

**Investigation into the circumstances surrounding the death  
of a man at HMP Leeds in December 2006**

**A report by the Prisons and Probation Ombudsman  
for England and Wales**

**September 2010**

This is the report of an investigation into the death of a man at HMP Leeds in a day in December 2006. Shortly before 6.00am that day, the man was found dead in his cell. A post mortem examination conducted by a consultant forensic pathologist at a medico-legal centre showed that the cause of death was hanging. The man died just before his 32<sup>nd</sup> birthday.

I offer my sincere condolences to the man's family and friends for their tragic loss.

The investigation was conducted by one of my colleagues. I also commissioned a clinical review of the management of the man's health needs while he was in custody. This was conducted by a doctor on behalf of the Leeds Primary Care Trust. I am grateful to the doctor for his contribution to this investigation. I should also like to express my appreciation to the then Governor and his staff at Leeds, and to the Director and staff at Altcourse, for their assistance during the investigation. I am especially grateful to the Principal Officers at Leeds and Altcourse for their invaluable contribution as investigation liaison officers.

The initial investigation uncovered no evidence that the full details of the man's attempted suicide during the course of his arrest following the murder of his girlfriend were passed on to Global Solutions (now G4S) escort staff or to reception staff at HMP Altcourse by Cheshire Police. In the draft investigation report I issued in December 2007, I expressed my view that the failure by the police to alert the Prison Service to the risk of suicide the man presented by the time he was remanded in custody on 2 October 2006 led to a flawed assessment of the man's risk of suicide at Altcourse. However, the police disputed this claim and, following a formal complaint lodged by the man's family, conducted an investigation supervised by the Independent Police Complaints Commission (IPCC). As a result, I directed that my investigator should take no further action with regard to the completion of my investigation until such time as the investigation by the police had been brought to a conclusion. The investigation was therefore formally suspended on 26 June 2008 and resumed on 18 December 2009.

My report takes account of the responses to earlier drafts from the Prison Service, Cheshire, North Wales and West Yorkshire Police and the man's family. It also takes account of further interviews conducted by my investigator at Altcourse in January 2010.

I recognise that the considerable length of time taken to produce this report will have added to the pain and frustration felt by the man's family and I offer them my sincere apologies for this.

I draw attention to two examples of good practice at HMP Altcourse.

I make a number of recommendations to the Director of HMP Altcourse and to the Governor of HMP Leeds.

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.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**September 2010**

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## SUMMARY

The man who is the subject of this report was a 31 year old from Cheshire. In the early hours of 26 September 2006, he allegedly killed his partner in a frenzied attack after drinking and taking cocaine. He was arrested at approximately 8.35pm that day. At the time, the man was on licence from an 18 month extended prison sentence handed down in 2005 for assaulting the same woman. The man had been released from this sentence at Acklington prison on 15 August 2006, just over a month prior to the commission of the alleged murder.

During the process of his arrest, the man was seen by the police to inject himself with a substance later confirmed as heroin. He produced a large bladed knife with which he threatened the officers who consequently sprayed him with CS gas, disarmed and arrested him. The police also noticed he had serious injuries to his hand, and cuts and grazes on his head. The man was also drifting in and out of consciousness. The police therefore called an ambulance and escorted him, under arrest, to hospital where his injuries were assessed. On 28 September, he was transferred to another hospital where he underwent an operation to repair the injuries to his hand. Whilst there, he admitted to a doctor, in the presence of a police officer, that he had killed his girlfriend and indicated that, having injected himself with heroin, he did not expect to wake up in hospital. The man remained under police escort throughout his stay in hospital. On 29 September, he was discharged from hospital and taken to the Northern Custody Facility at Runcorn for questioning. The following day, he was formally charged with murder and other associated offences.

The man remained in police custody until 2 October, when he was taken to a magistrates' court. Here, he was remanded in custody at HMP Altcourse, a privately managed local prison in Liverpool. A Detention Officer at the Northern Custody Facility at Runcorn noted on a Prisoner Escort Record (PER) that the man presented a risk of suicide or self-harm. Neither the details of the man's alleged crime, nor those of his suicide attempt during his arrest were known to the court staff who took possession of the PER. There was some doubt as to what risk information was contained on a medical form, completed by a doctor at Runcorn and passed on by the Detention Officer to the Prisoner Custody Officer (PCO) from Global Solutions Limited (GSL – now G4S), who escorted the man from the Northern Custody Facility in Runcorn to a magistrates' court. That PCO raised a self-harm warning form because she thought the man was depressed. The records show that, although the PER was signed at Altcourse, the self-harm warning form was not. There was some doubt as to which members of the reception team saw the information recorded on the PER or who, if anybody, saw the suicide/self harm warning form. None of the reception team was aware of the fact that the man had made a determined attempt to kill himself only one week earlier. The full details of his suicide attempt and his state of mind thereafter were recorded only in the police case summary – or Form MG5 – which the Police Liaison Officer at Altcourse requested from the Cheshire Police on 17 October 2006, 15 days after the man's arrival at Altcourse. Thus, it was not available to reception staff when the initial health screen took place and when the man's risk of self-harm or suicide was first assessed by Prison

Service staff. The Police Liaison Officer concerned told an IPCC supervised inquiry that the Form MG5 served merely to inform considerations by the Prison Service Category A Committee as to the man's dangerousness and likelihood of escape, rather than to assist in the assessment of his risk of self-harm or suicide. No clarity was established either by my investigator or by the police as to what happened to the Form MG5. The Prison Service told the police investigators that they had no record of the man having been reported to the Category A Committee as a potential Category A prisoner in October 2006, despite the assertion by staff at Altcourse that they received confirmation on 18 October that the man did not meet the criteria for Category A. I believe that the immediate assessment of the man's risk of self-harm or suicide during the reception procedures at Altcourse was undermined by the absence at that point of key information from the police about his attempt at suicide during his arrest only a week earlier. Key reception staff told my investigator that had they been aware of that fact, they might have assessed his risk differently. That said, none of them considered that the man was at risk of suicide when they assessed him. He displayed no obvious signs that he was at risk of self-harm or suicide thereafter at Altcourse.

The man was held at HMP Altcourse until 10 November 2006 when he was transferred to HMP Leeds for security reasons. Five days after his arrival, a request for information regarding sentence planning was sent to the man's Probation Officer. In his reply, the Probation Officer drew attention to his concern that, in view of the seriousness of the charges his client was facing, he presented a risk of self-harm. The investigation found no evidence that this information was acted upon by anyone at Leeds. Whilst it does not necessarily follow that had action been taken on this information a different result would have ensued, this was, in my view, a significant and unacceptable systemic failure.

The man did not settle at Leeds, and his behaviour deteriorated. He was warned on several occasions that, if his poor behaviour continued, he faced the possibility of being reduced to the basic regime. This would involve the loss of in - cell television and a reduction in his entitlement to letters and visits. However, on 28 November, a manager decided to try the man in another wing (C wing) in order to give him a fresh start.

On 30 November, an attempt was made to transfer the man to HMP Dovegate, a category B training prison near Uttoxeter. (I cannot understand why a prisoner awaiting trial for murder would have been considered for a move away from a Local prison.) After waiting in reception for about four hours, the man was told the transfer would not take place. I suggest this was an example of poor prisoner management. Certainly, the man reacted badly to it. He was apparently keen to move to HMP Dovegate because he had friends there, whereas at HMP Leeds he knew nobody. Matters were made worse when, on the way back to the main prison from reception, he was told he would be returning to D wing rather than C wing. The man initially refused to cooperate and demanded to be placed in the segregation unit. After being restrained, he then fully complied and went to D wing.

The next day, managers reviewed the man's position on the Incentives and Earned Privileges (IEP) scheme in light of his poor behaviour. They decided he should be reduced to the basic regime for a period of seven days. (This would have been reviewed the day after his death.) I judge that this outcome might have been avoided if his prospective transfer to HMP Dovegate had been better managed.

In early December, the man's solicitor passed him a copy of the prosecution papers setting out the evidence against him. According to a prisoner who saw him shortly afterwards, the man was very upset by what he read. The prisoner thought this was the trigger for the man's suicide. During an exercise period later that day, the man told an officer he was going to be charged with conspiracy to murder as well as murder. However, the officer did not think the man appeared to be suicidal.

That evening, the man called a family member and told her he had nothing to look forward to because he was never going to be released. He ended the call by saying, "I don't want to upset anyone but I can't do this forever." His call was not monitored. The family member did not read anything significant into the man's words as he apparently often made similar remarks. She therefore did not report the conversation to anyone at the prison. Shortly before 6.00am the next day, an officer found the man hanging in his cell.

I applaud the decision taken at HMP Leeds on 28 November to try the man in a different wing in order to give him a fresh start, but criticise the manner in which his prospective move to HMP Dovegate was managed. I also criticise the manner in which the man was told he was to go to D wing rather than C wing once the move to HMP Dovegate had been cancelled.

I am concerned that West Yorkshire Police gave the man's family erroneous information as to the existence of a series of farewell letters found by them in the man's cell after his death. This was a source of much distress. (West Yorkshire Police have since accepted this criticism, advised relevant staff regarding their conduct and apologised to the man's family.)

I draw attention to two examples of good practice at HMP Altcourse.

I make a number of recommendations to the Director of HMP Altcourse and to the Governor of HMP Leeds.

