

**Investigation into the circumstances surrounding the
death of a prisoner
at HMP Leeds in January 2010**

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

October 2011

This is the report of an investigation into the death of a prisoner at HMP Leeds. On 31 January 2010 the man was found hanging in his cell by a ligature attached to the window, despite every effort, he could not be revived. The man was 39 years old.

I offer my sincere condolences to the man's family and friends. The death of a loved one is always difficult, and that can be made so much more so when the death happens in custody. I hope my report addresses the questions the family may have. I apologise for the delay in issuing this report and any additional distress this may have caused.

The investigation was undertaken by one of my senior investigators. Both he and I would like to thank the then Governor of Leeds and his staff for their participation in the investigation. A doctor was asked by Leeds Primary Care Trust (PCT) to undertake a review of the man's clinical care. I appreciate his assistance throughout the investigation process and his final report.

The clinical reviewer found that although the man had received a high standard of care for his physical needs, the healthcare team at HMP Leeds failed to act on correspondence received from his community General Practitioner in relation to a recent suicide attempt and his drug and alcohol use.

I make five recommendations. Four of these are to the head of healthcare concerning the effective use of information provided, the identification and treatment of substance misusers and recording of cardio pulmonary resuscitation. The other is to the Governor and also concerns the effective use of key information provided to the prison. The National Offender Management Service have accepted three of these recommendations, and partially accepted the remaining two. The man's family have indicated that they have no comments to make on the draft report.

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Prisons and Probation Ombudsman

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SUMMARY

1. The man was remanded to HMP Leeds on 24 December 2009.
2. Healthcare staff requested medical records from the man's community General Practitioner, which were faxed to the prison on 29 December. These showed a history of substance misuse and a recent suicide attempt. The information in the document was not acted upon. Records show that the man's initial health screening did not give rise to any concerns, and the man was not referred for a mental health assessment or assessed in relation to his risk of suicide or self-harm.
3. The man had complex physical issues which were well addressed by the healthcare staff at Leeds. He was receiving medication for sciatic nerve damage and depression. Following a blood test, he was also found to be positive for hepatitis C, which was due to be treated.
4. The man appeared at Bradford Crown Court on 28 January and was sentenced to six years and six months imprisonment for robbery. Pre-sentence reports completed for the court showed that the man had expressed thoughts of taking his own life, had said that he had attempted to take his own life after being released from a previous prison sentence, had no contact with family or friends since being arrested and was in a "low mood" due to the recent breakdown of his relationship. Although the report assessed his risk of self harm as "medium" the offender manager suggested that "any emotional crisis would escalate the risk of self-harm and suicidal thoughts".
5. A probation report on the man also highlighted his vulnerability and assessed his emotional state as "fragile". Despite both the pre-sentence report and probation report being amongst the documentation provided to the investigator by the prison, neither appear to have been acted upon.
6. The man was worried about being bullied after details of his offence were published in the local press on 29 January. The next evening the man approached a wing officer and asked to be moved to another wing because he was being threatened by other prisoners. As it was lock-up time and the man was not worried by his cellmate, they agreed to deal with the move in the morning. Unfortunately in the early hours of 31 January the man apparently took his life using the crepe bandage from the dressing on his leg.
7. The man was discovered by his cellmate at 4.30am. Officers and healthcare staff provided a good quality of emergency response and paramedics were in attendance quickly and took over efforts to resuscitate the man. Sadly he could not be revived and paramedics confirmed he had died at 5.04am.
8. I consider the healthcare the man received whilst at Leeds and the emergency response on the day he died. I also consider the lack of effective use of information that might have triggered a mental health assessment, substance misuse treatment and crucially suicide prevention measures. I

make five recommendations, four to the head of healthcare and the other to the Governor of HMP Leeds.

THE INVESTIGATION PROCESS

9. My investigator formally opened the case at HMP Leeds on 4 February 2010. During the investigation he visited Leeds and spoke to staff and prisoners who had come into contact with the man during his time there. He interviewed four members of staff. These interviews were recorded and transcripts are annexed to this report. He also spoke to two other members of staff, and to the man's cellmate. The investigator told the Prison Officers Association, the Independent Monitoring Board, and the chaplaincy about his visit, but they did not ask to see him.
10. The investigator spoke to the Detective Superintendent who was leading the police investigation into the man's death. A thorough investigation had been undertaken at the prison at the time, and the police had found no evidence to suggest that the man's death involved anyone else.
11. Notices were posted to staff and prisoners about my investigation, inviting them to contact the investigator with any information they thought might be relevant. None was received. The investigator looked at all relevant prison records relating to the man. These include his main prison record, medical records, statements made by staff, and some of the man's personal papers.
12. Leeds Primary Care NHS Trust asked a doctor to carry out a review of the man's clinical care. I am grateful to him for undertaking this review. My investigator discussed aspects of the man's treatment both with healthcare staff at Leeds and with the reviewer.
13. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.
14. One of my Family Liaison Officers (FLOs) contacted the man's sister, his listed next of kin. She told her of my investigation and invited her and the man's family to ask any questions or raise any issues for consideration. The family asked if my investigation could consider:
 - Why did the man's cellmate not hear anything?
 - How long had the man had hepatitis?
 - As the man was disabled, why was he not on a hospital wing?
 - What treatment was he receiving for his drug addiction?
 - Why was there a few hours delay in the family being told of his death?
15. The man's family have considered the draft report and have not made any comments. I hope that my investigation will provide the man's family with a better understanding of his time in custody and the circumstances of 31 January.

