

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jaskiran Kainth on 3 May 2019, following self- harm while in the custody of Leicester Magistrates Court

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*



© Crown copyright, 2021

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

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

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

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

Mr Jaskiran Kainth died on 3 May 2019 in Leicester Royal Infirmary after strangling himself with his trousers at Leicester Magistrates Court on 29 April 2019. He was 18 years old. I offer my condolences to Mr Kainth's family and friends.

Mr Kainth was well-known to secondary mental health services in the community and had a comprehensive package of care including a community psychiatric nurse (CPN). His mental health deteriorated further in the period leading up to 29 April.

I am concerned that information about Mr Kainth's risk was not adequately communicated to the court custody officers charged with his care. I am also concerned that the court custody staff involved in Mr Kainth's care had not received sufficient risk assessment training and were unaware of factors that indicated that Mr Kainth was at high risk of attempted suicide.

HM Inspectorate of Prisons carried out an inspection of court services in the Lincolnshire, Leicestershire, Rutland and Northamptonshire Area in November/December 2018. Several of the concerns they identified were evident in this case. I have made recommendations in this report to address the issues at Leicester, but PECS and GEOAmev should ensure that the lessons from Mr Kainth's death are learned across all areas covered by the contract.

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

Sue McAllister CB
Prisons and Probation Ombudsman

November 2021

Contents

Summary.....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings.....	11

Summary

Events

1. Mr Jaskiran Kainth had a history of mental illness, substance misuse, violence and attempted suicide. He was prescribed anti-psychotic medication and had periods of assessment in secure mental health units. He had an extensive community mental health package and a dedicated Community Psychiatric Nurse (CPN). Mr Kainth was subject to a community protection notice that required him to be accompanied by an adult in public because of his risk to women and children.
2. On 27 April 2019, Mr Kainth told a psychiatrist at Leicester Royal Infirmary that he had suicidal thoughts and had tried to strangle himself but had talked himself out of it. The psychiatrist assessed him, concluded that he was not actively psychotic, and discharged him to the care of his family. Mr Kainth returned to the hospital the same night and claimed to have taken an overdose of Lemsip and cocaine. After further assessment he was again discharged to the care of his family.
3. On 28 April, police arrested Mr Kainth for damaging his father's and grandfather's cars. He spoke to a nurse in police custody but declined to talk to a mental health nurse. The next morning Mr Kainth was taken to Leicester Magistrates Court. His person escort record (PER) noted that he had taken an overdose of paracetamol four months previously, had tried to strangle himself in 2018 and had bipolar disorder and psychosis.
4. Court escort service officers asked when Mr Kainth had tried to strangle himself and were told it was in November 2018. The court custody officer who received Mr Kainth into the magistrate's court did not question him about his risk of suicide and self-harm because he thought his previous attempts were not sufficiently recent.
5. Officers became increasingly concerned about Mr Kainth after he rang his cell bell a number of times and asked a series of odd questions. A psychiatric nurse from the criminal justice court liaison and diversion team read his mental health record and tried to speak to him, but Mr Kainth refused to sign a consent form allowing her to assess him.
6. At about 12.30pm, officers removed Mr Kainth's jumper and shoelaces after he tied his jumper around his neck in an unusual way. They began suicide and self-harm monitoring procedures and planned six irregularly spaced checks every hour. About ten minutes later Mr Kainth asked to use the toilet. Two minutes after he returned to his cell, officers discovered him unconscious and naked on the floor with his trousers tied around his neck.
7. Staff and paramedics performed cardio-pulmonary resuscitation and a doctor managed to restart Mr Kainth's heart. He was taken to hospital but died four days later without regaining consciousness.