## INVESTIGATION PROCESS

1. The investigation was opened on 12 December 2006 by one of my Assistant Ombudsmen. On that day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone who wished to express any information relating to the man's death to make themselves known to my investigator.
2. The investigation was carried out by one of my colleagues. I also commissioned a clinical review of the management of the man's health needs while he was in custody. This was conducted by a doctor on behalf of the Leeds Primary Care Trust.
3. On 1 February 2007, my investigator and one of my family liaison officers met with members of the man's family at their home in the presence of their solicitor. During the meeting, a number of concerns were expressed about the manner in which the man was treated by the police and by the Prison Service. Those concerns have been addressed in this report.
4. Sixteen members of staff were interviewed at Altcourse. Thirteen members of staff and two prisoners were interviewed at Leeds. Four members of staff interviewed in March 2007 at Altcourse were re-interviewed in January 2010 at the request of the man's family solicitors.
5. The initial investigation uncovered no evidence that either the full details of the man's attempted suicide during the course of his arrest following the murder of his girlfriend, or of his stated wish to die were passed on to GSL escort staff or to reception staff at HMP Altcourse by the Cheshire Police. In the draft investigation report I issued in December 2007, I expressed my view that the significant failure by the police to alert the Prison Service to the risk of suicide the man presented when he was remanded in custody on 2 October 2006 led to a flawed assessment of the man's risk of suicide at Altcourse. However, the police disputed this claim and, following a formal complaint lodged by the man's family, conducted an investigation supervised by the Independent Police Complaints Commission (IPPC). As a result, I directed that my investigator should take no further action with regard to the completion of my investigation and report until such time as the investigation by the police had been brought to a conclusion. The investigation was formally suspended on 26 June 2008 and resumed on 18 December 2009 with the agreement of the police.

## **LEEDS AND ALT COURSE PRISONS**

### **Leeds Prison**

14. HMP Leeds is a Victorian local prison situated approximately two miles from the city centre. It serves Magistrates' and Crown Courts in the West Yorkshire area. The establishment is one of the most overcrowded prisons in England and Wales. At the time of the investigation it could hold up to 1,254 prisoners in 680 cells.
15. The accommodation comprises six residential wings, including the segregation unit. There are also rooms and wards for 55 prisoners in the healthcare centre. D Wing, where the man died, is the induction unit for the prison. The ground floor is used as the First Night Centre where newly received prisoners spend a short period adjusting to the experience of imprisonment before being moved onto the induction wing.

### **Her Majesty's Inspectorate of Prisons**

16. The prison was inspected by Her Majesty's Chief Inspector of Prisons in August 2005 when an unannounced inspection took place. The report of that inspection, published in October that year, remarked on how difficult it was to sustain progress in a crowded, inner city local prison in which cultures were hard to change and which was operating under considerable daily pressure. Her Majesty's Chief Inspector of Prisons wrote:

"It was to the prison's credit that it had largely managed to sustain the good first night procedures that we commended at the last inspection [in June and July 2003]; most prisoners felt safe at this time. However, other aspects of the early days in custody were under considerable pressure. Not all prisoners were able to be placed on the induction wing and some spent too long there. Less than a quarter of prisoners told us they had had induction."
17. The report commented that staff-prisoner relationships appeared to have deteriorated since the last inspection. It also expressed concern about the management of the segregation unit which was described as being run "in a militaristic fashion". The report also drew attention to a "high and mechanistic level of the use of force".
18. Although there had been some increases in activities for prisoners, there were still only spaces for 60 per cent of the population. The figures showing the periods when prisoners were able to spend time out of their cells were misleading and association periods were often curtailed. However, Her Majesty's Chief Inspector of Prisons singled out resettlement for praise. She commented

that a new resettlement policy had been agreed shortly before the inspection. She said resettlement was well managed, especially for short term prisoners.

19. A further inspection took place in December 2007. As this was a year after the man's death, I have chosen not to comment on its contents.

### **Independent Monitoring Board**

20. In their annual reports on Leeds for the 2005-2006 and 2006-2007, the Independent Monitoring Board drew attention to no issues or concerns relevant to this investigation.

### **Altcourse Prison**

21. Altcourse is a Category B local prison that opened in 1997. It is privately managed by Global Solutions Ltd (GSL). Situated near Aintree, some six miles from Liverpool city centre, Altcourse serves Magistrates' and Crown Courts in Cheshire, North Wales and Merseyside. At the time of the investigation, Altcourse held up to 1,108 male prisoners including 160 young offenders.
22. The accommodation at Altcourse comprises six main house blocks each divided into two units. Each of the units is named after one of the fences on the Grand National course at Aintree. Each unit is allocated a colour code for easy identification by prisoners with reading difficulties. Young offenders and adult prisoners are held together in all residential units. The two categories do not share cells.
23. The prison is divided along its centre by buildings containing the healthcare centre, rehabilitation unit, college, sports centre and segregation unit. An organisation called Medacs has a contract with GSL to provide healthcare at Altcourse. The healthcare centre has 24 hour nursing facilities and has beds for up to 11 inpatients.

### **HM Inspectorate of Prisons (HMIP)**

24. The HMIP inspection of Altcourse most approximate to the period during which the man was at the prison took place in February 2005. Although the report of that inspection drew attention to a number of weaknesses, the Chief Inspector concluded that Altcourse was a very good prison that had benefited from sustained and strong management. Towards the end of her introduction to the report, the Chief Inspector of Prisons wrote:

“Staff actively encouraged prisoners to engage in work and education: this heightened dynamic security and reduced opportunities for bullying or the likelihood of self-harm due to depression.”

25. The investigation found nothing at Altcourse to alter the favourable remarks made by the Chief Inspector of Prisons two years earlier.
26. In their annual report on Altcourse for the period July 2005 - June 2006, the Independent Monitoring Board commented positively on many aspects of the prison's operation, including the care and treatment of prisoners. However, they drew attention to their concern about the number of mobile telephones smuggled into the prison for illegal use by prisoners, an issue that has featured in this investigation.

## **BACKGROUND**

27. In 1998, the man met and married a girlfriend with whom he had a daughter. However, they had violent arguments and in 2003 they separated. Shortly afterwards, the man formed a relationship with the woman who was to become the victim of his alleged crime of murder. As with his previous relationship, the man began to have violent arguments with his new partner. In February 2005, the man was given an extended sentence of 18 months in custody and three years supervision in the community for causing her actual bodily harm. His partner claimed he had used drugs prior to assaulting her.

28. The man spent the latter part of his custodial sentence at Acklington prison in Northumberland. He was released on parole licence on 15 August 2006. The man's licence conditions required him to report immediately to his Probation Officer and to keep in touch with him in accordance with his instructions. The man was also required not to seek or communicate with his partner, or with his former wife, without the prior approval of his Probation Officer. His licence carried the following warning:

“Your sentence expires on 1.5.2010. If you are not recalled, your licence will expire on 30.12.2009. From the remainder of the period until the point at which your sentence expires you are liable to be returned to custody if you are convicted of a further imprisonable offence committed before your sentence has fully expired.”

29. During the evening of 19 September 2006, the man is reported to have met his partner and, with others, to have gone for a drink in a public house. Afterwards, they went to a friend's flat where some of them apparently took drugs. It is alleged that, during the evening, the man lost his temper with his partner and stabbed her many times with a kitchen knife. At 2.40am on 20 September, she was found dead in the flat by paramedics.

## **Arrest**

30. The man was apprehended at 8:35pm on Tuesday 26 September. As the police officers approached him, he appeared to inject himself with a substance in his left arm. When told to stop, he swore at the police and threatened them with a large knife. He was then sprayed with CS gas, disarmed and arrested. The police custody records show that the reasons for the man's arrest included an alleged assault on a woman, the alleged robbery of a motor vehicle, and the alleged false imprisonment of a number of people who were in the flat when the alleged murder took place.

## Admission to Hospital

31. As the man had injuries to his hand and appeared to be drifting in and out of consciousness, the police called for an ambulance. The man was taken to the Accident and Emergency Department at a local hospital, arriving at about 9.00pm. My investigator was given sight of the man's Accident and Emergency assessment sheet and other notes made after his admission to the hospital. These had been obtained by the man's family solicitors. The initial assessment sheet confirms that the man had injuries to his head and hand. On a separate form entitled, "Personal details on admission", the reasons for admission were logged as:

"unresponsive  
GCS 3 on admission to A+E  
Haematomis  
Suicide attempt/iv heroin"

The form also noted that the man remained in police custody whilst in the hospital.

32. The following are extracts from the notes by medical staff who saw him:

"26 September-

9.00pm: 31 year old man in police custody. Suspected of involvement in murder. Seen to inject hand with heroin. Unconscious with poor respiratory effort. (illegible entry).

"27 September-

"Under arrest. Heroin O/D or suicide attempt last night ... wounds to right thumb and right ... finger. "Right thumb – wound dorsal aspect. EHL distal tendon clearly seen and divided. Right .finger- tendon end clearly seen. Decreased sensation. For transfer to Whiston plastics..."

33. At 1.00am on 27 September, the man was transferred to Cubicle E in the Accident and Emergency Department of the local hospital. During the night, he frequently vomited and was very abusive to the nursing staff. He remained awake but drowsy for most of the night. At 9.00am, he suffered a panic attack and had difficulty in breathing. His temperature rose to 37.8 degrees. His notes show that, on occasions, he was tachycardic (i.e. experiencing an unusually rapid heartbeat).

