

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Johnson a prisoner at HMP Leeds on 24 June 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

Mr Matthew Johnson was found hanging in his cell at HMP Leeds on 22 June. He died in hospital two days later, without regaining consciousness. He was 28 years old. I offer my condolences to Mr Johnson's family and friends.

Mr Johnson had been at Leeds for just over a day. He arrived with well documented risk factors and repeatedly expressed his intention to kill himself. Staff began Prison Service suicide and self-harm prevention procedures when he arrived, but failed to recognise the severity of his risk and did not do enough to support a very vulnerable man during his early days in prison for the first time. It is troubling that, yet again, I have to raise concerns about the failings of suicide and self-harm procedures at HMP Leeds, failings, which the prison has previously committed to address.

I am also concerned that, because of a continued shortage of space in the vulnerable prisoners' unit, Mr Johnson was essentially segregated and given a very restricted regime, on the first night centre. The centre has been criticised by HM Inspectorate of Prisons as an impoverished facility and this can only have compounded Mr Johnson's vulnerabilities.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2017

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Summary

Events

1. On 20 June 2016, Mr Matthew Johnson was arrested and charged with raping his ex-partner. He had a history of mental health problems, suicide attempts and self-harm and had threatened to kill himself if he was remanded to prison. While in police custody, he banged his head against the cell wall. The police noted his risks on various documents.
2. At court on 21 June, Mr Johnson was remanded to HMP Leeds. Court escort staff completed a suicide and self-harm warning form, which together with the risk information recorded by the police arrived with Mr Johnson at Leeds. Prison reception staff began suicide and self-harm monitoring procedures (known as ACCT). Mr Johnson applied for vulnerable prisoner status because of the nature of his alleged offence but, as is normal practice at Leeds, he was spent his first night in a cell on the first night centre.
3. As there were no spaces on the vulnerable prisoners' unit, Mr Johnson remained in the first night centre after his first night in the prison. Because of the nature of his alleged offence, it was not considered safe for him to mix with other prisoners. As a result, Mr Johnson spent most of the time locked in his single cell, without a television, radio, books, or time in the fresh air. He was also subject to public protection monitoring procedures, so was not able to make any telephone calls to his family or solicitor in his first hours in prison.
4. On 22 June, Mr Johnson told staff that he thought he would harm himself if he did not get bail at his next court appearance in July. A supervising officer reviewed the ACCT plan with Mr Johnson later that day and, despite the wealth of recorded risk information about Mr Johnson, assessed him as at a low risk of suicide and self-harm. He instructed staff to check Mr Johnson once an hour and recorded no actions to help support Mr Johnson during his first days at the prison.
5. There is little evidence of meaningful staff contact with Mr Johnson, despite his identified risk and clear vulnerabilities. The last recorded entry in his ACCT plan was at 6.00pm that evening. At about 8.00pm, a prisoner who was passing Mr Johnson's cell saw that he was hanging from a sheet tied to the window bars. The prisoner alerted staff, who tried to resuscitate Mr Johnson. Paramedics stabilised Mr Johnson and transferred him to hospital. He did not regain consciousness and died two days later.

Findings

6. We found that, although staff identified that Mr Johnson was at risk of suicide and self-harm, they did not assess the severity of his risk or manage the ACCT process effectively. Despite his well documented risk factors and clear and repeated statements of intent to kill himself, staff took the view that he posed a low risk of suicide. That he was essentially isolated on the first night centre, with no meaningful regime and little apparent staff contact, compounded his vulnerability.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
 - Holding multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews.
 - More than one member of staff completing ACCT reviews.
 - Considering all known risks when assessing a prisoner's level of risk during an ACCT case review.
 - Setting clear responsibilities for undertaking and recording ACCT observations, which managers check to ensure they happen.
 - Setting caremap actions aimed at reducing a prisoners risks, which are reviewed and updated as necessary.
- The Governor should ensure that vulnerable prisoners held in the first night centre and those for whom there is no room on the vulnerable prisoners' unit, have a full regime and are checked regularly to ensure their wellbeing, particularly during their early days in custody.

