Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Parker a prisoner at HMP Leeds on 14 June 2016

A report by the Prisons and Probation Ombudsman
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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*

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.

On 14 June, prison staff discovered Mr Paul Parker hanging in his cell. Nursing staff attended and attempted to resuscitate him but paramedics pronounced Mr Parker dead He was 51 years old. I offer my condolences to Mr Parker's family and friends.

Mr Parker had some complex health needs and received a good deal attention from healthcare staff, but the clinical reviewer considered that there was an absence of an overarching strategy to deal with his problems. Similarly, while prison staff rightly placed Mr Parker on suicide and self-harm prevention monitoring in the period preceding his death, the management of these procedures fell short of expected standards. This is not the first time that I have raised concerns about the quality of suicide and self-harm procedures at HMP Leeds.

In spite of these weaknesses, I recognise that there was little to indicate that Mr Parker was at high or imminent risk of suicide and I am, therefore, satisfied that staff could not have predicted or prevented his death.

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 **February 2017**

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Summary

Events

1. On 2 September 1991, Mr Paul Parker was sentenced to life imprisonment for manslaughter. He remained in custody until 1 December 2014 when he was released on conditional licence. Within 48 hours of release he assaulted a member of female staff at a probation hostel, was charged with assault and had his licence revoked. He was returned to custody at HMP Leeds.

2. Shortly after his arrival at Leeds, Mr Parker's probation officer contacted the healthcare team and alerted them to Mr Parker's mental health history. As a result, the mental health team assessed Mr Parker. Mr Parker was diagnosed with depression and was prescribed medication. He continued to receive support from the mental health team regularly until 21 August 2015, when it was agreed that he no longer required this.

3. Mr Parker had been managed under Prison Service suicide and self-harm procedures (known as ACCT) 11 times between 2008 and 2014. He was also subject to ACCT monitoring between July 2015 and August 2015 after Mr Parker told staff that he felt vulnerable due to other prisoners knowing about his previous offences.

4. On 3 June 2016 it was established that Mr Parker had not been leaving his cell for several days, and had not been eating. An ACCT was opened. Mr Parker said that he had been receiving verbal abuse from other prisoners. An application for Mr Parker to be placed on the vulnerable prisoner wing was completed but he was moved to the induction wing, as there were no spaces immediately available on the vulnerable prisoner unit.

5. On 6 June, Mr Parker began shouting abuse and making threats to assault any member of staff who entered his cell. He had armed himself with a pair of electrical hair clippers and proceeded to set fire to items in his cell. The fire and ambulance services were called, and prison staff wearing protective clothing entered the cell and removed Mr Parker under restraint. Mr Parker was sent to hospital before returning to the prison the same day. He was initially held in the segregation unit before being returned to the wing from which he had come.

6. On 8 June, an ACCT review was completed and it was recorded that Mr Parker presented as confused when he arrived in the room, and spoke about other prisoners talking about him. Nursing staff present recorded that Mr Parker was presenting as paranoid and believed that people knew about his previous offences. Over the next few days, Mr Parker continued to be seen and monitored both by mental health nurses and primary care nurses. Nursing staff said that they had no concerns regarding Mr Parker's safety, and their concerns related to his physical well-being and its impact on his mental health.

7. On 14 June, at around 1.05am, Mr Parker was found suspended from the cell window with a ligature around his neck. When prison staff and nurses entered the cell, no signs of life were present and they began cardiopulmonary

resuscitation (CPR.) Paramedics arrived quickly, took over resuscitation, but despite their best efforts, Mr Parker was pronounced dead at 1.24am.

Findings

8. Mr Parker's period of monitoring under ACCT between 3 June and 14 June was poorly managed. Although he was not formally admitted to the segregation unit, mandatory actions that are to be carried out during any period in segregation were not completed and factors that indicated an increased risk were not immediately followed up.

9. We are satisfied that staff acted appropriately when Mr Parker stated that he felt unsafe and that appropriate action was taken in moving him to other areas where he felt safe.