34. At 1.30pm that day, the man was transferred to ward A5, still in police custody. The notes made at the time show that nurses were unable to complete all admission assessments as the man was still under the effects of heroin.
35. At 9.00pm, consideration was given to the man's fitness for transfer to another hospital. It was decided there was no medical reason to delay his transfer. Routine observations were to continue. However, he was kept in the original hospital overnight. It was noted the man needed a psychiatric review the following day. The investigation found no evidence in the hospital notes to clarify whether any psychiatric review took place at either of those hospitals.

### **Admission to Second Hospital**

36. Early on 28 September, enquiries were made to ascertain whether a bed was available for the man at the second hospital so that he could undergo an operation to repair the injuries to his hand. These enquiries revealed that the second hospital was not aware of any plan to transfer the man there. However, at 10.50am, confirmation was received that the man could be transferred. Later that day, the transfer took place. Whilst at the second hospital, the man said to a doctor, "I murdered my girlfriend, then took an overdose. These people must have got to me first. I didn't expect to wake up in hospital. That wasn't the plan." This statement was overheard by a policewoman who was guarding the man. She asked the doctor if he would be willing to testify as to what the man had said. The man subsequently gave his consent for the doctor formally to disclose his confession to the police by way of providing a witness statement. The doctor did so after taking advice as to patient confidentiality.

### **Northern Custody Facility at Runcorn**

37. According to police records, the man was discharged from the second hospital during the late afternoon of Friday 29 September. He was taken to the Northern Custody Facility at Runcorn, arriving at 4.47pm. The records show that, shortly after his arrival at Runcorn, the police asked the man if he had any illness or injuries. The man said he had severed tendons in his right hand and had sustained minor grazes, bruises and swellings. He said he had undergone an operation the previous night and was currently taking antibiotics and painkillers (fluocloxacillin and co-codamol). The man told the police his injuries had been self-inflicted. An entry made in the police custody record on 29 September shows the man was placed in a self-harm smock. At 9.05pm, the following entry was made in the custody record:

"Update from [doctor]. Dp [detained person] has longstanding depression, not taking meds, seen psychiatrist 10 years ago, admitted to mental health institution 10 years ago, voluntarily. Drinks 5 pints of alcohol a day and was released from prison 5 weeks ago. Smokes cannabis and snorts cocaine. Dp states

he took a heroin overdose 12 days ago, suicidal intent. Doctor suggests cctv constant watch.....”

38. The man was kept on constant watch throughout the remainder of his time in police custody. He was occasionally visited by a doctor and his solicitor.
39. At 3.12pm on 30 September, the following entry was made in the custody record:

“DO spoke to Dp through hatch due to Dp crying. Gave cup of water and tissue. Dp then stated, ‘I can’t live with myself. I feel ashamed. She’s only 23 and I’ve killed her. I was coked up and drunk.’ Dp then began to talk about his family and that his 8 year old daughter would know he was a murderer.”
40. As the man was on parole licence at the time of his arrest, the National Probation Service asked on 28 September for him to be recalled to prison. The reasons cited were as follows:

“[The man] has been arrested for murder and an indication of the strength of police evidence is likely to mean he will remain in custody. Recall is sought bearing in mind the serious nature of the offence before the court and the consequent breach of licence conditions.”
41. The request for the man’s recall to prison was agreed on 29 September while he was still in police custody.
42. At 8.17pm on Saturday 30 September, the man was formally charged with murder and associated offences. He was refused bail because of the seriousness of the charges.
43. Police records seen by my investigator show that, during interviews with police officers in the presence of his solicitor, the man said he hit himself with the same machete he used to kill his partner and “chopped his own finger with it”. He also said he had intended to kill himself with heroin, and when he was arrested he was “on his way to kill himself”.
44. At 10.10pm on 30 September, the following entry was made in the custody record:

“Dp in pain from injuries to right hand. Previously seen by [doctor] who verified medication in possession and left written instructions. Dp appears to have missed 5.00pm doses of both medications. 10.00pm doses given at 9.10pm due to same and dp in discomfort as a result. Dp clearly distressed,

anxious regarding being in a cell. Pain relief and antibiotics given at 9.10pm.”

45. The police continued to keep the man on constant observation. At 10.33pm, the doctor saw him and gave him 10mg Diazepam. The man slept until about 7.00am the next day when he was given a meal and a drink. At 4.16pm on 1 October, he was seen crying in his cell. At 5.29pm, he was allowed to make a call to his sister-in-law. Later, he called his brother. The man became very upset during both calls. However, he slept for most of the following night.

### **Appearance at Magistrates' Court**

46. Shortly after 8.00am on 2 October, the man was released into the custody of staff from Global Solutions Ltd (GSL), a private security company - now known as G4S - who escorted him to a Magistrates' Court.
47. A Detention Officer completed a Prisoner Escort Record (PER) before handing the man over to the GSL staff. The Detention Officer noted violence, weapons and drugs as risk factors. He also ticked a box to show there was a risk of suicide/self-harm. He recorded the following information in the section headed, 'Further information about risk':

“Injury to right arm. Further serious charges likely. Very violent offender.”

48. The Detention Officer later provided a written statement to the police in which he offered the following information:

“I cannot recall completing the PER form for [the man] but we had set procedures in place and I therefore make this statement from my usual practice. When preparing this PER I took into account [the man's] history and reviewed the entries on the PNC (Police National Computer) system regarding the man. This confirmed that the man had a history of violence and that he was known to carry weapons. I therefore marked the boxes confirming these concerns.

“I was also aware that on arrival in custody he had injuries to his hand which had required surgery. When asked whether he had ever tried to harm himself, he replied “yes”. He then confirmed that the injuries he had sustained were self-inflicted during the incident. I confirm that I was aware of this information when I completed the PER form. I therefore confirmed that he had a history of drug taking and that he was a known suicide/self harm risk.

"I cannot specifically recall whether or not the medical records would have been attached to the PER form but I confirm that this was my usual practice at the time. I believe that it is essential that the escort officer is given as much information as possible. Therefore the medical records would have completed the history of our dealings with [the man]. For the avoidance of doubt, the full Primecare notes would not have been attached as these are notes that are retained by Primecare staff. We do not have access to these records in the custody suite. The medical records that we would have attached would have been the short form notes that confirmed what Primecare had advised following the examination. These short form notes would have set out the brief detail of the examination and any medication prescribed. This information was also summarised on the custody record.

"I have reviewed the transcript of the evidence given by the escort officer. It is clear that she was fully aware of [the man's] medical condition and that he was fit to be transferred. She also made her own assessment of [the man's] condition. As I have said, I cannot recall attaching the medical report but I note that the escort officer has confirmed that it was attached. I can only assume that because this was my normal practice at the time, and from what the escort officer said, that I must have attached the form."

49. The Prisoner Custody Officer (PCO), who shall be referred to in this report as PCO 1, confirmed at her first interview with my investigator (in March 2007) that she was indeed the one who received the man into GSL custody at the Northern Custody Facility at Runcorn in order to escort him to a magistrates' court. PCO 1 told my investigator she arrived at the facility at about 7.40am on 2 October. She said the man was one of six prisoners she had to take to court that day. She said she could clearly remember the man because his right arm was in plaster and because of his mental state. PCO 1 confirmed that she saw the PER and signed it only to show that she had received the man from the custody suite staff, the other details on the form having been completed by the custody suite staff. PCO 1 went on to say that she later thought that the man seemed "very down" and initially reluctant to engage in conversation. PCO 1 also pointed out that she had read "his medical records that the doctor had opened up overnight". She said she could remember that these records had shown that the man was "quite depressed". (See also paragraph 55 below.)

### **Suicide/self-harm warning form**

50. Such was the PCO 1's concern about the man's state of mind that she decided to place him on a constant watch in the vehicle and therefore placed him in the cubicle nearest to where she sat. PCO 1 also raised a suicide/self harm warning

form. [The purpose of this form is to record any perceived risk of self-harm or suicide, and to communicate that information to the various agencies involved in the supervision of the prisoner, so that appropriate decisions can be made as to the management of the risk.]

51. PCO 1 recalled that there was another prisoner on board who had also been charged with murder. The man asked if the two of them could travel in the same cubicle. PCO 1 did not allow this, but remembered the man talking to the other prisoner and trying to compare their circumstances.
52. During the journey, PCO 1 succeeded in getting the man to talk to her. He told her he had injured his fingers during the “act of domestic violence” for which he had been arrested and that he was in pain. He was particularly concerned about the possibility of being photographed by the press at court. PCO 1 recorded in the warning form her concern that the man seemed depressed and that he had been talking to other prisoners about being photographed.
53. The escort vehicle arrived at the magistrates’ court at 8.40am. PCO 1 told my investigator that the man asked her if she would be able to escort him to prison after his court appearance, but she told him she had to go elsewhere. PCO 1 then left to complete her other duties. She did not see the man again.
54. At her second interview with my investigator (conducted in January 2010 at the request of the man’s family solicitor), PCO 1 confirmed that she saw nothing on the PER made out by the Detention Officer or from any other source with regard to the circumstances of the man’s arrest or what happened while he was in the two hospitals referred to earlier in this report. Although she was concerned about the man’s current state of mind, she was not aware that he had actually attempted to kill himself during the process of being arrested only a week earlier. PCO 1 told my investigator she had not, for example, seen the police custody record relating to the man’s detention at Runcorn or the police case summary (police form MG5) which included detailed information about the man’s alleged offence, his confession to the murder of his girlfriend and his disclosure to a doctor that he had injected himself with what he had hoped to be a lethal dose of heroin during the course of his arrest. PCO 1 also confirmed that she did not hear mention of any such details during the brief period she spent in the custody suite before leaving with the man and five other prisoners for the magistrates’ court.
55. During the same interview, my investigator asked PCO 1 to try to describe the “medical records” she had mentioned at her first interview. PCO 1 was able to recall that what she saw took the form of a one page document which she stapled to the PER. She agreed with my investigator’s suggestion that the form she could recall was probably the same document described by the Detention Officer. PCO 1 believed that the form to which she referred was made out at

10.00pm on 1 October - the night before she collected the man from the custody suite - and contained information about his fitness to be detained and to travel. She also thought it included comments about his lack of eye contact and his state of depression at the time.