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 her. No one responded.
8. The investigator visited Leeds on 27 June 2016. She obtained copies of relevant extracts from Mr Johnson's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Johnson's clinical care at the prison.
10. The investigator interviewed 11 members of staff and a prisoner at Leeds in July and August. The clinical reviewer and the investigator jointly interviewed some healthcare staff.
11. We informed HM Coroner for West Yorkshire (Eastern) of the investigation who sent us Mr Johnson's toxicology results and the results of the post-mortem examination. We have given the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Johnson's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They were sent a copy of the initial report, and noted that Mr Johnson's time of death was incorrect.

Background Information

HMP Leeds

13. HMP Leeds is a local prison holding up to 1,120 men. In April 2016, Care UK took over primary and mental health care provision.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Leeds was in December 2015. Inspectors identified failings in reception, including that reception staff did not always pass on key information about newly arrived prisoners' vulnerabilities. They reported that staff were unable to support all new prisoners effectively, which was consistent with concerns raised by the Prisons and Probation Ombudsman in recent investigations into deaths in custody. The first night centre routinely held a number of men who, because of their offence or some other reason, required accommodation on a vulnerable prisoners' wing. A lack of spaces meant that these prisoners spent prolonged periods in the first night centre. In addition, first night cells were dirty and poorly equipped and, given the relative vulnerability of this group of prisoners, inspectors found this particularly unacceptable.
15. Levels of self-harm at the prison had increased significantly since the last inspection in 2013. Inspectors found that ACCT processes were poorly managed; many ACCT reviews were not multidisciplinary and many were carried out by only one member of staff. Few cases had a consistent case manager and no key workers were identified. Some ACCT plans included good assessments, but, overall, procedures needed to improve.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest report, for the year to December 2015, the IMB considered that ACCT documents were not well completed and that there was a shortage of ACCT assessors.
17. The IMB reported that the first night centre was overcrowded because of a large number of vulnerable prisoners unable to be accommodated elsewhere, some of whom spent weeks in the first night centre.

Previous deaths at HMP Leeds

18. Mr Johnson's death was the fourth apparently self-inflicted death at Leeds in 2016. In previous investigations published in 2014, 2015 and 2016, we have raised concerns about staff at Leeds properly assessing risk, and the management of ACCT procedures.

Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner.

20. 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 multidisciplinary 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 on the caremap have been completed.
21. 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

20 June 2016

22. On 20 June 2016, Mr Matthew Johnson was arrested and charged with raping his ex-partner. He was examined by a nurse at the police station who noted that Mr Johnson had tried to hang himself in 2007, had drunk bleach in 2008, and had a history of mental health problems including a diagnosis of personality disorder and schizophrenia when he was 19 years old and, latterly, depression. While in his cell, Mr Johnson banged his head on the wall and threatened to kill himself, so the police constantly supervised him and the nurse treated a cut and swelling on his head.
23. Mr Johnson told the nurse that, if the court remanded him to prison the next day, he would bite off his tongue in the dock and choke on it. The nurse noted this on Mr Johnson's Person Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) and wrote a letter to escorting staff outlining Mr Johnson's mental state and risk. The nurse wrote that Mr Johnson should be assessed by the court mental health team and that prison staff should begin suicide and self-harm monitoring procedures (known as ACCT) if he was remanded.

