

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

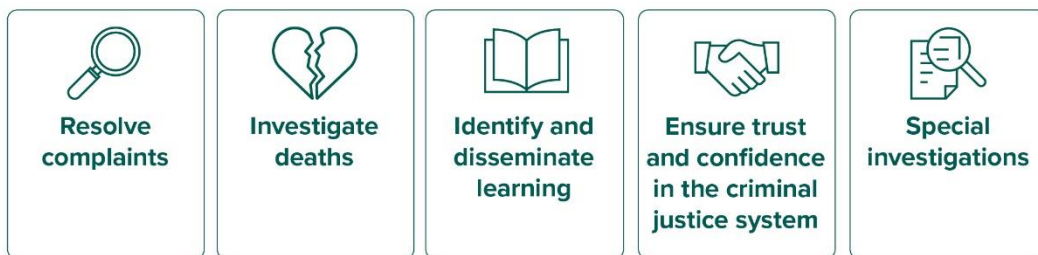
# **Independent investigation into the death of Mr Donald Livesey, a prisoner at HMP Leeds, on 15 November 2021**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO



## WHAT WE VALUE



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

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

Mr Donald Livesey, a prisoner at HMP Leeds, was found hanging from a ligature in his cell on 14 November 2021 and died in hospital the next day. He was 54 years old. I offer my condolences to Mr Livesey's family and friends.

Mr Livesey had been on remand for four months when he died. He had a history of substance misuse and depression and had self-harmed in the community and in police custody. Staff initiated procedures for prisoners at risk of suicide and self-harm when he arrived in prison.

On 19 July, Mr Livesey's cellmate tried to hang himself. Mr Livesey raised the alarm and supported him until help arrived. Two days later, the prison received an allegation that Mr Livesey had been involved. They moved him to the segregation unit to manage the potential risks. He remained there for five days, with ACCT monitoring and mental health support. When the police confirmed that they did not consider him to be a risk to other prisoners, Mr Livesey was moved back onto a standard wing. His ACCT was closed based on the reduced risk of suicide and self-harm. Mr Livesey seemed to settle on his new wing. He engaged well with staff and support services including the mental health team, the substance misuse team, and a care team from the military. He was in contact with family members.

On the morning of 15 November, staff found Mr Livesey hanging. They provided first aid until he was taken to hospital.

The clinical review into Mr Livesey's death found that the physical healthcare he received was equivalent to that which he could have expected in the community. It identified some gaps in his mental health care.

I am concerned that healthcare staff did not share information on an incident of self-harm in prison with prison staff, which would have informed care planning. I also note that when Mr Livesey was segregated while on an ACCT, staff did not document which other options had been considered. These factors are unlikely to have played a part in his death but might impact on outcomes for other prisoners if they are not addressed.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**February 2023**

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# Summary

## Events

1. Mr Donald Livesey was remanded to HMP Leeds on 12 July 2021, charged with the attempted murder of his partner. Based on records of two recent acts of self-harm, staff opened HMPPS procedures to support those at risk of suicide and self-harm (Assessment, Care in Custody and Teamwork, known as ACCT).
2. At reception, Mr Livesey said that he had no significant health issues but had suffered depression in the past. He said that he had misused alcohol but did not consent to a referral to substance misuse services. A nurse prescribed him an anti-depressant and medication to help manage alcohol withdrawal.
3. On 13 July, Mr Livesey told a nurse that he had tried to self-strangulate with a sock during the night.
4. On 17 July, Mr Livesey's cellmate tried to hang himself. Mr Livesey supported his bodyweight and called for assistance. Staff provided first aid until the cellmate could be taken to hospital for further treatment.
5. On 21 July, the prison was notified by police of an allegation that Mr Livesey had been involved in his cellmate's hanging. They relocated Mr Livesey to the segregation unit, on the basis of his potential risk to other prisoners. After five days, the police confirmed he was no longer felt to be a risk and he was transferred onto a standard wing. Staff agreed that he no longer needed ACCT support because his assessed risk of suicide and self-harm had reduced.
6. During August, Mr Livesey and some of his family members raised concerns with staff that his medication to help him sleep was not working, so it was adjusted. He said that he might be suffering from post-traumatic stress disorder (PTSD) related to his time in the military and would like to explore the impact it had had on him. He spoke to the prison's diversity officer and his army regiment's care team. He arranged a veterans' coffee morning and hoped to become a representative for Veterans in Custody. He began to engage with the substance misuse team to address the risk of alcohol misuse relapse after release. He told the mental health team that he felt stable, was in contact with his family who were supportive and felt positive.
7. Mr Livesey shared with staff, his sister, and his cellmate that he was anxious about his upcoming court case and was unhappy with his legal team.
8. On 14 November, staff unlocked Mr Livesey's cellmate for work. Mr Livesey said he did not want to go out and would stay in bed. When staff were conducting cell checks, an officer found Mr Livesey hanging. He raised the alarm and staff lowered Mr Livesey to the floor. Officers provided medical aid until and were supported by nursing staff from the prison healthcare team and ambulance paramedics, respectively. Paramedics transferred Mr Livesey to hospital. Staff contacted Mr Livesey's family, who joined him there. Following discussion between doctors and the family, life support was withdrawn, and Mr Livesey died at 6.25pm on 15 November. No post-mortem or toxicology tests were requested.

