Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry Kirkpatrick, a prisoner at HMP Leeds, on 29 May 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

This is the investigation report into the death of Mr Barry Kirkpatrick, who was found hanged in his cell at HMP Leeds on 29 May 2015. Mr Kirkpatrick was 24 years old. I offer my condolences to Mr Kirkpatrick's family and friends.

Mr Kirkpatrick had made a serious suicide attempt on 31 December 2014. On 23 May 2015, he was charged with serious violent offence against his partner - a factor known to increase the risk of suicide. Court staff completed a warning form to alert the prison to Mr Kirkpatrick's risk of suicide yet no one identified him as a risk when he arrived at Leeds and did not put in place measures to support him. It is difficult to understand how prison staff could have missed such an obvious risk. I am also concerned that further opportunities to assess Mr Kirkpatrick's risk were missed, as he appeared to bypass the first night and induction procedures and no one acted on information from his family and solicitor.

Poor assessment of the risk of suicide or self-harm is a recurring theme at Leeds and the Governor needs to ensure that all relevant staff, particularly in reception, understand and act on known risk factors.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

Contents

Summary 2
The Investigation Process 5
Background Information 6
Key Events 7
Findings 13

Summary

Events

1. On Saturday 23 May 2015, Mr Barry Kirkpatrick was charged with a serious violent offence against his partner. He was remanded to HMP Leeds on Monday 25 May. This was not his first time in prison. He had last been released from Leeds in November 2014. He had attempted suicide in December 2014 and had previously taken an overdose. At court, it was recorded that Mr Kirkpatrick was at risk of suicide and he arrived at Leeds with a suicide and self-harm warning form completed by the escort contractor. Despite his history and risks, reception staff did not begin Prison Service suicide and self-harm prevention procedures, known as ACCT, to support him.

2. Mr Kirkpatrick did not go to the usual first night wing but went to a standard residential wing. There is no record of any induction or second health screen, which should have happened.

3. On 26 May, Mr Kirkpatrick's sister tried to book a visit but she was not yet on her brother's approved list. She emailed the visits team and said she was concerned about him as he had recently tried to hang himself and had suffered a hypoxic brain damage. A member of the visits team gave her the prison chaplaincy's phone number and advised her to contact them if they had concerns. The same day, Mr Kirkpatrick's probation officer phoned the prison's safer custody team and alerted them to Mr Kirkpatrick's history of attempted suicide. The wing manager spoke to Mr Kirkpatrick, and accepted his assurance that he did not have any thoughts of suicide or self-harm.

4. The next day, Wednesday 27 May, Mr Kirkpatrick's solicitor faxed a letter to Leeds, noting that he had had made several attempts to commit suicide, suffered from hypoxic brain damage and should be monitored. No one acted on the information or passed the fax urgently to the safer custody team.

5. Around 9.00am on Friday 29 May, Mr Kirkpatrick's cellmate was released, leaving him alone in his cell. At 9.37am, Mr Kirkpatrick phoned his sister. They discussed the charges he was facing and were anxious about the length of sentence Mr Kirkpatrick might receive if he were found guilty. At 3.14pm, a prisoner went to Mr Kirkpatrick's cell and found that he had hanged himself. He alerted officers who radioed an emergency. Prison officers and nurses tried to resuscitate Mr Kirkpatrick, until paramedics arrived and took him to hospital. Sadly, Mr Kirkpatrick did not recover and, at 4.30pm, a hospital doctor recorded that he had died. The prison held a memorial service for Mr Kirkpatrick but did not invite his family to participate.

Findings

6. Reception staff should have identified that Mr Kirkpatrick was at risk of suicide and self-harm when he arrived at Leeds and begun ACCT suicide and self-harm prevention procedures. He arrived with a suicide warning: he was a young man with a recent serious suicide attempt and had been remanded to prison charged with a violent assault against his partner. He had only recently been released from prison for an offence for which he was still on licence. All of these are factors that raise the risk of suicide, yet staff discounted then as Mr Kirkpatrick said that he would be OK. Further opportunities to intervene were missed when

Mr Kirkpatrick's sister and his solicitor informed the prison that they were concerned about him. Mr Kirkpatrick bypassed usual first night and induction procedures as he had recently been at Leeds and there is little to indicate he received any further support after he arrived, including missing a second health screen, which would have been a further opportunity to identify his risk.