21 June 2016

24. On 21 June, Mr Johnson appeared in court. There is no evidence that the court mental health team assessed him, but court escort staff completed a suicide and self-harm warning form detailing his threats to bite off his tongue and swallow it. Mr Johnson was refused bail and remanded to HMP Leeds, to appear in court again on 19 July 2016. This was his first time in prison. Prison reception staff received a copy of Mr Johnson's PER, a police risk assessment form, the nurse's letter and the suicide and self-harm warning form, all of which detailed his risk of suicide and self-harm.
25. A Supervising Officer (SO), the reception manager that evening, asked an officer to begin ACCT monitoring. The officer completed the ACCT 'concern and keep safe form' noting that Mr Johnson had arrived at Leeds with a suicide and self-harm warning form and had said he would bite off his tongue and swallow it.
26. A healthcare administrator saw Mr Johnson and took details about his health. Mr Johnson said he had no concerns about his physical health and was not on any medication, but had thoughts of suicide and self-harm because of the allegations against him and his previous mental health issues. Mr Johnson's electronic medical records contained entries from his community GP, which discussed his depression and treatment in 2011.
27. A little later, a nurse assessed Mr Johnson and noted that he felt low, had not been in prison before, and seemed pessimistic about the future. Mr Johnson said he would rather be dead and that he planned to kill himself. He told her that he had head-butted a wall in police custody the day before. Mr Johnson said he had been prescribed antidepressants in the past, but was not currently prescribed any and that he had spent time in a psychiatric hospital when he was a child. Mr Johnson said he had difficulty sleeping and missed his children. She

asked if he would like to see a doctor about his sleeping problems, but he declined. She urgently referred Mr Johnson to the prison's mental health team (meaning he would be seen within 72 hours). Mr Johnson said he used cannabis daily and she explained how he could access help for this. It is not clear whether she referred him to the prison's substance misuse service.

28. Reception staff assessed Mr Johnson as unsuitable to share a cell because he said he would harm any cellmate if he was made to share. Staff noted that Mr Johnson was subject to a Public Protection Order, preventing him from contacting his ex-partner (the victim of his alleged offence). This meant that Mr Johnson could not make any phone calls until staff had checked and approved each telephone number
29. A SO completed the ACCT immediate action plan, noting that Mr Johnson would be given a single cell and that he had applied for vulnerable prisoner status because of the nature of his alleged offence. The SO noted that staff should check him twice an hour until he had been assessed under ACCT procedures.
30. In line with the local procedure, staff gave Mr Johnson a cell on the first night centre until he could be moved to the vulnerable prisoners' unit. They told the investigator that his cell was close to the healthcare office, which is where they try to place vulnerable prisoners. Mr Johnson's cell was furnished with only a bunk bed, a cupboard, a toilet and a sink. Almost none of the first night cells, including Mr Johnson's, had a television, radio or any reading material. Because Mr Johnson had applied for vulnerable prisoner status and vulnerable prisoners are kept separate from the general prison population, he was subject to a restricted regime. He spent more time locked in his cell than non-vulnerable prisoners, and was only unlocked to shower and collect his meals.
31. That evening, a prisoner and the Equality and Diversity representative, introduced himself to Mr Johnson (as he did with all new prisoners). The prisoner told the investigator that he and Mr Johnson spoke a little about Mr Johnson's children. Mr Johnson said that his "missus had stitched him up" and said he was concerned about being in prison. There is no record that any first night centre staff carried out a first night interview with Mr Johnson or had any meaningful contact with him.
32. During the night, a nurse checked Mr Johnson three times for any signs of drug withdrawal (as he had reported regular cannabis use) and noted no concerns.
33. An officer carried out ACCT checks throughout the night at regular, half-hourly intervals and recorded no concerns about Mr Johnson.

22 June 2016

34. At 9.00am 22 June, a mental health nurse assessed Mr Johnson after the previous nurse's referral the previous evening. Mr Johnson told her that he had been charged with rape and that he was innocent. He said he would hang himself if he did not get bail. They discussed his history of depression and medication. Mr Johnson said medication had not helped in the past and that he did not currently want to take antidepressants. She wrote in Mr Johnson's ACCT plan that, if he was refused bail at his next court hearing, this might trigger

increased thoughts of suicide or self-harm. The nurse planned another mental health review for 13 July, before his next court appearance.

