

**Investigation into the circumstances surrounding the
death of a man at HMP Leeds
in January 2009**

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

November 2010

This is the report of an investigation into the death from hanging of a man at HMP Leeds in January 2009. The man, a remand prisoner, was found at around 9.38am in his cell on C wing in an apparently seated position on the bottom bed of a bunk, having attached a ligature from the top bunk. (Although the cell was equipped for double occupancy, his cell mate had moved out two days earlier.) It was clear that he had been dead for some time and resuscitation was not attempted. He was aged 34.

I offer my sincere condolences to the man's family and to all those touched by his passing. I am conscious that this investigation report has been much delayed and that this will only have added to the family's anguish.

The investigation was carried out by one of my Investigators. He conducted the interviews jointly with another Investigator. Because of ill-health, he was unable to complete the investigation, and this report has been written up by other colleagues. A Family Liaison Officer and my Senior Family Liaison Officer have been in contact with the man's family.

A clinical review of the treatment the man received in custody was undertaken by a clinical reviewer on behalf of the Primary Care Trust. I am most grateful to him for his contribution. (A copy of his review is annexed to this report.)

I must also thank the Governor of Leeds and his staff for their assistance during the course of the investigation.

The man was fearful of the long sentence he expected to face if convicted. It is also probable that at the time of his death he was coming off illicitly obtained opiates. Although in retrospect his behaviour and attitude might also suggest he was clinically depressed, he gave few signs away to other prisoners or staff.

My report raises a number of issues about his treatment while in custody. However, I do not believe his actions in January 2009 could reasonably have been anticipated.

There are seven recommendations to the Governor, and eight in the clinical review for the attention of the Head of Healthcare.

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.

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November 2010

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SUMMARY

The man died in his cell on C wing in HMP Leeds in January 2009. He was aged 34 and had been in prison custody for over five months. He had a long history of drug use and mostly minor offending. However, he was fearful that the charge he was facing at the time of his death might have led to an indeterminate sentence for public protection.

On arrival in custody, there were inadequacies in the way his risk of self harm was assessed. The clinical review carried out as part of this investigation is critical of some decisions taken in respect of him by a prison doctor.

He shared with his co-accused for most of his time at Leeds, but he was the single occupant of a double cell at the time of his death. During December 2008, his behaviour became more unpredictable and he stopped attending a workshop. The investigation has uncovered evidence of illicit drug use, and possible depression and withdrawal symptoms.

It is unclear whether staff were considering reducing him to the basic regime shortly before his death. They were under a misapprehension that he was a sentenced prisoner and therefore required to work. Four days before he died, he pleaded guilty at an adjudication for failing to undergo a mandatory drug test. He was serving the punishment for this offence against the Prison Rules when he died.

When he was discovered in his cell it was judged that he was already dead and resuscitation was (correctly) not attempted. Comprehensive logs and records of action were kept.

I conclude that staff could not reasonably have predicted the actions that led to his death. However, the report contains seven recommendations for the Governor plus other matters for him to consider. In addition, the clinical review makes eight recommendations for the Head of Healthcare.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death at 12.15pm in January 2009.
2. An investigator was appointed as the Ombudsman's Investigator. He conducted the interviews jointly with another Investigator. Because of ill-health, he was unable to complete the investigation, and this report has been written up by other colleagues.
3. He arranged for notices about the investigation to be issued for staff and prisoners on 22 January. He also wrote on the same date to the local PCT to request a clinical review. (The clinical review by the clinical reviewer was received on 6 October 2009.) Contact was also made with HM Coroner.
4. One of the Ombudsman's Family Liaison Officers spoke to the man's sister on 26 January, and followed this up with a letter. On 10 February, the investigator and Family Liaison Officer met with the man's mother and her sister.
5. The family raised many questions that the investigation has endeavoured to answer. They asked whether and how his mental health was assessed in prison. They highlighted how his most recent custodial sentence seemed different to the other periods he had spent in prison. They wanted to know whether his mental health was reviewed on an ongoing basis.
6. The family were keen that my investigator speak to other prisoners who could provide helpful information about him. They asked why a member of staff checking on him did not see that he had hanged himself much earlier on the morning he died. They also wanted to know why the member of staff who found him had gone to his cell.
7. The family suggested that the prison's Family Liaison Officer (FLO) should be more readily contactable. They also thought that the FLO should assist a prisoner's family during the initial period of contact with the Coroner's office, for instance during a visit to the mortuary. Whilst they sympathised with the FLO's difficult role, they thought that there were some lessons to be learned in this instance.
8. The Ombudsman regrets that, because of the investigator's ill-health, the family have had to wait over a year since the man's death before reading this account of what occurred.
9. Following the Family Liaison Officer's retirement, the Ombudsman's Senior Family Liaison Officer has been in contact with the family.
10. The investigator shared his initial findings and conclusions with the Acting Deputy Governor of Leeds on 8 April 2009.

HMP LEEDS

11. HMP Leeds is a local prison serving the courts of West Yorkshire. It has four Victorian wings and two modern wings. The operational capacity (maximum crowded capacity) is 1,154.
12. The relevant report from the prison's Independent Monitoring Board (IMB) is dated 2009 but in fact covers the period for 1 January 2008 to 1 January 2009. (IMB members, who are unpaid volunteers, provide lay and independent oversight of prisons with each Board being responsible for submitting an annual report to the Secretary of State for Justice.) The Board's overall judgement in 2009 was that:

“... within the constraints of budgets and staff selection and recruitment, HMP Leeds is providing a generally safe environment for prisoners and slowly improving the respect shown to them by staff.”

13. The IMB judged Healthcare to be “a well managed and forward thinking department.” In respect of safer custody, the Board reported that details in Assessment, Care in Custody and Teamwork (ACCT) forms were “regularly checked for quality ... resulting in clearer, improved information.” ACCT is the National Offender Management Service's process for supporting and monitoring prisoners at risk of self-harm. The IMB praised the work of Listeners, prisoners trained by the Samaritans to support their peers, as “excellent”. However, the reception area was “totally unsuitable for its functions ... due to the large volume of prisoners received each day ...” The average time for prisoners to go through reception was said to be “30 to 50 mins”.
14. The Board referred to “often fraught relationships between prisoners and officers” and suggested the personal officer scheme was not operating well in the eyes of prisoners.
15. The most recent inspection of HMP Leeds by HM Chief Inspector of Prisons was an unannounced inspection carried out between 5-14 December 2007. In the introduction to her report, she referred to Leeds' “chequered history.” She added:

“This unannounced inspection found that there were still considerable problems in the prison, but that vigorous management attempts were being made to grapple with them. Leeds was still failing to perform sufficiently well in any of our key areas, except for resettlement ...”

16. She said that prisoner safety had rightly attracted management attention and first night support arrangements were much improved. There was also an “innovative safer custody unit, largely for those withdrawing from drugs”. However:

“this approach had not percolated down to staff on the wings ... Many of the prisoners' safety problems stemmed from the distant and

negative relationship between most staff and prisoners. Only around half the prisoners surveyed said that most staff treated them with respect.”

