

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terence Papworth, a prisoner at HMP Leeds, on 22 November 2020

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 Terence Papworth was found hanged in his cell at HMP Leeds on 22 November 2020. He was 45 years old. I offer my condolences to his family and friends.

Mr Papworth was monitored under suicide and self-harm prevention procedures (known as ACCT) on two occasions during his time at Leeds but was not being monitored when he died. His last period of ACCT monitoring ended in August 2020.

Mr Papworth was on remand, charged with murder. He attended court on 17, 18 and 20 November and his trial was due to start on 30 November. He had expressed anxiety about appearing in court.

My investigation found that staff potentially missed an opportunity to put ACCT monitoring in place in the lead up to Mr Papworth's trial. Information about Mr Papworth's potential risk of suicide and self-harm was not shared among relevant staff.

The investigation also found that Mr Papworth was not screened to assess his risk of suicide and self-harm when he returned from court as he should have been.

I also found that there was a lack of meaningful contact and engagement with Mr Papworth by both his key worker and prisoner offender manager in the months before he died, which meant opportunities to support him in the lead up to his trial were missed.

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

June 2021

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Summary

Events

1. Mr Terence Papworth was remanded to HMP Leeds on 8 June on a charge of murder. He arrived with a suicide and self-harm warning form.
2. Mr Papworth was supported using Prison Service suicide and self-harm prevention procedures (known as ACCT) on two occasions, from 9 to 30 June and from 15 July to 17 August, after he had taken an overdose of medication.
3. Mr Papworth attended court on 17, 18, 20 November and his trial was due to start on 30 November.
4. On 22 November, at around 9.28am, an officer unlocked Mr Papworth's cell for him to have exercise. The officer entered the cell and found Mr Papworth hanging from the window. The officer shouted for assistance and radioed a medical emergency code. Staff did not try to resuscitate Mr Papworth as it was clear he was dead. Paramedics attended and confirmed Mr Papworth's death at 9.35am.

Findings

5. Staff failed to start ACCT procedures for Mr Papworth when he first arrived at Leeds, despite him having several risk factors for suicide and self-harm. We note that ACCT procedures were started the next day, but we are concerned about failings in the reception screening process.
6. We found that, overall, the ACCT procedures were managed well once they had been opened. The involvement of Mr Papworth's mother was an example of good practice.
7. Mr Papworth told a mental health nurse on 12 November that he had taken an overdose a week before. She did not share this information with prison staff and did not refer him for physical health checks. This was a significant missed opportunity to provide additional support.
8. We are concerned that staff failed to identify that Mr Papworth's risk of suicide and self-harm might increase when he was due to appear in court at the start of his trial. Prison and healthcare staff were aware that he had become increasingly anxious about his court appearance. Also, there is no evidence that Mr Papworth was screened for his risk of suicide and self-harm when he returned from court.
9. While we understand that Mr Papworth's key worker met with him informally, there is no record of these contacts. Mr Papworth's offender manager also did not have regular contact with him and was unaware, until asked for information, that he was appearing in court before the start of his trial. This lack of regular meaningful contact was a missed opportunity to identify his concerns and provide additional support.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff:
 - consider all information arriving with the prisoner, particularly the PER and SASH form, when assessing their risk of suicide and self-harm;
 - start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; and
 - record the information considered and their reasoning when they decide not to start ACCT procedures.
- The Governor and Head of Healthcare should remind staff of the importance of sharing information about a prisoner's risk of suicide and self-harm so that all relevant factors are taken into account when deciding whether to start ACCT procedures.
- The Governor and Head of Healthcare should ensure that:
 - prisoners passing through reception on return to the prison after a court appearance are screened to assess their risk of suicide and self-harm and for potential health issues; and
 - PERs are completed fully and accurately in respect of the prisoner's risk of suicide and self-harm.
- The Governor should ensure that vulnerable prisoners are identified and prioritised for key work and that key workers are given time to meet regularly with the prisoners allocated to them.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Papworth's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Papworth's clinical care at the prison.
13. The investigator and clinical reviewer jointly interviewed nine members of staff and one prisoner at Leeds on 9 December and the healthcare manager on 14 December. The investigator also interviewed four members of staff. All interviews took place by video link or telephone due to COVID-19 restrictions.
14. 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.
15. The Ombudsman's family liaison officer contacted Mr Papworth's sister to explain the investigation and ask if the family had any issues, they wanted the investigation to consider. Mr Papworth's family wanted to know:
 - what medication Mr Papworth was prescribed;
 - when did Mr Papworth receive his medication;
 - was he allowed any medication in possession;
 - is there any evidence that he was neglected by staff;
 - was he on an ACCT and, if so, how often was he checked?