## Findings

### Assessment of suicide and self-harm risk

9. On 13 September, Mr Livesey told staff he had tried to strangle himself during the night. This was noted in his medical records by healthcare staff but was not shared with prison staff and therefore this did not inform care planning.

### Assessment, Care in Custody and Teamwork (ACCT)

10. Mr Livesey was rightly identified as at risk of self-harm in reception and ACCT procedures were opened. ACCT reviews were regular but not all were multi-disciplinary due to the adaptations implemented during the COVID-19 pandemic. They were overseen by a single case manager, who consulted healthcare staff as appropriate. In the circumstances this seems to have been a reasonable approach.
11. When there were allegations that Mr Livesey had been involved in his cellmate's hanging, staff moved him into the segregation unit on the basis of the potential risk of violence to others. HMPPS guidance requires that only in exceptional circumstances should prisoners under ACCT management be segregated. It also requires that reasons why alternative locations are not suitable must be clearly documented. Staff did hold an ACCT review and made notes in the defensible decisions log but did not document discussions on other options considered. The daily review section of the log was also not completed.
12. When the prison was told by police that Mr Livesey was no longer considered as a risk to other prisoners, a multidisciplinary ACCT review was held. The meeting agreed that the level of risk had sufficiently reduced for ACCT to be closed. Mr Livesey was transferred from segregation to a standard wing.

### Mr Livesey's healthcare

13. The clinical reviewer concluded that the healthcare provided to Mr Livesey in Leeds was equivalent to that which he could have expected in the community. However, she identified that there was no care plan for Mr Livesey, with which to monitor his needs and record decisions, including the prescribing of medication and the impact on Mr Livesey's mental health.
14. The clinical reviewer also had concerns about wider record keeping, training and supervision. We do not repeat these here, but the Head of Healthcare will wish to address them.

## Recommendations

- The Head of Healthcare should ensure that information regarding the safety and welfare of individual prisoners is appropriately shared and recorded.
- The Governor should ensure that managers authorising use of segregation for prisoners under ACCT management record their consideration of alternative locations and the rationale for discounting these when documenting decisions.

- The Governor should ensure that duty governors complete daily review summaries for prisoners in segregation while under ACCT management.
- The Head of Healthcare should ensure that prisoners being prescribed medication for their mental health have a clear care plan in place that is regularly reviewed.
- The Head of Healthcare should ensure that all staff have the appropriate training for the work that they are asked to undertake.

## 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 Livesey's prison and medical records.
17. The investigator interviewed six members of staff, one former member of staff and a former prisoner at Leeds. NHS England commissioned a clinical reviewer to review Mr Livesey's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
18. We informed HM Coroner for West Yorkshire, Eastern District of the investigation. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Livesey's wife and Mr Livesey's sister, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked about his mental health care, and the presence of prison staff in the hospital. We have addressed the latter point in separate correspondence.

## Background Information

### HMP Leeds

20. HMP Leeds is a local prison, serving the courts of West Yorkshire. It holds a maximum of 1,218 prisoners on remand, convicted or sentenced. Practice Plus Group (previously known as Care UK) is commissioned by NHS England and NHS Improvement to provide healthcare services, including mental health services, at the prison. This includes a 24-hour primary healthcare service.