56. At about 11.00am on 2 October, PCO 1 having already left, the man was due to move up from the court cells to appear before the Bench. However, he refused to attend the courtroom. In his absence, he was remanded in custody at Altcourse and ordered to appear at a crown court on 13 October.
57. A further Prisoner Custody Officer (who shall be referred to in this report as PCO 2) escorted the man from the magistrates' court to Altcourse. At her first interview with my investigator (in March 2007), she told my investigator she could remember the transfer. PCO 2 said she read the paperwork that had been completed in respect of the man. This included the Prisoner Escort Record (PER) and the suicide warning form made out by PCO 1. She, too, was unaware of the suicide attempt made by the man at the point of arrest. However, PCO 2 saw that the self-harm risk box in the PER had been marked. She said that when the man first boarded the van he was quiet. However, as soon as other prisoners boarded, he struck up conversations with them. PCO 2 said the man showed no sign of being suicidal during the journey to Altcourse.

## KEY EVENTS AT ALTCOURSE PRISON: 2 OCTOBER - 10 NOVEMBER 2006

### Handover of the man from GSL to Altcourse staff

58. The PER shows that the escort vehicle arrived at Altcourse at 3.30pm after a journey of about 55 minutes. PCO 2 said she clearly remembered handing the paperwork on the man to the admissions staff at the prison. At her first interview with my investigator, PCO 2 pointed to the fact that parts A and B of the PER were signed on her arrival with the man at Altcourse, showing that someone in reception must have seen them. She was also confident that the suicide and self-harm warning form was handed over to the admissions staff.
59. Prison Service Instruction (PSI) 51/2003 is the instrument which promulgated the introduction of the suicide/self harm warning form. The PSI sets out clear instructions for the handling of the form. Section 6 of the form should be signed by the reporting Prisoner Custody Officer - in this case PCO 1 - so that there is a record of who raised the form. Section 7 is for the admissions or reception staff to sign when the prisoner arrives. Paragraph 18 of the PSI sets out the requirement that, whenever a prisoner arrives at a prison accompanied by a warning form, the PER, once seen by the reception officer, must be passed with the warning form to the reception healthcare screener. Upon receipt of the warning form and the PER, the healthcare screener must decide, having spoken to the prisoner and considered all other information available, whether to open a F2052SH (or ACCT). [Both these forms are tools designed by the Prison Service to monitor and manage prisoners considered to be at risk of self harm or suicide. The ACCT system - Assessment, Care in Custody and Teamwork - replaced that of the F2052SH and was in place at the time of the man's period in custody at Altcourse and Leeds prior to his death.] Section 8 of the warning form should be signed by the reception healthcare screener. In respect of the man's form, neither box was completed. This omission might suggest one of two things. Either that the contents of the form were not communicated to the admissions staff (although PCO 2 said they were), or that they had been but the staff who received them simply did not sign the appropriate sections. My investigator ascertained that the person who signed the PER when PCO 2 took the man to the admissions area was an Admissions Manager. At interview, the Admissions Manager had difficulty recalling the events of 2 October, and could not specifically remember the man. However, he said he was sure he would have seen the PER and the warning form, even though the latter was not signed.
60. At her second interview with my investigator (also conducted at the request of the man's family solicitor) in January 2010, PCO 2 said that, although she could not be certain, she thought she was given the PER and the suicide/self harm warning form for the man before leaving the magistrates' court for Altcourse. She assumed that the warning form had been slipped inside the PER. PCO 2 told my investigator that she "wrote on part of the PER that he and his property were handed over to Altcourse – the PER and the warning form would have been

handed over". My investigator asked PCO 2 whether the short form (i.e. the medical record) mentioned by PCO 1 was also left with the prison. PCO 2 said, "I can't remember to be honest. If that was there it would have been handed in". When asked why the warning form had not been signed by anyone at Altcourse, PCO 2 said,

"I didn't know that. I just assumed they'd sign it and hand it back to you. They may have signed for the PER and the warning form was inside it. So they may just have missed signing the warning form."

61. Like PCO 1, PCO 2 said she did not see the police custody record or the police case summary (Form MG5) for the man.

### **Reception procedures and communication of risk information at Altcourse**

62. The initial reception of any prisoner entails the completion of a range of procedures. These include an initial fact finding interview with a reception/admissions officer (who adds personal and criminal data to the prisoner's core prison record), a first reception health screen and a cell sharing risk assessment.

### **Opening of core prison record**

63. At interview, the Admissions Manager told my investigator that a protocol had been agreed between Altcourse and the Courts Service whereby the first page of prisoners' core prison records is normally completed at court rather than at the prison. This is to save time during the reception procedures. The Admissions Manager confirmed that the man's details were taken at court. These showed he was born in Crewe in December 1974. The man said he was a builder and was separated. He said he had been living in Warrington and his mother was his next of kin.

### **Prison number**

64. The man was allocated a new prison number, as if he was a "new" prisoner. In fact, he should have been given the same prison number allocated to him on reception at the outset of his extended sentence. However, the investigation found that his previous sentence was not known by the admissions staff that day. This error was rectified the next day, when the man's status as a "licence revokee" was recognised. At this point, his prison number was changed. Although a new core prison record was opened for him, the medical file opened at the beginning of his extended sentence was quickly retrieved and continued. Thereafter, the man was treated as a sentenced prisoner subject to a further charge. (Since this time, the Prison Service has introduced an information technology programme known as PNOMIS by which it has become possible for

prisoners to be allocated the same prison number each time they are sent to prison.)

### **Referral as a potential category A prisoner**

65. During the reception procedures, a further PCO (who shall be referred to in this report as PCO 3) notified the security department at Altcourse that the man had been charged with murder so that action could be taken to refer him to Prison Service Headquarters as a potential category A prisoner. Confirmation was received on 18 October that the man did not meet the criteria for category A. (See also paragraph 96 below. The Cheshire police have asserted that details of the man's alleged offence, his arrest on 26 September and his subsequent disclosures in hospital were faxed to the Police Liaison Officer at Altcourse on 17 October in Form MG5 for the purpose of informing decisions made at the man's review by the Prison Service Category A committee. No clarity has been established as to what happened to the document.)

### **Cell sharing risk assessment**

66. The man's core prison record shows a cell sharing risk assessment was carried out during the reception procedures. The purpose of the risk assessment is to enable the staff to assess any risk of harm that a prisoner may pose to another if allocated to shared accommodation. The risk assessment form contains four sections, each of which has to be completed and signed by different staff.
67. The first section requires the author to record, amongst other things, whether he or she has received any documentation such as an open or closed F2052SH or ACCT form. In this man's case, the "no" box was ticked. This section was completed by PCO 3.
68. The second section asks ten questions, one of which is, "Does the prisoner have any previous convictions for the following: murder, sex offence, kidnapping, manslaughter, false imprisonment, GBH, ABH (and other offences)?" In this man's case, the "no" box was ticked. In fact, the man was already serving a sentence for Actual Bodily Harm. The other questions in the second section ask the user to confirm whether the prisoner has a current F2052SH or ACCT form and whether either of these documents has been opened in the past. This section was also completed by PCO 3 who ticked the "no" box for each question. At her first interview with my investigator (in March 2007), PCO 3 stressed the boxes she ticked and the comments she made on the form were based on the man's own responses to the questions she put to him.
69. The third section asks questions about the prisoner's mental condition and has to be completed by a member of the healthcare staff. The user must judge from a medical standpoint what level of risk a prisoner presents of harming others. In this man's case, the section was completed by a registered mental health nurse

(RMN) who judged that the risk was low. The form also requires the author to comment whether any self-harm issues have arisen. The registered mental health nurse ticked neither of the two boxes available. At her first interview with my investigator (in March 2007) she could not explain why she did not do so. She concluded that the man could share a cell.

70. The fourth and last section of the form requires the duty manager to countersign the assessment. In this man's case, the duty manager at the time confirmed he had no concerns and agreed that the man could share a cell.

71. After the cell sharing risk assessment had been completed, PCO 3 made the following entry in the man's core prison record:

"Prisoner states ok. No issues raised. No problems being here. No concerns raised. States no SASH [suicide and self-harm] issues."

72. At her second interview with my investigator (conducted at the request of the man's family solicitor) in January 2010, PCO 3 confirmed that she did not see the police custody record or the police case summary (form MG5) and had no knowledge of the circumstances of the man's arrest or of what happened when he was in the two hospitals mentioned earlier in this report. Thus, she did not know he had attempted to kill himself a week earlier.

