Investigation into the circumstances surrounding the death of a man at HMP Leeds in February 2007

Report by the Prisons and Probation Ombudsman for England and Wales

December 2009

This report considers the circumstances surrounding the death of a man at HMP Leeds in February 2007. The man, who was 35 years old, was found on his bed with a ligature around his neck at 4.00am.

I would like to offer this public expression of sympathy and condolences to his family and friends on their loss.

The investigation was led by two of my investigators. They were assisted by another investigator. A review of the man's clinical care in prison was carried out by Leeds Primary Care Trust. I am very grateful to the clinical reviewer for his review. I also thank the Governor and staff of HMP Leeds for their cooperation, and in particular the prison's liaison officer for carrying out his role to a high standard.

A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man's mother raised a number of issues with one of my family liaison officers and the investigators. I hope my investigation begins to offer answers to her questions.

This investigation was suspended for over 12 months whilst the police carried out an investigation into allegations that were made concerning the actions of prison staff on the night the man died. (No criminal proceedings have ensued.) In these circumstances there has been a regrettable but unavoidable, delay in my investigation and the subsequent completion of this report.

The investigation has revealed both some excellent care of the man who died, particularly regarding the mental health support that he received, but also some wholly unacceptable care on the night he died. Like previous reports for which I have been responsible, it raises questions about the circumstances under which staff feel able to enter cells at night. All of my recommendations were accepted by the prison at draft stage.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2009**

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SUMMARY

The man who died had suffered with mental health problems for several years. Psychiatric and medical support is well documented as far back as 1992.

In the time leading up to November 1992, the man had taken three overdoses and had been admitted to hospital on several occasions. He was increasingly irritable, impulsive and had often punched and banged doors and got into fights in the street. A consultant psychiatrist considered that the man was suffering from bipolar affective disorder. In January 1993, he received a course of Electro-Convulsive Therapy (ECT). In August of the same year he threatened to cut himself and was admitted to hospital.

Over the next few years the man was seen by a number of mental health specialists, his mother often paying for private consultations and treatment. She was concerned about his mental state and that he had impulses to be violent to himself and others.

In 2001, the man was diagnosed with Crohn's disease. This was the start of the man's anxiety about his physical illness affecting his mental health, and he would often reduce the dosage of his prescribed medication in the belief that it was making him feel worse. In 2005, his consultant was still warning him against this practice.

On 16 September 2005, the man was remanded into custody at HMP Leeds charged with murder. The first of seven ACCT plans were opened on his reception into prison. (ACCT plans are designed to support those prisoners who have been identified as being at risk of self-harm or suicide.) The man who died spent more than 50 per cent of his time at HMP Leeds being supported by an ACCT plan. The man did not think that he should have been sent to prison, believing that it was his condition, and/or the treatment of his condition, that was the cause of all of his problems. He continued to suffer with mental health difficulties.

On 7 April 2006, the man was sentenced to life imprisonment with a recommendation that he should serve a minimum of 20 years. He remained at Leeds prison. On 7 February 2007, his appeal against sentence was refused. When he returned to Leeds from the Appeal Court on 10 February, he was placed on another ACCT plan.

On the evening of 21 February, the man passed a handwritten letter to Senior Officer (SO) A and asked him to sign it as a witness. The letter was intended to change his will in the event of his death. The man was at that time being monitored hourly through the day, and half hourly through the night, as part of the ACCT plan. The SO sought advice from Officer A, who advised him to speak to the duty governor. The duty governor told him to arrange for the man to be assessed by a mental health nurse. The nurse was unaware that the man had recently been refused an appeal, although the information would have been available if he had checked his medical computer record. He asked the man if he intended to harm himself, asking how he was at that time, what the change of will was about, and whether he had any intention of hurting himself. The man said he was okay and it was just to keep his family in touch. He said that he was moving on to another prison and wanted to get

everything in order before he transferred. The nurse accepted the man's response that he would not harm himself. He knew that the man was located in a 'safer cell' (a cell designed to have reduced or no ligature points). The nurse also knew what his ACCT observation levels were and believed that he was not at risk. The observation levels on the ACCT remained unchanged.

The man returned to his cell. The SO signed the letter (his will) and asked the Night Orderly Officer (NOO) to sign it as well. The man was in cell D2-18, where he was the only occupant. Officer A, the wing night officer, made an entry in the ACCT at 8.15pm that the document had been "handed over to night staff". A management check was made by the SO at 9.05pm.

The man who died should have been observed every half hour and these observations should have been recorded. However, only hourly entries regarding the observations were made between 9.00pm and 3.00am. An OSG made three consecutive entries between 12.00am and 3.00am. He said that Officer A was asleep during this time. A final entry, recorded at 4.00am, was made by Officer A. This entry was made after the man's death.

At approximately 4.00am on 22 February, the OSG saw the man in his cell. He was immediately concerned about the way he was lying on the bottom bunk. He tried to get a response by calling the man's name and kicking the cell door. There was no response and he could see no signs of breathing. He was concerned and went to tell Officer A. Officer A went to the cell with the OSG and tried unsuccessfully to get a response from the man. Officer A knew the man and that he had recently been refused his appeal. He also knew about the will. Although he had a cell key for use in an emergency, and access to a radio with which he could quickly summon assistance, he walked off the wing to speak to the night orderly officer.

When the NOO was briefed by Officer A, there was no indication of urgency in his briefing. She telephoned the Healthcare Centre and spoke to a Healthcare Officer to ask him to send a nurse to D Wing as she was going to open a cell. The NOO then returned to the man's cell with Officer A and another officer. When she reached the cell she too tried to get a response from the man. She then opened the cell door. She found the man had a ligature attached tightly around his neck and fixed to the bed. It was removed. Nurse B arrived at the cell, and examined the man and felt a very weak pulse. He was placed on the floor and the nurse commenced CPR (chest compressions). She asked for a radio call to be made for further medical assistance. Shortly afterwards, two more nurses arrived and CPR continued until the paramedics took over resuscitation. Sadly, the man was not revived and was pronounced dead at 4.49am.

I am satisfied that, in the months leading up to 21 February 2007, staff at HMP Leeds did everything they reasonably could to care for the man's physical and mental health and to respond to the concerns raised by members of his family. However, I am not satisfied with the level of attention provided on the night of his death. The delay in gaining entry to the man's cell was, in my view, wholly unacceptable.

THE INVESTIGATION PROCESS

1. The investigators opened the investigation on 27 February 2007. They discussed the circumstances surrounding the man's death with the Police Liaison Officer at HMP Leeds. Due to concerns about the staff response on finding the man, a police enquiry was undertaken and presented to the Crown Prosecution Service (CPS). The allegations were not proceeded with and no staff were formally charged.

2. On 26 April, an investigator, accompanied by one of my Family Liaison Officers, met the man's mother, brother and family solicitor to discuss the investigation and to be briefed on the concerns raised by the family. Many of the concerns raised have been responded to in the Issues section of my report.

3. During this period my investigation was suspended so as not to compromise the police enquiries. A Detective Constable provided the investigator with a full set of documents used by the police, including witness statements. My investigators resumed their investigation in July 2008.

4. A post mortem examination was carried out. The report, dated 4 July 2007, concluded that the man death was caused by hanging.

5. During November 2008, the investigators interviewed discipline and healthcare staff. On 9 December, lead responsibility for the investigation was given to another investigator.

6. In January 2009, the investigator and the clinical reviewer, interviewed three nursing staff, two at HMP Leeds and one at HMYOI Wetherby. During February, the investigators interviewed another 17 staff at Leeds. They included nursing staff, discipline staff, a governor and a member of the Independent Monitoring Board.

7. My investigators met with a member of the IMB at Leeds. She informed them that the IMB had not received any applications from the man who died and had no recollection of him being brought to their attention.

8. On 11 March 2009, the investigator, accompanied by the Family Liaison Officer met the man's mother and her solicitor to provide a briefing on the progress of the investigation and respond to earlier concerns raised by the family.

9. Some further staff interviews were carried out in April. A total of 30 staff were interviewed in the course of my investigation.

HMP LEEDS

10. HMP Leeds is a category B local prison, dating from 1847. It accepts adult male prisoners from courts in West Yorkshire and has 680 cells, plus rooms and wards for 26 in the Healthcare Centre. The prison has an operational capacity (maximum crowded capacity) of 1,150 prisoners, and always functions at or near this figure. It expanded from four to six wings in 1994.

11. The 'Safer Custody Programme' was introduced as a pilot programme in Leeds in October 2003. The multidisciplinary programme is four weeks long and takes referrals according to a needs-based scoring system. Although detoxification plays a significant part in the programme (some 80 per cent of the prison population have substance use problems when they arrive), there are said to be good indications that prisoners who self-harm benefit from attending. The Safer Prisons Committee incorporates violence reduction, anti-bullying and suicide prevention into their monthly meetings and takes a broad view of safer custody issues. The meeting is multidisciplinary and attended by managers and Listener representatives.

12. A prison's Independent Monitoring Board (IMB) is appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record. The following extracts have been taken from the Leeds IMB annual report for the period 1 February 2006 to 31 January 2007:

    ”Healthcare is a well managed and forward thinking department. The Healthcare Manager has excellent working relationships with, and feels well supported by the Governor and Deputy Governor. The Mental Health In-reach Team, in house Mental Health nurses and counsellors have weekly case meetings and we are glad to report that mental health problems are well treated in the prison.”

    “The policy of group input works well towards the aim of safer custody at HMP Leeds. Members of the group include the responsible Governor, Suicide Prevention Coordinator, staff from Safer Custody Section, Anti-Bullying team, psychology department, Healthcare, Chaplaincy department, Wing Liaison officers, Samaritans, Prisoner Listeners from each wing, Listener Coordinator and GSL. Feedback is discussed and actions are decided at the monthly meetings. The opening and closing of ACCT self-harm files is monitored and statistics are produced for each monthly meeting. The opening and closing of ACCT self-harm files is monitored and statistics are produced for each monthly meeting. Staff are trained fully in the completion of the details which need to be endorsed on the files. Incidents of self harm are recorded in numbers and in types of

harm. To assist the work of the Suicide Prevention Officer, the role of Listener Coordinator was established and this has been very useful."

"Staff encounter difficulties in moving life/IPP prisoners on the first stage lifer unit. The Board understands that places are available but not necessarily within the area. Out of area transfers seem very difficult to arrange and the board feel that this is an issue that needs to be addressed nationally."

13. The IMB report concluded that HMP Leeds is a local prison always operating at full capacity, dealing with incidents on a daily basis, with a caring and dedicated staff working together, plus a good senior management team.

14. Dame Anne Owers, HM Chief Inspector of Prisons, carried out an unannounced full follow-up inspection of HMP Leeds between 22 and 26 August 2005. Her report described Leeds as:

> "… a large and overcrowded local prison. It is operating at 75 per cent above its certified normal accommodation, with a transient and usually short-stay population. It exhibits, in acute form, some of the problems associated with our overcrowded prisons. The prison had managed to sustain good first night procedures and most prisoners felt safe on reception into the prison. There were some good safer custody procedures and a well-regarded Listener scheme, which was effective and valued by prisoners and staff. The ACCT procedures had been introduced in March 2005 and interviews were taking place promptly, although there was some concern about the quality of the entries. There were 25 life-sentence prisoners in custody at the time of the inspection. Nine of these had spent over 12 months waiting to be transferred to a first stage lifer prison. A repeat recommendation was made that this process should be accelerated."

15. An area of good practice was the Leeds prison visitors centre, a charitable organisation set up and run with the support of the prison. It was described as an innovative and creative link between the prison, families and the community. My investigators support the view that this is good practice.