### HM Inspectorate of Prisons

21. The most recent full inspection of HMP Leeds was in November and December 2019. Inspectors found that the need for mental health support was high with 61% of respondents to the HMIP survey saying that they had a mental health problem. A mental health awareness training package had been developed for prison staff, but at the time of the inspection only 63 staff had received it. Inspectors recommended that prison managers and healthcare commissioners should ensure there are sufficient mental health resources to meet the needs of the population. Inspectors also found the levels of self-harm were significantly higher than at other local prisons and since their last inspection. They noted that ACCT case management was not good enough, despite previous PPO recommendations, and the safeguarding strategy was not effective in addressing risks or the needs of individuals in crisis.
22. HMIP carried out a short scrutiny visit to Leeds in June 2020 (along with two other local prisons), to assess how well they had responded to the COVID-19 pandemic. Inspectors reported that ACCT processes were being delivered efficiently and mental health professionals had remained accessible during the restricted regime.

### Independent Monitoring Board

23. 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 31 December 2020, the IMB reported that the COVID-19 pandemic had affected how care was given, but prisoners were treated fairly and humanely.

### Previous deaths at HMP Leeds

24. Mr Livesey was the twenty-third prisoner at HMP Leeds to die since the beginning of 2020. Six of the deaths were self-inflicted. We found no similarities between these and Mr Livesey's death.

### Assessment, Care in Custody and Teamwork

25. ACCT is the care-planning system used by HMPPS to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All

decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others, and from others (Safer Custody)*.

## **Challenge, Support and Intervention Planning (CSIP)**

26. Challenge, Support and Intervention Planning (CSIP) is a Prison Service scheme designed to address factors contributing to violence in prisons by managing the most violent prisoners and supporting the most vulnerable prisoners. Prisoners who are perpetrators of violence or who are vulnerable to violence or bullying are managed and supported on a plan with individualised targets and regular reviews.

## **Segregation**

27. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings.
28. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted, and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

# Key Events

## Reception and induction

29. Mr Livesey was remanded to HMP Leeds on 12 July 2021, charged with the attempted murder of his partner. It was recorded as his first time in prison, although Mr Livesey later suggested to staff that he had been in prison once before, over twenty years ago. Two days before arriving in prison he had attempted to hang himself and, while in police custody, he had tried to jump out of a moving police vehicle. Staff opened HMPPS procedures to support those at risk of suicide and self-harm (Assessment, Care in Custody and Teamwork, known as ACCT). Staff were to check on him at least once per hour.
30. Mr Livesey told staff that he had served in the military and suffered from post-traumatic stress disorder (PTSD). His cell-sharing risk assessment concluded that he was eligible to share with a cellmate.
31. At his initial health screening, Mr Livesey told a nurse that he had no significant health issues. He told her that he had been experiencing signs of depression, which he had suffered from in the past. He said that he was withdrawing from alcohol, which he had misused for some time, but did not consent to a referral to substance misuse services. Another nurse prescribed him an anti-depressant (sertraline) and two drugs (diazepam and thiamine) to help manage his alcohol withdrawal.
32. An officer gave Mr Livesey his first night induction. She explained prison rules and avenues of support available. She offered him a telephone call, but Mr Livesey did not know any telephone numbers he wanted to ring. He did not raise any other issues.
33. On the morning of 13 July, a Supervising Officer (SO) chaired an ACCT review which was attended by a nurse from the mental health team and an officer, who had conducted the assessment interview with Mr Livesey. Mr Livesey engaged but was low in mood, saying that he wanted to die. He said that he had an address he could write to and ask for a list of telephone numbers so that he could speak to his family. He was keen to engage with the healthcare team regarding his medications. He got on with his cellmate, who he said was supportive. The SO recorded that Mr Livesey's risk of self-harm was high, and that staff should check on him at least three times per hour, with at least one quality interaction each morning and afternoon.
34. That afternoon, a nurse undertook a mental health assessment on Mr Livesey. He said that he did not have any mental health issues but was tearful and said that he had tried to strangle himself during the night using his socks. No note was made on his ACCT document or NOMIS record and it was not shared verbally with other staff.
35. On 14 July, a member of the substance misuse team visited Mr Livesey. He refused to have any involvement with substance misuse services. That day, a SO held an ACCT review with Mr Livesey, having consulted a nurse from the mental health team. Mr Livesey was upset and said that he intended to take his own life.