Findings

8. Mr Kainth had a number of risk factors that indicated he was at high risk of suicide. His PER, completed by police, did not adequately reflect his risk factors.
9. Court custody staff involved in Mr Kainth's care did not follow GEOAmeY's risk assessment procedures and were inadequately trained to recognise risk. A number of indicators of risk were missed, as were opportunities to add to the risk information on Mr Kainth's PER.
10. We found no evidence that the mental health nurse at the court communicated important information about Mr Kainth's risk contained in his mental health records to court custody staff. Mr Kainth's risk to women was not passed on to all female staff or recorded on his PER.
11. Mr Kainth was left partially clothed in his cell after he removed his jumper and tied it around his neck. With hindsight staff should have considered leaving him fully clothed and on constant observation instead, although we cannot say that the removal of his jumper was a contributing factor in Mr Kainth's death.
12. We found no evidence that GEOAmeY offered financial assistance with Mr Kainth's funeral.
13. Post-incident support for staff was inadequate and options for ongoing support were badly explained and led to unnecessary distress for staff.

Recommendations

- GEOAmeY should discuss this case with the local police to ensure the information recorded on PERs gives a full account of a detainee's risk.
- PECS and GEOAmeY should ensure that court custody staff receive awareness training in the identification, assessment and management of detainees at risk of suicide or self-harm.
- PECS and GEOAmeY should ensure that court custody staff receive regular mental health awareness training in line with the recommendation made by HMIP in January 2019.
- PECS and GEOAmeY should provide extra guidance on how to manage detainees who attempt suicide and self-harm using articles of their clothing, including that detainees should be put on constant observation rather than being left partially clothed.
- PECS and GEOAmeY should ensure they have a death in custody contingency plan that covers actions to be taken following a death, including liaising with next of kin.
- PECS and GEOAmeY should ensure that after a serious incident staff are properly debriefed, made aware of the available options for support and able to access that support promptly.

The Investigation Process

14. The investigator issued notices to staff at Leicester Magistrates Court informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Kainth's custody record and mental health records. GEOAmev shared the report of their investigation into the events of 28-29 April. She interviewed five members of staff at Leicester Magistrates Court in June 2019.
16. NHS England commissioned a clinical reviewer to review Mr Kainth's contact with the mental health team at Leicester Magistrates Court. The investigator and clinical reviewer interviewed one mental health nurse in October 2019. The clinical reviewer also spoke to a Community Psychiatric Nurse by telephone.
17. We informed HM Coroner for Leicester of the investigation. The coroner provided us with Mr Kainth's cause of death. We have sent the coroner a copy of this report.
18. The investigator explained the investigation to Mr Kainth's father and asked if he had any matters he wanted the investigation to consider. Mr Kainth's father said he was extremely unhappy with the care offered to his son at Leicester Magistrates Court. We have sent him a copy of this report.

Background Information

Leicester Magistrates Court

19. Leicester Magistrates Court is a magistrate's court in Leicester city centre. The court is run by Her Majesty's Courts and Tribunal Services (HMCTS). The Prisoner Escort and Custody Services (PECS) arm of HM Prison and Probation Service (HMPPS) contract GEOAmev to provide court custody and escort services. There are 16 cells in the custody suite on the ground floor of the court. The Leicestershire Partnership NHS Foundation Trust criminal justice liaison diversion team provide mental health services at the court from Monday to Friday.

HM Inspectorate of Prisons (HMIP)

20. In January 2019, HMIP published a report on an inspection of court custody facilities in Lincolnshire, Leicestershire, Rutland and Northamptonshire in November/December 2018.
21. Overall, inspectors found a positive staff culture and that detainees were cared for and treated well in court custody facilities. However, they found that initial assessment of detainee risk lacked rigour. A recently introduced reception checklist did not provide sufficient focus on the identification and management of risk and was not used consistently. Detainees identified as being at risk of self-harm were questioned, but this was mostly rudimentary. The quality of information in person escort records (PERs) was variable. Relevant information about risk was not always recorded or was limited and not specific enough to indicate the type of risk or whether it was current or historic. The management of risk was better with checks completed at the required frequency.
22. Inspectors reported that most staff said that they had not received any training in identifying and supporting detainees experiencing mental health problems. HMIP recommended that staff should receive regular mental health awareness training.

