

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Franks, a prisoner at HMP Leeds, on 12 April 2019

A report by the Prisons and Probation Ombudsman

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 Richard Franks was found hanged in his cell at HMP Leeds on 12 April 2019. He was 39 years old. I offer my condolences to Mr Franks' family and friends.

Staff monitored Mr Franks under suicide and self-harm prevention procedures (known as ACCT) four times at Leeds. Although there was some good practice, I am concerned that staff did not fully address his risks. It is not the first time that I have identified deficiencies in Leeds' suicide and self-harm prevention procedures. This issue needs to be addressed urgently by the Prison Group Director for Yorkshire.

I am concerned that staff did not assess Mr Franks' risk of suicide and self-harm when he returned to Leeds from court on 11 April and missed a potential opportunity to put preventative measures in place.

There was a delay in the emergency response. While it did not affect the outcome for Mr Franks, the Governor will need to address this.

There were also failings in the keyworker process and the procedure for storing CCTV evidence securely.

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

January 2020

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Summary

Events

1. On 29 December 2018, Mr Richard Franks was remanded into custody at HMP Leeds, charged with actual bodily harm.
2. Mr Franks had a history of post-traumatic stress disorder (PTSD) and frequently harmed himself in prison. Prison staff managed him under suicide and self-harm prevention procedures (known as ACCT) on four occasions during his time at Leeds.
3. At an ACCT review on 4 January 2019, staff noted that Mr Franks had harmed himself the previous day but assessed that Mr Franks' risk of suicide and self-harm was low. Over the next two months, Mr Franks continued to harm himself and presented as low in mood after periods of increased stress, such as relationship difficulties and court appearances.
4. On 25 March, staff attended an ACCT case review and recorded that Mr Franks presented in a good mood and said that he hoped to be released after a court appearance in April. A supervising officer noted that Mr Franks had said that he had not had thoughts of self-harm for three days and decided to stop ACCT monitoring.
5. Mr Franks returned to Leeds from court at 4.45pm on 11 April. Prison records show that his case was adjourned for sentencing. A prisoner told the investigator that he spoke to Mr Franks after he returned to the wing at around 6.10pm. He said that Mr Franks was upset and told him that he was sentenced to five years in prison. He said that he told two officers to start ACCT procedures.
6. At 6.00am on 12 April, an operational support grade (OSG) opened the observation panel on Mr Franks' cell door to conduct a roll check. She saw Mr Franks lying face down on the floor and called out to him, but he did not respond. She radioed for further assistance and another OSG arrived shortly afterwards. He entered the cell and called a medical emergency code. A nurse arrived at 6.03am, but did not start cardiopulmonary resuscitation (CPR) as Mr Franks had clearly died.

Findings

7. We found that staff stopped ACCT procedures prematurely on 4 January and 21 March. Mr Franks had recently harmed himself in both instances and staff placed too much emphasis on his positive presentation when assessing risk. There were deficiencies in the way that staff managed the ACCT procedures. We have raised concerns about ACCT management at Leeds on several occasions and urgent action is now required to address the issue.
8. Staff should have assessed Mr Franks when he returned from court on 11 April but failed to do so.

9. Staff did not immediately call a medical emergency code when Mr Franks was found unresponsive, and this caused a short delay. While it made no difference to the outcome for Mr Franks, this could be critical in future cases.
10. Leeds was unable to provide the CCTV footage of the wing on 11 and 12 April. It was therefore not possible to corroborate what officers and prisoners told us happened after Mr Franks returned to the wing on 11 April.
11. Mr Franks' keyworker only met him on one occasion. We consider that the keyworker scheme was ineffective in offering support to Mr Franks.
12. The clinical reviewer concluded that the clinical care that Mr Franks received at HMP Leeds was equivalent to that which he could have expected in the community.

Recommendations

- The Head of Healthcare should ensure that initial mental health assessments are completed separate to the ACCT process.
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
 - restart ACCT procedures if a prisoner is at risk in the post-closure period;
 - understand that regardless of grade or discipline, they have a responsibility to start ACCT procedures where necessary;
 - consider all relevant factors when assessing the level of risk;
 - set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; and
 - consider whether cell sharing is appropriate and document the reasons for decisions.
- The Prison Group Director for Yorkshire should assure himself that meaningful action is being taken to ensure that ACCT procedures improve at Leeds.
- The Governor should ensure that CCTV evidence is stored securely and able to be retrieved after a death in custody.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of an emergency.
- The Governor should ensure that:
 - the keyworker scheme provides meaningful and ongoing support to prisoners; and
 - keyworkers are assigned an appropriate number of hours to allow them to fulfil their role.