35. Later that morning, an officer assessed Mr Johnson as part of the ACCT process. Mr Johnson said that he was very angry about the allegations made against him and felt this would affect his life, even if he was found not guilty. He was worried that he would not be allowed to see his children. Mr Johnson spoke of his history of self-harm and said he was having thoughts of suicide and self-harm, particularly if he was not given bail. The officer noted that it was Mr Johnson's first time in prison and that he had reported mental health problems.
36. A little later, a nurse assessed Mr Johnson as part of a routine second day health screening. Although she noted that Mr Johnson seemed in a low mood, he said he had no thoughts of suicide or self-harm at that time.
37. Mr Johnson was assigned vulnerable prisoner status but, as the vulnerable prisoners' unit was full, he remained on the first night centre and subject to the restricted regime. Staff told the investigator that the first night centre was short staffed, so no one was available to take vulnerable prisoners to the vulnerable prisoners' unit for association (when prisoners are unlocked and able to socialise with each other) or to use the exercise yard.
38. That afternoon, Mr Johnson attended his first ACCT case review with a SO. The SO said that he and the officer discussed Mr Johnson before the case review. Contrary to national instructions, nobody from the healthcare department attended. The SO said that the healthcare department was very busy that day with a number of emergency calls, so no one was available to attend.
39. The SO noted that Mr Johnson was anxious about his charge and said that he had done nothing except sleep and talk to staff. He said he wanted to go home to see his children. The SO wrote that Mr Johnson displayed a negative attitude (but did not explain what he meant by this). Despite Mr Johnson's recorded risk factors, including his statement of intent to kill himself if he was refused bail, the SO assessed him as at a low risk of suicide and self-harm and noted that he had no clear plans to harm himself. The SO reduced the frequency of checks to once an hour, and scheduled the next ACCT review for 29 June, when he noted that the mental health team should be invited. He made no entries on the ACCT caremap and did not record contact details for Mr Johnson's next of kin. When asked in interview, he could not explain why he had not done so.
40. At 1.30pm, Mr Johnson asked an officer whether he could make a telephone call and the officer told him he would be able to after dinner. Mr Johnson also asked the SO for his solicitor's telephone number, and the SO gave him an application form to complete. Mr Johnson did not make any calls in his short time at Leeds. Staff told the investigator that they usually offer to make a call on the prisoner's behalf if they were subject to Public Protection Orders and therefore unable to make calls immediately they arrived. However, nobody could recall offering to or making a call for Mr Johnson.
41. At 6.00pm, an officer recorded in the ACCT that he had asked Mr Johnson if he was okay and Mr Johnson said he was. Although staff should have checked Mr Johnson once an hour, there were no further ACCT entries, which we assume

meant that no one checked him after 6.00pm. There is no CCTV on the first night centre, so we were unable to verify this.

42. A prisoner said that he talked to Mr Johnson through the cell door hatch at about 6.30pm. He asked if Mr Johnson was okay and Mr Johnson said he was. At about 8.00pm, he walked past Mr Johnson's cell again, looked through the observation hatch and saw that Mr Johnson was suspended by a ligature made from sheets, which was tied to the window bars. He called for help.
43. A prison manager, who was close by, heard the prisoner's cry for help and went to Mr Johnson's cell. At 8.04pm, he radioed an emergency code blue (indicating that a prisoner is not breathing, or having breathing difficulties) and also shouted for staff. The officer in the control room telephoned immediately for an ambulance.
44. The prison manager went into the cell and a SO and an officer arrived within seconds. They helped lower Mr Johnson to the floor and removed the ligature from around his neck. He and the SO both checked Mr Johnson for signs of life but found none, so started resuscitation. He recalled that he completed three rounds of chest compressions and then checked Mr Johnson, who was now breathing.
45. Five nurses and the doctor on duty arrived shortly after the code blue with emergency equipment, including a defibrillator, which administered three shocks to Mr Johnson.
46. The paramedics arrived at the prison at 8.12pm, and reached Mr Johnson's cell at 8.15pm. They stabilised Mr Johnson and, at 9.01pm, transferred him to the ambulance and took him to hospital. A prison manager and an officer went with Mr Johnson in the ambulance.

Contact with Mr Johnson's family

47. Prison staff were unable to find Mr Johnson's mother's address or contact details (despite her address being in his electronic prison record) and asked the police for help. The police gave them an address and a senior prison manager visited that evening, but the address given was incorrect. The police eventually contacted Mr Johnson's mother directly and she and Mr Johnson's uncle arrived at the hospital at 1.40am.
48. Mr Johnson was located in the hospital's critical care unit. Over the next two days he remained unconscious. On the afternoon of 24 June, hospital staff withdrew life support and Mr Johnson was pronounced dead at 5.27pm.