Care Programme Approach

23. The Care Programme Approach (CPA) is an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.

Key Events

24. Mr Jaskiran Kainth had a history of mental illness including bi-polar disorder, anxiety, substance misuse (cannabis, cocaine and crack cocaine) and attempted suicide.
25. As an adolescent he was under the care of Child and Adolescent Mental Health Services (CAMHS). In August 2017, Mr Kainth was admitted to a secure psychiatric unit at Coalville Hospital following a psychotic episode. He was nursed by two nurses at a time because of his sexual disinhibition and risk to himself. While there, he swallowed a plastic ball which got stuck in his throat and had to be removed in hospital. We do not know if this was deliberate self-harm.
26. In October 2017, aged 17, he was transferred to the Psychosis Intervention and Early Recovery (PIER) service.
27. In 2018, Mr Kainth was placed under the care of safeguarding services after he made allegations of sexual assault against a member of his family. (He decided not to pursue these charges in January 2019.) On 3 September 2018, Mr Kainth reported he had tried to overdose on paracetamol but had been sick. On 4 September, he reported he had tried to strangle himself with his jogging bottoms but had passed out and woken up. On 19 December 2018, he was placed on the Care Programme Approach (CPA).

March - April 2019

28. On 3 March 2019, Mr Kainth was admitted to the Bradgate Unit (a medium secure mental health unit) after he took an overdose. On 6 March, he reported violent and sexual thoughts toward women and children and was detained in Belvoir Psychiatric Intensive Care Unit (PICU) under the Mental Health Act (MHA) 2003. On 8 March, he was released back to his family after a consultant concluded that he was not actively psychotic. On 15 March, he was made subject to a community protection notice which stipulated he should not be allowed out in public without an adult because of the risk he posed to women and children.
29. Between 15 March and 1 April, Mr Kainth received daily supportive visits from the Crisis and Home Treatment Team (CRHT). Mr Kainth was prescribed aripiprazole (an antipsychotic medication primarily used in the treatment of schizophrenia and bipolar disorder) by depot injection. Mr Kainth remained under the care of the PIER service and was allocated a community psychiatric nurse (CPN).
30. On 19 March, Mr Kainth's mental health record showed he was under investigation for an assault on a woman who he had attacked from behind, dragged to the floor and badly beaten. The police had documented other incidents in which Mr Kainth had attacked women from behind.
31. At 5.15pm on 27 April, Mr Kainth reported having chest pains and suicidal thoughts and was taken to Leicester Royal Infirmary (LRI) by ambulance. He said he had tried to strangle himself at home but had talked himself out of it. A senior clinical mental health practitioner assessed him but concluded Mr Kainth

was not actively psychotic, had insight and did not need to be admitted. He queried whether Mr Kainth had an emerging antisocial personality disorder and emerging paranoid schizophrenia. He noted that Mr Kainth had an extensive community care team, was due to see the CPN and had an appointment with a consultant forensic psychiatrist on 13 May. Mr Kainth was discharged into the care of his grandparents who had gone to hospital with him.

32. Mr Kainth returned to the LRI at 00.12am on 28 April, with his father, and reported an overdose of cocaine and Lemsip (cold and flu remedy). He told a doctor that he and his grandparents had not left the hospital after the senior clinical mental health practitioner discharged him. His grandparents had called his father who had “got on his case”. Mr Kainth said he swallowed three packets of Lemsip that he had in his bag, out of frustration. Blood tests showed no cocaine in his system. The doctor concluded that Mr Kainth did not require admission and discharged him home.
33. Both the senior clinical mental health practitioner and the doctor recorded their contact with Mr Kainth on the RiO electronic cases management system (mental health records).
34. Later the same day, police arrested Mr Kainth for damaging his father’s and his grandfather’s cars.

Police custody 28-29 April 2019

35. Police took Mr Kainth to Beaumont Leys police station at about 2.09pm. He was charged with two counts of criminal damage. His custody record showed that police decided not to release him on bail because “things are escalating at home and DP [detained person] is becoming more volatile”.
36. At 2.41pm, Mr Kainth told a member of the mental health triage team at the police station that he suffered from asthma, anxiety, bi-polar disorder and occasionally heard voices. He said he had been in hospital for about two nights for “hearing voices and bi-polar disorder”. He said that he was on a depot injection but was not due for his next dose for three weeks. Mr Kainth said he had tried to harm himself before and had taken tablets intending to kill himself “a long time ago”.
37. The mental health triage team noted that Mr Kainth would need to be accompanied by an appropriate adult and that he had self-harmed by punching himself when last in police custody. Mr Kainth said he had no current intention to harm himself and his risk was assessed as medium. Mr Kainth was checked every 30 minutes.
38. At 7.40pm, Mr Kainth asked to see a health professional. A nurse assessed him at 7.45pm. She said that he was alert, calm and cooperative and aware of why he was in custody. He told her he had asthma and had been taken to hospital about a week before for a few days but was ok now. She assessed Mr Kainth’s risk of self-harm as low.
39. At 8.23pm, Mr Kainth declined to see a mental health nurse, because he said that he felt more positive after seeing the first nurse. She said he appeared bright and engaging. She noted on Mr Kainth’s custody record that he was well-

