

**Investigation into the circumstances surrounding
the death of a man at HMP Leicester
in December 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2010

The man died on 5 December 2008 in his cell at HMP Leicester. I offer my sincere condolences to his family and friends for their sad loss. This report raises serious concerns over the care provided for him both by discipline and medical staff.

The investigation into the man's death was carried out by one of my Senior Investigators . A Family Liaison Officer from my office was also appointed to support the family. I thank the Governor of Her Majesty's Prison Leicester and the Deputy Governor, for making the necessary facilities and information available to my investigator. I am also indebted to the prison's Liaison Officer, for his assistance.

My report highlights a number of concerns about the level of care given to the man and raises questions about procedures and individuals. Due to the concerns I had relating to the man's care, I issued my first draft report, which included a number of recommendations, under the terms of my Advance Disclosure Policy. This allowed for any factual errors to be identified and corrected before the report was published to a wider audience.

The Prison Service responded to my report noting factual errors and attaching an action plan in response to my initial recommendations. I have attached a copy of the action plan to this report. They also forwarded me a copy of an internal disciplinary investigation report, along with a letter written by a manager mentioned in my report. Having been asked by the Prison Service and manager to consider their responses, further investigation work has been carried out, with the result that my report has been amended.

The man was received into prison custody just two days before his death. He had been transferred to Leicester from court by the private escort company, Global Solutions Ltd (GSL). A member of GSL staff at the court identified the man as being at risk of suicide or self harm, and, in order to keep him safe, placed him on constant monitoring.* To ensure the man's safety, a member of GSL raised a warning form noting the level of watch and passed the form to prison staff during the reception procedure.

Unfortunately, when he arrived at Leicester, the details of his vulnerability were not correctly identified by the staff who received him, and for a short time monitoring did not continue. However, and as part of the normal reception procedure, a nurse working in the reception department interviewed the man and identified him as being at risk of self harm. The nurse arranged for monitoring to begin under the Prison Service's suicide and self harm arrangements known as Assessment, Care in Custody and Teamwork (ACCT). After opening an ACCT document and recording his concerns, the nurse passed it to a prison manager for further action. However, it would appear that the nurse did not give the manager the GSL warning form, which meant that their concerns were not known to the manager.

*Constant monitoring meant that a member of GSL staff remained with the man at all times up to the point when he was received into prison custody.

Within two hours of the monitoring recommencing, an ACCT assessment and case review was carried out by the manager who decided that monitoring was unnecessary and stopped it. The manager was not trained to carry out ACCT assessments and was fully aware that he should not have done so. However, although the manager concerned has not shied away from his mistakes, he has said he was told to close the document by a principal officer. Although trained to carry out case reviews, the same manager also went on to hold a case review meeting by himself, which is not the correct procedure. The manager's actions in relation to the ACCT document and procedure are of a standard that has been described by one principal officer as "very poor". I agree fully with that view.

Due to his concerns, my investigator raised the manager's actions as an urgent matter with the Governor. After I issued my advance disclosed report, the Prison Service informed me that they had carried out an internal disciplinary investigation into the manager's actions. The Prison Service has forwarded me a copy of the report for my consideration. I must stress that their investigation was completed long before my advance disclosed report was issued and that the conclusions I have drawn were not known to that investigation.

Although the Prison Service investigation has concluded that the manager's actions do not warrant disciplinary action, it remains my belief that he knew that his actions were wrong. As a manager, he had a responsibility to ensure that the correct, well embedded procedures were carried out in order to protect the man. Regrettably, he did not.

It is also my belief that closing the ACCT document so rapidly left the man at high risk, and that the closure gave prison staff the false impression that he was not vulnerable. This meant that prison officers had no need to pay special attention to him, something they would have done had they known he was at risk.

On 5 December 2008, the man was found collapsed after apparently consuming a quantity of medication. Later that afternoon he was found to have harmed himself and, due to concerns about his vulnerability, ACCT monitoring recommenced. However, after only a short time, he was found hanged in his cell.

To assist my investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. A Clinical Reviewer was appointed by Leicester NHS Primary Care Trust (PCT) to undertake the review, and I am grateful for his report. This highlights a number of worrying issues relating to the man's medical care.

Prison staff manage and support some very difficult and dangerous people, and they do not always receive the public credit they deserve. Although this report is in many ways a very critical one, it also highlights that two officers directly involved in trying to rescue the man did so in extremely difficult and unhygienic conditions. Their actions placed themselves at high risk of cross contamination from body fluid. I am therefore very pleased to recommend that the Prison Service recognise their unselfish and brave rescue attempts by formally commending their actions.

I must apologise to the Coroner and the man's family for the lateness in issuing my report. This was due in part to my office having to wait for the clinical review. I understand that the reason for the delay was that the Clinical Reviewer was required to deal with emergency pandemic flu planning for Derbyshire Primary Care Trust and so had to prioritise his schedule. There has been further delay because of the additional investigative work I carried out after issuing my first draft report under advance disclosure.

After issuing my draft report, I received feedback from the Prison Service, the manager mentioned previously and a solicitor representing the man's mother. In their feedback, the solicitor referred to the use of a drug called lofexidine and suggested it should not have been given to the man. I asked the Clinical Reviewer to consider the question raised and am grateful for his opinion and supplementary report.

The solicitor also asked whether the prison had complied with both national and local policies regarding suicide and self harm. I believe this report has explored in great detail a number of issues relating to suicide and self harm and I have made a recommendation relating to it.

In their feedback, the Prison Service identified factual inaccuracies, which have been corrected. Additionally, they attached their action plan, which is annexed to this report. The manager's feedback does not identify any factual inaccuracies.

I make 23 recommendations to the Governor, Leicester PCT and SERCO. The number of recommendations reflects the serious failings identified during my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

March 2010

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SUMMARY

On 3 December 2008, the man was remanded into prison custody at a local Magistrates' Court. At court he was considered to be at risk and vulnerable and, in order to keep him safe, he was placed on constant monitoring by court custody staff. When he arrived at HMP Leicester that afternoon, the monitoring stopped for a brief period. However, a nurse working in the reception department identified him to be at risk of suicide or self harm and opened an ACCT document. Having opened the document, he passed it to a manager for further action.

This report will show that the manager who received the ACCT document did not deal with it correctly. Although knowing that he was untrained, he carried out an assessment and completed an important section of the document, after which he closed it. In his evidence, the manager concerned said he sought advice and was told to close the document by a principal officer. Although there is no dispute that he did speak to two managers, their evidence does not support his. Closing the document meant that the man was not properly assessed and remained at risk of harm.

On 5 December, a prison officer found the man lying on the floor of his cell, apparently unresponsive, after swallowing a large quantity of his in possession medication. Urgent medical assistance was requested and a nurse went to the man's cell. She decided that he had not swallowed sufficient medication to cause any harm and so returned to her normal duties. My report shows that, although the man appears to have intentionally consumed the medication, there was no consideration given by anyone at that time to begin monitoring him again under the ACCT procedures. Additionally, the nurse did not record her actions in the man's medical record.

A short time later, as part of the normal prison process for newly arrived prisoners, the man was moved from the first night centre and in his case taken to the prison detoxification wing. Very soon after moving into the cell, he was found to have cut his wrists. Once again urgent medical assistance was requested and the same nurse who had seen him earlier went to his cell and treated his injuries. Contrary to proper medical procedure, once again the nurse failed to make a record of her contact with the man.

Because the man had cut his wrist, the wing manager gave instructions for him to be placed on ACCT monitoring. As part of keeping him safe, the manager took into consideration the man's cell location and believed that he was in what she described to my investigator as a "safe cell". Regrettably, the manager was wrong, and rather than being in a cell with few ligature points, he was in fact in a cell with multiple ligature points. It was from one of these points that he anchored the ligature which he then used to hang himself.

Once the man had been found, prison staff responded quickly and began resuscitation attempts. In performing their rescue efforts, the officers worked in extremely difficult circumstances. Despite having to clear away vomit from the man's mouth, resuscitation was carried out without any mouth protection.

As well as concern relating to the ACCT procedures and monitoring, I have been disturbed to learn that, when the man was discovered, it took about eight minutes for a nurse to get to him and that, although it was available, she failed to take emergency resuscitation equipment with her. A further concern is that the nurse appears to have knowingly made a false written statement to her employer about the actions she took when she went to the man's aid. Her actions and statement are the subject of an internal investigation commissioned by her employer, SERCO.*

Additionally, although a doctor was present throughout the period that the nurse and paramedics were with the man, the doctor did not check his condition until paramedics said he had died. It concerns me that the doctor did not take control of the situation and examine the man when she arrived at his side. Had she done so, it would have informed the decision on whether it was decent and appropriate to continue with rescue attempts. Instead, prison officers were left with no professional medical guidance and valiantly kept up the resuscitation effort. I am aware that the Governor has asked SERCO to investigate the actions of its medical staff and to report the findings to her.

*SERCO provides the healthcare service to HMP Leicester and is commissioned by the Leicester National Health Service Primary Care Trust.

THE INVESTIGATION PROCESS

1. When my office was notified on 5 December 2008 of the man's death, the investigation was allocated to one of my senior investigators. He contacted the Deputy Governor, and arranged to travel to the prison to meet him and his team for the purpose of opening the investigation.
2. On 11 December, the Investigator met the Deputy Governor as arranged. He told my investigator that he had a number of concerns relating to the actions of a prison manager who had assessed and closed the ACCT monitoring document and those of staff who were meant to monitor the man. Additionally, the Deputy Governor raised concern at the actions of the nurse who went to the man's cell after he had been found hanging.
3. Before going to a separate briefing meeting with key staff and agencies, my investigator and the Deputy Governor were joined by a representative from SERCO, the company responsible for providing healthcare at the prison. He told them that he would be carrying out his own internal investigation into the management of the man's healthcare needs, and asked that his report be annexed to my own.
4. At the briefing meeting were three representatives of National Health Leicester City: the Assistant Director Commissioner Mental Health, the Clinical Quality Assurance Officer, and the Quality Assurance Officer. Also at the meeting were three officers from Leicester Police: a Detective Constable, a Detective Inspector and the prison's Police Liaison Officer. Also in attendance were the prison's Healthcare Manager representing SERCO, the prison's Safer Custody Co-ordinator, a Officer representing the local branch of the Prison Officers' Association, the prison's Family Liaison Officer, a Principal Officer, a representative from the Independent Monitoring Board (IMB), the prison's Head of Offender Management, the Prison Liaison Officer, and the Deputy Governor.
5. The Deputy Governor gave the meeting an overview of what had occurred on 5 December. His briefing helped identify a number of people who my investigator would want to speak to at a later date. In addition, others attending the meeting gave background information about the man and the prison. After the meeting, my investigator went to the cell where he had been found. He was able to view the cell and identify where the ligature had been attached.
6. In addition to viewing the cell, my investigator was able to examine a number of prison documents relating to him which had been prepared for him by the Liaison officer. Because of the Deputy Governor's concerns, the Investigator paid particular attention to the ACCT document which had been opened on the man.
7. Before leaving the prison, my investigator raised an immediate urgent finding with the Deputy Governor relating to the ACCT document and the actions of a

prison manager. The investigator had identified that the manager concerned had completed a section of the ACCT document which he was not trained to do and had closed the document incorrectly.

