Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dominic Noble, a prisoner at HMP Leeds, on 15 August 2020

A report by the Prisons and Probation Ombudsman

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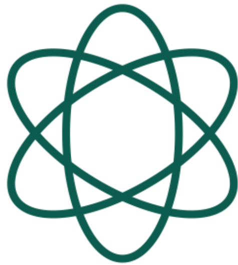
Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Dominic Noble was found hanged in his cell at HMP Leeds on 15 August 2020. He was 32 years old. I offer my condolences to his family and friends.

Mr Noble took his life just over two months after he arrived at Leeds. While some concerns were raised about his mental health, no significant concerns were raised when assessments were completed. Nonetheless, a routine referral was made for Mr Noble to see a psychiatrist. Unfortunately, this appointment did not take place before Mr Noble died as there was no coordinated system in place to ensure prisoners were seen promptly. We cannot say to what extent a psychiatric assessment might have addressed his needs.

However, I am satisfied that Mr Noble gave staff no indication that he was at imminent risk of suicide or self-harm before his death.

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

Sue McAllister CB
Prisons and Probation Ombudsman **July 2022**

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Summary

Events

1. On 8 June 2020, Mr Dominic Noble was remanded to HMP Leeds, charged with terrorist offences. His Person Escort Record (PER) said that he had depression, had tried to take his life by making a noose in December 2019 and smoked cannabis daily. Based on this information, the escort team completed a suicide and self-harm warning form which accompanied Mr Noble to prison.
2. On 10 and 14 July, a mental health nurse assessed Mr Noble after he said that he was hearing voices and had paranoid thoughts. He was referred for a routine assessment with a psychiatrist but this was not completed before he died.
3. On 17 July, Mr Noble damaged his cell, and was left with no running water. He was moved to a new cell four days later.
4. On 21 July, Mr Noble was moved to a different wing. He told staff he felt calmer there as it was quieter than his previous wing.
5. On 15 August, an officer found Mr Noble hanged in his cell. The officer radioed a medical emergency code blue and staff responded quickly. Staff tried to resuscitate Mr Noble until paramedics arrived and took over. They were unable to resuscitate Mr Noble and pronounced that he had died.

Findings

6. We are satisfied that staff reviewed Mr Noble's risk information and assessed his risk of suicide and self-harm appropriately when he arrived at Leeds.
7. We are satisfied that staff could not reasonably have predicted or prevented Mr Noble's actions on 15 August.
8. We are, however, concerned that Mr Noble spent four days in a damaged cell without running water. We cannot say whether this may have affected his mental state.
9. We also note that, like other prisoners, Mr Noble spent much of his time in his cell because of the restrictions in place during the Covid-19 pandemic. We cannot say whether this may have affected his mental state or whether staff would have been better placed to identify Mr Noble's distress if they had had more engagement with him.
10. The clinical reviewer concluded that the clinical care that Mr Noble received at Leeds was of a good standard and at least equivalent to that which he could have expected to receive in the community. His only concern was that there was no clear referral process for non-urgent cases to see a psychiatrist.

Recommendations

- The Governor should ensure that when a prisoner damages a cell to the extent that his basic needs cannot be met, prison staff should:

- move him to another cell as quickly as possible; and
- in the meantime, record the damage, monitor the wellbeing of the prisoner while he remains in the cell, and escalate the situation to managers to resolve promptly.

- The Mental Health Team Manager should ensure that there is a clear, time-bound referral process for prisoners to see a psychiatrist, even when it is considered that the case is not urgent.

The Investigation Process

11. 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.

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

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

14. The investigator interviewed nine members of staff and one prisoner at Leeds, some jointly with the clinical reviewer. The interviews were completed by video and telephone because of the restrictions imposed due to the COVID-19 pandemic.

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

16. We contacted Mr Noble's family to explain the investigation. Mr Noble's mother wanted to know the full circumstances leading to Mr Noble's death, including:

    - how much time he was allowed out of his cell and was he allowed to take a shower;
    - why he damaged his cell and why he was not relocated afterwards;
    - whether his risk of suicide and self-harm had been assessed and whether he was subject to suicide and self-harm monitoring;
    - what level of mental health care input he had received; and
    - whether he had used illicit substances in prison?

