Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Pallas, a prisoner at HMP Leeds, on 31 January 2020

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*

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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 Darren Pallas was found hanged in his cell at HMP Leeds on 31 January 2020. He was 40 years old. I offer my condolences to his family and friends.

Mr Pallas was monitored under suicide and self-harm prevention procedures (known as ACCT) on three occasions during his stay at Leeds. Staff did not operate some basic aspects of these procedures appropriately. However, Mr Pallas was not being monitored under ACCT procedures at the time of his death.

Mr Pallas had a history of anxiety, depression and poor sleep, and these risk factors remained during his time at Leeds. He was also concerned about his relationship with his partner. I am satisfied that Mr Pallas received appropriate physical and mental health care at Leeds and did not give any indication that he was at imminent risk of suicide or self-harm before his death

Mr Pallas's next of kin details were out of date which meant that the prison failed to contact his family about his death in a timely manner. I am also concerned that healthcare staff tried to resuscitate Mr Pallas despite the presence of rigor mortis.

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

Sue McAllister CB
Prisons and Probation Ombudsman **November 2020**

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Summary

Events

1. Mr Darren Pallas was remanded to HMP Leeds on 6 September 2019. He arrived with a suicide and self-harm warning form.

2. Prison staff opened suicide and self-harm prevention procedures, known as ACCT. It was recorded that Mr Pallas had paranoia, depression and anxiety. He was scared that other prisoners would attack him, that he would receive a long sentence and that his relationship with his partner would suffer. The mental health team supported him and prescribed antidepressants. He was monitored under ACCT procedures until 3 October.

3. Mr Pallas complained that he was not sleeping well and this affected his mental wellbeing. The mental health team repeatedly changed his antidepressants and gave him sleeping tablets.

4. On 12 November, staff started ACCT procedures after Mr Pallas told a nurse that he had harmed himself. He also disclosed that he had been sexually assaulted in prison in the past. Staff ended ACCT procedures around a week later.

5. On 29 November, Mr Pallas received a 12-year sentence. Afterwards, he said he had no thoughts of self-harm but wanted to stay at Leeds to maintain contact with his family.

6. On 15 January, staff started ACCT procedures after Mr Pallas cut his arms when he was told he had to share a cell. He felt anxious because of the historic sexual assault. Mr Pallas was supported under ACCT procedures and the mental health team reviewed his antidepressants. Staff ended ACCT procedures on 22 January.

7. On 30 January, Mr Pallas's partner phoned the prison because she was concerned about him. A safer custody officer spoke to Mr Pallas who said that he did not intend to harm himself. Staff raised no concerns about Mr Pallas that day and he interacted positively with others.

8. On 31 January, an officer found Mr Pallas hanged in his cell. The officer shouted for assistance, staff responded quickly and radioed a medical emergency code blue. Staff tried to resuscitate Mr Pallas until paramedics arrived and took over. They were unable to resuscitate Mr Pallas and pronounced that he had died.

Findings

Assessment of risk

9. When Mr Pallas harmed himself, staff appropriately monitored him under ACCT procedures. However, there were deficiencies in the way they did so. The ACCT reviews were not always multidisciplinary. His final ACCT caremap incorrectly noted that Mr Pallas had attended a GP appointment and had his medication reviewed.

Resuscitation

10. While we recognise that staff wanted to save Mr Pallas's life, rigor mortis was already present when he was found hanged in his cell. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Healthcare staff should therefore not have tried to resuscitate him.

Liaison with Mr Pallas's family

11. After his death, Leeds failed to keep in contact with Mr Pallas's family in a timely manner or appoint a deputy family liaison officer.

Recommendations

- The Governor and Head of Healthcare should ensure that:
    - prison, healthcare and mental health team staff work jointly to manage prisoners at risk of suicide and self-harm; and
    - staff do not end ACCT monitoring until all the risks noted in a prisoner's caremap have been adequately addressed and the caremap actions completed.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.
- The Governor should ensure that:
    - prisoners' next of kin details are kept up to date; and
    - when a prisoner dies in custody, a deputy family liaison officer is appointed and all contact with a next of kin is recorded to provide continuity of support in the absence of the designated family liaison officer.

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 one responded.

13. The investigator obtained copies of relevant extracts from Mr Pallas's prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Pallas's clinical care at the prison.

15. The investigator and clinical reviewer jointly interviewed members of staff at Leeds. The interviews took place on 27 and 28 February 2020.

16. We informed HM Coroner for West Yorkshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. We contacted Mr Pallas's family to explain the investigation. Mr Pallas's sister said she was informed of his death by phone and no one from the prison visited her after this. She was not happy that she had attended the prison to speak to someone about Mr Pallas's death and no one spoke to her. She wanted to know what medication Mr Pallas was taking during his time in custody.

18. Mr Pallas's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Leeds

19. HMP Leeds is a local prison holding a maximum of 1,218 prisoners on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including clinical substance misuse and mental health services. The prison has 24-hour primary healthcare cover.

20. In August 2018, Leeds was selected to be part of the "10 Prisons Project", which sought to improve safety, security and decency in the prisons involved. The project aimed to reduce violence, improve living conditions, prevent drugs from entering the prison and enhance the leadership and training available to staff.

