Investigation into the circumstances surrounding the death of a man at HMP Leicester on 25 January 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

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

This is the report of an investigation into the circumstances of the death of a Ugandan citizen and asylum seeker, who had been charged with murder on 3 January 2007. Following a court appearance on 5 January, he was remanded to HMP Leicester. Less than three weeks later, at 7.25 pm on 25 January, the man was found hanging in his prison cell. Cardio pulmonary resuscitation was carried out, but at 7.56pm he was pronounced dead. At the time of his death, the man had just passed his 32nd birthday.

I would like to offer this public expression of condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man's partner has raised a number of matters with one of my Family Liaison Officers. I hope my investigation begins to offer answers to these questions. I regret the delay in issuing this report.

The investigation was led by my colleagues. A clinical review was conducted by a doctor and I am grateful for his assistance. I also thank the Governor and staff at HMP Leicester for their co-operation with this investigation. I am particularly indebted to the investigation liaison officer.

Given the serious charge he faced, a previous overdose and a history of mental health difficulties, the man was placed on self harm/suicide monitoring whilst in police custody, and upon his arrival at HMP Leicester. He was initially placed in the inpatient unit of the prison's healthcare centre. However, four days later the visiting consultant psychiatrist assessed him as fit for ordinary location and not in need of any special observations. The psychiatrist did not detect any symptoms of mental illness and, despite a number of risk factors, the self-harm monitoring was closed the following day. A post-closure review of his Assessment, Care in Custody and Teamwork (ACCT) document was not carried out as it should have been on 17 January (and it appears that on the same day or thereabouts the man discovered that he had lost his last appeal to stay in the UK). On 23 January, the man transferred to ordinary location. Two days later, he was dead.

My report contains a number of recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2008**

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SUMMARY

On 3 January 2007, the man handed himself into Euston Street Police Station, Leicester. He spent the following two days in police custody and was charged with murder. During this time, he was placed on close supervision as he was deemed to be at high risk of self-harm/suicide. He was seen by two Forensic Medical Examiners (FMEs) and a consultant psychiatrist. Following a court appearance on 5 January, he was remanded to HMP Leicester.

On his reception at Leicester, the man was placed on an Assessment, Care in Custody and Teamwork (ACCT) document and located in the inpatient wing of the healthcare unit. He appeared to settle well there.

On 10 January, the man was seen by a visiting consultant psychiatrist and assessed as not suffering from a mental health illness and not at risk of self-harm. His ACCT document was closed and he was deemed fit for ordinary location. However, given his alleged offence he was only suitable for a single cell and could not be placed until one became available. The man was described as a 'lodger' in healthcare whilst he awaited a cell on the main residential wing.

The post closure ACCT review set for 17 January did not take place. That same day, the Immigration Service faxed a copy of a letter to the discipline department asking that it be given to the man. The letter indicated that he had no basis to stay in the UK and no further right of appeal. It is not known whether he was given this letter by staff. However, comments he made suggested that he was aware of the contents.

On 23 January, a single cell became available on the main wing and the man was moved from healthcare to cell L4 - 45. In moving to the main wing, the man did not go through the first night centre or undergo a full induction.

On 25 January, the man was seen by another visiting consultant psychiatrist who concluded that he was not showing any evidence of mental illness. Later in the afternoon, the man was visited by a solicitor. The man was distressed and spoke about suicide. Although concerned about him, the solicitor knew that the man was expecting a visit from his family the next day and did not believe him to be in imminent danger.

Following the visit, the man was seen in passing by a number of prisoners and staff but did not give any cause for concern. At 7.25pm during the evening roll check, he was found hanging. Cardio pulmonary resuscitation (CPR) was carried out by prison staff and paramedics but he was declared dead at 7.56pm.

This report is critical of a number of matters.

THE INVESTIGATION PROCESS

My investigators conducted a preliminary visit to HMP Leicester on 2 February 2007. They visited both the cell where the man died and the cell in healthcare where he was initially located. All the relevant documentation was reviewed and a chronology of events established. Feedback about the findings of the investigation was given to the Residential Governor and our liaison officer, on a regular basis.

Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my colleagues. No one came forward as a result. My investigators met with representatives of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB).

My investigators also met with police officers from Leicestershire Constabulary at HMP Leicester and a copy of their coroner's report was sent to my office. In addition, they shared copies of their interview statements.

Thirteen members of staff, both discipline and healthcare, were interviewed at Leicester by my investigators. Four prisoners were informally interviewed and notes from these interviews are annexed.

A doctor from the Medical Directorate at Leicester City Primary Care Trust, undertook a clinical review of the healthcare provided for the man at HMP Leicester. He conducted joint interviews of medical staff. Transcripts of these interviews were sent to him. The doctor also spoke with the locum prison doctor on the telephone. He followed this by sending the clinical reviewer a more detailed written account. Two consultant psychiatrists who saw the man whilst in custody were also interviewed. The clinical review is annexed.

During an interview with a member of the in-reach mental health team, it came to light that the in-reach file had been removed from the prison by Leicestershire Partnership Trust for the purpose of their own internal investigation. In the community, the man had been known to the trust's PIER (Psychosis, Intervention and Early Recovery) team. Despite a number of requests, a copy of this file was not passed to the clinical reviewer until two months after the start of the investigation. Consequently, the in-reach nurse had to be interviewed on a second occasion and some time after the man's death.

On the day he died, the man was seen by a solicitor. My investigator interviewed her informally and a summary is annexed. The man was using a different firm in relation to his immigration case. My investigators wrote to them asking for background information but they did not respond. The man had also had contact with another firm of solicitors allegedly about transferring his criminal case to them. My investigator spoke to a solicitor from this firm who explained that the man had wanted him to represent him. She wrote to the firm requesting confirmation of this, but did not receive a reply.

One of my Family Liaison Officers (FLOs) made contact with the man's partner offering the opportunity to meet. My staff met with the man's partner and her father

at their home. The man's partner provided a copy of a statement she had written with a solicitor that contained background information about the man.

A draft version of this report was sent to the Prison Service. An action plan was provided in response. The Prison Service indicated whether they accepted the recommendations or not. The responses can be found under the recommendations section of this report and have been produced in verbatim.

A copy of the report was also sent to the PCT and Leicestershire Partnership Trust. Again, comments made by the PCT have been repeated in verbatim. Leicestershire Partnership Trust have not made any representations.

The man's next of kin was sent a copy of the draft version of this report. A number of comments were made by her solicitor and these have been dealt with by letter.

THE MAN

The man was born on 21 January 1975 in Uganda. At the time of his arrest, he was living with his partner, her child and their new born baby. Upon entering HMP Leicester, he described himself as being a Catholic, having two children and working as a cleaner.

The man's partner provided my colleagues with a copy of a statement she had prepared with her solicitor that outlined the man's background as she knew it. In this, she said that she had first met him in 2002. She said the man had been planning to go back to Uganda to spend some time with his family but they then found out that they were expecting a baby. The man's partner felt that the man began to show signs of mental illness around this time and that his depression intensified once their son was born in August 2006.