    We have tried to address her concerns in this report as well as in separate correspondence attached to this report.

17. Mr Noble's family's solicitor received a copy of the initial report. They did not make any comments.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies in the report and accepted all recommendations. Their action plan is attached as an annex.

Background Information

HMP Leeds

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

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Leeds was in November to December 2019. Inspectors found the levels of self-harm were significantly higher than other local prisons and since their last inspection. They noted that the case management of suicide and self-harm prevention procedures, known as ACCT, was not good enough despite our recommendations and the safeguarding strategy was not effective in addressing risks or the needs of individuals in crisis.

21. Inspectors also noted that around two-thirds of prisoners were living in cramped cells which were designed for one person. Inspectors found that the capacity of the prison had been reduced slightly but overcrowding was a serious problem, which had a negative impact on many areas of prison life. They noted that a large proportion of disciplinary hearings were for damage to prison property.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. The IMB report for the year ending December 2018 found that prisoners were treated with humanity and respect given the current staff constraints. The IMB noted that unlike similar prisons, HMP Leeds did not have a dedicated mental health facility.

Previous deaths at HMP Leeds

23. Mr Noble was the eighth prisoner to die at Leeds since August 2018. Of the previous deaths, two were self-inflicted, three were from natural causes, one was drug-related and one death is awaiting classification. There have been two further deaths at Leeds since Mr Noble’s death, one self-inflicted and one from natural causes.

24. We have previously made recommendations about the mental health provision at Leeds.

Key Events

HMP Leeds

25. On 8 June 2020, Mr Dominic Noble was remanded to HMP Leeds, charged with distributing terrorist material. It was his first time in prison. He arrived with a suicide and self-harm warning form which noted that in December 2019, he had made a noose to strangle himself, and had written a number of suicide notes but had not acted on them. Mr Noble told escort staff that he had no intention of harming himself in prison. The escort officer recorded that Mr Noble's risk should be reassessed at Leeds.

26. The Person Escort Record (PER), which accompanied Mr Noble to Leeds, noted that he had a history of substance misuse (cannabis), had depression and a minor shoulder injury.

27. A Senior Officer (SO) started the reception screening process when Mr Noble arrived. He interviewed Mr Noble, reviewed the PER and suicide and self-harm warning form and assessed that it was not necessary to start suicide and self-harm procedures, known as ACCT.

28. An officer booked Mr Noble into Leeds and noted that he was considered a high-risk prisoner and should not share a cell. This meant Mr Noble would be located in a single cell and not share with another prisoner.

29. A mental health nurse completed Mr Noble's initial and secondary health screens at the same time due to the Covid-19 restrictions in place. Mr Noble said that he used cannabis, had depression and was not taking any medication. He said that he had no thoughts of suicide or self-harm. The nurse viewed the PER and suicide and self-harm warning form. He completed a mini mental health state examination (a screening tool for cognitive function) but had no concerns about Mr Noble's mental state. He noted that Mr Noble displayed no evidence of perceptual abnormalities or thought disorders and that he said he had no thoughts of suicide or self-harm.

30. Although the PER noted that Mr Noble smoked cannabis daily, he declined a drug test and input from the substance misuse team.

31. Mr Noble was sent to the First Night Centre on D Wing.

32. On 10 June, a member of staff from the security team spoke to Mr Noble about his offence and extremist beliefs. Mr Noble said that he had never been in prison before. She explained that prison held a number of prisoners from diverse backgrounds and his views may put him at risk if he tried to impose his beliefs on others. She advised Mr Noble to think carefully about this when interacting with others as his safety could be jeopardised.

33. On 11 June, a mental health nurse at Leeds, received a telephone call and email from a forensic nurse practitioner at the Counter Terrorism Policing North West Team. The forensic nurse practitioner said that Mr Noble had been referred to the community mental health team the previous month because of concerns about his mental health as he had (self-reported) anxiety and depression and displayed a high level of violence towards the police.