73. When asked whether she had seen on 2 October any type of medical notes relating to the man, PCO 3 said to my investigator, "Not that I can recall. If I had seen anything, it's picked up on. But I can't recall seeing anything." PCO 3 went on to say,

"I would have had his PER and his warrant and as far as I can remember, that's all I did have. Usually, you would get a suicide warning form if there were any concerns about that. I can't remember seeing that.

"Normally he's taken off the van and asked for his name and date of birth by a manager so if a form was there that would have been picked up by the manager. The manager on duty on 2 October would have taken the paperwork off the court services staff and he would have been at the counter. I would have seen [the man] next. Normal procedure is that anything like the suicide warning form would be passed on by the manager."

74. My investigator also put the following statement to PCO 3:

“The regulations at the time required the escort staff to sign section 6 of the warning form and the reception officer to sign section 7. On [the man’s] warning form neither of these sections was signed. There’s no doubt that a suicide warning form was raised. What is in doubt is what happened to it when [the man] arrived at Altcourse. The fact that the form was not signed by anyone in reception could mean that it was seen but not signed for or that it was not seen.”

75. PCO 3 suggested that the suicide warning form may have been inserted in the PER along with the man’s warrant. However, she told my investigator,

“If I had seen a warning form and it wasn’t signed, I still would have asked the prisoner. So the presence or absence of the form wouldn’t make any difference to what I asked him. The form would have acted as a sort of back up to the questions I would have asked him. If he had said to me anything about suicide or self harm, that would have prompted me to go deeper.”

76. My investigator asked PCO 3 if she thought she might have done anything differently if she had seen the case summary or the custody record and the suicide warning form. PCO 3 said she would have raised a SASH (i.e an ACCT form) regardless of what the man told her himself. She said that if he had told her he felt alright, she would have told him she had information indicating otherwise. However, PCO 3 reaffirmed the view she had expressed in her first interview about the risk she felt the man had presented when she saw him. She said,

“I feel I had no reason to open a F2052SH (ACCT) form. Today is the first time I knew anything about what had happened to [the man] when he was in hospital etc.”

77. PCO 3 confirmed that when she assessed the man’s risk of self harm or suicide she did not take into account the fact that he had been charged with murder (a factor that can lead to a heightened risk of suicide in some prisoners who face a long prison sentence, especially in cases where the crime is of a domestic nature.) She said she was satisfied that she had asked him the right questions and that the man displayed no behaviour indicating he was lying when he said he had no thoughts of self harm.

## Healthcare screen

78. The registered mental health nurse (RMN), who completed the healthcare element of the cell sharing risk assessment, also carried out a reception health screen on the man. Using the 'System One' electronic medical information system, the registered mental health nurse (RMN) recorded the man's height, weight, blood pressure and body mass index. The man disclosed to her that he had previously taken cannabis and had taken cocaine in the previous month. He told her he had severed tendons in his right hand for which he had undergone an operation at outside hospital. The man said he had been prescribed flucloxacillin (an antibiotic) and co-codamol (a painkiller).
79. As far as his mental health was concerned, the man said he had been prescribed Zispin - an anti-depressant - during the previous six weeks but had stopped taking it after being released from Acklington in August 2006.
80. At her first interview, the registered mental health nurse (RMN) said the man told her he had no history of self-harm or attempted suicide and did not currently have any such thoughts. She also said she could not remember whether she saw the self-harm warning form completed by PCO 1. However, the registered mental health nurse (RMN) confirmed that the man did not present to her as being suicidal on reception.
81. The registered mental health nurse (RMN) also told my investigator she referred the man for a mental health assessment as she thought he was depressed. The System One print-out does not make any mention of this referral. A further check of the programme on the computer itself, rather than the print-out, revealed that the registered mental health nurse (RMN) did indeed refer the man. The computer showed that the registered mental health nurse (RMN) had asked the man if he was suicidal, and that he said he was not. The print-out does not mention this. My investigator was advised that it was not always possible to gain a print-out of all the data logged on the System One programme.
82. At her second interview (conducted at the request of the man's family solicitor) in January 2010, the registered mental health nurse (RMN) reiterated that she could not recall seeing a suicide/ self-harm warning form. She said that if she had seen one, she would probably have opened a F2052SH/ACCT. The registered mental health nurse (RMN) told my investigator,  
  
"You'd be silly not to because the decision's made for you. I looked at his medical record on System One before I came over to see you and I saw that he told me he had no thoughts of self-harm. But if I'd seen the warning form as I say the decision's made for you."

83. When shown the PER that accompanied the man to Altcourse, the registered mental health nurse (RMN) told my investigator she had not seen it. The registered mental health nurse (RMN) also said she had not seen the one-page medical form that may have been stapled to the PER. Neither had she seen the form MG5 or the police custody record and therefore had no knowledge of the man's attempt to kill himself on 26 September. The registered mental health nurse (RMN) said that if she had known that, she would have opened a F2052SH/ACCT. However, she reiterated that at the time she conducted the health screen, the man gave her no cause for concern.

### **Allocation to First Night Centre**

84. Following the completion of the reception procedures, the man was allocated to the First Night Centre. Here, a number of forms were completed by a further PCO (who shall be referred to in this report as PCO 4). In the box headed, "Any immediate concerns to include suicide and self-harm and bullying history", PCO 4 wrote, "None".
85. The First Night Centre and the Induction Unit at Altcourse are jointly managed. One of the joint managers interviewed the man. During the interview, the man said he was aware that details of his offence had been reported in the press and claimed everyone at Altcourse knew the charges against him. The man said he was content to remain on normal location. The joint manager of the First Night Centre and Induction Unit at Altcourse recorded these details in the man's core prison record and noted that, because he had been at Altcourse before in a unit known as Melling Blue, he had asked to return there. The joint manager of the First Night Centre and the Induction Unit at Altcourse advised the man to make a formal application to do so.
86. My investigator was told that, as matter of routine, all prisoners undergoing their first night at Altcourse are placed in the First Night Centre and are observed at regular intervals - normally half hourly - throughout the night. Observations do not cease until approximately 10.00am the next day when the oncoming shift have had an opportunity to observe each prisoner themselves. My investigator was also told that if, after that period, any prisoner demonstrated that he was having difficulty in coping, observations would continue or, if necessary, self-harm monitoring procedures would be implemented.
87. Records show that the man was observed between 9.00pm on 2 October and 10.00am the next day without event. The man told the manager of the First Night Centre and the Induction Unit at Altcourse he had no thoughts of self-harm. As a result, a decision was made to remove him from his first night watch.
88. Later that day, the joint manager of the First Night Centre and the Induction Unit at Altcourse also recorded a conversation he had with the man about his arm injury. The man told the manager he had injured his arm "during the incident"

with his girlfriend and that “it had not been done on purpose”. It was about this time that the man moved from the First Night Centre to the Induction Wing.

### **Reception assessment by doctor**

89. On 3 October, a doctor saw the man. The doctor used System One to record his consultation. He took the man’s physical and mental health history. The man told him he had overdosed at the time of his offence but that this was an impulsive act only. (At consultation stage, the man’s mother expressed particular concern about this remark. She said that suicide attempts were often impulsive acts and that her son had overdosed on a substance he had not normally taken, pointing to the likelihood that he had tried on this occasion to take his own life and would continue to present a risk of further attempts. The man’s mother pointed to the likelihood that a killing in a domestic context would lead to a heightened risk. ) There were no notes available to the doctor to enable him to make a more informed judgement of the man’s state of mind. The doctor wrote:

“Obviously quite anxious and has been prescribed Zopiclone [a hypnotic drug] and Diazepam in custody. Change to Buspirone [an anti-anxiety drug] twice daily. RMN and counselling F.U. [follow up].”

### **Interview with Probation Officer**

90. On 4 October, the man was seen in the Induction Wing by his Probation Officer about his licence recall and his offence. At this time, the man was in touch with his eight year old daughter from his previous marriage. The Probation Officer completed an initial child protection risk assessment. The Probation Officer also noted in his record that he had been referred to counsellors and to the mental health team.
91. On the same day, the Probation Officer completed form LSP 0 (Life Sentence Plan). The form, completed in respect of any prisoner whose alleged criminal offence renders them liable to be given a life sentence if found guilty at court, requires the report writer to answer a number of questions. These, together with the responses given by the Probation Officer in the man’s case, are as follows:

Question: “Any information relating to possible self-harm?”

Answer: “Placed on first night watch. But did not wish to remain on the watch.”

Question: “Has the prisoner been located in Healthcare or normal location?”

Answer: “Located as per normal procedure in the First Night Centre.”

Question: "Does the prisoner require any additional support at this time?"

Answer: "Has seen Chaplaincy and carers. Wishes to see the counsellor."

92. The man's Probation Officer told my investigator that the man gave very little eye contact during her interview with him. She formed a clear impression that he did not wish to speak about his offence, not least because doing so might compromise his trial. But the Probation Officer also said the man was ashamed and devastated by what he had done. The Probation Officer also explained that the "carers" to whom she referred during her interview with the man were prisoners trained to listen to, and support, other prisoners in times of crisis. The Probation Officer thought the carers were equivalent to those used as Listeners in other prisons. Finally, the Probation Officer explained that the counsellors she mentioned were staff employed in that role by the healthcare centre.
93. At 9.50am on 6 October, the man refused to move from the Induction Wing to another wing. The record does not make clear to which wing he was due to transfer. The man told two PCOs (who shall be referred to in this report as PCO 5 and PCO 6) that his reason for not wanting to relocate was that he wanted to be left alone as the funeral of his ex-girlfriend, whom he had been accused of killing, was about to take place. As a result, PCO 5 decided to open a Suicide and Self-Harm Communication Form A. At interview, PCO 5 explained that this form is normally raised in respect of prisoners about whom staff are concerned, but whose condition is not such as to warrant the initiation of formal self-harm monitoring procedures. PCO 5 told my investigator that the Form A would normally be closed within 48 hours. If staff considered it necessary to keep the form open beyond that period, formal self-harm monitoring procedures would be started. In the man's case, the form was closed the next day after his state of mind had been re-assessed.