17. In the body of her report, she criticised reception processes as unsuitable (she recommended that the reception area should be replaced or “fully remodelled”). She added:

“Recent strategic attention had been paid to suicide and self harm policy but basic support for prisoners at risk was not good enough.”

18. She reported that vulnerable prisoners were held separately on A wing:

“Arrangements for holding an overflow of vulnerable prisoners on other wings were extremely poor. Some had spent some months in conditions where they felt unsafe and had few, or even no, opportunities for association or exercise.”

19. She further reported:

“Around 250 men were on drug maintenance programmes and about 50 were detoxifying. Clinical management was a joint responsibility of the substance misuse and health services ... Most prisoners could begin detoxification or maintenance programmes immediately. All new arrivals were considered for the safer custody detoxification programme, which provided good support. However, prisoners not on the programme had little or no psychosocial support.”

20. On 12 January 2009, the Governor of Leeds issued a Governor’s Order (2/09) on the subject of roll checks. Referring to the 6.30am unlock roll check, the Order said, “... an unlock roll check should be conducted and signed for (in the wing book) by **BOTH** the night start and early start staff from each area.” (Emphasis in original.) As I discuss in the ‘Issues’ section of the report, the officer who completed a roll check on the morning the man died had not yet familiarised himself with this instruction.

21. From 2004 until the date of this report, I and my colleagues have conducted 17 investigations at Leeds following apparently self inflicted deaths. In 2008 there was one such death and in 2009 there were three, including that of the man. The prisoner who died just over six months after him was also a vulnerable prisoner held on the overflow accommodation on C4 landing and he too was the sole occupant of his cell at the time of his death as his cellmate had gone to A Wing for a period of association.

KEY FINDINGS

22. On 21 July 2008, the man was arrested and charged with four offences involving driving. After appearing at court, he was granted bail.
23. On Sunday 10 August, he was arrested again and taken to a police station. He was charged with assault with intent to rob, burglary of a dwelling (committed while on bail) and – later that evening – with refusing to provide a sample to be tested for the presence of class A drugs (also, by definition, whilst on bail). The police doctor recorded that he was “very sleepy” but that he denied recent alcohol or drug abuse. He was prescribed methadone at 7.00pm on 11 August. A West Yorkshire Police Risk Assessment Report dated 12 August recorded he as saying ‘yes’ when asked if he took methadone but ‘no’ in respect of depression or self harm. He was not to regain his liberty before his death.
24. After appearing at Magistrates Court on Tuesday 12 August 2008, he (along with his co-accused) was remanded into custody at HMP Leeds. Details of his current prescription for methadone were faxed to the prison by the Drug Interventions Programme based in the police station. Contact was subsequently made by Leeds Healthcare with his community GP.
25. On reception into Leeds, he gave his mother as his next of kin. His religion was recorded as Roman Catholic and it was noted that he was a smoker.
26. On arrival at Leeds, he went through the standard first reception health screen. Nurse A recorded that he was on methadone and using street heroin. She noted that he had been prescribed Prozac (fluoxetine) for depression although he had taken none in the previous five days. She referred him on to the Substance Misuse Clinic, the Sexual Health Clinic, the Blood Clinic and to see the duty doctor. (He refused an opportunity to attend the genitor-urinary medicine clinic the following month.) The form also notes, “Need TB (tuberculosis) referral. Contact with known TB carrier.” (Following referral, no further action was deemed necessary.)
27. He acknowledged depression when asked if he had ever suffered from any form of mental illness. The first question on the health screen that relates to suicide risk factors is: “For some people coming into prison can be difficult, and a few find it so hard that they might consider harming themselves. Do you feel like that now, or even suicidal?” There is nothing handwritten underneath the question on the screening form to indicate whether or not he was either asked or indeed answered the question.
28. If the patient answers yes, an Assessment, Care in Custody and Teamwork (ACCT) form should be opened. (ACCT is the Prison Service’s system for supporting and monitoring prisoners at risk of harming themselves.) However, his replies to the other questions scored only a total of four, well below the threshold of ten which again should trigger the opening of an ACCT.

29. The nurse told the investigator that she and her colleagues regularly ask newly arrived prisoners if they are having any current thoughts of suicide. During interview, she also said that she would have made a specific note in his records if he had been tearful or seemed to be in a low mood.
30. His reception urine drug screen tested positive for methadone, Subutex, cocaine, opiates and amphetamines. On being questioned, he acknowledged heroin and methadone use, and infrequent use of amphetamines. He said he was not a user of crack or cocaine. (In interview, the nurse pointed out that prisoners may test positive for amphetamines without being users as heroin is often cut with amphetamines.)
31. The cell sharing risk assessment (CSRA) completed by Officer A judged that he was low risk to share a cell. However, the form also contains the following observations:

“On methadone for drugs misuse. States was very upset and considered suicide on this arrest due to the offence. On anti-depression tablets.”

Despite the reference to suicide, the officer did not open an ACCT document. It is not clear whether this form was seen by the nurse. In her interview, the officer said she had received no training in ACCT but would feel comfortable opening an ACCT form. She could not say if she had seen the co-accused before the man or if either had seen the nurse before they saw her. In her interview, the nurse thought it most likely that she would have seen the man after he had seen the officer.

32. According to the print-out of the man’s medical record, he was also seen by Prison Doctor A on 12 August. The record reads as follows:

“H/O depression

Has been using crack – therefore Prozac not written up. To have six weeks and then review mental health status.

Drug addiction – opioids

In view of sentence likely – pleading guilty to the charge written up for one week at 40mls and then reduce at 5mls per week and then on to the detox schedule.

Remanded on new charge of assault with intent to rob ... States he is facing 5-10 years and an IPP status as he has previous robbery on his record.” [Courts have the power in certain circumstances to impose an Indeterminate Public Protection (IPP) sentence to detain in prison people who pose a significant risk to members of the public until they no longer pose such a risk.]

33. The proforma received by Leeds Healthcare from the man’s community GP refers to “Depression – tremor ... so changed to sertraline 50mg daily.” Another hand has added, “Prison Doctor A said to withhold antidepressants.”

34. In interview, the doctor said the man told him he had been using crack cocaine. As noted above, he had not said this to the nurse.
35. The doctor's involvement with him is discussed at length in the clinical reviewer's clinical review and in that section of this report which summarises his findings.
36. The man's co-accused was also judged as low risk for cell sharing, and the two men were placed together in a safer cell in the prison's First Night Centre. The co-accused was on an open ACCT form, so sharing would have provided some additional protection for the man too. (The co-accused's ACCT was closed the next day. I note that it was closed by the co-accused and the Unit Manager alone, and that the timing of entries on the ongoing record was very predictable. The care offered to the co-accused is not a matter for this report, save in respect of its impact upon the man, but the Governor will wish to ensure that ACCT processes at Leeds are more robust than was evident on this occasion.)
37. On 13 August, the man applied for vulnerable prisoner status. He gave his reasons as follows:

"Other inmates have found out that I have just arrived back in prison and what my crime is. I now fear for my safety."