34. A nurse noted that Mr Noble had been discussed at the prison's mental health multidisciplinary team meeting. There was no evidence that Mr Noble had been prescribed mental health medication in the community but it was agreed he should be referred for a mental health assessment at Leeds.

35. On 12 June, Mr Noble's key worker saw and introduced herself to Mr Noble. Mr Noble said that he was 'okay' and did not need anything.

36. That day, Mr Noble's medical records showed that healthcare staff had received information from Mr Noble's community GP that he was not prescribed any medication.

37. On 16 June, a resettlement worker saw Mr Noble and completed his basic custody screen. She recorded information about Mr Noble's housing, accommodation on release, finance and family concerns. Mr Noble said that he used cannabis in the community but did not drink very often. He said that he was aware of the prison's substance misuse service and would contact them if he needed support. Mr Noble said that he had a problem with the way he thought but he did not specify a diagnosed mental health condition.

38. Later that day, a nurse from the mental health team saw Mr Noble in his cell. He noted that Mr Noble engaged well and displayed no evidence of a thought disorder. Mr Noble expressed some unusual ideologies but he suggested that this was due to his interest in science. He said that he used copious amounts of cannabis and denied using any other illicit substance. He said he had no thoughts of suicide or self-harm. The nurse found no evidence that Mr Noble had any mental health symptoms and was satisfied that he did not need further input from the mental health team.

39. An officer completed a key worker session with Mr Noble the next day. Mr Noble said that he was 'okay' and had no issues. He had however missed the daily exercise period because he was not yet used to the prison regime.

40. On 18 June, a nurse discussed the findings of Mr Noble's mental health assessment at the mental health multidisciplinary team meeting, which nurses and the Team Manager attended. On the basis of the findings, the team agreed that Mr Noble did not need further input from the mental health team and he was discharged from their caseload.

41. On 22 June, Mr Noble was moved to B Wing. An officer completed a key worker session with him.

42. On 23 June, Mr Noble attended a meeting by video link to speak to his solicitor. Staff noted no concerns.

43. That day, a nurse attended Mr Noble's cell to dress an abscess. Mr Noble said that he regularly got abscesses and was capable of dressing them himself. The nurse gave Mr Noble a supply of dressings and prescribed doxycycline (an antibiotic).

44. On 24 June, staff gave Mr Noble a disciplinary warning for constantly banging on his cell door and threatening staff. An officer spoke to Mr Noble who said he was upset about not receiving money that had been sent to his private prison account. The officer noted that despite reasoning with Mr Noble, he continued to be

disruptive. Consequently, Mr Noble was not allowed out for his shower and exercise that day and it was agreed that his food would be taken to his cell door (rather than allowing him out to collect it) until he calmed down and his behaviour improved.

45. On 25 June, it was recorded on prison intelligence reports that the security team had screened a telephone call in which Mr Noble had threatened to harm a member of staff, thought to be an officer. He also talked about killing other staff. The intelligence records noted that the officer had been informed and that a move to another wing was planned for Mr Noble.

46. Staff started a Challenge, Support and Intervention Plan (CSIP) because of Mr Noble's behaviour. (CSIP is a multidisciplinary approach which focuses on those who pose a raised risk of being violent and works to change their behaviour. It is centred on the needs of the individual to support an improvement in behaviour.)

47. On 26 June, Mr Noble attended court by video link. Later that day, a nurse saw Mr Noble again. She dressed his abscess and prescribed an antibiotic.

48. An officer saw Mr Noble on 29 June for a key worker session. She noted that Mr Noble had now been moved to E Wing. Mr Noble said that he had been moved because he had some issues with the food menu. He said that he had no issues with his new location.

49. That day, staff searched Mr Noble's cell. They found and removed two pieces of metal in his shoes.

50. On 7 July, an officer completed a key worker session with Mr Noble who raised a concern about ordering from the food menu which he said had been resolved. Mr Noble said he wanted more time out of his cell. The officer explained that the current regime was limited because of Covid-19. Mr Noble said that he understood.