The man's partner sought help for him and he was referred to the local mental health crisis team by their GP. Following this, the man was admitted as a voluntary patient to the local psychiatric unit for three weeks. The man's partner said that she did not feel that he was feeling any better when he was discharged in September 2006. There was some ongoing support and the man was prescribed 5 mg of olanzapine. In November, he gained work as a cleaner for an agency, but according to his partner he was not paid and was very worried about money.

It is not completely clear what the man knew about his immigration status. The Community Psychiatric Nurse (CPN) he saw at court on 5 January 2007 recorded that 'his application for leave to remain in the UK has been turned down, as have subsequent appeals'. In his ACCT document, written the same day, he was described as a 'failed asylum seeker and prior to incident had recently been turned down on his appeal to stay in country'. On 9 January, the psychiatrist who saw him wrote that he was 'awaiting outcome of immigration procedure' and on the day he died he told his solicitor that he had recently received a letter from the Home Office saying he could no longer stay in the UK.

On 5 January, a letter was sent to his home address by the Immigration Service. A copy of this letter was faxed to the discipline department at Leicester on 17 January, with an attached note asking that it be given to the man. It is not recorded whether or not he was given this letter. The letter concluded that:

> 'we have decided not to reverse the decision on the earlier claim and have determined that your submission do not amount to a fresh claim. You therefore have no further right of appeal. The asylum claim has reconsidered on all the evidence available, including further representations, but we are not prepared to reverse our decision on 17 October 2001 which was upheld at appeal on 7 June 2002. I must remind you that you have no basis of stay here and are liable for removal from the United Kingdom.'

HMP LEICESTER

HMP Leicester is a 19th Century prison, the gatehouse dating from as early as 1825. It is one of the smallest local prisons in the country estate and is able to hold only 385 prisoners. The main living accommodation is a long rectangular cell block with four landings. All prisoners coming into the establishment are housed for at least the first night in the First Night Centre (FNC), prior to being located into the main prison. The FNC is a dedicated landing currently located in the basement of the prison.

The inpatient unit, where the man was located for the majority of his time at Leicester, is on the top floor of the hospital wing. It consists of a three-bedded dormitory and four double rooms. He was located in one of these cells which was being used for single occupancy. There is a small day room, shower facilities, a kitchen and an office. HM Chief Inspector of Prisons, Ms Anne Owers, who carried out an announced inspection in July 2003, wrote the 'décor was pleasant and provided a therapeutic environment'.

In April 2004, the Prison Service began to transfer responsibility for the delivery of prison healthcare to local Primary Care Trusts. Eastern Leicester Primary Care Trust (now known as Leicester City PCT) took up commissioning responsibilities in April 2006, but tendered out the provision of health services. In February 2007, Serco took over the provision of the primary care medical services, including the inpatient unit. The service consists of doctors with General Practice training and nurse, some of whom but not all, have mental health training. The service provides the equivalent of General Practice outside prison, looking at both acute and long term physical illnesses in the prison's population, as well as mental health problems not deemed sufficiently severe to be referred to specialist services.

Specialist mental health service are provided to the prison by an In-reach team which is part of Leicestershire Partnership NHS Trust which provided NHS specialist mental health services across Leicestershire. The IN-reach team has two full-time equivalent mental health nurses within the prison and a visiting consultant psychiatric service for eight hours a week.

Ms Anne Owers conducted an unannounced short follow-up inspection of Leicester in August 2006. In her introduction to the subsequent report, Ms Owers wrote, 'Healthcare had deteriorated since the last inspection, and was well below the standard we now expect to find. It was over-reliant on agency nurses and lacked clinical governance and supervision.'

At the time of the inspection in August 2006, foreign national prisoners made up 14 per cent of the population. Ms Owers' report highlighted the need for a 'clear foreign national prisoner policy to be drawn up and implemented'. It is my understanding that this was being undertaken at the time of the man's death.

Since I took over investigations into death in custody in April 2004, there have been six apparently self-inflicted deaths at Leicester, including that of the man. Some of these have proceeded to inquest and a number have featured recommendations in relation to the healthcare department.

KEY FINDINGS

At 8.40 am on 3 January 2007, the man walked into Euston Street Police Station, Leicester, and told police staff 'I am just handing myself in'. As part of the routine process following an arrest, a police officer completed a Detainee Integrated Risk Assessment and care plan. This stated that, 'DP (detained person) states – mental health problems – depression – hallucinations' and that he was taking 'olanzapine 5mg daily'. In response to the man being asked 'are you currently in contact with, or have you had contact with any mental health services for any reason or condition?' the author recorded 'Brandon Unit, – LGH Crisis Team'. The man said that he had taken an overdose approximately six months previously. The author concluded that the man needed to be assessed to see whether he was fit to be detained and interviewed. He was placed on half hourly observations, as he was deemed to be at medium risk of self-harm.

At 11.45 am, the man was seen by a Forensic Medical Examiner (FME). The medical report said 'patient suffering from mental illness' and concluded 'CPS (close personal supervision), waiting for the Brandon Unit to arrange mental health assessment'. The man was viewed as being at high risk. Although fit to be detained, he was not fit for interview as he was waiting for mental health assessment.

According to an entry in the man's custody record he was seen by a Consultant Psychiatrist, at 4.37 pm. The notes read:

- has been in contact with psych services
- clear and coherent at present
- fit for interview with responsible adult present
- affective symptoms – a watch re. DSH/Suicide is necessary …

At 7.56 pm, the man was seen by another FME, and was prescribed paracetamol as he complained of a headache. The medical report concluded that he was at high risk and recommended close personal supervision. The man was already subject to this. At 10.00pm, he was given his olanzapine medication. The following day (4 January 2007, at 6.30pm), the man was charged with murder. At 10.00pm, he was again given his olanzapine.

At 10.00 am on 5 January, the man appeared at Leicester Magistrates' Court and was remanded until 13 April. The Prisoner Escort Form (PER), designed to communicate important information between the various criminal justice agencies, indicated the man's risk areas as 'mental condition, violence and suicide/self harm'. In a further section concerning risk issues, it stated, 'open ACCT (ineligible) depression, outpatient @ Brandon Unit, Hallucinations. Violent – committed murder by stabbing, suicide/DSH risk. SEE MED SHEET.'

In addition, an escort officer with responsibility for transporting the man between the police station, the court and Leicester prison, completed a suicide and self-harm warning form based on information given by the police. This indicated that the escort staff were intermittently observing him. The author wrote that the man had 'contact

with Brandon Unit Leics General Hosp Crisis Team, told police took overdose approx 6 months ago. Spoke to D/P says he is okay!!! Seems alert and responsive.'

Reception and induction at Leicester

The PER indicated that the man arrived at Leicester at 11.31 am. On arrival, he went through the usual reception procedures. These included completing form F2050, known as the core record. The personal summary sheet asks basic questions about religion, age etc, as well as asking the prisoner to provide the name and address of his next of kin. The man identified his partner and described himself as being Ugandan, a Catholic, having two children and working as a cleaner.

During the reception process, Sections 1 and 2 of the Cell Sharing Risk Assessment (CSRA) were completed by an officer. He ticked the form to indicate that the prisoner had an open F2052SH (self harm monitoring form) and that there was evidence that the prisoner had a previous F2052SH. In addition, the officer ticked yes to the questions 'do you have any concerns about sharing a cell?' and 'would you describe yourself as a person that gets angry/frustrated quickly?' He also wrote 'ex Brandon unit – mental health issues. 1st time in prison – murder charge.'