He did, however, show signs of forward planning. He had written to his ex-wife, had submitted orders for food, and brought some applications to ask for the SO's help with. The SO judged that his risk remained high, and maintained the observation levels previously agreed.

36. On 15 July Mr Livesey's sister contacted the prison and provided her contact details. These were passed to Mr Livesey.
37. On 16 July, Mr Livesey told his offender supervisor that he was undergoing detoxification and had no issues. His offender supervisor offered help with Mr Livesey's finances and accommodation if and when he wanted it.

## Events of 17 July

38. At approximately 11.20pm on 17 July, Mr Livesey awoke to find his cellmate hanging. He supported his bodyweight and called for assistance. The cellmate was taken to hospital. Staff spoke at length to Mr Livesey and offered support, before taking him to a new cell, which he was to share with a cellmate that staff had judged would be a good support system. The following morning, a SO conducted an interim ACCT review. She did so independently and did not consult the healthcare department. Mr Livesey said that he had no thoughts of harming himself, but based on the hanging of his cellmate, the SO left his observation levels as they were.
39. On the morning of 19 July, a SO held a further ACCT review. He consulted a mental health nurse beforehand. Mr Livesey found it difficult to talk about his cellmate but said that he was getting used to prison. He was taking his medication and had finished his detoxification. He had also written to his niece and was in telephone contact with his sister. He still had occasional thoughts of self-harm, but they were less frequent, and he had no intention of taking his own life. The SO left the ACCT open, with observations reduced to at least once per hour with quality interactions at least once each morning and afternoon.

## Segregation

40. On 21 July, the prison received notification of an allegation that Mr Livesey had been involved in his cellmate's hanging, which the police were to investigate. Mr Livesey was relocated to the segregation unit on the basis of risk of violence. In line with guidance, a member of the mental health team saw Mr Livesey, and segregation staff explained the regime. The duty governor held an interim ACCT review on Mr Livesey's arrival in segregation, with input from a nurse in the mental health team. Mr Livesey engaged well but said that he did not understand why he was in segregation. The duty governor explained that all she could say was that there was an ongoing police investigation. Mr Livesey said he had no thoughts of self-harm but was concerned at having too much time to think in segregation, so the duty governor arranged for him to be given distraction packs. She also increased his observation levels to at least five per hour.
41. Records show that staff conducted regular wellbeing checks on Mr Livesey in line with policy. On 23 July, the duty governor reviewed his segregation and held an ACCT review. The unit manager and a nurse from the mental health team were

also in attendance. Mr Livesey said he felt fine and had no thoughts of harming himself. He had been in contact with his family, and staff had provided him with a radio. They also allowed a telephone in his cell, which was not a standard procedure for prisoners in segregation. Observations were reduced to a minimum of once per hour.

42. On 26 July, the police informed the prison that they did not suspect Mr Livesey of involvement in his cellmate's hanging. At an ACCT review that morning, attended by an officer from the segregation unit and a mental health nurse, a duty governor told Mr Livesey that it had been agreed that he could move back to a standard prison wing. Mr Livesey was pleased, saying that he would ask staff for support if he needed it. All present agreed that ACCT procedures could be closed on the basis that the earlier risk factors had reduced. Mr Livesey returned to E wing, a standard prison wing.

### **Return to a standard prison wing**

43. At an ACCT post-closure review on 2 August, Mr Livesey told a SO that his mood had stabilised. He was in regular contact with family. His medication prescription was in place, but he asked if the mental health team could review it. He asked how he could apply for a job, and the SO explained the process. He said that he had no thoughts of self-harm and was aware of how to seek support if he needed it. The SO agreed that the ACCT should not be re-opened. He confirmed with the mental health team that a review of Mr Livesey's mental health was pending.
44. To support the move back from segregation, Mr Livesey was managed under Challenge, Support and Intervention Planning (CSIP) procedures. On 4 August, an officer conducted a CSIP review. Mr Livesey engaged well. He said that he had good relationships with staff and was engaging with the wing regime. It was agreed that all the CSIP targets had been addressed, but the support would remain in place.
45. On 9 August, an officer saw Mr Livesey for a key work session. The officer explained the purpose of key work and the support he could provide. Later that day, Mr Livesey appeared in court. When he returned to prison, staff conducted welfare checks on him. On 10 August, Mr Livesey saw a nurse. He told her that he had not been sleeping well. She agreed to adjust his medication.
46. On 12 August, an officer visited Mr Livesey for a further keywork session. He said that he had been given medication to help him sleep but it was not working. The officer said that he should put in an application to the healthcare department. If this did not help, he would contact them on Mr Livesey's behalf. Mr Livesey had no other issues to raise.
47. On 16 August, Mr Livesey's sister contacted the prison's safer custody department. She was concerned about what he had told her about his sleeping patterns, and that he was no longer on medication to address the issues. The safer custody department passed the message to the healthcare department. On 20 August, a member of the healthcare team saw Mr Livesey about his sleep patterns. They referred him for a mental health assessment.