The Investigation Process

13. 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.
14. The investigator visited Leeds on 18 April 2019. He obtained copies of relevant extracts from Mr Franks' prison and medical records.
15. The investigator interviewed sixteen members of staff and three prisoners at Leeds between 3 and 5 June 2019. He also conducted a telephone interview with one member of staff on 10 June.
16. NHS England commissioned a clinical reviewer to review Mr Franks' clinical care at the prison. She attended joint interviews with the investigator on 3 June.
17. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Franks' mother to explain the investigation and to ask if she had any matters that she wanted us to consider. His mother wanted to know:
 - why Mr Franks' court appearance on 11 April 2019 was not seen as a trigger for increased risk; and
 - why the prison did not know the outcome of the court hearing.
19. Mr Franks' mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Leeds

21. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.
22. In August 2018, Leeds was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focussed on reducing violence, improving living conditions, preventing drugs from entering the prisons and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Leeds was conducted in November 2017. Inspectors found Leeds to be an unsafe prison. They found the levels of self-harm were significantly higher compared to those of other local prisons. Inspectors found initial ACCT assessments were generally good, and reviews were often multidisciplinary. However, they noted that caremaps were inadequate and observations recorded by staff lacked meaningful interaction with prisoners. Inspectors considered that healthcare services were reasonable, but triage clinics for mental health were not effectively used.

Independent Monitoring Board

24. 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 noted that quality assurance of suicide and self-harm prevention documents and the introduction of keyworkers had led to a gradual improvement.

Previous deaths at HMP Leeds

25. Mr Franks was the seventeenth prisoner to die at HMP Leeds since April 2017. Of the previous deaths, seven were from natural causes, six were self-inflicted, two were drug-related and one was a homicide. There have been six deaths since Mr Franks’ death. Leeds agreed to implement our recommendations in other investigations about the management of suicide and self-harm prevention procedures, reviewing prisoners returning from court and calling emergency medical codes.

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide and 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. 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 carried out at irregular intervals to prevent a prisoner

anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

27. 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. 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. National instructions on ACCT procedures are set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

The keyworker system

28. Offender Management in Custody (OMiC) is a key part of the Prison Service's response to self-inflicted deaths, self-harm and violence in prison. It is intended to improve safety by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It includes the keyworker system which is currently being rolled out across the prison estate.
29. All prisoners in the male, closed estate must be allocated a keyworker (a prison officer) who is responsible for engaging, motivating and supporting them through their time in prison. Each keyworker is responsible for five or six prisoners and Governors must ensure that time is made available to allow keyworkers to spend an average of 45 minutes per prisoner per week on the keyworker role, including individual time with each prisoner. Within this allocated time, keyworkers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A keyworker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

30. On 28 December 2018, while in police custody, Mr Richard Franks placed a sling around his neck and made superficial cuts to his wrist.
31. On 29 December, Mr Franks was remanded into custody, charged with causing actual bodily harm to his partner, and sent to HMP Leeds. Mr Franks had served time in prison before. The person escort record (PER) indicated that he had a history of self-harm.
32. An officer conducted a reception interview and recorded that Mr Franks was tearful and said that his young son had recently been diagnosed with cancer. At 12.50pm, she started suicide and self-harm prevention procedures, known as ACCT. At 2.20pm, a Supervising Officer (SO) agreed an immediate action plan.
33. At 3.18pm, at an initial health screen, Mr Franks told a nurse that he had post-traumatic stress disorder (PTSD) and a lot of personal issues. He said that he had taken an overdose within the last twelve months and she assessed him as not suitable to keep and administer his own medication. Mr Franks declined a substance misuse referral but accepted a mental health referral. That afternoon, a Custodial Manager (CM) assessed his cell-sharing risk as high.
34. A Specialist Officer (previously known as physical education instructor) completed the ACCT assessment on 30 December. He noted that Mr Franks had cuts on his arms and was very concerned about his son.
35. At 11.00am, a SO chaired a first ACCT review for Mr Franks. Two CM's, the Specialist Officer, a mental health nurse and Mr Franks attended. The mental health nurse completed a mental health assessment and recorded that Mr Franks seemed preoccupied with his personal issues and displayed signs of mild depression and anxiety. Mr Franks said that he had been diagnosed with PTSD in 2017 and attributed this to the six years he had served in the British Army. The attendees assessed Mr Franks as a raised risk of self-harm and three actions were recorded on the caremap: for his mother's phone number to be submitted for approval, for him to be referred to the chaplaincy for personal support and to an officer the Veterans in Custody (VIC) co-ordinator.
36. On 2 January 2019, healthcare staff added Mr Franks to their waiting list for a managing emotions and wellbeing group and a managing stress group. The same day, prison staff reviewed Mr Franks' cell-sharing risk assessment and reduced his level of risk to standard. He was subsequently allocated a cellmate
37. On 4 January, a CM chaired an ACCT case review. A mental health nurse, a CM and Mr Franks attended. The attendees assessed Mr Franks' risk of suicide and self-harm as low and noted that all the actions on the caremap had been completed. Although they noted that Mr Franks had harmed himself by cutting the previous day, staff stopped ACCT monitoring. A post-closure review was scheduled to take place by 11 January.
38. On 5 January, an officer introduced himself to Mr Franks as his keyworker. The officer noted that he explained the keyworker role to Mr Franks and that Mr Franks said he might need some support if sentenced. There is no record that