16. The number of prisoners in the prison when the man died was 995.

17. There had been eight deaths at HMP Leeds between April 2004 and February 2007 and a further 11 since that date. This is the first self-inflicted death to occur in a safer cell at Leeds. In another case I investigated in 2007 I made the following observations and recommendations:

> "When the man was found, the alarm was raised via the prison radio net. The SO was in charge of the prison at the time. He added that as he approached the cell he shouted to Officer A to break into his sealed pouch and open the cell door. Officer B arrived at about the same time as the SO. He told my investigator that Officer A was still outside the cell at that time.

"In interview, the SO told my investigator that he would not expect any member of staff to enter a cell on their own at night. He added that officers are expected to wait for another member of staff to arrive. The Prison Officers' Association (POA) representative who accompanied the SO advised at the interview that, "It's down to the individual person's discretion, as long as they don't think it's a set up, I mean if there's only one person in the cell it's a bit clearer."

KEY FINDINGS

18. On 16 September 2005, the man was remanded into custody and taken to HMP Leeds. An ACCT plan was opened and he was located in the Healthcare Centre to be checked every half hour. The Prisoner Escort Report noted that the man suffered from depression and Crohn's disease. The Cell Sharing Risk Assessment recorded that he was very low in mood and had been receiving antidepressants for the previous 15-16 months.

19. Four days later on 20 September, an ACCT assessment was carried out and the man insisted that he did not feel suicidal or at risk of self-harm. He was described as detached from events, showing no emotion and very calm. It was decided that he should remain on the ACCT plan and he was referred to the Mental Health In-Reach Team (MHIT).

20. On 22 September, the man's previous medical records were faxed to Leeds MHIT. They confirmed a diagnosis of anxiety, depression and somatic physical symptoms. It was also confirmed that he had been prescribed Prozac 40mg. As there was no evidence of acute mental illness, plans were made to discharge the man to the main prison on 6 October. It was noted that he continued to be obsessed with his physical condition.

21. On 11 October, the man who died was seen by a psychiatrist who confirmed that he was fit to be moved from the Healthcare Centre to the main wing. Later that same day the man became aggressive and abusive and so it was decided that he should remain in the Healthcare Centre. The next day (12 October), the man barricaded his cell door. He eventually removed the barricade and was taken to the Segregation Unit and placed on a disciplinary report. The adjudication was later dismissed.

22. Although there is no specific record, it appears that when the man's mother and his two brothers went to visit him for the first time, the visit was not allowed to go ahead as the man was located in the Healthcare Centre and was only allowed to be unlocked by three staff. The family met a woman, Ms A, in the Visitors Centre. (Ms A woman was employed by a charitable agency and her role was to offer reassurance, information, advice and support to the families of prisoners.) Ms A was allowed access to the prison and its prisoners and she went to the Healthcare Centre to speak to the man at the request of his family. He signed a letter that was needed for his legal defence. Ms A informed the family that the man did not make eye contact with her, would not engage in conversation and seemed to be highly medicated.

23. On 24 October, the man broke two windows in his cell with his fist. He was moved to D Wing. The following day (25 October), the man was seen by Mr A from the Mental Health In-Reach Team. He told Mr A that he had smashed the windows because he felt an "inner turmoil". Mr A carried out a mental health assessment and described the man as displaying paranoid behaviour, but not showing any other psychotic ideas. No risks were highlighted and the man said that he felt fine about being moved to another wing.

24. The ACCT plan was closed following a review on 27 October which the man attended. The review concluded that, although the man's thoughts were disordered, he appeared to be managing well. He had not given any indication that he would deliberately harm himself since coming into custody.

25. On 2 November, the man's mother spoke to Mr A about her concerns. She was told by Mr A that he intended to see the man each week to monitor his condition.

26. Four days afterwards, on 6 November, the man's mother wrote to the prison asking for a meeting to discuss her son's mental and physical condition. She felt that he was not getting the help that he needed, his medication had been stopped, and he was deteriorating. This letter was followed by a further telephone call to the prison on 8 November.

27. Governor A wrote back to the man's mother on 11 November. He confirmed a conversation he had had with her by telephone on 8 November. He reassured the man's mother that her son's medication had not been stopped. He asked her to contact him if she had any further concerns. On the same day a second ACCT plan was opened as the man had made a small cut to his wrist whilst being seen by the psychiatrist. He stated that he was frustrated that his physical health needs were not being met and wanted something done quickly. He said that he had no suicidal thoughts or intentions.

28. During adjudications on 16 November and 18 November, the man was fined for damaging his cell furniture and denying staff access to his cell. The ACCT plan was subsequently closed following a review on 25 November.

29. On 28 November, the man was seen again by Mr A who thought he appeared more rational than on previous visits. The man's father also telephoned the prison as he was worried that he had not been contacted by his son since an earlier visit. The man was spoken to and said that the visit was not a good one, but that he was okay and would telephone his father.

30. The man who died next saw Mr A on 1 December when he said that he was concerned about what would happen at court. He denied any suicidal thoughts but said that might change depending on what happened at court. the man appeared at Court for the first time the next day and was remanded in custody for trial at a later date.

31. On 13 December, a third ACCT plan was opened on the man. He had scratched his wrists during the night and then told his mother. Again he said that he had thought about harming himself, but could not do it. (This ACCT plan remained open continuously for five months until 2 May 2006 and the man continued to have regular support from Mr A.)

32. The man often complained about his medication, stating that he self-harmed for this reason. It was reviewed by a doctor on 31 December, who agreed to his request to increase the Olanzapine and also prescribed Librium for his

anxiety. The man remained dissatisfied and asked for another review two weeks later.

33. During January 2006, educational material was arranged to be taken to the man as he did not want to attend education classes within the main prison. He wanted another review of his medication, not being satisfied with the one planned for 24 January. On 26 January, he was described as distressed, still unhappy about his medication and saying that Prozac would be better for him.

34. On 1 February, a risk profile assessment was completed by Leeds MHIT. It identified the man as a potential risk to staff and noted that he required a more detailed risk assessment. (Further psychological assessments were carried out on 18 September and 15 November by a clinical psychologist.) The man was displaying high levels of anxiety and was voicing concerns of being "unable to carry on". The assessment stated that the man was to be considered dangerous if his mental health was not continually monitored. Ongoing support was in place, including regular meetings with MHIT staff, medical reviews, access to Listeners, and referral for psychological work.

35. The man who died continued to be agitated during February, complaining that his medication was ineffective and wanting to change it. His mood was changeable, at times he did not cope or sleep well, and he asked for stronger medication. At other times his mood would improve. His mother wrote to the prison as did the woman from the Visitors Centre, and both voiced their concerns about him. Their letters were responded to by the Head of Healthcare, who said that the man was receiving the appropriate medical supervision. He continued to see Mr A on a regular basis.

36. On 15 February, the man told an officer that he was expecting a three year sentence when he went to court. He seemed very down and agitated and said that if he got a longer sentence he would not be able to cope.

37. The next day (16 February 2006), the man went to a Care Programme Approach (CPA) meeting. This was attended by several staff including Mr A , a Consultant Psychiatrist, Ms A, and the man's Personal Officer. The man's mother and brother were also there. The meeting had been arranged to discuss the man's physical and mental needs and to plan his care for the next few months. Minutes were produced and it appears that everyone present had the opportunity to contribute and voice any concerns. The meeting concluded that the man's complaints about his medication were more to do with his anxiety levels than with his medication. The man's mother asked that he return to the Healthcare Centre where she believed he would be more closely monitored. The consensus was that this would not help his anxieties and that the man could be monitored adequately on the wing where he would see the wing nurse every day. A Care Plan was agreed which included a short-term prescription of sleeping medication, the man was to try to engage in activities and Mr A would provide the man's family with regular updates. Ms A was to continue offering family support. An application made the same day by the man for a cleaning job on the wing was approved. However, on 22 February, he told staff that he no longer wanted to be a cleaner.

38. Despite the agreement reached at the CPA meeting, the man was seen the following day by the MHIT manager about a complaint he had submitted regarding his medication. He was advised that he should commit to his current treatment, but the man said that he no longer wished to take it. Self-harm was discussed and, although the man maintained that he felt suicidal, he had made no recent attempts to harm himself and had used some coping strategies. He asked to be admitted to the Healthcare Centre and was again told that this was not appropriate at the time.

39. March was similar in some respects to the previous month with the man complaining about his medication and wanting it to be changed. He often appeared distressed and asked to move to the Healthcare Centre. On 6 March, the man's mother rang the prison to say that he had called her and told her that he was going to kill himself because of his medication (he was currently prescribed Venlafaxine). He was spoken to by an officer but refused to repeat what he had said to his mother. The ACCT observations were increased from hourly to half hourly and a request was made for him to see someone from the MHIT the next day.

40. The man who died was seen the next morning at 8.00am by a nurse and again at 10.30am by Mr A. The man was agitated and at one point became hostile and was told to calm down. He was moved to the Healthcare Centre for a period of observation but continued to be preoccupied with his medication. Numerous comments, which indicate a positive attitude of staff in response to his anxieties, were documented. On 14 March, he was discharged from the Healthcare Centre and moved to E Wing. He was supervised when taking his medication (Venlafaxine) and ongoing appointments continued. He spoke with Listeners (prisoners trained by the Samaritans to support other prisoners who are at risk of self-harm) and settled on E Wing.

41. On 20 March, the man's trial started at Crown Court. He remained on ACCT monitoring but at 10.00pm the same day he cut his wrist with a razor blade. He was moved to a safer cell in the Healthcare Centre and was checked every 15 minutes. He said that he was worried about his trial but was not sure why he had harmed himself.

42. The man went to his trial each day until 4 April 2006 when he was found guilty of murder. He was spoken to by staff about how he felt and said that he felt emotionless, which he blamed on his medication. Staff talked to him throughout the evening and he was given medication to help him sleep.

43. The man who died refused to eat on 5 April, saying that he was not well and was on hunger strike. The next day he refused his medication and the opportunity to have a shower. He was seen by a Listener, and then collected his lunch. He was worried about his pending court appearance when he would be sentenced. He had a visit from his brother.

44. Two days later, on 7 April, the man was sentenced to life imprisonment with a recommendation that he should serve a minimum of 20 years. He was shocked by the sentence. When asked about his feelings about harming himself, he said "It's a thousand times worse," and claimed that he had committed the offence because of the effects of taking Prozac. An ACCT review was carried out and, due to the increased risk, he was checked every 15 minutes. The man appeared calmer over the next few days and he discussed his feelings openly with staff. ACCT observations were reduced to every 30 minutes. However, he had difficulty coming to terms with his sentence and was reluctant to accept his situation. He began to focus on the possibility of a reduction in sentence. The next two weeks saw a gradual improvement in his mood.

45. An ACCT review was held on 19 April. The man discussed his appeal and the need to "survive". It was agreed that he should be discharged from the Healthcare Centre to D Wing.

46. On 26 April, the man went to the Safer Custody Unit to begin the Safer Custody course. He began asking why he was on the ACCT and said that he wanted to come off it as he had no intention of harming himself. The ACCT plan was subsequently closed following a review on 2 May. On 10 May, the man who died was observed in group work, rocking backwards and forwards, repeatedly saying "20 years". Staff on the unit were concerned about his behaviour and he was seen by Mr A. They discussed his anxiety levels and Mr A noted that the man was "warm and engaging".

47. The ACCT document was reopened on 12 May after the man who died had a visit with his probation officer. He had become very upset when his sentence was explained. The probation officer was concerned about his welfare and state of mind. The man was moved to a safer cell and placed on hourly observations. He told staff that, if his appeal did not come through, they "would find him dead". He did not want to talk about how he would kill himself as he "did not want to be saved". It was agreed that the man would benefit from more time out of his cell, but he refused to consider educational activities as he found that they made him more agitated.

48. When the man was seen on 19 May by the Consultant Psychiatrist, he said that he felt much better, was not anxious or depressed, and had no complaints about his medication (Flupentixol and Venlafaxine). Paradoxically, he said he remained distressed about his sentence and blamed Prozac for everything. An ACCT review took place on 24 May and it was noted that the man continued to struggle with settling in a closed environment. At the end of May, the man was moved to E Wing at his own request.