known to secondary mental health services, early intervention services, forensic outpatients and community mental health services. He had a full package of care and was due to see his community psychiatric team on 13 May.

40. All of Mr Kainth's interactions with mental health services in police custody were recorded on the RiO system.
41. At 9.26pm, the appropriate adult (provided by the Appropriate Adult Service) told police that Mr Kainth wanted them to record that he felt victimised, harassed and verbally abused by all parties living at his home. No concerns were raised about Mr Kainth's behaviour for the remainder of his time in police custody.

Leicester Magistrates Court, 29 April 2019

42. The next morning, the police completed Mr Kainth's person escort record (PER). They recorded that Mr Kainth had taken an overdose of paracetamol a "few months ago", had tried to strangle himself in 2018 and suffered from bipolar disorder and psychosis. They made no record of Mr Kainth's very recent visits to hospital, when he had reported suicidal thoughts, attempting to strangle himself and taking an overdose, or of his risk to women.
43. At 9.05am on 29 April, Prisoner Custody Officer (PCO) A and PCO B collected Mr Kainth and three other detained persons from police custody. PCO A said that the police told him that Mr Kainth had a risk marker for mental health issues, but they had no concerns about his risk of suicide or self-harm.
44. PCO B said that the police told them that Mr Kainth needed to see a mental health professional. She asked them about the entry referring to strangulation in 2018 and the police consulted the police national computer (PNC) and told her this referred to an incident in November 2018. She did not add this extra information to the risk section of Mr Kainth's PER. She told the GEOAmeY investigator that she had been told that only the police should enter information on the PER. (This is not the case.) She said the attempt was six months ago and she did not think Mr Kainth's risk was current because he told her and her colleague that he did not feel like harming himself.
45. PCO A said he asked Mr Kainth if he was alright during the journey and Mr Kainth said that he was fine. He did not record this conversation on the PER as he should have done.
46. At 9.12am, Mr Kainth arrived at Leicester Magistrates Court. PCO C interviewed him at the desk in the court custody area. He was not available when interviews were conducted but we have read his statement and interview by the GEOAmeY investigator. He said he did not ask Mr Kainth about his current risk of suicide or self-harm because the PER entries relating to previous self-harm were not recent, and he had not arrived with a suicide and self-harm (SASH) warning form. He did not use the reception check list of questions (introduced by GEOAmeY in 2018 to remind PCOs to gather pertinent information on risk from detainees) because the court had run out of forms and the practice had lapsed.
47. The court occurrence book showed staff checked Mr Kainth in his cell at 9.29am, 9.54am, 10.15am and 11.00am. Two of these were formal checks and two, at 9.29am and 10.15am, were visits to the toilet requested by Mr Kainth. Staff said

that, in addition to the formal checks, Mr Kainth pressed his cell bell frequently. Mr Kainth sometimes just asked a number of questions. (The cell call system at Leicester Magistrates Court does not record the times of calls.)

