He had no significant withdrawal symptoms, other than some sleep disturbance and sweating.
33. On 4 December, an officer and a supervising officer (SO) were checking cells on F wing and found a bottle of fermenting liquid and damage to the window grill in the cell the man shared with another prisoner. Officers took the man and his cellmate to the segregation unit that day and on 5 December, the man was charged with two disciplinary offences, for possessing an unauthorised article and for destroying or damaging a part of the prison. A disciplinary hearing (known as an adjudication) was opened the next day, 6 December, and he pleaded not guilty to both charges. The hearing was adjourned for seven days to allow sufficient time for legal advice and for a report from the works department about the condition of the cell when he had arrived. In the meantime, he was moved to B wing.
34. On 11 December, the man appeared at Crown Court and pleaded guilty to charges of dangerous driving and assaulting two police officers. His case was adjourned until 7 January 2014, for sentencing, including for two other offences to which he had already pleaded guilty. He met his drug recovery worker that day and they discussed how his self-detoxification was progressing. He told her that he was down to four millilitres of methadone a day and he would remain on that until after Christmas and then complete his detoxification before he went back to court for sentencing. The drug recovery worker wrote in his clinical record that he did not raise any issues of concern and that she would review him in two weeks.
35. The man's cell mate on B wing told the investigator that, around this time, he found the man crying in their cell, but he was reluctant to tell him what was wrong. Eventually, he told his cellmate that he had owed £1500 to another prisoner on F wing because of a drug debt he had incurred in the community. He had been pressured to repay the debt by 'firing lines' over the prison wall. (A line is a thin strip of fabric or string thrown from a cell over the external wall of the prison or to another cell. Contraband items are tied to it and the line is drawn back into the cell.) He told his cellmate that he did not want to do this but was being forced. He said that had had not wanted to get involved because he did not want to jeopardise getting his children back. The debt had been 'bought' by another prisoner and had followed him to B wing. He had thought that the last line he had been asked to do would clear the debt but the illicit items had fallen into the prison grounds. Even though another prisoner later collected the items, the remainder of the debt, £300, still stood. He had

been told he would have to try again a week later. Neither prisoner told prison staff about the situation.

36. On 22 December, the man told a nurse that he had changed his mind about his method of detoxification and asked whether he could do a lofexidine detoxification instead. (Lofexidine helps to control the withdrawal symptoms after stopping taking an opiate.) The nurse passed his request to the drugs team and he was prescribed lofexidine from 28 December.

Events on 30 December

37. On 30 December at around 5.00pm, his cellmate was playing pool on B wing when he saw the man go into a room with another prisoner. The investigator interviewed this prisoner who said that he had asked the man to cast a line over the prison wall as he was known to be good at it. He said that he had asked other prisoners, but they had been unsuccessful. He admitted that he had arranged this.
38. At about 5.10pm, an SO received a radio message that a line was being thrown from B wing. He and a further officer found the prisoner and the man inside an interview room with the window open and a line hanging out. The officer saw the man trying to push something down his jeans. He asked him to hand it over and it was another line made out of fabric.
39. Both officers said that the prisoner was grinning mischievously, but the man was shaking and looked very frightened. The officer had worked at Leeds for some time and knew both prisoners well. He said that this prisoner was often in trouble for breaches of discipline but the man worked full-time at a prison job and was generally well behaved. In his police statement, the SO said that the man's reaction appeared excessive as he seemed really scared and upset. He thought that he had written this in an incident report but we did not find any record of this.
40. The orderly officer in charge of the operational management of the prison that day attended and agreed that both prisoners should be taken to the segregation unit and searched. B wing officers took the man to the segregation unit first. An SO and three officers were working in the segregation unit at the time. The man arrived in the segregation unit at 5.39pm¹ and the SO and two of the officers strip-searched him but found no illicit items. He was placed in cell S1-21, at the end of the landing. He was held under Prison Rule 53 which gives authority for prisoners who are to be charged with an offence against discipline to be segregated until the first hearing is opened
41. One of the officers said in his police statement that the man had seemed extremely unhappy and kept repeating that he had not done anything and he

¹ The Segregation Unit has Closed Circuit Television (CCTV). The timings, unless otherwise stated, are taken from the footage made available by Leeds to West Yorkshire police but cannot be confirmed.

should not be there. He knew the man as a happy and pleasant person and said he had never seen him like that before. He and the other officers told him that they could do nothing about it but he would have the opportunity to explain what had happened at his adjudication the next morning. He said this seemed to calm him.

42. At 5.54pm the SO and two officers took the man a meal. He told them again that he should not be there and asked where the other prisoner was. He said that there was excrement all over his cell floor. One of the officers said they told the man that he could clean his cell after his meal if he wanted. A few of minutes later, he began shouting and banging on his door.

Opening ACCT

43. At 6.20pm, a nurse arrived to carry out the required safety screens to assess whether a prisoner is fit to be held in the segregation unit. She assessed the other prisoner first and had no concerns about him. At 6.23pm, she went to the man's door accompanied by the officers. She said that she noticed that blood was spattered over the door observation panel. When the door was unlocked they found the man had cut his arm and blood was dripping on the floor. He said that he had told them he would do something like that.
44. The SO and three officers went into the cell and the nurse waited at the door. The man handed one of the officers a plastic knife with blood on it. The officer said in his police statement that he was surprised at the amount of blood, as the knife, which the man had been given with his meal was quite blunt and he must have made a determined effort to cut himself with it. A further officer said that he looked almost as if he was smirking about what he had done. He shouted that the cell smelled of excrement and said that he was going to smash all his furniture and harm himself again.
45. The nurse said that she went into the cell and checked the toilet area. She said to him that there was no smell in the cell. When interviewed she said that the cell was very clean but admitted that there was a small amount of encrusted faeces on the toilet rim. The man insisted that he was not going to stay there and if he was not moved to another cell he would find something to use as a weapon and something to hang himself with. She told him that she had assessed him as fit to stay in the segregation unit which made him more angry and he repeated that he would smash his cell up and hurt himself.
46. The SO told the investigator that he then decided that the furniture, apart from the mattress, should be removed from the cell and that the man should have his clothes removed and be given tear-resistant clothing (known in the Prison Service as alternative clothing). He kept saying that this would not stop him from banging on the cell door and that he would not be staying in the cell. He was cooperative and removed his clothing, exchanging them for a tear-resistant tunic and blanket. One of the officers told the police that he had told them that he intended to smash up his cell and hurt or kill himself. When he was given the tear-resistant blanket he said he knew how to 'get around' it which she later interpreted to mean that he knew how to rip it.