10. The clinical reviewer concluded that the majority of care Mr Parker received from individual health professionals was appropriate. However, she identified the lack of an overarching strategy to deal with a man with complex and challenging health problems combined with escalating high-risk behaviours and self-harm. She feels that a shared strategy would have ensured relevant information was shared promptly between prison and healthcare staff.

11. In spite of our concerns about the management of the ACCT procedures, there was little to indicate that Mr Parker was at high or imminent risk of suicide and we are satisfied that staff could not have predicted or prevented his death.

Recommendations

- The Governor must ensure that staff always manage prisoners at risk of suicide or self-harm in line with national instructions, including ensuring that:
    - Prisoners on open ACCTs are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances within the ACCT document.
    - Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate, and healthcare staff attend all first case reviews.
    - Staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk, such as further self-harm.
    - All staff receive adequate ACCT training to ensure that they are both confident and competent to carry out the role expected of them.
    - Staff set ACCT caremap actions, which aim to reduce prisoners risks to themselves, and review at each subsequent case review.

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

The Investigation Process

12. 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 responses were received.

13. HMP Leeds provided copies of relevant extracts from Mr Parker's prison and medical records.

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

15. The investigator interviewed eleven members of staff at Leeds.

16. We informed HM Coroner for Wakefield of the investigation. The Coroner provided the post-mortem results, which give the cause of death as hanging. Toxicology indicated that no illicit substances were present in Mr Parker's system.

17. One of our family liaison officers contacted Mr Parker's sister and brother to explain the investigation. Mr Parker's siblings raised the following issues:

    - The family believed Mr Parker damaged his cell approximately five or six weeks prior to his death and asked for details. They asked whether Mr Parker was relocated to the segregation unit after this.
    - The family said that Mr Parker had been suffering with serious nerve and back pain and asked for details of how the prison was managing his care.
    - The family asked for details and circumstances of the fire in Mr Parker's cell.

18. Mr Parker's family provided no response to the initial report or the recommendations that have been made.

Background Information

HMP Leeds

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

HM Inspectorate of Prisons

20. The most recent inspection of HMP Leeds was in December 2015. Inspectors identified failings in reception and induction processes and found that ACCT processes were poorly managed and many ACCT reviews were not multidisciplinary. Some ACCT plans included good assessments, but, overall, procedures needed to improve. Levels of self-harm at the prison had increased significantly since the last inspection in 2013, and there had been several self-inflicted deaths. Inspectors were concerned that some issues identified following earlier PPO investigations into recent deaths still needed to be fully addressed.

21. Inspectors also found that violence had significantly increased among prisoners, and that New Psychoactive Substances (NPS) were a factor. A prisoner survey indicated that many prisoners felt unsafe at times. The Inspectorate concluded that fundamental safety issues were destabilising the prison and needed to be addressed urgently.

Independent Monitoring Board

22. 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. They were also concerned about the level of violent incidents among prisoners.

Previous deaths at HMP Leeds

23. Mr Parker's death was the third apparently self-inflicted death at Leeds in 2016, and another prisoner has apparently taken his own life at the prison since then. 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 (ACCT)

24. 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.

25. 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 (a 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.

26. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody).*

Key Events

27. Mr Parker pleaded guilty to manslaughter on grounds of diminished responsibility, and was sentenced to life imprisonment on 2 September 1991. He was released from custody on licence on 1 December 2014. Within 48 hours of release he assaulted a member of female staff at a probation hostel, was charged with assault and had his licence revoked. He pleaded guilty on 2 December and was sentenced to three years imprisonment.

28. Mr Parker had a long history of self-harming behaviour and, while in custody, had been managed him under prison service suicide and self-harm procedures (ACCT) 11 times between 2008 and 2014. Prior to his release on 1 December 2014, his last period on an ACCT was between February and May 2014.