### **Appointment at Hospital**

94. On 11 October, the man was taken to outside hospital for a check-up following his operation. The PER for the journey contained no indication of any risk of self-harm.

### **Appearance at Crown Court**

95. On 13 October, the man appeared at a Crown Court where he was committed for trial.

### **Fax from Cheshire Police to Police Liaison Officer at Altcourse**

96. The Cheshire police have asserted that on 17 October a fax was sent to their Police Liaison Officer at Altcourse. The police said the fax included their own summary of the case against the man (form MG5). This summary, a copy of which was supplied to my investigator, clearly shows that the man had planned to take his own life during the course of his arrest on 26 September. (This was unbeknown to my investigator in March 2007, when no evidence of any such action came to light from the interviews he conducted. No clarity was obtained by my investigator during subsequent enquiries he made at Altcourse in January 2010 as to what happened to the document once the Police Liaison Officer at Altcourse had received it but it was clear that none of the staff my investigator interviewed had sight of it. This matter became the subject of a police investigation supervised by the Independent Police Complaints Commission in response to a complaint from the man's family. This matter is discussed further at paragraphs 155 - 173 below.)

### **Meeting with Mental Health In-Reach team**

97. On 20 October, a member of the Mental Health In-Reach team saw the man. He subsequently made the following entry in the man's medical record:

"Seen on Canal Unit in treatment room. Presented as a little anxious and tense but was not agitated and engaged freely in conversation. Discussed past and contact with services both inside prison and the outside. Only released from Acklington on 10 August 06 and is shocked by the circumstances that have led him back in prison. Has received letters and a visit from the family but states he is too ashamed to contact them and rather they just forgot about him. States that he comes from a small town where everyone knows each other and that his offence is a great source of shame to his family and friends. Denies any intent to self-harm as he feels he will adjust and recognises his need to be punished. States he has friends on the wing and that they help him although they can't understand his current situation. States he can't relax and he is experiencing nightmares. Discussed the use of medication but was unsure. Will see again."

### **Refusal to keep appointment at Hospital**

98. On 25 October, the man was due to return to outside hospital for a further appointment. However, he refused to attend. A Prison Custody Officer (who shall be referred to in this report as PCO 7) called the healthcare centre to inform them of this. A member of the healthcare staff went to speak to the man and advised him that, if he insisted on refusing, he would be required to sign a

disclaimer. The man cooperated with this, but gave no reasons for his refusal to attend for his appointment.

### **Mental health team consultation**

99. On the same day, a member of the Mental Health In-Reach Team saw the man again as promised five days earlier. He wrote in the man's medical record:

“Seen on the wing in order to follow up the discussion we had about the possible use of medication. Says he is finding it difficult to sleep and has lost his appetite. Clearly is having some understandable difficulty in adjusting to his current circumstances. Eye contact was poor but didn't present as being overly pre-occupied or distracted. Advised to contact me should he feel his symptoms worsening. To make an appointment with our GP regarding his medication. Has been on Zispin [an anti-depressant] in the past.”

100. At interview, the member of the Mental Health In-Reach team explained that when he said “our GP”, he meant whichever doctor was on duty the next day. He told my investigator he did not see the man again. He also said he made an appointment for the man to see the doctor the next day, but the man did not attend. The member of the Mental Health In-Reach team explained that it was for a doctor to consider and prescribe appropriate medication and that this was the point of referring the man.

### **Discovery of mobile phone and accusations of threatening calls to a member of the public**

101. At about 9.00pm on 25 October, a further PCO (who shall be referred to as PCO 8) carried out the last roll check of the day in Canal Blue unit, where the man was located. As he checked the man's cell, he saw him inside using a mobile phone. PCO 8 summoned the assistance of other staff who carried out a search of the cell occupied by the man and his cellmate as well as the adjacent cell. The back cover of a mobile phone was found under the mattress on the bed used by the man's cellmate who was subsequently placed on a disciplinary report for this matter. No action was taken against the man. No other mobile phone parts were found.
102. On 27 October, the following entry was made in the man's security file:

“Control Officer on nights received a call from a very distressed female who would not give her name. She informed the officer that she had just received a call from [the man] from a mobile phone in his cell. He had made very bad threats towards her. She was very distressed about [the man]

having phoned her from his cell and wants the mobile phone removed at once from him. Officer informed the night duty Operational Manager of this and asked that the female phone security in the morning.”

### **Further refusal to attend a hospital appointment**

103. On 1 November, the man was told he was to be taken to hospital but again he refused to go. On the same day, it was noted that the man had been offered a chance to take part in education classes but he declined. On 7 November, he again refused to take part in education classes.

### **Transfer to Leeds**

104. On 10 November, the man was transferred to HMP Leeds. My investigator interviewed the Head of Operations at Altcourse in connection with this matter. The Head of Operations at Altcourse explained that the man was regarded by some staff at Altcourse as an influential prisoner “with a finger in every pie”. Staff were used to seeing him, “surrounded by flocks of other prisoners who were doing his bidding”. The Head of Operations at Altcourse also said the man had earlier sent a friend to the cell of another prisoner whose sister would have been called as a prosecution witness at his trial. On the man’s instructions, the friend told the prisoner that he was a “grass” and that he would be assaulted.
105. The Head of Operations at Altcourse said the man and another, unnamed, prisoner were moved from Altcourse to Leeds in exchange for two prisoners Leeds wanted to move. The Head of Operations at Altcourse said the man’s transfer to Leeds was arranged primarily because of his use of the mobile phone on 25 October and the intelligence about threatening the brother of a prosecution witness. The Head of Operations at Altcourse stressed the transfer was a temporary measure only, “for a respite”.
106. The PER for the journey between Altcourse and Leeds noted that violence and the concealment of weapons were considered to be risk factors for the man. The PER carried no notation of any risk of self-harm.
107. The man’s core prison record was transferred to Leeds by the escorting staff, along with his medical record. The medical file for the man presented to my investigator had initially been opened at Altcourse in April 2005 at the outset of the man’s previous period of custody. This file took the shape of a traditional paper record, known as the Inmate Medical Record (IMR). The file contained numerous notes and documents relating to the man’s time at Altcourse and Acklington prisons. However, at the time of his next admission to Altcourse on 2 October 2006, the system for recording the details of prisoners’ medical history was in the process of changing from the IMR to System One. When he transferred from Altcourse to Leeds on 10 November, no print-out of the System

One record for the man for the period he was at Altcourse was inserted into the paper file that travelled with him to Leeds.

## **KEY EVENTS AT LEEDS PRISON: 10 NOVEMBER - 6 DECEMBER 2006**

108. The man arrived at Leeds at 2.00pm on 10 November 2006. The PER for the journey carried no notation of any risk of self-harm.

### **Cell sharing risk assessment**

109. Upon his arrival at Leeds, the man underwent a cell sharing risk assessment. The man told the officer who completed the assessment he was not a person who easily became frustrated or angry. He said he had no concerns about sharing a cell. The form shows there were no concerns about the man's risk of harming himself. He was assessed as presenting a low risk of harming others. He was therefore allocated a shared cell in D Wing.

### **Reception health screen**

110. The man's medical notes show that he was seen on reception by a doctor who wrote in the file,

“Has been depressed for last few years. It started on marriage splitting up. Not suicidal. Injury to right middle finger dorsally. Unable to move IP joints. To be seen by RMN [Registered Mental Nurse].”

The doctor prescribed Buspirone to reduce anxiety and Paroxetine, an anti-depressant.

(My investigator was presented with no evidence to show that the man was seen by a member of the mental health team before he died or that he was definitely due to be seen on the day of his death. The medical record presented to my investigator contained no prescription charts. Thus, it was not possible to verify that the medication mentioned above was dispensed to the man. These were matters of concern to the man's family.)

### **Request for sentence planning information**

111. Five days after his arrival at Leeds, a clerk in the Sentence Planning office sent a form RFI (1) - Request For Information - to the Probation Service office in. The man's Probation Officer received the form and responded on 20 November. In his response, he wrote:

“[The man] was recalled to prison having been charged with the murder of his ex-partner, the victim of his offence of Section 47 Assault x2. Concerns are raised in relation to self-harm due to the serious nature of this charge with no plea entered at this time.”

112. The investigation found no evidence that this risk information was acted upon. The clerk who sent the form to the man's Probation Officer guessed that it was probably filed in the man's sentence planning folder by whoever received the reply and kept there to await confirmation of the man's conviction and sentence at a later date, at which point the sentence planning process would have begun in earnest. (See also my comments at paragraph 192 below.)

### **Discovery of mobile phone**

113. On 21 November, officers found a mobile telephone wrapped in a towel in the man's cell. Although he was sharing a cell at the time, the man admitted ownership of the phone. Both prisoners were placed on a disciplinary report. The man was made subject to closed visits.