47. The man told the nurse that he had cut himself because he wanted to be moved from the smelly cell. The nurse did not consider that he was psychotic or had any other symptoms of mental illness. She told the investigator that at some points in their conversation, he was quite calm, but was also very angry and frustrated and wanted his demands met. She said he threatened to harm himself but did not threaten anyone else. Because of his self-harm she told him that she would be beginning ACCT suicide and self-harm prevention procedures. The nurse said that she and the officers left the cell at 6.28pm.
48. At around 6.30pm, the duty governor went to the segregation unit to formally authorise the man's and the other prisoner's searching and the segregation safety screens that the nurse had completed. He and the SO went to the man's cell and he noticed some blood smeared on the cell wall. The man said the cell smelt and he would smash it up if he was not moved to another one. The duty governor told the investigator that he did not see any need to move him. He said that the man began shouting and swearing and they left the cell as he thought that he might assault the SO. The man began banging on his door again.
49. The duty governor discussed the man with the nurse, who told him that she had opened an ACCT. Prison Service instructions, including on the segregation safety screen, say that a prisoner on an open ACCT plan must be located in segregation unit or special accommodation only under exceptional circumstances. (Removing the furniture from the man's cell meant under that it should now have been regarded as special accommodation for which certain procedural safeguards apply.) The duty governor wrote that the man had made superficial cuts to his left wrist and no immediate concerns had been identified. He wrote that he had considered alternative locations for the man to move to such as the first night centre, for new arrivals, the healthcare centre or a standard wing but, decided that the segregation unit was the most appropriate location. He did not refer to the fact that the man was in an unfurnished cell or give any reasons for his decision as Prison Service instructions require.
50. At interview, the duty governor explained that he did not consider the healthcare centre appropriate for the man as he did not have an on-going medical condition. He regarded his behaviour as too aggressive for the first night centre and as his alleged breach of Prison Rules had occurred on his residential wing he did not think it was appropriate for him to return to a standard wing. There were two safer cells² in the segregation unit, but one was already occupied by a prisoner with a history of self-harm whose ACCT had been closed only that day and the other was out of use for repairs.
51. The duty governor is the manager at the prison with the title of Head of Safety who had managerial responsibility for the segregation unit and safer custody procedures, including ACCT. He had been in post since the end of November

² A safer cell is one which is designed to have a reduced number of ligature points to help manage those at risk of suicide by ligaturing.

2013. At interview, he said that he had given the SO permission to remove the furniture from the man's cell but was not aware that this made it special accommodation and required the prisoner to be observed at least five times an hour. He did not recall ever being asked to authorise removing furniture from a cell before. He did not know that Prison Service Instruction (PSI) 64/2011 (Safer Custody) requires a mandatory enhanced case management review when protective clothing is used or that its use, like special accommodation, should be considered measures of last resort. He admitted that he had not read PSI 64/2011 at the time of the man's death and, at the time the investigator interviewed him in March 2014, he said he had only read parts of it and was not aware that an enhanced case review was required in these circumstances. He said that he had discussed the opening of the ACCT with the nurse but did not read the actual document.

52. The nurse filled out the concern and keep safe form (the first document that needs to be completed when a prisoner is managed under the ACCT process). Of the six categories of concern, she ticked that the man had made a statement of intent to take his own life, he had injured himself and that he had problems relating to drug or alcohol withdrawal. The nurse told the investigator that she then obtained a log number for the document from the control room and left the ACCT in the segregation unit. She told the officers that she was going to check the man's healthcare records and if there was any other relevant information she would come back. She said she told them to contact her if they needed her and that she would ask another nurse to bandage the man's cuts. She left the unit at 6.37pm.
53. PSI 64/2011 says that an immediate action plan must be completed for a prisoner on ACCT within an hour it being opened. The SO told the police that he forgot to fill out the immediate action plan as he was 'more concerned with caring for [the man]'. He went off duty at about 6.40pm that evening, very shortly after the ACCT had been opened, and told the investigator that he saw the duty governor completing a section on the ACCT plan as he was leaving the unit. However, the duty governor told the investigator that he believed that the ACCT would have been passed to the SO for him to complete the immediate action plan. In the event, no one completed this part of the procedure which is supposed to record the most appropriate environment and regime needed to support the prisoner at risk until the first case review. It includes setting out the level of observations required. The ACCT document says that the unit manager will usually be responsible for this and list tasks that must be completed before going off duty including briefing staff and making an entry in the observation book. The SO told the investigator that he did not know what an enhanced case review was.
54. The senior officer and two officers all finished their shifts at around 6.40pm, which left one officer as the only member of staff on duty in the unit. The officer wrote in the wing observation book that the man had threatened to smash up his cell and had cut his left wrist so had been given anti-tear clothing and an anti-tear blanket. He checked the man through the cell observation panel at 6.56pm and wrote in the ACCT record at 7.00pm that he had stuck two fingers up at him. At 7.15pm the officer looked into the man's

cell and again at 7.28pm. In his police statement, he said that his view into the cell was limited because the observation panel was slightly obscured. He did not say whether he asked the man to clear it but said he could hear him move about and see him through the toilet observation panel. He made his last check, at 7.28pm by standing on a chair to look through the gap at the top of the cell door and said he saw him standing in his cell. As he got down he said the man asked him if he was spying on him and then cleared his throat as if about to spit at him. He warned the man not to do that and then updated the on-going record in the ACCT plan at 7.30pm. He also completed the first page of an F213SH self-harm form which is used to record any deliberate act of self-harm and an incident report.