29. On 4 December 2014, when Mr Parker arrived at Leeds, a nurse recorded that Mr Parker had been recalled to prison, had a history of sexual offences, and had applied for vulnerable prisoner status. The nurse also recorded that Mr Parker suffered from sciatica, and had been prescribed gabapentin, which Mr Parker said he had brought into custody with him. Mr Parker did not disclose previous mental health problems at reception, despite having a history of mental health treatment. He denied any thoughts or intention of self-harm or suicide. The healthcare department at Leeds also provided information regarding Mr Parker's clinical history, confirming personality disorder, obsessive-compulsive disorder, a learning disability and a long history of self-harm and attempted suicide. Mr Parker was referred to the mental health team as a non-urgent referral for further assessment. Following reception procedures, Mr Parker was initially located on D wing - the induction wing at Leeds.

30. On 15 December, mental health nurse visited Mr Parker for a mental health triage. She recorded that Mr Parker was settled and engaged well, he denied being under the influence of drugs and alcohol at the time of the offence that resulted in his recall. A prison GP assessed Mr Parker later that day and recorded that he was "feeling depressed since his re-imprisonment, had some thoughts of self-harm but would not act on them". The GP prescribed Mr Parker sertraline (an anti-depressant.) On 30 December, the mental health nurse completed a full mental health assessment. The assessment indicated that Mr Parker was demonstrating increased levels of anxiety and depression. However, no additional treatment was prescribed alongside that already prescribed by the GP.

31. Later in December, Mr Parker moved from the induction wing to A wing, where he settled well. He began attending the prison workshops. Mental health staff saw him weekly to provide ongoing support. He engaged well with the mental health team, and continued to receive regular support. During meetings with mental health staff and a psychiatrist between December 2014 and July 2015, Mr Parker often mentioned feeling anxious and on occasions feeling vulnerable. He was supported appropriately and, when asked, denied any thoughts of intentions of self-harm.

32. On 11 July 2015, Mr Parker spoke to a pharmacy technician, who opened an ACCT procedures document after Mr Parker told her that he was feeling

suicidal and that other prisoners wanted to kill him. An ACCT review recorded that Mr Parker claimed that other prisoners had bullied him on the wing for tobacco and he requested to be moved from A wing. A nurse said that Mr Parker became tearful and said he felt staff were not listening to him. Mr Parker said that he was not taking fluids but denied that he wanted to die. The nurse recorded that he considered Mr Parker's presentation to be a 'cry for help', as he felt threatened. The ACCT review concluded that there was no evidence of increased risk, and Mr Parker should remain on hourly observation until staff could facilitate a move from A wing to E wing. Two days later, a mental health nurse spoke with Mr Parker following referral. She recorded that he claimed to have been bullied and was feeling vulnerable. In her view, Mr Parker presented no risk of self-harm but was at risk of self-neglect. On 16 July, a nurse and a locum GP saw Mr Parker. It was concluded that Mr Parker's sertraline would be raised, ACCT observations would be increased to half hourly and the primary care team would monitor Mr Parker until his move to E wing.

33. The ACCT remained open until 4 August when, following a case review, staff decided that it could be closed. Although the mental health team had been providing regular support to Mr Parker, there is no indication that they were involved in the review or the decision to close the ACCT.

34. Mr Parker continued to be support by the primary care mental health team. On 21 August 2015, the mental health team recorded that he had no mental health issues evident and did not require further support. Mr Parker was informed of the decision and agreed that he would contact the team if he needed assistance. From this point onwards, Mr Parker attended work in the kitchens daily, was said to have engaged well on E wing. There were no further issues reported until June 2016.

1 June - 14 June 2016

35. On 1 June, a nurse examined Mr Parker in his cell after staff raised concerns. She recorded that Mr Parker was able to move around his cell and did appear to be in pain from his lower back. She confirmed that Mr Parker was due to see the GP. While being assessed, Mr Parker told her and the officers present that he did not feel safe on E wing, as he believed other prisoners were aware of his offence.