HM Inspectorate of Prisons

21. The most recent full inspection of HMP Leeds was in November to December 2019. Inspectors found the levels of self-harm were significantly higher than other local prisons and since their last inspection. They noted that ACCT case management was not good enough despite our recommendations and the safeguarding strategy was not effective in addressing risks or the needs of individuals in crisis. Inspectors completed a short scrutiny visit in June 2020 and found that key worker time was sensibly targeted at those identified as most vulnerable.

Independent Monitoring Board

22. 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. The IMB report for the year ending December 2018 found that prisoners were treated with humanity and respect given the current staff constraints. The IMB noted that the availability of psychoactive substances (PS) had posed particular challenges.

Previous deaths at HMP Leeds

23. Mr Pallas was the 24th prisoner to die at Leeds since January 2018. Nine of the previous deaths were self-inflicted, one was a homicide, one was drug-related, 11 were from natural causes and the cause of one death is currently unknown. We have previously made recommendations about staff responsibilities during emergency responses and family liaison after a prisoner's death.

Key Events

HMP Leeds

24. On 6 September 2019, Mr Darren Pallas was recalled to prison, charged with robbery and remanded to HMP Leeds. He arrived with a suicide and self-harm warning form (SASH). Mr Pallas had a history of substance misuse issues, including psychoactive substances (PS) and alcohol. He had served a number of prison sentences and was last released from custody in 2017. He had depression, anxiety and difficulty sleeping.

25. An officer started suicide and self-harm prevention procedures, known as ACCT, when Mr Pallas arrived. An officer from the Safer Custody Team saw Mr Pallas and noted that he felt under threat from other prisoners at Leeds. She set Mr Pallas's ACCT observations at three an hour.

26. A nurse completed Mr Pallas's initial health screen. He said that he would kill himself in prison. Mr Pallas had previously been prescribed mirtazapine (an antidepressant) but had not taken any medication for some time. Mr Pallas said that he was not sleeping well. The nurse referred him to the mental health team. Mr Pallas declined to see the substance misuse service.

27. Mr Pallas was sent to the First Night Centre. A Supervising Officer (SO) completed Mr Pallas's ACCT assessment. Mr Pallas was tearful and said he struggled with his mental health. He said he expected a long sentence but did not want to die and had his partner's and sister's support. The SO phoned Mr Pallas's partner because Mr Pallas was concerned that she did not know where he was.

28. On 7 September, an SO chaired Mr Pallas's first ACCT review with a nurse from the mental health team. The SO noted that Mr Pallas presented as extremely anxious, paranoid and was petrified of being attacked by other prisoners. He said that he had anxiety and depression but said that his previous medication, mirtazapine, had affected his sleep and increased his paranoia. The nurse referred him to the GP to review his medication. Mr Pallas said that he had used cannabis since he was young. The SO referred him to the substance misuse team.

29. The nurse suggested that Mr Pallas's cell sharing risk should be increased from standard to high for three months to allow time for him to see the GP and be prescribed medication. Mr Pallas was worried about his relationship with his partner given his potentially long sentence. He said he had no thoughts of self-harm. The ACCT panel reduced Mr Pallas's observations to hourly. Staff were required to have three quality conversations with him each day. Mr Pallas's risk was considered to be raised. The SO noted in the caremap that Mr Pallas would be referred to the substance misuse team and the GP, his cell sharing risk would be increased to high and he would be moved to B Wing once he had completed his induction. He also noted that Mr Pallas felt anxious about his forthcoming court hearing.

30. A nurse then completed Mr Pallas's secondary health screen. Mr Pallas said that he had had blackouts a few times over a few months. His physical observations

were taken and were within a normal range. She arranged for him to see a GP about his blackouts.

31. That evening, a nurse assessed Mr Pallas's mental health. Mr Pallas said that he felt paranoid and believed that other prisoners were out to get him. He said he had been assaulted in prison in 2012. He said he was not sleeping well due to the night ACCT checks. The nurse noted that Mr Pallas was worried that his partner might leave him but showed no evidence of a thought disorder. The nurse agreed to prescribe antidepressants and to refer him to the mental health team who later discharged Mr Pallas from their care.

32. On 10 September, a member of the substance misuse team assessed Mr Pallas who said that he had not had any drug or alcohol issues for three years. He talked about wanting to share a cell with his cousin. She noted that Mr Pallas did not need intervention from the substance misuse team.

33. On 12 September, an SO from the Safer Custody Team chaired Mr Pallas's second ACCT review as the previous SO was on leave. A member of the chaplaincy team attended. No one from the healthcare team attended. Mr Pallas said that he was settled at Leeds but anticipated a long sentence. He had moved to D Wing at his request the previous day as he believed his cousin lived there. However, his cousin lived on B Wing. The SO agreed to speak to the wing movements officer to see if Mr Pallas could move to B Wing once a space became available. Mr Pallas said that he had had thoughts of self-harm but had never harmed himself and did not want to die. The SO noted that Mr Pallas's risk was low and reduced his ACCT observations to one every two hours. The number of staff conversations remained at three a day.

34. On 13 September, an officer introduced himself to Mr Pallas as his key worker. They discussed a progression plan for Mr Pallas.

35. On 19 September, an SO chaired Mr Pallas's third ACCT review. A member of the chaplaincy team assisted. No one from the healthcare team attended. Mr Pallas had recently moved to B Wing and said he felt much better. He said he generally kept to himself. He said that he had no thoughts of self-harm. They noted that Mr Pallas's risk was low and reduced his observations to four at night, with staff required to have three conversations with him a day.

