Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Riley, a prisoner at HMP Leeds, on 10 March 2022

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

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 Christopher Riley died in hospital of a lack of oxygen to the brain on 10 March 2022, two days after he was found hanging in his cell at HMP Leeds. He was 35 years old. I offer my condolences to Mr Riley's family and friends.

Mr Riley had been at Leeds for less than a month when he hanged himself. Reception staff failed to identify several risk factors for suicide and self-harm, including a recent suicide attempt. Healthcare staff in Reception identified his risk factors but placed too much emphasis on their perceptions of Mr Riley's state of mind, and not enough emphasis on his known risk factors. As a result, staff did not consider whether he should be managed under suicide and self-harm prevention procedures (known as ACCT).

It is disappointing that I have once again identified deficiencies with the identification and management of a prisoner's risk on arrival at Leeds. The Prison Group Director for Yorkshire will need to address this issue urgently.

I am concerned that two administrative errors meant that healthcare staff failed to promptly refer Mr Riley to the mental health team. Once the mental health team identified the referral, they did not see Mr Riley for an initial assessment 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.

Caroline Mills
Acting Deputy Prisons and Probation Ombudsman November 2022

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Summary

Events

1. On 12 February 2022**,** Mr Christopher Riley was remanded to HMP Leeds, charged with attempted robbery. An officer interviewed Mr Riley when he arrived at Leeds but did not review the Person Escort Record (PER) and did not therefore identify significant information about his risk of suicide and self-harm.

2. A nurse conducted an initial health screen and noted that Mr Riley felt anxious about being in prison for the first time. She reviewed the PER and noted that Mr Riley had been admitted to a mental health hospital in September 2021 after he had tried to hang himself. There is no record that she considered starting suicide and self-harm prevention procedures (known as ACCT). The nurse made a mental health referral but, due to an administration error, it was not picked up by the mental health team.

3. On 14 February, a police liaison officer submitted an intelligence report saying that Mr Riley had a history of substance misuse and depression and that his family were concerned that he might try to take his own life again if he was sent to prison.

4. On 15 February, a custodial manager noted that she had completed a risk of suicide identification form following receipt of the police information. An administrator emailed two supervising officers to ask them to see Mr Riley for a welfare check. The check did not take place. Later that day, a healthcare assistant saw Mr Riley for a secondary health screen and made a mental health referral. However, the referral was not received as she mistakenly sent it to herself.

5. On 22 February, a substance misuse worker saw Mr Riley for an initial assessment. She recorded that Mr Riley did not report any thoughts of suicide and self-harm and made a mental health referral. However, Mr Riley was not reviewed before his death.

6. On 5 March and 7 March, Mr Riley had some difficult telephone calls with his partner, during which they ended their relationship.

7. At 8.42am on 8 March, an officer let Mr Riley's cellmate into their cell after he had been out for exercise. Seconds later, his cellmate banged on the door. The officer unlocked the cell, saw Mr Riley hanging by a ligature and shouted for staff to attend. He entered the cell, radioed an emergency medical code blue and began to cut the ligature. Additional officers arrived, removed the ligature, and started cardiopulmonary resuscitation (CPR). At 9.44am, paramedics took Mr Riley to hospital.

8. At 2.00am on 10 March, an officer recorded that hospital staff planned to withdraw Mr Riley's life support equipment later that morning. Officers continued to conduct hourly observations until 5.30pm. At 5.57pm, Mr Riley died.

Findings

9. Reception staff at Leeds did not adequately identify information about Mr Riley's risk of suicide and self-harm. A reception officer did not recognise information about Mr Riley's risk that was identified in the PER, and a reception nurse gave too much weight to Mr Riley's presentation rather than his range of risk factors. Although Mr Riley had a number of significant risk factors, staff did not start ACCT procedures.

10. We are concerned that the information provided by the police on 14 February was not shared more widely with prison staff and that, despite a request, wing staff did not conduct a welfare check.

11. We have previously identified similar deficiencies in identifying and managing risk when prisoners arrive at Leeds. Urgent action is needed to address the issue.