49. On 6 June, the man went to court and received a further sentence of nine months for an assault carried out on 10 May 2005. An ACCT review was held. Although he was frustrated by the additional sentence, he had begun to go to education which took him out of his cell, and he said he had no more thoughts of harming himself.

50. ACCT plan reviews were carried out on 13 and 20 June. The man still complained about his medication, saying it was wrong and that he should be in a hospital and not a prison. He mentioned that his solicitor was talking about him going to Rampton.

51. The man who died was seen by the Consultant Psychriatrist on 23 June. He was very low, tearful, emotionally isolated and showing a lack of will. He felt hopeless about his future in prison and said that he wanted to give up. He was distressed that his crime had led to a life sentence and felt that he had not been thinking correctly at the time of the offence. He asked to return to the Healthcare Centre. The Consultant Psychriatrist increased the Venlafaxine, looked to increase his activity on the wing and said that wing staff and Mr A would support him.

52. Further ACCT plan reviews were carried out on 27 June and 4 July. There was no change in the man who did not want to do anything productive. It was noted that his medication had been increased and that he had no current thoughts of self-harm.

53. On 4 July, the Head of Healthcare Services, wrote to the man's mother in response to her letter dated 24 June. She told her that her son's condition had been fully investigated and that he was receiving appropriate medication. The Head of Healthcare Services had talked to Mr A and was assured that he had been seen on numerous occasions by the Consultant Psychiatrist. She wrote that the man was being encouraged to participate in prison activities such as education, and asked the man's mother for her support and encouragement. The Head of Healthcare Services ended the letter by saying that she hoped that a joint approach towards the man would help him and, if she had any further concerns, she should contact her.

54. The man met the Clinical Psychologist on 6 July, for the first of a number of sessions. She had been asked by Mr A to assess the man. He met the Clinical Psychologist again a week later. She noted that he was "brighter" and they discussed goals for therapy. The man was happy to work on his thoughts which might help reduce his agitation, alongside other interventions, such as medication and daily activity. The man missed his next appointment on 20 July as he did not get out of bed, but later insisted that staff had not called for him.

55. ACCT reviews were carried out on 18 July, 21 July and 4 August. The man was feeling better and staff were trying to organise a job for him. He felt that his ACCT observations could be reduced to hourly as he had no more thought of self-harm. He appeared to be responding to staff encouragement by coming out of his cell more often and going to association and exercise.

56. The man met the Clinical Psychologist again on 7 August. He was noted to be agitated and low in mood. His sleep pattern was disrupted and he slept through the day but not at night. He said that he did not like being in prison and was waiting for his court appeal. He felt negative and had thought of ending his life, although he denied any self-harm. He was not motivated or

interested in any activities and continued to link his medication with his stomach and bowel problems. He agreed to a change in his medication and the Flupentixol was stopped.

57. On 8 August, another ACCT review took place. The man's mother had told him that his appeal had been refused. He had built up his hopes on the appeal and now felt hopeless. He said that he did not feel like getting out of bed or taking care of himself, and did not know if he could move forward. The ACCT observations were increased to 30 minute intervals. A further review was carried out the next day when the man was initially stable, but then became more and more upset. He was focussed on his anxieties about his health and thought that if they were addressed he would be able to face the future. He was assured that he would not be alone.

58. The next day a friend of the man sent a letter to the Governor. He had visited the man and was concerned that he was not receiving the right attention, that he had deteriorated, and that he believed him to be suicidal. The friend thought that the man should be sent to a secure hospital. (My investigator has found no evidence of a response to this letter.)

59. The man's mother wrote the same day to the Consultant Psychiatrist and the Head of Healthcare enclosing copies of a psychiatric report from Doctor A and a letter from Doctor B (a friend of the family). Dr A's report had been completed in February 2006 and was prepared at the request of the man's defence solicitors. The report concluded that the man displayed characteristics of a number of personality disorders, which were not however sufficient to justify compulsory hospital treatment and did not constitute a mental illness. The man's mother was asking for the medical help that she felt her son needed in a hospital environment. The Head of Healthcare Services responded on 11 August, saying that the man had received all of the clinical care possible whilst he was a prisoner at HMP Leeds and would continue to do so. In respect of a secure unit, she wrote that this would require the man to be compulsorily admitted under the Mental Health Act by two consultant psychiatrists. She commented that Dr A did not agree with this course of action at the time.

60. An ACCT review was carried out on 10 August. The man was reportedly much brighter, had had a haircut, and talked about the future and a further appeal. He also discussed interventions by the MHIT and was happy to engage with them. His ACCT observations were reduced. He met the Clinical Psychologist the same day. They talked about his physical symptoms and the Clinical Psychologist noted the man's severe anxiety about his health. They discussed how to focus on the psychological factors that affected it. She also discussed his early years. The man said that he was keen to pursue an appeal against his sentence, which he would be discussing with his solicitor.

61. Another ACCT review was held on 22 August. The man was tearful and asked for help from the MHIT and a transfer to a psychiatric facility. An ACCT review was held a week later at which the man who died appeared more

stable. He said he was feeling good and had no more thoughts of self-harm or suicide. After a lengthy discussion it was agreed that his observations should be reduced to hourly.

62. On 31 August, a receipt for a renewal for leave to appeal was received. The man met with the Clinical Psychologist the same day when he seemed upbeat and not as agitated as usual. He said he would eventually like to come off his medication. He discussed his teenage years.

63. An ACCT review was held on 5 September when the man said that he had no more suicidal thoughts. The review considered whether to close the ACCT plan and the man agreed that it should happen. The ACCT plan was closed that day.

64. On 7 September, the man met the Clinical Psychologist again. He was very focussed on his stomach problems and linked them with his Flupentixol medication. He appeared to realise that there were techniques that could reduce his physical symptoms and to accept that the symptoms of Crohn's could not be cured. A further meeting with the Clinical Psychologist took place a week later. The man said that he was not sleeping very well and wanted to stop taking his medication. They discussed methods of coping, such as relaxation, distraction and exercise. He mentioned the ringing in his ears again.

65. The Clinical Psychologist completed a Clinical Psychology Assessment Report on the man on 18 September. She reported that he had attended ten one-hour sessions with her. The conclusion to her four page document was that she intended to continue working with the man. Although he was not yet convinced of the benefits of psychological work, he was beginning to see the link between his experiences and his current symptoms. He continued to blame his symptoms and his anxiety on the medication, but recognised that thinking negatively affected his mood and his health.

66. The man who died next met the Clinical Psychologist on 21 September. He said that he had stopped taking some of his medication (Flupentixol), but had not told the Consultant Psychiatrist. He said he did not feel agitated since stopping the medication and had noticed that the ringing in his ears had lessened.

67. Another ACCT plan was opened on 27 September as the man said he felt suicidal and was pacing around his cell. He said he could not control his feelings, was not sleeping, was depressed and had problems with his medication. He was moved to a safer cell on D Wing, with hourly observations. The man said that he had tried to kill himself, and that he was tired and worn out.

68. The following day, an ACCT review and a second CPA meeting were held. The man's mother and brother were present at the latter, along with Governor A, the Consultant Psychriatrist, Nurse A (RMN), Ms B (Probation), Mr B (MHIT), Officer B (Personal Officer), and other MHIT staff. They discussed an

assessment for his suitability to transfer to the Dangerous and Severe Personality Disorder Unit at HMP Frankland. This assessment had not been fully completed at the time of the man's death, but it was unlikely to have been the appropriate place for him to transfer to. The man said that the safer cell had no benefit to him and there was no air in it. Suggestions were made about attending the gym and trying to engage in meaningful activity. The man felt that his problems were caused by his stomach and that this affected the rest of his body. He did not believe that his stomach problems had been properly investigated. He wanted to continue the antidepressants (Venlafaxine) but said he did not feel suicidal. He said that he used being on ACCT monitoring as a means of seeing Governor A.

69. Officer B commented during the meeting that the man spent most of his time in his cell as he did not work. Work on different wings had been offered, but he felt that none of the jobs were appropriate. Officer B believed that being on an ACCT plan might actually be hindering the man's progress. He highlighted that the previous ACCT had been closed several days previously on 5 September, and that the current ACCT was opened due to the man's frustration about his medication and physical condition. At interview, Officer B described this as shortcutting the system as some prisoners believed that they could get quicker access to governors and doctors if they were on ACCT. Governor A said that he had seen the man on many occasions and was happy to see him whenever he made an application. He believed that the man was "giving in" and needed to try harder to help himself and admit to himself that most of his problems were related to anxiety. Governor A also believed that the man did not need to be on an ACCT. The Care Plan noted that the man was to see the doctor, go to the gym for remedial work, and move to another cell with a larger window. The man met with the Clinical Psychologist again the same day.

70. The man's next weekly meeting with the Clinical Psychologist took place on 5 October. She noted, "conspiracy theories, medication and physical symptoms". An ACCT review was held on 9 October. The man said that he had seen the doctor that morning (although there is no record of the consultation). He claimed that he was still receiving medication, felt well but was not yet ready for the gym, and could still hear ringing in his ears. The man who died was mixing with others on the wing, felt less stressed and was sleeping a lot better. He also said that he felt he had a lot going for him.

71. The man was next seen by Mr A on 10 October. He was very jovial and recognised the link between his low mood and his preoccupation with his physical symptoms. An ACCT review was also held. The man said that he had seen the doctor that morning and was feeling well, and repeated what he had said to Mr A.

72. The man met the Clinical Psychologist on 19 October. He was animated and spoke at length about the effect of antidepressants on his symptoms (ear, nose and throat problems as well as Crohn's disease). He said that he felt let down by the National Health Service and should not be in prison.

73. On 23 October, a letter was sent for an ear, nose and throat appointment at a hospital to investigate the “ringing” in the man’s ears. The man who died also met Mr B (MHIT) and Mr A. His conversation was entirely focussed on his physical symptoms, medication and his efforts to appeal against his sentence.

74. The next day, the man met Ms C. Ms C works on the Safer Custody Unit as a drug and alcohol therapist in a multi-disciplinary team. She had been approached by one of the Listeners and asked to speak to the man because of his emotional state (during interview she could not recall the interaction with the Listener nor remember his identity). The man repeated what he had said to the MHIT regarding his medication problems and the ringing in his ears, and asked to see Governor A. Ms C believed that it might be beneficial for the man to attend the Safer Custody programme again. He agreed and it was arranged for him to go on 30 October. Ms C said that she would speak to Mr A about this.

75. On 26 October, the man met the Clinical Psychologist again. He brought several pieces of paper with him, with lists of symptoms and explanations about why he felt unwell. The Clinical Psychologist noted that there was no clear rationale or evidence in what he produced, other than his personal interpretation. The man talked about wanting to sue the professionals responsible for his problems and said that he wanted to see his solicitor. The Clinical Psychologist challenged how the issues were linked. He said that he was thinking more clearly since stopping his medication (Flupentixol and Venlafaxine). He said that he had started to “put it all together”. The man later said he was now taking his medication again.

76. The Clinical Psychologist concluded that the man’s thought processes were extremely disordered and he had deteriorated mentally. She noted that she would inform the Consultant Psychiatrist. The man saw the Consultant Psychriatrist a few days later on 30 October when he was co-operative, not anxious or agitated, and said that he felt better. Although preoccupied with his thoughts, there was no evidence of hopelessness, self-harm or suicidal ideas and no delusions or hallucinations were noted. The man who died had started taking his medication again, and it was reassessed. The Flupentixol was increased to 0.5 mg and Venlafaxine continued as before.