36. On 3 June, a Supervising Officer (SO) recorded that, after speaking with Mr Parker, she had established that he had not left his cell for several days, and had not been eating. She recorded that Mr Parker had been spoken to about his concerns, but was unwilling to provide any names, and at this time, declined a move to another wing. She said that after speaking with Mr Parker she did not at that point feel that an ACCT was necessary. She also spoke with the mental health team, who were aware of Mr Parker, as he was on their list for assessment. Later that afternoon, after discussing the situation with colleagues, she said that despite her initial view she decided to open an ACCT to provide Mr Parker with additional support. She said that Mr Parker was not happy with this and stated that he had no thoughts of self-harm.

37. On 4 June, an ACCT assessment was completed during which Mr Parker said that he had back pain caused by a trapped nerve. He also said that he had received verbal abuse from other prisoners but was not keen to move wings. Following the assessment, a SO chaired an ACCT case review attended by a mental health nurse. During the review, Mr Parker spoke about feeling under threat due to a previous sexual offence. He said that once he felt safe he would start eating again. It was agreed that the mental health team would provide support and an appointment would be arranged for Mr Parker to attend The Harbour, a separate, dedicated mental health unit at Leeds. An application for Mr Parker to be placed on the vulnerable prisoner wing was also completed but, as no spaces were immediately available, he was initially moved from E wing to D1 landing, induction wing.

38. The nurse also recorded that Mr Parker was refusing food, which he said was because of the threats he had received. She recorded that this was something he had done a number of times during his 26 year sentence. She wrote that up to this point Mr Parker had been working, and was a 'model' prisoner. She recorded that he denied any thoughts or intentions of suicide, but that in the past he had taken food refusal to extremes. Primary care nurses were asked to assess Mr Parker's back pain and she arranged a further mental health review for 22 June.

39. Later that afternoon, a nurse visited Mr Parker on D wing at the request of the previous nurse. She recorded that Mr Parker had eaten some lunch, but said that he did not want to consume too much as he had not been eating. He told her he was drinking tea, and that he felt better since moving from E wing. Mr Parker said that he was not on a formal food refusal but had felt under threat.

40. On 6 June, at approximately 9.00am, without reason or provocation, Mr Parker began shouting abuse and making threats to assault any member of staff who entered his cell. He had armed himself with a pair of electrical hair clippers and set fire to items in his cell. The fire and ambulance services were called and prison staff wearing protective clothing entered the cell and removed Mr Parker under restraint. Staff said that Mr Parker put up significant resistance. Once he was out of the cell, nursing staff at the scene assessed Mr Parker.

41. A nurse said that when she arrived on D wing staff had already called an ambulance. She said that Mr Parker was able to speak in full sentences but was clearly unwell. His oxygen levels were low so he would have been light headed and dizzy, but she saw no visible injuries. She remained with Mr Parker until paramedics arrived and he was transferred to hospital.

42. At hospital, an escorting officer noticed marks on Mr Parker's neck. When he asked him about these, Mr Parker said that, while in his cell, he had wrapped the cord of the hair clippers around his neck and had been in and out of consciousness. A consultant in Accident and Emergency assessed Mr Parker and recommended that he be monitored every 30 minutes for the next six hours due to smoke inhalation. Mr Parker refused the recommended treatment and asked to return to prison.

43. Notices displayed in the reception area at Leeds inform staff that when a prisoner is returned from a hospital appointment in the community or other

external escort, nursing staff should be informed. However, when Mr Parker was returned to Leeds at approximately 1.00pm, the escorting staff were instructed to take him directly to the segregation unit. It is not clear why, and there is no evidence that prison staff working in the reception area saw Mr Parker or that nursing staff were informed that he had returned.

44. A Custodial Manager (CM) was duty manager in the segregation unit on 6 June. He said that he had no prior knowledge of Mr Parker and had not been informed that he would be arriving. He said that the escorting officers informed him that Mr Parker had set fire to his cell on the first night unit that morning, he had been treated in hospital for smoke inhalation, and that officers had been instructed by the duty manager to bring Mr Parker directly to the segregation unit on their return to the prison.