Recommendations

- The Governor and Head of Healthcare should introduce new, clear and effective reception operating procedures so that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:
  - Have a clear understanding of their responsibilities and the need to record relevant information about risk.
  - Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records.
  - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.
- The Governor should ensure that all staff understand how to report any concerns from families and external agencies about a prisoner's state of mind or risk of suicide and self-harm to an appropriate manager, who should consider whether to open an ACCT and record the information and action taken in the prisoner's record.
- The Governor should ensure that first night and induction procedures are delivered in line with PSI 7/2015 and that all newly arrived prisoners receive essential information about prison processes.
- The Head of Healthcare should ensure that all prisoners are offered a general health assessment in line with PSO 3050.
- The Governor should ensure that families of deceased prisoners are consulted about and invited to memorial services held at the prison.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator visited Leeds on 9 June 2015 and obtained copies of Mr Kirkpatrick's prison and medical records. He interviewed 18 members of staff and five prisoners at Leeds in July and September.

9. NHS England commissioned a clinical reviewer to review Mr Kirkpatrick's clinical care at the prison.

10. We informed HM Coroner West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. The investigator and one of the Ombudsman's family liaison officers, met Mr Kirkpatrick's parents and their solicitors to explain the investigation. They told us that they had not been able to contact the prison's chaplaincy team to pass on their concerns about Mr Kirkpatrick and they were upset that they had not been invited to a memorial service at the prison. Mr Kirkpatrick's family had the following questions they wanted the investigation to consider:

    - Was Mr Kirkpatrick assessed when he arrived at Leeds and what risk factors were considered?
    - Why had Mr Kirkpatrick been located on F Wing?
    - Did staff at Leeds take any action when they received information about Mr Kirkpatrick's risk of suicide from external sources?
    - Who discovered Mr Kirkpatrick hanged?

12. Mr Kirkpatrick's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Leeds

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

HM Inspectorate of Prisons

14. The most recent inspection of HMP Leeds was 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 ACCT suicide and self-harm monitoring procedures needed improvement. They were positive about reception processes but recommended tracking to ensure that all prisoners received a full induction.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its 2014 annual report, the IMB reported that there were insufficient spaces in the prison's first night centre for new arrivals. The Board noted that the prison had fully reviewed safer custody procedures after several deaths at the prison and had prioritised identifying socially isolated prisoners and those with mental health issues.

Previous deaths at HMP Leeds

16. There were three self-inflicted deaths at Leeds in 2014. Our investigations into these deaths found that prison staff took insufficient account of prisoners' risk factors when they arrived at the prison and did not begin Prison Service suicide and self-harm prevention procedures when they should have done. We found the same issue in this investigation. We have also previously raised the need for secondary health assessments after reception.

Assessment, Care in Custody and Teamwork

17. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

18. In January 2014, Mr Barry Kirkpatrick was convicted of assault occasioning actual bodily harm. The offences were against a previous partner and there was a restraining order preventing him contacting her. He was later sentenced to 16 months in prison and was released on licence in November 2014. On New Years' Eve, Mr Kirkpatrick tried to hang himself. He spent some time in hospital in an induced coma and suffered a hypoxic brain injury, for which he received treatment from a community neurology rehabilitation service.

19. On Saturday 23 May 2015, the police arrested Mr Kirkpatrick and charged him with grievous bodily harm with intent, after he had assaulted his partner, who was in a serious condition in hospital as a result. After his arrest, Mr Kirkpatrick was taken to hospital with a suspected racing heart, but was soon discharged to police custody.

20. The police noted that Mr Kirkpatrick had a history of suicide and self-harm. He had made scratches to his neck in February 2012, taken an overdose of drugs in March 2013 and tried to kill himself by hanging on 31 December 2014, from which he had suffered brain trauma. Mr Kirkpatrick told the police that he had no intention to harm himself but they assessed him as a medium risk of suicide and self-harm. After a period of constant observation during his first day in police custody, the police reduced the level of observation to half-hourly checks, although Mr Kirkpatrick was held in a cell with a CCTV camera.

Monday 25 May

21. On Monday 25 May, Mr Kirkpatrick appeared at Leeds Magistrates' Court. The police noted on his Person Escort Record (PER, a document that accompanies all prisoners when they move between police stations, courts and prisons) that he had taken an overdose in 2013 and had attempted to hang himself in 2014. The police noted that Mr Kirkpatrick's alleged offence had been extremely violent and that he had been taken to hospital for a racing heart on 23 May.