Support for prisoners and staff

49. The Head of Safer Custody debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. A number of staff involved in the emergency response said they had not been invited to the debrief, and the care team did not contact them. The Governor issued a Notice to Staff, informing all staff of the support available.

50. The prison posted notices informing other prisoners of Mr Johnson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Johnson's death.

Post-mortem report

51. The post-mortem report concluded that Mr Johnson died as a result of a hypoxic brain injury caused by hanging. A toxicology report showed that Mr Johnson had not taken any medication or illicit substances.

Findings

Assessing and managing Mr Johnson's risk of suicide or self-harm

52. Prison Service Instruction (PSI) 64/2011 Safer Custody and PSI 07/2015 Early Days in Custody both list a number of risk factors and potential triggers for suicide. These include being charged with an offence against a family member, first time in prison, a history of mental illness, and a history of self-harm and attempted suicide, all of which applied to Mr Johnson.
53. In police custody and after he had arrived at Leeds, Mr Johnson expressed suicidal thoughts. He was appropriately identified as at risk of suicide and self-harm by reception staff at Leeds, who began ACCT procedures. He was still subject to ACCT procedures when he was found hanging in his cell a day later. The investigation identified failings in the assessment and management of Mr Johnson's risk and the operation of the ACCT process.
54. Only Mr Johnson and a SO attended the first ACCT review on 22 June. No member of healthcare staff attended, which is a mandatory requirement of PSI 64/2011. The lack of multidisciplinary attendance is particularly troubling, given Mr Johnson's history of mental health concerns. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff.
55. Despite Mr Johnson's well documented risk factors and his repeated statements of his intent to kill himself, the SO assessed him as at a low risk of suicide and reduced the frequency of observations to once an hour. The PSI instructs that ACCT caremap actions should be completed, and should be detailed and time-bound and aimed at reducing a prisoner's risk. They should reflect a prisoner's needs, level of risk and the triggers of their distress and cover issues accordingly. The SO made no entries on Mr Johnson's caremap and could not explain why.
56. Although staff should have been checking Mr Johnson once an hour, there is no record that anyone checked him after 6.00pm on 22 June.
57. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often staff place too much weight on their perception of a prisoner and do not consider all the relevant information. We reinforced this in a recent learning lessons bulletin in February 2016, about early days in custody.
58. We consider that staff engagement with Mr Johnson was little more than superficial and clearly failed to identify and consider Mr Johnson's risk factors, take a holistic approach to managing his risk or use the ACCT process appropriately.
59. Mr Johnson had been granted vulnerable prisoner status, but a shortage of spaces on the vulnerable prisoners' unit meant he remained on the first night centre beyond his first night at Leeds. As a vulnerable prisoner, Mr Johnson was subject to a restricted regime on the centre and staff shortages meant that he largely remained effectively isolated in his single cell, with little to distract him and

little interaction with staff or other prisoners. We consider that staff's failure to properly identify his risk, their lack of meaningful contact with him, and an isolative and apparently uncaring regime that amounted almost to segregation, but without the safeguards that a segregation unit has in place, increased his vulnerability significantly. We have recently made a similar finding about assessing risk in another investigation into a self-inflicted death at Leeds. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **Holding multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews.**
- **More than one member of staff completing ACCT reviews.**
- **Considering all known risks when assessing a prisoner's level of risk during an ACCT case review.**
- **Setting clear responsibilities for undertaking and recording ACCT observations, which managers check to ensure they happen.**
- **Setting caremap actions aimed at reducing a prisoners risks, which are reviewed and updated as necessary.**

The Governor should ensure that vulnerable prisoners held in the first night centre, and those for whom there is no room on the vulnerable prisoners' unit, have a full regime and are checked regularly to ensure their wellbeing, particularly during their early days in custody.

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