36. On 24 September, an advanced nurse practitioner reviewed Mr Pallas's antidepressants. Mr Pallas said that he felt paranoid and was worried about being back in prison because he had previously been assaulted. The nurse diagnosed Mr Pallas with anxiety, prescribed him fluoxetine, an antidepressant, and referred him to see a psychiatrist.

37. On 25 September, an SO chaired Mr Pallas's fourth ACCT review, assisted by a member of the chaplaincy team. No one from the healthcare team attended. Mr Pallas said that he was keeping busy. The ACCT panel noted Mr Pallas's risk was low and reduced his observations to one every two hours at night, with staff required to have three conversations with him each day.

38. Mr Pallas attended court by video-link on 26 and 27 September. The court adjourned his hearing.

39. On 27 September, an SO from the Safer Custody Team chaired Mr Pallas's fifth ACCT review. A nurse from the mental health team contributed beforehand. Mr Pallas said he had no thoughts of self-harm. The SO noted that another SO was helping Mr Pallas work through his outstanding ACCT caremap actions. She therefore decided to continue ACCT procedures but recorded his risk as low. She set his observations at six times at night, with staff required to have three conversations with him each day.

40. On 3 October, an SO chaired Mr Pallas's sixth ACCT review. A member of the chaplaincy team attended. No one from the healthcare team attended. The SO noted Mr Pallas seemed positive and his adjourned court hearing had not appeared to lower his spirits. Mr Pallas said he had no thoughts of suicide or self-harm and had made some friends. However, he still had paranoia so remained in his cell, only coming out to collect meals and have a shower. The SO noted Mr Pallas's risk level as low and stopped ACCT monitoring. He reminded Mr Pallas that he could ask wing staff for support nearer to his hearing.

41. On 8 October, a prison GP saw Mr Pallas about his blackouts. He examined Mr Pallas and diagnosed him with post-vasovagal twitching (a brief loss of consciousness due to a fall in blood pressure). He arranged for an electrocardiogram to monitor his heart activity. It showed no abnormalities.

42. On 22 October, a nurse reviewed Mr Pallas's antidepressants (fluoxetine). He had twice not collected his medication in the previous month. The nurse noted that Mr Pallas appeared anxious. He said that he felt paranoid that others knew that he had been sexually assaulted. He was still frightened to leave his cell at times but said that he had no thoughts of self-harm. The nurse changed Mr Pallas's antidepressants to mirtazapine. She referred Mr Pallas to see a psychiatrist and the mental health team as she felt he presented with an extremely high level of anxiety.

43. On 23 October, a nurse from the mental health team reviewed the nurse's referral which noted an increase in anxiety levels. She noted that Mr Pallas's history related to an assault and considered that psychiatry would not offer anything different to Mr Pallas taking antidepressants.

44. On 24 October, a nurse from the mental health team saw Mr Pallas. He denied any recent substance misuse. Mr Pallas said he had no mental health concerns. The nurse noted that Mr Pallas did not present as paranoid, acutely mentally unwell or agitated. Mr Pallas said that he did not require further input and the mental health team discharged him from their caseload. Mr Pallas agreed to tell staff if he felt at risk of self-harm.

45. On 27 October, an officer introduced herself to Mr Pallas as his key worker. He explained that he had paranoia and preferred to stay in his cell. He added that he was due to get a wing job which would help him leave his cell.

46. On 6 and 8 November, Mr Pallas's key worker completed a key worker meeting with Mr Pallas who said he was doing well. He had previously asked to see his offender manager and his key worker told him that someone would visit him soon.

47. On 11 November, a prison GP reviewed Mr Pallas's medication. He noted that Mr Pallas appeared anxious. Mr Pallas said he had no thoughts of self-harm. The GP increased his antidepressant dosage and allowed him to keep and administer his medication. He referred Mr Pallas to the mental health team. The medication administration chart recorded that between 23 October and 11 November, Mr Pallas had not taken his mirtazapine on four occasions.

48. That day, a nurse assessed Mr Pallas. She noted that he had initially engaged well but at times appeared as though he might cry. Mr Pallas said that he was not doing well. He talked about a past incident when a prisoner had strangled him and made him lose consciousness in the shower. He said that when he woke up, he believed that someone had inserted something into his anus to transport illicit substances. He felt anxious and on "the edge" after this.

49. Mr Pallas said that he had cut himself four days earlier. The nurse told the investigator that she did not see Mr Pallas's cuts. Mr Pallas said that he had tied ligatures around his neck more than once. He said that he had not tied them tight but wanted to see how they felt. Mr Pallas had moved to a single cell the previous week as his cellmate was disturbing him. He said that he had also made ligatures when he shared a cell. Mr Pallas was due to attend court on 29 November and believed that everything would fall apart after this. He talked about his partner as a protective factor.

50. The nurse started ACCT procedures. Mr Pallas became agitated and hostile. The nurse assessed Mr Pallas's mental health and noted that he displayed no signs of a thought disorder. She noted that his paranoia was not symptomatic or psychotic and he showed good insight into his mental state. Mr Pallas said he was depressed but he did not want mental health support. He said he wanted to be left alone and left the meeting.

51. An SO completed the ACCT immediate action plan. He noted that Mr Pallas would live in a single cell and set his ACCT observation levels at four times an hour. That evening, an officer saw Mr Pallas and completed an ACCT assessment. He noted that Mr Pallas had historically been assaulted in prison, he was terrified that others would find out about it, he had tied ligatures around his neck, felt he could not serve a long prison sentence but said his partner supported him.