The application was granted "due to the nature of the offence, which involved an elderly man." The co-accused made the same application and it too was granted. The two men continued to share their accommodation.

38. The co-accused's history sheets contain only two items relevant to this investigation. The first (dated 12 September 2008) says he was well settled on the wing and with his long-term cell mate (the man). I report on the second entry below.
39. A Safer Custody Access Programme Referral Form was completed on 13 August, noting as risk factors the man's methadone use, the charge of assault, and the fact that he had "fallen out with family". The triage outcome completed by a registered mental nurse, Nurse B, said no further actions were required, albeit he was described as "Very guarded. Monosyllabic in responses." In interview, she said the only written information she had was the referral form itself.
40. The man was also referred to the prison's CARATs drugs team. (CARATs stands for Counselling, Assessment, Referral Advice and Throughcare Services. The non clinical treatment needs of the majority of prisoners with substance misuse problems are met through CARATs.) His file contains a note saying that he had "No history of overdose/self harm/attempt suicide". It suggests that he said he first started abusing drugs at the age of 27, and that half his friends were heroin or crack users and half were non-users. It was said he had limited support from his family as "he stole from them." He said he was using £20 worth of heroin daily "IV [intravenous] arms x2" and £50

worth of crack twice a week. He had been in touch with the Lifeline Drugs Intervention Project for ten months prior to coming into custody and been prescribed methadone but “used on top of script”.

41. According to his CARATS case record, in November and December 2008, three unsuccessful attempts were made to complete a new Drug Interventions Record (DIR). He was either on exercise, association (when prisoners are unlocked from their cells to socialise, make telephone calls and shower) or at court. On one of these occasions, he did not respond when an officer shouted for him.
42. Because of the variety of charges that he faced, his status as a prisoner is somewhat complicated to follow. (In addition to the charges above, he had also been convicted of criminal damage on 19 June 2008 and fined £170 with a default term of seven days.) Save for the most serious charge – that of assault with intent to rob – the Ombudsman does not believe that the disposal of the various charges is relevant to the circumstances of his death. However, for the sake of completeness, it should be explained that on 28 October he pleaded guilty to the charge of assault with intent to rob. His legal advisers asked the court to defer sentencing and the court agreed to this. He was therefore held in custody as a convicted, Judgement Respited (JR) prisoner (judgement respited, or delayed).
43. On 5 November, he was sentenced to 17 weeks imprisonment for dangerous driving and seven days concurrent for the fine default. A charge of taking and driving away was discontinued, and no separate penalty was imposed in respect of two Road Traffic Act offences (driving without insurance and driving without a licence). However, as the court ordered that the 85 days that he had by then spent on remand should be allowed against his sentence, in practice he was a convicted prisoner for just four days (5-8 November inclusive).
44. This meant that after 8 November, he reverted to being held in custody as a JR prisoner in respect of the charge of assault with intent to rob until 23 December. On that date, it was recorded that his guilty plea had been cancelled and he reverted to being a prisoner on remand awaiting trial. This was because he had changed solicitors and his new legal advisers disagreed with the advice he had previously been given to plead guilty. They successfully persuaded the court to accept a reversal of his earlier plea. His unconvicted status may be relevant to the circumstances of his death as will be shown below.
45. He was located in cell C4-08 from 19 August to 17 November, and in cell C4-05 thereafter. (C wing houses the overflow of vulnerable prisoners from A wing.) He shared with his co-accused first in C4-08 and then in cell C4-05 until 16 January 2009 when the co-accused moved next door but one into C4-07. Between 16 and 18 January, he shared with another cellmate (who had moved from I1-23). The cellmate moved to cell A2-15 on 18 January, leaving the man as the sole occupant of a double cell. It is apparent from records that

he had been offered the opportunity of moving to A wing but both he and the co-accused had declined.

46. It is not clear why they stopped sharing. The co-accused says in interview that it was simply that they were doing everything together “and it was getting too much for both of us”. In his interview, Prisoner A alleged that the two men had been arguing as the man said he played no part in the robbery while the co-accused blamed him for carrying a knife. The man’s former personal officer, Officer B, simply notes, “I was surprised that they’d actually split up because they were very close.”
47. During the autumn of 2008, the man made a variety of court appearances via videolink in respect of the charges he was facing. Again, it is not believed that the details are crucial for an understanding of the circumstances of his death. It may be noted in passing that, on 5 September 2008, the police requested His production at the police station for an identity parade but that on 11 September he refused to attend. Healthcare staff deemed him fit for court on 19 August, 5 September, 5 November, 17 November, 17 December and 23 December.
48. He received a visit from his mother on 30 October 2008.
49. The Police National Computer print-out for him at the time of his arrest in August had warning signals for violence and escape risk. The Prisoner Escort Record (PER form) that accompanied him from the police station to Magistrates Court on 12 August is likewise marked for violence and escape risk, and for drugs/alcohol. A note on the form reads:

“PNC markers for violence and being an escaper. Graze to chin. Uses methadone. No other information disclosed. Methadone given in custody under doctor’s supervision.”

50. Other PER forms are retained on his core file. The details of warning markings are as follows:

19 August	Medical: Mental Warnings: Violence Others: Drugs, VP [vulnerable prisoner]
5 September	Medical: Condition Warnings: NK [Not known] Others: NK
5 November	Medical: Condition Warnings: NK Others: VP
16 November	Medical: Mental Vulnerable

R45-VP [R45 refers to the Prison Service rule for identifying vulnerable prisoners.]

17 December Mental issue
VP

23 December Violence
VP

There are evident discrepancies between the forms, but none flags up a concern for self-harm.

51. The following entries appear on the man's history sheets from September onwards:

5.9.08 Located C4-08

3.11.08 This prisoner says he is a TX [meaning unconvicted] but the computer says he is now a JR. I have explained to him that as a JR he has to go to work. I will be unlocking him from [sic] work this afternoon.

3.11.08 Warning not given, awaiting education interview. Has been told that he is required to attend if accepted.

16.11.08 Spoke with the man who is settled as he is sharing with the co-accused. No concerns raised at the moment.

30.11.08 The man is allocated workshop 3 and has been attending which is a positive step.

9.11 (a misprint for 9.12).08 The man has been offered a move to A wing to assist with his going to Shop 3. He however declined as he wanted to stay with the co-accused. No other problems at the moment.

10.11 (a misprint for 10.12).08 Regular entries good comments a fair representation. [A management check]

11.12.08 Given a warning by myself after being caught in a cell after being brought from C wing to A wing for work. When told of my actions became argumentative and also aggressive. I had informed him that this was not the first time I had caught him. [Entry by an officer] The Incentives and Earned Privileges [IEP] warning report adds the detail, "became argumentative and aggressive calling me an 'idiot' and telling me to do what I want." (IEP is the Prison Service system for awarding privileges, such as extra visits, for good behaviour.)