77. The man met the Clinical Psychologist on 2 November. He talked about the conspiracy against him in his criminal case. He did not talk about his physical symptoms and was preoccupied with his case. He wanted reassurance that he was not talking rubbish. The Clinical Psychologist said that it was difficult for him to prove any of his allegations and they discussed his role in the offence. He had moved from accepting that he was partially responsible, saying that the victim’s family were 100 per cent to blame. He was unwilling to consider that he was responsible.

78. The man’s next meeting with the Clinical Psychologist was a week later. He was more relaxed than in previous sessions, but continued to talk about a conspiracy by the police, government, officials and medical staff. The Clinical Psychologist asked how he thought he would cope with his 20 year tariff if his

appeal was not successful. He said that he would keep his head down, and keep fit because "he has a job to do". The Clinical Psychologist asked him what this job was but he said that he preferred not to say. He indicated that justice would be done with his victim's family. He said he would win his appeal and did not entertain the idea that he would have to complete his sentence. He blamed the offence on his medication, the police, the government and the victim's family. He apportioned only a small amount of blame to himself.

79. The Clinical Psychologist arranged a psychological assessment on 15 November in order to better understand the man's personality. The assessment was carried out by Mr Adams. In summary, the man said he was being open and honest during the assessment. He presented as over-emotional with severe personal difficulties. The Clinical Psychologist believed that this could either be a reflection of his personality, or a reaction to being in prison and having a long sentence. He seemed unable to talk about his feelings and often reverted to focussing on symptoms or blaming others for his offence. He was agitated, preoccupied and low on occasions. His profile suggested that he was prone to chronic depression. His outlook on life was negative and fatalistic. There was an undercurrent of anxiety and he was emotionally detached, whilst dependent on key figures (such as his mother and family) to help him cope with difficulties and problems.

80. The next day, the man met the Clinical Psychologist again. They talked about how angry he felt towards authority figures and how his symptoms seemed to be linked. The man said that his sessions with the Clinical Psychologist were helping. They met again the following week. On 23 November, the man was in good spirits and told the Clinical Psychologist that he was thinking about reducing his Venlafaxine again as he believed it was linked with his physical problems. She advised against reducing his medication without first discussing it with the Consultant Psychiatrist, and the man who died agreed. They talked about his offence and he said he wanted his victims to pay. He felt that his offence would not have taught the family a lesson and wanted compensation from the victim.

81. On 29 November, the man was seen by a locum doctor. He had reduced his Venlafaxine by breaking open the capsules and taking half the contents (75mg down to 37.5mg) so the doctor prescribed 37.5mg tablets to replace the 75mg capsules.

82. The man saw the Consultant Psychiatrist on 4 December. The man said that he felt well and had no problems with his mood or anxiety. He was coping well and was bright and reactive during the interview. They discussed his medication and he agreed to continue taking the reduced dose. He continued to link his medication with his throat and catarrh problems. He was preoccupied with his offence and said that his solicitor had told him that new information had come to light. He felt hopeful about his appeal and that he would not have to spend the next 20 years in prison.

83. Mr B (MHIT) met the man's mother in the Visitors Centre on 5 and 11 December.

84. The man was seen on a number of occasions during December by different medical professionals, including Dr A regarding his Crohn's disease. He complained about his medication and the effect it had on his health. He refused to take the Flupentixol as he believed it was causing rectal bleeding. He signed a disclaimer to this effect on 16 December.

85. At 5.00 pm on 17 December, another ACCT document was opened. The man had been seen rolling about on his bed in his cell, saying he wanted to be "put down". He was allowed to telephone his mother and also talked to a MHIT nurse and the wing Listeners. The man complained about how his health was affecting his state of mind. Initially he said he was not suicidal and would not harm himself. However, when he saw the MHIT nurse, he spoke at length about his physical and mental problems and that he "wanted to end it". He said that he would end his life that night as he could not carry on any more. He asked to see the doctor the next day. The Healthcare Centre was contacted but it was decided not to admit him. The man was placed on hourly ACCT observations. He spent a large part of the day with Listeners and access to a Listener overnight was arranged if required. Mr A was asked to review the man.

86. At 3.00 pm the next day, an ACCT assessment interview was carried out. the man complained of feeling generally unwell and bloated. He said that he had passed blood and felt that his stomach was on fire and so wanted to change his medication. He said that he had felt low the previous day and that, if he had had the means to do so, he would have killed himself. Instead he chose to seek the help of the Listeners. He went on to say that he now felt good, had seen the doctor that morning and felt much more confident and positive. He believed that things would get better. Dr A had reviewed his medication and noted, "will continue same medication pro temp. All seems on a relatively even keel at present." The man was no longer having suicidal thoughts and, when asked if he wanted to kill himself, responded "No, I can sort this out."

87. The man was seen again at 4.00 pm for an ACCT case review. It was carried out by Senior Officer (SO) C, but no other members of staff were present. The man told SO C that he felt a lot better and that he had no feelings of self-harm or of attempting suicide. He appeared to be in better spirits and admitted that he felt better about himself, largely due to his medication being "sorted out". SO C closed the ACCT. There is no record of a post closure interview, which should happen whenever an ACCT document is closed.

88. At approximately 7.45 pm on 20 December, the man was assaulted by another prisoner whilst he was queuing to use the telephone. He was struck on the face and his jaw was fractured. Staff did not witness the assault and no prisoners came forward with any information. The man was unable to identify his assailant, as he was struck from behind. The prison's Police Liaison Officer spoke with the man shortly after the incident and he said that

he did not want to pursue the matter. The man was taken to hospital for surgery to repair the damage to his fractured jaw.

89. Principal Officer (PO) A wrote to the man's cousin on 9 January 2007, in response to a letter she had sent to the prison on 23 December. PO A outlined the circumstances of the assault and said that he had spoken to the man, who had told him he had no idea why it had happened nor who had struck him. PO A had told the man that the prison would investigate any information and would also pass the matter to the police, but the man who died had maintained that he did not wish to pursue it.

90. The man telephoned his mother on 8 and 9 January. He told her he was becoming ill again, could not get help and was very upset. He said he did not want to live anymore. (The man's telephone conversations were not being monitored at the time.) On 10 January, an officer noticed that the man was in an emotional state after making a telephone call. He said that he always got upset when he talked to his family, but that he had no feelings of self-harm. A note was made in the wing observation book by Officer C and night staff were asked to "keep an eye on him". An ACCT was not opened.

91. On 10 January, the man's mother talked to Mr B. She told him that her son was very upset and quite suicidal (presumably from the earlier telephone call). He said he was not getting an "update" on his medication. Mr B said he would speak to the man to tell him that he would get his medication the next day. The following morning, the man was seen by the Consultant Psychiatrist who prescribed 500 micrograms of Flupentixol. Mr B later explained to the man the changes in his medication (he had previously refused to take the Flupentixol).

92. A week later (17 January), the man rang his mother. She felt that he was "very suicidal" and rang Mr B to tell him. The man was seen by the Clinical Psychologist and Mr A the next day. They discussed the assault in December and he said that he did not know who had hit him, but felt he might be at risk again. Despite this comment, the man said he was unaffected by the assault and cared only about his physical health. The man who died gave permission for the MHIT to contact his father with a view to interviewing him for the RAMAS assessment. (Risk Assessment Management and Audit Systems, known as RAMAS, is a system of case planning, treatment and management of people posing a risk to themselves or others.)

93. On 23 January, the man rang his mother and he begged her for help. She rang Mr B again and asked him to see her son. The next day, the man rang his mother once more. He was very upset and crying and said he was poorly.

94. The man was seen by the Clinical Psychologist two days afterwards on 25 January. He was low in mood and said that he was fed up with his medication causing stomach problems. He said that he felt powerless to do anything as he had no future. The Clinical Psychologist asked if he felt suicidal to which he replied he had done since coming to prison. She asked if he had any present thoughts of suicide. The man replied that he did not, but he was fed

up with his situation. He spoke continuously about his health throughout the session. He talked about nightmares that he was having and cried when he described them. The Clinical Psychologist said she would ask the Consultant Psychiatrist to review his medication (which at that time was Venlafaxine 37.5mg and Flupentixol 500 micrograms).

95. A letter was received from the Criminal Appeal Office confirming that the man's appeal date had been set for 7 February.

96. On 6 February, the man transferred to HMP Brixton in order that he could go to his appeal hearing. The next day the man attended the Court of Appeal Criminal Division where his appeal was refused.

97. The man returned to Leeds on 10 February. He was seen in Reception by Nurse C and told her he had lost his appeal. Nurse C opened an ACCT plan at 3.52pm as she was concerned that he had previously contemplated suicide, had lost his appeal and was very low in mood. She wrote that the man had a history of mental health problems and had previously been on an ACCT plan. The Immediate Action Plan was completed by SO D at 4.35pm. It specified hourly observations during the day, with documented interactions in the morning, afternoon and evening, and half hourly observations during the night. The man remained on the induction landing on D wing.

98. Two days afterwards (12 February), Officer D carried out an ACCT assessment interview (this assessment should have been carried out on 11 February). The man said that the doctors were not prescribing the right medication for him. He did not think they knew what was wrong with him and he knew that he should not be in prison. He said he had previously harmed himself and was really fed up. He said that he was in prison due to doctors "fucking" his life up with the wrong medication. He told her that he had been diagnosed with Crohn's disease, depression and social anxiety disorder. He was not getting much sleep and not really eating at the time. When asked if he had any current thought of suicide, the man told Officer C to write down that he was "happy". Officer C wrote the comment "obviously not". The man who died said that he wanted to see someone from the MHIT.

99. On 12 February at 2.05pm, an ACCT case review was carried out by SO E accompanied by three other officers, including Officer D. The man asked for someone from the MHIT to come and see him. The team was contacted and the message left for Mr A, his case manager. The man seemed very quiet and withdrawn in the review. SO E wrote:

> "He has returned from the Court of Appeal with no change in his status and still blames the doctors for not prescribing him the correct medication. I asked him how he felt and he said he was 50/50. He said he was not going to do anything and he last harmed himself 16 months ago. After lengthy discussion we have decided to leave this document open."

100. SO E completed the CAREMAP, listing medication and mental health as issues for the man. He included the action points that he was to be seen by a

doctor and was waiting to see the mental health case worker. SO E also completed the observation section at the front of the ACCT plan. He recorded:

> “3 x conversations per day, 1xam 1xpm 1xE.D. All documented plus hourly observations during the day and ½ hourly at night, plus documented handovers. All documented.”

101. On 13 February, the man met the Clinical Psychologist again. He spoke about his appeal and said that he felt very disappointed that his sentence was not reduced. He discussed his health and said that he had no feelings at all. He said he wished he could feel sad and happy but just felt numb. He believed that it was the ECT that made him feel that way, as well as the various medications he had tried. He said he had reduced his medication.

102. At 11.30am the same day, the man who died was seen by Mr A who noted in the ACCT plan that the man:

> “Denies any suicide or self-harm ideation, seems quite up-beat in mood, continues to believe he is on the wrong medication.”

At 4.00pm the same day, Mr A noted in his ACCT plan that the man had:

> “Stated that he was fine when asked. Whether he could have some clean clothes before he had a shower. Informed him that I would try and sort it out for him. No problems at present.”

103. The next ACCT case review was carried out three days later on 16 February by SO E, accompanied by three staff. SO E noted,:

> “The man returned from his visit with his mother and stated that it went well although he seemed subdued and unhappy. I asked him how he felt and he said that he was fine and did not want to be on this document and we did not need to keep an eye on him. His main problem stems from his medication and he still says that the prison is not giving him the correct medication. The man is relocating upstairs and I have informed him to get a job and keep himself active but he said he was too ill. After lengthy discussion we have decided to keep this document open.”

104. The man who died saw Mr A on 19 February. He talked initially about the side effects of his medication, and then moved on to his belief that he had been given an excessive sentence. He believed that the independent review of his treatment prior to committing his offence would somehow get his sentence reduced. Mr A explained that the review was about his community care and would have no bearing on his sentence but the man disagreed. He denied any thoughts of self-harm.