22. After he arrived at court, Mr Kirkpatrick's solicitor told court staff about his previous suicide attempt. The court remanded Mr Kirkpatrick to prison and attached a supplementary sheet to the remand warrant, noting that he was a suicide risk. The document stated, "Suicide Watch – has attempted suicide recently".

23. Court escort staff completed a Suicide/Self-Harm Warning Form and attached it to the PER and court warrant forms to be handed to prison staff. An escort officer, A, signed the form at 12.20pm and noted that Mr Kirkpatrick's solicitor had been concerned about him and asked for him "to be put on self-harm" because he had recently tried to hang himself. The officer noted that Mr Kirkpatrick had told him he had no current thoughts of suicide or self-harm.

24. Officer B interviewed Mr Kirkpatrick when he arrived at HMP Leeds and signed the suicide and self-harm warning form at 1.40pm to confirm he had seen it. Mr Kirkpatrick identified his partner and his mother as his next of kin. The officer noted that Mr Kirkpatrick had been released from Leeds in November 2014 and

was due in court on 8 June 2015. He did not record anything about Mr Kirkpatrick's risk of suicide or self-harm.

25. Officer B told the investigator that he had only vaguely remembered speaking to Mr Kirkpatrick about his suicide attempt but he remembered that Mr Kirkpatrick had told him that he had taken a lot of drugs and alcohol and could only remember coming out of the coma. He said that Mr Kirkpatrick had told him that he did not know why he had tried to hang himself and did not intend to try to kill himself again. The officer said that he did not recall seeing the supplementary sheet that had been attached to Mr Kirkpatrick's court warrant about his risk of suicide. He said that Mr Kirkpatrick told him that he was okay and he took his word for it. He told the investigator that he did not know what charges Mr Kirkpatrick was facing. He therefore did not consider whether the nature of the charges increased his risk.

26. At 2.52pm, Nurse A, a mental health nurse, completed an initial health screen. He noted in Mr Kirkpatrick's medical record that Mr Kirkpatrick had a history of suicide and self-harm; he had tried to hang himself in January 2015 and had been in a coma for two months afterwards. He also noted he had previously taken an overdose. Mr Kirkpatrick told the nurse he was stressed at the time he took the overdose and had not intended to kill himself. He said he had not thought about the impact his actions would have had on his family. Mr Kirkpatrick said he had no current thoughts of suicide or self-harm and, although he had had problems with his partner, everything was now okay between them.

27. Nurse A told the investigator that he was not aware of the extent of Mr Kirkpatrick's alleged offence, although he knew that it involved domestic violence. He did not take account of his charges in his risk assessment. He recorded that Mr Kirkpatrick was relaxed and made good eye contact. The nurse had no concerns about Mr Kirkpatrick and based on his presentation, assessed that he was not at risk of suicide or self-harm. He signed the suicide and self-harm warning form (underneath Officer B's signature) to confirm he had read it and ticked a box to show that ACCT suicide and self-harm prevention procedures had not been opened. The nurse said Mr Kirkpatrick was eager to by-pass the first night centre and wanted to go straight to a residential wing. He did not want to be referred to the mental health team and the nurse told him about the support services available in the prison.

28. Officer C interviewed Mr Kirkpatrick after his reception screening. He told the investigator that no one had told him about Mr Kirkpatrick's history of attempted suicide attempts or that there were any current concerns about him. The officer said he did not recall that Mr Kirkpatrick had any identified risks of suicide or self-harm, although he had access to Mr Kirkpatrick's records, which contained the suicide and self-harm form that had arrived with him. The officer completed a "First Night Centre Handover" sheet. He recorded that Mr Kirkpatrick was on remand, was suitable to share a cell with another prisoner, smoked and had arrived with £15 cash. Because his charge involved domestic violence, Mr Kirkpatrick was not allowed to telephone anyone until his telephone numbers had been checked. The officer told the investigator that, in these circumstances, if prisoners want this, officers make a call on their behalf to let someone know their whereabouts.

29. Mr Kirkpatrick was taken to B Wing, the prison's first night and induction centre. All new prisoners normally spend their first night on B Wing but at 3.41pm, Officer D recorded that she was asked to collect Mr Kirkpatrick and take him to F Wing. The officer said she did not know Mr Kirkpatrick or that he had just arrived at the prison that afternoon. She said that he was polite and he told her that he had previously been on F Wing and had no concerns about going there.