51. A Custodial Manager (CM) and an officer completed a CSIP review with Mr Noble on 8 July. The CM recorded that Mr Noble had been unsettled and had damaged the contents of his cell. Mr Noble said that he did not want to be on E Wing and wanted to be on the "old side of the prison". The CM noted that the mental health team had assessed Mr Noble and referred him for a non-urgent appointment with the psychiatrist. Staff arranged for Mr Noble to move to C Wing, which he was happy about. The CM noted that CSIP monitoring would continue as a result of Mr Noble's recent poor behaviour and his impending move to C Wing.

52. On 10 July, Mr Noble told a wing officer that he was hearing voices and saw figures on the wall. Staff reported this to the healthcare team and said that Mr Noble appeared to be paranoid and in a state of distress. A nurse requested that the mental health team should see Mr Noble for an urgent assessment.

53. A mental health nurse saw Mr Noble in his cell and assessed him for emerging psychotic symptoms. Mr Noble said that since he had been on E Wing, his mental health had declined. He believed that he could hear staff and prisoners mocking him and felt paranoid that someone would try to enter his cell at night and harm him. He spoke about hearing people plotting against him. Mr Noble said that he was unsure if his thoughts were real or hallucinatory. The nurse noted that Mr

Noble was able to rationalise some of his thoughts. He considered that Mr Noble would need a more comprehensive psychiatric assessment in the mental health clinic. He referred Mr Noble to see the prison psychiatrist. Mr Noble was placed on a waiting list. This appointment was not considered urgent as the nurse's assessment was that Mr Noble's presentation did not warrant this as he did not appear distressed and demonstrated no evidence of hallucinations.

54. On 13 July, an officer from the Safer Custody Team visited Mr Noble after a telephone call from his mother. Mr Noble's mother was concerned about her son after he had told her by telephone a few days earlier that another prisoner was making a gun to kill him and that prison officers "were in on it". Mr Noble's mother said that Mr Noble had been very paranoid in the community but had refused to see a GP.

55. Mr Noble told the officer that he believed the prison had a secret room on the wing, where a gun was being made. He also believed that the fire alarm in his cell was being used as a covert monitoring tool. The officer emailed a senior mental health nurse, about this. The nurse replied to say that Mr Noble was due to have a mental health assessment the next day.

56. The next morning, the nurse noted in Mr Noble's medical record that she had received information from the security team who had screened a telephone call from Mr Noble the previous night. Mr Noble had left a message saying that someone in the prison had a gun and was trying to kill him, and he needed to get out of the prison. He said that he had problems sleeping and was hearing others talking about him. He said that he needed help and wanted to get in touch with the police.

57. That afternoon, a nurse completed a mental health assessment for Mr Noble. He said he had sleeping problems but was eating well, participating in exercise and taking regular showers. He said that he had no thoughts of suicide or self-harm but had made a noose in the first night centre, which he had later disposed of as he did not intend to use it. He confirmed that he had not harmed himself since or tried to take his life. He denied that he had used any illicit substances, except for cannabis, which he had used daily from November 2019 until his arrest.

58. The nurse noted that Mr Noble displayed no evidence of distress, hopelessness or helplessness during the assessment. She described him as articulate and insightful and said that he presented as grandiose at times in the way he explained things. Mr Noble expressed paranoid thoughts and auditory hallucinations and could not identify if they were real. The nurse noted that he displayed personality disorder traits. She assessed that he did not present as acutely mentally unwell or psychotic. She felt that Mr Noble should see a psychiatrist but not as a matter of urgency. She was aware that he was already on the psychiatrist's waiting list.

59. On 16 July, staff gave Mr Noble a disciplinary warning after he damaged the cell door observation panel.

60. On the morning of 17 July, a nurse reviewed Mr Noble's abscess, which was healing. She noted that Mr Noble said he was uncertain about his medication and believed he had been poisoned. She noted that Mr Noble appeared to have mental ill health and that he was under the care of the mental health team.