105. Later at 7.30pm the man saw Nurse D. Her note in the ACCT says:

"Seen this evening at request of Governor B, who states that officers are concerned about him. The man's presentation is no different, he remains anxious and sometimes tearful, but soon calms down when given reassurance, which is what he seeks all the time. Advised about his medication, he wants to come off supervised medications but has been advised that this will not happen at the moment, due to his open ACCT. I have told him that I will ask MHIT Mr A to see him tomorrow. He appears quite happy with this."

At 7.30pm an entry was made in the ACCT:

> "Spoke with Samaritans at length. States he feels reassured to a point but still anxious. Handover given to night staff."

The night of 21 and 22 February

106. On 20 and 21 February 2007, a note by Nurse B indicates that the man refused to take his Flupentixol. A note made at 7.20pm in the man's ACCT on 21 February states, "The man was feeling down tonight" (the name of the person who made this entry cannot be determined).

107. Between 7.20pm and 8.00pm, the man who died passed a handwritten letter to SO A and asked him to sign it as a witness. The letter was intended to change his will in the event of his death. (The man was at that time being monitored hourly through the day and half hourly through the night.) SO A sought advice from Officer A who was just arriving for his night shift duty. Officer A advised him to speak to the duty governor, Mr C, who told SO A to arrange for the man to see a mental health nurse.

108. The man was taken to see Nurse A at about 8.00pm. The nurse assessed the man as an extra patient during what was a busy evening reception and saw him in a clinic room. Nurse A had little background information, although it was available on the medical computer record. The nurse did not know that the man's appeal had recently been refused and he had refused to take his medication for the past two nights. Nurse A asked the man if he intended to harm himself and how he was at the moment. He also asked what the change of will was about and whether he had any intention of hurting himself. The man who died replied that he was okay, and that it was just to keep his family in touch as he was moving to another prison and wanted to get everything in order beforehand.

109. Nurse A accepted the man's response that he would not harm himself. The nurse knew that the man was already located in a safer cell and what the man's ACCT observation levels were. The observation levels were continued at the same level and the man returned to his cell.

110. Nurse A made an entry in the ACCT, but not on the medical record. SO A signed the man's letter and asked the NOO to sign it as well. The NOO talked to the man later on in the evening at about 9.00pm when she went to the wing to make the management checks. (Management checks require the NOO to

visit every accommodation area at random, speak to the staff and check and sign various documents including ACCT's.) She had had previous conversations with the man about his will. He told her that he was "not letting the banks have my money, it's my mum's money". She was aware that the duty governor, SO A, and Nurse A had all discussed the letter and believed that they had considered any change to his risk level. SO A and Nurse A went off duty at 8.30pm.

111. During the evening and night of 21 February, D wing was patrolled by Officer A and an OSG. (An OSG is an Operational Support Grade. They do not carry out the same range of duties as officers and are not trained to the same level.) This was their third night on the wing out of a set of seven. D wing had nine prisoners on open ACCT forms that night, including the man who died. Each prisoner's observation levels were different and the man's were half hourly. All checks should have been recorded, but the man's ACCT plan only includes a record of one check per hour. In interview, both Officer A and the OSG said they made the checks every 30 minutes, but mistakenly thought they only needed to record alternate checks.

112. An entry made by Officer A at 8.15pm indicates that a handover from day to night staff took place. The NOO made an entry at 9.05pm that she had conducted a management check. The ACCT ongoing record pages indicate that Officer A checked the man at 9.00pm, the OSG at 10.00pm and Officer A again at 11.00pm. This last entry reads, "Observed resting on bed". The next entries are made by the OSG for the checks recorded at 12.00am, 1.00am, 2.00am and 3.00am. They all read, "Observed, looks to be asleep".

113. The OSG said in his interview with my investigator and the police that Officer A had told him that they would split the night into two. Officer A would carry out all of the duties, including ACCT checks, until 1.00am. The OSG would take over until 4.00am or 5.00am. Officer A told him that he would go to sleep when the OSG was carrying out the checks. He told the OSG that he could sleep when it was Officer A's turn to carry out the checks. (The OSG said that, on the previous evening, Officer A had slept in D2 office for part of his shift.)

114. The OSG said that Officer A did not give him any specific information regarding any concerns about the man or tell him about the letter changing his will. He only knew that he was on an ACCT plan. At about 11.00pm, Officer A intended going to sleep but received a telephone call. The OSG said he was on the telephone for over an hour. After the call was finished he told the OSG that he was going to go to sleep.

115. Although the OSG said he checked on the man every half hour, he also said he had been told that he did not have to record half hourly observations in the ACCT. He made hourly entries in the ACCT, and the last was recorded at 3.00am. Both this entry and the one for 2.00am were written in the margin of the ACCT 'Ongoing record of observations sheet'. The OSG explained during interview that this was because he had run out of continuation sheets and did not want to wake Officer A by going into the office for more of them.

116. At 4.00am, the OSG saw the man in his cell and was concerned about the way he was lying on his bed. He first thought that he had fallen asleep in an awkward position and spent a minute observing him, looking for any signs of breathing or movement. He could not see any and so kicked the door a couple of times and called out, without a response. The OSG estimates that he spent three to four minutes trying to get a response from the man. Although he had been told that a safer cell was suicide proof, and he could not see a ligature, the OSG was concerned about the man.

117. The OSG went across the landing to the office where Officer A was. The OSG said the door was closed and the lights were off. He stood outside and called out Officer A's name.

118. Officer A responded straightaway and came out of the office. (It is not clear if they went straight to the cell, or if the OSG briefed Officer A outside the office.) When they arrived at the cell, Officer A tried to get a response from the man. He called his name, kicked the door and looked to see if there was a response. Officer A did not have a radio as he had given it to the OSG. He said he would go and get the Night Orderly Officer and washed his face beforehand.

119. The OSG stayed at the cell watching the man. He was there for a couple of minutes before Officer A returned. He recalls that the NOO was either with Officer A or arrived very shortly afterwards with other officers.

120. Officer A has denied that he was asleep. When asked during interview why he had made no entries after 11.00pm he said, "I think it must have just been the way we decided to work the evening between us …" Officer A said that he was doing some paperwork when the OSG came into the office at about 4.00am. He said that the OSG appeared anxious and concerned about the man who was lying in an "unusual position" and that he could not get a response from him. He said that they went to cell D2 – 18, which is about 20 yards from the wing office (on the same landing). Officer A looked through the door hatch and saw that the man was lying at an angle on the bottom bunk, with his body face-down, his feet nearest the door. His head and neck were obscured from sight by the ladder that gave access to the top bunk and one of his legs was "dangling" off the bed. Officer A described this as "an unusual position".

121. The officer began to try to rouse the man by kicking on the door and calling his name. Officer A said that he did have a radio and that he told the OSG to stay at the door and continue to try to get a response from the man. Officer A said that he "quickly made my way to the orderly officer's office, which is on the Centre just at the end of D wing". The officer said he "walked briskly" and got to the Centre where the NOO was. He told her that they had been trying to raise the man because they were concerned about the way he was positioned in bed. He said that the NOO immediately went to D wing with him and that another officer accompanied them.

122. In fact, the NOO rang the healthcare unit first and asked for a nurse to go to D wing as well. When the NOO was briefed by Officer A, she said there was no indication of urgency and he had told her, “I can’t get a response out of the man”. She telephoned healthcare where she spoke to a Healthcare Officer and asked him to send a nurse to D Wing as she was going to open a cell. No urgency was mentioned in this request either. The Healthcare Officer asked Nurse B to go to D Wing.

123. Nurse B said she was in H3 in-patients at 4.10am when the Healthcare Officer received the call from the NOO. He told Nurse B that there did not appear to be any reason to hurry. However, the nurse said she immediately made her way to D2 landing and that she was carrying a radio. At no point was the radio used to summon assistance. Nurse B said she knew that her radio worked because there had been a net test call (when all staff carrying a radio are asked to reply to the radio centre operator) a short while earlier.

124. The NOO, Officer A and another officer, Officer E, made their way to cell D2-18 where the OSG was still standing. The NOO looked through the hatch, called the man’s name and then opened the cell door. (My investigator estimates that between six and eight minutes had elapsed from the time that the OSG had his first concerns and the cell being opened.) Upon approaching the man, the staff could see that there was a small ligature around his neck made of a thin piece of green sheet. Officer A said that the ligature was attached to a screw that was holding the bed frame to the wall. The officer used his anti-ligature knife to cut the ligature. Nurse B had also come into cell by this time.

125. Nurse B said that as she went through the Centre gate onto D2 landing she saw the staff outside the cell. No one called or gestured to her to quicken her pace. The NOO told her when she arrived that it was a blue call “hanging”. Nurse B said she ran inside the cell and saw the man lying on the bottom bunk. In her police statement she said that she felt a weak carotid pulse. Both of his pupils were fixed.

126. Nurse B asked for assistance from the other nurses and the emergency equipment. The call was logged in the control room at 4.17am. Officer E helped her to move the man onto the floor. Nurse B rechecked for a pulse, found none, and then commenced chest compressions. In interview, the nurse described signs of cyanosis around his lips, nose and ears. (Cyanosis refers to the bluish coloration of the skin due to the presence of deoxygenated blood in blood vessels near the skin surface. It can occur in the fingers and extremities (called *peripheral cyanosis*), or in the lips and face (*central cyanosis*). Central cyanosis suggests the problem is to do with the heart's ability to pump blood, or the state of the blood itself.[1]) She said that the man was still warm to the touch.

127. Staff Nurse E and the Healthcare Officer arrived shortly afterwards and cardio pulmonary resuscitation continued. A defibrillator had been brought and this

[1] English Wikipedia.

advised not to administer an electric shock to the man at any stage. (A defibrillator is a machine that administers a controlled electric shock to the chest or heart to correct a critically irregular heartbeat that cannot drive the circulation.) The paramedics arrived at the prison at 4.27am and they continued the efforts to resuscitate the man. Sadly, they were unsuccessful and he was pronounced dead at 4.49am.

After the man’s death

128. The prison’s death in custody contingency plan was put into action. All the relevant parties were contacted with the exception of the Independent Monitoring Board (IMB). A hot debrief was immediately carried out by the duty governor. Minutes were not taken and it is not known how many staff attended or if a member of the duty care team was present.

129. The man’s mother was visited at home at 9.20am on 22 February by Dr B, the Chaplain and SO F. The police were already there, as were the man’s brother and some family friends. The family were provided with details of what had happened and the chaplain said prayers. A prison contact number was given to the family. At 10.40am, the man’s father was informed of his death by the same prison staff. The prison subsequently offered to make a contribution towards funeral costs.

ISSUES

130. In this section I consider all the issues arising during the man's imprisonment, including his healthcare, and the issues raised by his family.

Clinical Care

131. The clinical review carried out by Leeds Primary Care Trust concludes that the man had a long history of mental health problems. He suffered from severe anxiety, low mood, thoughts of suicide, and poor compliance with treatment which he believed affected his physical health problems. He had harmed himself on several occasions over a long timescale. He believed that his treatment with Fluoxetine at the time of his offence had contributed to the impulsive aggressive behaviour. He had major difficulty in coming to terms with his offending and its consequences. The clinical reviewer judges that the man was treated appropriately with anti-depressants, major tranquillisers and psychological support.

132. The man had Crohn's disease and believed that his psychiatric medication aggravated this condition. The clinical reviewer judges that he was appropriately referred for specialist review and treated with the correct medication.

133. The psychiatric care provided by the prison In-reach Team is described by the clinical reviewer as exemplary and should be commended.

The mental health in-reach team deserve special praise for the diligent, professional and focussed work which they undertook with the man who died and his family. This is good practice and should be encouraged.