48. On 22 August, Mr Livesey's niece contacted the prison expressing concerns about him. Staff checked on him, and he said that he had some issues around his sleep patterns and that he had been referred to the mental health team. Staff contacted his niece and let her know they had checked on him.
49. Mr Livesey had submitted various applications over a period of time. On 24 August, a mental health support worker visited him to discuss his requests. Mr Livesey had a number of complaints, including about his clothing, applying for jobs, not seeing the Veterans in Custody representative, and not seeing his key worker. He said he had had no input from the mental health team since his ACCT was closed, and he was concerned that his medication was incorrect. He had been told that he would have a medication review, but this had not happened. He wanted to explore whether he might have PTSD. She said that she would help him with these issues and would chase up his mental health assessment. Her note of the meeting said that Mr Livesey seemed content with her suggested way forward.
50. On 25 August, the prison's diversity officer asked the mental health team and the safer custody team to review Mr Livesey, with a view to support in line with his being a military veteran with possible PTSD.
51. On 26 August, a nurse held a mental health review. Mr Livesey said that he wanted to explore other medication, as the ones he had been prescribed had stopped working and so he stopped taking them.
52. On 31 August, Mr Livesey moved into a shared cell. Staff carried out a welfare check to follow up the transition. Mr Livesey raised no issues and said that he was happy to be sharing.
53. On 1 September, an officer held a CSIP review. Mr Livesey said he was doing well and did not want to be under CSIP management. He had met all the CSIP targets. Wing staff confirmed that Mr Livesey caused no problems. He was not under ACCT management. The officer confirmed with the mental health team that Mr Livesey was not currently on their caseload. He therefore closed the CSIP process.
54. Mr Livesey's sister contacted his army regiment's care team asking for support on his behalf. On 1 September they contacted the prison. The diversity officer spoke to Mr Livesey, who said that he would be happy for the team to contact him. They arranged for a visit on 15 September.
55. On 8 September, Mr Livesey told a nurse that his medication was not working. She agreed to change his medication.
56. On 14 September, the mental health support worker accompanied the diversity officer on a welfare check on Mr Livesey. After discussion, he agreed to work with substance misuse services.
57. On 15 September, a member of the Yorkshire Regiment Care Team visited Mr Livesey. They discussed ways that they could help him. Mr Livesey told the diversity officer that he was pleased to have had the contact.
58. On 20 September, a worker from the Drug and Alcohol Recovery Team (DART) contacted Mr Livesey. He said that he would like to work towards relapse

prevention when released. He had used cocaine in the past but wanted to focus on alcohol. She provided information and in-cell work for him to complete.

59. On 28 September, the mental health support worker saw Mr Livesey. He told her that he felt like he was in a good place. His mental health felt stable, he was taking exercise and feeling positive. He was in contact with his family and felt supported.
60. Mr Livesey saw the DART worker on 8 October. She noted that he had completed the in-cell work to a high standard and said it had helped him to gain insight into how he had been using alcohol. He said that he was in contact with his family, which kept his spirits up. He had arranged a veterans' coffee morning the previous day and was looking forward to arranging the next one.
61. A nurse checked on Mr Livesey on 11 October. He said that he felt stable and like he was moving forward with no thoughts of self-harm, but continued anxiety. He said that he had experienced some trauma in his life that he had bottled up and would like help addressing the impact of this. She said she would pass this to the mental health team.
62. On 18 October, an officer made a welfare check on Mr Livesey. He was in a good mood and said that he had asked to speak to the mental health team about his PTSD. He was hoping to become a representative for Veterans in Custody.
63. On 23 October, the mental health support worker assessed Mr Livesey for any further support he needed for his anxiety. He said it was his first time in custody and he was concerned about his upcoming court case. He had applied to be a Listener (prisoners trained by the Samaritans to provide peer support). He wanted to explore the possibility of working with a psychologist. She explained that that service was not available in Leeds, but he could take that forward once he was transferred to another prison or released.
64. On 5 November, an officer saw Mr Livesey for a keywork session. He said that he was working with the mental health support worker, which he found helpful.
65. On 8 November, Mr Livesey attended court for a meeting with his solicitor. When he arrived back in prison, staff made a welfare check. Mr Livesey said that the meeting did not go well. He was thinking of changing his legal team.
66. On 10 November, Mr Livesey saw the DART worker. He spoke mainly about his upcoming trial. They discussed focussing on distraction techniques. He agreed it would be helpful to write a poem about the effect alcohol had on his life. He said that he had no other concerns and knew how to request support if he needed it.
67. On 12 November, Mr Livesey telephoned his sister twice. He said that he was dissatisfied with his legal team and wanted to change solicitors.