12. The prison was unable to provide the PPO with a copy of the risk of suicide intervention form, which would have helped to clarify what action staff took to identify Mr Riley's risk factors.

13. The clinical reviewer found that the care that Mr Riley received at HMP Leeds was not equivalent to that which he could have expected to receive in the community. Healthcare staff failed to refer him promptly or properly to the mental health team and did not conduct an initial assessment.

14. We are also concerned that prison staff conducted ACCT observations while Mr Riley was on life support with no chance of recovery.

Recommendations

- The Governor and Head of Healthcare should ensure that staff identify and manage newly arrived prisoners at risk of suicide and self-harm in line with PSI 64/2011 and PSI 07/2015. In particular, reception, healthcare, first night staff an all others who assess risk should:
    - recognise the additional vulnerabilities of newly arrived prisoners and have a clear understanding of their responsibilities and the need to review all relevant records, including the Person Escort Record;
    - start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; and
    - document the information considered when deciding whether or not to start ACCT procedures.
- The Governor should ensure that safety custody welfare checks take place as requested.
- The Prison Group Director for Yorkshire should write to the Ombudsman to set out what action she has taken to satisfy herself that meaningful improvements have been made to the assessment and management of the risk of suicide and self-harm at HMP Leeds.

- The Head of Healthcare should:
  - ensure that mental health referrals process is promptly identified, processed and acted upon;
  - ensure that mental health assessments take place in line with local guidelines; and
  - ensure that substance misuse reviews take place as scheduled and that, when it is not possible, a reason is documented in the prisoner's medical record.
- The Governor should ensure that staff do not conduct ACCT observations for prisoners who are unconscious and on life support in hospital.
- The Governor should remind staff of the importance of retaining paperwork relating to a prisoner's risk of suicide and self-harm, so that it is available to the PPO if required.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

15. 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

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

17. The investigator interviewed ten members of staff and one prisoner at Leeds between 24 March and 27 April.

18. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Riley's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare and prison staff.

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

20. The Ombudsman's family liaison officer contacted Mr Riley's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Riley's family asked the following questions:

    - What mental health information did the police shared with the prison?
    - What support did Mr Riley receive for his mental health?
    - Did Mr Riley have an induction?
    - Was Mr Riley subject to suicide and self-harm monitoring?

    We have addressed these questions in this report.

21. Mr Riley's family received a copy of the initial report. They did not raise any further issues or comment on the factual accuracy of the report.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found a factual inaccuracy and the report has been amended accordingly.

Background Information

HMP Leeds

23. HMP Leeds is a local prison holding up to 1,218 men who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services. Midlands Partnership Trust provides psychosocial substance misuse services.

HM Inspectorate of Prisons

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

25. HMIP also carried out a short scrutiny visit to Leeds in June 2020 to look at issues of key importance to prisoners during the Covid-19 pandemic. They found that the prison was calm and well-ordered, despite the continuing and severe restrictions to the regime. Although regime restrictions were accepted as being necessary early on in the pandemic and were, at that point, similar to those in the community, prisoners had become confused about why community restrictions were easing but restrictions in prisons were not. This, along with the lack of purposeful activity, meant that many prisoners were bored and frustrated.

Independent Monitoring Board

26. 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 latest annual report for the year to December 2020, the IMB reported that they had raised concerns with the Governor about the death of a first-time prisoner who had received a long sentence within five days of imprisonment. They were informed that such prisoners, and those on remand and awaiting trials for serious offences, would be targeted by keyworkers to build a relationship and to identify risks of self-harm.

Previous deaths at HMP Leeds

27. Mr Riley was the twenty fourth prisoner to die at Leeds since March 2020. Of the previous deaths, fifteen were due to natural causes, seven took their own lives, one was drug-related, and one is awaiting classification. There have been two deaths since, one due to natural causes and one awaiting classification. We have previously made recommendations about identifying and assessing whether newly arrived prisoners are at risk of suicide and self-harm.

Key Events

28. On 12 February 2022**,** Mr Christopher Riley was remanded to HMP Leeds, charged with attempted robbery. It was his first time in prison.