134. Care Programme Approach meetings were held to discuss the man's ongoing care. These meetings were attended by a multi-disciplinary group of staff including medical professionals, uniformed staff and governors. The man's family were invited to and attended these meetings.

The level of support provided by the Care Programme Approach meetings for the man, and the involvement of his family, is good practice and should also be encouraged.

135. Nevertheless, in the two months prior to his death the man had significant physical, psychological and social problems to cope with. He had sustained a serious fracture to his jaw requiring surgery. He was troubled by his Crohn's disease, blaming it on his psychiatric medication. He lost his appeal against sentence in early February 2007. He was seen regularly by the psychologist. She noted that he seemed to have 'lost his fight' on 25 January 2007 and he cried when describing his nightmares.

136. The man's family have asked about the assessment of the member of staff from the mental health in-reach team who saw the man on the night he died. The member of medical staff who saw the man during the evening was Nurse

A. He is not from the in-reach team, but is a registered mental health nurse. He was interviewed by my investigators. He was unaware that the man's appeal had recently been refused, although the information would have been available to him if he had checked his computer record. He asked whether the man intended to harm himself. The man who died replied that he was okay. Nurse A accepted the man's response that he would not harm himself and so did not change the existing ACCT plan level of observations (which were half hourly through the night).

137. The clinical reviewer comments that writing his will should have alerted the prison to a heightened suicide risk and, although Nurse A made an entry in the ACCT on-going record, this entry makes no reference to any consideration given to increasing his level of observations. Nurse A assessed the man as an additional patient during a busy evening reception clinic in his clinic room, without knowing of recent events, or that he had refused to take his medication, or of the work of the Clinical Psychologist and her colleagues. He was not aware of the man's refusal to take his night medication.

The healthcare manager should arrange a clinical review when prisoners refuse or change their psychotropic medication themselves.

Medical staff carrying out assessments should consult the prisoner's medical record before making recommendations regarding their care. All consultations should be recorded.

138. Nurse A believed that the man would be observed twice every hour throughout the night, and he knew that he was located in a safer custody cell. Consideration should have been given to increased observations and this should have been documented appropriately.

139. The nurse assessment at this time should have been more thorough and properly recorded in the medical record. Reference should have been made to the recent clinical entries on the medical computer record. The clinical reviewer also comments that the completion of the on-going record in the ACCT plan on 22 February was of a poor standard.

The ACCT observations log should be completed contemporaneously, accurately and after an appropriate observation of the prisoner. The ACCT observations should be recorded in the correct place and format to remove any doubt as to the thoroughness of the process.

Family concerns about the man's care in the community

140. The man who died had a long history of psychiatric support in the community. The family were concerned that more could and should have been done for him and that he could have been prevented from committing the offences. Whilst it is not within my remit to respond to these concerns, I do acknowledge the depth of feeling that the family have on this matter. The independent inquiry commissioned by the Strategic Health Authority,

supported the view that the man's offence and his mental health difficulties were unrelated.

Allegation by another prisoner

141. My investigators were asked by the man's family to enquire into an allegation made to them by an ex-prisoner who had been a Listener at Leeds. The allegation was that on a particular day during July/August 2006, the man had spent some time with a Listener. The Listener was concerned about the man's frame of mind and, later in the evening, spoke to an officer to ask him to "keep an eye" on him. The officer is alleged to have responded that the man could "rot in Hell as he had murdered my best mate's son". This comment was also alleged to have been overheard by a senior officer. The same allegation was made to the police when they interviewed the Listener.

142. My investigators interviewed the officer, Officer F, who was asked about his knowledge of the man who died. He described the man as: "Quite an intelligent lad. He could put himself over, he could come across quite well when you were speaking to him, very emotional." He confirmed that he knew the victim of the man's offence as he had gone to school with him and they were friends from the age of 12 to 15 although they had lost contact when they left school.

143. When the specific allegation was put to him, Officer F denied making the comment. He said that he was not the victim's best friend and had not had contact with him for several years. Officer F said that, if he had thought his professionalism would have been affected by the man's presence on the unit, he would have spoken to the Governor.

144. My investigators were unable to identify the senior officer who was alleged to have witnessed the alleged remarks of Officer F. The only person working on the wings with the same name at that time was an officer who was interviewed but had no knowledge of the alleged incident.

145. The man's family are understandably concerned by the allegation. They felt that, if true, this officer could have influenced the attitude of other staff in their management of the man. However, there is no supporting evidence that the attitude of anyone directly responsible for the man's care was influenced by Officer F. The allegation made by the Listener remains just that: an allegation and one person's word against another's.

Monitoring the man's letters and telephone calls

146. The man's family have asked whether his letters and telephone calls were monitored and, if they were, whether any action was taken in response. Only a small proportion of letters and calls in a prison are monitored at random. Specific targeting of a prisoner's mail and calls is restricted and the man did not come within the criteria for his communications to be monitored.

Assessment for transfer to HMP Frankland

147. The man was being assessed by the mental health in-reach team for consideration for the Dangerous and Severe Personality Disorder Unit at HMP Frankland. This assessment was close to completion at the time of his death. His family have asked whether his suitability for transfer to the unit could have been accomplished without a lengthy assessment process. My investigator discussed these issues with the member of staff at Leeds who was responsible for transfers.

148. After a prisoner is given a life sentence, the Lifer Section at Prison Service Headquarters determines where the prisoner serves their sentence. Initially it was appropriate for the man to be held at Leeds as this was the prison that received him from court. He was sentenced on 7 April 2006 and it was not unusual that he was still at Leeds ten months later. At that particular time there were a significant number of prisoners serving an indeterminate sentence who were awaiting transfer. It was not unusual for life sentenced prisoners to remain at their first prison for 18-20 months before being transferred. Even if the assessment had been completed and the man found suitable, a transfer to Frankland would have to have been agreed with Lifer Section. The assessment process being carried out by the MHIT would not have replaced this.

ACCT monitoring

149. Assessment, Care in Custody and Treatment (ACCT) was implemented at Leeds on 28 March 2005. The man was subject to an ACCT plan on seven different occasions. The time spent on each ACCT ranged from one day to 141 days. He spent more than 50 per cent of his period in custody on an ACCT plan. The clinical reviewer comments that the prison records contain approximately 500 pages of ACCT documentation throughout his detention which represent a high level of concern and vigilance. However, there were some deficiencies in its implementation.

Carrying out ACCT assessments/reviews

150. The assessment interview for the ACCT plan opened on 10 February 2007 was not carried out until 12 February. The first case review was also not carried out until 12 February. According to PSO 2700 annex 8G, both the assessment and the case review should have been carried out within 24 hours of the ACCT being opened. My investigator was told that, at that time, the assessor's rota was covered by contract supplementary hours which are a form of overtime. The rotas operated Monday to Friday but did not include weekends. This meant that trained staff were not always available to complete the ACCT plans within the prescribed timeframe.

There should be arrangements in place, seven days per week, to ensure that there are sufficient trained staff available to complete the prescribed assessment and review stages of ACCT plans.

Entries in the ACCT on-going record

151. The front cover of an ACCT plan records the required frequency of conversations and observations. The last instruction regarding the man's observations was both clear and unambiguous. He should have been observed every half hour during the night and these observations should have been recorded. The ongoing record of the ACCT shows a number of occasions when staff did not record observations in accordance with the instructions. On 21/22 February, the overnight observations have been recorded hourly. Both Officer A and the OSG state that they checked the man every half hour, yet there is no record to support their comments. I am concerned that the man who died may not have been observed in accordance with the instructions.

The Governor should remind staff that instructions regarding the recording of observations of prisoners on an ACCT must be complied with.

Closing an ACCT

152. At 5.00pm on 17 December, an ACCT plan was opened. At 4.00pm the next day, the man was seen at an ACCT case review which was carried out by SO C with the man but without any other staff. The man who died told SO C that he felt a lot better and had no thoughts of self-harm or of attempting suicide. He appeared to be in better spirits and admitted that he felt better about himself, largely due to his medication being 'sorted out'. SO C closed the ACCT. There is no record of a post closure interview. Nor were any enquiries made of healthcare to determine if the man's issues with his medication had been resolved.

153. SO C carried out the review on his own, when Prison Service policy [PSO 2700 Suicide Prevention and Self-Harm Management] clearly states that:

> "The Unit Manager must chair the first Case Review and appoint a Case Manager (it may be the same person - minimum grade of Senior Officer or Band 5 Nurse). Where the at-risk prisoner has severe mental health problems, the case manager can still be from the unit on which they are located. However in this event, the mental health professional must be invited to case reviews (and given as much notification as possible of the review time) and the Case Manager must seek their advice about how the individual is managed."

154. I believe it was inappropriate for the ACCT document to be closed so quickly, and for the decision to be made by one member of the staff on his own.

Staff should be reminded of the need to carry out case reviews in accordance with PSO 2700, Suicide Prevention and Self-Harm Management. Where there are mental health issues, a mental health professional must be invited to attend the review and the Case Manager must seek their advice about how the individual is managed.

Post closure reviews

155. A post closure review should be carried out within seven days of closing an ACCT plan. This is intended as a follow-up review to ensure that the person remains safe after closing the plan. My investigators were not provided with any evidence of post closure reviews having been carried out for any of the man's six ACCT plans. They were told that at that time the wings were responsible for completing the reviews and keeping them with the wing history sheets, but it was accepted that many were not carried out. A new system was introduced in May 2008 that was designed to address this issue.

Post closure reviews should be carried out in accordance with Prison Service Order 2700. Records of these reviews should be retained.

Safer cells

156. The man's family have asked how he managed to kill himself when he was in a safer cell. (These are cells designed to have reduced ligature points. They contain bed(s), storage area, toilet and sink. A cell of this design makes it more difficult for someone to use a ligature point, but does not eliminate the risk completely.)

157. Many of the staff interviewed at Leeds believed that it was impossible to self-harm in a safer cell by using a ligature. This is not a realistic view. Safer cells contain furniture and fixtures which are designed to make the attachment of ligatures difficult. The design provides accommodation that offers heightened protection from impulsive or spontaneous self-harm and suicide attempts. However, it is possible for a prisoner to damage the fabric, furniture or fixtures in a safer cell if they are determined to do so and thereby create a ligature attachment point.

158. The family also asked whether anyone heard the man chip away at the mastic in the cell. Although it was originally thought that the man had removed the material that sealed the bed to the wall (mastic), a subsequent investigation at the prison identified that by pushing against the ladder attached to the foot of the bunk bed, pressure would be applied to the bracket and bolts that held the frame to the wall. In doing so, the bolts that fixed the bed to the wall would loosen and a gap could be created between the bracket and the wall. A ligature could be put around this gap. The immediate action after the man's death was to attach the plates back to the wall with extra bolts in all of the safer cells in use at that time.

159. The prison has subsequently reviewed the design of the bed, and on 25 June 2007 work was carried out to strengthen the fixture. My investigator has confirmed that this work was carried out. The type of bed on which the man who died slept has now been replaced at Leeds.

160. Although safer cells can provide a safer environment for prisoners at risk of self-harm, it does not mean that it is impossible for a prisoner to harm

themselves. It is important that safer cells are carefully examined daily for any damage that may increase the risk of self-harm. Although I make no recommendation, the Safer Custody Offender Policy Group may wish to consider whether this examination should be documented separately from other cell fabric checks.

161. The man's family have enquired about the reason he had a bed sheet rather than special suicide risk bedding, given that he used a thin piece of torn up green sheet as a ligature. However, prisoners who are monitored by an ACCT plan should be treated as normally as possible. Replacing a bed sheet with an anti-tear quilt, or indeed, removing other items of clothing or possessions, is not encouraged by the national instruction (PSO 2700) on caring for those at risk of suicide or self harm. I share that view.