HMP LEEDS

16. HMP Leeds is a Category B local prison, serving the courts of West Yorkshire. It has capacity to hold just over 1000 male prisoners. The prison has four Victorian wings and two modern wings; one of the wings is the vulnerable prisoners' unit. (Prisoners are most often deemed vulnerable due to the nature of their offences but may also include those who are less able to cope on the main prison wings for other reasons. Vulnerable prisoners are kept separate from other prisoners.) Cells are either single or shared by two prisoners. All wings have both prisoners who are on remand and convicted.
17. There is 24 hour healthcare cover at Leeds: the prison has its own in-patient healthcare centre, operated by the local Primary Care Trust (PCT). In daytime hours a doctor is in the prison, and there is nursing cover at all times. Nursing staff are not based in the healthcare centre, but are allocated to wings. Although they work on other wings on occasions when staffing levels require it, they are usually based on their own wings.
18. Facilities available to prisoners include a gym and education which is contracted out to The Manchester College. There are approximately 30 voluntary and community service organisations working within the prison. These include the Samaritans, Prison Visitors, Bereavement Counselling and minority interest groups.

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT is the prison service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff believe the risk of harm to be very high, the prisoner may be constantly supervised, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of supervision may be several times an hour or day. Supervision can also take place during the night. As part of the process a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is also included in review meetings.

Night state

20. When prisoners are locked up for the night, the prison is in night state. Staffing levels are at a minimum. The officer in charge of the operation of the prison is the Night Orderly Officer (NOO), and has keys to access all cells. Other officers on duty have cell keys in sealed pouches, only to be used in an emergency. They are free to use their discretion when deciding to enter cells,

including the ratio of how many members of staff to the number of prisoners in the cell. But in doing so they must take into account security, including their own safety. The radio operates on an open network, so that all staff on duty are able to hear any message sent out.

Cell Sharing Risk Assessment (CSRA)

21. The CSRA assesses the risk a prisoner poses to other prisoners and whether they are suitable for sharing a cell. The assessment considers a range of factors including the prisoner's past offences, whether they have displayed bullying or violent tendencies in the past, any substance misuse or mental health problems and whether they might try to harm themselves while in prison. The prisoner is asked whether they have any concerns about sharing a cell and this is also taken into account. One part is completed by a discipline officer and one part by a member of healthcare staff. The staff conducting the assessment must decide whether the prisoner poses a low, medium or high risk to other prisoners. Those assessed as high risk will generally be placed in a single cell, and the risk assessment should be reviewed frequently. The prisoner may be required to work on those factors that make them high risk.

Previous deaths in Leeds

22. The death of the man was the fifth self-inflicted death at HMP Leeds since the start of 2008. Since the man died there has been one further self-inflicted death. I draw the Governor's and head of healthcare's attention to previous recommendations made concerning effective management of medical and individual risk information.

Her Majesty's Chief Inspector of Prisons

23. The most recent inspection report published by Her Majesty's Chief Inspector of Prisons, was following an unannounced inspection in March 2010. The report noted that whilst prisoners did not report high levels of victimisation by other prisoners, systems to investigate and monitor alleged incidents were weak. Reporting of violence-related incidents and potential bullying had improved, with a more focused strategy, but there were still no effective procedures to ensure that investigations took place promptly and that alleged bullies and their victims were monitored. The Chief Inspector also comments that a great deal of attention had been given to suicide prevention strategies and procedures, following a large number of self-inflicted deaths, and in general support arrangements had improved.
24. The inspectorate report commented on the in-patient facility. It recommended that it should not be used to accommodate prisoners with disabilities unless there was a need for clinical inpatient care.

Independent Monitoring Board

25. Each prison in England and Wales is also monitored by an Independent Monitoring Board (IMB) formed of volunteers from the local community. IMB members have full access to every prisoner and all parts of the prison. The Board produces an annual report, the report for 2010 notes that “staff are now strongly encouraged to report all incidents of violence, which includes bullying”. The report goes on to say that staff are now recording “more thoroughly acts of indirect violence, being the victim of gossip for example”.
26. The report also raises the issue of improved communication between the prison and outside agencies, particularly in relation to cell sharing risk assessments, where outside agencies have had “knowledge of a person’s violent tendencies, strong racial views or mental health issues” but not shared these with the prison.