We have answered their questions in this report.

16. Mr Papworth's family received a copy of the initial report. They did not identify any factual inaccuracies.
17. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP Leeds

18. 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. Practice Plus Group (previously known as Care UK) provides healthcare services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Leeds was in November/December 2019. Inspectors found that the need for mental health support was high, with 61% of respondents to the HMIP survey saying that they had a mental health problem. A mental health awareness training package had been developed for prison staff but at the time of the inspection, only 63 staff had received it. Inspectors recommended that prison managers and healthcare commissioners should ensure there are sufficient mental health resources to meet unmet need.
20. Inspectors found the levels of self-harm were significantly higher than at other local prisons and since their last inspection. They noted that ACCT case management was not good enough despite PPO recommendations and the safeguarding strategy was not effective in addressing risks or the needs of individuals in crisis.
21. Inspectors found key working was developing well. All prisoners had a key worker, and staff and prisoners were reasonably positive about its value.
22. HMIP carried out a short scrutiny visit to Leeds in June 2020 (along with two other local prisons), to assess how well they had responded to the COVID-19 pandemic. Inspectors reported that Leeds was calm and well-ordered, despite the severe restrictions on the regime. Leeds had experienced a significant outbreak of the virus but had controlled it effectively. Prisoners reported being kept well informed.
23. Inspectors noted that the key worker scheme at Leeds was targeted at those prisoners who had been identified as most vulnerable during the pandemic.

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. In its annual report for the year ending December 2018, the IMB reported that prisoners were treated with humanity and respect despite current staff constraints. However, the Board was concerned about high levels of violence at Leeds.

Previous deaths at HMP Leeds

25. Mr Papworth was the 22nd prisoner to die at Leeds since November 2018. Eight of the previous deaths were self-inflicted, one was drug-related, 11 were from natural causes and the cause of one death is currently unknown. We have

previously made recommendations about reception screening procedures, identifying prisoners who may be at increased risk before their trial, the need for proper assessment when a prisoner returns from court and meaningful interactions by key workers.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and support the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.
27. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Key worker scheme

28. HMPPS's policy document, *Managing the Custodial Sentence Policy Framework*, set out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:
 - All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.
 - All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
 - Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance, so it is important that they are sufficient.

Key Events

29. On 8 June 2020, Mr Terence Papworth was remanded in prison, charged with murder, and taken to HMP Leeds. It was his first time in prison.
30. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose), court staff had recorded that Mr Papworth had overdosed on 15 May 2020, had a cut to his right index finger and the letter A (the initial of his alleged victim) scratched on his skin between his hip and groin. It also noted that Mr Papworth was a drug user and had depression. The PER was accompanied by a suicide and self-harm warning (SASH) form (also known as a BD007, the form number).
31. An officer carried out the reception screen but an Operational Support Grade (OSG), made the entry on Mr Papworth's prison record. The entry says that Mr Papworth had arrived with a SASH form but, when interviewed, said he had no thoughts of suicide or self-harm.
32. A nurse completed the first and second health screens (at the same time due to the COVID-19 restrictions). He incorrectly noted Mr Papworth had been to prison before and that he was not charged with murder or manslaughter. He noted that Mr Papworth had self-harmed in the past 12 months and had taken an overdose of drugs, but said he had no current thoughts of suicide or self-harm. The nurse referred him to mental health services for an urgent assessment. Mr Papworth said he had previously used cocaine, cannabis and ecstasy but he declined a referral to substance misuse services.
33. Mr Papworth was moved to a shared cell on D Wing, the reverse cohorting unit (RCU – where newly arrived prisoners are located for 14 days to prevent the spread of COVID-19).