The man was seen by a reception nurse for the purpose of completing the First Reception Health Screen. (The nurse was not interviewed as part of this investigation as he has since left the Prison Service). The purpose of the form is to gather medical information from the prisoner about his physical and mental health. The man gave his GP's name but did not provide an address. He did not give details of any physical problems, but said that he had seen a doctor in the last few months for a repeat prescription. This was for olanzapine 5mg. He later said that he suffered from depression and stated that treatment was provided by 'a doctor, Brandon Unit, Sept 06.' He said that he been a patient at the 'Brandon Unit September 06.'

Question 15 asked 'have you ever tried to harm yourself?' and the nurse has written 'O/D, auditory hallucinations, voices similar to his family'. The nurse recorded his impressions of the man as 'polite and co-operative and first time in prison'. Question 16 asks whether the prisoner feels suicidal now and this is ticked yes. The nurse ticked yes to both the prisoner seeing a doctor and having a referral to the in-reach mental health team.

At 12.15 pm, the nurse initiated the opening of an Assessment, Care in Custody and Teamwork (ACCT) document. (An ACCT is used to monitor and support those deemed to be at risk of self-harm and suicide. It has replaced the F2052SH.) The nurse gave details of his concerns: 'overdose September 2006, murder charge, says he feels full of remorse, says his mood is stable although his affect seems flat, high profile offence.'

The nurse also completed section 3 of the CSRA and indicated that there was 'high' risk of harm to others. He recorded that he had 'initiated ACCT, high risk, high profile due to his index offence, known to the media and his mental health issues.' He recorded his actions in the Clinical Record (CR). A nurse from the in-reach mental health team, also made an entry in the CR, 'seen in reception with [the

reception nurse] – HCC advised he would be admitted to HCC c/o index offence also known to LPT services. Plan/ see Dr – Tuesday in clinic. Contact Pier Team for further information.'

In her first interview, the mental health nurse said that she had known of the man's arrival at Leicester because she had been telephoned by a community psychiatric nurse (CPN), based at Leicester Magistrates' Court. The CPN had said that the man was known to Leicester Partnership Trust and gave the mental health nurse an in-depth risk assessment and detailed history. As a result, she sat in on some of the interview with the reception nurse. She then completed an in-reach referral form including the information she had been given by the CPN.

The mental health nurse said in interview that there had been some sensitivity around the man's case. Whereas normally they would be given information by a key worker within the Trust, in the man's case any request for information had to go through the services manager. However, later that afternoon, the man's records from his contact with community services were faxed to the mental health nurse by her manager. In both interviews with the mental health nurse (who was accompanied by her manager), there was confusion to exactly when they had received the records from Leicester Partnership Trust. They both felt that these had arrived some days after the man's initial remand into custody. However, this was not the case and, having checked, the manager later confirmed that he had faxed the documents to the mental health nurse on 5 January. All documents collated were placed in the man's in-reach file which was available to the in-reach team and the visiting psychiatrist.

The mental health nurse completed an Initial Risk Screening form which formed part of the in-reach file. She had ticked 'no' in response to questions about 'history of self harm' and 'thoughts or plans which indicate there is a risk of self-harm or suicide'. Where the form asks 'is a fuller assessment of risk indicated?' she ticked 'no' and wrote 'seen by PIER – felt to be low risk of DSH/Suicide – denies any intent at present'. In interview, the nurse said that the man denied any history of self-harm to her. She said that, had she been made aware of his previous overdose, she would have ticked 'yes' to history of self-harm question.

The man's core record of events confirmed 'FNC interview completed'. This refers to the interview that is conducted with prisoners when they leave the reception area and enter the first night centre (FNC) in Leicester. Upon entering the FNC, all prisoners are interviewed, given information about what to expect and also allowed a three minute phone call. However, it is known that the man went straight to healthcare and so did not go to the FNC or go through the FNC induction process. It has been concluded that the entry in his core record was written in error.

The Locum Medical Officer saw the man at approximately 2.00pm in healthcare. In interview, the locum doctor said that prior to his consultation with the man he spoke to the mental health nurse about him. He recalled being shown some documentation relating to the man's previous psychiatric history and medication. He described spending 15 minutes with the man. During this time, the locum doctor gathered similar information to that collected before about the man being at the Brandon Unit. In addition, the locum doctor recorded that the man spoke about coming from

Uganda and that he had left there six years before. He reported that he had been a witness to war and violence, and suggested to the locum doctor that some of his 'visions' related to the violence he had seen. He did not elaborate further on this.

In his notes in the CR, the locum doctor wrote that the ACCT should continue, there should be a psychiatric review when available and that the man should continue with the olanzapine 5mg. In the notes he provided to the clinical reviewer, the locum doctor wrote that, 'due to several factors, he [the man] was at increased risk of self-harm. These included: the nature of his conviction, the fact that this was his first time in prison and also his (alleged) psychiatric history.'

The locum doctor completed a prescription card for olanzapine for 28 days, with a review date of 9 January - the day the man was due to see the psychiatrist. Written under the section asking about the nature of the complaint/diagnosis, is 'agitation/anxiety'. This was not written by the locum doctor and it is not known who did write it. The locum doctor said that he was shown documentation by the mental health nurse which indicated that the man had previously been given olanzapine and that he had received it in the police station. However, the mental health nurse could not recall showing the locum doctor any documents about the man's medication. The locum doctor wrote:

> "my assumption was that the police surgeon would not have prescribed this without clear direction and I did not want to risk stopping his medication until review by appropriate Consultant Psychiatrist. My usual practice would have been to continue any psychiatric medication unless there was a clear indication that it should be discontinued.".

At 3.00pm, an officer carried out the ACCT assessment interview with the man. The officer said that, prior to seeing the man, he was already aware of who he was and the charges against him, as the case had attracted a lot of local media attention. He thought that the man might come across as very vulnerable because of this but, in interview, said that when he spoke to him the man seemed 'surprisingly calm, relaxed, quite settled in appearance anyway'.

The ACCT asks for the prisoner to describe in their own words what they believe their problems to be. The officer wrote the following:

> "The man states that he has a history of depression which included an overdose approx 6 months ago. He came to the UK approx 6 years ago from Uganda where his father was an officer in the army. The reason for him coming to England was to escape the war in his home country. The man states that while in Uganda he witnessed may scenes of violence and brutality. Since coming to England he has married and now has a child and a step child. Despite this he finds life in England isolated and stressful. He says he has been feeling low for several months. This is his first time in prison and is unsure how he will cope."

The man was then asked about previous acts of self-harm/suicide attempts and his response was recorded as follows:

> "The man states that approx 6 months ago he took an overdose of tablets. He is unsure as to why he did this but said that he was 'under pressure' at the time. He said on interview that he did not take the overdose with the intent of killing himself. The man added that prior to this incident he had never contemplated self-harm and since then he has never had the urge to self-harm. He states that the overdose incident was a 'one off'".

In terms of his current mental health state, the officer wrote:

> "The man seemed calm and responsive on interview. He was polite but quietly spoken. Eye contact was good and generally appeared relaxed. States that there are no issues with sleeping or eating at present. The man informed me that he does suffer from depression and there is documented evidence that he is known to the Mental Health Team at the Brandon Unit where he has been an in-patient and been prescribed medication. LCBM In-reach team aware of this."