8. Additionally, my investigator raised concerns at the way the man had been monitored after the ACCT document was re-opened on 5 December and how he was then left in an apparently inappropriate cell. The initial findings suggested that the manager who re-opened the ACCT document believed that the man was in what she said was a "safe cell" when he was not.
9. My investigator also examined the actions of a nurse on duty at the time when the man was discovered. In her written statement the nurse said she had taken emergency resuscitation equipment with her when the request for medical assistance was made. However, a number of staff had given contradictory statements saying she had not. Additionally, it appears that she took over eight minutes to get to the man.
10. Before leaving the prison, my investigator arranged to return at a later date to begin his investigation. He had identified a number of staff that he wanted to speak to, and agreed to return to the prison in January 2009 to begin his work.
11. On 12 December, my investigator followed up his verbal feedback by writing to the Governor, explaining his findings. In his letter he told the Governor about the ACCT procedure and the urgent finding. Additionally, he raised a further urgent finding relating to the nurse's apparent failure to take emergency medical equipment to the man. As well as posting the letter, the investigator emailed a copy of the letter to the Deputy Governor to ensure that it was received at the earliest opportunity. My investigator also shared the urgent medical finding with the SERCO investigator and with the clinical reviewer.
12. Later that same day, the Deputy Governor emailed my investigator to tell him that he had taken action relating to the urgent findings. He said he had removed the manager who had assessed and closed the ACCT document from any further ACCT duties, and would require him to be re-trained in ACCT procedures. Additionally, he supplied two notices telling staff what was expected regarding ACCT and reminding nursing staff that they must take emergency medical equipment to any request for medical assistance. I welcome the Deputy Governor's prompt actions to my investigator's findings and concerns.
13. Following any death in prison, I publish a notice to staff and prisoners inviting anyone with information and who wishes to contact me to make themselves known to my investigator. The notices were displayed around the prison and were available both to prisoners and prison staff. I can confirm that no staff or prisoners responded to my notices.

14. On 31 December, my investigator received a letter from the Governor, telling him what she had done in relation to his urgent findings. At about the same time, my investigator received a report from the representative from SERCO regarding his internal investigation and findings.
15. The following month, on 26 January 2009, my investigator returned to the prison to begin his investigation. The investigator met the Governor and discussed the arrangements for feedback and the actions that the Governor had taken in response to the earlier urgent findings. Over the next four days he interviewed a number of prison staff and assisted the Clinical Reviewer by carrying out joint interviews with medical staff.
16. In the meantime, one of my Family Liaison Officers had been in contact with the man's family. She explained my role and offered the man's family the opportunity to meet her and the investigator. The purpose of offering the meeting was for his family to contribute towards my report and ask any questions they would like me to examine.
17. On 16 February, my investigator, accompanied by one of my Assistant Ombudsmen, returned to HMP Leicester to re-interview three members of healthcare staff. The purpose of re-interviewing them was to clarify information received during the first interviews. However, one of the nurses (Nurse A) was unavailable and was not re-interviewed.
18. In March, my investigator and FLO met the man's father at his home address, where they were made welcome by him and his partner. He told my staff that the man had a drug addiction and had started taking heroin in 2008. He added that his son had been prescribed anti-depressants and had overdosed on heroin, but did not know if this was a deliberate act or not.
19. The man's father said his son had made two previous attempts on his life a few years earlier. He said one attempt was just prior to an appearance in court and another when the man was in Glen Parva Young Offenders Institution.
20. The man's partner said she had received a telephone call from the man after he arrived at HMP Leicester. He had told her that he had been remanded into custody and asked for money to be sent to him. She said he sounded fine, but that he was not the kind of person to say anything if something was wrong.
21. During the meeting, the man's father said the prison chaplain, a manager, and two police officers had informed him of the man's death. He said they offered him the opportunity to visit the prison and also assistance with the cost of his son's funeral. The man's father said the information given to him following his son's death by prison staff was conflicting, and he asked me to try and clarify the events for him.

22. The man's father said that when he went to the Chapel of Rest to see his son he was asked to identify someone with a different first name. He said he was confused and was hoping that the person was not going to be his son. He said this error caused him further distress.
23. Before my investigator left, the man's father said that his son had recorded him as his next of kin and he had expected to receive his property. However, with the exception of a set of keys, he had since learnt that his son's property was given to his mother. He said the man's mother had a number of documents removed from his cell, including a medical record. The man's father would like to know why the property was not returned to him.
24. In her response to my draft report, the Governor has apologised for any misunderstanding caused. It would appear that an agreement had been reached between the man's parents regarding dividing the property up between them.
25. My investigator and the clinical reviewer met Doctor A at her home address, at her request, on 17 March. Doctor A was accompanied by Doctor B, who was representing her on behalf of the Medical Defence Union. I am grateful to Doctor A for her assistance in allowing my investigator and the clinical reviewer to meet her at her home.
26. In June 2009, I issued a draft report under my advance disclosure policy as I had concerns relating to the man's care. Before issuing it to a wider audience, I wanted to ensure those mentioned had had the opportunity to comment and correct any factual errors.
27. On 13 July, the Prison Service wrote to me enclosing their comments as well as an action plan addressing my recommendations. The action plan shows that the Prison Service, Primary Care Trust and SERCO had accepted all but one of the recommendations, and had partially accepted the other.
28. In addition to the action plan, the Prison Service supplied me with a copy of their internal disciplinary investigation report regarding the actions of Senior Officer A, for my consideration. They also enclosed a written submission made by him, responding to my advance disclosed report.
29. The Prison Service report was completed on 9 March and its findings passed to the Governor. However, neither it nor its findings had been shared with my investigator until after I had issued my advance disclosed report. Therefore, at the time of issuing my advance disclosed report, I was unaware of it.
30. Senior Officer A commented that two members of staff named by him as having agreed his course of action in closing the ACCT had not been interviewed. My investigator decided that he should do so. On 30 July he interviewed Principal Officer A at Leicester Prison, and on 25 August he interviewed a member of staff (was previously a Principle Officer) who by this time had been promoted and had transferred to HMP High Down. For ease, I

refer to him as Principle Officer B. As a result of the feedback and further interviews and the comments of both Principle Officer A and Principle Officer B, my report has been amended.

31. In October 2009, I issued my draft report and invited comment. The following month I received feedback from the Prison Service, Senior Officer A and, the solicitor legally representing the man's mother. In his feedback, the solicitor referred to a number of documents which he said were relevant. They are:

- NOMS Prison Drug Treatment and Self harm policy
- Department of Health Guidance on the Clinical Management of Drug Dependence in Adult Prison setting
- NICE Guidelines on Drug Misuse Opioid Detoxification
- PSO 2700 Suicide and Self harm Prevention
- Note of a conference presentation of a Professor
- Drug Misuse and Dependence UK Guidelines on clinical management

32. To enable me to properly consider the points made by the solicitor, I asked the clinical reviewer for his comments. In February 2010, the clinical reviewer sent me a supplementary report covering the medical question raised by the solicitor. The doctor makes it clear that the points raised by the solicitor refer to draft guidelines and, as far as he is aware, they have not been issued in a definitive form. The clinical reviewer refers to the executive summary, which, he says makes it clear that the document is aspirational and would hopefully be implemented within three years. He adds that at the time when the man was in prison, the guidelines were not in force which is why he did not refer to them in his clinical review.

33. The clinical reviewer said the man was offered and accepted lofexidine in a standard regime, based upon recommendations in the British National Formulary (a reference book giving advice about medication and prescriptions). He said the drug is used to relieve the intensity of some of the withdrawal symptoms.

HMP LEICESTER

34. The prison is situated close to the city centre of Leicester. Originally built in the Victorian era, it has undergone extensive refurbishment. The establishment is a local prison, which generally means it is used to accommodate remand prisoners, although there are a number of sentenced prisoners too.

Assessment, Care in Custody and Teamwork (ACCT)

35. ACCT has been in place in every prison since April 2007 and requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document is available to all staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be interviewed by a trained ACCT assessor. To aid the assessor, there are eight specific subject areas along with reminders intended to assist the assessor record their comments. Following the assessment, a case review meeting is held, chaired by a case manager and which the Prison Service say must not be carried out in isolation. At Leicester, wing managers (who have the rank of senior officer) take on the role of case manager, and oversee the management of the ACCT document. At the end of the meeting, a care and management plan, known as a CAREMAP, is drawn up.
36. At Leicester, any prisoner being monitored under ACCT is recorded on the prison's computerised information system, to which all staff have access. It is updated daily by the night manager and overseen by the Safer Custody Co-ordinator and senior managers. Additionally, it notes all case review dates and all post closure review dates.

Anti Ligature Knives (Fish Knives)

37. Staff in contact with prisoners are issued with specially designed anti ligature knives, commonly referred to as "fish knives", which are used in an emergency to remove a ligature. The knives have a concealed blade which is placed against a ligature and which can be pushed forward to cut it without harming the prisoner.

Care Team

38. Each prison has its own care team. Care team staff are drawn from all areas of the prison and are trained specifically to help and support staff following any serious incident.

Cell Sharing Risk Assessment (CSRA)

39. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account the situational context of any previous violence. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a risk minimisation plan for those identified as high or medium risk. This risk is reviewed at regular intervals.

Emergency response codes

40. In the event of urgent medical assistance being required, a number of prisons, including Leicester, have chosen to adopt codes to alert medical staff to particular incidents. The most common codes are code red and code blue, although some prisons have opted for code one and code two.

41. Code red or one informs the medical staff that the patient is bleeding. Code blue or code two alerts them that the patient is in breathing difficulty. In prisons where codes are used, the healthcare departments have created emergency response bags which contain the necessary equipment to deal with the particular incident. This ensures that medical staff take the correct emergency equipment with them and helps provide the necessary medical care as quickly as possible.

42. HMP Leicester has a designated nurse who, in the event of a medical emergency, is the first medical person contacted and asked to attend a patient. The designated nurse carries a prison radio with the call sign "Hotel 4".

Independent Monitoring Board

43. Each prison has an Independent Monitoring Board (IMB) and their role is to monitor the prison and to report any concerns regarding how prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part. The Board produces an annual report for the Secretary of State for Justice.

Police investigations of deaths in custody

44. With all deaths in prison custody, the police are notified as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that my investigators can begin their own investigations.

45. At the meeting with my investigator on 11 December, the police officers confirmed that the man's death was not being treated as suspicious and that no final note had been found. The officers also agreed that my investigator could enter the man's cell for the purpose of familiarising himself with the cell layout. My investigator shared with the officers a copy of the Memorandum of Understanding between my office and the Association of Chief Police Officers.

Prison Service Orders (PSOs)

46. Prison Service Orders are long term mandatory instructions which are intended to last for an indefinite period. Any mandatory instructions to Governors are written in italics. Each PSO is given a title and unique reference number.

Prison officer grades

47. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

48. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

49. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

50. In addition to prison officer grades, there are a group of staff known as Officer Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same functions as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example, the gate.

Reduced Risk Cells

51. The majority of cells at Leicester have barred windows and contain Prison Service standard issue furniture. The beds are generally made from a tubular steel frame construction, with some converted to bunk beds. Additionally, there is at least a locker, table and a chair in each cell.

52. At Leicester, they refer to having "reduced risk cells". They are described as having reduced ligature points with the windows having been replaced with sealed units. The units have ventilation slats built in, offering little in the way of a ligature point. The metal beds have been replaced with wooden ones with the frame secured and sealed to the cell wall. The seal prevents the prisoner from attaching a ligature between the frame and wall. The remaining furniture has been replaced with wooden equipment which, like the bed, has been secured to the floor and wall. Like the beds, the units have been sealed to

prevent a ligature being passed between the furniture and wall. However, while they are much safer than standard cells, the reduced risk cells cannot be deemed to be ligature proof as, for example, the sink has taps which would allow a ligature to be placed around them.