61. At around 11.00am, Mr Noble damaged his cell door observation panel by removing it from the door, using a plank of wood which he obtained by damaging the cell's wooden privacy screen. Staff removed two pieces of wood from outside his cell. Mr Noble continued to damage his cell by removing the sink from the wall. This resulted in the flooding of the wing landing and another prisoner's cell below. He also removed his toilet seat and threw it out of the observation panel. Staff used a stand-alone shield and sandbags to contain the situation. However, Mr Noble used a weapon he had made from a piece of wood to attack the shield outside his cell door, while continuously shouting abuse at other prisoners and staff.

62. Mr Noble was charged with a disciplinary offence for this behaviour and was placed on restrictions, which included access to his television and canteen (the prison shop).

63. Mr Noble was not immediately moved to a new cell and remained in his cell despite the damage he caused. This was in line with local instructions, issued on 31 March 2020 which stated that, during the Covid-19 pandemic,

> "…prisoners will not be relocated from a cell which they have damaged…The risk is too great, in the current climate, for internal repair staff and/or external contractors to enter the establishment and/or individual cell/s to undertake work that has been deliberately caused by the occupant of that cell."

64. Mr Noble's cell had no running water to the damaged sink. However, the toilet was working, despite damage to the seat. Staff issued Mr Noble with a large bottle of water on a daily basis. The investigator was told that wing staff had allowed Mr Noble to clean his cell after it had been flooded.

65. Mr Noble attended a disciplinary hearing on 20 July for his recent behaviour. He was found guilty of smashing the observation panel in his cell and his privileges were forfeited for 28 days. On 3 August, Mr Noble was also found guilty of damaging the cell, for which he had to pay damages and lost 42 days of access to canteen and private cash.

66. The CM held a CSIP review on 21 July. The mental health team contributed to the review. Mr Noble was moved to a 'robust cell' (in which metal fixtures and fittings are attached to the floor and walls) on C Wing.

67. On 28 July, a prison GP saw Mr Noble about an abscess and prescribed him a prolonged course of antibiotics.

68. On 29 July, Mr Noble attended court by video link and was further remanded into custody. The next day, Mr Noble was moved to a standard cell on C Wing.

69. On 4 August, an officer from the Safer Custody Team completed a CSIP review with Mr Noble. A nurse contributed. She said that the mental health team had assessed him but did not consider him acutely unwell despite occasional paranoid thoughts and behaviour. The officer noted that since Mr Noble had moved to C Wing, his behaviour had improved and he had not damaged the two cells he had lived in. Staff reported Mr Noble was happy, progressing well and engaged positively with staff and other prisoners. Mr Noble had told an officer on C Wing, that the more enclosed structure of C Wing suited him more than E Wing as it was much quieter. Mr Noble said that he wanted to move to the "fours" landing (fourth

floor top landing) as this would further lessen the wing noise. An officer recorded that Mr Noble would be moved to the fourth landing as it would help his mental health and support his progression. As Mr Noble was positive and settled, the officer stopped CSIP monitoring and moved Mr Noble to the fourth landing.

70. On 8 August, an officer completed a key worker session with Mr Noble in his cell. Mr Noble said that he was doing well and felt calmer on C Wing. He talked about his time on E Wing which he said had been 'frustrating' and resulted in him damaging his cell.

71. On 9 August, an officer spoke to Mr Noble after it was alleged that he had recently said that he would kill a member of staff because he had not received mail from his solicitor. Mr Noble denied that he had said that. He said that he had shouted out at a member of staff who was walking across the landing to ask why his mail had been delivered to E Wing when he no longer lived there. The officer explained the mail process to Mr Noble who appeared to understand and apologised for his behaviour. Mr Noble also confirmed that he had recently received his legal mail.

72. An officer completed a key worker session with Mr Noble on 11 August in his cell. He had no issues to raise.

73. On 12 August, Mr Noble attended court by video link. The court further remanded him into custody.

15 August 2020

74. On the morning of 15 August, an officer told us that Mr Noble left his cell for a shower and exercise. He returned to his cell afterwards.

75. Mr Noble phoned his grandmother at 11.04am and asked her for money and clothes.

76. CCTV footage shows that Mr Noble collected his lunch from the servery at 11.11am and was seen talking to other prisoners on the wing before he returned to his cell.