Finally, the assessment asks the author for any other areas of discussion. The officer wrote:

> "Due to the serious nature of the charge (murder) and the extensive media coverage of the murder the man will be known to his peers. This could make him extra vulnerable. This situation should be closely monitored. First time in prison. The man is a failed asylum seeker and prior to incident been turned down on his appeal to stay in the country. The man states that he has no drug or alcohol problems or history of abuse in this area."

The officer completed the assessment by agreeing what was to happen next with the man. He listed the following points:

- Staff support/vigilance
- Encourage contact with family (letters/phone calls)
- To be seen by clinical psychiatrist on 09/01/07
- Access to Listeners (scheme has been explained to the man)
- To remain on healthcare until review by psychiatrist on 09/01/07
- To remain on ACCT document until at least above review is completed
- When moved from healthcare to go first to FNC (First Night Centre)

Following the assessment, the officer and an acting Senior Nurse devised an immediate action plan. It was agreed that the man would be observed half hourly overnight and that there would be three daily conversations recorded. He would be allowed access to a three minute phone call and to Listeners as required. The other notes were that he was 'not for IP (in-possession) meds and arrange to see in-reach team'.

A case review was then held by the acting Senior Nurse, with the man, the officer and the mental health nurse. The acting Senior Nurse recorded the summary as follows:

> "Gives history of low mood/depression over the past 4 years, one off episode of drug overdose. Known to mental health services who have been contacted to complete a psychiatric assessment. Good eye contact on interview, able to give good history of life events. States he is not currently suicidal but this is his first time in prison and does not appear to have got reality of the situation yet. To remain in HCC for observation and assessment of mental state."

A review of the ACCT was set for 9 January. Following the case review, the Senior Nurse went through the man's care map with him covering the goals and actions needed to try and reduce his risk of self-harm. The goals were, 'to maintain contact with family, to assess and monitor mental health state, maintain safety and to encourage purposeful activity and continue to monitor mood level.'

The Lifer Officer (a specialist in lifer management), met with the man that afternoon to complete the 'Identification of potential life sentence prisoner' form. The Lifer Officer wrote 'shocked but calm' and in interview said the man was 'very confused'. He recalled him asking about the likely length of sentence. The Lifer Officer explained to the man that he would spend some time in healthcare being observed and assessed. He said that the man was concerned that he would then move onto the main wing of the prison. The man seemed to have the impression that all the prison was centred in the healthcare.

The Lifer Officer introduced the man to a trusted prisoner who was working as an orderly on the inpatient healthcare wing. In interview, the prisoner said that the Lifer Officer had asked him and another orderly to keep an eye on the man and help him settle on the wing. Both orderlies said that the man was quiet initially and spent a lot of time in his cell. After a couple of days, they said that the man was more relaxed and mixed more with the other prisoners and staff.

At 4.00pm on 5 January, an entry in the man's ACCT document states, 'talked to at the hatched medication', but the signature on the prescription chart could not be identified by the head of healthcare. There are no entries for 6 and 7 January, which suggests that the man was not given medication. The nurse on duty on the weekend of 6/7 January was unable to recall whether the man's medication was there or not. The locum doctor explained that, from his experience at Leicester, when medication is required over the weekend and is not kept in their stocks, a private prescription is used to acquire the necessary medicines from a local chemist.

Records indicate that the first prescription for olanzapine was dispensed from the prison pharmacist on 9 January. In total, the man was given 18 pills whilst in HMP Leicester. However, only nine were used from the prescription. This suggests that either the man was not given as many as were recorded or some pills existed from another source. The man's partner recalled that the police removed his medication from their house. However, this is not recorded in the list of evidence held by the police and there is no record that the man's property included medication. The man was given his olanzapine on 8 January and continued to have it daily until 25 January.

As a patient in healthcare, a daily record of nursing care was kept. On 6 January, it recorded that the man 'continues to socialise well and associate with peer group …

spent time watching a film in cell but happy to interact with staff when approached. ACCT document maintained. No dsh/suicidal intent evident.' On 7 January, it recorded, 'out of cell for short period this afternoon watching TV. Remains polite when spoken to but does not initiate conversation. Minimal interaction with peer group. Taken all meals offered. ACCT document maintained.'

The locum doctor said that he had attended the prison on several occasions over the weekend, including healthcare. He did not specifically visit the man but recalled seeing him a few times at a distance. He asked the staff how he was and recalled being told that he was 'settled' but 'isolated'.

On 8 January at 6.47 pm, the man made his first and only telephone call. He rang his partner. As part of the first night procedures, prisoners are allowed to make one phone call. The man does not appear to have been given this option until three days after he arrived at Leicester. In interview, a nurse said that he realised that the man had not made his phone call after he took a call from the man's partner trying to speak to the man. The nurse then arranged for the man to ring his partner and he recalled that the man had been very grateful.

The same day, as part of the induction process, the man was seen by Probation and the CARAT (counselling, assessment, referral, advice and throughcare) team. Nothing of any concern was documented. In the evening, the man was routinely seen by the Roman Catholic chaplain as part of the induction to newly arrived Catholics. He chatted with him for a few minutes. As the man was in healthcare, he was not able to attend mass, but declined the chaplain's offer to receive communion. The chaplain recalled the man as being upbeat and having a cheerful demeanour.

Leicestershire Partnership Trust provide the services of two psychiatrists for two sessions a week, amounting to eight hours in total. On 9 January, the man was seen by one of the visiting Consultant Psychiatrists, and the mental health nurse. The psychiatrist took a psychiatric history from the man. Of interest, he noted that the man was 'awaiting outcome of immigration procedure'. He also recorded, 'have not received old records yet'. The psychiatrist knew of the man previously as he had spoken to the psychiatrist who saw the man in the police station. However, this had been more about legal procedure matters than the specifics of the man's illness.

The prison psychiatrist could not recall exactly what information he had seen or knew about before he saw the man. He did not think he had been aware that the man had previously taken an overdose or that he had been an in-patient at the Brandon Clinic. In his notes of their review, the only reference the prison psychiatrist makes regarding suicide is 'not suicidal'. He concluded that there was, 'no evidence of any symptoms of mental illness, totally incomprehensible what happened and why during homicide. Recommendation – no need to be on healthcare wing, no need for special observations.' In interview, the prison psychiatrist said that there must be a reason to keep someone in healthcare. The last entry in the man's daily nursing care notes says, 'seen by the psychiatrist – cersion (sic) can be discharged to the main wing tomorrow'.

At 4.10pm, the mental health nurse wrote an entry in the ACCT, 'seen by visiting consultant psychiatrist for assessment. States has too many thoughts in his head, -

not elaborated responsive, denies any suicidal ideation.' At 6.30pm, another nurse wrote, 'to go to main wing 10/01/07. Seems to be fine with this.' Records also indicate that the man had a legal visit from his solicitor that day.