Tuesday 26 May

30. Prison Service instructions require that every prisoner should be offered a secondary (general) health assessment after the first reception. There is no record that Mr Kirkpatrick was offered an assessment. Healthcare staff requested Mr Kirkpatrick's records from his community GP on 26 May. (The records were received on 29 May, the day Mr Kirkpatrick died.)

31. Mr Kirkpatrick's probation officer in the community, told the investigator that when he found out that Mr Kirkpatrick had gone to Leeds, he phoned the safer custody team on 26 May and spoke to a member of staff, to ensure they were aware of Mr Kirkpatrick's recent suicide attempt and his brain injury. The member of staff said that she noted the call in Mr Kirkpatrick's record and phoned the F Wing manager, to pass on Mr Franklin's concerns. She also phoned the mental health team and left a message for a mental health nurse, B, about Mr Kirkpatrick's circumstances.

32. The F wing manager told the investigator that the member of the safer custody had mentioned the concerns about Mr Kirkpatrick's wellbeing and his mental health but did not mention the suicide attempt. He said he spoke to Mr Kirkpatrick in his cell that afternoon for about 25 minutes. Mr Kirkpatrick told him about his suicide attempt on 31 December 2014, when he had taken drugs. He said he did not recall what he had taken but had not tried to harm himself since and had not intended to kill himself. The F wing manager said he spoke about the future in a positive way and he did not consider there was anything about his demeanour to suggest he was at risk of suicide or self-harm. He reminded Mr Kirkpatrick of the support available in the prison, including the Listener scheme (prisoners trained by the Samaritans to offer support). He phoned the member of the safer custody and told her that Mr Kirkpatrick was okay and had no current thoughts of suicide or self-harm. The member of the safer custody updated the F wing manager.

33. Nurse B recorded the concerns about Mr Kirkpatrick in his medical record at 11.23am, and discussed them with her team leader. She checked his medical record and saw that Nurse A had completed the reception health screen and had not noted any concerns. However, as Nurse A had not recorded any details about Mr Kirkpatrick's head injury, Nurse B sent an email notification to the head injuries team for them to assess him. (Leeds has a programme for prisoners with brain injuries.)

34. Mr Kirkpatrick's family's solicitor gave the investigator copies of emails between Mr Kirkpatrick's sister and Leeds' visits team. At 11.07am on 26 May, Mr Kirkpatrick's sister emailed the visits team and said she had tried to book a visit by phone several times. Someone replied immediately with the number of the

prison visits phone line and the operating times, noting that she would need Mr Kirkpatrick's prison number.

35. At 11.26am, Mr Kirkpatrick's sister replied by email with Mr Kirkpatrick's prison number and his date of birth. The visits team replied at 11.33am, and noted that they could not book a visit for her because her name was not on his approved visitors list. They said that it was the prisoner's responsibility to add visitors to the list and his sister could send a message to him about this through the "email a prisoner" website, which would be delivered the next day.

36. At 11.47am, Mr Kirkpatrick's sister emailed her brother and asked him to put her name on the visitor list. At 12.06pm, she emailed the visits team again. She said that Mr Kirkpatrick had tried to hang himself in January, had hypoxic brain damage and she was really worried about him. Someone from the team responded within two minutes and said that, if she was concerned about Mr Kirkpatrick, she should contact the prison chaplaincy and gave the telephone number.

37. Mr Kirkpatrick's sister said that she phoned the chaplaincy on the number given the same day, but no one answered. She said there was no ansaphone facility and so was unable to leave a message. The investigator spoke to three members of the chaplaincy team and established that someone from the team was in the prison every day. They said that there was an answer phone for people to leave a message when no one was in the office. As Mr Kirkpatrick's sister, was unable to make successful contact with the chaplaincy team, no one from the chaplaincy went to see him.

Wednesday 27 May

38. At 1.58pm on 27 May, Mr Kirkpatrick's solicitor sent a fax to the Offender Management Unit (OMU) at Leeds, outlining that he had a history of attempted suicide and self-harm and had been diagnosed with hypoxic brain damage for which he attended weekly hospital appointments. His solicitor asked that the prison should monitor Mr Kirkpatrick because of his risk of suicide and self-harm and because of his brain injury. We do not know who dealt with the fax in the OMU but it was sent in the internal mail to the prison's business hub unit, which deals with legal correspondence and complaints. The fax did not reach the safer custody team office until 4 June.