staff completed a progression plan or set goals for Mr Franks to work towards, as required.

39. At 1.25pm on 14 January, Mr Franks' cellmate pressed their emergency cell bell and told an officer that Mr Franks had taken 50 paracetamol tablets. The officer asked healthcare staff to attend and started ACCT procedures. In the meantime, a nurse arrived and found Mr Franks unresponsive on the top bunk. She called a medical emergency code blue (used to indicate that a prisoner is unconscious or having difficulty breathing) and after around 10 minutes, he regained consciousness. Paramedics took Mr Franks by ambulance to hospital, where he was admitted and treated for a paracetamol overdose.
40. At 10.15am on 16 January, Mr Franks returned to HMP Leeds. A nurse reviewed him and noted that he did not need a follow-up hospital appointment. At 3.28pm, a SO completed the ACCT assessment and recorded that Mr Franks found it difficult being in prison and having a young son with cancer. He also wanted to know when he would see the VIC co-ordinator.
41. At 4.20pm, a CM chaired the first ACCT review. A SO and a mental health nurse, attended. Mr Franks told staff that he did not plan to end his life and had acted impulsively after an argument with his partner. The mental health nurse completed a mental health assessment and noted that Mr Franks did not show signs of an acute mental illness. She concluded that his low mood appeared to be made worse by social stressors such as his son's cancer diagnosis. Mr Franks said that he had taken antidepressants in the past and would consider taking them again. Staff assessed his risk as raised and scheduled a review for 23 January. Five actions were noted on the caremap: to arrange a GP appointment, chase the VIC referral, find out why Mr Franks could not contact his partner, for him to occupy his free time and to get a job.
42. On 21 January, Mr Franks told an officer that he felt under threat on the wing and that someone had urinated under his cell door. Prison staff moved Mr Franks to a shared cell on a different wing and a CM chaired an ACCT review, which a second CM and Mr Franks attended. Mr Franks said that he was happy with the cell move and felt that it would be positive.
43. On 23 January, a CM chaired an ACCT review which Mr Franks attended. She recorded that Mr Franks said that he felt more settled, had made up with his partner and his son was responding to cancer treatment. A SO ended ACCT monitoring but did not record a post-closure review date. The following day, the CM completed a post-closure review and recorded that Mr Franks was in contact with his partner again, was working through issues relating to his son and had distraction materials in his cell.
44. On 25 January, Mr Franks' cellmate left, and he remained in the cell on his own. At 4.25pm, Mr Franks approached an officer and showed him several superficial cuts that he had made to his left wrist. The officer searched Mr Franks' cell and found a ligature under his mattress. He initiated ACCT procedures at 5.23pm and a SO agreed an immediate action plan at 5.40pm. There is no record that staff considered re-opening the ACCT document that the CM had closed two days earlier.