On 10 January, an ACCT review took place with the man, the acting Senior Nurse and the mental health nurse present. The Senior Nurse wrote the summary notes of the review, 'denies any suicidal intent or ideation. Would prefer to go onto wing and take part in education /employment to occupy his time whilst awaiting trial. Seen by psychiatric team on 09.01.07 (Psychiatrist and mental health nurse). Decision made to close ACCT. Will have follow up care by mental health in-reach team.' The ACCT was closed and a post-closure review was set for 17 January.

The man was now deemed fit for ordinary location. Given the nature of his alleged offence, he was not suitable to share a cell and it would seem that no single cell was available on ordinary location at the time. The man then became what is known as a 'lodger' on healthcare, awaiting a vacant cell. At this time, as he was no longer a patient in healthcare, he would not have had a care plan.

On 11 January, the man saw the chaplain again. He gave no case for concern. On 12 January, he again saw his solicitor and the following morning he was visited by his partner. On 14 January, the nurse who arranged the man's first phone call wrote the first entry in the man's record of events, 'weekly review. Admitted to the unit on arrival. Polite and cooperative with all regimes. No behavioural issues of concern noted yet. ACCT document closed.'

On 17 January, the Immigration Service faxed the prison a copy of a letter that had been sent to the man's home address on 5 January, requesting that the letter be given to him. The letter indicated that the man would not be allowed to stay in the country and had no further right of appeal. It is not known whether the man had already received an original of the letter through the prison post, or was told about the letter by his partner on a visit. It is also not known if the man was given the faxed copy of the letter. Had it been passed to him, staff said it would have been recorded in his notes. However, the man later mentioned a letter he had received, which suggests he had got it by some means.

The post-closure ACCT review set for 10.00am on 17 January did not take place. In interview, the Senior Nurse said she did not know why except that day to day crisis management could have led to it being missed. She said that she had wanted the mental health nurse to be present at the review because she was going to have continued involvement with the man. She recalled that the mental health nurse was working on her own at the time and had been very busy. The mental health nurse could not recall why the post-closure review had not taken place.

On 18 January, the man saw the other consultant psychiatrist at the prison, who was now seeing him in place of her colleague, and the mental health nurse. The consultant psychiatrist had discussed the man with his colleague. In interview, she said:

> " we spoke about suicide and self-harm. I always do that as a matter of course, to probe people in such anxiety provoking circumstances as with this

> serious criminal offence. And he told me that he did not feel suicidal and did not have current thoughts of self-harm. We discussed his contact with psychiatric services which was very vague and told me that he'd been taking olanzapine 5 mgs daily, which is an extremely low dose. And that he had actually not experienced hearing voices, and I put that in inverted commas, in prison. And I felt at the time that these voices that he was complaining of didn't have the quality of true auditory hallucinations, but that they were an expression of high expressed anxiety of the circumstances in which he'd found himself, coupled with circumstances that had brought him to Britain, things that had happened in Uganda which, from accounts, were extremely traumatic."

In the clinical record, the consultant psychiatrist noted, 'appeal for asylum – turned down and awaiting appeal (turned down)', which suggests that the man was aware of the contents of the letter from the Immigration Service. However, in interview, the consultant psychiatrist said that she was not aware until after the man's death that his application had been turned down. It may be that the man did know but the consultant psychiatrist had not realised exactly what he was referring to. She said:

> "obviously he wasn't told about it then, the final application had been refused, although in retrospect I do not believe I would have made any different sort of decision at the time. He didn't make me think that 'oh well it's been refused, so something terrible is going to happen', but I wasn't aware of that at the time. It isn't a mechanism through which we are given all the information that's relevant unfortunately."

Later that day, the man was again seen by the Roman Catholic chaplain for a few minutes. In his police statement, the chaplain said:

> " I didn't delve too deeply and the conversations were generally quite short as the man made it clear that he was quite busy writing letters. I did wonder if this was a way to keep the conversations short and superficial, possible as a coping mechanism."

On 23 January, a single cell became available on the 4s landing. A prisoner needed to be in healthcare, so the man and he were swapped. A Healthcare Officer accompanied the man from healthcare to his new wing. The healthcare orderly also went with them. The man was placed in cell L4-45 which is in the far corner of the landing and furthest away from the officers' office. In interview, the healthcare Officer said that he thought the man had not particularly wanted to go over to the main wing. However, he and the healthcare orderly had spent some time reassuring him that the healthcare orderly was located nearby and the man could speak with him if he needed.

In the man's history of events record, a nurse wrote, 'transferred over to the main wing today not too happy about this' and dated it 22 January. (This should have been 23 January.) In addition, the nurse completed a Cell Occupancy Risk Assessment and made the recommendation that the man have a single cell 'because of his charge'. Again this is dated 22 January. In interview, the nurse was unable to remember much of the detail of any conversation with the man at this time.

However, he was familiar with the man from healthcare, where he said the man had settled well.

The nurse described the regimes in the main prison and healthcare as 'like two different worlds'. In particular, the nurse had a vague memory of the man being told that the cells were much smaller on the main wings than those in the healthcare wing. The nurse recalled having a conversation with the man in which he expressed his worries about how his wife would view him because of his alleged offence. However, he did not know when this conversation took place

An officer wrote a memorandum following the man's death. The officer recalled seeing the man on the day he was moved over from healthcare. In interview, he said he had introduced himself to the man in his capacity as his personal officer. He recalled the man as being very quiet, but did not think he was unhappy about being moved onto the wing. The officer said that he was aware that the man had been in healthcare and had been on an ACCT. The officer was then off duty for a couple of days.

My investigators spoke with two prisoners who shared the cell opposite the man. One said that he had known the man in the community because 'as a black African, Leicester was a small city and people knew each other'. He described the man as a nice person whom he would not have expected to see in prison. The prisoner said he and his cell mate tried to help acclimatise the man to the regime when he transferred from healthcare. He said that the man looked lost when he came onto the landing and did not understand how the regime worked.

During association on the evening of 24 January, the man had spent over an hour talking to another prisoner. A principal officer spoke to the prisoner following the man's death about their conversation that evening. The prisoner said that he and the man spoke the same language and had got on well. He said that the man had been worried that he was going to be transferred to another prison near London and that he had concerns about his case. My investigators spoke to the prisoner but he did not want to provide any further details than those already given to the PO. The prisoner's own situation was difficult in that he was awaiting deportation following the end of his sentence. When he spoke to my colleagues, he indicated that he felt quite desperate about his situation. Had he been convicted, the man would have been in the same situation after he had served his sentence.

25 January

In the morning on 25 January, the man went to the gym and worked out with the other prisoner. A nurse walked him back from the gym at around 9.45am to attend an appointment with the psychiatrist. The nurse was familiar with the man as they had chatted previously when the man was in healthcare. She said the man previously had told her a little about life in Uganda and his fears about going back there. That morning, he spoke about his family visit the next day and the nurse had no concerns about him.

The man was seen by the consultant psychiatrist and mental health nurse for a continued assessment interview. In interview, the psychiatrist said:

> ” I believe he’d been on the landings for a week at that stage and he actually appeared quite animated, I would say more animated than he appeared at the time of the first consultation. A little more apprehensive at the first consultation than he was at the second, but that did not arouse any concern because after all he had seen me before and he was, as many patients, are pleased to see me and want to talk about things again.”