53. In their response to my advance disclosed report, the Prison Service said “Reduced risk cell is not a recognised term in NOMS [National Offender Management Service]. As this paragraph describes, whilst some aspects of safer cell furniture have been installed in the cells, other possible ligature points, such as sanitary ware, possibly light fittings etc are still present. In this case, the risk of ligature has not been reduced simply shifted from one part of the cell to another. The ethos of a safer cell is to remove all known ligature points. If a cell does not meet these criteria then it is considered to be normal accommodation.” The Governor will wish to share this with her staff.
54. The detoxification wing (B2) has 16 cells. None of the cells is classed as being a reduced risk cell. I understood from the Governor at the time of my investigation that the Prison Service had plans in place to convert all cell windows at Leicester and replace them with sealed units. The target date for starting that work was 2012. However, since issuing my advance disclosed report and receiving feedback from the Prison Service, I understand the project has been put back by NOMS Property Services. It is now my understanding that there is no date scheduled for replacing the windows.

Report of self harm/attempted suicide (F213SH)

55. Whenever a prisoner injures themselves, form F213SH should be completed. The form is then passed to healthcare for recording and any necessary medical action.

Her Majesty’s Chief Inspector of Prisons

56. Her Majesty’s Chief Inspector of Prisons, reports on all Prison Service establishments. The majority of inspections are pre-announced and allow the prison being reported on to prepare for inspection. However, a number of inspections are carried out without prior warning and are known as unannounced inspections.
57. In June 2008, the Chief Inspector carried out an announced inspection of HMP Leicester. In the introduction to her report, she described the prison as a small, crowded Victorian city centre prison, which has had to manage an ever changing population, many with significant needs, in ageing and inadequate accommodation. The Chief Inspector went on to say that, although previous inspections had been critical of the prison, she had detected some early signs of improvement with a greater emphasis being placed on safety and resettlement. However, the Chief Inspector acknowledged that more needed to be done.

58. One of the areas to which the Chief Inspector referred specifically was safety. She said that, after a tragic recent period when a number of deaths had occurred, the prison had placed greater emphasis on safety. Despite a cramped reception area and some poor quality accommodation, first night centre prisoners received good quality care and spoke positively of their early experiences in custody. The Chief Inspector said that efforts had been made to improve violence reduction and safer custody procedures, adding that there was still a good deal of development work to do in these areas.
59. Under the section dealing with self harm and suicide, the Chief Inspector made six recommendations and identified three areas of good practice. She said there was a full time safer custody coordinator and the quality of ACCT assessment was good, although reviews were insufficiently multidisciplinary. As a result, the Chief Inspector made the following recommendation, “assessment, care in custody and teamwork case reviews should be multidisciplinary” [Recommendation 3.32].

KEY FINDINGS

3 December

60. The man was arrested at his home by police and produced at a local Magistrates Court . At 9.25am a Prison Custody Officer (PCO), one of the court custody staff, opened a Prison Service Suicide and Self Harm Warning Form on the man. The form is a triplicate, self copying document. The top copy is retained by the prisoner escort staff, whilst the remaining two are handed over to the prison healthcare screener. One of the two copies is white and placed in the prisoner's medical record, whilst the remaining copy is yellow and placed in the prisoner record or ACCT document, if one has been opened.
61. The Prison Custody Officer noted on the warning form that the man was depressed and that he had said he had not been out of bed for a week. He added that the man had told him that he had attempted to strangle himself two days earlier. The Prison Custody Officer also noted that the man said that he had tried to harm himself within the previous six months by hanging or strangulation. As a result, and in order to keep the man safe, the Prison Custody Officer placed him on intermittent watch. However, after further consideration, just over one hour later the level of watch was increased to what was noted as "constant watch" and another Prison Custody Officer remained with the man at all times to ensure he did not come to harm.
62. In their feedback, the Prison Service said that, although the form said the man had been placed on constant watch he was in fact monitored five times per hour. They add that this was in accordance with GSL operating procedures and that the handover to prison staff would have reflected this.
63. Later that day, after being remanded in custody, the man was taken from court by the private escort agency Global Solutions Ltd to HMP Leicester, where he arrived at 1.45pm. After leaving the escort vehicle, he entered the prison reception area to begin the normal routine for receiving prisoners. As part of that procedure, the warning form raised earlier by the Prison Custody Officer was handed over to Officer A one of the reception officers employed by Leicester. The time noted by Officer A on the form was 2.05pm.
64. At 3.15pm, and in line with normal prison procedure, the man was allowed to make a telephone call to his family to let them know what had happened to him that day at court and to tell them where he was. The prison telephone system allows for telephone calls made by prisoners to be recorded and, if necessary, downloaded and played back. My investigator has obtained a copy of the call made by the man. It shows that he telephoned a mobile number, which was answered by a female voice, and that the call lasted 28 seconds. The man asked the woman if his father was there and was told that his father was driving. Unable to speak to his father, he asked the woman to tell him that he had been remanded in prison for two weeks. She acknowledged the man's message and the call ended very soon afterwards.

65. During the reception procedure a cell sharing risk assessment (CSRA) form was completed (again, this is normal practice). The man's answers at sections one and two show that he told the officer completing the form, Officer B, that he had abused alcohol and drugs in the past. It also shows that the man expressed concerns to the officer about being allocated to a shared cell. It was noted by the officer that the man had shown unpredictable or unexplained aggression towards a prisoner in a shared cell during a previous prison sentence. The officer also noted that the man said he had attacked another prisoner with a "blade" for no apparent reason. Additionally, the man said he had been monitored previously on ACCT, although the form does not say when.
66. Although not formally interviewed, my investigator spoke briefly to Officer B and asked him if he could recall receiving the man into the prison. He said that he remembered the man as appearing "distant" and that he did not offer information freely. Officer B said the man was a polite man, adding that he did not appear to be concerned at the thought of being in an adult prison.
67. Officer B said that the man could not explain why he had injured the prisoner referred to in the CSRA form. He said the man told him that "he just felt like doing it". The officer told my investigator that the self harm warning form received from court had been handed to Nurse A, but he did not know what happened to it after that. He assumed it was kept in the medical record.
68. Nurse A was the nurse on duty in reception when the man arrived, and he completed section three of the CSRA. Having spoken to the man, he assessed the risk associated with him sharing a cell as being high. He recommended that the man should be allocated to a single cell due to his past psychiatric history. At interview, Nurse A said he did not know what the psychiatric history was and was simply recording what the man had told him.
69. At the same time as carrying out the CSRA, Nurse A opened an ACCT document. He noted in the "Concern and Keep Safe" section of the ACCT that the man had harmed himself in the past and that his mood was low. He told my investigator that he had seen and read the suicide and self harm warning form that had been opened earlier that day by the Prison Custody Officer. However, contrary to proper procedure, Nurse A did not complete section eight of the warning form "Confirmation of action taken by healthcare screener" to show that he had opened an ACCT document. When my investigator asked him why he had not, the nurse was unable to offer an explanation. (My investigator later discovered that the copy of the warning form that he had been given (yellow copy) differed from that held in the man's medical record. The one in the medical record (white copy) shows that a tick has been placed in section eight to show an ACCT document has been opened. However, it does not show the name of the person who added the tick or at what time. I deal with this issue later in my report.)

70. As the man had arrived at the prison along with an open suicide and self harm warning form, Prison Service instructions say that it should have been attached to the newly opened ACCT document. PSO 2700, "Suicide Prevention and Self-Harm Management", contains the following mandatory instruction under the heading "Receipt of prisoners with a suicide/self-harm warning form". At section 4.5.5 of the PSO the instruction says: "...and the remaining (yellow) copy goes in the ACCT plan ..."
71. After completing his section of the CSRA and the ACCT document, Nurse A passed the ACCT document to Senior Officer A. He was the Manager of the First Night Centre, where the man had been taken for the night. However, despite the mandatory instruction, it would appear that the nurse had not attached the yellow copy of the warning form to the ACCT document.
72. As a Prison Service employee, Senior Officer A has received basic training in how to open an ACCT document. The prison training records show that he completed the training on 20 February 2006, when he was a basic grade prison officer. As part of his development for being a manager, Senior Officer A received further specific ACCT training designed for those designated to be case managers. He completed that training on 2 April 2008.
73. As well as the training to be an ACCT case manager, there is also specialised in depth training for those designated to work as ACCT assessors. ACCT assessors are specifically trained to carry out assessments on anyone who has an ACCT document opened on them, and they must demonstrate competency before being allowed to assess. The training enables the assessor to complete the ACCT "Assessment Interview" section. PSO 2700 gives clear instructions that ACCT assessors must have been selected in accordance with the guidance relating to competences for assessors, and have successfully completed the training for ACCT assessors.
74. To aid her staff, on a weekly basis the Governor publishes the names of the duty ACCT assessors and other key people on duty that week. This helps staff to quickly identify the correct person to speak to and, if an ACCT assessor is required, the list shows the name and contact number of the duty assessors.
75. Prison records show that there were two trained ACCT assessors available on 3 December. At interview, Senior Officer A said he knew where this information was kept and confirmed that he was not trained in the role of ACCT assessor.
76. Senior Officer A said the two roles (assessor and case manager) are different, with the case manager being the driving force for the action plan. He said the case manager's role is not done in isolation and, as a minimum, he has the prisoner available and at least one member of the wing landing staff. He went on to say that he can also draw upon other staff including those from healthcare, chaplaincy and anyone highlighted on the care plan.

77. Senior Officer A told the investigator that as a case manager, he obtains information from the observations of the assessor, what the initial concerns were and the immediate action plan. He said that as far as possible, he likes to have the assessor attend the review, and then incorporate their recommendations into the care plan. The Senior Officer went on to explain the rationale for the case manager and assessor being two different people. At interview he said "... the two would be in conflict a little bit, if you've got too much of that knowledge as a case manager, it can mean a conflict with what you are trying to do." My investigator asked the Senior Officer if it could cloud judgement. Senior Officer A said, "I believe it could."
78. At interview, Senior Officer A said that usually, once an ACCT document is opened, the immediate action plan section is completed, pending an assessment. The immediate action plan focuses on explaining to the prisoner the Listener Scheme, use of Samaritans telephone, and ensuring they were content to share a cell overnight, until an assessor was available within the following 24 hours.
79. When Senior Officer A returned to his office, he found the ACCT document on his desk. He looked at the document and as there was "scant information" he wanted more information before completing the immediate action plan section. He said he had not seen the warning form which had been opened at court.
80. Senior Officer A then spoke to the man. He took him to an office and had a general conversation with him, and made a note of this in the assessment section of the ACCT document. The Senior Officer said he wanted to make a note of the interview but had done so in the wrong place. He said it was a log of what the man had said and not an assessment.
81. After speaking to the man, Senior Officer A returned to his own office and told Principle Officer B about the conversation. (Principle Officer A was also in the office.) He told Principle Officer A that after speaking to the man, he did not believe there to be an issue. The Senior Officer said, "I was advised that if I was happy with it, I could close the document straight away." He went on to say that Principle Officer A told him to record it in the ACCT log and then open and close it in the computer to show that someone had concerns initially, but that the document was then closed.
82. My investigator asked Senior Officer A when he had completed the assessment section. He said he did so after speaking to Principle Officer A. The SO was asked if it had crossed his mind that what he was doing was wrong. He said no, adding that he thought he was doing quality work because he was told to close the document. He went on to say that he had been told previously by the prison Safer Custody Coordinator, that it was not always necessary to have an assessment done, and an ACCT document could be closed straight away.
83. My investigator also discussed the assessment procedure with Senior Officer A. He said that he could have obtained the names of the assessors, but as it was about 4.30pm, he did not know whether they would have still been on duty. He

said that assessors were not available 24 hours per day. However, he later agreed that the assessment should be carried out within 24 hours of the opening of the document and therefore it was not necessary to have completed it that evening.