48. PCO D said that she became gradually more concerned about Mr Kainth. At one point he stood with his back to her when she answered his cell bell. He turned around when asked to and asked her a series of questions. She said that Mr Kainth was calm and polite, but she found his questions very odd, and they did not relate to his court appearance or personal comfort that morning. She told him that there was a psychiatric nurse available in the court and Mr Kainth asked to speak to her.
49. The psychiatric nurse said PCO E telephoned her and told her that Mr Kainth had asked to speak to her. She looked Mr Kainth up on the RiO system. Mr Kainth had an outstanding appointment with the consultant forensic psychiatrist on 13 May and had not yet received his appointment letter. She printed off a copy of the letter for him and telephoned his CPN for some background information. The CPN told her that Mr Kainth had not showed psychotic symptoms during their contact sessions. He said he was not concerned about Mr Kainth's mental health, but he was concerned about his risk to others in the community.
50. At interview the nurse said she remembered reading the senior clinical mental health clinician's entry describing his assessment of Mr Kainth at hospital on 27 April but was not sure whether this was before or after she first met Mr Kainth. She did not tell court custody staff about Mr Kainth's recent visit to hospital and suicidal thoughts, nor did she add it to his PER.
51. The nurse spoke to Mr Kainth in an interview room. She explained that he needed to give his consent so she could assess him and gave him a leaflet to read. Mr Kainth read the leaflet and told her he did not want to sign the consent form.
52. The nurse said that she tried to keep Mr Kainth talking in order to explore why he had asked to see her and if there was anything on his mind. He said, "The Bradgate Unit". She gave him his appointment letter and he said he did not need it as he would not be going to the clinic and got up and left the room. She saw him laughing and smiling with the officer outside the interview room. When he had gone, she told PCO D that she should not see Mr Kainth alone, because he was a risk to women. This information was not added to Mr Kainth's PER as it should have been.
53. Mr Kainth's solicitor arrived in the custody area as the nurse was recording in Mr Kainth's PER that he had refused consent but was mentally well. She said the solicitor disagreed with her that Mr Kainth was mentally well. She said she tried to talk to him about this, but the solicitor said he did not need her opinion because he had a report from an intermediary who had spent six hours with Mr Kainth. (We asked the Coroner to obtain a copy of this report, but we had not received it at the time of writing.)
54. PCO E said the solicitor visited Mr Kainth at about 11.30am but stayed only a few minutes (Mr Kainth's PER showed the visit took place between 11.35am and 11.40am). When the solicitor came out, he said, "I'm going to get him out of

here". Staff said that Mr Kainth's solicitor did not give them any other information about Mr Kainth's state of mind, raise concerns for his safety or suggest he should be checked more frequently.

55. At about 12.30pm, PCO F, who was not carrying a cell key, asked PCO G to check Mr Kainth because she thought he was making a strange noise. PCO G said Mr Kainth had tied his jumper loosely around his neck and was standing to the left of his door. (Mr Kainth's jumper was hanging in front of his chest like a bib, and he had looped the sleeves around the back of his neck and tied them at the mid-point of his chest.) He untied the jumper and asked Mr Kainth why he had tied it in that manner. Mr Kainth did not answer the question.
56. PCO G said he thought it was an odd thing to do, so he removed Mr Kainth's jumper and coat from his cell leaving him bare chested. PCO F was on sick leave following an assault when the PPO interviews took place and was not interviewed. She told the GEOAmev investigator that Mr Kainth asked why they were taking his jumper and said he was cold but did not appear distressed or upset. The court does not have anti-ligature clothing and PCO G told the investigator he had no alternative but to leave Mr Kainth partially clothed.
57. PCO G told PCO E what he had done and began suicide and self-harm monitoring procedures. Mr Kainth was placed on six intermittent observations an hour. PCO E rang the court and asked them if they would expedite Mr Kainth's hearing.
58. Shortly afterwards, two PCOs also removed Mr Kainth's shoelaces from his shoes. One of them said they explained to Mr Kainth why they were removing his laces and he said, "That's fine". Mr Kainth was the only person in his age range in custody that morning and there was no one suitable for him to share a cell with.
59. At about 12.40pm, PCO D and PCO G answered Mr Kainth's cell bell and he asked to go to the toilet. He told PCO D that he was alright. She said she told him she was going to get the lunch ready and that he said, "Thank you".