KEY EVENTS

27. Following an offence on 17 December 2009, the man was arrested on 23 December and charged with robbery. When prisoners are moved between different areas of custody, they are accompanied by a Person Escort Record (PER). The man's PER when he was transferred from police custody, his PER notes physical health risks as "injuries to right leg" and mental health risks as "depression". His risk assessment additionally notes an infection to one of his toes.
28. He was remanded to HMP Leeds on 24 December. A cell-sharing risk assessment (CSRA) carried out that day noted no concerns at the man sharing a cell, simply noting that he was a smoker. The assessment noted that the man should be allocated a cell on the ground floor. In answer to the question as to whether he was currently dependent on drugs or alcohol, the man said that he was. He said that he had previously had mental health problems, and the assessment shows that while he had previously harmed himself, he had no such thoughts of doing so again.
29. The man's reception health screening was carried out by a Staff Nurse. The man said that he had been seen by his General Practitioner in the last few months and was receiving medication for sciatic nerve damage and depression. The Staff Nurse noted that the man had reduced mobility and used crutches due to his fractured right hip and an ulcer and cellulites (non contagious spreading bacterial skin infection) on his right foot. It was also noted that he was waiting for an operation on his right hip. The man was found to be positive for hepatitis C (a serious viral infection of the liver). It is not clear from the records whether the man was aware of this previously or if this was the first time he had been diagnosed. He said that he had seen his doctor in recent months both to receive medication for damage to his sciatic nerve, and for depression. He denied any drug or alcohol issues.
30. Later the same day the man was seen by a prison doctor. The man confirmed that he been prescribed medication by his General Practitioner, and had brought this in with him. This included a low dose of amitriptyline. Amitriptyline is sometimes used as an anti-depressant, but the clinical reviewer notes that the low dosage prescribed to the man suggests that it was prescribed primarily for pain relief, with perhaps some small potential benefit for depression. The medication was confirmed by the doctor. The doctor also prescribed other medication to the man for his physical health issues, including pain relief and antibiotics.
31. Between 25 December and 4 January 2010, healthcare staff regularly dressed the man's foot and another prison doctor, reviewed his medication.
32. On 4 January 2010 the man appeared at Bradford Crown Court. He was convicted of robbery, but not sentenced at that stage. The man returned to HMP Leeds.

33. Regular dressings of the man's foot continued over the next two weeks, this included the application of a crepe bandage for protection and to keep the dressings in place. When changing the dressing on his foot on 19 January, the nurse noted a rash on the man's face and abdomen, as a consequence he saw another prison doctor later that day. The doctor confirmed that the rash had become infected, and he prescribed erythromycin (antibiotic), flucloxacillin (antibiotic) and loratadine (anti-histamine, for treatment of allergies).
34. The man did not require 24 hour in-patient care (had he been outside prison he would not have been in hospital) so remained on a normal prison wing. He did, though, continue to be seen by healthcare staff on a regular basis to redress his foot and review his medications. On 25 January, the man was seen by the doctor concerning the best way to treat his hepatitis C, further blood tests were requested and the doctor was to review treatment once the results were received.
35. On 27 January the man's foot was redressed, no signs of infection were noted. In common with previous treatments, the dressings were held in place by a crepe bandage.
36. The man appeared in court on 28 January and was sentenced to six years and six months imprisonment.
37. Pre-sentence reports completed for the court show that the man had expressed thoughts of taking his own life when he was received into custody. He also said that he had attempted to take his own life after being released from his previous prison sentence. The report also says that the man had no contact with family or friends since he had been arrested, due to the nature of the offence and he was in a "low mood" due the recent breakdown of his relationship. The report assesses the man as "medium risk" of self-harm, however the offender manager suggests that any "emotional crisis would escalate the risk of self-harm and suicidal thoughts". There is no evidence to suggest that this important information was passed to the prison via the court or probation service on the day the man was sentenced.
38. As a sentenced prisoner, the offender assessment (known as OASys) which was completed on the man by his offender supervisor (probation officer) which informed the court report should have been provided to the prison. It describes the man as isolated, with a low opinion of himself. The report confirms the man said that he had attempted to take his own life by taking an overdose shortly before he committed his latest offence. He also said that he had thoughts of killing himself on the day he committed the offence, and again when remanded into prison. He said that he had been prescribed anti-depressant medication. He felt disgust at his offence, although he claimed he was no longer overwhelmed with thoughts of wanting to harm himself or end his life. The assessment judges his emotional state at that time as fragile, but concludes that although there had been self-harm issues in the past, there were none at the time the OASys report was completed.