29. At 10.50am, an Operational Support Grade (OSG) made an entry in the advance booking record stating that Mr Riley was due to arrive from court and that he did not have any self-harm markers.

30. A short while after Mr Riley arrived at Leeds, an officer conducted an initial reception interview. In his prison statement, he said that Mr Riley did not raise any concerns. However, there is no record of the interview or an entry in the prison's case management system. There is also no evidence that he reviewed the Person Escort Record (PER – which accompanies prisoners on all journeys between police stations, courts and prisons to communicate risk factors).

31. In the afternoon, a nurse conducted an initial health screen and noted that Mr Riley felt anxious about being in prison for the first time but said that he could manage. She reviewed his PER and noted that Mr Riley had a history of emotionally unstable personality disorder, had tried to hang himself in September 2021 and was subsequently detained under the Mental Health Act (1983). She also recorded that he was prescribed sertraline (an anti-depressant) and did not report any thoughts of suicide and self-harm. She referred Mr Riley to the mental health team for a triage assessment but there is no record that the referral was actioned or that staff considered starting suicide and self-harm prevention procedures (known as ACCT).

32. Later that afternoon, an officer completed a first night interview and recorded that Mr Riley did not have any self-harm alerts on his prison record. There is no record that he was aware of the risk factors identified in the PER or that he considered the fact that Mr Riley had not been to prison before.

33. At 1.05pm on 14 February, a police liaison officer submitted an intelligence report saying that Mr Riley had a history of substance misuse, experienced depression and had previously tried to take his own life which had resulted in him being admitted to Lynfield Mount Mental Health Hospital. She recorded that Mr Riley was known to struggle with managing his emotions and that his family were concerned that he might try to take his own life again if sent to prison. At 1.21pm, a Custodial Manager (CM) from the prison's security department emailed the safer custody department's generic mailbox to ask if a member of staff could see Mr Riley for a welfare check.

34. At 7.42am on 15 February, a CM recorded that she had completed a risk of suicide identification form and that Mr Riley did not have any increased risk factors. However, the investigator was unable to review the document as the prison said it was no longer available.

35. At 10.00am, a safer custody administrator emailed two Supervising Officers (SO) to ask them to conduct a welfare check on Mr Riley. However, there is no record that this took place.

36. At 11.14am, a Healthcare Assistant (HCA) saw Mr Riley for a secondary health screen. She recorded that Mr Riley had a possible diagnosis of emotionally

unstable personality disorder and referred him to the mental health team. There is no record that the referral was actioned.

37. At 10.33am on 22 February, a substance misuse worker from the drug and alcohol recovery service conducted an initial assessment in response to a self-referral submitted by Mr Riley. She recorded that Mr Riley said that he frequently used cocaine and drank one bottle of whiskey a day in the community. He said that he used cocaine to self-medicate and that his drinking had been a problem for several years. She noted that Mr Riley said that he would like to work with the drug and alcohol recovery service, did not report any thoughts of suicide or self-harm and identified his three children as a protective factor. She arranged for Mr Riley to move to the substance misuse recovery wing (A wing).

38. At 6.08pm, a mental health nurse responded to the task by recording that Mr Riley was now on the waiting list for a full mental health review. There is no record that Mr Riley had a mental health assessment before to his death.

39. On 25 February, an officer introduced himself as Mr Riley's key worker and explained what support he could offer. He recorded that Mr Riley did not report any concerns but asked whether his clothing and property had arrived.

40. On 5 March, Mr Riley telephoned his partner and they talked about their relationship. His partner told him that she wanted to move on but for them to remain friends. Mr Riley said that he was expecting that to happen. (All prisoners telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed. Mr Riley's telephone calls were not listened to before his death.)

41. At 10.25am on 7 March, Mr Riley telephoned his mother and told her that he was happy in prison and was getting the support he should have in hospital. At 5.54pm, Mr Riley called his ex-partner who told him that she had been out with his friend and that she "did not know where it was going". She added that they were "just friends at the moment". Mr Riley said, "I'm going to go" and ended the call.