- 12.12.08 Warning endorsed for above entry.
- 30.12.08 Change of status from JR to trial (successful application to vacate plea).
- 6.1.09 Warning raised for failing to attend Shop 3. [Officer] (The IEP warning report adds the detail, "Just slammed the door shut.")
- 7.1.09 Warning endorsed. When speaking to the man, he stated 'the job was doing his head in'. I offered to contact the workshop and enquire about an alternative job in the shop, but this was not good enough. Still said he wouldn't go!! [Officer]
- 12.1.09 Unlocked for Shop 3. Refused to go. I told him if he didn't go he would get a warning issued. He refused to speak to me and just turned over in bed. A very poor attitude. [Officer] (The IEP warning report adds the detail of what the officer said: "You are convicted and have to go to work. If you refuse you will be given a warning.")
- 12.1.09 This is his 3rd warning in a few weeks. I think a stint on basic. Paperwork pulled together for basic review. [Unsigned]
- 15.1.09 The man refused to attend a random MDT [Mandatory Drug Test]. It was explained to him the consequences of his refusal, but he still refused. Subsequently P.O.R. [Put on report.]
52. The behaviour report for the IEPs review notes that he was "Not enthusiastic, no motivation, does as little as possible." Under wing behaviour, it was noted that his attitude was poor, and behaviour, conformity and cleanliness were all below average. It is not known if he was in fact reduced to basic regime at the time of his death.
53. Also on his file is a change of status form from JR to TRL (Trial) with effect from 23 December 2008. In other words, the grounds for giving him the IEP warnings and eventually reducing him to basic were ill-founded. As Officer C, an instructional officer in workshop 3, pointed out in interview, "... he decided to go no work, no pay which as a remand prisoner that was his right to do." (The officer's evidence is also to the effect that he was adamant of his innocence and blamed his co-accused.)
54. On 16 January 2009, he faced an adjudication (a prison disciplinary hearing) presided over by the Governor. He pleaded guilty to a charge under paragraph 51-22 of the Prison Rules for refusing to obey a lawful order (that is, his refusal to undertake the MDT). He was punished with seven days stoppage of earnings at 50 per cent, ten days loss of canteen/use of private cash, and five days loss of association.

55. It seems certain that he was using illicit drugs while in custody. Prisoner A has alleged that he was taking morphine in the form of injecting crushed tablets (the prisoner further alleges they were supplied by the co-accused). The co-accused said in interview that the man was “trying to buy tramadol and stuff.” (Tramadol is a synthetic pain relieving medication which can be abused.) In his interview, the man’s cousin says that four days before his death his demeanour had changed – perhaps because he was withdrawing, perhaps because he feared an IPP sentence. In interview, Prisoner A says that on the night before his death the man was without tobacco and “rattling” (symptoms of enforced withdrawal from drugs).
56. There are no references to the man (or to either of his cellmates) in the C wing Observation Book for January 2009.
57. Officer C made the early morning roll check at roughly 5.00am to 5.30am. He said in interview that he could not guarantee that he saw each prisoner as it was still dark.

Events in January 2009

58. According to his incident report, the man was discovered hanging at approximately 9.38am by Officer D. Around 40 minutes earlier, he had been unlocking those vulnerable prisoners on the 4’s landing who required treatments/medication. On unlocking cell C4-07 [he says C4-06 but I think he may have been mistaken], the co-accused asked if he could be let out to get some tobacco from his former cellmate in C4-05. He was told this was not possible at that time, as the staff were trying to clear the landings for a staff meeting. After the meeting, the officer returned to the landing and attended to a cell bell from the co-accused who again asked if he could get some tobacco, and if the officer could get it from his former cellmate. The officer opened the observation panel to cell C4-05, “it appeared that the man was sat on the edge of the bottom bunk with his head down”. The officer opened the cell door and saw that he was suspended from the top bunk in an apparently seated position with a ligature around his neck. The officer who, like the other landing staff, was not carrying a radio, “immediately raised the alarm whilst running towards the general alarm on the 4’s landing informing Officer E we needed a nurse or medic at cell C4-05 and pressed the general alarm.” He then returned to the cell and cut him down with his ligature knife. Another two officers then entered the cell and Officer F checked for a pulse but without success. Officer D’s statement continues:

“I noticed that the man’s hands were tightly clenched and red in colour. His face was drip white and his lips were blue. His eyes were open.”

Officer D then left the cell and was taken to a quiet area where he was supported by members of the staff care team and other members of staff. (The officer was new in service and had only been at Leeds since December 13 2008.)

59. Officer E's statement says that he followed Officer D into cell C4-05, closely followed by two more officers. He says that Officer G was assisting Officer D before Officer D left the cell and Officer F entered. Officers F and G then pulled the man's body 1 ft into the cell to enable them to close the door and seal the area. Officer F placed a towel over the man's face. In interview, Officer E added little to this account.

60. Officer G's report reads as follows:

"I was on duty on C3 landing When I reached the cell, Officer D was inside the cell. I saw that he was using his 'fish knife' to cut a ligature which was tied to the top bunk bed. I asked Officer D to move further into the cell so that I could assist him. He managed to cut through the ligature and the man fell to the floor ... I took hold of him and I immediately noticed that his body was cold and clammy, his eyes were partially open and appeared lifeless, his hands were in a clenched fist position and all his joints were stiff and rigid. It was impossible to place him in any type of recovery position. The ligature, a torn bedsheet, was tight around his neck.

"Officer F came into the cell and checked for a pulse. I told Officer D to leave the cell. Officer F confirmed there was no pulse. We then moved the man approx 1 foot further into the cell to clear the door area and allow closure, after Prison Doctor B attended the scene. I secured the cell door."

In his interview, Officer G confirmed this account, adding that the man's television was on.

61. Officer F's report confirms this account. He says he checked for a pulse but found none. He adds:

"In my opinion, just the sight of him and the colour of his face and hands being blue, also the stiffness of his body, that he was already dead."

62. Senior Officer A's report simply says that she attended on responding to a general alarm bell, and confirms the details of the man's body. A Principal Officer (the Orderly Officer, known by the code sign Oscar 1) then attended and she handed over the incident to him. She repeated those details in interview, adding that she had left the cell with Officer D who was "obviously quite visibly shaken".

63. When found, the man was fully clothed.

64. In interview, several of the officers mentioned that the primary care manager was at the cell very quickly and that it was she who called for a doctor.

65. A comprehensive Scene Log was kept separately by three different officers. It shows that the man was found by Officer D at 9.40am. Three officers

attended, along with Officer H and Senior Officer A. The doctor attended at 9.45am. The prison's Police Liaison Officer viewed the cell at 10.20am. At 10.58am, Senior Officer B was told that paramedics would not be attending. The police were present at 11.00am, and a Detective Inspector and a Scenes of Crime Officer arrived with other police officers at 11.35am. Photographs were taken. The Coroner's Officer arrived at 1.25pm, and the man's body was removed from the cell at 2.25pm.