39. The man's cellmate, told my investigator that on his return to prison on 28 January, the man had been suffering some anxiety over the length of his sentence, and "some of the other lads were giving him a hard time when they found out what he was in for".
40. The man's cellmate said that after being locked into their cell on the evening of 29 January, he and the man talked into the early hours of the morning. The man's cellmate told the investigator that apart from being dejected over the length of his sentence, the man showed no signs of being depressed or at risk of harming himself.
41. Several local newspapers printed reports of the trial on Friday 29 January, including details of the offence. The man's cellmate said that the man was concerned about other prisoners knowing these details. Staff later received information that a prisoner had put a copy of one of these newspaper stories on the wing notice board, it is not clear whether this was on the Friday or Saturday, but it appears to have been quickly removed by another prisoner. It is also not clear whether the man was aware of this, but the possibility must exist that if he did, this was part of the reason he felt he was being bullied.
42. At weekends prisoners are locked into their cells for the night at 5.00pm. Shortly before being locked up on the evening of Saturday 30 January, the man asked to speak with a Senior Officer (SO). The Senior Officer took him into an office on the wing where they could speak privately. The man then told the Senior Officer that he had been threatened by another prisoner (who he identified) on the wing and he asked to be moved to another wing. The Senior Officer asked if the man was asking to be segregated for his own safety, but the man said he was not. He said that had been threatened by another prisoner on the wing, and just wanted to move to another wing but wanted to stay on normal location.
43. The man confirmed to the Senior Officer that he had no problems with his cellmate and did not feel unsafe with him. The Senior Officer spoke to the man's cellmate, who said that he knew about the threats. He said that he did not have a problem with the man or with continuing to share a cell with him, despite the man's offence becoming common knowledge and despite the threats the man had received. The Senior Officer then told the man that he would deal with the request to move first thing in the morning. Prisoners were just about to be locked into their cells for the night, and the man had said he felt safe until the morning, when the Senior Officer would deal with securing a move for him. The man said that he was content with this course of action.
44. The Senior Officer said in interview that he had convinced himself that the man was safe from the prisoner who had threatened him, was safe with his cellmate, and was himself content for the matter to be addressed the following morning. The Senior Officer said that the man gave no indication that he might harm himself during the night, and therefore he saw no need to open an ACCT document to ensure special monitoring and support measures were in place. The man therefore returned to his cell and the prisoners were locked up for the evening.

45. The prison officer on duty on D wing that night was an Officer serving the sixth of seven scheduled consecutive night shifts. The Officer said that when on night duty he patrolled each of the three landings for which he was responsible once or twice per hour. The man and the man's cellmate's cell was only two doors along from the wing office, so each time The Officer left the office he passed close by the cell. He said that throughout the previous week he recalled hearing the man and the man's cellmate talking to each other fairly late into the night. On the 30 January, this continued and the two men were talking into the early hours of Sunday morning. When speaking to my investigator, neither the man's cellmate nor the Officer could be specific about the time, but both agreed it was approximately 2.30am when the two prisoners stopped talking in order to go to sleep.
46. Because of his disability, the man occupied the lower bunk bed in the cell, and the man's cellmate the upper. Shortly before 4.30am, the man's cellmate said he awoke and decided to smoke a cigarette. As he looked around the cell, he saw the man leaning back against the wall, suspended by a something attached to the bars on the cell window. The man's cellmate said ran to the door, pressed the cell's emergency call bell, then ran back to the man and tried to support his weight, all the while shouting for help. He told the investigator that the man was cold to the touch, and although the man's cellmate has no medical training, he did not think that he was alive.
47. At this moment, the Officer was just leaving the wing office in order to check on another prisoner. He heard the man's cellmate call for help, and was at the cell door in a matter of seconds. He looked through the observation panel, and saw the man's cellmate with his arm around the man at the opposite end of the cell. He saw that the man was hanging by a ligature and immediately put an emergency call across the radio. The Officer used the call sign Code Blue. This is the emergency code indicating that a prisoner is not breathing, with the possibility that this might be due to a ligature. The emergency call went out at 4.30am.
48. When the Officer's emergency call went out, the Senior Officer and the Night Orderly Officer were in the office on B wing, which is only a few yards from the entrance to D wing. They immediately went to assist, reaching D wing in what the Senior Officer estimated to be approximately 15 seconds. Having put the emergency call out over the radio, the Officer had decided to go into the cell. He was in the process of breaking the seal on his cell key pouch when the Senior Officer arrived. Through the observation panel, the Senior Officer could see the man suspended by a ligature, his weight being supported by the man's cellmate, who was visibly upset. He opened the cell, and the three officers went in. The man was suspended by a bandage which he had taken off his foot, and whilst the other two officers supported the man, another Officer used his anti-ligature knife to cut him down, cutting the bandage between the ligature point and the man's neck. The Officer told my investigator that the man was cold to the touch, and his initial impression was that the man was already dead.