55. The officer contacted the orderly officer, as his shift had finished at 7.30pm and no one had come to relieve him. The orderly officer told him to handover to one of the two A wing officers so the officer went to A wing, which is directly above the segregation unit and agreed with a colleague that he would carry out the late evening duty in the segregation unit. His colleague had previously been unaware that he was expected to do this. When his colleague went down to the segregation unit he heard a prisoner banging on his door. The officer handed over to him and told him there were two prisoners on ACCTs, one of whom was this man, who was the person banging on his door. He said that a nurse should be coming to bandage the man's cuts and that the orderly officer would arrange for other staff to help when they needed to open the man's cell. The officer left at about 7.40pm.
56. At around 7.30pm, a custodial manager had arrived to take over as the night orderly officer in charge of the prison. The leaving orderly officer told him that there was a prisoner in the segregation unit on an ACCT in 'anti-tear' clothing.
57. A nurse went to the segregation unit at around 7.45pm to examine and dress the man's wounds. He had been delayed because of another incident. When he arrived, the officer telephoned the orderly officer to ask for three officers so that he could open the man's cell. The orderly officer, who was still the orderly officer in charge until 8pm, advised him to ask B wing, which he did, but they did not have sufficient staff. A senior officer and two officers were passing the entrance to the segregation unit so the officer asked them to help. The officers and the nurse stood outside the man's cell at 7.56pm and the officer spoke to him through the locked door and explained that the nurse had arrived to look at his arm. The man stopped banging his door and told him to 'fuck off'. The observation panel was obscured on the inside with tissue paper. The officer asked him to remove it which he did briefly. He continued to refuse to see the nurse.
58. At 7.50pm the nurse wrote on the medical section of the F213SH self-harm form initiated by the officer that the man refused attention from him and was banging on his cell door and being aggressive so no further action would be taken for the moment. The nurse wrote a similar entry in the ACCT document.

59. One of the officers told the police that as he walked off the unit, he saw the orderly officer and an officer he did not know, near the desk outside the segregation unit office. He said that he heard the officer ask what observation periods the prisoner should be on. The officer was the only member of staff who said that he saw the orderly officer in the segregation unit. Leeds has not provided us with the identities of the staff captured on CCTV in the segregation unit. We were unable to interview the orderly officer as he was suspended from duties on another matter and so we do not know if he was there and, if he was, whether he saw the ACCT document. The orderly officer's daily briefing sheet for 30 December mentions the times that the man and the other prisoner were taken to the Segregation Unit and that the man died but does not state that he was on an ACCT.
60. When the other officers left, the remaining officer read the ACCT document. He noticed that it had been opened less than two hours previously and that there was no set frequency of observation on the front but observations had been recorded at half hourly intervals in the ongoing record. He discussed it with his colleague, who had arrived in the segregation unit and was due to take over from him at around 8pm. His colleague remarked to him that the frequency of observations had not been recorded and the immediate action plan had not been completed. Neither officer checked this with a manager, but the officer said that he had been doing half hourly observations.
61. The officer took over duty from his colleague between 8.00pm and 8.15pm. It was the first time he had worked on night duty for four years. There were 14 prisoners on the segregation unit but he told the investigator that when he took over he checked only those prisoners who were serving a punishment of cellular confinement. He said that he believed that his colleague would have checked the other prisoners on the unit before he arrived. He decided that he would check the man every half hour as other staff had been doing which he considered was quite frequent. He said that he had checked the man's case notes on the computer to help get some background about him but there was no relevant information recorded.

Discovery of the man hanging

62. The officer said that he checked the man at around 8.20pm, who had stopped banging on his door about five minutes before that. He said he did not attempt to look through the observation panel in his cell door because he already knew the man had covered it up. Instead, he used the observation panel in the toilet area and the gaps in the door frame. He wrote in the ongoing record of the ACCT that the man was lying on his bed, staring at the ceiling. It is the last entry in the ACCT document. At interview he said that he could see the man because the cell light was on. He said his head was towards the back of the cell, his feet were towards the door and he could see his eyes were open. He said that he had not asked the man to uncover his observation panel because he assumed someone had already asked him and he could see him through the gaps in the door. He said he was aware that the man had cut himself earlier but he did not speak to him to check how he

was feeling. The officer told the investigator that he was not aware that the man had been wearing tear-resistant clothing at the time.