Events from 8 to 10 March

42. At 8.00am on 8 March, an officer unlocked Mr Riley's cell and asked him if he wanted to go outside for exercise. Mr Riley said "no".

43. At 8.04am, CCTV footage shows that Mr Riley's cellmate left the cell to go outside for exercise. At interview, he told the investigator that Mr Riley initially told him that he would go out for exercise but changed his mind and said that he wanted to make a phone call.

44. At 8.12am, Mr Riley telephoned his ex-partner. He sounded angry and said:

> "Are you actually serious, what you fucking said yesterday. You're going to get together with my best mate … I've not slept all night as I've been awake working out how I'm going to kill the both of you ... I've got a better idea, yeah ... You and [name] have done this."

45. The call then ended. At 8.26am, Mr Riley telephoned his ex-partner again and said, "You can listen to this ... I hope you're listening." There is background noise and the call ends.

46. At 8.41am, CCTV footage shows that Mr Riley's cell mate returned to the cell and looked through the observation panel on the door. He then walked a short way along the landing before stopping to look over the railing. At 8.42am, Officer A walked down the landing and let the cellmate back into the cell. In his prison statement, Officer A said that the cell was dark and that neither of them noticed anything unusual.

47. Seconds later, the cellmate banged on the cell door and shouted "boss". Officer A opened the door and the cellmate said, "he's dead boss", while pointing towards the cell window. The officer saw Mr Riley hanging by a ligature attached to the window. He shouted over the railing for staff to attend. He then entered the cell and radioed an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing difficulties). The control room operator telephoned for an ambulance.

48. Officer A started to cut the ligature and was joined in the cell by another officer, who assisted by taking Mr Riley's weight. They laid him on the floor and checked his vital signs but could not find a pulse. In the meantime, another officer arrived and started cardiopulmonary resuscitation (CPR).

49. At 8.45pm, a care support worker arrived with a medical emergency bag and prepared a defibrillator. At 8.46pm, two nurses arrived. One nurse managed Mr Riley's airway while the other nurse conducted an assessment and assisted officers with CPR. Staff attached the defibrillator, but it did not issue a shock.

50. At 8.52am, an ambulance arrived at the prison and, at 8.55am, paramedics reached Mr Riley's cell. Paramedics provided emergency care and confirmed that Mr Riley had a faint pulse at 9.10am. In the meantime, a SO started ACCT procedures and set Mr Riley's observation requirement as one every hour, with quality conversations attempted. At 9.44pm, paramedics took Mr Riley to Leeds General Infirmary. Two officers went with him and did not use restraints. Hospital staff conducted a computerised tomography (CT) scan, which showed a significant brain injury, and admitted Mr Riley to the Intensive Care Unit.

51. Mr Riley had written "[Name of friend] did this" on his stomach and left a note with an arrow pointing to where he was found, saying, "[Name of ex-partner] and [Name of friend] did this".

52. At 2.00am on 10 March, a hospital doctor told one of the escort officers that they planned to switch off Mr Riley's life support equipment later that morning. Officers continued to conduct hourly ACCT observations, and the last one took place at 5.30pm.

53. At 5.57pm, hospital staff pronounced that Mr Riley had died.

Contact with Mr Riley's family

54. At 10.15am on 8 March, the prison's appointed family liaison officer (FLO) established that Mr Riley had named his ex-partner as his next of kin. She made

several attempts to contact her by telephone. At 11.25am, she spoke to Mr Riley's ex-partner and told her what had happened.

55. At 11.48am, the FLO notified Mr Riley's mother by telephone. Later that afternoon, she met Mr Riley's ex-partner and mother at the hospital to explain her role as family liaison officer and to offer support. She asked them if they would like her to contact them the following day, but they declined.

56. At 7.20pm on 10 March, the FLO telephoned Mr Riley's ex-partner and offered her condolences and support. The following day, the FLO and a prison offender manager visited Mr Riley's ex-partner at home to provide support and explain the next steps.