84. Senior Officer A next action was to write in the case management section. In the comment box, he wrote, "Closed on assessment by Senior Officer A." When asked why the document was not completed, the SO said, "At that point, that's the first time I'd done anything like that, I wasn't even advised on writing anything in it, that was just me taking the initiative to write something in there and yes I wrote it in the wrong place." He said that what he had done was neither a case review, nor an assessment. Instead, he had recorded a conversation, because he had to formulate an immediate action plan. Senior Officer A confirmed however that he had not completed an action plan, as closing the document meant that there was no need for a plan.
85. Principle Officer B told my investigator that he had completed a half day ACCT foundation course, but not case management, or assessor training. He said there is a list of trained assessor names held at the prison. Principle Officer B said that, whenever an ACCT document was opened, it was usually a residential senior officer who dealt with the document and principal officers were not normally involved. Senior officers were responsible for managing reviews and ultimately would be the ones to decide when a document would be closed.
86. My investigator asked Principle Officer B if he had seen records of assessments and attended case review meetings, and he confirmed that he had. Principle Officer B said it was normal to have more than one person at review meetings, including prison discipline staff [wing officers]. He said there had been occasions when case review meetings had been held with just the case manager and prisoner present.
87. The PO said that on 3 December when the man arrived at the prison, he was the Orderly Officer and had based himself in the centre office. (The Orderly Officer is normally responsible for the daily operational routines.) He said he could not recall Principle Officer C being in the room.
88. At interview, Principle Officer B said he remembered Senior Officer A entering the office and asking if he could close an ACCT document at any time. Principle Officer B told my investigator that he was unsure of the procedure and told Senior Officer A that, providing he had the evidence, he could do so. He confirmed to my investigator that, by evidence, he meant that the SO could justify the action that he was about to take.
89. My investigator asked Principle Officer B what evidence he believed Senior Officer A to have considered. He said he did not know what information he had. He said that his expectation was that the ACCT document was being dealt with correctly and that staff had an understanding of their own responsibilities. He confirmed that he did not see the ACCT, and that he did not know that the ACCT

referred to the man. Principle Officer B added that he regarded the question from Senior Officer A as a general one and not specific to anyone.

90. As part of the interview process, my investigator showed the ACCT document to Principle Officer B. The PO confirmed that this was the first occasion that he had seen it. He was asked to comment on Senior Officer A's entry which said "closed on assessment by Senior Officer A". Principle Officer B said that it read like the ACCT document has been closed following an assessment taking place. He added that, from his recollection, the conversation with Senior Officer A was during the evening duty. He questioned whether it could have been 4.30pm, as stated on the ACCT.
91. My investigator asked Principle Officer B what his impression and assessment of the man's ACCT document was. He said it had not been completed fully or correctly. Principle Officer B said the work had not been completed to a satisfactory standard. He said he was surprised, adding that Senior Officer A was a keen, proactive and supportive member of staff.
92. At interview, Principle Officer C said she had not received any training in ACCT and the only training received in suicide prevention was when she attended a course relating to the previous system known as F2052SH. She said that, whenever she needed to deal with an ACCT document, she followed the flow chart printed in the ACCT document. Principle Officer C said she regarded her training needs in ACCT as low priority and had never asked for training in the subject.
93. Principle Officer C told my investigator that a list of all trained ACCT assessors employed at the prison is held in the centre office. She said that at weekends it often proved difficult to find an assessor, although she added that the situation had improved since the man's death. Principle Officer C said if there were no assessors available, she would speak to the prisoner concerned, along with the relevant SO and staff, with the intention of identifying the problem and assessing the options for care, such as arranging for observations.
94. My investigator asked Principle Officer C if she had ever attended a case review meeting. The PO said that she had, although it had been some time since she had done so. She said case reviews are chaired by senior officers and that they receive specific training to carry out the task. The PO said the case review is a multi disciplinary meeting and at Leicester, whenever a case review is held, representatives from the chaplaincy team and healthcare are always there and occasionally probation. She went on to say that the reason for healthcare attending is that they may have some valuable input which the prisoner might not realise. The PO said that the Governor had been "pushing" to make attendance at case reviews high profile and was something that had improved.
95. Principle Officer C said that both she and Principle Officer B were in the centre office when Senior Officer A entered the room. She said the SO had an ACCT document in his hand and asked if it was okay to close it. At interview, Principle Officer C said that both she and Principle Officer B looked at each other and

asked the SO why it would not be. She said the SO told them that the ACCT document had been opened and he could not see why, and it was he who suggested to them that he should close it. Principle Officer C said she told Senior Officer A that she did not think there was anything anywhere to say he could not close it and that, if he felt it did not need to be opened, then he could close it.

96. My investigator asked Principle Officer C if they had discussed the document. She said no, adding that the SO asked a question, looked at the document and left the office. Principle Officer C went on to say that she had presumed that the SO was doing an assessment, as he had the ACCT document in his hand. When shown the ACCT, Principle Officer C said that, although she could see from the document that Senior Officer A had spoken to the man, she would have expected him to make the duty PO (PO C) aware that he was not an assessor. She was surprised to learn that Senior Officer A had carried out the assessment when he was not trained to do so, and when there had been two trained assessors on duty that afternoon.
97. My investigator asked Principle Officer C whether she had ever read comments written by case managers. She said she had. Principle Officer C said they were usually in depth and gave an account of what had been identified and planned. The case manager also recorded the names of all those attending the review meeting. She said that the man's ACCT document had not been completed correctly and that had she seen the document, she would have asked the SO to complete it. She added that it "does not tell us anything" and agreed that "closed on assessment" meant to her that an assessment had been carried out. She described Senior Officer A's work on this occasion as "poor, very poor".
98. I referred earlier to Senior Officer A telling my investigator that he had been told by the Safer Custody Manager, that if case managers felt that an ACCT had been opened unnecessarily, then they could close it without assessment. My investigator spoke informally to the Safer Custody Manager and he was quite clear that this was not the case. He told the investigator that an ACCT document could only be closed after an assessment had taken place, and following the initial review. The Safer Custody Manager went on to say that he had reminded managers of this in an email sent five days after the man's death, on 10 December.

4 December

99. On 4 December, the man submitted a self referral CARATs (CARATs: Counselling, Assessment, Referral, Advice and Throughcare, is designed to help prisoners who have misused or continue to misuse drugs) application form. He gave limited information on the form, simply noting his name, prison number, date of birth, cell location, next court appearance date, and his reason for the application. The man simply noted the reason for the referral as "heroin", and gave no other information.

100. The man also went through the normal prison induction procedures for all newly arrived prisoners. From what has been gleaned from the available documents, the induction period appears to have been uneventful. He signed the induction checklist document to show that he had been given information about the prison and, more importantly, how to raise any concerns that he might have and about keeping safe.
101. Nurse B is a substance misuse nurse. At interview, the nurse said that she had met the man on one occasion (on 4 December). She said that she had seen and read the notes made by Nurse A when he interviewed the man's during the reception procedure. Nurse B described the man as polite and cooperative, but said he was vague when answering her questions. She told my investigator that she had asked the man if he was going to harm himself, and he had said no. Her recollection of the man was that he appeared happy to be in prison as he believed it would help him to get away from drugs.
102. The clinical reviewer notes that Nurse B had identified symptoms of withdrawal from opiates. His report shows that the nurse had noted that the man had been sneezing and yawning and that his skin was moist. Additionally, his pupils were widely dilated, his nose running, and he had been vomiting. The clinical reviewer adds that the nurse had seen evidence of recent intravenous drug use. He notes that the nurse had recorded the man as having a significant tremor and that he had complained of aching in his lower back. The clinical reviewer also notes that Nurse B had recorded the man as being malnourished, which he had said was due to his poor diet and lifestyle, and that she had referred him to the prison In-Reach Team which forms part of the mental health service.
103. My investigator asked Nurse B if she had been invited to the man's case review meeting, and she said that she had not. She went on to explain that as she was the only substance misuse nurse at the prison, it meant that she did not have the time to attend case reviews. However, she felt that she ought to be invited and given the time and opportunity to attend.

5 December

104. (For the purpose of my investigation, Nurse C was interviewed twice. The reason for this was to seek clarification of information that she had given during her first interview, which was held on 27 January 2009. The second interview was held on 16 February.)
105. At her first interview, Nurse C told my investigator that she had been asked by Senior Officer B to speak to the man. Nurse C said that the reason for this was because she had been told by the SO that the man was quiet. The nurse said that, when she went into the man's cell, which she thought was about 2.00pm, he was sitting on the floor with a blanket wrapped around him. She said that, when asked how he was, he said he was fine. Nurse C told my investigator that she had no concerns about the man, other than noting he was quiet. The nurse added that she thought his behaviour had something to do with tobacco, but did not know what this issue was about.

106. My investigator asked Nurse C if there had been any discussion between her and prison staff about opening an ACCT, and she replied that there had not. He asked the nurse if she had been aware that the man had been monitored under ACCT when he first arrived into prison, and she said “not necessarily”.
107. When my investigator spoke to Senior Officer B about her recollection of events, she said it was not her who had asked the nurse to speak to the man. My investigator later established that it was in fact Officer C.
108. Officer C told my investigator that, at about 2.00pm, she went to the man’s cell to tell him that he was being moved to a cell in the detoxification wing. When she looked into his cell, the officer noticed him “slumped” on the floor. She also noticed that the man’s medication was missing and that he was unresponsive. Suspecting an overdose, Officer C asked for urgent medical assistance and, in response to that request, Nurse C attended.
109. Officer C said that the man spoke to the nurse and told her that he had taken his medication because his stomach was hurting and he wanted to relieve the pain. She said the nurse took the man’s blood pressure and checked his eyes and pulse, after which the nurse told the officer that the medication would not harm him.
110. At her second interview, my investigator asked Nurse C to clarify and confirm his (the investigator’s) understanding of events. On this occasion, Nurse C said she remembered going to see the man, but said the circumstances were “sketchy”. My investigator asked if she had completed a form F213SH and she said that she had not. He also asked if an F213SH would be completed for a prisoner who took all, or the majority, of his medication. Nurse C said that it would depend on the amount, explaining that if it was day five or six of a week’s course then, depending on the type of medication, an F213SH would not be completed. Otherwise, it might be. Nurse C said that in such circumstances she would have to check the medical records to determine the type of medication.
111. Nurse C said that she had not considered either opening an ACCT document or completing an F213SH. The nurse said that the man’s behaviour was “childlike”, that he was sitting in the corner and would not speak to her. She said that, with hindsight, his behaviour should have prompted the opening of an ACCT, adding that he was acting in this way before she went to see him.
112. The investigator asked Nurse C why there was no entry on System One (System One is a computerised medical record) of her having seen the man. Nurse C was unable to offer an explanation as to why she had not recorded it.
113. A little while later, the man moved to cell B2.07 which is located on the detoxification wing. At about 3.00pm, Officer D spoke to the man to ask him how he was. At interview, the officer said the man simply “grunted” at her.