49. Two other officers also heard the emergency call and made their way to D wing. On arrival, one of the Officers began to keep a log of events. A Nurse was the emergency response nurse on duty on 31 January. At 4.30am she heard the Code Blue call from D wing across the radio network, and immediately made her way to the cell. She arrived just as the officers were going in. The prison's log shows that she arrived at 4.31am.
50. The officers assisted the man's cellmate out of the cell. Operational Support Grade (OSG) was on duty with an Officer on C wing when she heard the Code Blue call over the radio. They made their way to D wing. On arrival, the OSG found the man's cellmate outside the cell in a distressed state, so she began to talk to him. She took him aside and offered him support.
51. The officers laid the man on the cell floor. The Officer began to feel the effects of shock, so handed his anti-ligature knife to the Senior Officer who managed to cut the bandage away. He radioed through to the communications centre to request an emergency ambulance. He also asked that the duty governor be informed. The Nurse and the Senior Officer began to perform cardiopulmonary resuscitation (CPR) while the Officer held the oxygen tank.
52. Another Nurse was on duty in the healthcare centre and, hearing the emergency call, made his way to D wing. The log shows that he arrived at the cell at either 4.36am or 4.38am (the log gives both times). He took over from The Senior Officer. The Officer had heard the emergency call on the radio and made his way to D wing, and one of the nurses asked him to collect the resuscitation bag from the treatment centre. The nurses attached a defibrillator (a machine which detects whether there is any activity in the heart and, if so, will advise a shock to assist the heart back into rhythm). The defibrillator did not detect any activity in the man's heart and did not advise them to deliver a shock, so they continued with CPR.
53. The ambulance arrived and the crew were escorted to the cell by an Officer arriving there according to the log at 4.47am. They took over from the nurses.
54. The paramedics worked to try to resuscitate the man until 5.04am, when they confirmed that he had died.
55. The OSG was still talking to the man's cellmate, who was visibly upset. He told the OSG that two nights previously the man had said that he felt suicidal, and that if anything should happen to him the man's cellmate should tell his daughter that he loved her. However, after the man spoke to the wing Senior Officer, he thought that he had seemed to be more relaxed, so he didn't tell anyone. He also said that the man had appeared to be fine that night before the man's cellmate had fallen asleep. The man's cellmate then indicated that other prisoners had "started getting on at him and making his jail time hard. I think it pushed him over". The OSG told the man's cellmate that he could request counselling if he wished and this appeared to calm him down.

56. The OSG supported the man's cellmate until approximately 5.30am. At this point the man's cellmate was taken to another cell, with a Listener (Listeners are prisoners trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress).
57. A hot debrief was held for staff (a hot debrief is held as soon as possible on the same day after a death in custody. They are held to ensure that all staff involved have an opportunity to discuss any issues arising). Support was offered for any who felt that they needed it.
58. The Governor posted notices to staff and to prisoners informing them of the man's death, and letting them know how to obtain support should they feel it would be of benefit to them.
59. A debrief session was held on 2 February, chaired by a Governor. All available staff who had been involved on 31 January attended.
60. A note from the man to his sister was found in his diary a few days after his death which although not clear, seems to indicate his intention to take his own life.

Breaking the news to the man's family

61. The man had listed his next of kin as his sister. The prison Governor, and a Sister from the chaplaincy went to the address given to inform the family of the man's death. However, when they arrived at the address the man's sister was not at home. They spoke to her son, and decided it was not appropriate to break the news to him. He did, though, provide an address for another sister (his aunt), and the Governor and the Sister then travelled to this address and broke the news to the man's sister.
62. The family commented that they were grateful for the contact they had had from the prison's family liaison officer, who they described as helpful.

Post mortem

63. A post mortem was held on 31 January. The cause of death was given as hanging.

ISSUES

Healthcare

64. The clinical reviewer says:

“the healthcare team at HMP Leeds afforded him [the man] a high standard of physical health care but missed the clear opportunity to explore his mental state and drug issues as they failed to react to correspondence from his GP or recognise from his presentation that these were important issues.”

65. The man’s reception health screen confirmed that he suffered from depression but, despite him saying that he was dependent on them in his CSRA, also showed that he denied any drug or alcohol issues. The prison healthcare sought information from the man’s community General Practitioner, which was provided on 29 December 2009. This clearly documented a recent overdose and attempted suicide, treated at the local hospital accident and emergency department. The community General Practitioner also described injected heroin use, the use of crack cocaine, poly drugs and excessive alcohol.

66. The clinical reviewer confirms that the issues of “injecting drug use and self-harm through overdose are not considered subsequently by the healthcare team at HMP Leeds”. There was also “no evidence of exploration or follow-up of the documented depression at HMP Leeds”.

67. This is a serious omission by the healthcare team at Leeds. Although we will never know whether this lack of action on the man’s substance misuse issues, depression and recent overdose contributed to him taking his own life, these issues should have been considered key indicators of risk and followed up accordingly. I therefore agree with the clinical reviewers concerns and make the following recommendations:

The head of healthcare must ensure that a system is put in place so that correspondence from a patient’s community General Practitioner is routinely shown to the prison doctor. Also that the records are appropriately endorsed to confirm that the information has been read and will be responded to appropriately.