66. The Control Room Incident Checklist shows that a General Alarm was sounded on C wing at 9.38am and that Oscar 1, Oscar 2 (the Assistant Orderly Officer), and Victor 1 (the Duty Governor) were informed. Oscar 1 (the Principal Officer) was asked to attend C wing at 9.42am. The command suite was opened at 9.45am when the man's death was confirmed. The ambulance was called at 9.47am but stood down in light of the confirmation that he had died.
67. The Control Room Death in Custody Action Sheet also shows that correct actions were followed. An ambulance was called at 9.57am, the IMB was informed shortly after 10.00am, and the police were contacted at 10.10am. National Offender Management Service (NOMS) Headquarters had been informed by 10.27am.
68. The Control Room log is equally comprehensive. It shows, amongst other things, that the command suite was opened at 9.50am. Arrangements for a hot debrief to be held in the centre boardroom were already under way by 10.04am. A member of the prison's care team had been with those first on scene. There was a subsequent discussion "to ensure support later for staff as so many of them are new to the Service."
69. At 10.50am, an entry in the log reads as follows:

"Interview with the officer indicates that he signed for the role [sic] but did not complete role check [sic]."

A handwritten note of interview with the officer timed at 10.36am and signed by the duty governor says, amongst other things:

"Roll check – signed for number
No roll check
Night staff did roll check – Officer C."
70. Reviews of the 27 prisoners on open ACCTs were to be completed by the afternoon.
71. By 11.27, taxis were being ordered to take the prison's Family Liaison Officers to inform the man's next of kin. They were to be accompanied by a governor. They left the prison at 11.54am, arriving at his mother's home at 12.40pm (where they also met his sister). They stayed until 1.55pm. A Family Liaison log was opened.

72. An entry in the Control Room log at 12.15pm reads:
- “SO C spoke to Officer I who said, ‘Prisoner A and Prisoner B, cell C4-46 stated that they had seen the man on the floor and wanted to know why staff didn’t administer CPR.’ Referred to chaplaincy. After seeing chaplaincy, one prisoner stated that the man’s cell bell light was on when the door opened.”
73. In interview for this investigation, the prisoner repeated the allegation that the cell bell light was on, saying that he was 100 per cent certain. He alleged that Officer F turned it off. However, in his interview the officer raised no issues about CPR (Cardio pulmonary resuscitation) and expressly said that the man’s cell bell light was not on – although two lights further along the landing were illuminated. Officer D said in interview that the man’s television was on but his cell bell light was not illuminated. Officer F denied in interview that he had turned off any cell bell light.
74. Original documents were collated for the police liaison officer, and incident reports were gathered from Officer G, SO A, Officer E, Officer D, and Officer F.
75. The Control Room log was closed at 2.04pm.
76. The Action Sheet completed by the duty governor is also comprehensive. It confirms that the Governor was informed at 9.55am, and that he then rang the area manager at 09.57. NOMS National Operations Unit was informed at 10.15am. Notices for prisoners and staff were drafted. (The duty governor does not normally work at Leeds but was assisting because other senior staff were on an away-day.)
77. Minor and insubstantial inconsistencies with respect to timing aside, I am very impressed both by the quality of the documentation and the actions taken. This was good practice.
78. Prison Doctor B pronounced death at 9.45am. Her entry in the man’s medical record says:
- “Call to C wing at 09.40, staff report he was found hanging from upper bunk, when seen by me had been cut down, ligature still around neck. Was lying on his back, cold and blue, rigor mortis advanced, arms flexed.”
- In interview for this investigation, the doctor repeated that “there was already quite advanced rigor mortis” when she examined him. For this reason, she did not think it was critical that the ligature was still around his neck, “At that point blood certainly wouldn’t have flowed.”
79. The post mortem report by the Home Office Consultant Forensic Pathologist records the medical cause of death as hanging. The pathologist concludes that there was “no evidence of any other natural disease or other injuries that

could have caused or contributed towards death". Toxicological analyses revealed the presence of a low level of morphine. The toxicology report says the opiate concentration was "unlikely to have contributed to the mechanism of death. It is unclear if this [the finding of opiates] originates from therapeutic or illicit use of morphine containing compounds." (As reported earlier, the man had not been prescribed methadone for some months and it must be concluded therefore that the opiate use was in fact illicit.)

80. The man left no letter or note to explain his actions or intentions. In his interview for this investigation, the co-accused said that on the night before his death the man had asked for a stamp so that he could write to his mother. No such letter has been traced.

81. An entry in the co-accused's history sheets for 20 January 2009 reads as follows:

"At 11.00hrs spoke to co-accused about the death in custody of the man. He stated that he had known him since the age of 9. He says he was shocked by his actions but was coming to terms with what had happened ..."

In interview, the co-accused said he had known the man since they were in children's homes, but that before meeting in July 2008 they had not seen each other for 15 years or so.

82. The man's funeral was held on 16 February 2009.

ISSUES

Clinical review

83. The clinical review (attached as annex 1) was compiled by a clinical reviewer, a General Practitioner based in Leeds. It is relevant that his practice has a reputation for assisting otherwise hard-to-reach patients and socially excluded groups such as those with substance misuse problems. He is accredited as a GP with a special interest in addiction services. My office received his review on 6 October 2009.
84. He begins his review by noting that prisoners in general, and white prisoners on remand in local prisons and who have a history of substance misuse or mental health problems, are disproportionately at risk of suicide. He adds, "Change of location or routine as well as disciplinary problems are also factors." However, he rightly says that it remains very difficult to identify those prisoners most likely to attempt to harm themselves. In respect of asphyxia, he says that unconsciousness can occur within several seconds with brain death through oxygen starvation occurring within a few minutes.
85. He sets out what happened to the man on reception in respect of the First Reception Health Screen and the Cell Sharing Risk Assessment. He notes that no answer was given to Question 15 on the Health Screen which asks if the prisoner feels like harming himself or is suicidal. As reported earlier, the score for the other questions was four (below the trigger level of ten), an ACCT was not opened.
86. He records that Prison Doctor A prescribed what were to become weaning doses of methadone and that, by the middle of September 2008 the man had stopped receiving methadone medication.
87. The clinical reviewer notes a second entry by the prison doctor (also reported earlier): "history of depression. Has been using crack – therefore Prozac not written up. To have six weeks and then review mental health status." During interview, the doctor said he would have expected the prisoners themselves to be responsible for making arrangements for this mental health review. However, as the clinical reviewer points out, this first consultation with the doctor was in fact the only time the man was seen by a doctor during his time in Leeds.
88. After his first night in custody, the man was seen by a mental health nurse, Nurse B. This was an automatic referral because of the risk factors (drug misuse, nature of offence, isolation from family) that had been identified. As shown above, he was very guarded in his responses and the nurse did not have access to other sources of information (medical notes, First Reception Health Screen, CSRA).
89. A standard proforma was sent to the man's GP in the community on 13 August. The reply from the GP confirmed that he had been treated for depression with fluoxetine initially but that, because of a side effect, this had

been changed to sertraline 50mg daily. A hand-written note on the GP's reply reads, "Prison Doctor A said to withhold antidepressants." In a subsequent report (dated 8 June 2009), the GP said the man was an infrequent attendee at her practice (twice in 2005, then nothing until 13 June 2008 when he had complained of suffering low mood for at least a year). She gave details of his heroin usage, his occasional use of crack and cocaine, and his "history of using significant amounts of stimulants which was giving rise to emotional lability [instability]."