162. Furthermore, taking away a prisoner's normal bedding changes the designation of the cell to temporary special accommodation (the conditions for which are laid down in Prison Service Order 1700). For someone who is subject to ACCT monitoring, this would only be done in the most extreme circumstances when the prisoner was violent towards himself or the things in his cell. I am satisfied that the man who died did not meet this threshold.

The letter changing his will

163. On 21 February 2007, the man passed a handwritten letter to SO A and asked him to sign it as a witness. The letter was intended to change his will in the event of his death. The man was at that time being monitored hourly through the day and half hourly through the night as part of the ACCT plan. SO A sought advice from Officer A and the duty governor, Governor A. He spoke to the Night Orderly Officer who also signed the letter as a witness. He also arranged for the man to be seen by Nurse A. All of these actions indicate a heightened level of concern, but the only record is an entry in the ACCT plan from Nurse A: "Spoken to this evening. States letter written is for attention of his mother and states not any intentions of taking his life at this time."

164. The NOO was made aware of the letter during the evening handover before the change of shift and she spoke to the man at approximately 9.00pm. She found him to be in a low mood, which she later told the police was typical of him. She said that she had never seen the man who died in anything other than a low mood. The NOO told the man that she had seen his letter and was aware that he had lost his appeal, but he did not engage in conversation. She said during her police interview that the man found it difficult to talk to female staff.

165. The entry made by Nurse A in the ACCT plan was inadequate. It did not provide a proper account of the concerns raised, as discussed in paragraph 118, nor did it make any reference to an increased risk or to increasing the observation levels. SO A made no entry whatsoever. The NOO talked to the man later in the evening, but she did not record her conversation either. Prison Service policy [PSO 2700 Suicide Prevention and Self-Harm

Management] clearly states that, “Significant events, conversations with and observations of the at-risk prisoner must be recorded in the On-Going Record, and accompanied by the recording member of staff’s printed name and signature.”

Staff involved in monitoring prisoners on an ACCT Plan should be reminded of the need to record significant events and conversations in the on-going record.

A significant event, such as a prisoner discussing changes to his will, should be documented in the ACCT and should detail what considerations were given to increased risk and increasing the observation levels.

Events on 21/ 22 February

166. The man’s family have asked what the two prisoners in the cells either side of him knew about the night that he died. There is no record of the police interviewing any prisoners during the course of their investigation. Further consideration to this question was not given until my investigator took over my investigation in December 2008. He asked for information about prisoners in adjoining cells. However, given the time that had elapsed due to the investigation having been suspended, Leeds were unable to tell him. Cell movement and location information is only retained for a short period. I regret that I am unable to answer the family’s question.

167. They have also asked what checks were made and recorded on the night of the man’s death and, in particular, when the last check was made before 4.00am on 22 February when he was found. As we have seen, the ACCT document instructed staff to observe the man every half hour during the night, and to record these observations, but only hourly observations were documented. Both staff on duty that night, Officer A and the OSG, said during interview that they did observe the man every half hour, even though they only recorded hourly observations. The last recorded entry prior to 4.00am was at 3.00am. The entries at 12.00am, 1.00am, 2.00am and 3.00am all said that the man appeared to be asleep.

168. The man’s family also want to know whether he was offered contact with a Listener during his last night, and whether any contact took place. If he refused to see a Listener, they wonder why he was not transferred back to the Healthcare Centre.

169. Listeners are available 24 hours per day, seven days per week. It is a voluntary service in that a prisoner may ask to speak to a Listener and arrangements are made for this to happen. Although there is no record of contact with a Listener on the night of 21/22 February, it is clear from the man’s earlier ACCT plans that he was aware of the Listeners and had spoken to them on a number of occasions. There is no evidence, either from the records or from interviewing staff, that consideration was given to re-locating

the man in the Healthcare Centre that evening and the staff did not think the man's risk level had changed.

Response when The man was found hanging

170. The family have asked about the use of emergency procedures. They wonder why the procedures were not activated by using a radio and summoning help by calling a Code Blue. This code is used in a radio transmission to indicate that a prisoner requires medical assistance for problems specifically related to breathing e.g. asthma attack, ligature. Medical staff then attend, bringing equipment including oxygen and a defibrillator with them.

171. As I will go on to discuss in greater detail, I believe there was a serious error in judgement when the man was first seen by Officer A in not going straight into the cell to determine the man's condition and calling a Code Blue emergency, particularly as Nurse B's initial assessment when she did arrive was of a possible faint carotid pulse.

172. At approximately 4.00am on 22 February, the OSG saw the man his cell. He was immediately concerned about how he was lying on the bottom bunk. The OSG estimates that he spent three to four minutes trying to get a response from the man and then went to speak to Officer A. (It is at this point that the OSG's and Officer A's evidence differs significantly. Officer A states that he was in the office preparing documents, but the OSG believes that he was asleep.)

173. Officer A said there was no sign of injury and no blood. During interview with my investigators, Officer A went on to say:

> "That led me to feel that there was a great risk here. I had a feeling of risk, for potential hostage situation; a feeling of risk for myself and indeed for the OSG. I was not confident at all that what I was observing was necessarily the situation …"

174. My investigator asked Officer A whether he weighed his fear of it being a hostage situation against the knowledge that the man was on an ACCT, had just had his appeal refused, and had that evening spoken about signing a new will. Officer A replied that his "decision process was primarily one of safety … I had a potential hostage situation here …" Officer A went on to say that, although there was the potential risk to the man, he felt that the risk to himself and his colleague was paramount. Officer A said, "I knew that it would be a matter of a number of seconds before the people [additional officers to unlock the cell] would be there with me."

175. Prison Service Order 2710 (Follow up to deaths in custody) says in section 2:

> "The first person on scene must summon help and request local emergency clinical assistance. If establishments use codes to alert clinical staff to the type of emergency and type of first aid equipment that will be needed, local contingency plans must explain clearly the code definitions.

> Local contingency plans must provide for the summoning of an ambulance and alerting key personnel and state clearly who should do this. If the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible, following the local strategy for safely doing so. Local protocols must contain clear instructions covering cell entry, especially for Night Patrols."

176. Leeds' local instructions say: "Where there is, or appears to be, immediate danger to life, cells may be unlocked with one member of staff". The local instructions for staff observing prisoners on an ACCT state that: "If it is impossible to view the prisoner, every effort must be made to gain a response. If this is not possible, the Night Orderly Officer must be contacted."

177. Decisions about whether to enter a cell in what appears to be an emergency occur many times in my investigations. I understand the dilemma facing an officer working alone when he or she has to make a quick judgement about whether to unlock a cell at night. There are several factors that an officer may consider, such as the height, build and offence of the prisoner, whether there is a cell mate, how the emergency situation appears, and any information about the prisoner, such as whether they are on an ACCT, on frequent observations and so on. It is a difficult decision to make and I do not readily criticise staff.

178. However, I find it hard to view Officer A's decision not to go into the man's cell as reasonable. He was not alone and the OSG was present. He could see that the man was lying in an unnatural position and that attempts to get a response had failed. He knew the man was being checked frequently and was on an open ACCT. He knew that the man's appeal against his 20 year life sentence had recently been refused. He also knew that the man had, that very night, changed his will. All this was apparently outweighed by a feeling of risk to himself and the OSG.

179. I would have thought it reasonable for the officer to have called for emergency assistance on his radio (which by Officer A's own admission would have arrived "in a matter of seconds"), broken the seal on his cell key pouch, unlocked the cell and gone inside. Back-up would have been moments behind. Instead, Officer A decided to walk off the wing in order to speak with the night orderly officer. The OSG said in his interview that Officer A went to wash his face first. Officer A's actions are even more unacceptable if this is true. The clinical reviewer also comments that the man's care on the night of his death was unsatisfactory and that the delay in gaining entry to the cell to begin resuscitation was unacceptable.

180. The NOO was briefed by Officer A but there was no apparent sense of urgency in his briefing.

181. Nurse B states that, when she arrived at the cell, the NOO and the officers were outside the cell, the door was open and the man was lying on the bottom bunk. The NOO and Officer A state that Nurse B arrived as they cut the ligature. Clearly there would be an issue if the man was not receiving

attention when the nurse arrived. From the timings taken by my investigators, had the NOO spent two or three minutes trying to get a response from the man, opening the cell door and then checking his condition before realising that there was a ligature, it is possible that the Nurse arrived at about the same time as staff found the ligature.

182. My investigators timed the interval between the OSG being initially concerned about the man, and the time taken to open the cell door. Allowing a minimum time for walking backwards and forwards, briefings, and attempts to get a response from the man, I estimate that a period of between of six and eight minutes passed before the cell door was opened.

183. Furthermore, a call for more healthcare assistance was not made for at least a further four minutes and was prompted by Nurse B after she reached the cell. Additional medical support would have taken another four minutes to arrive from the Healthcare Centre. The time before CPR was started was therefore at least ten minutes and probably somewhat longer – the OSG said he first saw the man at 4.00am, Nurse B said she received the telephone call at 4.10am, and she asked for additional healthcare support at 4.17am and commenced chest compressions at the same time. So it is more likely that the time which elapsed was about 15 minutes.

184. Nurse B submitted a written incident statement within one hour of the man's death. She stated that when she first examined the man, she "initially felt a very weak carotid pulse". Her recollection when interviewed by my investigators was "that it was like a flutter and I'm not sure to be honest if I imagined it. I wasn't sure then and I'm not sure now if I imagined it but if there was a pulse it would mean that his heart was still beating or it had just finished beating." She checked again for a pulse after the man was placed on the floor and before starting resuscitation, but by then it was absent.

185. A statement was submitted by Professor A dated 18 January 2008 in response to a request from West Yorkshire Police. Professor A was asked to comment specifically whether early intervention by prison staff might have prevented the man's death. Professor A says that the man could have hanged himself any time from 3.00am to 4.00am and that death may have taken a matter of seconds or minutes. He comments that, if he had hanged himself shortly before he was found, it is possible that releasing the noose and starting resuscitation immediately might have given a slim chance of recovery.

186. We cannot know whether the man's life might have been saved had the cell door been opened quickly by Officer A. But the description of the sequence of events and unnecessary delays in opening the door, should in my view, lead to steps being taken by the Prison Service to ensure that this does not happen again.

The Governor should review the protocols for opening cell doors during Patrol State. Consideration should be given to providing specific instructions on opening the cell door of a prisoner subject to an ACCT

plan to ensure that these cells can be opened without undue delay. Staff on patrol should be instructed to contact the Night Orderly Officer by UHF radio immediately if they have any concerns about the personal safety of a prisoner.

In light of the findings of this report, and of others for which I have been responsible, the NOMS Safer Custody and Policy Group should consider if additional national guidance on the opening of cell doors for those on open ACCTs would be desirable.

187. The allegation that Officer A was asleep on duty was investigated by the police. They concluded that there was insufficient evidence to prove, beyond reasonable doubt, that he was asleep.

188. Being asleep would not have caused the man's death as the OSG had already carried out the required observations. However, notwithstanding the inconclusive nature of the police investigation, I must consider for myself the possibility that Officer A was asleep on duty. If a member of staff were asleep, there could have been a delay obtaining medical assistance at the earliest time. It would also highlight an issue about the management supervision of night staff.

189. From the entries in the man's last ACCT it is clear that there are six nights when no entries were made by a manager. There are six more nights when a night manager has only made one entry. The latest of the entries is at 11.10pm and the earliest is at 5.30am. As night managers are instructed to make entries in ACCT plans whenever they visit a wing, I can only conclude that night managers did not visit the wing on six nights, only visited the wing once on the other six nights, and that their visits did not happen in the middle of the night.

190. There is a pattern in the entries made by Officer A during the three nights when he was on duty. They show that there was a four hour period between midnight and 4.00am when he did not make an entry but the OSG did.