57. The FLO provided ongoing support to Mr Riley's family until his funeral, which took place on 30 March. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

58. On 8 March, a SO debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. After Mr Riley died, a prison manager debriefed the officers present at the hospital.

59. The prison posted notices informing other prisoners of Mr Riley'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 Riley's death.

Post-mortem report

60. The post-mortem report concluded that Mr Riley died of a lack of oxygen to the brain caused by hanging. Post-mortem toxicology tests were not conducted.

Findings

Identifying risk of suicide and self-harm

61. Prison Service Instruction (PSI) 07/2015 on early days in custody says that all prisoners should be assessed for the risk of harm to themselves, to others and from others and that prisoners assessed as at risk of suicide and self-harm should be supported. It says that the PER and any other available documentation must be examined in Reception to ensure they assess a prisoner's risk of self-harm, harm to others and harm from others.

62. Mr Riley arrived at Leeds with a suicide and self-harm warning noted on the PER, but the Reception officer did not see it. He told the investigator that an electronic PER had recently been introduced at Leeds and that he did not know it was available to view on the digital system. However, a paper copy was available as a nurse had access to it at the health screen. We therefore consider that the officer missed a potentially crucial piece of information. We are also concerned that he did not document his interaction with Mr Riley and told us that he could not remember him, which highlights the importance of documenting each interview. While we accept that Reception can be a busy environment, it is critical that staff obtain and record as much information as possible, so that any risk factors can be identified and explored, and they can properly consider if ACCT monitoring is necessary.

64. The nurse did not assess Mr Riley as presenting a risk of suicide or self-harm. At interview, she told us that although Mr Riley said that he could be very reactive to things and would just "flip" and get angry, when she spoke to him, he presented as calm. She said that he did not say much about his ligature attempt in September 2021 but said that he acted on impulse and did not feel like he would do it again.

65. Mr Riley had a number of risk factors for suicide and self-harm which are set out in PSI 64/2011 on safer custody. These included that it was his first time in custody, he had a history of mental health problems, including a hospital admission under the Mental Health Act, and he had recently tried to take his own life. In this context, staff relied too heavily on Mr Riley's calm presentation. Although a prisoner's presentation can reveal something about their level of risk, it is only a reflection of their state of mind at the time that staff assess their risk and should be considered as a single piece of evidence. It is critical that all risk factors are considered to ensure that a prisoner's level of risk is judged holistically. We therefore consider that an opportunity to start ACCT procedures was missed.

66. Although we recognise that no one who met Mr Riley in the days before his death considered that he was at increased risk, we are concerned that the information provided by the police liaison officer on 14 February was not shared more widely. We consider that had staff known that Mr Riley had mental health difficulties and had previously expressed concern about going to a mainstream prison, it may have enabled them to provide more focussed support. We are particularly concerned that two SOs did not review Mr Riley despite being asked to conduct a welfare check. One SO told us that he and the other SO both missed the email but was unable to offer an explanation as to why.

67. We consider that prison and healthcare staff missed several opportunities to identify indicators of Mr Riley's increased risk of suicide and self-harm, to explore these further and consider whether he needed the support of ACCT procedures. We therefore make the following recommendations:

The Governor and Head of Healthcare should ensure that staff identify and manage newly arrived prisoners at risk of suicide and self-harm in line with PSI 64/2011 and PSI 07/2015. In particular, reception, healthcare, first night staff and all others who assess risk should:

- **recognise the additional vulnerabilities of newly arrived prisoners and have a clear understanding of their responsibilities and the need to review all relevant records, including the person escort record;**
- **start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions;**
- **document the information considered when deciding whether or not to start ACCT procedures.**

The Governor should ensure that safer custody welfare checks take place as requested.

68. We have previously made recommendations intended to address Leeds' failure to identify effectively whether newly arrived prisoners are at risk of suicide and self-harm. In response to our previous investigations, the prison told us that a risk of suicide identification form was introduced in February 2021 and that staff were required to consider multiple risk factors, such as first time in custody, and refer to accompanying paperwork, such as the PER. They also said that a regular review process was in place to allow for continual improvement and learning.