90. The man's prison medical records contain no other entries of significance, save that he failed to attend a routine healthcare triage clinic on 19 September 2008. The clinical reviewer speculates that this may have been to follow up the mental health review suggested on his first night in custody. He notes that there was no follow up of this missed appointment.
91. The clinical reviewer also sets out the other events (remaining on A wing, ceasing attending the workshop, probable illicit drug use and withdrawal, fears about likely sentence, single roll check) that have been outlined earlier.
92. His findings and conclusions are as follows:
 - Potentially important information given at the CSRA was not available to or shared with the nurse or doctor conducting the initial screenings.
 - An ACCT might have been opened if the concerns regarding self-harm raised at the CSRA had been further discussed with the clinicians.
 - The reception health screen does not have a prompt to ask how long a prisoner has suffered from a condition like depression.
 - Although Prison Doctor A recorded a history of depression, there is no record of any discussion about the severity, history, or the effects of treatment:

"In fact Prison Doctor A appears more concerned that the man was potentially taking crack so he made a decision to stop the antidepressant medication. There was no attempted assessment as to the amount of crack cocaine that the man was taking and it is possible that he was an infrequent user. It does seem therefore a little odd that, if an interaction between the two was the major concern (and the doctor would have known that crack cocaine is not an illicit drug often used in prison), the antidepressant was stopped. The apparent concerns over the use of crack cocaine and SSRI [selective serotonin reuptake inhibitor] antidepressants expressed by the doctor during interview are not supported by any literature that I have come across. Personally I would have had no issue with prescribing an SSRI antidepressant to someone with a drug misuse problem and depression though recognising the likely difficulties in achieving progress in the depression if the underlying cause of

this is habitual use of cocaine. The doctor would have known that the crack cocaine usage would now be at an end once the man was in custody so why was the medication not continued whilst information was obtained from the GP who had prescribed it? There does appear to be a request that a mental health review is undertaken though I am not sure that relying on the prisoner to make his own appointment for this was appropriate. Even if this is the usual practice then there needs to be a robust mechanism in place to either follow up a 'Did Not Attend' appointment or better still to formally request a review from a prisoner by attendance or outreach visit. I would have preferred a mental health review to take place within the first two weeks and certainly it would have been appropriate to have assessed his mental health during and at the end of his enforced detoxification from methadone which would have been approximately six weeks later."

- The clinical reviewer criticises the fact that the mental health nurse, Nurse B, had no access to information on the CSRA or the healthscreen or medical notes: "... this is just another instance where sharing information preferably prior to consultation is the minimum standard that should be achieved."
- It is likely that the man was suffering withdrawal symptoms from illicit drugs:

"He refused a mandatory drugs test a few days prior to his death and certainly his supply of illicit drugs appeared to dry up when his cell-mate moved out 4 days prior to his suicide. The lack of morphine leading to opiate withdrawal symptoms and his reluctance to seek help in prison for his addiction would have certainly compounded any depressive feelings. It does appear that he had significant withdrawal symptoms the day or so prior to his death and he described the sense of despair he felt at this and other issues to a fellow prisoner who says he did ask staff to keep an eye on him. However he did not flag up his problems to any of the staff and this would have been in keeping with his personality. Obviously if he had not been going through an acute withdrawal then he may not have made the decision to take his own life. If this drug misuse problem and acute withdrawal had been flagged up then appropriate help could have been offered and he might have been observed more closely."

- It is likely that he died in the early hours of 20 January:

"On the day of his death it is probable that a roll check was not done in the early morning at about 6.30am-7.00am. His body was discovered just three hours later but since the stage of rigor mortis (the stiffening of a body due to muscle contracture after

death) appeared to be pretty advanced then it is more than likely that death had occurred before this time and probably more likely in the early hours of the morning.”

93. The clinical reviewer judges that the man’s clinical care at the time of his reception into Leeds could have been improved:

“Whether antidepressant medication should have been continued is certainly an issue as is the lack of a formal assessment of his depression. That said I feel that the deficiencies as highlighted above did not have a significant impact on the eventual unfortunate outcome.”

He summarises his report as follows:

“The man was facing the prospect of a long sentence in prison. This was certainly a major concern to him especially the thought of having a very long sentence. This was not the first occasion that he had been in prison and he was in HMP Leeds for five months before he took his own life by the method of hanging himself with a ligature made out of a bed sheet. He also had a long history of drug misuse problems and though he was receiving treatment for this at the time of his arrest he had remained an intravenous poly drug misuser up to being taken into custody. He had also begun treatment for a depressive episode two months prior to his arrest and arrival at HMP Leeds. This treatment was stopped when he came into prison and he was not reassessed at any stage to see if such treatment needed restarting. It is possible that his depression had recurred though it was not apparent to those who knew him and come in to contact with him. It is also very likely that he had been taking illicit morphine for some time prior to his death though it is probable that the supply of this had stopped a few days before January 20th 2009. This would have led him having to endure opiate withdrawal symptoms in the few days before his death. He did not seek any help for this or indeed with regard to any depressive feelings he had. On the day of his death it is likely that a roll check of prisoners was not done and so discovery of him was probably delayed. However I do not feel this had any bearing on the tragic outcome.”

94. He makes the following recommendations to the Head of Healthcare, all of which I endorse:

Procedures/protocols for information sharing between reception staff need to be reviewed to ensure that information received by one party is available to all.

Documentation (First Reception Health Screen) used at reception needs to be reviewed and updated to gather more useful data with regard to mental health issues.

Important medical information gathered at reception screening (by whoever) should find its way into the medical notes – coded where possible and preferably added to the record via a suitable template.

The pro-forma sent to GPs requesting information needs to be reviewed and updated to be able to prompt for more information especially for certain conditions such as mental health problems.

Information/letters received from outside agencies such as those from drug clinics also needs to be reviewed by healthcare staff and coded where possible and again recorded via a suitable template.

Antidepressant medication should be continued unless there are compelling reasons to stop it. It should be continued until at least both the following have been completed: A suitable assessment of the depression and confirmation of medication and rationale for its use.

Information on any mental health issues raised at reception, with consent, should be readily available to all healthcare and possibly wider staff groups who come into contact with a prisoner in the first few days and possibly longer.

A protocol for review appointments and follow up of defaulters should be developed that is clear and does not rely on the prisoner to make his own appointment.

95. The clinical reviewer says it is pleasing that a number of these recommendations have already been highlighted by the Healthcare department following their own review.

It should be noted that Prison Doctor A presented a robust defence of his decisions in respect of the man – notably the decision not to prescribe anti-depressants and placing the responsibility to arrange a mental health review on the patient – in his interview which is reproduced as an annex to this report.