63. CCTV footage at 8.28pm shows that the officer walked up the middle of the landing past the man's cell. The timings on the CCTV appear to be around four minutes fast. We believe that the footage timed at 8.28pm is actually that of the observation that the officer wrote that he carried out at around 8.20pm. He looked towards the man's door and then walked to the end of the landing, turned round walked past the cell and again looked towards the door but did not go up to it. It does not show him looking through the door frame or into the toilet area as he claimed. At 8.36pm, an (unidentified) officer walked downstairs from A wing into the segregation unit, talked briefly with the officer, looked at an ACCT document on the desk and then left the unit at 8.38pm.
64. At 8.49pm, the officer turned off the unit lights. He told the investigator that he had waited half an hour since he last saw him then looked into the toilet area of the man's cell at around 8.50pm but could not see him. He looked through the gap at the side of the door and he did not appear to be on the bed. He then opened the door observation flap and said something was smeared on the glass so he could not see through it. He then put his head close to it and could see through a small gap. He saw the man suspended by a ligature tied to the window bars at the back of the cell. He said he was shocked and took a step back, then looked again to make sure of what he had seen.
65. The officer radioed the control room at 8.56 pm, asking for staff assistance as a prisoner was hanging in a cell. In his police statement the night orderly officer said the first radio call was incoherent and had to be repeated. An operational support grade working in the control room immediately requested an ambulance. The officer saw a nurse walking down the stairs connecting A wing and the segregation unit and shouted to her for help. He opened his sealed pouch containing a cell key for use in an emergency at night and went into the man's cell. He was immediately followed by the nurse and an officer who was on A Wing, directly above the segregation unit. The night orderly officer followed directly behind them.
66. The officer cut the fabric from which the man was suspended and his body fell to the floor and he hit his head. The night orderly officer cut the ligature from the man's neck and the nurse, who was unable to find a pulse, began cardiopulmonary resuscitation (CPR). Other nurses had arrived and a further nurse assisted her by maintaining the man's airway. A further nurse brought an emergency bag and attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The defibrillator did not advise a shock and CPR continued. The officer from A wing kept a log. The ambulance arrived at the segregation unit at 9.06pm. Paramedics took over his care but declared the man dead at 9.32pm

Events after the man's death

67. The duty governor was informed at home of the man's death and returned to the prison. At 10.22pm, the prison informed police and two police officers

went to the prison at 10.55pm followed by other police personnel during the night. The police took photographs in the segregation unit. One, of a whiteboard in the staff office, shows the names of the prisoners there and their cell locations. Next to two prisoners' names is the word 'ACCT', but there is nothing written next to the man's name.

68. The investigator spoke to three prisoners who were in the segregation unit at the time of the man's death. The first one described him as 'obviously desperate'. He said he could tell because there was no humour in his voice when he was banging on his door.
69. The second prisoner accepted that he had asked the man to help him throw lines out of the prison, which was a regular activity for this prisoner. Contrary to the officers' accounts, he said that the man had not looked bothered when they were caught with the line. He said he could hear the man banging on his door in the segregation unit, but he had not been concerned about him as he said that gaol desensitises the emotions and he did not consider that the man had any problems in his life.
70. The third prisoner said that he had been looking out onto the landing through the gaps around his cell door on 30 December as he was opposite the man's cell. He said that he had heard the supervising officer tell the man he did not care if he killed himself, but was not sure what time he had heard this. It has not been possible to verify the prisoner's account. The prisoner also said that the segregation unit only had two tear-resistant blankets and that, about a week before the man's death, he had been using them both. Staff asked him to give one back as another prisoner needed it and he said he had kept the newer one because it was in better condition. He said that the one he handed back had a tear in it. It is not clear whether the blanket that he handed back to staff was the one which was later given to the man.
71. The police requested a forensic examination of the ligature. A summary report of the findings described the sheet from which the ligature was made as two layers of thick blue fabric sewn together with red thread forming a diamond pattern. There were burn holes in one of the layers of fabric. However, the report author's opinion was that there was no damage to the sheet which would suggest any pre-existing damage in the area where the sections of ligature were torn. It was also her opinion that a large degree of force would be needed to tear the sheet. When attempts were made to recreate the damage, it proved very difficult to tear. The forensics expert suggested that if the sheet was anchored for example on a window handle and the full force of a person's body weight applied in a tugging action, it could generate sufficient force to tear the sheet.

Contact with the man's family

72. The contact details of the man's next of kin, his sister, had not been entered on his prison case notes. The duty governor was unaware that they had been noted in his medical record and no one checked. He eventually managed to obtain the details from paper records at around midnight. The man's sister

lived locally, but the duty governor decided it would be better to visit her to break the news in the morning. A family liaison officer and an operational manager visited his sister at midday on 31 December to inform her of her brother's death. The solicitor representing the man's sister told the Ombudsman's family liaison officer that a prisoner had telephoned a family friend to tell them of the man's death before they were officially notified. The family were deeply upset at the delay and that they had heard it from another source.

Support for staff and prisoners

73. Listeners (prisoners trained by Samaritans to listen confidentially to prisoners experiencing crisis), officers and members of the chaplaincy supported prisoners affected by the man's death. Prisoners assessed as at risk of suicide or self-harm were reviewed in case they had been adversely affected by the news. However, his cell mate on B wing was moved to another cell at 3.00am after the man's death so that his belongings could be secured. No one told him what had happened to the man until he later overheard an officer telling another prisoner.
74. The prison did not hold a hot debrief for the staff involved, on the evening of his death. The night orderly officer said that it had not been possible because of the limited staff numbers on night duty. On 1 January, a separate debrief for healthcare workers involved in the man's death was held.
75. A post-mortem examination gave the cause of death as compression of the neck due to hanging.

ISSUES

Clinical care

76. The clinical reviewer noted that the man had a long history of substance misuse. The initial reception screening was comprehensive and his drug misuse problem was identified and assessed appropriately and there were no other physical or mental health concerns. He also observed that no concerns about the man's physical or mental health had been identified while he had been in the segregation unit for three days earlier in December when he was seen on three separate occasions by two nurses and a doctor.
77. The clinical reviewer considered that the man received good support from the integrated drug treatment service (IDTS) at Leeds. Neither was there any indication during his interactions with IDTS staff and nurses during December that he was having any difficulty with his detoxification or mentioned any mental health concerns linked to his opiate withdrawal. While the man told a nurse that he was involved in an on-going detoxification programme when she assessed him in the segregation unit on 30th December, his acute agitation and distress was not focused on his substance misuse treatment or issues connected with his detoxification. The clinical reviewer was satisfied that the man received good treatment for his drug misuse at Leeds, had excellent and timely reviews, and was offered interventions and treatments based on up to date national professional drug misuse treatment guidelines.
78. Although opiate detoxification can cause low mood and generate feelings of anxiety and agitation, the man had already got down to very low doses of methadone before he switched to lofexidine and the clinical reviewer said that sudden onset of very low mood or severe anxiety and agitation from withdrawal from these lower doses of opiates would be unusual. Neither is there anything to suggest that the use of lofexidine contributes to a significant change in mental state. While any detoxification leads to an increased risk of suicide and self-harm, the clinical reviewer did not consider that this played a major part in the man's mental state on 30 December.