45. At 11.05am on 26 January, an officer completed the ACCT assessment. He noted that Mr Franks said his issue stemmed from the previous day, when he had attended court hoping to be released, but was instead returned to prison. At 2.30pm, a SO chaired the first ACCT review. A mental health nurse, and Mr Franks attended. Staff assessed Mr Franks' risk as raised and noted three actions on the caremap: for Mr Franks to be referred to the VIC, for support with a bail address and to attend the peace educational programme (PEP – a programme to support prisoners to explore the values of personal peace and inner resources).
46. On 1 February, a SO chaired an ACCT review. A nurse and Mr Franks attended. Mr Franks said that he had still not seen the VIC officer and that he not did want another cellmate as he had a lot going on. The SO agreed to chase up the VIC referral and to speak to the wing manager about a single cell.
47. At 12.05am on 3 February, an officer looked through Mr Franks' cell observation panel to conduct an ACCT check and noticed that he had a ligature around his neck. The officer radioed a medical emergency code blue and an Operational Support Grade (OSG), attended. They entered Mr Franks' cell, cut the ligature and placed him in the recovery position. Shortly afterwards, a nurse arrived and recorded that Mr Franks was conscious and responsive. Prison staff moved him to the first night centre and placed him under constant watch.
48. At 9.05am, a prisoner manager chaired an ACCT review which a SO and a mental health nurse attended. The prisoner manager noted that Mr Franks said that he had meant to end his life because he was having difficulty coping with pressures outside prison. He asked Mr Franks if he had pre-planned this action as he had recently asked for a single cell, but Mr Franks said he had been in a single cell for over two weeks and preferred his own company. The mental health nurse noted that Mr Franks said that he felt disheartened by the ACCT process because staff did not always carry out the actions agreed. The attendees assessed Mr Franks' risk of suicide and self-harm as high and added four actions to his caremap: for chaplaincy to offer support for his son's illness, for the VIC referral to be followed-up, for a GP appointment and for staff to identify a possible job for Mr Franks.
49. On 4 February, a SO chaired an ACCT review which a Father and Mr Franks attended. Mr Franks raised concerns about feeling anxious and depressed and said that despite requesting a GP appointment on several occasions, he had not had a response. The attendees looked at the caremap and the SO recorded that the prisoner manager had followed up all the actions.
50. On 8 February, Mr Franks pressed his emergency cell bell and showed an officer several superficial cuts that he had made to his left wrist. A CM chaired an ACCT review which a mental health nurse and Mr Franks attended. She recorded that Mr Franks said that he had harmed himself to release stress after a difficult conversation with his mother. She noted that Mr Franks seemed more relaxed after the review and decided that his observations could remain at one every two hours.
51. On 14 February, a SO chaired an ACCT review which a mental health nurse and Mr Franks attended. The review assessed Mr Franks' risk of suicide and self-

- harm as low. The SO recorded that Mr Franks had a GP appointment booked for 27 February and presented in high spirits. Mr Franks told staff that he had recently had a visit from the police and had worked out with his solicitor that he might be released when he next attended court, and this had 'put his mind at rest'. There is no record that staff considered what might happen if Mr Franks was not released.
52. On 17 February, a SO chaired an ACCT review which, a mental health nurse, Mr Franks' mother and step-father, and Mr Franks attended. The SO recorded that Mr Franks' parents formed a large part of his support network and the prison wanted to include them. Mr Franks said that he was in a 'better place' than when he first came to prison and wanted to focus on himself so that he could face his issues about his son having cancer and re-building his relationship with his partner once he left prison. Later that day, Prison Service staff raised Mr Franks' cell sharing risk to high.
 53. At around 10.25pm on 19 February, Mr Franks told an OSG that he had made cuts to his torso. He asked for assistance and a nurse cleaned Mr Franks' wounds. At 10.30pm, a CM chaired an ACCT review which a nurse and Mr Franks attended. Mr Franks told staff that he had asked all day to see a member of the mental health team, but nobody had come to see him. He said that this caused him to 'stress out' and he harmed himself. The CM increased Mr Franks' observations to hourly and requested a mental health review. The next day, a nurse and a SO tried to see Mr Franks on the wing but he had gone to a class. Due to time constraints, they decided to wait until his next ACCT review.
 54. On 21 February, a SO chaired an ACCT review which a nurse and Mr Franks attended. Mr Franks said that he was 'in a good place' and 'just had a bit of a relapse'. The SO noted that Mr Franks had missed the managing emotions course due to an unplanned roll check, but staff had managed to add him to the course the following week.
 55. At 11.27am on 25 February, a mental health nurse reviewed Mr Franks before he went to court. He noted that Mr Franks 'threatened to swallow his dentures if taken to court', but he assessed him as fit to attend. At 11.51am, a nurse recorded that a prison manager wanted an update on Mr Franks' mental state as staff had allocated him a single cell on mental health grounds. The nurse spoke to her healthcare colleagues, reviewed Mr Franks' medical record and noted: 'no clinical indication for a single cell, sharing adds a protective factor in terms of risk management'.
 56. At 8.04pm, a nurse reviewed Mr Franks after he had returned from court and recorded that he presented as upset and extremely low in mood. Mr Franks said that he had expected to be sentenced but his case had been adjourned for trial due to additional evidence and the possibility of extra charges. The nurse requested a GP appointment to discuss antidepressant medication and noted that Mr Franks was subject to hourly ACCT observations.
 57. On 26 February, Mr Franks refused to attend a managing emotions course and staff withdrew him from the course. The next day, a prison GP reviewed Mr Franks and noted that he had a history of self-harm, mood swings and anxiety.