Safer custody

96. The man died some five months after entering custody. Because of the time that had elapsed, I do not consider that any failures in respect of his initial health screening directly contributed to his death. However, it is clear that such failures did occur in that those making decisions about his welfare seem not to have been in possession of all the relevant information. It is not entirely clear in what order the first reception health screen and the cell sharing risk assessment were carried out, nor what information was before the nurse who carried out the health screen. However, in retrospect it is surprising that there was no mental health referral for him and it is arguable that, in possession of all relevant information, either the nurse or the officer conducting the CSRA could reasonably have opened an ACCT form. It is also noteworthy that Nurse B, who conducted the safer custody triage, did not know about his depression, previous prescription for Prozac, or suicidal thoughts. However,

the fact that he was placed in a cell with his co-accused who was on ACCT monitoring must, in effect, have provided initial extra protection for the man himself.

97. The Ombudsman understands that, since the man's death, Leeds has introduced new procedures to try to ensure that information about a prisoner's risk is effectively shared between staff. The following recommendation is intended to reinforce those procedures:

The Governor should review information sharing in respect of prisoners' risk factors for suicide and self-harm.

Prisoner Escort Record (PER) forms

98. As noted in the text, the information included on the man's various Prisoner Escort Records during his time in custody was not consistent from form to form. Again, this cannot be related to the circumstances of his death, but is a matter the Governor will wish to review:

The Governor should review the quality of entries on PER forms and advise staff accordingly.

Incentives and Earned Privileges Scheme (IEPS)

99. It is not clear from the paperwork seen by the investigator whether the man was in fact reduced to the basic level of the IEPS shortly before his death. The fact that he retained his television suggests he had not actually been reduced to basic. However, it is also clear that some staff were under the misapprehension that he was a convicted prisoner and therefore required to work. As it was, his plea had been vacated and he should have been treated as a remand prisoner who could choose to work but was not required to. The fact that he had signed a No Work – No Pay form seems to have been overlooked during the IEPS process.
100. It is also disappointing that little or no effort seems to have been made to ascertain the reasons that he wanted to stop working in the workshop. In retrospect, it seems very possible that he was experiencing a depressive episode or suffering the effects of illicit drug use or withdrawal therefrom.

The Governor should satisfy himself that the IEPS is being operated appropriately, and that those prisoners who are not required to work are not being improperly reduced to basic level.

Adjudication and Drug Taking

101. Four days before his death, he faced an adjudication and pleaded guilty to refusing to obey a lawful order to undertake a mandatory drugs test. He was serving the punishment of seven days stoppage of earnings at 50 per cent, ten days loss of canteen/use of private cash, and five days loss of association when he died.

102. There can be no criticism of the decision to bring a charge against him. A prisoner's refusal to undertake an MDT undermines the Prison Service's anti-drugs policy. If anything, the punishment he received – presumably reflecting his demeanour and guilty plea – was at the lenient end of the spectrum. There was no reason to suppose that he was at significantly greater risk of self-harm as a result of the adjudication and punishment.
103. It seems certain, according to information supplied by other prisoners after his death, that he was using illicitly obtained drugs while in custody – probably in the form of injecting crushed tablets of prescribed drugs. It also seems likely that he was suffering from withdrawal symptoms in the days running up to his death. Although no formal recommendation is justified, the Governor will wish to consider if, following an adjudication for refusing to undertake an MDT, staff could be more proactive in investigating a prisoner's possible drug use. It is notable that none of the staff interviewed had identified that he was taking drugs or considered that drug misuse might have explained his mood and behaviour in the period before his death.

Roll check

104. In interview, the night officer on C wing, Officer C, explained that he had carried out the early morning check at roughly 5.00am to 5.30am. It would appear from his interview that he could not guarantee seeing every prisoner during the check as it was dark. According to Principal Officer A, "Officer J had signed for the prisoners and allowed Officer C to leave from his night duties without actually checking the prisoners and doing a physical count on the wing ..." It seems that Officers J and K did not carry out a separate check.
105. The Governor's Order mandating a different approach to the first roll check of the day is dated 12 January 2009. However, it is unclear if the procedure that both night and incoming day staff carry out a physical check was actually implemented on C wing before the day of the man's death
106. Officer J told the investigation that he understood that new instructions regarding morning counts had been placed on the prison's intranet but he had not had a chance to read them. It was the first time he had done a 6.30am start and he was not familiar with the procedures, "... as was customary at the time, I accepted the roll from [Officer C]." He said he understood from Officer C that the man "was sat on the end of the bed, watching the television." Officer F said in interview that the television was still on in the cell when he entered it on responding to the alarm.
107. It seems almost certain that the man had died some hours before the early morning roll check, and that therefore this uncertainty as to the correct procedure was not relevant to his death. However, the Governor will wish to use the opportunity afforded by this investigation to review how effective are the current roll check procedures:

The Governor should satisfy himself that roll check procedures are being operated appropriately.

Was the man's cell bell light on?

108. One prisoner has alleged that the man's cell bell light was illuminated when he was found. The implication would be that the man had rung the bell but that no member of staff had come to check on him. Although one cannot be certain, the weight of evidence suggests that the prisoner is mistaken. His fellow prisoner has not endorsed his recollection, the co-accused has explained why Officer F went to the cell when he did, and the evidence of staff members (Officers D, F, and G) is that the cell bell light was not illuminated.

Raising the alarm

109. Officer D had no radio and did the right thing in raising the alarm in the way he did. However, the Governor should review the provision of radios. Readers of my report may find it surprising that wing staff are not routinely in possession of a radio:

The Governor should review the provision of radios to wing staff.

110. It is also questionable whether Officer D should have entered the man's cell before raising the alarm. In interview, the officer said: "...we're trained not to go into a cell in that situation on our own because it could well be something that's been set up." This is not in line with Prison Service guidance which is that there are circumstances when life may be threatened when it is acceptable to enter a cell alone. Although it is not believed that it made any difference to the man, it could do so on some future occasion when seconds may be critical to life or death:

The Governor should remind staff of the circumstances in which it is proper to enter a cell alone.

Was it right not to attempt resuscitation?

111. The accounts given by the officers and by SO A, all include evidence that rigor mortis had set in by the time the man was discovered. Prison Doctor B confirmed that in her entry in the medical record. In these circumstances, it was entirely reasonable not to commence resuscitation efforts. Attempting resuscitation on someone who is already clearly dead is not respectful to their memory nor fair to those engaged in the effort.
112. However, although no personal criticism of Officer D is intended (he was an inexperienced member of staff placed in an unenviable position), it is surprising that the ligature was not cut in such a way that it was no longer around the man's neck. Although it is not believed that it had any impact on the outcome for him, it too could be the difference between life and death on another occasion.

The Governor should remind staff that anti-ligature knives should be used to cut through a ligature where it attaches around the neck.

Quality of record keeping

113. As noted in the body of this report, the logs kept and actions taken after the man was discovered were first rate.

This was an example of good practice.