First ACCT: 9 - 22 June

34. On 9 June, a nurse completed the mental health assessment. She noted that Mr Papworth was emotional when talking about the events that led to his arrest and that he faced a long sentence. She recorded that Mr Papworth's mood was low, that he had fleeting thoughts of suicide and self-harm and that he could not identify any protective factors to prevent self-harm. She started suicide and self-harm prevention measures (known as ACCT).
35. At the ACCT assessment later that day, Mr Papworth said that since the age of 28, he had tried to kill himself 'loads of times' by overdose, ligature and cutting his wrists.
36. On 10 June, during the first ACCT review, Mr Papworth said that the previous night, he had taken 16 paracetamol tablets and tied a ligature with a shoelace. Staff arranged for him to be supported by the chaplaincy team, facilitated contact with his family and referred him to the drug and alcohol recovery service (DARS), though he later said he did not need help with substance misuse.

37. On 22 June, Mr Papworth was moved from D Wing to E Wing. Staff continued ACCT monitoring until 30 June. Mr Papworth told staff that although he preferred D Wing, he was more settled and had good support from his family.

Second ACCT: 15 July – 17 August

38. On 15 July, staff started ACCT procedures again after Mr Papworth's mother contacted the prison to say that Mr Papworth had told her he had taken 56 paracetamol and 26 co-codamol tablets the previous night. A nurse examined him and found his physical observations were within normal limits, other than raised blood pressure. She arranged for urgent blood tests to check his liver function, which came back normal, and no further treatment was required. The nurse referred Mr Papworth to the prison GP. The GP referred Mr Papworth for an urgent mental health assessment and prescribed antidepressant medication (mirtazapine).
39. On 16 July, a nurse received a telephone call from the pathology laboratory who were concerned that, on reviewing Mr Papworth's paracetamol levels, they were at a level that required treatment and monitoring. Staff took Mr Papworth to hospital where he was admitted. He returned to Leeds on 18 July.
40. Staff supported Mr Papworth under ACCT procedures until 17 August. During that time, Mr Papworth said he was finding it hard coming to terms with his offence and being in prison, was very anxious about appearing in court and would rather die than go on trial and speak in public. He continued to receive support from his mother, who staff involved in the ACCT procedures. On 17 August, Mr Papworth said he was feeling more positive and although he was still not sleeping, had arranged a GP appointment for 19 August.

August - November

41. Over the next few months there were no further issues or concerns about Mr Papworth's risk of suicide and self-harm. He was employed as a wing cleaner and on 1 October, was upgraded to the enhanced regime on the Incentives and Earned Privileges scheme. He was employed full-time in the clothing exchange store (CES) from 7 October.
42. On 7 November, an officer received a telephone message from a caller to say they were concerned for Mr Papworth's safety. (The caller's name is not recorded but we assume it was Mr Papworth's mother.) The officer spoke to Mr Papworth who said that although he was stressed about his court case, he had no intentions of harming himself. The officer reminded Mr Papworth of the support available to him.
43. On 9 November, Mr Papworth attended court by video link and was again remanded and, on 11 November, he met with his solicitor, also by video link.
44. On 12 November, Mr Papworth requested a single cell, as he wanted to prepare for his court appearance, but when a Custodial Manager (CM) told him this might not be possible, Mr Papworth seemed disgruntled and said, 'Just wait and see what happens'. The CM was concerned that Mr Papworth's cellmate might be at risk. He asked for an urgent mental health assessment with a view to updating

Mr Papworth's Cell Sharing Risk Assessment (CSRA) to high so that he could get a single cell.