52. On 13 November, an SO completed Mr Pallas's first ACCT review. A nurse from the mental health team and a worker from Catch22, which delivers intervention and rehabilitation services, attended. An officer contributed before the meeting. The nurse noted that Mr Pallas briefly attended the review. Mr Pallas said he was extremely overwhelmed by the number of people in the room and that he did not want to be managed under ACCT procedures. The nurse was concerned that Mr Pallas had not dealt with the trauma of his assault. Mr Pallas said he would rather be alone in his cell. The SO escorted him to his cell.

53. The SO noted in the ACCT caremap that Mr Pallas had not engaged and it was therefore difficult to assess his risk. However, they agreed that Mr Pallas's risk was raised and they set observations at four per hour at irregular intervals, with staff required to have three conversations with him each day. The next ACCT

review was scheduled for 14 November. An officer and the mental health team were identified to support Mr Pallas.

54. On 14 November, an SO chaired Mr Pallas's second ACCT review. A nurse attended. They noted that Mr Pallas initially presented as stressed, anxious and agitated. He eventually became calmer than he had been the previous day. He said his anxieties were exacerbated by his charges and being in prison where he had previously been assaulted. Mr Pallas said that he had had suicidal urges for several years. The panel noted that Mr Pallas displayed no evidence of paranoia or psychosis. He said that he welcomed mental health support and asked for any reviews to be managed more privately. The panel reassured him about this. Mr Pallas believed that he could lose his partner if he received a long prison sentence and this could cause him to take his own life. The nurse noted that Mr Pallas's partner remained supportive and that she had told him that she would wait for him. Mr Pallas said that he spoke to his partner regularly by phone. His sister also visited him and supported him financially.

55. Mr Pallas asked for ACCT monitoring to be stopped or his observations reduced as they were disturbing his sleep. The panel agreed to reduce his observations to hourly, with staff required to interact with him twice daily. Mr Pallas's risk was noted as low.

56. That afternoon, Mr Pallas's key worker completed a key worker session with Mr Pallas. Mr Pallas said he liked to be left on his own, with his cell observation flap closed. He said it was very disruptive when staff checked on him. He talked about his partner and said he would not harm himself as she needed him.

57. On 17 November, a pharmacy technician recorded in Mr Pallas's medical record that she had to explain to him that as he was being monitored under ACCT procedures, he would not be allowed to keep and administer his mirtazapine. Mr Pallas was not happy and said he would not attend the medication hatch.

58. The next day, Mr Pallas's key worker saw Mr Pallas for his key worker session. Mr Pallas said he was tired and had not been sleeping well because of the ACCT monitoring and not having his medication which helped him sleep. He said that taking his medication in the afternoons was not appropriate as the effects wore off by night time. His key worker explained that there was no pharmacist on duty at night. Mr Pallas said he was not happy being monitored by ACCT procedures but was glad that his observation levels had been reduced. He was also making more of an effort to socialise with others. Mr Pallas talked about his partner and said that he had started to write poetry. He also wanted to work towards enhanced IEP status so that he could have extra visits.

59. On 20 November, an SO chaired Mr Pallas's third ACCT review. A nurse attended. Mr Pallas said he felt much better. He said he had no thoughts of suicide or self-harm. The nurse noted that Mr Pallas showed no signs of paranoia or psychosis. He told Mr Pallas that it was important to deal with his trauma but it was unlikely this could be completed at Leeds as Mr Pallas would probably be transferred after he was sentenced. They noted that Mr Pallas's risk of self-harm would be heightened around his court hearing date. Mr Pallas asked if it was possible for him to keep and administer his own medication as he struggled to sleep. The nurse said that this would be reviewed when ACCT

monitoring stopped. Mr Pallas said that he would not take his own life as he was aware it would affect others and he enjoyed his job. He had also displayed clear future planning about his court hearing and sentence. They agreed to stop ACCT procedures.

60. Afterwards, Mr Pallas's key worker saw Mr Pallas for a key worker session. Mr Pallas was happy that ACCT monitoring had ended. He asked his key worker if she would check on him around his court hearing date as he was nervous. His key worker said that Mr Pallas had shown a "massive improvement" in his behaviour.

61. On 25 November, a prison GP reviewed Mr Pallas who reported that he had rectal bleeding around three times a week. The GP concluded that Mr Pallas likely had haemorrhoids and referred him to the hospital.

62. Mr Pallas also asked for a change in his antidepressants. His medication administration chart showed that he had missed his medication five times since having to collect it from the medication hatch. The GP changed his medication to sertraline. He also prescribed Mr Pallas zopiclone to help him sleep.

63. On 27 November, an officer recorded that Mr Pallas had shown positive behaviour and helped staff on the wing.

64. On 28 November, a nurse checked on Mr Pallas before his impending court hearing. Mr Pallas said he would appreciate a welfare check the following day. The nurse agreed to do so and noted that Mr Pallas was not agitated, showed no signs of distress and had no thoughts of suicide or self-harm. Mr Pallas said he was not sleeping well.

65. On 29 November, Mr Pallas received a 12-year sentence. A nurse from the mental health team checked on Mr Pallas. He said that he was relieved as he had expected a sentence of 16 years or more. He said his partner had been supportive but he had received a letter from her in which she had threatened to leave him. The nurse told Mr Pallas that the recent change to his medication may take time to work. The nurse noted that Mr Pallas maintained good eye contact and did not present as agitated, distressed or anxious. He denied thoughts of suicide or self-harm. Mr Pallas agreed to speak to staff if he needed support. The nurse concluded that Mr Pallas was not in a mental health crisis and zopiclone would address his sleep issues.