The head of healthcare should ensure that the healthcare team are more vigilant in identifying drug users and more confident in taking substance misuse histories and that all healthcare staff are trained in the Integrated Drug Treatment System to an appropriate level.

68. Instructions and guidance to the Prison Service are contained in Prison Service Orders (PSOs) and Prison Service Instructions (PSIs). PSO 3550 addresses clinical services for substance misusers, and contains a mandatory requirement to provide a service for the management of alcohol misusers, which includes identification during reception screening of alcohol

dependency and those at risk of developing withdrawal symptoms and provision of managed and supervised treatment. Although I accept that the man may not have admitted his excessive use of alcohol during the reception screening, this clearly became apparent from the documentation faxed by the community General Practitioner (29 December) and from the OASys report. I am therefore disappointed that although he saw a number of healthcare professionals, in addition to the lack of action in relation to the man's drug dependence and depression, there was also an apparent lack of action in relation to his alcohol issues.

69. Unsupported withdrawal from drugs and/or alcohol can have a serious affect on someone's state of mind. It is impossible to say whether the outcome would have been different if the man had received appropriate support and medication, but the possibility must exist that his state of mind at the time of his death may have been affected.

Mental health issues

70. The man clearly stated during his reception health screen on 24 December that he suffered from depression, this is indicated on the reception checklist. Also noted in his medical records is, that along with a number of other medications (relating to his physical health issues) he is prescribed the anti-depressant amitriptyline. Amitriptyline is, though, also used to relieve pain, and the low dosage prescribed to the man suggests that this may have been the primary reason he was prescribed. The records do not make this clear.
71. On 29 December (more than a month before he died), the prison received faxed documentation from the man's community General Practitioner which clearly shows that he had been treated in accident and emergency at the local hospital for a recent overdose, which was considered a suicide attempt.
72. I am very concerned, that despite these two key indicators of risk that the man was not referred to the mental health team for an assessment, and make the following recommendation:

The head of healthcare should ensure that there are processes in place to capture and act upon all relevant information in relation to the physical and mental health of prisoners.

Offender Assessment System (OASys) Report

73. The OASys report was completed by the man's offender manager on 29 January and subsequently sent through to the prison. Although primarily designed for the management of risk to the community and sentence planning, the document clearly sets out the man's history of depression, self harm and his recent suicide attempt. The offender manager assessed his emotional state as 'fragile'. I accept that the report was completed just two days before the man's death, however it is not clear whether the OASys report was ever read by any member of prison staff. It is apparent that it was

not acted upon and had it have been so the man might very well have been more closely monitored or at least spoken to.

74. PSO 2700 addresses suicide prevention and self harm management. It covers “Other sources of risk information or assistance concerning prisoners”. This makes clear that agencies and individuals outside of prison can help with warnings, assessment and referral. The document states:

“Establishments must have in place robust systems for receiving and recording, and passing to the area of the prison where the prisoner resides, information coming into the establishment from families, agencies, Offender Managers/Supervisors and other parties outside the establishment who have a concern for a prisoner who may be at risk of self-harm or suicide”.

75. There is no evidence that HMP Leeds has in place any system that ensures OASys reports are swiftly read and acted upon. Such a report can be invaluable especially if it contains information that might prove vital to protect a prisoner from harm and I suggest that it should be considered a source of key information and treated accordingly:

The Governor should ensure that OASys documents are reviewed upon receipt, and staff should be reminded that they might contain valuable information about a prisoner’s state of mind and risk of self harm or suicide.

76. It is recognised that prisoners may be more vulnerable at times surrounding court appearances. This can be particularly heightened at times of conviction, and sentencing, especially if the sentence is for a long period. The man was sentenced to six years and six months imprisonment on 28 January, just three days before he apparently took his life. There is no note on the electronic Person Escort Record (PER) which accompanied the man back from court on 28 January to suggest that there were any concerns at his state of mind. The pre-sentence report (PSR) prepared for the court, however, makes clear that the man was in a “low mood” and any “any emotional crisis would escalate the risk of self-harm and suicidal thoughts”. There is no evidence to show that this important information about the risk to the man’s well being was passed on to the prison as a matter of urgency either by the court or probation service. The PSR was in the papers provided by the prison to my investigator, but it is not clear when this arrived at the prison or if it was ever read by prison staff – it is clear however, that it was not acted upon. This was another missed opportunity to consider the man’s state of mind and risk of suicide.
77. Despite this prison staff should be aware that a change of status can increase the vulnerability of a prisoner and the Governor may wish to remind staff to be particularly vigilant when a prisoner returns from court with a significant change of status.