He prescribed trazadone (an antidepressant) and requested a review in two to three weeks.

58. On 1 March, an officer gave Mr Franks a document to sign that would allow him to contact the Ministry of Defence to confirm that he was a former soldier. The same day, he emailed a SO but to say that he had spoken to Mr Franks about his current circumstances and offered support. At interview, the officer told us that he gave Mr Franks a copy of the paperwork to sign on several occasions, but he never returned it.
59. On 4 March, a SO chaired an ACCT review which a prison chaplain, a nurse and Mr Franks attended. Mr Franks told the attendees that he had seen a GP, spoken to his son and met an officer for PTSD support. The SO noted that Mr Franks appeared to have turned a corner and staff stopped ACCT monitoring.
60. On 8 March, Mr Franks started a job, working as wing painter (he subsequently progressed to a wing cleaner). On 11 March, the SO completed the ACCT post-closure review and noted that Mr Franks said the issues that had resulted in him harming himself had resolved.
61. On 20 March, a prison GP reviewed Mr Franks who said that he had had headaches since starting trazadone. Mr Franks said that he did not feel suicidal but had started cutting himself again. The prison GP stopped trazadone and prescribed sertraline (an antidepressant) and promethazine hydrochloride (to assist sleep). However, there is no record that he considered starting ACCT procedures.
62. On 21 March, Mr Franks stopped the SO on the wing and asked her when he would have an ACCT review. She told him that ACCT monitoring had stopped, which prompted him to tell her that he had disclosed his self-harm to a GP. The SO told the investigator that she did not know whether she could start ACCT procedures and be the case manager, so she asked an officer, who collected Mr Franks from his GP appointment, to initiate ACCT monitoring. Shortly afterwards, the SO completed an immediate action plan.
63. A SO completed the ACCT assessment at 9.25pm on 22 March. He noted that Mr Franks said that he felt bullied by three cleaners on the wing and had harmed himself to cope with his anxiety. Immediately afterwards, the SO chaired an ACCT review, which a mental health nurse and Mr Franks attended. Mr Franks did not report any thoughts of suicide or self-harm and said that he would think about whether he wanted to move wings. The attendees assessed his risk as low and recorded one action on the caremap: to make a challenge support intervention plan referral (CSIP – a national case management model for managing those who are violent or pose a raised risk of harming others through violent behaviours). Prison records show that an officer started a CSIP and investigated the bullying allegations. However, there is no record that prison managers reviewed her findings.
64. On 25 March, a SO chaired an ACCT review which a nurse and Mr Franks attended. Mr Franks told the attendees that he was feeling much better as one of the prisoners who he felt bullied him, had gone to court. He said that he hoped to be released when he attended court in April and did not report any

thoughts of suicide or self-harm. The SO recorded that Mr Franks presented in a good mood and had not had any thoughts of self-harm for three days. Staff decided to stop ACCT monitoring but the caremap action was not marked as complete despite an officer making a CSIP referral.

65. On 1 April, the SO completed the ACCT post-closure review. She noted that the issues that had caused Mr Franks to self-harm had resolved and that he was 'just waiting for court'.