114. About one hour later, Officer D went to the man's cell and saw him lying on his bed, with his arm hanging over the side with cuts on his wrist. The officer told my investigator that the cuts were superficial. Officer D asked for urgent medical assistance using the code red procedure. Whilst waiting for medical assistance, the officer stayed with the man and helped him to sit up. She said the man sat looking at his hands, and described him as sad and unhappy. The officer said the man gave no explanation for what he had done.
115. The Orderly Officer that day was Principle Officer D. Principle Officer D was carrying a prison radio with radio call sign Oscar One.
116. Principle Officer D received a radio message telling him that there was a code red incident in cell B2.07. As the Orderly Officer, Principle Officer D responded to the call and, when he arrived at the cell, he saw the man sitting on the bottom bunk bed holding his left wrist. He could see a number of cuts to the man's wrist. Principle Officer D gave the man a towel and told him to place it over the injury and apply pressure, which he did.
117. At interview, Principle Officer D said he tried to speak to the man to find out why he had cut his wrist, but the man would not speak to him. At about the same time and in response to the code red radio message, Nurse C arrived and entered the cell. Nurse C told my investigator that she tried to speak to the man, but he would not answer her. The nurse examined the injury and decided that the man needed to be taken to a treatment room to have the wound cleaned and dressed.
118. At about the same time, and because the man had harmed himself, an ACCT document was opened. In the section "On going record", the time was noted as 4.00pm. The person making the entry noted that the ACCT document was opened because the man had made superficial cuts to his left arm.
119. Once the man's injuries had been treated, he returned to his cell. Because the man had injured himself, Officer D completed an F213SH. Whilst filling in the form, she saw the man and spoke to him. At interview she said that the man was agitated and told her to "fuck off". The officer went to speak to him in his cell, but as she did so, he slammed the cell door closed and repeatedly told her to "fuck off". After completing the F213SH form, Officer D handed it to Nurse C. However, when my investigator asked to see a copy of the F213SH, it could not be found and was not with the man's medical record.
120. At about 4.10pm, and because the man was on ACCT monitoring, Officer D went to the man's cell to tell him that he would have to hand in his knife and fork. She said that he agreed and that his attitude had changed and he was no longer aggressive. The officer said that the man collected his meal and that she saw him place the meal on his table and sit down in readiness to eat.
121. Between five and ten minutes later, Officer D locked the man up. She said he was fine and confirmed that at that point he was alive. As she had to go to another landing, Officer D spoke to Officer E who was the officer taking over

from her. At interview, Officer D said she told Officer E about what had occurred earlier and asked him to check on the man.

122. As the prison was being locked up, Officer E carried out a roll check. At interview he said that he remembered going to the man's cell and looking inside. He said he did not remember being told that the man had cut his wrist, or that there was an ACCT document in place. The officer said he remembered looking into the man's cell and seeing him on the bottom bunk. Satisfied that all of the prisoners on the landing where he was working were accounted for, the officer confirmed that his landing roll was correct.
123. At interview, Officer E said that, after completing the roll check, Senior Officer C asked him to check the man. He said the time was approximately 4.45pm and that he was unaware of the man being monitored on ACCT. Officer E went on to say that he did not have the opportunity to do what had been asked of him and had not gained any sense of urgency in what he had been asked to do.
124. The next entry in the ACCT on going record was made by Senior Officer C at 5.00pm. She noted that the man had refused to engage with her when she went to speak to him. At interview she said that in her opinion the man should have been placed on ACCT monitoring after he had taken his medication. Additionally, the SO said that it was her understanding that the cells in the detoxification wing were what she called "reduced risk cells".
125. At 5.30pm, Senior Officer C completed the ACCT "Immediate Action Plan" section. The immediate action plan has five specific areas where the writer can note any necessary action under each heading. Under the heading "Location", Senior Officer C noted that the man had been allocated to a safer cell and had taken all his detoxification medicine. In the next section, headed "Frequency of staff support", the SO wrote that he was to be observed twice per hour until he was assessed. Senior Officer C noted that the assessment was to take place the following day. In the remaining sections, the SO noted that the man was to have access to a telephone as required and if practicable, and that he had no medication in his possession.
126. My investigator discussed with Senior Officer C her understanding of what she called "safer cells" and her impression that all cells on the detoxification wing were safer cells or "reduced risk cells". At interview, Senior Officer C said she was unaware, until my investigator told her, that there were no such cells in the detoxification wing. The SO added that even had she been, she would not have changed her decision to allocate the cell to the man.
127. Shortly afterwards, Senior Officer C went to the man's cell to check him. When she looked into the cell she saw that he was hanging by a sheet which had been attached to the window bars and that he was fully suspended with his feet off the ground. As soon as she saw him, Senior Officer C pressed an alarm button and also called for assistance using the prison radio emergency code procedure, issuing a code blue call. The prison log shows the time as 5.37pm.

128. Senior Officer C entered the cell and took hold of the man's legs to support his weight. Due to supporting the man's weight, the SO was unable to get to her fish knife to cut the ligature and so had to wait for help to arrive. In response to the request for urgent assistance, Officers F, G and H arrived.
129. Officer H was the first member of staff to enter the cell after Senior Officer C. He said that when he arrived he saw the SO supporting the man's weight. Using his fish knife, the officer cut the ligature and he, the SO and Officer G moved the man out of the cell and onto the landing where there was more room. Officer H told my investigator that the man's body was cold/cooling to touch. He said that Senior Officer B and Officer G began cardiopulmonary resuscitation (CPR), but that Officer F took over from Officer G.
130. Officer G told my investigator that the man's body was limp and that he had urinated. The officer checked for signs of life but did not detect anything, after which he then began CPR chest compressions.
131. In the meantime, Senior Officer B heard the request for assistance and went to the detoxification wing. When she arrived she saw the man being carried from his cell to the landing. Senior Officer B said that when she got to the man she called out his name, and checked for a pulse and breathing but could not detect anything. Senior Officer B said she tried to do mouth to mouth breathing using a resusciate (a one way face shield for administering mouth to mouth resuscitation, designed to protect the rescuer from ingesting body fluids from the patient), but it would not work. She tried a second, but again she could not get it to work. Unable to use the resusciate, Senior Officer B began mouth to mouth resuscitation without any protection between her and the man's mouth. She told my investigator that air was going into the man's body because she could see his chest rising when she blew into his mouth. Whilst she had been doing mouth to mouth breathing, Officer G had been doing chest compressions.
132. Shortly afterwards, Officer F took over mouth to mouth resuscitation from Senior Officer B and, in turn, SO B took over chest compressions from Officer G. As was the case with SO B, Officer F did not have any protection between him and the man's mouth. At interview, Officer F said that during the resuscitation attempts vomit was coming from the man's mouth and that he had to clean it away before continuing. Officer F said that he was later handed a mouth guard which he then used to protect himself.
133. Hotel 4 on that evening was Nurse D. She told my investigator that she had taken over from Nurse C. Before going off duty, Nurse C had told her that the man had taken all of his medication.
134. At the time the code blue alarm was raised, Nurse D was working at a computer in a part of healthcare known as the Enhanced Care Facility (ECF), which is an inpatient unit. She said that she was concentrating on a patient care plan and was not listening to the radio and had assumed that she was being called to the man because he had taken his medication. When she realised that the

message was a code blue message she said that she had first to log off from the computer, explaining that she should not leave the computer open while working on a care plan.

135. Nurse D said that, after closing the computer down, she went downstairs to another floor below where she had been working and told a patrol officer that she was going to the wing. As she was making her way through healthcare, the nurse saw Doctor A and asked the doctor to accompany her. The nurse said she told the doctor there was a prisoner hanging.
136. At interview, Nurse D said it would normally take Hotel 4 about five minutes to get to the man's cell, but because of the route she had taken it took longer. The nurse explained that this was partly as a result of Doctor A not carrying keys, and her having to open and close doors and gates for the doctor. The nurse went on to say that she estimated the time taken to be between thirteen and fifteen minutes. (The prison incident log shows the time taken from the code blue being called to Nurse D arriving at the scene to be eight minutes.)
137. Nurse D said that, when she and Doctor A arrived at the man's cell, they saw officers carrying out CPR. She said that she handed the oxygen equipment to Senior Officer B, adding that the SO did not want her to do anything. The nurse explained that this was because SO B was aware that she had not been well and did not want her to be taken ill again. The nurse said she placed the oxygen mask over the man's mouth, but despite the tank being full there was confusion as to whether oxygen was being delivered to him or not. The nurse said that prison staff continued with resuscitation, using a mouth piece. Nurse D said she checked the man's carotid artery, but could not detect any sign of life.
138. The prison log shows that at 5.49pm paramedics arrived at the man's cell and began resuscitation attempts. For the next 31 minutes, CPR continued after which it was stopped. At this point, Doctor A intervened and confirmed that the man had died. Nurse D told my investigator that the doctor had not touched or examined the man until after paramedics said he had died.
139. At interview, Doctor A said that Nurse D had telephoned her to say there was an attempted suicide and that she was going to collect her. The doctor said that both she and the nurse ran as fast as they could to the detoxification wing.
140. Doctor A said that when they arrived at the man's side he was lying flat on his back, with a number of officers around him. She described the man's colour as "awful" and believed him to be dead. Doctor A said she could see that prison officers were carrying out CPR "extremely well" and that the man had vomited. She asked Senior Officer B if she would like any assistance with CPR, but the SO shook her head to indicate that she did not want any assistance. The doctor said that, from what she could see, there was nothing to make her feel that she should take over, adding that she believed everything was being done properly.

141. In his clinical review, the clinical reviewer notes that Doctor A thought that Nurse D had carried a large bag from the medical department to the main wing. He adds that the doctor could not recall any equipment to be lacking, but says that, after the paramedics had packed their equipment away, she had asked Nurse D if there was any suction equipment available. Although she could not remember what the nurse had said, she assumed that the nurse would have used it if it had been available.
142. At interview, Doctor A was asked if she could recall seeing a defibrillator before paramedics arrived. She said she could not remember asking whether one was available, although she added that she expected the prison to have one. The doctor went on to say that, had one been available before paramedics arrived, she would not have been prepared to use it, but expected someone present to have been trained and able to use it.
143. Doctor A told my investigator that since the man's death she had seen a modern defibrillator demonstrated to her at a CPR refresher course held in February 2009. She said her previous CPR training was in 1999 when she was working in Australia.
144. In his clinical review, the clinical reviewer notes that Doctor A confirmed that she did not check the man's condition during the resuscitation attempts, nor did she check his pupils. She said the reason for not doing so was because she was waiting for paramedics to arrive and "hoped for a miracle to happen". The doctor added that she did not feel as competent in resuscitation as a paramedic would be, because of the time since her last CPR training.
145. During her interview, Doctor A said she remembered seeing Doctor A and that the doctor had said the resuscitation ratio was 15 - 2 (meaning fifteen compressions to two breaths). Senior Officer B said she disagreed with the doctor and told her the correct ratio was 30 - 2. The clinical reviewer asked Doctor A if there had been any conversation between her and Senior Officer B about the ratio. She said that they had not discussed it, adding that in her last updated training in 1999 the ratio was 6 - 1 and that she was unaware of any changes since then. (The current recommended ratio is indeed 30 - 2 as Senior Officer B had indicated.)
146. At interview with Doctor A, the clinical reviewer pointed out that the training for lay people is that they should continue CPR until medical help arrives and that they can then expect the qualified person to take over. Doctor A said that, if this was the case, she would expect a lay person to make a gesture to her and make her aware that that is what they were expecting. She added that she had assumed that prison officers would be trained to a higher degree in CPR than the ordinary member of public.
147. Senior Officer B also told my investigator that Nurse D did not have any equipment with her and that the nurse had to be told to collect it. Officer H also told my investigator that the nurse had not taken any equipment to the scene. He said that, when the nurse arrived, she told him that she did not have her "kit"

with her and so he accompanied her to a treatment room to collect it. He said that, although there were more than two bags visible, the nurse told him which bags to collect. After collecting the bags, he ran back to the man's cell.