## **Events of 14 November**

68. At approximately 9:00am on Sunday 14 November, an officer unlocked Mr Livesey's cellmate for work. He asked Mr Livesey if he wanted to go out onto the exercise yard. He declined and opted to stay in bed. At 9.19am the officer let the cellmate back into the cell to collect his asthma inhaler. In interview, the cellmate

said he asked Mr Livesey if he was okay, and he replied that he was and he was just having a rest. He then went back to work. At 9.26am, the officer asked Mr Livesey if he wanted a shower. Mr Livesey said that he did not.

69. At approximately 9.45am, during a round of cell checks, the officer arrived at Mr Livesey's cell. He switched on the light and saw Mr Livesey hanging from a ligature made from a bed sheet. He used his radio to call a code blue emergency (meaning a prisoner unable to breathe, or having trouble breathing). This prompted the control room to call an ambulance. Ambulance Service records show that the request was received at 9.47am. The officer also shouted for assistance and used his anti-ligature knife to cut the sheet. Other staff had reacted to the emergency call. CCTV footage shows that another officer arrived within a minute. She helped to lower Mr Livesey to the floor. Mr Livesey had also tied his right leg to the bed, so an officer cut that free as more prison officers arrived. Staff assessed Mr Livesey for signs of life but, unable to find any, began to perform cardiopulmonary resuscitation (CPR).
70. Healthcare staff had responded to the emergency call and, at 9.47am, a nurse arrived in the cell and took over CPR. Another nurse had collected the emergency bag and at 9.49am arrived at the cell, soon joined by more nurses. They applied a defibrillator (a machine that in some instances can restart the heart) and continued to attempt to resuscitate Mr Livesey until ambulance paramedics arrived and assumed control. They detected a pulse and transferred Mr Livesey to hospital.
71. When Mr Livesey was taken to hospital, one of the prison's senior managers contacted Mr Livesey's family. They travelled to the hospital.
72. Following discussion between Mr Livesey's family and doctors, life support was switched off. Mr Livesey died at 6.25pm on 15 November. His family were with him.

## **Contact with Mr Livesey's family**

73. The prison had contacted Mr Livesey's family when he went to hospital. The prison subsequently appointed a family liaison officer, and he remained in contact with them. In line with Prison Service guidance, Leeds offered a contribution to the costs of Mr Livesey's funeral.

## **Support for prisoners and staff**

74. After Mr Livesey's death, a prison manager debriefed the staff involved in the emergency response and in Mr Livesey's care in hospital to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
75. The prison posted notices informing other prisoners of Mr Livesey'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 Livesey's death.

## **Post-mortem report**

76. No post-mortem report was produced for Mr Livesey. No toxicology tests were undertaken.

# Findings

## Assessment of risk

77. On 13 September, Mr Livesey told a nurse that he had tried to strangle himself with socks the previous night. This was noted in the medical record but there is no evidence that it was passed on to prison staff to inform care planning. There is no note in Mr Livesey's ACCT document or on his electronic C-NOMIS record.