Bullying

78. The man told his cellmate that he was worried that if the nature of his offence was revealed he would be subject to bullying from other prisoners. On 29 or 30 January pages from local newspapers were posted on notice boards on the wing. These identified the man and gave details of his offence. It is not known whether the man knew about this, I understand they were swiftly removed by another prisoner. However if he did it could clearly have added to his feelings of concern.
79. The man identified an individual who he believed was threatening him to an officer on the night that he died. He spoke to the Senior Officer in private and asked to be moved to another wing. This was around 5.00pm on Saturday 30 December, the time that prisoners are locked up for the night at the weekend. Having checked with the man that he felt safe for the night and had no issues with his cellmate, the Senior Officer and the man agreed to deal with the issue the following morning. Unfortunately during the early hours of the following morning the man apparently took his life.
80. The Senior Officer ensured that spoke to the man in private, so he would have been able to voice any concerns he had out of earshot of other prisoners. However the man did not give any indication to the officer that he would feel unsafe locked up overnight. He also confirmed he was happy with his cellmate, indeed they had been heard chatting into the early hours by wing staff over the previous few nights. I am satisfied that the Senior Officer did all he could to ascertain that the man was safe overnight, with a view to arranging a move to another wing the following morning. The Senior Officer also considered and decided against opening at ACCT. In making such a decision, staff must consider how the individual prisoner is currently presenting, as well as other information. Given the information available to him – and we cannot say whether the Senior Officer would have made a different decision even had all the information been available to him - I am able to understand why he made this decision. Indeed, even if the man had been subject to special monitoring, there is no way of knowing if this would have prevented what happened.
81. However it is clear that none of the information that had been available (from the community General Practitioner, PSR and OASys) on the man's drug and alcohol issues, mental health and previous suicide attempt had been effectively managed and acted upon. If the Senior Officer had been in possession of this key information, he may have made a very different decision. It is impossible to say whether a different decision would have prevented the man from taking his own life, but being without the information referred to above, the Senior Officer was clearly prevented from making informed decisions on both moving the man immediately and opening an ACCT plan by the earlier failings discussed in this report. Indeed a full assessment of the man's risk of self-harm of suicide might very well have already been carried out if the information available had been acted upon.

Events on 31 January 2010

82. Following the discussion with the Senior Officer, the man and his cellmate were locked up at approximately 5.00pm on 30 January. They were heard talking to each other into the early hours of the next morning. The Officer who was on duty that night said that he had both men talking to each other until fairly late throughout the previous week.
83. Around 4.30am, the man's cellmate got up for a cigarette and discovered the man suspended from the window. He pressed the cell bell and then tried to support the man whilst calling for help.
84. The Officer responded immediately, he looked through the observation panel and saw that the man was hanging by a ligature. The Officer put an emergency call out over the radio, using the call sign Code Blue. This effectively informs others that a prisoner is not breathing and that a ligature might be involved. It is good practice to use such codes as this ensures the correct response from staff (such as bringing the right equipment).
85. Officers entered the cell quickly and the ligature was cut using an anti-ligature knife (a tool designed for that specific purpose). The man had used the bandage used to dress his leg wound as a ligature.
86. As already stated earlier in this report, the man's physical health needs had been well addressed and the use of a crepe bandage to protect his wound and hold the dressing in place, would not have been seen as a risk by healthcare staff. However if the information available from the community General Practitioner, PSR and OASys report had been acted upon, a full assessment of the man's risk of self-harm or suicide should have taken place. If the result had been to open an ACCT, the risk of using a crepe bandage may have been considered.
87. CPR was started by a nurse and the Senior Officer, also assisted by another Nurse. A defibrillator was also used, which advised not to administer a shock. The paramedics arrived at 4.47 am and despite continued attempts to resuscitate the man, he was confirmed dead at 5.04am.
88. The Clinical Reviewer notes that there is no information as the use of an airway, oxygen or resuscitation drugs. He also notes that there are no records of the man's condition such as colour, pulse, respirations or blood pressure. It is important to effectively record vital signs, equipment and drugs used when administering CPR and I endorse The Clinical Reviewer's recommendation:

The head of healthcare should ensure that a detailed record of CPR is kept including a description of the patient's vital signs and the equipment and any drugs used.

Support for Staff and Prisoners

89. According to staff, the man's cellmate, the man's cellmate, was clearly upset and visibly shaken. The man's cellmate was assisted out of the cell and was

clearly well supported by the OSG, including advising him that counselling was available for him. The OSG stayed with the man's cellmate until 5.30am. He was then supported by a Listener.

90. I am pleased to see that the man's cellmate told my investigator that he was well supported on the evening.
91. Staff were satisfactorily supported through a hot debrief held on the day, ensuring that all staff involved were able to discuss any issues arising. In addition support was offered to anyone who felt they needed it.
92. Also notices were posted to both staff and prisoners informing them of the man's death and indicating how to access support if needed.