Thursday 28 May

39. On Thursday 28 May, nothing was recorded about Mr Kirkpatrick in his prison record.

Friday 29 May

40. Mr Kirkpatrick's cellmate, told the investigator that Mr Kirkpatrick was quiet and did not talk much. He said he sometimes seemed unhappy and always looked as if he was thinking about something. Mr Kirkpatrick told his cellmate that he had problems with his girlfriend but did not mention any thoughts of suicide or self-harm. The cellmate was released from prison at about 9.00am on 29 May.

41. There was an association period on F Wing between 9.30am and 10.30am, when prisoners are able to mix with each other, take showers and make telephone calls. At 9.37am, Mr Kirkpatrick phoned his sister. The call lasted five minutes. His sister told him that she had had trouble booking a visit. They discussed the charges he was facing and that he might receive a long sentence if he was found guilty. Mr Kirkpatrick did not mention that he felt unable to cope or that he was feeling suicidal.

42. The prisoner who was in the cell next to Mr Kirkpatrick. He said that he had gone to see Mr Kirkpatrick in his cell during the association period and he seemed okay. The prisoner swapped his mattress with Mr Kirkpatrick's cellmate, as it was in better condition. He said that he had joked with Mr Kirkpatrick about this.

43. At 10.21am, Mr Kirkpatrick's community GP faxed confirmation of his medical history to the healthcare unit. There was a record of 7 January 2015, noting that Mr Kirkpatrick had attempted suicide by hanging (apparently referring to the incident on 31 December 2014). The hanging had resulted in a hypoxic brain injury for which he was treated at a community neurology rehabilitation unit. It noted that he had taken an overdose of tramadol and another drug in 2013 and suffered from depression and asthma.

44. Prisoners were unlocked from their cells to get lunch between 12.00pm to 12.30pm. The prison next door and his cellmate, who shared a cell, told the investigator that they saw Mr Kirkpatrick collecting his lunch and he seemed okay. Officer E said that she had seen him collect his lunch and spoke to him briefly, when he got back to his cell. She had no concerns about him and said that he had said, "See you later Miss", when she locked his cell door.

45. At 2.45pm, officers unlocked prisoners who had not had an association period that morning. The prisoner who was next door to Mr Kirkpatrick and another prisoner went to look for Mr Kirkpatrick's cellmate, as they did not know he had been released. They looked through the observation panel of the cell and saw Mr Kirkpatrick hanging and that his face was blue. The prisoner next door to Mr Kirkpatrick alerted two prison officers on the landing below by waving and beckoning to them.

46. Officer F and Officer G went up to the cell looked through the door observation panel and saw Mr Kirkpatrick hanging from the bed frame from a ligature made from bedding. As neither officer had a radio, both shouted to officers on the lower landing that there was a code blue emergency. Officer F unlocked the cell and they went in immediately.

47. Officer H heard Officer F's shout and radioed a code blue emergency. (This indicates that a prisoner is unconscious or not breathing.) The officer, who was working in the control room, recorded the code blue at 3.14pm and repeated it over the prison radio network. She then immediately called an ambulance and remained on the phone to the ambulance controller to provide further information about the incident as it was relayed from the wing. When the call ended, she recorded in the control room log at 3.18pm that she had called an ambulance.

48. Officer F cut the ligature from around Mr Kirkpatrick's neck and lowered him to the floor. He could not find a pulse. As Mr Kirkpatrick was not breathing, he started chest compressions. Officer G then took over.

49. Four nurses arrived at Mr Kirkpatrick's cell within three minutes. Nurse A took over chest compressions from Officer G and Nurse D ensured Mr Kirkpatrick's airway was clear. Nurse D brought an emergency bag and Nurse D inserted a guedal airway into Mr Kirkpatrick's mouth. Mr Kirkpatrick showed no signs of life. A defibrillator (a life-saving device that can re-start the heart by giving an electric shock in some cases of cardiac arrest) was used, but it found no shockable heart rhythm. Within five minutes, Nurse E arrived and took over chest compressions. There was no change in Mr Kirkpatrick's condition.

50. The nurses rotated chest compressions until paramedics arrived at 3.28pm. They took charge of the resuscitation attempt and decided to take Mr Kirkpatrick to Leeds General Infirmary. At 4.30pm, a doctor recorded that Mr Kirkpatrick had died.