45. The CM contacted the duty manager, who asked him to keep Mr Parker on the unit until staff could find alternative accommodation. He said that he explained to Mr Parker that he would house him in the holding room while the unit staff dealt with the normal routines on the unit. He said he raised Mr Parker's ACCT observations to five per hour, which is standard at Leeds for any prisoner held in segregation who is subject to ACCT monitoring.

46. The CM said that if Mr Parker was to have been held on the unit formally, he would have made a formal assessment of risk but as he was lodged there temporarily, he did not do so. Mr Parker was provided with a meal and checked regularly.

47. Staff reported that Mr Parker had removed his clothes. The CM asked Mr Parker, who was squatting in the corner of the room, what he was doing. He said that Mr Parker refused to go anywhere until he had had family contact. Mr Parker explained to him that his phone numbers had been burned in the cell fire and he wanted to speak to his sister and my brother. He said that Mr Parker stated that he would not put his clothes back on until the matter was resolved.

48. The CM said it was clear to him that Mr Parker was not fit to be held on the unit so he contacted a governor at Leeds with responsibility for the segregation unit. He explained what was happening and outlined his concerns. In the meantime, he obtained Mr Parker's approved telephone numbers, along with additional credit for the prisoner telephones.

49. The CM and the governor both spoke to Mr Parker, who began dressing when told of the additional phone credit. The CM said that Mr Parker requested new shoes and he told him that staff would get him fresh clothes, as it was obvious he was still wearing the clothes he had on that morning. He and the governor asked Mr Parker where in the prison he felt safe. Mr Parker replied that he had been on E wing and felt safe there, and said he would be happy to return there. He said that Mr Parker did not mention any concerns about E wing and that he himself was unaware of the earlier issues that had led to Mr Parker's move to D wing. He said that had he been made aware that Mr Parker had been moved off E wing and was awaiting a space on the vulnerable prisoner wing at the time he set fire to his cell, then he would not have arranged for him to return to E wing.

50. The CM said that many prisoners want to go to E wing because it is smaller and more settled. He instructed a member of staff to try to secure a space for Mr Parker on E wing, and while this was being done, allowed Mr Parker to use the telephone. He said that Mr Parker spoke to his sister or brother for about ten minutes. He said that he did not have any immediate concerns for his well-being as he was going somewhere he said he felt safe, he had been given a meal and fresh clothes, enjoyed the family telephone contact and appeared happy.

51. A Supervising Officer (SO) was also on duty in the segregation unit on 6 June. He said that he had spoken with Mr Parker and had provided him with a hot meal and fresh clothes. He said that Mr Parker had been on the unit for around two hours when he was informed that a space had been found for Mr Parker on E wing, and he was asked to escort him across.

52. The SO said that he noticed in Mr Parker's paperwork that he had applied for vulnerable prisoner (or 'VP') status. He said that he decided to carry out what he described as an "ad hoc" ACCT review. (While a review was required this did not conform to proper procedures.) He said that apart from initial ACCT training he had not received any other training since he had been promoted to supervising officer.

53. The ACCT review took place in the segregation holding room and the SO said that no one else was present. He said that his objective was to listen to any concerns that Mr Parker may have had about moving to a new location. Mr Parker said that he did not wish to remain in the segregation unit, and was happy to return to E wing; he knew the staff and had been employed in the kitchen. He said that he reduced the frequency of observations from five per hour, to hourly, before escorting Mr Parker to E wing.

54. The SO said that, on reaching E wing, he spoke with the wing manager. He said it was his belief that a full multi-disciplinary ACCT review would take place once Mr Parker had been found a cell. Healthcare staff had not seen Mr Parker while he was on segregation, nor was he seen by any healthcare staff when located on E wing. No further reference to the cell fire was made.