Management of ACCT procedures

79. When the man arrived in the segregation unit on 30 December, he was very upset. It is possible that this was because he had been coerced into participating in attempts to get contraband into the prison and felt frustrated and angry about the consequences. It does not appear that the officers who discovered him with the line passed on the extent of his anxiety and the segregation unit staff who dealt with him when he arrived appeared to have interpreted his behaviour as aggressive rather than a sign of distress. However, after the man self-harmed, a nurse appropriately initiated ACCT procedures.
80. When the nurse completed the concern and keep safe form at 6.30pm, most of the members of staff in the segregation unit, including the senior officer,

were about to finish their shifts, leaving only one officer on duty. She left the ACCT plan in the segregation unit, on the understanding that the staff would take the required action forward. Although it does not appear that the nurse physically handed over the ACCT in person as PSI 64/2011 requires, the senior officer, the unit manager and the duty governor were in the unit at the time and knew that the ACCT had been opened. The senior officer, as the unit manager, should have taken responsibility for completing the immediate action plan but was about to finish his shift and left without doing so. He made no arrangements with the orderly officer or the duty governor to take on the task, although he appears to have assumed that the duty governor would do this. As a result, no one completed the immediate action plan to set out what needed to be done to keep him safe until his first ACCT case review, including the level of observations required. This also meant that an opportunity was lost to consider whether he was in an appropriate environment and to review the decision to remove his cell furniture and clothes. No supportive interventions were considered. As the duty governor was present in the segregation unit at the time, we are surprised that he did not ensure that the immediate action plan was completed.

81. Chapter 5 of Prison Service Instruction (PSI) 64/11 describes the ACCT process as necessarily prescriptive and says 'it is vital that all stages are followed in the timescales prescribed.....the identification and management of prisoners at risk of suicide and/or self-harm is everyone's responsibility.' A key component of the immediate action plan is to set the frequency of staff support and to make sure that it is written on the front cover of the ACCT plan. As the frequency of observations were not agreed and written in a prominent place, staff who were required to monitor him were therefore confused about what was expected. The officers appeared to believe that there needed to be documented checks every half hour but is not clear how they reached that conclusion, other than each of them following on from the pattern of the other. Although they noted that the immediate action plan had not been completed, none of them queried this with a manager. The officer said that he had continued with observations every 30 minutes as he thought this was a sufficiently short interval between each check.
82. The officer wrote an entry in the ACCT plan that at 8.20pm the man was lying on his bed staring at the ceiling. We have reviewed the CCTV footage from that evening which shows that he walked up the landing and glanced at the man's door while he was walking past. He did not approach the door or attempt to look through the observation panel or the sides of the door. We do not consider that the officer could have observed him effectively in this way in order to make the entry he did.
83. The man was in a distressed state, had just cut himself, had threatened to hang himself later that evening and was held in the extreme conditions of an unfurnished cell, with his clothing removed, in the segregation unit. It is very difficult to understand how someone who was apparently such a risk that he needed to be in such conditions was not observed more frequently. As the man's furniture was removed his cell should have been regarded as special accommodation. (See Segregation Unit below). Mandatory instructions for

special accommodation require the duty governor to specify the frequency at which prisoners will be observed and at a minimum this has to be five times an hour at irregular intervals. The duty governor should have ensured this was done. Such a level of observation might well have saved him.

84. PSI 64/2011 says that alternative clothing must only be used as a measure of last resort and for the shortest possible time. Rather than using it, the instruction says that consideration needs to be given to alternatives, such as locating a prisoner who is considered to be at high risk of suicide in a safer cell or under constant supervision with high levels of staff observation. Reasons for the use of alternative clothing must be documented in the ACCT plan. Nothing is recorded in the ACCT.
85. An enhanced case review is a supportive mechanism to allow staff to respond more effectively to a prisoner's individual needs especially in managing a particular period of crisis. It is a mandatory requirement of PSI 64/2011 that placing an at-risk prisoner in alternative clothing must trigger an enhanced case management review and increased interactions. It is a serious concern that the duty governor as the Head of Safety was not aware that the use of alternative clothing for prisoners on open ACCTs should trigger such a review and that the senior officer, responsible for the segregation unit that day, was unaware what an enhanced case review was. This would suggest that the prison does not routinely adhere to these mandatory procedures.
86. The ACCT process is designed to help keep prisoners safe when they are at risk of suicide and self-harm, but there were a series of fundamental failures by managers and staff in the operation of the ACCT procedures on the evening of 30 December. We understand that operational managers and prison staff work under pressure, but Prison Service Instructions contain important mandatory instructions which need to be followed to safeguard prisoners. Managers responsible for areas such as the segregation unit and safer custody need to be familiar with the mandatory requirements that govern procedures in those areas.
87. In particular, we are concerned that managers did not ensure an immediate action plan was completed and the failure to do so led to a lack of clarity and consideration of appropriate levels of observations. It is unacceptable that alternative clothing and unfurnished accommodation were used without the mandatory safeguards that apply; there was no clear understanding that this might increase the risk of a vulnerable prisoner and should be used only as a last resort. We are not satisfied that the entry in the ACCT document of 8.20pm was accurate or that the man was appropriately observed at that time.
88. We consider that the deficiencies and failures to follow mandatory Prison Service Instructions were sufficiently serious to merit a disciplinary investigation into the actions of the staff that night. We also consider that the prison needs to ensure that ACCT procedures operate effectively to support prisoners at risk. We make the following recommendations:

The Governor should commission a disciplinary investigation into the actions of the duty governor, the senior officer and the officer from the segregation unit in relation to the operation of the man's ACCT on the evening of 30 December and report the outcome to the Prisons and Probation Ombudsman.