51. Mr Kirkpatrick left a note in his cell, in which he said that he loved his partner and would never do anything to hurt her. He believed that the police had wrongly accused him based on his previous offences. He said to tell his partner and family that he was sorry and that he loved them.

Contact with Mr Kirkpatrick's family.

52. Supervising Officer (SO) A was the prison's family liaison officer. The SO and the operational manager went to see Mr Kirkpatrick's mother later that afternoon, informed them of his death and offered condolences. The operational manager explained what would happen next and offered his and Mr Knowles' support. In line with national policy, the prison contributed to the cost of Mr Kirkpatrick's funeral.

Support for prisoners and staff

53. Another operational manager debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

54. The prison posted notices informing prisoners of Mr Kirkpatrick's death and outlining the support available to them. Officers spoke to all prisoners on F Wing and offered them support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Kirkpatrick's death. On 3 June, the prison held a memorial service for Mr Kirkpatrick, which was well attended by prisoners. The prison did not inform Mr Kirkpatrick's family or invite them to attend.

Post-mortem report

55. The post-mortem report concluded that Mr Kirkpatrick's cause of death was due to hanging.

Findings

Assessment of risk of suicide and self-harm

56. The Prison Service Instruction (PSI) covering safer custody, PSI 64/2011, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, and being charged with violent offences. Staff should interview new prisoners in reception to assess their risk of suicide and self-harm. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should address any concerns, including opening an ACCT if necessary.

57. After Mr Kirkpatrick appeared at court, the court clerk attached a supplementary information document to his remand warrant, noting that he was a suicide risk, had attempted suicide recently, and should be placed on "Suicide Watch". Escort staff completed a Suicide and Self-Harm Warning Form, noting that Mr Kirkpatrick had attempted to hang himself in the last six months and had been in a coma as a result. The escorts added that Mr Kirkpatrick's solicitor had asked that he should be monitored as a risk of suicide and self-harm.

58. Officer B saw the suicide and self-harm warning form but told us that Mr Kirkpatrick had assured him that he would not harm himself. He did not record any assessment of Mr Kirkpatrick's risk of suicide and self-harm. Officer C, who completed Mr Kirkpatrick's cell sharing risk assessment and the first night handover form, said that it was the initial reception officer's responsibility to assess a prisoner's risk of suicide and self-harm. There was no recorded evidence that either officer assessed Mr Kirkpatrick's risk of suicide and self-harm and no clear reception procedures outlining responsibilities. Nurse A saw the suicide and self-harm warning form and noted Mr Kirkpatrick's history but based on what Mr Kirkpatrick told him, did not consider that he was at risk of suicide or self-harm. Nurse A did not have full information about the charges Mr Kirkpatrick was facing so could not have taking these into account when assessing his risk.

59. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we found that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Kirkpatrick had several risk factors for suicide and self-harm – he was charged with a violent offence against his partner, there was clear information that he had recently made a serious suicide attempt and was a young man with relationship difficulties. We consider that reception staff should have given more weight to Mr Kirkpatrick's obvious risk of suicide and opened an ACCT. We have criticised reception staff's assessment of risk at Leeds in three investigations into deaths at the prison in 2014, and it is concerning that Mr Kirkpatrick's obvious risk was not identified when he arrived at the prison.

60. We are concerned that only the nurse recorded an assessment of Mr Kirkpatrick's risk and then without full information. A prisoner's presentation 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.

Prisoners intent on suicide rarely say so. There is a need for reception staff to share information about risk effectively. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

61. There were further missed opportunities for staff to recognise Mr Kirkpatrick's risk of suicide. When Mr Kirkpatrick's probation officer called to voice his concerns, the wing manager spoke to Mr Kirkpatrick, but again relied solely on what he told him. When Mr Kirkpatrick's sister and solicitor separately voiced their concerns about his risk of suicide, no one took any action.

62. Prison Service Instruction 64/2011 contains a mandatory instruction which states that:

> *"All staff who receive information, including from concerned family members … must communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan…."*

> "*Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form."*

63. We do not consider that Leeds complied with this instruction in this case, and information about Mr Kirkpatrick's risk was not handled appropriately. Managers told us that they would expect any member of staff to pass on concerns that a prisoner might be at risk of suicide or self-harm to the safer custody team. However, the Head of Operations, responsible for the visits team, told us that the team does not have an instruction about dealing with such information from family and friends. While it was misguided for the visits team to pass Mr Kirkpatrick's sister the telephone number of the chaplaincy rather than passing the information on directly, it is a managerial responsibility to ensure that all staff working in prisons understand their role when they receive such important information. Similar information from Mr Kirkpatrick's solicitor sent to the prison's offender management unit was very poorly handled and did not reach the safer custody team until some days after Mr Kirkpatrick's death. Someone should have identified the importance and the urgency of the information in the fax.