45. A nurse from the mental health team assessed Mr Papworth. She noted that he presented well during her assessment, did not present with any signs of mental illness and gave no indication that he was at risk of suicide or self-harm. She documented in Mr Papworth's medical record that he told her he had taken an overdose of 20 mirtazapine tablets on 5 November. She did not share this information with prison staff.
46. When asked why she had not considered starting ACCT procedures, the nurse said that Mr Papworth did not seem distressed, there were no statements of intent to self-harm and no bizarre thoughts. She said that she would open an ACCT where there were signs that a prisoner was in crisis, but she saw no signs of this when she saw Mr Papworth. She also said that Mr Papworth did not hold mirtazapine in his possession and that he had sounded flippant when he said he had taken an overdose.
47. The nurse documented on Mr Papworth's medical record that in her opinion there was no evidence that a single cell was required on mental health grounds and that no further mental health input was required at that time, but that Mr Papworth would be reviewed once he had been sentenced. Mr Papworth had no further involvement with mental health services before his death.
48. A CM reviewed the CSRA and assessed Mr Papworth as high risk, due to what he perceived as a veiled threat towards his cellmate. Mr Papworth's cellmate was moved to another cell. The CSRA was scheduled to be reviewed on 7 December.
49. On 17, 18 and 20 November, Mr Papworth appeared at Sheffield Crown Court for preliminary hearings before his trial, which was due to start on 30 November. On the PER form completed on 17 November, prison staff noted that Mr Papworth's ACCT had been closed on 17 August and a nurse ticked the form to say there were no relevant physical or mental health issues or risks. The next day prison staff noted the same information as 17 November and the same nurse completed the PER noting there were no mental health issues or risk, but that Mr Papworth had hypertension. The PER for Mr Papworth's court appearance on 20 November had 'N/A [not applicable]' next to the various risk factors; there was no information about his history of suicide attempts and self-harm. A different nurse completed the medical section and noted there were no mental health issues or risks, but that Mr Papworth had hypertension.
50. Staff at Leeds hold a weekly Safety Intervention Meeting (SIM) to discuss managing risks to prisoners and the prison. It is attended by Heads of Function, including Safer Custody, OMU and healthcare managers. On 18 November, Mr Papworth was listed for discussion having been identified as a prisoner facing a potential life sentence. At the meeting, a CM said that Mr Papworth had been increased to a high risk CSRA and had not been his usual self but had been assessed by the mental health team. Mr Papworth's offender manager told the meeting that Mr Papworth was in court that day, and speculated it was to see his solicitor. Further information was requested for the next meeting.

51. Mr Papworth maintained contact with his family and friends throughout his time at Leeds. All prisoners' telephone calls, except those that are legally privileged, are recorded and prison staff listen to a random sample. The investigator was provided with a summary note of the calls made by Mr Papworth in the days before he died. On 19 November at 10.46pm, Mr Papworth spoke to his mother and sister for just over 13 minutes. He was tearful and worried for their safety at court, but they reassured him and said they would continue to support him.
52. On 20 November, after he returned from court, Mr Papworth made a total of 13 calls to family and friends, four of which were not answered. During these calls he spoke about the court proceedings and his concerns about attending court the following week. There was nothing in these calls to suggest he was in crisis.
53. On 21 November at 3.08pm, Mr Papworth made his last telephone call to his mother, which lasted just over 14 minutes. Although Mr Papworth said he was concerned about the court case, he also spoke about having a suit handed in to wear for his trial. There was nothing during this conversation to suggest Mr Papworth was considering suicide. At 4.11pm, Mr Papworth collected his meal and was locked in his cell for the night. The landing lights were switched off around 6.30pm, but Mr Papworth had his cell light on. At 8.45pm an officer looked through the observation panel on Mr Papworth's cell and CCTV shows that the officer gave him a thumbs up sign before closing the observation panel.

22 November

54. CCTV shows at 12.11am Mr Papworth turned his cell light off. At 5.30am, the night patrol officer completed the early morning roll check. When he arrived at Mr Papworth's cell, he opened the observation panel, shone a torch to check the cell and moved to the next cell. At 7.17am the landing lights were switched on.
55. At 9.28am, an officer opened Mr Papworth's cell to let him out for morning exercise. At first, he thought Mr Papworth was asleep in bed but when he entered the cell, he discovered him hanging by a piece of bed sheet attached to the window. There was also blood on the floor from cuts on Mr Papworth's wrists.
56. The officer radioed a code blue medical emergency (indicating a prisoner not breathing) and, as he was unable to move Mr Papworth on his own, he briefly left the cell to call for help. Staff who were close by responded immediately. One officer activated her body-worn video camera (BWVC). They helped to cut the ligature and lowered Mr Papworth to the floor. They described Mr Papworth as cold, stiff and grey and did not start cardiopulmonary resuscitation (CPR) as it was clear that he was dead.
57. At 9.31am, three nurses responded to the code blue and entered Mr Papworth's cell. A nurse recorded that Mr Papworth was cold and rigor mortis was present, signs that he had been dead for some time, and agreed with prison staff that CPR would have been inappropriate.
58. Yorkshire Ambulance Service confirmed they received a request for an emergency ambulance at 9.29am. Paramedics arrived at Mr Papworth's cell at 9.35am and confirmed his death.