66. Mr Pallas kept and administered zopiclone himself and there is no evidence to suggest that Mr Pallas did not take the medication.

67. Mr Pallas's key worker completed a key worker session with Mr Pallas on 2 December. Mr Pallas said he was okay but it had started to sink in that he had received a 12-year sentence. He said he had kept himself busy by making things in his cell and had been mixing with other prisoners on the wing. He also wanted to start going to education workshops. His sleeping tablets were working and he had managed to get seven hours sleep, which had had a positive effect on his mental wellbeing. Mr Pallas also said his partner appeared to accept his sentence.

68. On 4 December, Mr Pallas's key worker completed a key worker session with Mr Pallas. She told him that the Offender Management Unit had confirmed that his transfer was not urgent. Mr Pallas said it gave him time to come to terms with his sentence. He had started to attend the gym and exercise. His key worker noted no concerns about Mr Pallas who said that he no longer needed sleeping tablets.

69. On 10 December, Mr Pallas's key worker conducted a key worker session with Mr Pallas. He said he had no concerns about his medication. He had recently applied for enhanced IEP status. He wanted to become a Listener. Mr Pallas said he was happy to remain at Leeds as it meant his partner and family could visit but hoped to receive news of his prison transfer in the new year.

70. That day, an offender supervisor spoke to Mr Pallas about his release and parole eligibility dates. Although Mr Pallas said he was happy at Leeds, the offender supervisor told him to think about a transfer to complete rehabilitation programmes so that he could progress towards getting parole.

71. Mr Pallas's medication administration chart showed that between 29 November to 12 December, he did not keep and administer his own medication but had attended the medication hatch daily. From 12 December, Mr Pallas was assessed as suitable to keep a week's supply of medication in his cell. There was no evidence to suggest that he was not taking his medication.

72. On 18 December, Mr Pallas's key worker completed a key worker session with Mr Pallas who said his medication made him feel better and he enjoyed working.

73. The next day, Mr Pallas's key worker saw Mr Pallas who said he had not slept well and wanted sleep medication. He linked his sleeping issues with his relationship issues as his release date had weighed on his mind which affected his partner. He planned to discuss his relationship with his partner and consider whether they should just be friends. His key worker noted that Mr Pallas would move cells that day. He said he was happy about this as he had friends there.

74. On 24 and 26 December, Mr Pallas's key worker visited Mr Pallas for a key worker session and reported no concerns. Mr Pallas's IEP status was also upgraded to enhanced. Prison records noted that his attitude and behaviour were good.

Events from January 2020

75. On 5 January, Mr Pallas's key worker saw Mr Pallas for a key worker session. She noted that he was not his usual chatty self. Mr Pallas said that he had not slept well but had sleeping tablets. He said staff did not always unlock him to attend work in the morning. He did not like to press his emergency cell bell to let them know. He added that he had not exercised over the last few days. His relationship was also struggling due to his sentence. He had explained to his partner that they would always be friends. Mr Pallas said he had submitted several applications for in-cell education courses but had not yet had a response. His key worker said she would chase it up. Mr Pallas became chattier towards the end of the session and his key worker had no concerns about him. She noted that she would keep an eye on him over the next few sessions.

76. On 15 January, an officer started ACCT procedures after he answered Mr Pallas's cell bell and found that he had cuts his forearms. Mr Pallas gave the razor blade to the officer and said he was worried that he would have to share a cell. A nurse examined Mr Pallas and noted that he did not need treatment as the wounds were superficial.

77. A Custodial Manager (CM), the night manager, placed Mr Pallas on two observations an hour and noted that the mental health team should review him.

78. At around 8.00am, staff unlocked Mr Pallas and found that he was still sleeping. Shortly afterwards, Mr Pallas told staff that he would not be attending work and was staying in bed. At 9.00am, a member of the chaplaincy team visited Mr Pallas but he was still asleep.

79. At 10.13am, Mr Pallas's key worker visited Mr Pallas who remained asleep. Wing staff told her that Mr Pallas had been very withdrawn, had not gone to work and suggested that he was concerned about sharing a cell. His key worker noted that Mr Pallas's cell sharing risk remained high although he was allowed to share a cell with someone of the same ethnicity. She said she would talk to Mr Pallas about this at their next meeting.

80. At 2.30pm, an officer completed an ACCT assessment. Mr Pallas said that he was told that he would have to share a cell which made him anxious and caused him to self-harm. He said his actions were a cry for help and he did not want to take his own life. He said he felt better as staff had confirmed that he did not have to share a cell. Mr Pallas said that his sleep was disturbed. The officer noted that Mr Pallas wanted a medication review and to have his observation levels reduced.

81. Afterwards, an SO from the Safer Custody Team chaired Mr Pallas's first ACCT review. A nurse attended. An officer contributed before the meeting. The SO noted that Mr Pallas seemed anxious and tearful. He talked about his historic sexual assault. The nurse confirmed that Mr Pallas had trauma from the incident. Leeds did not offer any trauma-focused therapies and Mr Pallas had to rely on antidepressants. It was agreed that a prison GP would review Mr Pallas's medication with a view to increasing his dosage. The SO noted that Mr Pallas should remain in a single cell. Mr Pallas was relieved and said he had no thoughts of suicide or self-harm. The SO noted Mr Pallas's risk was raised and set hourly observations, with staff required to have two conversations with him each day.