64. The prison needs to have clear and effective procedures in reception to ensure that all staff understand their responsibilities and properly record their assessment of risk of suicide and self-harm and the factors they have taken into account. When prisoners arrive with suicide and self-harm warning forms and the prison does not open an ACCT, we would expect the reasons to be fully recorded. All information received by the prison about a prisoner's risk of suicide and self-harm should be actively and urgently considered by those responsible for his care. We make the following recommendations:

The Governor and Head of Healthcare should introduce new, clear and effective reception operating procedures so that all staff understand the

procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

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

The Governor should ensure that all staff understand how to report any concerns from families and external agencies about a prisoner's state of mind or risk of suicide and self-harm to an appropriate manager, who should consider whether to open an ACCT and record the information and action taken in the prisoner's record.

Induction

65. Prison Service Instruction 7/2015 (Early Days in Custody) states that, as soon as all reception procedures have been completed, new prisoners should be moved to a first night centre, or other accommodation, such as the segregation unit or healthcare centre , as necessary, where they will spend their first night. They should receive information about prison life.

66. In a PPO review of self-inflicted deaths in 2013-14, which we published in March 2015, we noted that a number of prisoners in the study had not received a proper induction, and were therefore not always aware of basic prison procedures. We highlighted that prisons should ensure that all prisoners receive a basic induction.

67. Mr Kirkpatrick spent less than an hour in the first night centre before being moved to F Wing. The reasons were not noted in his record. PSI 7/2015 says that every prisoner's knowledge and previous experience of custody should be explored with them during the reception and first night stages, and all prisoners requiring induction should be referred onwards. It notes that prisoners with extensive experience of prison might need less input than those comparatively new to prison, but staff should take into account that some prisoners might not retain information for very long and will need reminding.

68. There is no record that any staff explored Mr Kirkpatrick's induction needs with him or that he received an appropriate induction. Mr Kirkpatrick had been at Leeds before and might have been familiar with the prison regime, but a proper induction would have reminded him of the support he could get from the chaplaincy, Listeners (prisoners trained by the Samaritans to offer support) and other support agencies, how to book visits and to raise any concerns he had. The fact that he had suffered a brain injury since he had last been at Leeds might have made this more important. In its most recent inspection of Leeds, HM Inspectorate of Prisons found that, although the first night procedures were satisfactory, the prison did not have a tracking system to make sure prisoners received a full induction. We make the following recommendation:

The Governor should ensure that first night and induction procedures are delivered in line with PSI 7/2015 and that all newly arrived prisoners receive essential information about prison processes.

Clinical care

69. The clinical reviewer concluded that the overall clinical care Mr Kirkpatrick received was comparable to that which he could have expected in the community. However, Prison Service Order 3050, Continuity of Healthcare, states that all prisoners should be offered a general health assessment to gather further information and to check how the prisoner is settling. Mr Kirkpatrick did not receive a secondary health screen, which would have presented another opportunity for healthcare staff to discuss his issues and in particular to assess his brain injury and how this might affect him in prison. Although Nurse B referred Mr Kirkpatrick to the brain injury team on 26 May after the safer custody team informed her about his history, this was the result of information from Mr Kirkpatrick's probation officer rather than from a health assessment. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners are offered a general health assessment in line with PSO 3050.

Memorial Service

70. PSI 64/2011 has a mandatory instruction that governors must arrange for the chaplain or other religious leader to offer to hold a memorial service for the family, other prisoners and staff. The prison held a memorial service for Mr Kirkpatrick on 3 June, but Mr Kirkpatrick's family told us that they were not informed about it.

71. The family liaison officer told the investigator that the chaplaincy team did not tell him that they intended to hold a memorial service and when he found out, he did not have time to tell Mr Kirkpatrick's family. This was unfortunate, and not in line with the national instruction. We make the following recommendation:

The Governor should ensure that families of deceased prisoners are consulted about and invited to memorial services held at the prison.

Prisons & Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141