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

- **Completing ACCT documents fully and accurately and in accordance with mandatory timescales;**
- **Setting appropriate observation levels and recording this clearly on the ACCT;**
- **Using measures such as alternative clothing and special accommodation only as a last resort;**
- **Holding multidisciplinary case reviews, including enhanced case reviews when required by PSI 64/2011, which include all relevant people involved in a prisoner's care**

Observations through the man's cell door

89. We are concerned that when the man covered his observation panel, the officer did not ask him to remove the obstruction. Instead, he peered through gaps between the door and the frame. He said that at one point he even stood on a chair to get a better view of the cell. When a nurse arrived to tend to the man's cut wrist, his observation panel was covered. An officer asked him to clear it, which he did for a brief time. The officer on duty in the segregation unit did not even attempt to use the observation panel on the grounds that he 'knew' it was obscured. The man had harmed himself, said he was going to hurt or kill himself and had told an officer explicitly that he was going to hang himself that evening. It is dangerous to allow prisoners at high risk of suicide and self-harm to cover their observation panels and impede important safety checks. Instead of adapting the way they carried out observations, officers should have actively challenged the man to remove the obstruction and recognised his behaviour as a sign that he needed to be watched more closely. We make the following recommendation:

The Governor should ensure that observation panels in cell doors are kept clear to enable safe observations and that staff actively challenge prisoners who cover them.

The Segregation Unit

90. We had some concerns about the operation of the segregation unit. As with ACCT procedures, managers and the staff who worked in the segregation unit did not appear to have a sufficient understanding of the procedures which applied there to safeguard prisoners, yet almost all of them working there on 30 December were regular segregation unit staff. For example, Prison Service Order (PSO) -1700 which covers segregation procedures, defines special accommodation as a dedicated cell or improvised normal

accommodation with “any one (or more than one) of the following items removed in the interests of safety: furniture, bedding, sanitation” . The removal of furniture from the man’s cell made it special accommodation but the managers and staff seemed to have been unaware of this, or if they were did not follow the required procedures. The failure to record such use of special accommodation means that monitoring of its use is inaccurate.

91. No special authority was completed as should have happened and the duty governor did not appoint an SO or equivalent to monitor its continued use. The PSO says that time spent in special accommodation should be kept to a minimum – minutes rather than hours- yet there was no plan to review the man’s location. The instructions say that staff conducting checks at least five times an hour “must make every effort to talk to the prisoner and de-escalate the situation to minimise the prisoner’s time in special accommodation”. There was little evidence of any meaningful interaction with the man and the combination of a bare cell with no furniture or clothing, other than an anti-tear tunic must have been dehumanising and alienating.
92. We found that the segregation unit records for December 2013 had considerable gaps. Some days were fully completed, others partially, and others left blank. Residential daily management checks were not completed for 13 of the 30 days of December 2013. The daily diary sheet for 30 December did not contain any information about the man. We are concerned that poor segregation record keeping and inconsistencies in management checks can have a direct effect on prisoners’ wellbeing.
93. Segregation unit staff gave inconsistent accounts of the general requirements to check on prisoners in their care and seemed unclear about what was expected of them. The investigation also revealed weaknesses in handover procedures in the segregation unit which impacted on continuity of care for prisoners there. At the time of the shift change at 6.30pm, staff were unaware of who was detailed to work in the unit that evening and which senior manager had overall responsibility for the unit. This confusion appeared to have been part of the reason why no ACCT immediate action plan was completed.
94. PSI 64/2011 says that prisoners on open ACCT plans must be located or retained in the Segregation Unit only in exceptional circumstances. We are not satisfied that the man’s circumstances were so exceptional as to justify him remaining there when the ACCT was opened and a move to another more suitable location might have helped de-escalate the situation. We also note that there was one other prisoner on an ACCT at the time the man was there and one other whose ACCT had just been closed. We accept that there are occasions when the segregation unit is an appropriate place for a prisoner on an ACCT but it should be exceptional. The investigator asked the prison for its monthly statistics on the number of prisoners on ACCTs held in the segregation unit, but was told that they only had figures for the number of ACCTs opened in the segregation unit and did not keep figures, as required, for all those on an ACCT, including those who arrived already subject to ACCT procedures.

95. We consider that organisational and procedural failures in the segregation unit were so serious that the operation of the segregation unit needs scrutiny from managers external to the prison to ensure it functions safely and effectively. In particular, managers and staff need to understand and follow the requirements of PSO 1700; the numbers of prisoners held in the segregation unit on an open ACCT and the use of special accommodation should be accurately recorded and monitored; management checks need to ensure that mandatory documentation is completed fully and accurately; staffing and handover arrangements should ensure that crucial information about prisoners' welfare is not missed; and prisoners subject to ACCT should remain in the segregation unit only in exceptional circumstances. We make the following recommendation:

The Deputy Director of Custody for Yorkshire and Humberside should satisfy herself that the segregation unit at HMP Leeds operates fully in accordance with mandatory Prison Service requirements designed to safeguard prisoners.

Condition of alternative clothing/bedding

96. Another prisoner in the segregation unit at the time of the man's death told the investigator that he had handed a torn anti-tear blanket back to segregation unit staff around a week before the man's death. It has not been possible to establish whether the blanket the man was given was already torn. However, in the light of the information from this prisoner and the fact that the man was able to tear his blanket to use as a ligature, we consider that it is important that the condition of alternative clothing and bedding is checked before it is issued. We make the following recommendation:

The Governor should ensure that alternative clothing and anti-tear blankets are checked as undamaged when they are given to a prisoner and that this is recorded.