Events from Thursday 11 April to Friday 12 April

66. At 7.45am on 11 April, a nurse reviewed Mr Franks in reception before he left for court. He assessed him as fit to attend and noted that he did not report any health concerns. At 4.45pm, Mr Franks returned to Leeds and an officer signed his PER. In his prison statement, the officer said that he checked Mr Franks' status and noticed that he had been remanded until 9 May. He also said that Mr Franks did not report any concerns.
67. At 4.47pm, a prison GP used the prison's electronic medical record to send the following task to healthcare staff: 'if this man hasn't been released, would you book another appointment for review of mental health [sic]'. However, there is no record that healthcare staff actioned the task before Mr Franks died.
68. A prison Listener (a prisoner trained by the Samaritans to support other prisoners), told the investigator that he spoke to Mr Franks after he returned to the wing at around 6.10pm. He said that Mr Franks went into his cell, burst into tears and said that he had been sentenced to five years in prison. The prison Listener said that after Mr Franks had left, he told an officer that Mr Franks was 'in a bad way' and asked him to start ACCT procedures. He said that an officer advised him to speak to another officer as he was on duty that evening. The officer told us that he spoke to a Listener about Mr Franks, but that the Listener did not report any concerns about him. The prison Listener said that he spoke to the other officer about starting ACCT procedures and that he said that he would speak to Mr Franks.
69. A prisoner in one of the cells adjacent to Mr Franks' cell, told us that he spoke to Mr Franks after he returned to the wing and he said that he 'got five years'. The prisoner said that Mr Franks told him that he did not say anything to suggest that he would harm himself, but he thought it was a little strange that Mr Franks was giving away his belongings.
70. At around 7.00pm, an officer locked Mr Franks in his cell for the evening. (The prison could not identify the officer.) At 8.20pm, an officer looked through Mr Franks' cell observation panel to conduct a roll check. He told us that he did not notice anything unusual.
71. At 6.00am, on 12 April, an OSG opened the observation panel on Mr Franks' cell to conduct a roll check. She noticed that the bed was empty, and that Mr Franks was lying face down on the floor, with his head facing away from her. Mr Franks did not respond to her attempts to rouse him, so she radioed for assistance and waited outside the cell.

72. Shortly afterwards, a second OSG arrived and looked through the cell observation panel. He entered the cell and noticed Mr Franks lying on the floor, with his head resting on a hot water pipe. He told us that he noticed red marks around Mr Franks' neck and a piece of loose fabric attached to the cell window, and that he called a medical emergency code red (used to indicate severe bleeding).
73. At 6.03am, a nurse arrived at the cell. She noted that Mr Franks did not have a pulse and was cold and stiff. She did not start cardiopulmonary resuscitation (CPR) as it was clear that he was dead. At 6.24am, a paramedic pronounced that Mr Franks had died.

Contact with Mr Franks' family

74. At 7.05am, the prison appointed an officer as the family liaison officer (FLO). He established that Mr Franks had named his mother as his next of kin and visited her with a CM. At 8.25am, the FLO broke the news to Mr Franks' mother and offered his support.
75. The FLO and another officer who was also a FLO provided ongoing support to Mr Franks' mother until his funeral, which took place on 24 May. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

76. After Mr Franks' death, a prison manager 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.
77. The prison posted notices informing other prisoners of Mr Franks' 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 Franks' death.

Post-mortem report

78. A post-mortem examination found that Mr Franks died of hanging. Toxicology results identified therapeutic levels of sertraline in Mr Franks' blood and urine and paracetamol in his urine. The post-mortem report concluded that the absence of paracetamol in Mr Franks' blood did not exclude excessive use before his death.

Findings

Management of Mr Franks' risk of suicide and self-harm

79. Prison Service Instruction (PSI) 64/2011 (Safer Custody) requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures, as set out in PSI 64/2011.
80. Mr Franks was monitored under ACCT procedures on four occasions at Leeds. The case reviews indicate that staff made concerted efforts to work with Mr Franks to reduce his risk. They were aware of the difficulty he had managing his emotions, they demonstrated compassion and understanding, helped him get a job and involved his parents in the ACCT process. Despite this positive work, we have some concerns about the management of ACCT procedures.

Mental health assessments

81. Mental health staff completed an initial mental health assessment during the first case review the first and second time ACCT procedures started. Although both assessments were comprehensive, staff should have referred Mr Franks for a mental health assessment, as stated in PSI 64/2011. The Head of Healthcare said that as mental health staff are required to complete a mental health assessment for prisoners subject to ACCT procedures within 24 hours, it is easier for them to conduct the assessment at the first ACCT review. The PSI states that first ACCT case reviews should be used for care planning to reduce a prisoner's risk. We therefore consider that mental health assessments should take place separately.

Assessment of risk

82. Staff considered that Mr Franks was at low risk of suicide and self-harm and stopped ACCT procedures on 4 January despite the presence of risk factors, including harming himself the day before and ongoing personal stresses. This should have caused more concern as these risk factors raised his risk. Instead, staff relied heavily on Mr Franks' comments that he did not intend to harm himself. We consider that staff stopped ACCT monitoring prematurely.
83. When staff started ACCT procedures on 25 January, they did not consider re-opening the ACCT document that had been closed two days earlier. This meant that relevant information in the previous ACCT document was not immediately available to staff to enable them to make a more informed risk assessment.
84. Mr Franks went to court the day before he died and although it is not clear why, he appears to have believed that he was sentenced to five years in prison when in fact, his case was adjourned. Mr Franks had spoken about his court case on several occasions and it was noted as a positive factor when staff assessed him as low risk and decided to end ACCT monitoring on 25 March. However, no one other than a prison GP seems to have considered what might happen if he were not released. A SO told us that there was no reason to continue ACCT monitoring and that if Mr Franks received a sentence, which she recognised

would have been a trigger, Prison Service and healthcare staff would have reviewed him due to a change in circumstance.