### **Recall hearing**

114. On 22 November, the man's recall to prison was reviewed by the Parole Board. The Board decided he should not be released. Instead, they set a further review date for 22 June 2007 when they would seek information about the outcome of his outstanding court proceedings.

### **Issue of prisoner warning reports**

115. The investigation found that at Leeds the staff are empowered to impose strikes (minor sanctions) on prisoners for misdemeanours not sufficiently serious to merit a disciplinary charge. A strike must be preceded by a formal warning to the prisoner about his behaviour. If two strikes are awarded within 28 days, the prisoner is normally warned that his status on the Incentives and Earned Privileges (IEP) scheme might be reduced. If a third strike is imposed within the same period, a reduction to the basic IEP level is normally activated. This results in the removal of the privilege of watching in-cell television. It may also affect the prisoner's entitlement to letters and visits.
116. On 23 November, the wing manager issued the man a formal warning after he had failed to get out bed in time for education classes. The wing manager warned the man that, if he refused to do so, he would be issued a strike. In response, the man said, "Strike me. I've done education all over the place." In the event, no strike was imposed on that occasion. However, later that day, an officer issued a further warning to the man for ignoring previous warnings about his habit of approaching other prisoners' cell doors. When the officer issued the warning, the man said to him, "You want to bring it on with me and you will lose." As a result, the man was given a strike.
117. The next day, 24 November, the man was issued another warning by the same officer after refusing to move away from another prisoner's cell. When the officer

issued his warning on this occasion, the man said to him, "I don't give a \*\*\*\*. Don't f\*\*\*ing hassle me." The strike was therefore issued.

118. That same day, yet another warning was issued to the man, this time by another officer. This was after the man tried to take receipt of something from under another prisoner's cell door and refused to move away when told to do so. The man swore at the officer and became aggressive towards her. The officer therefore issued a strike. In response, the man said, "I don't give a fuck about how many strikes I get." The officer decided to count this and the previous strike as one.
119. The next day, an entry was made in the wing Staff Observation Book warning staff of the man's aggressive behaviour. On 27 November, a further strike was issued to the man after he displayed similar behaviour. He was also told he would be considered for a reduction from the standard to the basic level of privileges.

#### **Transfer to C Wing for fresh start**

120. In view of the man's deteriorating behaviour, the wing manager decided to make a positive intervention by considering whether a move to another wing might help give the man a chance to make a fresh start. The next day (28 November), the man was moved to C Wing.

#### **Cancelled transfer to Dovegate**

121. On 30 November, the man was taken to reception in order to prepare for a transfer to Dovegate, a Category B training prison. Although there is no record of the time the man was taken to reception from his cell, my investigator was told it was likely to have been about 10.00am. At about 2.00pm, he was told Dovegate had refused to accept him and his transfer would not take place. The combination of having to wait in reception for four hours only to be told his transfer was not going to take place annoyed the man. He reacted by refusing to move from reception unless he was placed in the segregation unit. (This is a unit in which prisoners are held if they are awaiting or serving a punishment for infringements of prison rules, or if they need to be separated in their own interests.) The Duty Governor of the day took charge of this incident. He told the man he was to return to D wing as his cell in C wing was no longer available to him. At about 2.30pm, the Duty Governor of the day managed to persuade the man to leave reception. The Duty Governor of the day and two colleagues accompanied the man back towards the wing. As they arrived at a point along the route known as the "under-centre", adjacent to the segregation unit, the man again refused to move and repeated his earlier demand to be segregated. At this juncture, the Duty Governor of the day decided the man should be restrained and moved to D wing by force. Three members of staff therefore used Control and Restraint techniques to restrain the man. These involved the use of arm and

head locks. The Duty Governor of the day told my investigator that these methods were applied for a matter of seconds as the man quickly agreed to move to D wing of his own accord. Thereafter, the man was escorted to cell D2-41, a single cell, without further ado. The Use of Force forms completed by the staff involved in restraining the man show he sustained no injuries.

122. At interview, the Duty Governor of the day said he had no knowledge of the reasons behind the plan to transfer the man to Dovegate. Neither did he know why Dovegate refused to accept him. My investigator could find no one at Leeds who took the decision to arrange the transfer. A senior officer, (who shall be referred to in this report as Senior Officer A) later speculated that the transfer might have been cancelled because of the man's outstanding court appearances.

### **Review of cell sharing risk**

123. On 1 December, Senior Officer A chaired a meeting convened to review the man's cell sharing risk assessment and his status within the Incentives and Earned Privileges Scheme. The following notes were made on the cell sharing risk review proforma:

“Located from reception under escort by segregation staff, duty governor, and duty orderly officer. Not happy about transfer cancellation and relocation back to D Wing. Previous threats, aggression. Placed on basic. Remain single cell status. Access to Bereave.”

“Review date 8.12.06. Remain single cell status until after 22.12.06 - court appearance at Crown Court. Allowed access to Chaplaincy, Samaritans and Listeners.”

124. The proforma was countersigned by a Governor who wrote:

“Review in one month or earlier if appropriate once he has had time to come to terms with offence.”

125. At interview, Senior Officer A told my investigator that the decision to place the man on the basic regime meant he lost his television set, two letters per week and one visit per month. He also lost association - the ability to mix freely with other prisoners in the wing at certain times of the day. Senior Officer A confirmed that this loss of privileges was to last for seven days until 8 December. At that point the man's privilege level was to be reviewed. She also said the man's behaviour improved after his privilege level had been reduced. Instead of being aggressive, the man did everything that was asked of him.
126. The record of the cell sharing risk review makes reference to the Samaritans and Listeners (prisoners trained by the Samaritans to listen to prisoners in distress).

This implies that the review panel might have thought the man was at risk of suicide. My investigator put this point to Senior Officer A. He also put to her the point made by the man's family that his mental state was the cause of his bad behaviour and that the reduction in privileges further contributed to his distress. Senior Officer A said there was no information in the man's history sheet, from either the healthcare or security departments, or in the man's actual behaviour to cause staff to have concerns about distress. Senior Officer A said she and the man had a discussion about his offence. During this discussion, Senior Officer A talked in general terms about Listeners, the Samaritans and the chaplaincy as people to whom he could talk if he wished. She said the man did not want to see any Listeners or the Samaritans because he did not want to talk about his personal business. The man told Senior Officer A he was not a religious man but sometimes "used the chaplaincy".

### **Visit by the man's solicitor**

127. On 5 December the man's criminal solicitor visited him at 10.00am. The purpose of the visit was to enable the man's criminal solicitor to pass to her client a copy of the prosecution papers. As she handed the papers to the man, the criminal solicitor advised him that he might be upset by some of the contents. She therefore offered to remove the statement she thought would be the most distressing, but the man insisted on reading all the evidence.
128. The man told his criminal solicitor about the cancelled transfer to Dovegate. He said he was particularly upset by this development as he did not know anyone at Leeds but had friends at Dovegate with whom he could discuss his case.
129. The man's criminal solicitor advised the man that the psychiatrist she had instructed to assess him would see him the next day. The man told her he did not want to tell the psychiatrist everything about his past as he was worried his disclosures would upset his family. The solicitor told him the report would not be read out in open court and advised him to tell the psychiatrist everything.

### **Conversation with an Officer on the exercise yard**

130. Later that day an officer, a regular member of the D wing staff, spoke to the man in the exercise yard shortly after he had seen his solicitor. In a statement submitted by the officer five days after the man's death, he reported as follows:

"At approximately 14.00hrs on Tuesday 5 December 2006, I was on duty on D Wing. At this time, I was supervising D Wing exercise with [a fellow officer]. I was stood counting prisoners out onto the exercise yard when I recognised [the man] from the week before when he was in cell D3-14. When I saw the man, I said, 'Ey up what you doing back on here?' The last time I had seen him was when he moved over to C

Wing. [The man] replied, 'Don't ask. I went down to reception last week to go to Forest Bank and sat in reception all morning. They then twisted me up and took me to the seg. I then came back on here as basic high risk. I have also been told that I am getting charged with conspiracy to murder as well as murder and stuck here until 22.12.06 so I am now f\*\*\*ed.' At this point [the man] walked off down the steps onto the yard and walked around talking with prisoners. He seemed to me to be his usual self.

"When [the man] walked past me at the end of exercise he said, 'Ta Gov. See you later.' That was the last time I spoke to or saw [the man] that day."

131. My investigator was presented with no evidence that the man was to be transferred to Forest Bank prison. The officer later confirmed he meant to refer to Dovegate rather than to Forest Bank.
132. At interview, the officer emphasised that at no stage did the man appear to him to be suicidal.
133. In a statement later given to the police by the fellow officer who was in the exercise yard at the time, he said that at about 7.00pm he noticed that the man's cell call light was on. When the officer approached the cell to ascertain what the man wanted, he told the officer he wished to make a telephone call. The officer told him he would arrange for him to make a call towards the end of the association period at about 7.50pm. In his statement, the officer confirmed that he saw the man using the telephone at about 8.05pm. He did not clarify who let the man out of his cell to make the call or who it was that returned him to his cell afterwards.
134. The investigation discovered that the call the man made was to a member of his family. During the conversation, he referred to the fact that he had received the prosecution papers setting out the case against him, a matter which had an effect upon him. (See also my comments at paragraph 235 below.) The man also said he was due to see a psychiatrist the next day. In earlier telephone calls to his family, the man had expressed his concern to seek help for his inability to relate to women. He was nevertheless of the view that nothing positive would come from his meeting with the psychiatrist. The man told his family he was anticipating having to stay in prison for a very long time indeed and could not face up to that prospect. He also said he could not live with himself after killing the woman he loved. The man ended his conversation with the words:

"I've got nothing to look forward to at all because they're never going to let me out. I don't want to upset everyone, but I can't do this forever, do you know what I mean?"