Emergency Response

97. When the officer discovered the man hanging in his cell he did not use an emergency code blue to convey the nature of the emergency to other staff. At interview he said he was in shock at the time. He went into the cell and cut the blanket the man was suspended from, resulting in the man falling to the floor and hitting his head. Contingency plans on discovering a prisoner hanging state that their body should be supported before the ligature is cut.
98. Prison Service Instruction (PSI) 3/2013 Medical Emergency Response Codes, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all

prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. While we are satisfied that in this occasion the failure to call an appropriate emergency code did not lead to any undue delay in the emergency response, we are concerned that Leeds does not have an emergency protocol as the PSI requires. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Leeds has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

Contact with the next of kin

99. The man's sister's address was recorded in his medical records but not in his general records and was not immediately available. The prison found his sister's contact details at around midnight on 30 December, but staff from the prison did not go to inform her of brother's death until midday on 31 December, even though she lived only a few miles from the prison. By that time, a family member had already learned of the man's death from another source. PSI 64/2011 specifies that prisons must notify the prisoner's next of kin promptly as time is of the essence to ensure the family do not find out about the death from another source. We consider that someone from the prison should have gone to inform the man's sister of his death on the night he died. We make the following recommendation:

The Governor should ensure that contact details for prisoners next of kin are kept in accessible records and that, in line with PSI 64/2011, the next of kin is informed of a prisoner's death as soon as possible.

Support for prisoners and staff

100. Prison staff moved the man's cell mate from his cell at 3.00am on the night of the man's death without giving him any explanation either that night or in the morning. He did not learn of the man's death until the next morning when he overheard an officer on B wing telling another prisoner about it. We consider that this was inappropriate and prison staff should inform prisoners in person when they have had close associations with a prisoner who had died. We make the following recommendation:

The Governor should ensure that when a prisoner dies, prisoners who were cell mates, friends or close associates are informed in person and offered support.

101. PSI 08/2010 – Post Incident Care - requires a senior member of staff to hold a hot debrief immediately after all deaths in prisons, to which all staff directly involved are invited. The purpose is to offer support and share any thoughts about the management of the emergency. A member of the prison's staff care team must attend. The prison did not hold a debrief and said it was not possible because of staffing levels at night. Many deaths in prison occur at night and we do not consider that this is a satisfactory explanation not to offer staff support after a traumatic incident. We make the following recommendation:

The Governor should ensure that a hot debrief is held after a serious incident or death and that it chaired appropriately

RECOMMENDATIONS

1. The Governor should commission a disciplinary investigation into the actions of the duty governor, the senior officer and the officer on duty in the segregation unit in relation to the operation of the man's ACCT on the evening of 30 December and report the outcome to the Prisons and Probation Ombudsman.
2. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Completing ACCT documents fully and accurately and in accordance with mandatory timescales;
 - Setting appropriate observation levels and recording this clearly on the ACCT;
 - Using measures such as alternative clothing and special accommodation only as a last resort;
 - Holding multidisciplinary case reviews, including enhanced case reviews when required by PSI 64/2011, which include all relevant people involved in a prisoner's care
3. The Governor should ensure that observation panels in cell doors are kept clear to enable safe observations and that staff actively challenge prisoners who cover them.
4. The Deputy Director of Custody for Yorkshire and Humberside should satisfy herself that the segregation unit at HMP Leeds operates fully in accordance with mandatory Prison Service requirements designed to safeguard prisoners.
5. The Governor should ensure that alternative clothing and anti-tear blankets are checked as undamaged when they are given to a prisoner and that this is recorded.
6. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Leeds has a Medical Emergency Response Code protocol which:
 - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
 - Ensures staff called to the scene bring the relevant equipment; and
 - Ensures there are no delays in calling, directing or discharging ambulances
7. The Governor should ensure that contact details for prisoners next of kin are kept in accessible records and that, in line with PSI 64/2011, the next of kin is informed of a prisoner's death as soon as possible.
8. The Governor should ensure that when a prisoner dies, prisoners who were cell mates, friends or close associates are informed in person and offered support.
9. The Governor should ensure that a hot debrief is held after a serious incident or death and that it chaired appropriately.

ACTION PLAN: [prisoner's name] at HMP Leeds on 30/12/2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should commission a disciplinary investigation into the actions of the duty governor, the senior officer and the officer on duty in the segregation unit in relation to the operation of the man's ACCT on the evening of 30 December and report the outcome to the Prisons and Probation Ombudsman.	Accepted.	An investigation has been commissioned in accordance with Prison Service Instruction 06/2010 Conduct and Discipline. The Deputy Governor from a different establishment is the Lead Investigator.	<p>Governing Governor</p> <p>The investigation was commissioned immediately after advance disclosure of the PPO Report. The investigation has now been concluded and has been submitted to the Governing Governor for consideration.</p> <p>The outcome will be reported to the PPO as soon as possible after the completion of the full process as described in PSI 06/2010.</p>	
2	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:	Accepted.	A full review of the Safer Custody department has been undertaken and new management is now in post. A comprehensive action plan has been developed and agreed between the Governor, the Regional Safer	Head of Safety. Completion date: August 2015	