82. As Mr Pallas was being monitored under ACCT procedures, healthcare staff noted that he would not be allowed to keep and administer his medication.

83. On 22 January, an SO chaired Mr Pallas's second ACCT review. The nurse was unavailable to attend. He gave Mr Pallas the option of having a member of the chaplaincy team present. The SO said he was mindful that Mr Pallas should feel comfortable about who attended his ACCT review. Mr Pallas said he would rather the ACCT review was held with the SO alone. He said he found it difficult to talk about his assault in front of people whom he did not know.

84. The SO noted that Mr Pallas was calm and settled. A nurse had contributed beforehand and stated that the mental health team had no current concerns about Mr Pallas and had arranged a GP appointment for him. Mr Pallas said that he felt a lot better and was happy to have a single cell. He had not harmed himself since his last review and said he had no current thoughts to do so. He said that his partner and family were his focus. The SO noted that Mr Pallas had made plans to progress in prison, noted his risk level as low and ended ACCT monitoring, noting that all caremap actions had been completed.

85. On 24 January, Mr Pallas's key worker saw Mr Pallas for a key worker session. She initially spoke to the wing staff who said that Mr Pallas slept during the day and then struggled to sleep at night. He had not been exercising, despite encouragement. When an SO opened Mr Pallas's cell door, he was asleep. However, he woke up and said that he would not exercise that day. His key worker noted that his behaviour was a "big backwards step".

86. On 29 January, an SO saw Mr Pallas and completed his post-closure ACCT review. He noted the issues raised on Mr Pallas's ACCT had been resolved, he had good family support and was keeping himself busy with prison activities.

87. That day, a nurse reviewed Mr Pallas's sertraline. He said that he did not think the medication worked. Mr Pallas's medication administration chart showed that he had missed five days of medication between 18 January to 29 January when he had to go the medication hatch to collect it.

88. Mr Pallas said that he felt anxious and had not been sleeping well. He explained that he had previously been prescribed mirtazapine but stopped taking it because he was given it in the mornings. He asked if the medication could be prescribed again but to take in the afternoons. He said he had no thoughts of suicide or self-harm. The nurse diagnosed Mr Pallas as having a low mood and anxiety. She stopped his prescription for sertraline and changed it to mirtazapine from 31 January. She also prescribed him zopiclone for three nights from 30 January.

89. That evening, Mr Pallas phoned his partner who told him that she loved him but hated their situation and thought that their relationship may have to end. She was tearful and said that she had started going downhill and drinking again. Mr Pallas reminded his partner that her children should be her main priority and she should not jeopardise this with her poor behaviour. He said he understood that if she wanted to "call it a day" then so be it. He said that his partner was hurting him more not by ending their relationship but by her behaviour.

90. Mr Pallas phoned his partner again at 9.29pm. She was crying because she believed she had let him down. Mr Pallas said he probably would not want to see her. He asked her if she had met someone else to which his partner replied no. Mr Pallas said his head was all over the place and told his partner that he had done something stupid but refused to tell her what it was. Mr Pallas's partner said she intended to contact the prison as she was concerned about him.

30 January 2020

91. Mr Pallas had a hospital appointment that day. Mr Pallas did not attend the appointment and told staff that he was not in the right frame of mind to go.

92. At around 1.30pm, an officer from the Safer Custody Team checked on Mr Pallas after his partner had left a voicemail that morning in which she said that she had had a difficult phone call with Mr Pallas about the future of their relationship and the call had ended abruptly.

93. The officer said he had reviewed Mr Pallas's prison records and was aware that he had previously been monitored under ACCT procedures. He spoke to Mr Pallas at great length about his partner's concerns and continually gauged if he presented a risk to himself. He said that Mr Pallas was candid about his relationship issues. He said that he had had a difficult conversation with his partner and was unlikely to initiate future contact with her. The officer noted that Mr Pallas was realistic and said he knew that his conversation with his partner was inevitable given his long sentence and he had subconsciously prepared for it. The officer said he pointed out that Mr Pallas's partner had been a protective factor in his life which had now been removed.

94. Mr Pallas was aware of this but said that his previous self-harm was triggered by his anxiety about sharing a cell. He said that this had now been resolved. He said his job on the wing was going well and staff had been very supportive. Mr Pallas said he accepted his sentence length and was focused on achievements in his life. He hoped that as his sentence progressed, he would acquire more skills and educational achievements. He said that he did not have thoughts of suicide or self-harm. He said that he struggled to sleep and ACCT checks would aggravate this. The officer noted that as their conversation ended, Mr Pallas reiterated his disappointment about his relationship breakdown. The officer said that they shared a joke as he left Mr Pallas's cell. The officer then phoned Mr Pallas's partner to tell her that he had checked on him.

95. At around 6.30pm, an officer unlocked Mr Pallas. CCTV footage shows that Mr Pallas mixed with other prisoners and took a shower.

96. An SO was on duty on B Wing that evening. In his statement, he said that there was an incident on the wing when a new prisoner refused to move to his new cell. The SO said that Mr Pallas helped staff without any prompting, and spoke to the prisoner directly to resolve the situation. The prisoner agreed to comply with staff instructions and Mr Pallas even helped to carry the prisoner's personal belongings to the cell.