85. Again, we are concerned that staff assessed Mr Franks as a low risk of harm to himself despite harming himself three days earlier. Staff placed too much reliance on Mr Franks saying that he felt positive about the prospect of release. While we do not suggest that Mr Franks should have been subject to ACCT procedures until his court appearance, staff should have done more to identify any increased risk after he returned to prison.

Caremaps

86. PSI 64/2011 states that completing a caremap is an integral part of the ACCT process and that it must reflect the prisoners needs, level of risk and the triggers of their distress. The PSI also notes that the caremap should be tailored to the individual needs of the prisoner and time bound.
87. We consider that not all the caremap actions set for Mr Franks were sufficient. A referral to the VIC co-ordinator for PTSD support was noted on Mr Franks' first ACCT caremap but an officer did not see him for three months. While we recognise that a prisoner manager and a SO all set and completed caremap actions to chase the VIC referral, it would have been more meaningful to arrange a meeting with an officer within a set timescale. We also consider that when the outcome to Mr Franks' court hearing was not positive for him, staff should have identified this as a trigger and appropriately addressed it in a caremap.

Cell sharing

88. When a prisoner is subject to ACCT procedures, it can sometime be helpful for them to share a cell as it reduces isolation. PSI 20/2015 on cell-sharing risk assessments categorises a high-risk prisoner as one for whom evidence indicates they might be severely violent to a cellmate or vice versa.
89. Prison Service staff raised Mr Franks' cell-sharing risk to high on 17 February and moved him to a single cell. The prison could not find the assessment, but medical records and information which a SO provided indicate that staff raised Mr Franks' risk on mental health grounds. Although a mental health nurse concluded that there was no medical indication for a single cell a week later, there is no record that staff whether explored cell sharing would have been beneficial for Mr Franks. An officer told us that she was not involved in any discussions about Mr Franks sharing a cell and did not speak to him about it in ACCT reviews. Although we do not suggest that sharing a cell would have prevented Mr Franks taking his life, we consider that ACCT reviews should have explored it.

Starting ACCT procedures

90. PSI 64/2011 requires that all staff start ACCT procedures if they are concerned that a prisoner may be at risk. A prison GP told us that he did not consider initiating ACCT procedures on 20 March as Mr Franks did not say that he felt suicidal. We consider that Mr Franks' report of self-harm meant that he

presented a risk to himself and therefore the prison GP should have started ACCT procedures.

Reception procedures for returning prisoners

91. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court, sentencing at court or being questioned by police are factors that might have a significant impact on the health of a prisoner. For those prisoners passing through reception, prisons are required to have protocols in place for screening them to identify any potential healthcare or suicide and self-harm issues. PSI 07/2015, *Early Days in Custody*, states that the PER and any other available information must be examined by reception staff and the prisoner must be interviewed to assess their risk of suicide and self-harm.
92. An officer told us that he checked Mr Franks' PER to see whether his circumstances had changed, but he did not record this anywhere. At interview, The Head of Healthcare told us that Leeds has implemented a risk screening checklist for all prisoners returning from court. He said that officers now have to document whether a prisoner's circumstances had changed and to ask them a series of questions, designed to identify any potential triggers that might increase their risk of suicide and self-harm. We are satisfied that this action is appropriate.
93. Leeds have previously accepted our recommendations intended to address the quality of ACCT procedures, but we are concerned that we have identified more deficiencies in this report. Urgent action is now required to address this. We therefore make the following recommendations:

The Head of Healthcare should ensure that initial mental health assessments are completed separate to the ACCT process.

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

- **restart ACCT procedures if a prisoner is at risk in the post-closure period;**
- **understand that regardless of grade or discipline, they have a responsibility to start ACCT procedures where necessary;**
- **consider all relevant factors when assessing the level of risk;**
- **set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; and**
- **consider whether cell sharing is appropriate and document the reasons for decisions.**

The Prison Group Director for Yorkshire should assure himself that meaningful action is being taken to ensure that ACCT procedures at Leeds improve.