**The Head of Healthcare should ensure that information regarding the safety and welfare of individual prisoners is appropriately shared and recorded.**

## Assessment, Care in Custody and Teamwork (ACCT)

78. Mr Livesey was rightly identified as at risk of suicide and self-harm on arrival in Leeds, and ACCT procedures were opened. ACCT reviews were regular but not all were multi-disciplinary. These reviews were held during the COVID-19 pandemic, in which processes were adapted to reduce interpersonal contact. The ACCT was overseen by a single case manager, thereby providing continuity of care by a manager who knew Mr Livesey. He did consult healthcare staff before holding all but one of the reviews. The case manager made good records of the reviews undertaking and updated Mr Livesey's electronic C-NOMIS record regularly. Overall, the approach to ACCT management seems reasonable, and therefore we make no recommendations regarding attendance at ACCT reviews.
79. When the prison learned of the allegations that Mr Livesey had been involved in his cellmate's hanging, they moved him into the segregation unit. Mr Livesey was under ACCT management at the time.
80. Guidance on segregation is contained in Prison Service Order (PSO) 1700 *Management of Segregation Units and Management of Prisoners under rule 45 (YOI rule 49)*. Segregation is an isolating form of custody used for prisoners who have misbehaved or who cannot be kept safely in normal prison accommodation. Prison Service Instruction (PSI) 64/2011 *Managing Prisoner Safety in Custody* says that 'prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances'. PSO 1700 says that 'this could include when a prisoner is judged such a risk to others that no other suitable location is appropriate and where all other options have been tried or considered inappropriate. The reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted'.
81. The duty governor explained in interview that the allegations against Mr Livesey were of a serious assault on another prisoner. It was her judgement that segregation was the only way to guarantee his safety and the safety of other prisoners. Given that there was no further information available to her at that stage other than that Mr Livesey's alleged actions could have ended the life of another prisoner, this decision seems reasonable.
82. The duty governor completed the defensible decision log. She did not, though, note which other locations had been considered for Mr Livesey, nor why they were considered inappropriate.

**The Governor should ensure that managers authorising use of segregation for prisoners under ACCT management record their consideration of alternative locations and the rationale for discounting these when documenting decisions.**

83. Once the duty governor signed the defensible decision log on initial segregation, there is no further information on defensible decisions in Mr Livesey's segregation papers. The duty governor did see him daily, as per guidance, but there are no further entries on the daily review summary section of Mr Livesey's defensible decision log. As Mr Livesey was under ACCT management, we accept that notes were made in his ACCT document, including a review of his segregation on 23 July. Segregation is an extreme and isolating form of custody, particularly for prisoners under ACCT management. Regular review of decisions to continue segregation must be undertaken and properly recorded. We make the following recommendation:

**The Governor should ensure that duty governors complete daily review summaries for prisoners in segregation while under ACCT management.**

84. On 26 July, staff told Mr Livesey that he would be leaving segregation. ACCT procedures were closed, Mr Livesey to be supported in his move back to standard conditions under Challenge, Support and Intervention Planning (CSIP) procedures. In interview the case manager explained that the main risk factors had been addressed. Mr Livesey was in contact with his family, and he was familiar with the support mechanisms available to him in prison. He was also leaving segregation and making a move that he said he was looking forward to. At the post-closure review, the case manager explored the impact of previous events and the transition back to a standard wing with Mr Livesey and based on his progress did not judge that he needed further ACCT support.

### **Mr Livesey's healthcare**

85. The clinical reviewer concluded that the healthcare provided to Mr Livesey in Leeds was equivalent to that which he could have expected in the community.
86. In regard to his mental health, Mr Livesey did have appropriate medication. The clinical reviewer noted inconsistency in the prescribing of his medication and irregular ongoing monitoring of his mental health. The review also found no evidence of a referral for psychological therapy when Mr Livesey requested help with his anxiety. Mental health services were involved during the ACCT process, but not regularly thereafter, and there was no evidence of a care plan in his records. He was prescribed anti-depressant medication on arrival in prison, but this would not take effect for 14 days. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners being prescribed medication for their mental health should have a clear care plan in place that is regularly reviewed.**

87. On his arrival in prison, a nurse prescribed anti-depressant medication for Mr Livesey. In interview, she said that she did not have mental health training. We make the following recommendation:

**The Head of Healthcare should ensure that all staff have the appropriate training for the work that they are asked to undertake.**

88. The clinical reviewer also had concerns about record keeping, training and supervision. We do not repeat these here, but the Head of Healthcare will need to address them.

## **Inquest**

89. The inquest, held from 22 to 30 January 2024, concluded that Mr Livesey died by suicide.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

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