	<ul style="list-style-type: none"> • Completing ACCT documents fully and accurately and in accordance with mandatory timescales; • Setting appropriate observation levels and recording this clearly on the ACCT; • Using measures such as alternative clothing and special accommodation only as a last resort; • Holding multidisciplinary case reviews, including enhanced case reviews when required by PSI 64/2011, which include all relevant people involved in a prisoner's care 		<p>Custody Lead and the Deputy Director of Custody. The action plan has now been implemented and progress will be reviewed at the monthly Safer Custody meetings. The action plan includes development activity for every member of the staff group, starting with a safety-themed training shut down morning.</p> <p>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 consistently fail to deliver care in line with national guidance.</p> <p>Greater awareness of PSO 1700 has been introduced with Segregation staff and the Senior Management Team fully briefed on the special accommodation instructions. Posters and staff information have been published. A local policy is being developed in accordance with the national policy.</p> <p>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.</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>	
3	The Governor should ensure that observation panels in cell doors are kept clear to enable safe	Accepted	A local notice to staff will be issued explaining the importance of keeping observation panels clear. Local prisoner notices will be displayed on all	Head of Residence Head of Safety Completion date:	

	observations and that staff actively challenge prisoners who cover them		<p>residential units and staff and prisoner information desk (PID)* workers will reinforce this message.</p> <p>These notices will describe the consequences of observation panel obstruction, up to and including downgrade on the Incentives and Earned Privileges scheme. They will be provided in a number of different languages.</p> <p>* PIDs are desks on each wing staffed by trained prisoners that contain all the latest notices, as well as the various application forms that a prisoner may need.</p>	January 2015	
4	The Deputy Director of Custody for Yorkshire and Humberside should satisfy herself that the segregation unit at HMP Leeds operates fully in accordance with mandatory Prison Service requirements designed to safeguard prisoners.	Accepted	<p>The Deputy Director of Custody commissioned a review of the segregation unit as a result of this incident. The Deputy Governor of a different establishment completed this review and the resulting recommendations have been accepted. Actions to address them have been built in to the safer custody action plan described above and are in the process of being implemented. The Regional Safer Custody Lead will work with the Senior Management Team to track progress and ensure that the revised procedures become embedded in practice.</p> <p>A comprehensive local segregation policy is being developed as part of this work.</p> <p>Closer working between the Segregation Unit and Safer Custody department (now brought together as part of the Safety function) has commenced and continues to be built on as part of the overall safety</p>	<p>Head of Safety Completion date: January 2015</p> <p>February 2015</p> <p>Completed</p>	

			<p>vision.</p> <p>The recruitment of a core staff group for the Segregation Unit is under way, and those selected will receive specific training on managing complex behaviours and heightened risk. Additional staffing resources have been approved by the DDC and deployed to the Segregation Unit.</p>	January 2015	
5	The Governor should ensure that alternative clothing and anti-tear blankets are checked as undamaged when they are given to a prisoner and that this is recorded.	Accepted	<p>A booking out log for the issue of alternative clothing will be implemented on each residential unit. It will include space for recording the name of the issuing member of staff, the name of the manager authorising the use of alternative clothing, ensuring it is only used as a measure of last resort, and confirmation that the clothing and/or blankets are in an undamaged condition.</p> <p>An inventory will be established and held by the Safer Custody team recording the amount and whereabouts of alternative clothing and anti-tear blankets within the establishment.</p> <p>In addition the use of Care Plans and comprehensive review documentation will be reiterated at Band 4 training.</p>	Head of Safety Completion date: January 2015	
6	The Governor should ensure that all prison staff are made aware of and understand PSO 03/2013 and their responsibilities during medical emergencies and that Leeds has a Medical Emergency Response Code	Accepted	<p>A Notice to Staff will be issued to remind staff of the requirements of PSO 03/2013.</p> <p>Contingency plan exercises will be developed to include involvement from Control Room operatives to</p>	Head of Operations Head of Safety Completion date:	

	<p>protocol which:</p> <ul style="list-style-type: none"> • Provides guidance to staff on efficiently communicating the nature of a medical emergency; • Ensures staff called to the scene bring the relevant equipment; and • Ensures there are no delays in calling, directing or discharging ambulances 		<p>ensure that the Ambulance Protocol is fully understood. Safer Custody and Operations departments will audit all medical emergency calls to ensure compliance.</p>	<p>February 2015 Reviewed annually.</p>	
7	<p>The Governor should ensure that contact details for prisoners next of kin are kept in accessible records and that, in line with PSI 64/2011, the next of kin is informed of a prisoner's death as soon as possible</p>	<p>Accepted</p>	<p>Contingency plans will be reviewed and updated to ensure that they prompt next of kin (NOK) contact.</p> <p>NOK details are kept on PNomis. Hub data is monitored monthly to identify missing data and action will be taken to ensure that any anomalies are rectified.</p>	<p>Head of Operations Head of Safety Completion date: February 2015</p> <p>Head of Performance Head of Safety Completion date: March 2015 then reviewed monthly</p>	
8	<p>The Governor should ensure that when a prisoner dies, prisoners who were cell mates, friends or close associates are informed in person and offered support</p>	<p>Accepted</p>	<p>The Death In Custody contingency plan will be reviewed and updated to include this prompt. It will prompt the Senior Management team to identify both current and previous cell mates as well as close friends and associates via staff and other prisoners. These will then be informed in person and offered support by the Safer Custody team and Chaplaincy team..</p>	<p>Head of Operations Head of Safety Completion date: June 2015</p> <p>Head of Safety Commenced</p>	

			<p>In addition a local prisoner information notice will be issued following a death in custody, and this will include information about the various sources of support available for all prisoners</p> <p>Safer Custody and Chaplaincy staff will work jointly in delivering this support.</p>		
9	The Governor should ensure that a hot debrief is held after a serious incident or death and that it chaired appropriately.	Accepted	<p>The contingency plans have been reviewed and updated to include the need to complete a hot debrief after a serious incident or death. All staff involved in a serious incident or death along with members of the care team will be invited, and it will be chaired by a senior member of staff.</p> <p>The Senior Management Team will take part in a regular contingency planning exercise to ensure full understanding of these requirements.</p>	<p>Head of Operations SMT Completed</p> <p>Completion date: Annual</p>	