Family liaison

114. The news that the man had died was passed on in person by two Leeds family liaison officers accompanied by a governor. This was in line with Prison Service guidance and was good practice. The man's mother explained to the investigator that she was told by staff at the mortuary that she could not see her son's body until after the post mortem was completed. I recognise the distress caused to the family.
115. The family say that landline telephone numbers were left by the Leeds staff but that they had great difficulty in getting through. The family have suggested that it would be better had they been left a dedicated mobile number. Although the Ombudsman makes no formal recommendation, he is sympathetic to the family's concerns and the FLOs at Leeds may wish to reflect upon this suggestion for the future.
116. The family also say that they would have found it helpful if a FLO had accompanied them to the mortuary. They would also have found it helpful if the FLO could have liaised with the Coroner's Officer on their behalf.
117. The family have suggested that the FLO would arrange to ring at a specific time and then be up to an hour late in calling. They also say that they did not receive answers to all their questions, and on one occasion the family feel she spoke too freely in front of the Coroner's Officer. They appreciate that it was her first experience as a FLO and that this must have been hard. However, they would like to give clear feedback from their experience.
118. The prison made a contribution of £3,500 to the funeral expenses.
119. Again, the Ombudsman draws all these comments to the attention of the prison.
120. The family's comments aside, it should be noted that the FLO kept a very comprehensive Family Liaison log.

Staff and prisoner care

121. So far as the Ombudsman can judge, Leeds reacted well to the tragedy of the man's death in terms of the support that it offered other prisoners at risk and to the staff involved. In the immediate emergency situation, SO A did

especially well to remove Officer D from the cell given that he was clearly distressed by the experience.

CONCLUSIONS

122. The man did not come to frequent attention, and those staff who spoke about him referred to his generally quiet demeanour, general politeness, and small circle of friends. However, it could also be argued that there was limited evidence of proactive efforts to get to know him. His probable abuse of illicit opiates while in custody, though known about by some of his prisoner friends and acquaintances, was not noted by staff.
123. It would appear that he was entirely content to be located on C wing, and for most of the time he was co-located with his co-accused. The co-accused himself has given an account of why the two men stopped sharing, but it is possible that the tensions between them were rather deeper.
124. During December 2008, the man's behaviour became more unpredictable. In retrospect, his decision to stop attending the workshop and his general lethargy may have been an indication of a recurrence of his depression or of withdrawing from drugs. However, there was little attempt by staff to inquire into this, save for a misplaced attempt to reduce his IEPs level to basic – apparently in the false belief that he was a convicted prisoner and therefore required to work.
125. At the time of his death, he was serving a relatively modest punishment for refusing to undergo a mandatory drug test. He was also in single occupation of a double cell, having shared for the previous five months in custody. Nevertheless, there was no reason for staff to suppose that these two factors placed him at much greater risk of suicide or self-harm. He was also far from alone in facing the prospect of an indeterminate sentence if convicted.
126. In sum, he did not present in such a way that staff could reasonably have anticipated that he would take his own life. Nevertheless, the investigation has revealed a significant number of issues that the Governor and Head of Healthcare will need to take forward.

RECOMMENDATIONS

To the Head of Healthcare:

1. Procedures/protocols for information sharing between reception staff need to be reviewed to ensure that information received by one party is available to all.

The recommendation was accepted. The Ombudsman received the following response:

'There is currently in place an information sharing agreement between the prison and the PCT.'

2. Documentation (First Reception Health Screen) used at reception needs to be reviewed and updated to gather more useful data with regard to mental health issues.

The recommendation was accepted. The Ombudsman received the following response:

'Health screening is now electronic. As part of the reception team a Mental Health Nurse is allocated to reception to work with patients with potential mental health issues.'

3. Important medical information gathered at reception screening (by whoever) should find its way into the medical notes – coded where possible and preferably added to the record via a suitable template.

The recommendation was accepted. The Ombudsman received the following response:

'Medical information is entered into the patients notes following an electronic template. Medical issues are Read Coded and Flagged if there are any health issues.'

4. The pro-forma sent to GPs requesting information needs to be reviewed and updated to be able to prompt for more information especially for certain conditions such as mental health problems.

The recommendation was accepted. The Ombudsman received the following response:

'A review of the current pro-forma and procedure will be carried out.'

5. Information/letters received from outside agencies such as those from drug clinics also needs to be reviewed by healthcare staff and coded where possible and again recorded via a suitable template.

The recommendation was accepted. The Ombudsman received the following response:

‘All medication received and given via drugs agencies is entered into the clinical notes. In the case of medication being given from outside services’ e.g. methadone, confirmation of the dose is obtained. If no confirmation, then a dispensing process is in place to maintain the patients’ care.’

6. Antidepressant medication should be continued unless there are compelling reasons to stop it. It should be continued until at least both the following have been completed: A suitable assessment of the depression and confirmation of medication and rationale for its use.

The recommendation was accepted. The Ombudsman received the following response:

‘In this particular case there was a compelling reason for the Doctor not to prescribe the anti-depressants. The GP will make his decision and if needed the primary care mental health team will offer an assessment.’

7. Information on any mental health issues raised at reception, with consent, should be readily available to all healthcare and possibly wider staff groups who come into contact with a prisoner in the first few days and possibly longer.

The recommendation was accepted. The Ombudsman received the following response:

‘A review of the existing practice will be carried out to discover the best way of passing this information on without breaching the patient’s confidentiality.’

8. A protocol for review appointments and follow up of defaulters should be developed that is clear and does not rely on the prisoner to make his own appointment.

The recommendation was accepted. The Ombudsman received the following response:

‘A review of the current procedure will take place, with a view to improving all follow up appointments.’

To the Governor:

9. The Governor should review information sharing in respect of prisoners’ risk factors for suicide and self-harm.

The recommendation was accepted. The Ombudsman received the following response:

'New systems were audited during a Prison Service Standards Audit Unit visit in January. There were found to be effective.'

10. The Governor should review the quality of entries on PER forms and advise staff accordingly.

The recommendation was accepted. The Ombudsman received the following response:

'A selection of PER forms are now checked as part of the management process to ensure they have been completed in accordance with national instructions.'

11. The Governor should satisfy himself that the IEPS is being operated appropriately, and that those prisoners who are not required to work are not being improperly reduced to basic level.

The recommendation was accepted. The Ombudsman received the following response:

'IEP procedures are subjected to regular internal audit. A recent audit has been completed with an action plan to ensure 100% compliance due to be completed by the end of July 2010.'

12. The Governor should satisfy himself that roll check procedures are being operated appropriately.

The recommendation was accepted. The Ombudsman received the following response:

'Each day an area or areas are tested as to their ability to maintain an accurate roll.'

13. The Governor should review the provision of radios to wing staff.

The recommendation was accepted. The Ombudsman received the following response:

'A review of the provision of radios to wing staff will be undertaken.'

14. The Governor should remind staff of the circumstances in which it is proper to enter a cell alone.

The recommendation was accepted. The Ombudsman received the following response:

'Night staff will be reminded of the procedure as part of their 'start of duty' briefing.'

15. The Governor should remind staff that anti-ligature knives should be used to cut through a ligature where it attaches around the neck.

The recommendation was accepted. The Ombudsman received the following response:

‘Staff Information Notice to be issued and re-issued annually.’

Good practice

16. The logs kept and actions taken after the man was discovered were first rate.