69. While we recognise that Leeds has made positive steps to improve reception processes, we are concerned that despite implementing these changes, failures to identify and manage the risk of suicide adequately in reception and during their early days in custody have continued. We therefore consider that urgent action is now required. We make the following recommendation.

The Prison Group Director for Yorkshire should write to the Ombudsman to set out what action she has taken to satisfy herself that meaningful improvements have been made to the assessment and management of the risk of suicide and self-harm at HMP Leeds.

Clinical care

70. The clinical reviewer considered that the clinical care that Mr Riley received at HMP Leeds was not equivalent to that which he would have expected in the community.

71. When a nurse made a mental health referral on 12 February, she mistakenly selected the "send to admin" box on the prison's electronic medical record when sending the task. (Healthcare staff at Leeds have to send an electronic task to the relevant team to make them aware of the referral.) The task was subsequently sent to an administrator, who did not forward it on. The clinical reviewer considered that staff missed an opportunity to assess Mr Riley.

72. When the nurse referred Mr Riley to the mental health team on 15 February, she mistakenly sent the task to herself and marked it as complete. This meant that the mental health team were again not aware of the referral. We agree with the clinical reviewer that this indicates a potential underlying issue with the referral process.

73. The clinical reviewer considered that a nurse correctly assessed Mr Riley as requiring a full mental health assessment and that a routine five-working day referral was appropriate. However, we are concerned that the assessment did not take place before Mr Riley was taken to hospital over two weeks later. The Head of Healthcare told us that low staffing levels and a high demand for the service meant they were not meeting the required target. While we recognise that external factors can impact on service delivery, it is important that these are addressed and that prisoners are assessed promptly.

74. We cannot know whether a full mental health assessment or follow-up substance misuse review would have changed the outcome for Mr Riley, particularly as he appears to have acted impulsively upon receiving the news about his friend and ex-partner. However, he had previously tried to take his own life following the breakdown of a relationship. A full mental health assessment would have meant that staff could have explored his personal relationships in more detail to identify any immediate risks or needs. It is also likely to have resulted in additional support and the formulation of a care plan. We make the following recommendation:

The Head of Healthcare should:

- **ensure that mental health referrals are promptly identified, processed and acted upon; and**

- **ensure that mental health assessments take place in line with local guidelines.**

ACCT observations

75. We are concerned that prison staff conducted ACCT observations while Mr Riley was on life support in hospital and that there was a requirement for staff to attempt conversations. A CM from the prison's safer custody department told the investigator that although it was procedure to include conversations, she recognised that staff could have taken a more conscientious approach. However, the question is not how frequently ACCT observations and conversations should have taken place but why they were thought necessary at all.

76. ACCT observations are designed to provide support to a suicidal prisoner and to reduce his risk of suicide or self-harm. As Mr Riley was unconscious with little to no chance of survival, it is very difficult to understand why the prison thought ACCT observations were necessary. We note that they even continued after doctors told staff they were switching Mr Riley's life support off. This suggests a fundamental misunderstanding of the point of the ACCT process. It is also possible that ACCT checks could cause additional distress to a prisoner's family at what is already likely to be a distressing time. We make the following recommendation:

The Governor should ensure that staff do not conduct ACCT observations for prisoners who are unconscious and on life support in hospital.

Record keeping

77. PSI 58/2010, the Prisons and Probation Ombudsman (PPO), states that as a basic principle, the PPO must have unfettered access to documents during their investigation.

78. Prison staff told us that they did not retain the risk of suicide identification form that a CM completed on 15 February. This meant that we were unable to form a judgement about the quality of the assessment. Assessments of risk can provide crucial evidence for investigations, and we would expect the prison to ensure that these are easy to obtain after a death in custody to enable appropriate scrutiny and accountability. We therefore make the following recommendation:

The Governor should remind staff of the importance of retaining paperwork relating to a prisoner's risk of suicide and self-harm, so that it is available to the PPO if required.

Learning lessons

79. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend that:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

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Independent Investigations

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