94. A prisoner told the investigator that he asked both officers to start ACCT monitoring for Mr Franks. An officer told us that he had a passing conversation with a Listener who said that he had spoken to Mr Franks, but that he did not report any concerns about him. The second officer said nobody spoke to him

about Mr Franks and that if they had done, he would have spoken to Mr Franks, put an entry in the wing observation book and started ACCT procedures.

95. The prison downloaded the CCTV footage of the wing on 11 and 12 April to an external hard drive to prevent the CCTV system overwriting the evidence (which happens automatically after 28 days). However, the hard drive corrupted the data and the footage was irretrievable. We have therefore been unable to confirm whether Mr Franks went into the prisoners cell, whether he gave his belongings away or if the prisoner spoke to the second officer.
96. In the absence of CCTV, we make no finding or recommendation about whether Prison Service staff should have spoken to Mr Franks and considered starting ACCT procedures. However, while we recognise that the prison tried to ensure the CCTV footage was saved, we are concerned that the outcome was that they lost footage. We therefore make the following recommendation:

The Governor should ensure that CCTV evidence is stored securely and able to be retrieved after a death in custody.

Emergency response

97. In line with PSI 03/2013 on medical response codes, Leeds' local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
98. An OSG radioed for further assistance when she found Mr Franks unresponsive. She said that she did not call a code blue as prisoners often sleep on the floor and she wanted a second opinion. She was aware of the policy about risk assessments and entering cells at night but told us that she did not enter Mr Franks' cell as it was her first ever week of nights and she did not think that he was dead. While this caused a short delay in Mr Franks receiving attention, a second OSG arrived swiftly and entered the cell. He told us that he thought she called a code blue and that he called a code red when he saw red marks on Mr Franks' neck. However, she told us that the second OSG called a code blue shortly after calling a code red.
99. We are satisfied that her decision not to open Mr Franks cell until support arrived was reasonable in the circumstances. However, she should have called a code blue. Radioing a code blue earlier would not have changed the outcome for Mr Franks, but in other circumstances, a delay could be critical. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of the emergency.

Keyworker support

100. His keyworker should have had a weekly meeting with Mr Franks but he only met him once during a period of four months. While we recognise that Mr Franks said that he did not need support, more should have been done to engage him. Most of the help that Mr Franks received was through the ACCT process. Regular meetings with his keyworker would have added an extra layer of support for Mr Franks, particularly during the periods when he was not subject to ACCT procedures. We therefore consider that a keyworker should have had a more active and supportive role.
101. We are concerned that the keyworker was only assigned 13.5 hours for keywork out of 553.39 paid working hours between 30 December 2018 and 20 April 2019. During that time, he was allocated keywork for 8 hours on 5 January and for 1.5 hours on 15 February, equating to a total of 9.5 hours. At interview, the keyworker told us that reduced staffing levels often meant that his detail changed at the last minute. Although we appreciate that operational pressures can lead to staff changes, the prison needs to ensure that officers have enough time to complete keyworker duties. We make the following recommendation:

The Governor should ensure that:

- **the keyworker scheme provides meaningful and ongoing support to prisoners; and**
- **keyworkers are assigned an appropriate number of hours to allow them to fulfil their role.**

Violence reduction

102. A PPO publication on *violence reduction, bullying and safety*, issued in October 2011, noted the links between bullying, violence and the self-inflicted deaths of prisoners. In our PPO thematic report into self-inflicted deaths from 2013 to 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and robustly addressed. HMP Leeds use the CSIP case management model to address bullying and violent behaviour.
103. When Mr Franks reported bullying in March, an officer appropriately made a CSIP referral and investigated the allegations. A CM told us that following an investigation, a prison manager should review the referral and decide what action is required. Although the 'decisions and actions' aspect of the CSIP was not completed, we are satisfied that the prison took appropriate action by supporting and monitoring Mr Franks through the ACCT process.

Clinical care

104. The clinical reviewer concluded that the overall care that Mr Franks received at Leeds was equivalent to that which he could have expected to receive in the community. Mental health staff completed appropriate assessments, contributed to the ACCT process and referred Mr Franks for intervention to help him manage stress and his emotions more effectively. We are satisfied that although there was a delay prescribing Mr Franks an antidepressant, the overall care that he received was of a good standard.

105. The clinical reviewer identified the need for improvement in some aspects of the prison's healthcare services such as access to psychological therapies and the use of formal risk assessment tools in primary mental health. The Head of Healthcare will need to address these concerns.

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