After Mr Papworth's death

59. A prisoner that worked with Mr Papworth in the CES, said that a few weeks before Mr Papworth went to court, he appeared depressed, said he could not manage his situation and spoke of 'stringing up' [taking his own life]. He said he asked Mr Papworth if he was okay, but he said Mr Papworth joked about it and said it was difficult to know if he was being serious.
60. The prisoner said during this time Mr Papworth gave him a package, which he said contained letters and information about his court case that he wanted his mother to have. He said it was a large package that Mr Papworth would not be able to send himself, so he agreed to take it to his mother when he was released. He said he was not suspicious about the content of the package and simply believed it was a way of circumnavigating the prison postal system.
61. The prisoner said in the week before Mr Papworth appeared in court, he was a changed man; he was talkative, laughing and joking at work. He said as soon as he found out that Mr Papworth had killed himself, he handed the unopened package to prison staff. He said he did not know what was in the package and had never opened it.
62. West Yorkshire Police confirmed that there were several suicide letters in the package. It is not known when they were written. There were two main letters, one addressed to Mr Papworth's mother and the other to his best friend, together with some shorter notes to friends. In the note to his mother Mr Papworth wrote that he was anxious about speaking in court. He also wrote that 5 November was when he 'went out with a bang', which was the day he told a mental health nurse he had taken an overdose of prescription medication.

Contact with Mr Papworth's family

63. Leeds appointed an officer as the family liaison officer (FLO). While under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO, government advice at the time prohibited all but essential travel and required social distancing to prevent the spread of the COVID-19 virus.
64. The officer contacted Mr Papworth's family to break the news of his death by telephone. In line with Prison Service instructions, the prison contributed towards the costs of Mr Papworth's funeral, which was held on 18 December.

Support for prisoners and staff

65. After Mr Papworth's death, the 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 Papworth'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 Papworth's death.

Post-mortem report

66. The post-mortem report concludes that Mr Papworth's death was due to hanging.

Findings

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

Reception

67. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* sets out the procedures (known as ACCT) that staff must follow when they identify that a prisoner is at risk of suicide and self-harm. It lists risk factors and potential triggers for suicide and self-harm.
68. Mr Papworth arrived at Leeds with a number of these risk factors: it was his first time in custody; he was charged with the murder of his partner and faced a life sentence if found guilty; he had a history of mental health and substance misuse issues and he had recently tried to take his own life. Although he arrived with a suicide and self-harm warning form, neither the reception officer nor the reception nurse started ACCT procedures. We acknowledge that a mental health nurse started ACCT procedures the next day, but we are concerned that reception staff failed to do so despite Mr Papworth's obvious risk factors. They recorded that Mr Papworth denied any thoughts of suicide and the nurse recorded Mr Papworth's risk factors incorrectly. We recommend:

The Governor and Head of Healthcare should ensure that reception staff:

- **consider all information arriving with the prisoner, particularly the PER and SASH form, when assessing their risk of suicide and self-harm;**
- **start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; and**
- **record the information considered and their reasoning when they decide not to start ACCT procedures.**

Disclosure of overdose

69. Mr Papworth told a nurse on 12 November, that he had taken an overdose on 5 November. The nurse assessed that he showed no signs of being at risk of suicide and self-harm and considered that she did not need to start ACCT procedures. However, she did not share the information about the alleged overdose with wing staff. We consider that she should have done and there should have been a discussion about whether Mr Papworth should be supported under ACCT. Wing staff were aware that Mr Papworth was anxious about his trial and it is possible that they may have started ACCT procedures if they had they been made aware of the alleged overdose. We recommend:

The Governor and Head of Healthcare should remind staff of the importance of sharing information about a prisoner's risk of suicide and self-harm so that all relevant factors are taken into account when deciding whether to start ACCT procedures.