The emergency response

60. At about 12.42pm, PCO G and PCO H checked Mr Kainth and found him naked on the floor of the cell with his trousers tied around his neck. PCO H said Mr Kainth had lost control of his bladder and bowels. He and PCO G removed the trousers from around Mr Kainth's neck and called for assistance. Four PCOs responded immediately. Initially they thought they detected a pulse and started to put Mr Kainth in the recovery position, but a PCO noticed he was not breathing. They laid him on his back instead and began cardiopulmonary resuscitation (CPR). A PCO telephoned for an ambulance.
61. A PCO went up to the court to collect the defibrillator. Another PCO began rescue breaths after collecting a venti-aid breathing mask from the first aid kit and a PCO attached the defibrillator. The defibrillator advised no electric shock and they continued CPR until ambulance paramedics arrived at 12.48pm. A PCO continued CPR while they assembled their equipment. The paramedics took over CPR. The air ambulance crew also arrived with a doctor. He

recovered a pulse and they transferred Mr Kainth to hospital. As they were leaving the building, a member of court staff said that Mr Kainth had been released on bail.

62. Two PCOs went to the hospital with Mr Kainth and subsequently met his father there. They returned to the court shortly afterwards.
63. Mr Kainth was placed in an induced coma in hospital. He did not recover consciousness and died on 3 May 2019.

Contact with Mr Kainth's family

64. The area Contracts Delivery Manager for the Prisoner Escort and Custody Service (PECS) asked HMP Leicester for help with family liaison because GEOAmeY did not have a dedicated family liaison officer. A trained family liaison officer from the prison contacted Mr Kainth's father, as did GEOAmeY's Operations Director. However, Mr Kainth's father subsequently asked for GEOAmeY to cease contacting him.
65. We have not seen evidence that GEOAmeY contributed to Mr Kainth's funeral expenses.

Support for staff

66. After Mr Kainth's death, the GEOAmeY area manager attended the custody area and spoke to the staff involved in the emergency response. Several staff told the investigator that they felt there was a lack of support from senior management above the area manager and GEOAmeY human resources staff. There were also significant delays in providing counselling support for the staff involved and staff considered that options for support were poorly communicated, which added to their distress.

Post-mortem report

67. A post-mortem report was not completed because Mr Kainth died in hospital and was not in custody at the time. The consultant treating Mr Kainth in hospital gave the cause of death as hypoxic brain injury (lack of oxygen to the brain) caused by asphyxiation.

Findings

Identification and assessment of Mr Kainth's risk

68. Mr Kainth had a number of factors that indicated he was at high risk of harm to himself and others, including: a history of attempted suicide, mental illness, contact with psychiatric services, violence, substance misuse and a domestic offence. The day before he was arrested, Mr Kainth attended hospital after complaining of chest pains and suicidal thoughts and said he had tried to strangle himself.
69. Mr Kainth's period in police custody is not within the remit of this investigation. Although we were given access to his police custody record, it is not clear exactly how much information was available to the police about his visit to hospital on 27 April. It appears, however, that the police had more detailed knowledge of Mr Kainth's risk than the entries on the PER indicated, including: the date he attempted to strangle himself in 2018, the scope of his mental health issues and treatment, his "disintegrating" domestic situation, and that he was a very serious risk to women. We consider that the information passed from the police to prison escort staff on the PER did not adequately reflect the risk Mr Kainth posed to himself or others. We recommend:

GEOAmeY should discuss this case with the local police to ensure the information recorded on PERs gives a full account of a detainee's risk.

70. Despite the inadequacy of the information received from police, we also found some missed opportunities by court staff to gain a more accurate picture of Mr Kainth's risk. PCO B properly asked for further information on Mr Kainth's previous attempt to strangle himself but did not add this information to the PER, because she thought, wrongly, that only the police were allowed to write on it. In addition, she did not pass on to PCO C the date of the strangulation attempt, because she did not think it was relevant as the attempt was six months ago and Mr Kainth said that he was ok.
71. PCO C did not use the GEOAmeY checklist of questions designed to help identify risk. The GEOAmeY investigation found that the court had run out of these forms and the practice of using them had lapsed. We note HMIP's reservations about the efficacy of this form, but the PCO also disregarded what little information there was on Mr Kainth's PER because he considered that his previous attempted suicide was not sufficiently recent. He did not question Mr Kainth about his current risk as he should have done, regardless of whether Mr Kainth had any history of attempted suicide and self-harm.
72. The nurse had access to the information about Mr Kainth's suicidal thoughts and an attempt to strangle himself two days before, on the RiO system. She was also aware that he was a risk to women. She was on long term sick leave at the time of the investigation. As a result, we did not interview her until 31 October 2019, when she said she could not remember what information she saw on RiO. Although she told PCO D not to be alone with Mr Kainth, we have not seen any evidence that she passed information about Mr Kainth's risk to other staff, and she did not put it on his PER.