In interview, the psychiatrist said that she had suggested it might be a good idea to stop the man’s olanzapine. She said that, ‘there was no indication that he was unhappy about that or concerned’. At this time, the psychiatrist had not spoken to the community medical team about the man’s medication. She had hoped that by the time she saw the man two weeks later she would have done this and got more of an idea about why it had been prescribed. She said:

> “He’d been on and off it from, how I understood it he’d taken it rather intermittently as and when he felt like it. It was such a low dose that it is certainly not being used as an anti-psychotic, its use would have been minimally to reduce anxiety. And mindful of the fact that change, the changes to the man’s life had been such that there was a profound amount of anxiety regarding the circumstances to himself, I didn’t want to make changes just for the sake of making changes so I left him on olanzapine.”

The psychiatrist commented further:

> ” I was curious as to why he was on such a low dose of olanzapine. I did want to make contact with the community medical team about the circumstances so we could explore the circumstances further. Five mgs of olanzapine to my mind would have had an anxiety lasting effect on somebody and that’s about all. There is some clinical evidence to suggest that low dose olanzapine also has an anti-depressant effect on people but that’s not the primarily the reason why he’d use it.”

In the CR, the psychiatrist’s notes concluded, ‘there is no evidence of mental illness at this stage. Review 2-3 weeks.’

An officer wrote in the man’s history of events:

> “The man spoke to me this morning saying he was lonely in cell. I think the move from healthcare to the wing was not expected. Explained to him the reasons why he had was classified single cell briefly. Today the man saw the psychologist who may have new relevant information which may affect his risk assessment.”

In his police statement, the officer said that the man accepted this in a calm and understanding manner and never gave any indication that he was going to take his life.

In the afternoon, the man saw a solicitor from the firm representing him. This was the first occasion that the solicitor had met the man, although she knew something of

the case from her colleagues. The solicitor said that the man had been due a legal visit on 18 January, but they had been told by staff that he was not feeling well. There is no record that the man had either been unwell or cancelled a visit.

When the solicitor saw the man that afternoon, he told her that he wanted to go back to healthcare. This was the first time that her firm of solicitors were aware he had been moved to the main residential unit. The solicitor said that the man had mentioned his alleged crime to an Asian prisoner and that he was fearful that this could bring recriminations. The man also mentioned that he had recently received a letter from the Home Office saying that he could no longer stay in the UK.

The solicitor recalled that during the visit the man skipped from one subject to another and that he was all over the place at times. The man kept talking about suicide, and on a number of occasions the conversation came back to committing suicide.

The man told the solicitor that he had attended a psychiatric assessment earlier in the day and had been told he would be coming off the medication in the next few weeks. This was of concern to him. When the solicitor asked if he felt low in mood, the man said that he felt the same. He also felt the same when moving from healthcare to the main wing. Although the man did not like to be on the main landing, he was unable to specify what he did not like about the landing.

The man told the solicitor that he feared returning to Uganda as he had been kidnapped but had escaped the authorities. He also mentioned to her that he had experienced voices in his head and sleepless nights. The man told her that things had started to go wrong for him following the birth of his child about five months before.

The solicitor said that the man had not been animated during their meeting but had become upset and cried a couple of times. He had mentioned that he was expecting a visit form his partner the following day. At the conclusion of the visit, the solicitor said that she would see him the following week for a legal visit. Although she had some concerns about the man, she felt that he was not in imminent danger of harming himself as he was expecting a visit from his partner the next day. It had been the solicitor's intention to contact prison healthcare at Leicester the following morning to inform them of her concerns about the man's state of mind.

An officer was supervising visits that afternoon. He was aware of the man because of the press coverage and was concerned that other prisoners might be similarly aware. In interview, he said that nothing had occurred. He noticed that the man had a female visitor and watched them for a couple of minutes. He said that the man appeared calm; there was no agitation and he had no concerns.

Another officer, who knew the man, had also been working in the legal visits department that day. He too had seen the man talking to his solicitor. He did not recall seeing anything unusual about the man. Prior to the visit, the man had approached the officer and spoken to him about the length of sentence he might receive:

> ” he couldn’t get this, he couldn’t seem to grasp that he may be in prison for a long time. He wanted to know a definite time. I guess that’s possibly how I felt, looking back on it he wanted to know ‘am I going to here for 1 year, 2 years’. I said you can prepare yourself to be in prison I think for a long time because of the severity of the offence.”

The healthcare orderly said that he walked back to the landings from legal visits with the man as he too had been on a visit. The man seemed to be okay.

A little after 4.00pm, the chaplain went to see the man in his cell as he realised he was on the main residential wing. In his police statement, he said:

> ” Once again he seemed cheerful and he met me with his wide, toothy grin. I mentioned that, now he was in the main wing, he could attend Mass if he wished and he said that he would like to. He seemed quite enthusiastic about it and I agreed to put him on the list. I asked how he was coping on the main wing and whether he had made any acquaintances or friends, anyone who could help him get into the regime and he assured me he had. We discussed the prison routine and he said it was all new to him and that he wasn’t used to it yet and he hadn’t been to prison before … He seemed quite cheerful and seemed be coping all right.”

The two prison orderlies both recall seeing the man at about 5.00pm in the queue at the servery. The one who had walked back from legal visits with the man said that he asked him about how he could get a haircut. He said that he explained the process to the man and did not suspect that anything was wrong. The other orderly recalled him as happy and laughing. The man returned to his own cell with his food. He also collected his medication during this time.

Between 6.20 and 6.30pm, the man was seen by an officer who was collecting prisoners’ plates from their cells. This involved unlocking each cell door and asking the occupant to put their plate out. She is unable to recall anything in particular about the man at that point.

During a roll check at approximately 7.25 pm, the officer discovered the man hanging. Having looked through the door flap, she was unable to see anything as the cell was in darkness. She switched on the night light which was located outside the cell door. She then shouted ‘staff’. She also called to an officer who she could see on the landing below and then shouted ‘staff’ again. By shouting ‘staff’, the officer knew colleagues would know there was an incident and that she needed assistance. The officer was carrying a radio but, since she could see staff on the landing below, she thought it would be quicker to shout.

Another officer arrived very quickly and unlocked the door. He also shouted out for staff as others were arriving. The man was hanging from the window bars with a ligature made from bed sheets. The officer who unlocked the cell cut the ligature with his anti-ligature knife. The officer from the landing below supported the man, placed him on the floor and removed the ligature from his neck. He checked for a pulse but could not find one. He noticed that the man’s skin was cold to touch. Another officer entered the cell and checked for vital signs. He found none. He and

the officer from the landing below then commenced cardio pulmonary resuscitation (CPR), One delivered breaths using a respirator aid and the other giving chest compressions. The officer delivering breaths said that the man was motionless and his eyes were wide open.

A Senior Officer who had been following the other officers, pressed the general alarm. The nurse was Hotel 4 (a radio call sign which indicates a medical emergency) responded to a request for her attendance. She was not told the nature of the emergency. Once she had arrived at the cell, the nurse checked that the two officers were able to continue with CPR. She then went to collect the emergency rucksack which was in the treatment room two landings below. She estimated that this took two to three minutes. The nurse asked for the doctor to be summoned. Returning to the cell, the nurse took over from the officer delivering breaths and attached the oxygen. The nurse said that she was using the oxygen when the paramedics arrived. However, the officer delivering breaths said that he had resumed doing mouth to mouth because they could not see the chest rising when using the oxygen.