55. At approximately 7.20am the following morning, a SO answered the cell call bell in the cell occupied by Mr Parker. She told the investigator that she was initially surprised to see him as she was unaware that Mr Parker had returned to E wing. Her last contact with him had been on 4 June, after she had helped to arrange a move for Mr Parker out of E wing where he had stated he was under threat.

56. Mr Parker showed the SO superficial cuts he had made to his forearms. She said it was not clear whether the cuts were fresh, and they looked to her as though they were old injuries. In discussion with her, Mr Parker said he was happy to remain on E wing and had no thoughts of self-harm. She said that she was aware that Mr Parker was due an ACCT review the following day, so decided to see how matters developed and told Mr Parker to let her know if anything changed.

57. The SO said that, in her opinion, the level of risk that Mr Parker posed to himself had not changed, and hourly observations were sufficient. She said that, after speaking to Mr Parker, she had contacted nursing staff to inform them of his injuries. As they were not life threatening she would not expect them to respond immediately.

58. Just before 1.00pm, two nurses were on E wing when staff asked them to see Mr Parker. One nurse recalled that he had some superficial cuts to both arms. These were cleaned and dressed. She said that this was the first she was aware that Mr Parker had cut himself. She said that regardless of the severity, if prisoners cut themselves and staff inform nursing staff, then the prisoners would be seen as soon as possible.

59. On 8 June, an ACCT review was completed, chaired by a SO and attended by a mental health nurse. The nurse recorded that Mr Parker presented as confused and paranoid and believed that people knew about his previous offences. Mr Parker said that he had previously been asked whether he had used NPS (new psychoactive substances). Although he had initially denied this, he now said that when he had moved from E wing to D1 landing another prisoner had given him a cigarette containing NPS. The ACCT review added no new actions to the caremap, and there was nothing detailed to indicate how or what would be done to support him further. Mr Parker was due to attend the segregation unit later that afternoon for adjudication in relation to the cell fire. The nurse contacted the unit and told them that Mr Parker's mental health had deteriorated and, in her opinion, he would benefit from not attending. The adjudication took place the following day instead.

60. Over the next few days, Mr Parker continued to be seen and monitored by both mental health nurses and primary care nurses. He was also seen by a psychiatrist in his cell on 9 June, along with a nurse. The psychiatrist diagnosed a depressive episode and prescribed 20mg citalopram (an anti-depressant) and the nurse followed this up the next day. She was unable to speak to Mr Parker for long but told the investigator that she had no concerns regarding self-harm at the time although was concerned about his physical deterioration. She felt he should undergo a social needs assessment.

61. On 12 June, wing staff asked a nurse to speak with Mr Parker, as they were concerned about his mental state. The nurse recorded that Mr Parker was sat in the corner of his cell with his head in his hands, refusing to engage. Mr Parker only responded by saying that he was "done with talking". The nurse told Mr Parker that there were always staff to speak to and other support if needed, although she did not specify what this support was. The nurse recorded that Mr Parker should continue to be supported by the ACCT. The nurse no longer works at Leeds and was unavailable for interview. It is not clear whether any ACCT review was considered following the nurse's contact with Mr Parker, but none is recorded.

62. On 13 June, a nurse visited Mr Parker again. Two other nurses were attempting to take scheduled blood tests but Mr Parker was declining. She said that, otherwise, Mr Parker appeared more talkative than he had previously and more alert. She said she had no concerns regarding Mr Parker's safety but had

concerns regarding his physical well-being and the impact this was having on his mental health.

63. On 14 June, at around 1.05am, an Operational Support Grade (OSG) was on duty on E wing. She went to cell E3-24, occupied by Mr Parker to check on him as part of the ACCT procedures. She had last checked on Mr Parker at 12.00am, and recorded that he was lying in bed on his right side and that she had seen movement. When she looked into the cell at approximately 1.05am, she saw Mr Parker suspended from the cell window with a ligature around his neck. She called to a nurse who was on the wing, and the nurse used her radio to call an emergency code blue.