77. At 11.19am, the officer checked on Mr Noble as part of the wing roll check. She raised no concerns about him.

78. At 11.27am, Mr Noble phoned his mother but no one answered. (This was the fourth time that Mr Noble had tried to call his mother that morning.)

79. At 11.30am, staff started the process of handing out canteen items. As Mr Noble had not ordered anything, staff had no reason to go to his cell. Staff had their lunch break from 12.30pm to 1.30pm.

80. After lunch, two officers started the accommodation and fabric checks (AFCs) on the fours landing. Just before 2.04pm, an officer tried to unlock Mr Noble's cell to complete the AFC but the door would not open. She took a step back to examine why the door had not opened and noticed there was a bolt on it. (An officer normally worked on E Wing, where the cell doors do not have exterior bolts.) She called to the other officer, who was nearby and unbolted the door for her.

81. As an officer was walking away, the other officer looked through the cell door observation panel and noticed it was “pitch black” inside. She looked a second time and thought she saw the shape of a person hanging. The officer shouted for help and called a medical emergency code blue, indicating a life-threatening situation. The control room log recorded that this occurred at 2.04pm and an ambulance was called at 2.05pm.

82. As an officer, still only yards away, returned to Mr Noble’s cell in seconds. She shouted for further staff assistance and entered the cell, followed by the officer. Mr Noble was suspended from the light fitting by a ligature made from a torn bed sheet and was facing the back window. The officer could see that his feet were dangling off the floor and so quickly used her fish knife (cut-down tool) to cut the ligature. Mr Noble fell to the floor and hit his head.

83. Three other officers arrived at Mr Noble’s cell at 2.06pm. Two officers checked Mr Noble for signs of life. A nurse arrived at 2.07pm. She examined Mr Noble and confirmed he had no pulse. She directed an officer to start cardiopulmonary resuscitation (CPR). A Healthcare Assistant and another nurse arrived with the emergency medical equipment within a minute. They used a defibrillator which advised no shock and that CPR should continue. Mr Noble showed no signs of life, his pupils remained fixed throughout but there were no signs of rigor mortis (stiffening of the body).

84. Healthcare and prison staff continued CPR until paramedics arrived at 2.20pm and assessed Mr Noble. At 2.30pm, they pronounced his death.

Contact with Mr Noble’s family

85. After Mr Noble died, staff identified that he had listed his mother as his next of kin. The prison appointed a SO as the prison’s family liaison officer (FLO). The FLO and the Head of Residency visited Mr Noble’s mother at 5.45pm and broke the news of Mr Noble’s death.

86. The prison provided ongoing support and contributed towards the costs of Mr Noble’s funeral in line with national instructions.

Support for prisoners and staff

87. After Mr Noble’s death, the Head of Residency 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 Noble’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 Noble’s death.

Post-mortem report

88. The post-mortem report concluded that Mr Noble died from hanging. No illicit substances were detected in his system.

Findings

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

89. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-harm. Mr Noble arrived at Leeds with a number of these risk factors: it was his first time in prison, he had depression, he had a history of substance misuse and had tried to take his life in 2019. He also arrived with a suicide and self-harm warning form.

90. Although we would generally expect staff to consider or start ACCT procedures for a prisoner who arrived with a suicide and self-harm warning form, we note that a senior officer and mental health nurse assessed him in Reception and determined that his risk to himself was low and that he did not need ACCT monitoring at that time. The suicide and self-harm warning form was based on historical information which had occurred six months earlier and Mr Noble maintained from the time the warning form was completed until his arrival at Leeds that he had no current thoughts of harming himself. Mr Noble's initial reception screen also included a mental health assessment, which raised no concerns about his risk to himself. Although it was a finely balanced decision, we consider that the assessment of Mr Noble's risk when he arrived was not unreasonable.

91. During his two months at Leeds, Mr Noble did not express any thoughts about taking his own life. Although he had incidents of mental distress, none were considered life-threatening or indicated that he posed a risk to himself. He was also under the care of the mental health team. For the last four weeks of his life, after he was moved to C Wing on 21 July, staff had no concerns about him, and he appeared to be progressing well.