The prison doctor and two paramedics arrived at the cell at 7.40pm. Their statements indicate that they found the two officers working on the man. They then took over the attempts at resuscitation. The doctor described the man's skin as very cold and the paramedics said that he was unresponsive to all efforts to resuscitate him. The doctor pronounced the man dead at 7.56pm.

Later that evening, a member of the prison chaplaincy and a police officer went to break the news of the man's death to his partner. Understandably, the man's partner was distraught.

A few days later, the man's partner and her father visited the prison at the invitation of the Governor. They visited the cell where the man had died. At the request of the family, the funeral service was led by the prison chaplain who had broken the news to the partner. The man's partner told my family liaison officer that she was very grateful for the support she had received from the prison and, in particular, their liaison officer.

ISSUES

When the man arrived at HMP Leicester, significant information was already known about him as indicated on his PER and reports from the FMEs. Furthermore, the CPN at the court had telephoned the in-reach nurse giving background information. During his first reception health screen, the man said that he suffered from depression, was on medication, had been an in-patient at the Brandon Unit, and had previously taken an overdose.

An ACCT was opened and a number of risk factors were identified by the assessor. These included the nature of the man's offence, this being first experience of prison, being a failed asylum seeker, a history of depression and being on medication. The assessment is very detailed and full. The man was placed in healthcare for observations.

An attempt by the in-reach nurse to gain further background information from the community mental health team (PIER) was allegedly hampered by Leicestershire Partnership Trust's own investigation. This meant that the usual procedure of the in-reach nurse talking directly to a keyworker did not take place. Notwithstanding that, a faxed record of the man's contact with the community services was received by the mental health nurse the same day. What then is confusing is who saw this and what information came to the attention of those in the in-reach team, including the visiting psychiatrists. The mental health nurse completed a form on 5 January which said that the man did not have a history of self-harm, and the first consultant psychiatrist wrote in the clinical record on 9 January, 'have not received old records yet'. These are both inaccurate. In interview, the first consultant psychiatrist said he did not think that he had been aware that the man had taken an overdose or that he had been an in-patient at the Brandon Clinic.

Having seen the man on 9 January, the first consultant psychiatrist concluded that the man was not suffering from any mental illness. He did not therefore need to be in healthcare, and there was no need for special observations. The man's ACCT was closed the following day and he was deemed suitable for ordinary location, albeit in a single cell.

In his clinical review of the care received by the man, the clinical reviewer has written, 'there seems to be general acceptance that the man was not mentally ill. There were problems with internal communication, lack of overall clinical responsibility role and continuity of care and it is unclear whether the full catalogue of emerging risk factors for the man were given appropriate weighing.' He goes on to say, 'there appeared to be no agreement within healthcare and the in-reach services as to who had clinical responsibility for the man. No-one person held the "overview" picture.'

This lack of effective communication and clarity of roles gives rise to a number of worrying features in relation to the man's medication. First, there is the question of where the medication given to the man came from. The number of pills remaining following the man's death suggests that there was another, unrecorded, source of olanzapine in addition to the prison prescription. The man's partner said the police had taken some medication from the house which may have been included in the

man's property when he got to HMP Leicester. However, there is no mention of this in the police record of evidence, or in the man's property card or medical record.

All in-possession medication brought into the prison, or prescribed on reception, must be recorded in the clinical record.

There is no record of any contact being made with the man's GP to get more information about his prescription. In interview, the mental health nurse explained that one of the functions of the second health screen is for healthcare staff to contact a prisoner's GP to get a more detailed picture of their history. However, there is no record of the nurse having a second health screen.

Healthcare staff must conduct a second health screen on all new prisoners.

Given that the man was seen by the in-reach nurse and it had been the second consultant psychiatrist's intention to make further enquiries about his medication following their session on 25 January, the most appropriate action would have been to ascertain all relevant information from the GP at a much earlier stage.

The in-reach team must ensure that the prescribing GP is contacted when the prisoner is in their care.

The man's prescription chart indicates that he was not given his medication on the weekend of 6/7 January. Although he was a resident in the healthcare unit, there is no record of this being followed up by either the healthcare staff or the in-reach team.

The Chief Executive of the PCT should remind all staff of the importance of following up any prisoners who have missed their medication whilst resident in healthcare.

Failure to hold a post-closure ACCT review

The post-closure review was one of a number of changes introduced when self-harm suicide monitoring changed from F2052SH monitoring to the ACCT system. When the man's ACCT was closed, a post-closure meeting was arranged for 17 January at 10.00am. For some unknown reason, this did not take place. Neither the Senior Nurse nor the mental health nurse who were at the closure review, could offer an explanation as to why the review did not take place. The Senior Nurse suggested that the day to day crisis management of healthcare may have been a factor. However, there does not appear to have been a system to check whether these post-closure reviews are carried out or not. If such a system had been in place, a review could then have been arranged.

The Governor and the Chief Executive of the PCT should develop and implement a process to check whether post-closure ACCT reviews have taken place.

The man's transfer to the wing

On his reception into HMP Leicester, the man went straight to healthcare bypassing the First Night Centre and thereby missing the induction process. We know that representatives from probation and the CARAT team did see the man in healthcare as part of their routine induction. However, the man was not given the opportunity to make the reception telephone call, to which he was entitled, until his third day. This suggests that it may be relatively easy for routine induction tasks to be forgotten in healthcare, where staff may not be familiar with the process.

As part of the ACCT document, a care plan was written for the man. The final action point on this plan was, 'when moved from healthcare to go first to the FNC (First Night Centre)'. This was not picked up by staff, possibly as a result of the failure to conduct a post-closure review. However, Leicester's protocol is for all prisoners to be re-routed through the induction unit once they are fit for discharge from a specialist unit. Clearly, this did not happen in the man's case.

The Governor should ensure that all staff are familiar with Leicester's protocol for all prisoners to be re-routed through the FNC once they are discharged from a specialist unit.

On 10 January, when the man was deemed fit for ordinary location, the expectation was that he would leave healthcare promptly. However, having been assessed as suitable only for a single cell, he waited 13 days before a space became available. This was unacceptable. At this stage he was classed as a 'lodger' and formal nursing supervision ceased. He remained on the caseload for the in-reach team and saw the psychiatrist. However, it is not entirely clear what it means to be on the in-reach caseload and how this fits with a prisoner who is lodging in healthcare. Again, it may be that this played a part in the man 'slipping through the net' in terms of not having a post-closure review.

It is not known how well the man was prepared for the move to the main wing and, having waited nearly two weeks, whether he fully understood what was happening when the time came. Once he was moved, there are numerous accounts of him saying he was unhappy and unfamiliar with the regime in the main part of the prison. The actions of the healthcare officer in arranging for the man to be accompanied to the wing by an orderly with whom he appeared to be comfortable, were well judged and are to be commended.

When the man first arrived at Leicester there was a flurry of appropriate activity – he was placed in healthcare and put on an ACCT. The ACCT assessment was excellent and identified a number of highly relevant risk factors. These factors had also been identified by the CPN at court and passed to the in-reach team. However, the man was then seen by the visiting psychiatrist, who may or may not have had all the background information. He was deemed not to be suffering from any mental illness and fit for ordinary location. Given his behaviour in healthcare, which appeared to be settled, the ACCT was closed.