97. A prisoner, who lived on the wing, told the investigator that he was good friends with Mr Pallas. He said he noticed a change in Mr Pallas's demeanour from around 28 January and believed this was triggered by relationship problems. He said that Mr Pallas had appeared withdrawn but had never mentioned any thoughts of harming himself.

98. Mr Pallas returned to his cell at 7.06pm. Healthcare staff gave Mr Pallas his zopiclone tablet and prison staff completed a roll check at 7.15pm. An officer completed the night roll check and checked on Mr Pallas at 8.40pm.

99. At 9.25pm, Mr Pallas spoke to his partner by telephone for 23 minutes. Mr Pallas told his partner that he was having bad thoughts and had already written a note in case things went bad. He believed his partner had already found someone else and had shattered his dreams. Mr Pallas's partner said that she loved him

but could not guarantee anything as he had a long sentence. Mr Pallas said he did not think he would be around when she visited him. (His partner had scheduled a visit for 9 February.) He said that he did not want to come out of his cell. His sleeping tablets were not working and he was thinking about taking drugs to get over his relationship difficulties. Their phone call ended abruptly.

31 January 2020

100. On the morning of 31 January, an officer completed the morning roll check at around 5.45am and raised no concerns about Mr Pallas. At around 7.46am, the officer started unlocking prisoners to attend workshops and education. Mr Pallas was not unlocked at this time.

101. At 9.41am, an officer unlocked Mr Pallas's door for association. When he looked in the cell, it was dark and he initially could not see Mr Pallas. He looked to the back of the cell and saw Mr Pallas hanged from the medicine cabinet in the corner of the cell, with a ligature made from a bed sheet around his neck. He immediately shouted for staff assistance and then supported Mr Pallas's body weight. CCTV shows two officers arrived to help within 37 seconds.

102. An officer immediately called a medical emergency code blue, indicating a life-threatening situation. The control room log noted that an ambulance was called at 9.43am. An officer cut the ligature and the other officer helped him to lay Mr Pallas on the floor. An officer started cardiopulmonary resuscitation (CPR). He noticed that Mr Pallas's face was very blue and he was also cold to touch and stiff. Other prison staff arrived to help.

103. Two nurses arrived first at 9.43am. One of them noted a number of signs that that Mr Pallas was dead. A third nurse arrived with emergency equipment at 9.44am. Healthcare staff helped the officer with resuscitation efforts while a CM took over chest compressions.

104. Healthcare staff administered oxygen and used a defibrillator. No shock was advised indicating that no heart rhythm was detected. Healthcare staff noted that Mr Pallas had extensive signs of rigor mortis. Healthcare and prison staff continued CPR until paramedics arrived at 9.54am and assessed Mr Pallas. At 9.59am, they pronounced his death.

Contact with Mr Pallas's family

105. After Mr Pallas's death, staff identified that his next of kin details were out of date and referred to a previous partner. The prison was aware that Mr Pallas's current partner had contacted the prison the previous day because she was concerned about him. Prison records also showed that he had had recent visits from his partner and sister. The prison therefore decided to visit them both to inform them of Mr Pallas's death.

106. The prison appointed an SO as the prison's family liaison officer (FLO). The FLO and the Head of Residence visited Mr Pallas's partner before 12.00pm and broke the news of Mr Pallas's death. Afterwards, they visited Mr Pallas's sister to break the news to her but she was not at home. Her daughter said that she was away for a few days. She called her mother and allowed the FLO to speak to her. The FLO broke the news of Mr Pallas's death by telephone and offered support. Mr

Pallas's sister said that she would contact the prison on her return. The FLO and Head of Residence then returned to the prison.

107. Later that afternoon, a member of staff told the FLO that a member of Mr Pallas's family was in the visitors' centre. When the FLO telephoned the centre, she was told that the person had left. The FLO then had to leave the prison to attend a family emergency and did not return for around a week.

108. Entries in the prison FLO log began at 7.35pm on 31 January when an officer was asked to take over the FLO role. The second FLO recorded in the log that when he arrived for duty on 1 February, he was unaware of Mr Pallas's next of kin and he had only been told that they had been told of his death. He looked for the family liaison information and the Head of Residence eventually updated him. The second FLO later spoke to Mr Pallas's sister who had called the prison that day. She was upset that she had not been listed as Mr Pallas's next of kin.

109. The second FLO visited Mr Pallas's sister on 2 February. Mr Pallas's sister was upset that she had been told about her brother's death by telephone and that no one had contacted her again. She said she had also visited the prison on the afternoon of her brother's death and was left waiting in the visitors' centre to speak to someone but no one came. She said that she was initially told that the FLO was at lunch but was aware that she was waiting. She was then told that someone from the prison would contact her later that day but no one did. The second FLO explained to Mr Pallas's sister how the prison would support her and what would happen next. He told her that he had now informed all the relevant agencies that she was Mr Pallas's next of kin.

110. The prison provided ongoing support and contributed towards the costs of Mr Pallas's funeral in line with national instructions.

Support for prisoners and staff

111. After Mr Pallas's death, the Deputy Governor 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. The prison posted notices informing other prisoners of Mr Pallas'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 Pallas's death.

Post-mortem report

112. The post-mortem report concluded that Mr Pallas died from hanging. Toxicology results concluded that there was evidence of zopiclone use in the hours before his death. No illicit substances were detected in his system.