148. In contrast to Senior Officer B and Officer H, Officer G said he thought that the nurse and doctor arrived with what he described as "relevant equipment". However, he later added that he could not be certain whether the doctor was with the nurse, or whether they were carrying medical equipment.
149. In order to try and clarify what it was that Nurse D had done following the code blue, my investigator returned to the prison to re-interview her. On this occasion, and at the request of the investigator, he was accompanied by one of my Assistant Ombudsmen.
150. At the second interview, my investigator reminded Nurse D that following the man's death she had made a written statement to her employer about her actions. He told the nurse that, because there was some discrepancy in what he had been told by others interviewed, he wanted to clarify the information. He reminded Nurse D that she had told her employer that she had taken emergency equipment. At the second interview, the nurse confirmed that when she went to the cell on the first occasion she did not have any equipment and that she had to "go back" to collect it. She confirmed that the statement made to her employer was untrue.
151. My investigator asked the nurse to clarify the route taken to get to the man from the ECF. He explained the reason for this was because he and the clinical reviewer had walked the route and it had taken just three and a half minutes. Nurse D explained that she had not heard the first call because she was concentrating on what she was doing at the computer. She repeated her previous account of events and said that, when she did hear the call, she had to close down the computer. However, on this occasion, instead of saying she went downstairs to tell the patrol officer where she was going, she changed her evidence to say that the patrol officer had in fact been sitting alongside her when the call came through.
152. The investigator asked the nurse why, when there was an officer with her, she felt it more important to close down the computer rather than immediately attending an emergency. She told him that, apart from not wanting to lose her work, officers should not be allowed to see patient information. My Assistant Ombudsman asked Nurse D why she could not simply lock the computer. The nurse said that the computer system goes off if left, which she said means any unsaved work is lost.

Following the man's death

153. After it had been confirmed that the man had died, the prison chaplain said prayers at the man's side. At 9.45pm, the man's body was taken from the prison to the local Mortuary.

154. I understand that a review of prisoners being monitored at being of risk of suicide or self harm was carried out. This is in line with the Prison Service procedure following any death in custody. Additionally, I understand there was a de-brief meeting with those staff involved and that the prison care team was on hand to support staff.

ISSUES

Suicide and Self Harm Warning Form

155. My investigator has examined the man's medical record, and inside the file was a copy of the suicide and self harm warning form raised by GSL. However, unlike the investigator's copy, the one contained in the medical file shows that section eight had been partially completed and a tick placed in the box showing an ACCT document was opened. Given the fact that the man's original record was copied for my investigation after the man had died, I am unable to explain how the copy in the medical file differs from both the original and my own copy.

156. Although there may be a simple explanation, as part of the normal procedure for giving feedback to Governor my investigator pointed out the discrepancy in his letter to the Governor dated 17 February. On 18 February, the Governor wrote to SERCO enclosing a copy of the investigator's feedback letter. In her letter, the Governor asked SERCO to investigate a number of matters relating to the man's medical care, including asking when the document was amended and by whom.

Senior Officer A

157. Senior Officer A is an experienced prison officer and manager. Prior to being a wing manager, he was the prison's Training Manager. At interview, he confirmed that he had not been trained to carry out the task of ACCT assessor. He also told my investigator that he knew who the duty assessors were that day, but said he had not contacted them. He went on to say that he had only the best intentions in what he did.

158. However, although not an ACCT assessor, Senior Officer A has received training in the role of case manager. He told my investigator that he had carried out a number of case reviews and was familiar with the proper process. At interview he said assessors and case managers were two different roles, with the case manager being the driving force for the action plan. He added that the reason for the two roles being carried out by different people is because there would be conflict, which, he said, could cloud judgment.

Guidance on the closure of the ACCT document

159. At interview SO A said he had sought advice and been told that he could close the ACCT document. However, in his evidence Principle Officer B said the SO asked him if he could close an ACCT document at any time. PO C said that her recollection was that SO A had an ACCT document in his hand and asked if it was okay to close it. It is clear from the evidence that SO A did not show the ACCT to either of the POs, nor did he make it clear that he was referring to a specific prisoner. It would appear from both PO's that the question was a general enquiry.
160. On the balance of probability, I am satisfied that SO A did not make himself clear and that his question was ambiguous. Equally, I am satisfied that PO B and PO C were not given the full picture, including the fact that SO A was not a trained ACCT assessor. In his evidence, PO B said he told the SO that he should have the evidence before closing an ACCT. PO C said she would have expected SO A to have made them aware that he was not an assessor.
161. Both POs also said they had no reason to doubt that SO A was following the correct procedures. PO C said that as a PO she would never have to check an ACCT document or make sure an assessment or case review had been carried out, as they would be done automatically. PO B said he did not tell the SO to close it.

ACCT Assessment

162. The purpose of assessment is to try and establish why the individual is at risk of harming themselves. Contained within the ACCT document is a flowchart which gives unambiguous instructions on what to do once an ACCT has been opened. It clearly shows that an assessment is required to take place within 24 hours and must be done by a trained assessor. ACCT assessment is not a task that can be rushed and nor should it be. Assessors are specially selected and receive specific training in how to ask probing, in depth questions. Their skills help them to record the prisoner's feelings accurately and make informed judgments about the interviewee.
163. As part of his evidence, SO A said he had been told by the Safer Custody Coordinator, that an assessment need not take place and that an ACCT document could be closed without one. When my investigator met the Safer Custody Coordinator, he was quite clear that this was not the case. He said an ACCT document can only be closed after an assessment had taken place. Why SO A thought otherwise is not clear.
164. At interview, SO A said he took the man into an office where he had a conversation with him. The SO stressed that it was not an assessment, but said that he made a mistake by writing his note of that conversation in the

assessment section. He was quite clear in his own mind that PO B and PO C knew that he was going to speak to the man and that he told staff in the first night centre that he was not concerned about him. He added that the first night centre staff were also not concerned about the man.

165. I have considered whether an assessment was, or was not, carried out. The mere fact that a trained assessor was not asked to carry out an assessment leads me to believe that a proper assessment was not done.
166. That said, I now wish to consider what SO A actually did. The SO said the meeting with the man was a conversation and that he simply made a note of that conversation in the wrong area. However, his record of that conversation matches five of the eight assessment subject headings and appears to reflect the aide memoir following each heading. One of the remaining three sections has "N/A" entered into it, the second has "none" and the remaining one has been left blank. In my opinion, by completing five specific sections, and making entries in two others, SO A has considered each individual section and answered accordingly.
167. Further to this and under the heading "Action Following Assessment" the SO has written "closed on assessment by SO A". What is clear is that he does not refer to a conversation and has chosen the word assessment. When shown the document, PO B said, "It reads like the ACCT document has been closed following assessment." PO C said it meant "an assessment had been carried out". I agree with both PO B and PO C - I am of the opinion that SO A did carry out an assessment.

Case Review

168. Whenever a case review takes place, the prisoner concerned is invited and encouraged to take part in the review meeting. They are also encouraged to be involved in the decisions taken to keep him or her safe. The case manager is responsible for chairing the meeting, recording the salient points of the review and formulating an action plan. However, as we now know, the man's case review meeting was carried out in isolation, contrary to Prison Service procedure.

Immediate Action Plan

169. SO A told my investigator that he had spoken to the man in order to formulate an action plan. The SO later went on to say that there was no need for an action plan, because he had closed the document. I accept this, but had the assessment and case review been carried out correctly there should have been an action plan in place to ensure the man's safety.

Post Closure Interview

170. Following the closure of an ACCT document, the final action for the case review manager is to arrange a post closure interview. Post closure interviews are meant to occur seven days after closing the ACCT. It is clear from the ACCT document that SO A did not arrange this review.

The decision to close the ACCT

171. I am satisfied that, had the ACCT document not been closed so rapidly, it would have meant that prison officers would have been interacting with the man far more than they do when someone is not being monitored. Knowing that an ACCT document was opened, officers would have gone out of their way to talk to the man, even if it was simply to ask if he was okay. He would have had regular contact with staff, but instead the decision to close the ACCT document meant that he was not given that basic level of interaction with prison staff.
172. When my investigator learned of what SO A had done, he raised it immediately with the Deputy Governor as an urgent finding and later with the Governor. The Deputy Governor, supported by the Governor, took the prompt decision to remove SO A from any further ACCT responsibilities pending re-training. Additionally, the Governor decided to await further information from my investigation before deciding whether any additional action was necessary.
173. I have considered SO A's actions that afternoon carefully and can come to no other conclusion than that he left the man vulnerable and incorrectly cared for. His mitigation is that he sought advice from two principal officers. Although there is no doubt that he did speak to them, it would appear from their evidence that he did not give them the whole story. In her interview, PO C said "... the SO told [us] that the ACCT document had been opened and he could not see why, and he suggested to [us] that he should close it". PO B said he did not tell the SO to close the document. Additionally, the safer custody manager said he had not told SO A an ACCT document could be closed without assessment. As a manager, SO A had a responsibility to ensure a proper assessment and case review was carried out and was fully aware of the correct procedures.
174. Since issuing my advance disclosed report I have been made aware that an internal investigation has taken place and concluded that other than addressing a training need, no further action is necessary. I have earlier pointed out that the Prison Service investigation had concluded before my own report was released to them, which means my report and evidence had not been considered by their investigator. It remains my view that SO A's actions were so serious as to warrant further investigation by the Prison Service and that the following recommendation was justified.

The Governor should consider investigating the actions of Senior Officer A further.

Senior Officer C

175. When SO C completed the reopened ACCT document, she wrote her instructions in the mistaken belief that the man was in a safer cell. At interview, she said that, even had she known it was not a safer cell, she would still have allocated him to the same cell. Why she thought the cell was designated as a safer cell remains a mystery. Although I make no formal recommendation, I invite the Governor to consider including this issue within her terms of reference for the wider internal investigation examining the ACCT procedure relating to the man. I understand from the Prison Service feedback, that the Governor decided to investigate the actions of SO C. However, I am not aware of the outcome of that investigation.

Clinical Review (The clinical reviewer's opinions and recommendations)

Nurse A

176. In his clinical review, the clinical reviewer says that, after Nurse A completed a routine reception screening interview with the man, he recommended a single cell and opened an ACCT document. The clinical reviewer notes that Nurse A documented his concerns which led to the opening of the ACCT document, but adds that there was no amplification of his statements. The doctor says that low mood and a history of self-harm are common in prisoners, and in his opinion there must have been something in the interview with the man that concerned Nurse A. He goes on to say that, had the nurse recorded his subjective reasons for concern, it might have helped other members of staff assess the man.
177. In addition, the clinical reviewer says he was surprised that, at interview, given the fact that the man died only two days after the nurse had seen him, Nurse A was unable to recall any detail regarding him. The doctor adds that Nurse A gave him the impression that he had little interest in what had happened to the man, although he accepts that the nurse may have found the interview situation stressful. (My investigator told me that he had spoken informally to the liaison officer about his concerns relating to Nurse A's attitude at interview. The investigator described Nurse A as appearing uninterested.)
178. The clinical reviewer also says that, if it was Nurse A who ticked the box on the man's suicide/self-harm warning form to indicate that an ACCT document had been opened, it was poor practice for him not to have signed and dated the entry. However, if he made no entry on the form and that it was somebody else who ticked the box, this too was poor practice. The clinical reviewer makes the following recommendation to SERCO:

SERCO clinical management should review Nurse A's appraisal history and work with him to assess his attitude to his job and ensure that he is performing to his full potential.

Nurse B

179. The clinical reviewer says in his clinical review that, in light of the man's stated low mood and his history of self-harm, it was appropriate for Nurse B to refer the man to the In-Reach Team. He says that it had been good practice for the nurse to discuss the man's case with a member of the In-Reach Team and for them to have come to a joint decision about the urgency of the referral. The clinical reviewer adds that the decision to make an urgent referral (to be seen within three working days), but not an emergency referral, was appropriate. As the man had said he would not harm himself and had expressed some positive thoughts, it was reasonable to conclude that there was a background risk of suicide, but no immediate risk of self-harm.