Whilst the presence of a mental illness can be one indicator of vulnerability to self-harm/suicide, its absence would not, to my mind, be enough to suggest that an

individual was not at-risk. Prior to his alleged offence, the man was in contact with the community mental health team and, according to the team's assessment, was vulnerable. He then entered custody, for the first time, as the only suspect in a murder charge. These factors would raise his risk significantly. After coming into custody, it is believed that the man received notification that his immigration appeal had failed. Whether or not this was known by healthcare staff is not clear. However, the man was placed on ordinary location but judged suitable only for a single cell. It is not clear if and when this would have been revisited. It is not Leicester's policy to keep all prisoners charged with murder in a single cell following a period of assessment.

The letter from the Immigration Service

The Immigration Service faxed a letter to the prison's discipline office on 17 January. However, there is no record of whether or not the man received this letter and, if he did, how it was delivered, given its sensitive nature. If we knew conclusively that he had received this letter, I might well be making a recommendation that all correspondence of significance should be recorded and an account given of how the prisoner responded to the content. However, it has not been possible to say what became of the letter. The man made reference to a letter and a failed appeal, but it is not known if this was in response to a letter received via the discipline office.

The man's meeting with his solicitor

On 25 January, the man spoke to his legal advisor about his suicidal thoughts. In interview, the solicitor said that she was very concerned for the man but felt that he would not do anything immediately because of his family visit the next day. She said that she intended to inform the prison by telephone the following day. Had the solicitor told prison staff there and then, the man could have been assessed. My colleague went to the legal visits area of the prison and noticed that there was no information about what visitors can do if they are worried about someone.

The Governor should consider displaying posters in the legal visits area, informing visitors to notify staff immediately if they have any concerns about a prisoner.

Emergency calls

When the man was found hanging, a call was put out to H4, the nurse responsible for attending an emergency. Without further details, the nurse did not know what type of incident she was attending and what emergency equipment she might need. When the nurse attended the cell she realised that oxygen might be needed and had to leave to collect the necessary equipment.

The Governor should give consideration to developing and implementing a code system for emergency calls to signify the nature of the incident.

Family contact

I would like to commend the quality of contact with the man's family. This is the second investigation at Leicester in which I have been very impressed by the quality of the family liaison. The chaplain visited the man's partner to break the news and at the request of the partner, she subsequently conducted the funeral service. The family was invited to visit the prison and meet the Governor. Funeral expenses were offered promptly.

The clinical review

The clinical review reaches the following conclusions in his clinical review:

- There needed to be a named individual who had *overall clinical responsibility* for the clinical care of the man. This was crucial in order to see the emergent whole picture as developments evolved.

- There needed to be clear responsibility for ensuring the chasing up of previous medical information or that contact had actually been made with the external agencies involved with the man.

- Appropriate faxed clinical information received at the prison needed to be passed onto appropriate in-reach and healthcare staff promptly.

- Important clinical judgements should not have to be made on limited information and under time pressure constraints.

- A 2nd health screen must be performed. Systems need to be in place for identifying this or following up on this if not performed.

- A post closure ACCT review must be performed. Systems need to be in place for identifying this or following up on this if not performed.

- There need to be processes to monitor and act on missed medication.

- Failed asylum seeker status notification should be regarded as highly pertinent information and should have been recorded in the man's IMR and made available to all involved in his healthcare.

- The significance of failed asylum seeker status should have been considered strongly with existing risk factors.

- There should be Induction training for all staff.

These recommendations need to be seen in conjunction with the results and recommendations from the Leicestershire Partnership Trust enquiry into the death of the man. The results of the latter were not available at the time of completion of this report.

RECOMMENDATIONS AND GOOD PRACTICE

1. All in-possession medication brought into the prison, or prescribed on reception, must be recorded in the clinical record.

Not accepted. A system was in place already for medication to be noted in the clinical record if brought in by a prisoner. There is no evidence to suggest that the man came into prison with any medication and consequently no evidence to suggest that the system needs reviewing.

2. Healthcare staff must conduct a second health screen on all new prisoners.

Accepted. A member of Healthcare Staff is detailed to carry out Second Healthcare Screenings on a daily basis. System reviewed to incorporate prisoners who are located straight into the HCC have a second healthcare screening completed by In-Patient medical staff.

3. The in-reach team must ensure that the prescribing GP is contacted when the prisoner is in their care.

Partially accepted. A copy of the PPO Report and Recommendations will be forwarded to the PCT who commission the services, and to Leicester Partnership Trust who manage the In-Reach Team. (The Governor cannot accept this recommendation on the behalf of the PCT.)

4. The Chief Executive of the PCT should remind all staff of the importance of following up any prisoners who have missed their medication whilst resident in healthcare.

Partially accepted. A copy of the PPO Report and Recommendations will be forwarded to the PCT. The Healthcare Manager has put a protocol in place whereby any prisoners who miss 3 days of medication are checked and investigated by HCC staff. (The Governor cannot accept this recommendation on behalf of the PCT.)

The PCT requested that the recommendation be amended. This recommendation has now been altered to:

The Prison Healthcare Provider should remind staff of the importance of following up any prisoners who have missed their medication whilst resident in healthcare.

5. The Governor and the Chief Executive of the PCT should develop and implement a process to check whether post-closure ACCT reviews have taken place.

Partially accepted. ACCT Post-Closure Reviews are now scheduled into the ACCT Diary System and monitored by the Safer Custody Co-ordinator, Safer Custody Principal Officer and Head of Residence on weekly management checks. All reviews (including Post-Closure Reviews) are noted on the full staff daily briefing emailed to all staff at HMP Leicester.

The PCT requested that the recommendation be amended. This recommendation has now been altered to:

The Governor and the Prison Healthcare Provider should develop and implement a process to check whether post-closure ACCT reviews have taken place.

6. The Governor should ensure that all staff are familiar with Leicester's protocol for all prisoners to be re-routed through the FNC once they are discharged from a specialist unit.

Accepted. Basic information will be given to all prisoners on their initial arrival regardless of location. Protocol published to ensure that all prisoners who do initially enter the establishment through the Healthcare Centre are assessed to be located onto the FNC once discharged. This must be done where practicably possible. Where this is not possible i.e. Due to mobility issues, Induction staff must ensure that the relevant full interviews and documentation are completed in the new location.

7. The Governor should consider displaying posters in the legal visits area informing visitors to notify staff immediately if they have any concerns about a prisoner.

Accepted. Notices are prominently displayed in the Legal Visits Area that inform visitors of what to do if they feel their clients are 'At Risk' in any way.

8. The Governor should give consideration to developing and implementing a code system for emergency calls to signify the nature of the incident.

Accepted. 'Code Red/Code Blue' System in place for Medical Assistance. Code Red being blood injury, Code Blue for respiratory matters. These are called over the radio system to ensure medical staff are aware of situation and will respond with appropriate equipment.

Good Practice

- **The actions of the healthcare officer in arranging for the man to be accompanied to the wing by an orderly with whom he appeared to be comfortable, were well judged and are to be commended.**

- **This is the second investigation at Leicester in which I have been very impressed by the quality of the family liaison.**