Court appearance

70. Prison Service Order (PSO) 3050, *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. There is no record this was done in Mr Papworth's case. Also, information on the PER about Mr Papworth's risk of suicide and self-harm was inaccurate or missing.
71. The Head of Safety and the acting Head of Healthcare told the investigator that they are revising the arrangements for reviewing prisoners returning from court. The protocol in place at the time of Mr Papworth's death was that prisoners sentenced to over 10 years would be referred to mental health for review, but there was no arrangement for routine review or assessment prior to sentence.
72. The Head of Safety said that since 9 December 2020, following the deaths of Mr Papworth and another prisoner who had both recently appeared in court, staff are now doing a wellbeing check of every prisoner returning from court, and this will be recorded on the prisoner's record for every court appearance.
73. The Head of Safety said there was no mechanism in place to identify prisoners or situations that might be triggers for suicide and self-harm. He said that key dates, such as trials and sentencing, and the nature of certain offences that might increase risk were now flagged as part of the weekly Safety Intervention Meetings (SIM) and there is an expectation that this information is shared with relevant departments, including healthcare. Since 25 January 2021, a daily report of all prisoners on this list with the key dates has been sent to all managers.
74. The Head of Safety provided some context to the pressures faced at Leeds around the time of Mr Papworth's death. He said that during October and November, around 120-150 staff were absent from the prison because they had either tested positive for COVID-19 or were isolating. He said he was confident that despite the challenges faced, the revisions in the process for identifying prisoners possibly at increased risk of suicide or self-harm could be implemented but would continue to be reviewed.
75. We acknowledge the significant difficulties Leeds faced due to the COVID-19 pandemic, and that Leeds have already reviewed and revised processes for identifying those men who may be at increased risk. However, these new protocols need to be implemented and understood by all those involved in the reception process and those receiving information from the daily SIM reports and contributing to the weekly SIM meeting.
76. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **prisoners passing through reception on return to the prison after a court appearance are screened to assess their risk of suicide and self-harm and for potential health issues; and**

- **PERs are completed fully and accurately in respect of the prisoner's risk of suicide and self-harm.**

Clinical care

77. The clinical reviewer concluded that the healthcare Mr Papworth received was of a mixed standard and not wholly equivalent to that which he could have expected to receive in the community.
78. The clinical reviewer found that Mr Papworth received appropriate and responsive care for his physical healthcare issues and from substance misuse services.
79. The clinical reviewer also found that Mr Papworth was offered responsive, appropriate care from mental health services while he was subject to ACCT procedures. However, the clinical reviewer was concerned that the nurse did not share information about Mr Papworth's alleged overdose or arrange follow up care.
80. The Head of Healthcare held an investigation into the nurse's actions on 12 November. He informed us in an email on 2 March 2021, that the nurse was unsuccessful in completing her probationary period and is no longer employed by the Practice Plus Group. We therefore make no recommendation.

Key work scheme

81. Key work was formally suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. On 12 May, the Prison Service issued an Exceptional Delivery Model (EDM) for key work which was introduced nationally and provided a framework of principles within which establishments must operate, leaving the details of the delivery to local determination. The EDM set out the expectations of contact and that all contacts and concerns should be recorded on a prisoner's record. The EDM identified priority prisoner groups where it was recommended that key work should continue, which included those prisoners at risk of suicide or self-harm.
82. Mr Papworth's key worker met him once on 8 July; she tried again on 18 November, but he was in court. She said she had planned to see him on the morning he died. Despite Mr Papworth being subject to ACCT measures, there is no evidence of meaningful contact with his key worker in over four months. She said she had met and spoken with Mr Papworth on other occasions but had not made an entry in his prison record. She said Mr Papworth spoke about preparing for his trial and that there was nothing in these exchanges that caused her concern. She acknowledged she should have made entries in Mr Papworth's prison record.
83. Mr Papworth's prisoner offender manager was asked to contribute to the SIM meeting with an update about Mr Papworth's court appearances in mid-November. She said she had not recently seen Mr Papworth and only realised he was in court on 17 November, when she received a notification to contribute to the SIM. She said she was confused as she understood Mr Papworth's trial

was due to start on 30 November. She did not contact the court herself for an update and did not speak to Mr Papworth's key worker.

84. We have previously identified concerns about the key worker scheme at Leeds during the pandemic. We acknowledge the significant pressures faced at Leeds around the time of Mr Papworth's death due to low staff numbers. However, we consider that prisoners who may be at increased risk of suicide and self-harm, especially at significant times such as the start of a trial, should be a priority group for key work support. Our investigation has also identified the need for improved communication between those working with prisoners to ensure information is appropriately shared to identify, manage and mitigate risk. We therefore make the following recommendation:

The Governor should ensure that vulnerable prisoners are identified and prioritised for key work and that key workers are given time to meet regularly with the prisoners allocated to them.

**Prisons &
Probation**

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