Nurse C

180. On 5 December, Nurse C was called on two occasions to see the man, but did not record either of her actions in his medical record. In his clinical review, the clinical reviewer says that Nurse C's actions were poor practice. He adds that any clinician who has a consultation with a patient should make a permanent record of that consultation, either contemporaneously, or as soon as possible. This is so that any other clinician who has cause to see the patient at a later date knows what has transpired. The clinical reviewer says that Nurse C's failure to make a record of her first consultation with the man explained why, at interview, she was unable to remember the reason that she had been asked to see him.

181. The clinical reviewer adds that, on the balance of probabilities and taking into account what others have described the nurse as saying, he believes that the man had taken more of his in-possession medication than had been prescribed for him, but had not taken enough to do himself any harm. It is the clinical reviewer's belief that Nurse C probably came to the conclusion that the man had done so in order to try and reduce his withdrawal symptoms, rather than as an act of self-harm. This being the case, he feels that it was appropriate that an ACCT document was not re-opened at that time.

182. I have considered the clinical reviewer's view and have to say I do not agree with him. It is clear that the man had been found on the floor of his cell, in what has been described as a collapsed state, and that urgent medical assistance was summoned. There appears to be no doubt in anyone's mind that he had consumed all, or the majority, of his medication. What we do not know is why. It may have been to relieve the symptoms of withdrawal, or for a more sinister reason. On that basis, it is my view that consideration should have been given to opening an ACCT and, had that happened, a proper assessment could have taken place and a more informed judgement made. Additionally, an F213SH

should have been completed. To simply ignore the man's actions was not an appropriate response.

183. Nurse C also failed to make a note of her second meeting with the man. The clinical reviewer says that she should have made a record of her discussion with him, and her conclusions, in the man's clinical record. She should have made a record noting the injuries sustained, the nursing procedure she had undertaken, and the fact that the ACCT document had been reopened. This information could have been helpful to both prison healthcare staff and to members of the In-Reach Team.
184. The clinical reviewer notes that Nurse C told both Doctor A and Nurse D before going off duty that she had had dealings with the man, but adds that this was not sufficient. The clinical reviewer makes the following recommendation to SERCO:

SERCO should review Nurse C's performance on the afternoon of 5th December with a view to determining whether she has training needs and whether her breach of the Nursing and Midwifery Council's directions regarding record keeping was an isolated incident, or whether it reflects a pattern of poor performance.

Nurse D

185. Although not an issue for the clinical reviewer to consider or report on, I must refer to the written statement made by Nurse D in which she said she took emergency equipment to the scene. During her second interview, and contrary to her written statement, the nurse told my investigator that she had not taken emergency equipment with her.
186. Additionally, she changed her account of events to say that the patrol officer was in fact sitting with her and was not elsewhere in the building as she originally said. I believe these are matters that SERCO will wish to investigate and make the following recommendation:

SERCO should consider whether further investigation is required into Nurse D's actions.

187. In relation to the emergency equipment, the clinical reviewer says in his clinical review that cardiopulmonary resuscitation is a holding measure until the patient can be assessed and definitive treatment (defibrillation) given if appropriate. He adds that it is important to maintain a clear airway in a patient who is receiving CPR, and that entry of vomit into the lungs prevents this and may do irreversible damage to the lungs. It is therefore important for a defibrillator and suction equipment to be taken to the scene of any resuscitation attempt as soon as possible.

188. As we know, there is some discrepancy about the type of equipment taken to the man and about when it was taken. The clinical reviewer comments that these are the two most important pieces of equipment to take to the scene of a resuscitation attempt, and that the presence of oxygen is useless if a clear airway cannot be maintained. He makes the following recommendation:

The PCT in partnership with SERCO should review the healthcare training and ensure that any member of healthcare staff acting as Hotel 4 takes a defibrillator and suction equipment to the scene of resuscitation.

189. The clinical reviewer has considered the actions of Nurse D in taking cut down equipment to the man. He notes that the nurse felt that it was important to take the emergency grab bag, which she referred to as the cut down bag, in case the ligature was too strong to be cut by the “fish knives” carried by prison officers. The clinical reviewer is of the opinion that it should not be the responsibility of healthcare staff to take the heavy duty cut down shears to the scene of a hanging, and this is an opinion which I support. The doctor makes the following recommendation:

The Governor should reconsider the availability of tools for cutting strong ligatures and ensure that it is not the responsibility of healthcare to supply them.

190. At interview, Nurse D said she felt unable to carry the grab bag, the defibrillator, the suction bag and the oxygen cylinder together, while negotiating locked gates within the prison. My investigator and the clinical reviewer have seen the four bags and agree with the nurse that it is very difficult. The clinical reviewer makes the following recommendation:

The Governor, in partnership with the PCT and SERCO, should consider the positioning and availability of defibrillators, suction equipment and oxygen cylinders, and particularly their transportability.

191. The clinical reviewer says that he would expect a doctor and a nurse arriving, either separately or together, at the scene of a resuscitation being attempted by non-clinical staff to take charge of the resuscitation attempt. He says they should be aware of what equipment was, or could be made, available and to be proficient in the use of that equipment. He judges that both Doctor A and Nurse D failed in these respects. The clinical reviewer makes the following recommendations:

SERCO should explore with Nurse D why the defibrillator and suction equipment were not made available while awaiting the arrival of paramedics.

SERCO in partnership with the PCT should review the content and frequency of resuscitation training for all healthcare staff, and particularly those who may be called upon to act as Hotel 4, to ensure that they can function effectively at the scene of an attempted resuscitation.

The clinical reviewer adds that if the current training regime is deemed to be adequate, he recommends:

SERCO should explore with Nurse D why she could not make the oxygen cylinder work and take further action, as appropriate.

192. The clinical reviewer says that at the time when the code blue was called, Nurse D was acting as Hotel 4. She was the only nurse on duty in the Enhanced Care Facility, and could well have been dealing with a crisis in the ECH, while at the same time being required as Hotel 4. The clinical reviewer makes the following recommendation:

The Governor in partnership with the PCT and SERCO should undertake a review to determine whether the risk of such an occurrence is acceptable, or whether staffing rotas should be altered to ensure that a nurse working on her own in the Enhanced Care Facility is not given the task of Hotel 4.

193. At interview, Nurse D said that she may have been delayed in her response to the code blue call because she was working on clinically sensitive, personally identifiable information, when the call came through. She said that she had to save her work and close the computer down. Although he commends her attention to patient confidentiality, the clinical reviewer says he was surprised to learn that the nurse was unable to save her work and lock her workstation within a matter of seconds. The clinical reviewer makes the following recommendation:

The PCT in partnership with SERCO should ensure that all healthcare staff receive full and ongoing training in the use of System One.

Doctor A

194. The clinical reviewer says that Doctor A appears to have received very little induction training on her first appointment to the prison and none at all concerning her role in an emergency. He regards this as a startling omission and makes the following recommendation:

The Governor, in partnership with the PCT and SERCO, should develop a comprehensive induction pack for doctors commencing temporary or permanent appointments at HMP Leicester and any other establishments at which it is contracted to provide medical services. This should include a clear description of the role of the doctor and the expectations of him/her. It should also include a full set of protocols under which the healthcare department works and include a clear description of the support that the doctor can expect from other members of staff, both in healthcare and discipline.

195. The clinical reviewer goes on to say that Doctor A made a number of assumptions when she was called unexpectedly to attend the man, including the availability of equipment and the training of other staff present. In his opinion, she should have taken immediate steps to establish whether her assumptions

were well founded. Doctor A should have realised that, as the only medically qualified person at the scene of a medical emergency, other people would be looking to her for leadership. Additionally, she should at least have asked questions to establish whether there were others there who were better qualified than she was in basic or advanced life support to whom she could explicitly defer.

196. The clinical reviewer also notes the conflict of evidence between Doctor A and SO B regarding a discussion about the ratio of chest compressions to ventilations in CPR. The clinical reviewer says that no one else recalled the conversation, and that Doctor A's basic life support training was so far out of date that she would not have been aware of the 15 - 2 ratio that SO B says she mentioned. On the balance of probabilities, the clinical reviewer is of the opinion that the conversation did not take place between Doctor A and SO A. However, he adds that it is possible that someone mentioned it to SO A, but because she was concentrating so hard on what she was doing she did not register who it was.
197. Further to this, the clinical reviewer notes the conflict of evidence between Doctor A and SO B regarding whether the doctor asked the SO if she would like her to take over CPR. He says that SO B was concentrating on what she was doing and may have missed Doctor A asking her. On the other hand, no other witness recalls Doctor A asking SO B if she would like her to take over, although they simply may not have heard. The clinical reviewer has been unable to reach a conclusion on whether Doctor A asked this question or not.
198. In the clinical reviewer's opinion, the performance of Doctor A on 5 December fell short of what might have been expected of her as a doctor but he notes that her role had not been defined to her. He has been unable to determine whether Doctor A's performance was indicative of her general performance as a GP, or whether it reflected a one-off response to a difficult set of circumstances. The clinical reviewer makes the following recommendation:

The Clinical Governance Lead for Leicester City PCT should consider whether Doctor A's performance warrants formal referral for further investigation to the Clinical Governance Lead at the Primary Care Organisation on whose performers list Doctor A appears.

The Clinical Governance Lead for Leicester City PCT should invite Doctor A to reflect upon this incident as a formal part of her professional development.

The Clinical Governance Lead for Leicester City PCT should invite Doctor A to consult her appraiser (or if she is between appraisers, her local Post Graduate Tutor) about the learning points from this incident, without waiting for her next appraisal.

The Clinical Governance Lead for Leicester City PCT should invite Doctor A to consider the desirability of annual updating in basic life support (as

encouraged by the Quality and Outcomes Framework for all clinical staff in General Practice).

The Clinical Governance Lead for Leicester City PCT should invite Doctor A to consider whether she needs to develop her clinical leadership skills and whether she needs to undertake assertiveness training.

199. I have been concerned to learn that Doctor A did not examine the man when she arrived, choosing instead to allow prison officers to carry out CPR in extremely difficult conditions, hoping for a miracle. I am in full agreement with the clinical reviewer in that she should have taken control of the situation and examined the man. Had she done so, it might have informed the decision on whether it was right, proper and decent to continue with CPR. Instead, she did nothing.

Cardiopulmonary Resuscitation (Officer F)

200. The clinical reviewer reports:

“... cardiac arrest is the term used to describe the state where the heart stops pumping blood around the body. There are very many causes of cardiac arrest but only a few mechanisms whereby the heart ceases to be able to pump effectively. The commonest mechanisms are asystole and ventricular fibrillation. Asystole describes the complete cessation of electrical activity within the heart, leading to a complete failure of the heart muscles to contract and pump blood. Ventricular fibrillation describes a major disorganisation of the electrical activity of the heart, leading to complete disorganisation of contractions of the heart muscle, leading in turn to failure of the heart to pump blood. Ventricular fibrillation can sometimes be treated by applying an electric shock to the heart (defibrillation) but, if left untreated, it decays into asystole, which is irreversible (except in some special circumstances in the hospital setting). Cardiopulmonary resuscitation is designed to keep a basic circulation going until the cardiopulmonary status of a pulseless patient can be adequately assessed and defibrillation attempted if there is ventricular fibrillation. It can be delivered by one trained person but is more effectively delivered by two trained people. CPR has a low success rate – even in hospital, where facilities are optimum, only about 14% of people in whom CPR is attempted survive to be discharged from hospital.”