Findings

Management of Mr Pallas's risk of suicide and self-harm

113. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody lists risk factors and potential triggers for suicide and self-harm. Mr Pallas arrived at Leeds with a number of these risk factors: he had a history of mental health and substance misuse issues, was identified as at risk of suicide and had been recalled. Staff appropriately started ACCT procedures when he arrived and appropriately referred him to the mental health and substance misuse teams.

114. Staff appropriately monitored Mr Pallas under ACCT procedures on two further occasions. He was supported by the mental health team and staff addressed his issues.

115. Although Mr Pallas's incidents of self-harm indicated mental distress, none were life-threatening. Given this and the information available at the time, we do not consider that staff could reasonably have predicted that Mr Pallas was at imminent risk of suicide. Staff were aware that his partner had raised concerns the day before his death. A member of the safer custody team spoke to Mr Pallas at great length and was reasonably assured that he had no thoughts of self-harm at the time. Mr Pallas's relationship issues had been ongoing and had not recently been identified as a risk factor for suicide or self-harm.

ACCT reviews

116. PSI 64/2011 requires a multidisciplinary approach for ACCT case reviews and where possible, the ACCT assessor and staff from the healthcare team, including the mental health team, should attend the first ACCT review. Mr Pallas's first ACCT reviews on each of the three occasions that ACCT procedures were started, met these requirements.

117. After the first ACCT review held on 6 September, staff completed five ACCT reviews. However, although Mr Pallas was under their care and had been prescribed antidepressants, no one from the healthcare team attended four of these. When ACCT monitoring ended on 3 October, there is no evidence that the healthcare or mental health team contributed to this decision.

Caremap

118. PSI 64/2011 requires that ACCT caremaps reflect a prisoner's needs, level of risk and the triggers of their distress.

119. Mr Pallas had sleeping problems and this was one of the two issues highlighted under ACCT monitoring on 15 January. The caremap noted that Mr Pallas had a GP appointment to review his medication. When ACCT procedures ended on 22 January, Mr Pallas's medication had not been reviewed but the caremap stated that this action had been completed on this date. The ACCT post-closure review took place on 29 January and inaccurately repeated that all actions on the caremap had been completed. We therefore make the following recommendations:

The Governor and Head of Healthcare should ensure that:

- **prison, healthcare and mental health team staff work jointly to manage prisoners at risk of suicide and self-harm; and**
- **staff do not end ACCT monitoring until all the risks noted in a prisoner's caremap have been adequately addressed and the caremap actions completed.**

Resuscitation

120. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. It states that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines define examples of futility as including the presence of rigor mortis.

121. Prison and healthcare staff who responded to Mr Pallas considered that Mr Pallas was dead when he was found, and noted a number of signs that he was dead, including rigor mortis. The Head of Healthcare said that if officers had started CPR, healthcare staff would continue rather than stop. He said that if healthcare staff were first on scene, they would have the opportunity to assess the prisoner and decide whether to start CPR.

122. While we understand the wish to attempt and continue resuscitation until death has been formally recognised, staff are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Clinical care

123. The clinical reviewer noted that overall, the health care that Mr Pallas received was of a good standard and was equivalent to that which he could have expected to receive in the wider community.

Mental health

124. Mr Pallas found himself back in prison after a long time in the community. He had historically been sexually assaulted within the prison environment. This caused him anxiety and paranoia about the intentions of other prisoners and the prospect of having to share a cell. Mr Pallas had also identified his partner as a protective factor and his relationship difficulties at times contributed to his thoughts of self-harm.

125. The clinical reviewer concluded that Mr Pallas presented with fairly low-level symptoms of depression and anxiety and healthcare staff treated these appropriately. She noted that the mental health team completed robust risk

assessments for Mr Pallas and identified plans to mitigate his risk and address his concerns such as letting him live in a single cell and changing his medication at his request. It was well documented that resolving his issues improved his wellbeing and symptoms.

Medication

126. In the days before Mr Pallas's death, he refused to accept some of his medication. Mr Pallas was assessed to have the capacity to make an informed choice about whether to accept medication. Healthcare staff made an appointment for Mr Pallas and at his request, the medication was changed. The clinical reviewer noted that the number of doses Mr Pallas had missed before the appointment may have interfered with the optimal benefits of his medication but was unlikely to have had a significant impact on how he presented.

Liaison with Mr Pallas's family

127. PSI 64/2011 on safer custody requires prison staff to communicate with a prisoner's next of kin following death. Mr Pallas's sister was unhappy about Leeds' contact with her and said that no one had contacted her again after she was told of Mr Pallas's death. She said that she had visited the prison and tried unsuccessfully to talk to the prison FLO.

128. A second FLO took over family liaison as the initial FLO had to attend a family emergency. While the second FLO was promptly appointed to the role, he was not updated about the contact between the prison and Mr Pallas's next of kin after Mr Pallas's death. He had to find out this information before he could speak to Mr Pallas' sister. This caused a short delay. Mr Pallas's recorded next of kin details were also out of date. We were unable to establish why no one from the prison was able to speak Mr Pallas's sister on the day of his death, when she was waiting in the visitors' centre. It is important that prisons have contingency plans in place to cover staff absences and that they maintain effective contact with the bereaved family. We therefore make the following recommendation:

The Governor should ensure that:

- **prisoners' next of kin details are kept up to date; and**
- **when a prisoner dies in custody, a deputy family liaison officer is appointed and all contact with a next of kin is recorded to provide continuity of support in the absence of the designated family liaison officer.**

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