92. We do not therefore consider that prison staff could reasonably have predicted that Mr Noble was at imminent risk of suicide and we are satisfied that his behaviour could not reasonably have given staff cause for concern that he would take his life when he did.

Mr Noble's stay in a damaged cell

93. Mr Noble damaged his cell on 17 July, which left it flooded and without running water to his sink. He was given a large bottle of water daily and the toilet remained in working order. Mr Noble lived in his damaged cell for four days before he was moved to a new cell. He was not immediately moved due to local instructions on the consequences of damaging a cell during the Covid-19 pandemic.

94. Although the investigator was told that Mr Noble was allowed to clean his cell, we were not given any information about how Mr Noble coped during this period in a damaged cell without running water. We are concerned about the conditions Mr Noble had to live in for four days and the impact on Mr Noble's dignity and mental and emotional wellbeing, particularly as he was waiting to see a psychiatrist.

95. The investigator drew our concerns to the attention of the HMPPS Safer Custody Team during the course of our investigation. He was told that the local instructions had been rescinded due to concerns that the PPO had raised about the death of

another prisoner in a different prison, where there were identical local instructions not to move prisoners from damaged cells.

96. We understand Leeds' position in not wanting external contractors to repair damaged cells because of the risk of bringing Covid-19 into the prison. We also understand that prison overcrowding may add to the difficulty in moving prisoners to another cell. We were also pleased that the local instruction not to move prisoners from damaged cells was rescinded promptly once we raised our concerns. However, it is important that when a prisoner has a damaged cell in which their basic needs cannot be met, staff should address the situation as a matter of urgency. We make the following recommendation:

The Governor should ensure that when a prisoner damages a cell to the extent that his basic needs cannot be met, prison staff should:

- **move him to another cell as quickly as possible; and**
- **in the meantime, record the damage, monitor the wellbeing of the prisoner while he remains in the cell, and escalate the situation to managers to resolve promptly**.

COVID -19 restrictions

97. We note that the restrictions imposed in response to the Covid-19 pandemic meant that prisoners were spending long periods locked in their cells, with less interaction with staff and other prisoners than would normally have been the case. Although Mr Noble continued to have some contact with his key worker, this was limited in nature. We cannot say if the long periods of isolation affected Mr Noble's decision to take his life, or whether staff might have picked up on signs of distress if they had had more contact with him.

Clinical care

98. The clinical reviewer noted that overall, the healthcare that Mr Noble received was of a good standard and was equivalent to that which he could have expected to receive in the wider community. However, he raised concerns about Mr Noble's referral to see a psychiatrist.

Mental health

99. The mental health team assessed Mr Noble on three occasions: 16 June, 10 and 14 July. On each occasion, it was noted that he communicated effectively and showed no evidence of an acute mental illness. On two of these occasions (10 and 14 July), the nurses referred him to a psychiatrist for a more comprehensive assessment as he showed evidence of paranoid thoughts (although he showed awareness in identifying that he was not sure if these thoughts were real).

100. The clinical reviewer noted that the nurses' mental health assessments were completed in a timely manner. He considered that it was reasonable that the nurses concluded that the referral to a psychiatrist was not urgent as they did not consider that Mr Noble was acutely unwell mentally and we understand why he was placed on a waiting list and not prioritised. However, we are concerned that he did not see a psychiatrist before his death on 15 August.

101. Staff interviewed were not aware of any timescales to be seen by a psychiatrist following referral. We were given no clear reason why Mr Noble was not seen before his death, other than he was not an urgent case and therefore remained on the waiting list to be seen.

102. The clinical reviewer noted that in the community, there were significant waiting times for a psychiatric assessment. (NHS Guidance states that the maximum waiting time for a non-urgent consultant-led treatment is 18 weeks and Mr Noble had been waiting for 6 weeks.) However, Mr Noble had not been given an appointment date or an indication of how long his waiting time may be and we are concerned that there was no clear system in place to oversee non-urgent referrals in a timely manner. We therefore make the following recommendation:

The Mental Health Team Manager should ensure that there is a clear, time-bound referral process for prisoners to see a psychiatrist, even when it is considered that the case is not urgent.

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