Issues arising following the death of the man

93. Cell sharing risk assessments (CSRAs) had been carried out on both the man and the man's cellmate, both were assessed as low risk and suitable for a shared cell. The police have investigated the man's death and there is no suggestion that the man's cellmate was involved in the death of the man.
94. However on a security incident report (SIR) filled out by the Senior Officer after the incident, there is a note that the man's cellmate has an "extensive security file re bullying/drugs through visits". During the investigation the investigator also received a letter from another prisoner suggesting that the man's cellmate was "bullying" the man, although there was no other evidence to support this.
95. At lock up on the night he died, the man told an officer that he wished to be moved to another location because he was being bullied, he gave the name of the prisoner concerned and also confirmed that he was happy to be in the same cell as the man's cellmate. The officer discussed his concerns and they both agreed to follow up his request in the morning, as the officer and the man felt he would be safe locked up overnight. Despite the SIR and letter received from another prisoner, neither this investigation or that of the police found any evidence that suggested the man's cellmate was bullying the man or involved in his death.
96. I am greatly concerned however that the security file referred to by the Senior Officer cannot be located by the prison and that the CSRA on the man's cellmate cannot therefore be effectively updated. The Governor may wish to follow up this issue.

CONCLUSION

97. The man apparently took his own life at HMP Leeds on 31 January 2010. He had been remanded in prison since 24 December 2009 and was sentenced to six years and six months imprisonment on 28 January.
98. Although his physical health needs were addressed very well by the healthcare department at Leeds, it is clear that he was failed in terms of his mental health, and drug and alcohol issues. He was not referred for a mental health assessment despite clear information about all three issues being made available to the healthcare department by the man himself when he arrived in the prison, then again by the community GP on 29 December, over a month before the man died.
99. In addition, vital information concerning the man's state of mind and previous suicide attempt set out in the PSR provided to the court, and his OASys record was not acted upon by prison staff. As a result there was no discussion concerning his risk of self-harm or suicide. Also prison staff did not appear to consider his increased vulnerability following sentencing.
100. The man was worried about being bullied by other prisoners, especially if details of his offence became known. He asked to be moved to another wing and named a prisoner who had threatened him. He confirmed to the wing officer that he was not worried about spending one more night on his current wing as he was about to be locked up, and he was not concerned about his cellmate. Unfortunately during the early hours of the following morning, the man took his own life. The officer made the decision to deal with the man's request the following morning based on the information he had available. Should the full picture of the man's vulnerable state been apparent the wing officer may very well have made a different decision. I make no criticism of the officer.
101. I make five recommendations, four to the head of healthcare and one to the Governor, concerning the effective use of information provided to the prison/healthcare department, the identification and treatment of drug users and effective recording of CPR.

RECOMMENDATIONS

1. The head of healthcare must ensure that a system is put in place so that any correspondence from a patient's community GP is routinely shown to the prison doctor. Also that the records are appropriately endorsed to confirm that the information has been read and will be responded to appropriately.

The National Offender Management Service (NOMS) has partially accepted this recommendation. The service commented:

"The correspondence from the community GP is seen by a nurse every day and triaged. All relevant correspondence is tasked to the GP on duty, and they will respond appropriately".

2. The head of healthcare should ensure that the healthcare team are more vigilant in identifying drug users and more confident in taking substance misuse histories and that all healthcare staff are trained in the Integrated Drug Treatment System to an appropriate level.

The National Offender Management Service (NOMS) has accepted this recommendation. The service commented:

"The first night reception screen includes a number of questions to identify drug users when they first come in and those identified as drug users then undergo further screening relating to their drug use.

All staff will complete IDTS awareness as part of their induction training.

All IDTS staff and other relevant healthcare staff working with drug users are trained up to RCGP Part 1 or equivalent."

3. The head of healthcare should ensure that there are processes in place to capture and act upon all relevant information in relation to the physical and mental health of prisoners.

The National Offender Management Service (NOMS) has accepted this recommendation. The service commented:

"All information given in reception by the patient is used to determine if further assessment is needed by primary care mental health, IDTS or long term conditions team. Task referrals are made to the appropriate team via Systemone (the electronic medical record system) by the healthcare reception screening staff. This referral process negates the need for paper referrals and provides a full audit trail of when referrals are made, received and actioned.

Correspondence requesting confirmation of medical history and any current treatment or interventions is sent the next working day after reception to the GPs and when returned is triaged by a nurse and the GP and any other relevant team is tasked according to the information provided. Each team responds accordingly."

4. The Governor should ensure that OASys documents are reviewed immediately upon receipt, and staff should be reminded that they might contain valuable information about a prisoners state of mind and risk of self harm or suicide.

The National Offender Management Service (NOMS) has partially accepted this recommendation. The service commented:

“West Yorkshire Probation currently use a 24/7 telephone/fax to ensure that any information that they are in possession of (including OASys) is brought to the attention of the Prison as soon as they are aware that a prisoner has been remanded/sentenced to custody. This is acted upon immediately when received.”

5. The head of healthcare should ensure that a detailed record of CPR is kept including a description of the patient’s vital signs and the equipment and any drugs use.

The National Offender Management Service (NOMS) has accepted this recommendation. The service commented:

“All staff will complete training in record keeping as part of their annual CPR training to include patients vital signs, equipment used and any drugs used.”