64. The control room recorded the code blue call at 1.08am and an ambulance was requested immediately. The night orderly officer heard the emergency call over his radio at approximately 1.08am and made his way directly to E wing. He said that it only took him about a minute to get to E wing and, en route, he confirmed with the control room that an ambulance had been requested using his radio. When he arrived at E3-24, at approximately 1.10am other staff had also arrived and he unlocked the door. Two officers entered the cell; they cut the ligature from around Mr Parker's neck and lowered him to the floor. No signs of life were present and nursing staff began CPR.

65. Paramedics arrived and quickly and took over attempts at resuscitation. However, despite their best efforts, Mr Parker was pronounced dead at 1.24am.

Contact with Mr Parker's family

66. A custodial manager was appointed as the prison's family liaison officer. The Duty Governor visited the home of Mr Parker's sister and informed her of her brother's death. The custodial manager then took over liaison with the family and offered condolences and support. He informed the family of the processes that would follow and answered any immediate questions. The prison contributed to the funeral costs, in line with national policy.

Support for prisoners and staff

67. After Mr Parker's death, a governor de-briefed the staff involved. Members of the staff care and welfare team made themselves available to those staff that required their support.

68. The prison posted notices informing other prisoners of Mr Parker's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by Mr Parker's death.

Post-mortem report

69. The Coroner has confirmed that the initial post mortem concluded that the cause of death was hanging. Results from toxicology indicate that Mr Parker had not taken any illicit substances prior to his death.

Findings

Assessment, care in custody and teamwork (ACCT)

70. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody*). During his recent period at Leeds, Mr Parker was subject to ACCT monitoring twice. The first ACCT was opened in July 2015 and remained open until 4 August, with mental health staff attending or providing input into most case reviews. Despite having regular contact with Mr Parker at the time, it is not clear whether the mental health team were involved in the decision to close the ACCT in August 2015. The second ACCT was opened on 3 June 2016 when Mr Parker said he felt unsafe on the wing and as a result had not been collecting meals, although he had been taking fluids.

71. A full ACCT assessment and a first case review, chaired by a SO and attended by mental health staff, were completed. Mr Parker agreed to move to the vulnerable prisoner unit, but due to lack of space was given a cell temporarily on the first night unit, D wing. ACCT observations were set hourly.

72. On 6 June, Mr Parker set fire to his cell on D wing and required treatment in hospital. Mr Parker refused treatment and asked to return to the prison. However, while at hospital, escort staff noted marks on Mr Parker's neck which Mr Parker said were caused when he had wrapped electrical flex around his neck. Staff recorded this in the ACCT document. When they returned Mr Parker to Leeds, there is no evidence to suggest that the escort staff highlighted the marks to anyone. Mr Parker was taken straight to the segregation unit to be held temporarily, while an appropriate cell was found for him on a residential unit. Nursing staff did not see Mr Parker on his return from hospital or while on the segregation unit. Mr Parker was held on the unit for around two hours.

73. In relation to segregation, PSI 64/2011 states that:

- *'Prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include other options that were considered and discounted.'* The reason for Mr Parker's location in segregation and other options considered were not recorded in his ACCT.

- *'The ACCT plan must be reviewed as soon as it is practicable prior to location in the segregation unit or immediately thereafter.'* It is accepted that Mr Parker's ACCT could not be reviewed prior to his location in the unit as he was at hospital. However, no formal or appropriate review of the ACCT in line with procedures set out in PSI64/2011 took place while Mr Parker was on the unit.

- *''When a move from a Segregation Unit is planned, a pre-discharge case review must take place before a prisoner is returned to normal location.'* A SO carried out what he described as a case review, but this was not in line with the expectations of an ACCT review as set out in PSI 64/2011.