73. At interview, several staff told the investigator that the PER was their main risk assessment tool. They said they had not received risk assessment training and did not know which factors indicated a person might be at high risk of suicide and self-harm. Specifically, they did not know that the biggest indicator of risk of suicide is a history of attempted suicide. This information does not go out of date and remains pertinent when assessing a person's current risk. We are concerned that the court custody officers have not received adequate training in risk assessment of suicide and self-harm and consequently there is no safety mechanism if risk factors are not identified on the PER.
74. In addition, the court staff involved in Mr Kainth's care had not received any training in mental health awareness even though many of the detainees they look after, including Mr Kainth, are mentally unwell. We note that both these issues were identified in HMIP's report of court services in Leicestershire and the surrounding areas in January 2019, and that HMIP recommended that staff should have regular mental health awareness training. We make the following recommendations:

PECS and GEOAmeY should ensure that court custody staff receive awareness training in identification, assessment and management of detainees at risk of suicide or self-harm.

PECS and GEOAmeY should ensure that court custody staff receive regular mental health awareness training in line with the recommendation made by HMIP in January 2019.

The removal of Mr Kainth's clothes

75. Standing Operating Procedure (SOP) 063, which gives guidance to GEOAmeY staff on managing detainees identified at risk of self-harm and suicide, says that the officer in charge must consider whether it is necessary to remove items such as belts and shoelaces from detainees. It goes on to say:
- “Where removal of clothing or footwear is considered necessary, authority must be obtained from an ABM grade or higher and the PER updated accordingly.”
76. The cell occupied by Mr Kainth was a small, featureless and windowless room with only a bench in it. There were no obvious ligature points, and the ceiling was high. We consider that the staff were faced with a difficult decision when Mr Kainth removed his jumper and tied the arms around his neck. Mr Kainth was dressed only in jumper, trousers and shoes and the removal of his jumper and coat left him bare chested in a cell he had already said was cold. There is no alternative clothing available in the court (and we do not criticise this, as its use should always be a last resort).
77. We understand why staff took Mr Kainth's jumper and coat and we have seen no evidence to indicate that the removal of these items caused him particular distress. However, we do not consider that a mentally ill 18-year-old should be left semi-naked in a bare court cell. It would clearly have been completely unacceptable, and against GEOAmeY guidance, to take Mr Kainth's trousers as well. However, given that they were the only means left to him of trying to kill

himself, with hindsight a better course of action would have been to leave him with his jumper and coat and put him on constant observations instead. We recommend:

PECS and GEOAmeY should provide extra guidance to staff on how to manage detainees that attempt suicide and self-harm using articles of their clothing, including that detainees should be put on constant observation rather than being left partially clothed.

Family liaison

78. The PECS area manager asked for help from a trained family liaison officer at HMP Leicester in liaising with Mr Kainth's father. Mr Kainth's father was contacted by the family liaison officer and a senior manager from GEOAmeY, but Mr Kainth's father subsequently asked not to be contacted any further. We note, however, that GEOAmeY did not offer to contribute to the funeral expenses as happens in prison deaths. We appreciate that there are very few deaths in court custody but make the following recommendation:

PECS and GEOAmeY should ensure they have a death in custody contingency plan that covers actions to be taken following a death including liaising with next of kin.

Post-incident support

79. Almost all the staff interviewed said that they felt unsupported and criticised by senior management after Mr Kainth's death. They were provided with telephone numbers for free counselling, and it was not made clear until some six weeks later that GEOAmeY would also pay for counselling if staff wanted it. A death in custody is traumatic for those involved and a number of the staff interviewed were visibly upset. We make the following recommendation:

PECS and GEOAmeY should ensure that staff are properly debriefed, made aware of the available options for support and be able to access that support promptly.

**Prisons &
Probation**

Ombudsman
Independent Investigations