191. If Officer A had to be woken from sleep and then wash his face before speaking to the Night Orderly Officer, this would have caused a further delay in opening the cell door. There does not appear to be a reason why the OSG would fabricate an allegation that Officer A was asleep. All the evidence – the lack of entries in the ACCT record between midnight and 4.00am on each of the three nights they worked together, the absence of management checks during this time, and the fact that the OSG wrote his last two observations in the margin of the observation sheet rather than go into the office to get new sheets - point to the likelihood that Officer A was indeed asleep.

192. I make no recommendation in respect of Officer A on the basis that he is no longer employed by the Prison Service.

The Governor should review the Night Operating Procedures to ensure that Night Orderly Officers visit all the prison wings frequently during

the night and that at least one of their visits should be between midnight and 3.00am. These visits should be recorded in the night locking up sheets and in individual's ACCT documents.

All staff working in prisoner accommodation areas during the night should carry radios and respond individually to radio net test calls carried out by the Control Room during the night.

193. Cut-down tools are implements designed to cut ligatures. They are also known as anti-ligature knives. All unified and uniformed staff should be provided with their own personal issue tool and carry them on duty in line with PSO 2700 (section 11.3). On 22 February 2007, the NOO did not carry a cut-down tool.

The Governor should make sure that, in accordance with Prison Service policy, all uniformed staff are provided with, and carry on duty, their own personal issue cut-down tool.

Support for the family

194. The man's family received a great deal of support from Ms A who worked in the Visitors Centre. Ms A would regularly go and see the man who died in response to concerns raised by his mother. She became the family's main point of contact at the prison and was able to provide them with emotional support. She not only spent time talking to them in the prison but also on the telephone.

The level of support and liaison with family members provided by Ms A and the Visitors Centre is good practice and should be commended.

Training for night staff

195. The OSG joined the Prison Service in September 2006. He had little experience of night duties, having only served one set of nights prior to February 2007. He benefited from no formal training for night duties and received guidance from a colleague OSG on how to check prisoners in their cells and make entries in the ACCT plans. His duties included using an electronic pegging device at set times throughout the night to prove that rounds were being carried out. He was also told to carry out regular checks on prisoners who were on ACCT plans. The OSG's training record shows that he received 2.5 hours suicide awareness training on 5 September 2006, shortly after he first joined the prison. He recalls this as being for about two hours out of a two week training course.

Appropriate guidance should be provided for staff prior to carrying out night duties for the first time. This training should include specific instructions relating to prisoners on ACCT plans.

After the man's death

196. The prison's death in custody contingency plan was put into action. All relevant parties were contacted with the exception of the Independent Monitoring Board (IMB). The incident log incorrectly recorded that the duty IMB member was telephoned at 5.30am. After a complaint by the IMB and checking telephone records, it was confirmed that the call did not take place. The incident log was amended and an apology offered to the IMB.

The IMB should always be notified at the earliest opportunity of a death in custody.

197. A hot debrief was carried out by the duty governor immediately after the man was found. Minutes were not taken and it is not known how many staff attended or if a member of the duty care team was present.

198. An extraordinary suicide prevention meeting attended by representative staff and Listeners from across the prison was held on 23 February.

199. The prison completed a death in custody checklist in accordance with its contingency plans. (This checklist is an action plan intended to evidence actions taken following a fatal incident.) The checklist notes that a Critical debrief was held at 6.30am on 22 February. I believe that this was in fact the Hot debrief that was led by the duty governor and that the Critical debrief is referring to a Critical Incident debrief. A Critical Incident debrief gives the staff involved in an incident the opportunity to discuss the personal impact of the incident with others, encourages and enhances mutual support, provides information on the effects of post trauma stress and encourages coping strategies and support networks. A Critical Incident debrief was not requested or held following the death of the man.

Critical Incident Debriefs should be held following every death in custody.

200. Operational debriefs are designed to check that contingency plans are correctly followed and changes are made in light of any lessons to be learned. An Operational Debrief was not held to review the establishment's contingency plans.

An Operational Debrief should be carried out following a death and the contingency plans updated where necessary.

CONCLUSION

201. The investigation has revealed both some excellent care of the man who died, particularly regarding the mental health support that he received, but also some wholly unacceptable care on the night he died.

202. Leaving aside the exact actions or inactions of the staff on duty at the time, it is manifest that a delay of just a few moments in providing emergency care can mean the difference between life and death. It is impossible to say categorically when staff should enter a cell at night because circumstances will differ. I also acknowledge that some staff may be reluctant to enter a cell alone for fear that the prisoner might attempt to overpower them. However, in the circumstances described in this report it is difficult to see how anyone could reasonably conclude other than that the level of risk to staff was low. If two prison staff lack the confidence to go into a single cell when a prisoner is on an open ACCT, is clearly unresponsive, has no history of assaulting staff, and has just asked for a letter changing his will to be signed, it is difficult to imagine any circumstances when they would feel safe to do so. It is for this reason, that the sad death of the man raises issues not just for HMP Leeds but for the Prison Service as a whole.

RECOMMENDATIONS

The Head of Healthcare

1. The mental health in-reach team deserve special praise for the diligent, professional and focussed work which they undertook with the man and his family. This is good practice and should be encouraged.

The prison accepted this recommendation at draft consultation stage and said, "The head of healthcare to send a memo to the MHIRT to acknowledge their work. In addition, primary care mental health were involved in the man's care so a 'well done' will be extended to them".

2. The level of support provided by the Care Programme Approach meetings for the man, and the involvement of his family, is good practice and should also be encouraged.

The prison said that this good practice will be acknowledged.

3. The healthcare manager should arrange a clinical review when prisoners refuse or change their psychotropic medication themselves.

The prison accepted this recommendation at draft consultation stage and said, "An email will be sent reminding all clinical staff of the requirement for wing nurses to inform the relevant agencies if a prisoner is refusing medication. It is also a requirement that refusals should be recorded in medical records".

4. Medical staff carrying out assessments should consult the prisoner's medical record before making recommendations regarding their care. All consultations should be recorded.

The prison accepted this recommendation at draft consultation stage and said, "All staff have now completed Health Record Training. Health records are audited annually and peer reviews also take place. All consultations are recorded on SystemOne and a read coding system is in the process of being introduced to enhance the accuracy and robustness of clinical reporting from the assessment process".

The Governor

5. The ACCT observations log should be completed contemporaneously, accurately and after an appropriate observation of the prisoner. The ACCT observations should be recorded in the correct place and format to remove any doubt as to the thoroughness of the process.

The prison accepted this recommendation at draft consultation stage and said, Staff have received training in the completion of ACCT documents. Comprehensive management checks are now completed weekly by the Safer Custody team. Additionally wing managers complete 100% daily checks, Duty Governor's 10% daily check and Group Managers 10% weekly checks".

6. There should be arrangements in place, seven days per week, to ensure that there are sufficient trained staff available to complete the prescribed assessment and review stages of ACCT plans.

The prison accepted this recommendation at draft consultation stage and said, "Leeds now have 39 trained ACCT assessors (the team are multi disciplined) who provide 7 day cover...this is done via a rota which is co-ordinated and published by the Safer Custody team".

7. The Governor should remind staff that instructions regarding the recording of observations of prisoners on an ACCT must be complied with.

The prison accepted this recommendation at draft consultation stage and said, "Staff Information Notice (SIN) 345/2009 ACCT Observation has been issued to reinforce the requirements of PSO2700 in regards to recording of observations".

8. Staff should be reminded of the need to carry out case reviews in accordance with PSO 2700, Suicide Prevention and Self-Harm Management. Where there are mental health issues, a mental health professional must be invited to attend the review and the Case Manager must seek their advice about how the individual is managed.

The prison accepted this recommendation at draft consultation stage and said, "Governor's Order 14/2007 ACCT Reviews has been published. This is complemented with the management checks outlined in (recommendation 5) above".

9. Post closure reviews should be carried out in accordance with Prison Service Order 2700. Records of these reviews should be retained.

The prison accepted this recommendation at draft consultation stage and said, "When closed ACCT documents are sent to the Safer Prisons team. A case review is scheduled for the seven day stage. The ACCT together with a post closure review form is taken to the relevant unit and collected following the review".

10. Staff involved in monitoring prisoners on an ACCT Plan should be reminded of the need to record significant events and conversations in the on-going record.

The prison accepted this recommendation at draft consultation stage and said, "Guidance notes have been placed in all staff area's which provide simple advice on how to open ACCT documents and what should be recorded. SIN 132/07 introduced the notes".

11. A significant event, such as a prisoner discussing changes to his will, should be documented in the ACCT and should detail what considerations were given to increased risk and increasing the observation levels.

The prison accepted this recommendation at draft consultation stage and said, "Senior Officers have received ACCT case managers training which covers decision making and the need to record.
ACCT foundation training covers identifying risk factors. The establishment is working towards ensuring that all contact staff have received this training".

12. The Governor should review the protocols for opening cell doors during Patrol State. Consideration should be given to providing specific instructions on opening the cell door of a prisoner subject to an ACCT plan to ensure that these cells can be opened without undue delay. Staff on patrol should be instructed to contact the Night Orderly Officer by UHF radio immediately if they have any concerns about the personal safety of a prisoner.

The prison accepted this recommendation at draft consultation stage and said, "Night Operating procures were completely overhauled in April 09. They include the requirement to immediately inform the NOO of any concerns about prisoners and gave instructions of risk assessment processes about opening cell doors during the night state".

13. The Governor should review the Night Operating Procedures to ensure that Night Orderly Officers visit all the prison wings frequently during the night and that at least one of their visits should be between midnight and 3.00am. These visits should be recorded in the night locking up sheets and in individual's ACCT documents.

The prison accepted this recommendation at draft consultation stage and said, "Revised Night Operating Instructions include this requirement".

14. All staff working in prisoner accommodation areas during the night should carry radios and respond individually to radio net test calls carried out by the Control Room during the night.

The prison accepted this recommendation at draft consultation stage and said, "All night staff working in prisoner areas now carry radios. Local security instructions require a radio check to be conducted. This is recorded".

15. The Governor should make sure that, in accordance with Prison Service policy, all uniformed staff are provided with, and carry on duty, their own personal issue cut-down tool.

The prison accepted this recommendation at draft consultation stage.

16. The level of support and liaison with family members provided by Ms A and the Visitors Centre is good practice and should be commended.

The prison accepted this recommendation at draft consultation stage.

17. Appropriate guidance should be provided for staff prior to carrying out night duties for the first time. This training should include specific instructions relating to prisoners on ACCT plans.

The prison accepted this recommendation at draft consultation stage and said, "A national OSG induction programme has just been launched which new starters will attend.
"Local support is provided by the NOO to all night staff. ACCT guidance notes are provided on all wings.
"It is intended that all contact staff will receive ACCT foundation training (see 11). Job descriptions have been updated as part of the Night Operating Instructions Review".

18. The IMB should always be notified at the earliest opportunity of a death in custody.

The prison accepted this recommendation at draft consultation stage and said, "All contingency plans make this requirement clear. The requirement is frequently endorsed by the Governor at operational briefings. IMB clerk publishes the IMB rota and contact number".

19. Critical Incident Debriefs should be held following every death in custody.

The prison accepted this recommendation at draft consultation stage and said, "Critical Incident Debriefs are a requirement in the establishment's DIC contingency plan and are coordinated with Employee Support. This is in addition to hot debriefs".

20. An Operational Debrief should be carried out following a death and the contingency plans updated where necessary.

The prison accepted this recommendation at draft consultation stage and said, "The Head of Operations has the responsibility for reviewing contingency plans following any incident where they are deployed".

National recommendation

21. In light of the findings of this report, and of others for which I have been responsible, the NOMS Safer Custody and Policy Group should consider if additional national guidance on the opening of cell doors for those on open ACCTs would be desirable.

The prison accepted this recommendation at draft consultation stage and said, "Safer Custody and Offender Policy, in consultation with Security Group, will consider how best to disseminate all the lessons learned from this investigation".