- *'The residential manager, or equivalent (or case manager if different) from the receiving residential unit must be invited to the pre-discharge review. If it is not possible, a representative from the residential unit must attend in order to ensure that all relevant information and risk is shared and understood.'* He conducted the review on his own; no-one from E wing was asked to attend. Although he said that he gave a handover to E wing staff when he located Mr Parker, this did not form part of a case review.

- *'The case manager must complete the 'review prior to discharge from segregation' form and update the caremap, frequency of conversations and observations and trigger factors on the front cover of the ACCT as required.'* The stated form was not completed for Mr Parker. While in segregation, he had been observed five times per hour, as per segregation policy. However, when he returned to E wing, observations returned to hourly.

74. Staff noted the marks on Mr Parker's neck while at hospital and he had said these were self-inflicted. On 7 June, Mr Parker showed a SO cuts to his arms which, he again stated, were self-inflicted. PSI 64/2011 states that '*in addition to planned case reviews, where an ACCT trigger is activated (i.e. event actually occurs) or there are other concerns such as an increase in frequency or lethality, e.g. from cutting to using ligatures, or information is received from family or friends or other external parties, a case review must be held.'* Case reviews did not take place as a result of the two acts of self-harm reported by Mr Parker.

75. It is a requirement for all staff working in prisons with direct prisoner contact to have received Suicide and Self-harm Awareness training. It is also a requirement for separate Case Manager training to be provided to staff at the level of Supervising Officer or above who are expected to undertake this role. Neither SO have received such training.

76. In relation to the management of the ACCT process at Leeds we make the following recommendations:

The Governor must ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, ensuring that:

- **Prisoners on open ACCTs are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances within the ACCT document.**
- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attending first case reviews.**
- **Staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk i.e. further self-harm.**
- **Staff receive adequate ACCT training to ensure that they are both confident and competent to carry out the role expected of them.**
- **Staff set ACCT caremap actions, which aim to reduce a prisoner's risks to themselves and review at each subsequent case review.**

Assessing changes to risk

77. Prison Service Order 3050, *Continuity of Healthcare for Prisoners*, indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase someone's risk of suicide and self-harm. Prisons are requires to have protocols to screen prisoners passing through reception for any potential healthcare or suicide/self-harm issues.

78. Mr Parker had been to hospital in the community following a cell fire and was on an open ACCT document. Nursing staff at Leeds told the investigator that following a previous recommendation by the Prisons and Probation Ombudsman notices were displayed in the reception area at Leeds informing staff that a nurse should be informed and see any prisoner returning to the prison from outside the establishment. We are concerned that, despite efforts being made to implement our previous recommendation, staff were still failing to follow the mandatory procedures of PSO 3050 and nursing staff missed an opportunity to assess Mr Parker's risk and well-being after the cell fire. We repeat the recommendation:

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

Clinical care

79. The clinical reviewer concluded that the majority of care Mr Parker received from individual health professionals was appropriate. However, she states that the overriding issue in this case was the absence of an overarching strategy to deal with a man with complex and challenging health problems, combined with some high-risk behaviours and self-harm. She says that a shared strategy would have ensured relevant information was shared promptly between prison and healthcare staff.

80. Individual contacts with health staff were reasonable and there was evidence of good attention to Mr Parker's needs. However, the clinical reviewer comments that there was little evidence of a coordinated approach between healthcare and the prison, which she says is clearly illustrated by the fact that healthcare staff were, at times, unaware that Mr Parker was on an ACCT and, equally, may not have always communicated fully their concerns to prison staff. Mr Parker had a history of self-harm and while at times he clearly stated that he would not act upon his thoughts, she says that the risk remained.

81. Mr Parker had exhibited signs of self-neglect including a loss of weight. The clinical reviewer says that while this was identified by prison staff and Mr Parker was prescribed food supplements, this seemed to come late in the day. She also comments that there was no formal care plan to inform a shared approach by health and prison staff.

82. As a result of her review of the healthcare provided to Mr Parker, the clinical reviewer has made a number of recommendations in her report, which the Head of Healthcare will need to address. We do not repeat them here.

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