201. Bearing in mind that Officer F was performing resuscitation for some considerable time, the clinical reviewer has considered his actions. In his clinical review, he says that it is recommended that, providing there are sufficient trained people available to enable the tasks to be rotated, no one person should continue CPR for more than two cycles. This is because a person's ability to effectively maintain a circulation declines with time due to fatigue. The clinical reviewer makes the following recommendation:

The Governor should consider reviewing CPR training to ensure that trainees understand the importance of not continuing cardiac compression

for too long, providing there are others present who can take over and give them a rest.

202. The clinical reviewer adds that he has made a previous recommendation in relation to HMP Leicester for the Governor to consider whether there should be a structured approach to ensuring that officers with basic life support skills are available in all parts of the prison at all times. Although I make no formal recommendation, I invite the Governor to consider the point.

Resuscitation masks

203. The clinical reviewer says that Officer F showed dedication in continuing to try to ventilate the man, despite profuse vomiting. However, he adds that the officer placed himself at personal risk of aspirating vomit, which could have had short term or long term effects upon his health. (I comment further on Officer F's actions below.) The clinical reviewer makes the following recommendation:

The Governor in partnership with the PCT and SERCO should consider the provision of Rescusi-Aid mouth protectors (or similar) for all staff, especially those who have been trained in CPR.

The Governor in partnership with the PCT and SERCO should consider the necessary training and regular updating in their use.

The Governor in partnership with the PCT and SERCO should consider the widespread provision of the more robust, effective and safer Laerdal (or similar) masks and the training and ongoing updating of appropriate staff.

204. The clinical reviewer concludes that, on the basis of the observations of the various witnesses and on the balance of probabilities, the man was beyond resuscitation by the time he was found and taken onto the landing. He says that Nurse D and Doctor A are timed as having arrived on the scene eight minutes after the alarm was raised and five minutes after resuscitation had begun. The clinical reviewer adds that he had personally walked from the Enhanced Care Facility to the scene in three and a half minutes, but had allowed no extra time for closing down a computer, speaking to the doctor or collecting equipment. He estimates that this might have added an extra minute or so to the time. The clinical reviewer adds that he has been unable to determine any clearly avoidable cause for delay, other than Nurse D possibly missing the initial call and then logging off the computer. He goes on to say that it is possible that Nurse D and Doctor A moved more slowly than he did. (However, as noted, Doctor A said they ran.)
205. The clinical reviewer says that paramedics arrived four minutes after Nurse D and Doctor A and then took over resuscitation one minute later. He believes that it would have taken most of that four to five minutes to get the suction machine and defibrillator to the scene. Further delay would have been caused by having to unpack them, to suck out the man's airway, prepare the defibrillator and to apply the pads to him.

206. The clinical reviewer does not think that any of the slight delays which might have been avoided would have made any difference to the ultimate outcome for the man. He adds that he has made his recommendations on the basis that in different circumstances, for example where a prisoner was found earlier and where the paramedics' arrival was delayed, there is a potential for improving matters and possibly altering outcomes.

Senior Officer B and Officer F

207. Without doubt, SO B and Officer F could be forgiven had they decided not to attempt mouth to mouth resuscitation without proper protection. The man had vomited, but despite this they chose to attempt rescue without waiting for replacement equipment. This meant that they placed themselves at potential risk of cross contamination.

208. It is my view that both officers went far beyond that which is expected of any member of prison staff and that they are a credit to the service that they represent. It is for this reason that I make the following recommendation:

I invite the Governor and Prison Service to formally commend the actions of Senior Officer B and Officer F.

CONCLUSION

209. Considering the man was in prison for just two days, the investigation into his death has exposed a number of issues that are a cause for considerable concern. Equally, it has identified the extraordinary lengths some members of prison staff will go to in order to try to save a life. Although of no comfort whatsoever to the man's family, the actions of Senior Officer B and Officer F were exemplary.
210. That said, I cannot be satisfied with the way the man was cared for at HMP Leicester. The Prison Service has well embedded tried and tested systems in place to protect those who are vulnerable and at risk of suicide or self harm. The man was entitled to receive that level of care, but instead he was let down and left unsupported for the majority of his short period in prison. I also believe that the actions of several of the medical staff who dealt with him were inadequate.

RECOMMENDATIONS

1. The Governor should consider investigating the actions of Senior Officer A further.

Accepted: "A disciplinary investigation into the actions of SO A was carried out by the Health Care Manager at HMYOI Glen Parva. The investigation identified a number of errors in line with the PPO findings but also identified other staff who were involved in the decision to close the ACCT document. The report recommended a number of actions relating to training and development which have all been accepted and implemented."

2. SERCO clinical management should review Nurse A's appraisal history and work with him to assess his attitude to his job and ensure that he is performing to his full potential.

Accepted: "SERCO have conducted an investigation and a disciplinary hearing based on their findings. Nurse A has received a written warning and is currently undergoing a supervised three month training programme. This matter will also be referred to the Nursing and Midwifery Council."

3. SERCO should review Nurse C's performance on the afternoon of 5th December with a view to determining whether she has training needs and whether her breach of the Nursing and Midwifery Council's directions regarding record keeping, was an isolated incident, or whether it reflects a pattern of poor performance.

Accepted: "A SERCO investigation has taken place, the outcome of the disciplinary hearing which follows will be forwarded to the Nursing and Midwifery Council for direction."

4. SERCO should consider whether further investigation is required into Nurse D's actions.

Accepted: "A SERCO investigation has taken place, the outcome of the disciplinary hearing which follows will be forwarded to the Nursing and Midwifery Council for direction."

5. The PCT in partnership with SERCO should review the healthcare training and ensure that any member of healthcare staff acting as Hotel 4 takes a defibrillator and suction equipment to the scene of resuscitation.

Accepted: "Additional defibrillator has been ordered, SERCO staff have undergone training in Immediate Life Support (ILS), SERCO have employed a trainer in ILS as part of their nursing team. "

6. The Governor should reconsider the availability of tools for cutting strong ligatures and ensure that it is not the responsibility of healthcare to supply them.

Partially accepted: "All staff at HMP Leicester with prisoner contact are issued with a cut down knife, further equipment is held in all prisoner areas, this included a tool for cutting strong ligatures."

7. The Governor, in partnership with the PCT and SERCO, should consider the positioning and availability of defibrillators, suction equipment and oxygen cylinders, and particularly their transportability.

Accepted: "An additional defibrillator has been ordered, the East Midlands Ambulance Service has been asked to review all of the emergency equipment at HMP Leicester."

8. SERCO should explore with Nurse D why the defibrillator and suction equipment were not made available while awaiting the arrival of paramedics.

Accepted: "A SERCO investigation has taken place, the outcome of the disciplinary hearing which follows will be forwarded to the Nursing and Midwifery Council for direction."

9. SERCO in partnership with the PCT should review the content and frequency of resuscitation training for all healthcare staff, and particularly those who may be called upon to act as Hotel 4, to ensure that they can function effectively at the scene of an attempted resuscitation.

Accepted: "Immediate Life Support, SERCO have employed a trainer in ILS as part of their nursing team. Training in ILS has already been delivered to SERCO staff."

10. SERCO should explore with Nurse D why she could not make the oxygen cylinder work and take further action, as appropriate.

Accepted: "A SERCO investigation has taken place, the outcome of the disciplinary hearing which follows will be forwarded to the Nursing and Midwifery Council for direction."

11. The Governor in partnership with the PCT and SERCO should undertake a review to determine whether the risk of such an occurrence is acceptable, or whether staffing rotas should be altered to ensure that a nurse working on her own in the Enhanced Care Facility, is not given the task of Hotel 4.

Accepted: "The nurse carrying the Hotel 4 response radio is no longer given a task working alone on the Enhanced Care Facility."

12. The PCT in partnership with SERCO should ensure that all healthcare staff receive full and ongoing training in the use of System One.

Accepted: "The PCT will provide training in System One for all SERCO staff; an ongoing training programme will then be in place."

13. The Governor, in partnership with the PCT and SERCO should develop a comprehensive induction pack for doctors commencing temporary or permanent appointments at HMP Leicester and any other establishments at which it is contracted to provide medical services. This should include a clear description of the role of the doctor and the expectations of him/her. It should also include a full set of protocols under which the healthcare department works and include a clear description of the support that the doctor can expect from other members of staff, both in healthcare and discipline.

Accepted: "The Governor in consultation with the PCT and SERCO will produce an induction package for all doctors working at HMP Leicester. SERCO will take this forward nationally."

14. The Clinical Governance Lead for Leicester City PCT should consider whether Doctor A's performance warrants formal referral for further investigation to the Clinical Governance Lead at the Primary Care Organisation on whose performers list Doctor A appears.

Accepted: "Information regarding Doctor A's conduct will be forwarded to Leicester City PCT's Fitness for Practice team, who will take the matter to the Performance Review Group and the Local Review Group to determine the course of action in line with the PCT policy and procedures. The Fitness for Practice team will identify the Performers list that Doctor A is on and her current employer."

15. The Clinical Governance Lead for Leicester City PCT should invite Doctor A to reflect upon this incident as a formal part of her professional development.

Accepted: "Information regarding Doctor A's conduct will be forwarded to PCT's Fitness for Practice team, who will take the matter to the Performance Review Group and the Local Review Group to determine the course of action in line with the PCT policy and procedures. The Fitness for Practice team will identify the Performers list that Doctor A is on and her current employer."

16. The Clinical Governance Lead for Leicester City PCT should invite Doctor A to consult her appraiser (or if she is between Appraisers, her local Post Graduate Tutor) about the learning points from this incident, without waiting for her next appraisal.

Accepted: "Doctor A will be contacted by the Fitness to Practice team clinical practice issues and professional development issues, as per the PCT policy and procedures."

17. The Clinical Governance Lead for Leicester City PCT should invite Doctor A to consider the desirability of annual updating in basic life support (as encouraged by the Quality and Outcomes Framework for all clinical staff in General Practice).

Accepted: "Doctor A will be contacted by the Fitness to Practice team regarding the clinical practice issues and professional development issues, as per the PCT policy and procedures."

18. The Clinical Governance Lead for Leicester City PCT should invite Doctor A to consider whether she needs to develop her clinical leadership skills and whether she needs to undertake assertiveness training.

Accepted: "Doctor A will be contacted by the Fitness to Practice team regarding the clinical practice issues and professional development issues, as per the PCT policy and procedures."

19. The Governor should consider reviewing CPR training to ensure that trainees understand the importance of not continuing cardiac compression for too long, providing there are others present who can take over and give them a rest.

Accepted: "Prison staff trained in CPR will attend further briefing sessions facilitated by SERCO's Immediate Life Support trainer, this will include CPR handover techniques and the use of the Laerdal Mask."

20. The Governor in partnership with the PCT and SERCO should consider the provision of Rescusi-Aid mouth protectors (or similar) for all staff, especially those who have been trained in CPR.

Accepted: "Additional Laerdal masks have been purchased and will be located so that they are readily available in all prisoner areas."

21. The Governor in partnership with the PCT and SERCO should consider the necessary training and regular updating in their use.

Accepted: "Prison staff trained in CPR will attend further briefing sessions facilitated by SERCO's Immediate Life Support trainer, this will include CPR handover techniques and the use of the Laerdal Mask."

22. The Governor in partnership with the PCT and SERCO should consider the widespread provision of the more robust, effective and safer Laerdal (or similar) masks and the training and ongoing updating of appropriate staff.

Accepted: "Additional Laerdal masks have been purchased and will be located so that they are readily available in all prisoner areas. Prison staff trained in CPR will attend further briefing sessions facilitated by SERCO's Immediate Life Support trainer, this will include CPR handover techniques and the use of the Laerdal Mask."

23. I invite the Governor and Prison Service to formally commend the actions of Senior Officer B and Officer F.

Accepted: "Both Senior Officer B and Officer F received commendations from the Area Manager."