135. My investigator spoke to the family member who answered the man's call. She said she did not read anything significant into the call as the man had often spoken in the same manner. She said she had no reason to believe he was about to commit suicide.
136. During his time at Leeds, the man's mail was monitored. His telephone calls were tape recorded but not simultaneously monitored. Thus, staff would not have listened to this last telephone call.

### **Events on Day of Death**

137. On duty in D Wing during the night/early morning of the man's death were an officer and an Operational Support Grade (OSG). The officer was principally responsible for patrolling D2, D3 and D4 landings, while the OSG was deployed mainly to the First Night Centre on D1 landing. The officer told my investigator that at times when he was not patrolling he spent some time in the staff office on D2 landing. This office is located opposite the cell occupied by the man at the time.
138. At interview, the officer principally responsible for patrolling D2, D3 and D4 landings explained that before 5 December he knew nothing of the man as he had been on leave in Australia until then. Before he started his shift, the officer principally responsible for patrolling D2, D3 and D4 landings familiarised himself with the cases of those prisoners for whom ACCT forms had been opened. The man was not subject to an ACCT form. The officer said that at no stage during the night could he recall hearing the man having any conversations with prisoners in other cells. The officer explained that, in any event, it was never easy to hear what prisoners in separate cells were saying to each other because of the competing noises coming from televisions and stereo equipment. He also pointed out that prisoners who wanted to communicate between cells usually shouted through their windows where they knew they could make themselves heard. Thus, their conversations were hardly audible to staff through the cell door. The officer principally responsible for patrolling D2, D3 and D4 landings also confirmed that the man did not press his cell bell that night.

### **The discovery of the man hanging**

139. The officer principally responsible for patrolling D2, D3 and D4 landings described his night shift as relatively quiet. He said nothing untoward occurred in the wing until about 5.50am on the day of the man's death when he began his routine roll check of the wing prior to handing over to the day shift. At that time, the officer approached the man's cell. As he did so, he noticed the cell light was on. The officer lifted the flap over the observation panel in the man's cell door and immediately saw him hanging from the conduit fixed to the ceiling. The man had used a piece of bedsheet as a ligature. He was in a sitting position on the

top bunk, facing towards the cell wall and with his legs out in front of him. It appeared to the officer that, after attaching the ligature to the conduit, the man had deliberately fallen backwards so that the ligature would tighten when he was in a position from which he could not rescue himself.

140. The officer used his radio to put out a “blue call” for urgent assistance. He explained to my investigator that the term is a code used to draw attention to any incident in which a prisoner is likely to have suffered some form of asphyxiation and whose life is therefore in danger. The control room responded immediately by broadcasting the same request to all staff. The officer said the control room automatically calls for an ambulance whenever a “blue call” is sent over the radio.
141. The officer principally responsible for patrolling D2, D3 and D4 landings told my investigator he was reluctant to enter the man’s cell on his own. He explained that in the past staff had been taken hostage after entering cells on their own in response to what seemed to be a genuine emergency. The officer said there were no policies or instructions in place at Leeds forbidding staff from entering cells on their own. Rather, it was left to individual judgement as to when it was appropriate to do so. The officer was convinced the man was dead. He explained that this was not the first time he had found a prisoner hanging or had seen a dead body. He said he could tell that the man was lifeless, even as he was looking through the observation panel.
142. As the officer withdrew the cell key from his sealed pouch, the Night Orderly Officer arrived at the cell followed by a number of other staff who had responded to the emergency call. The Night Orderly Officer saw that the officer principally responsible for patrolling D2, D3 and D4 landings had just withdrawn his key but she said to him words to the effect, “Don’t bother, I’ll use mine.” The Night Orderly Officer unlocked the cell door and let the officer into the cell. The officer principally responsible for patrolling D2, D3 and D4 landings estimated that the time lapse between his initial arrival at the cell and the Night Orderly Officer’s arrival was about “two minutes or so”.
143. The officer principally responsible for patrolling D2, D3 and D4 landings entered the cell with his colleagues (who shall be referred to in this report as officer 3 and officer 4). The officer principally responsible for patrolling D2, D3 and D4 landings stood on a table so that he could reach and cut the ligature. Officer 4 passed him a pair of ligature scissors. (Although the officer principally responsible for patrolling D2, D3 and D4 landings had a pair of his own on his belt, he had difficulty withdrawing it from its pouch at the back of his belt.) The officer cut through the ligature and removed it. He was very critical of the quality of the scissors, likening them to the sort of scissors “they issue kids in a kindergarten”.

144. As the officer principally responsible for patrolling D2, D3 and D4 landings cut the ligature, Officer 3 and Officer 4 took the man's weight and lifted him to the floor of the cell. As they did so, they realised his limbs were stiff. His eyes were closed and there was evidence of "pooling" (i.e. his blood had collected towards his skin). A nurse arrived at the cell at this point. At interview, she confirmed that as soon as she saw the man she knew he was dead and there was nothing she could do for him. She nevertheless attached a defibrillator to the man's chest "for confirmation". The machine advised not to shock.
145. At 5.59am, a paramedic crew arrived at the cell. They pronounced death at 6.02am. At this time, no-one noticed any final letters from the man to his family or friends. However, at a later date, the police discovered a number of such letters amongst other papers removed by Scenes of Crime Officers when they first examined the man's cell. (This matter is discussed further at paragraphs 214 - 216 below.)
146. Both the nurse who had attached the defibrillator to the man's chest and the officer principally responsible for patrolling D2, D3 and D4 landings told my investigator of their disappointment at the lack of care offered to them in the aftermath of their response to the emergency. The nurse said that none of her managers asked her whether she was alright, either on the day or later. The officer principally responsible for patrolling D2, D3 and D4 landings said that, after he had left the man's cell, someone asked him if he needed the care team. The officer said he was a member of the care team. He said whomever it was he spoke to then left, possibly under the illusion that, as he was a member of the care team, he did not need any offer of care and that it was not necessary to call on the services of anyone else in the team.
147. My investigator interviewed prisoners in the adjacent cells to see whether they could cast any light on the man's frame of mind during the previous day or during the night. Both prisoners said they saw him the previous day and they had several short conversations with him during the night in which they had talked about football and other general topics. Both prisoners confirmed that at no stage did the man say anything about wanting to kill himself during their conversations with him that night.
148. However, one of the prisoner's in the adjacent cells said to my investigator,
- "[The man] did say on the exercise yard he was going to kill himself before he handed himself in (sic). He didn't say he would do it in here. He didn't say to me personally that he was going to do it in here but he did intimate to me later he was going to do it outside before he came in.
- "I spoke to him the day before he died. I spoke to him when he went to see his solicitor in the morning and he's come

back with his statements. He said to me I could go to his cell to read his statements. When I went to see him at dinner time, I could see he was upset. His face was all red like he had been crying and all the statements were all round him. The last time I saw him was just before six.”

149. The same prisoner was also interviewed by the police. In a statement he provided to them, he said,

“[The man] was in the next door cell from 13 November. Since then he got more and more depressed. I knew he had been in trouble with staff and had been placed on basic regime with no tv, radio, or anything. He told me he couldn't face doing any of prison time. He once told me he should have killed himself after he had killed his girlfriend.”

150. Both prisoners in the adjacent cells said that, at some stage during the night, they heard a distinctive noise coming from the man's cell as if a chair had fallen over. However, neither prisoner attached any significance to this and so did not report it to staff.

#### **Informing the man's next of kin**

151. At 6.25am, the Duty Governor of the day telephoned one of the establishment's Family Liaison Officers to inform her of the man's death. The Family Liaison Officer immediately made her way to the prison. Upon her arrival at the prison, the Deputy Governor asked the Family Liaison Officer, the Governor and another senior manager at Leeds to inform the man's next of kin of his death in person.
152. The man's mother was listed in his prison record as his next of kin. The Family Liaison Officer and her two colleagues left Leeds prison at 9.15am to go to the address recorded. On their way, the Family Liaison Officer checked with the police that the address was correct. She was told the house was for sale and had been vacated. The Family Liaison Officer arrived at the house at 11.00am and found it was indeed unoccupied. The police advised the Family Liaison Officer to try another address where they thought the man's mother might be staying. The Family Liaison Officer and her colleagues left for that address and arrived at 11.15. Nobody was in. The Family Liaison Officer therefore contacted the man's Probation Officer/Offender Manager and asked him if he knew of any other addresses. He said no other addresses had been registered. At this point, the Family Liaison Officer felt it was appropriate to contact the man's mother on her mobile telephone. However, there was no answer. The Family Liaison Officer then telephoned the man's brother on his mobile telephone. The man's sister-in-law answered. The Family Liaison Officer gave no details about the man but asked if she and her colleagues could visit them. She was told they could do so. The Family Liaison Officer and her colleagues arrived at 12.15.

They initially broke the news of the man's death to his brother, and, when they arrived later, to his mother and sister.

### **Funeral service**

153. The man's funeral took place on 21 December. At the family's request, no one from the prison attended. At interview, the Family Liaison Officer confirmed that the Governor had offered to pay £1,000 towards the funeral expenses.

## ISSUES ARISING FROM THE MAN'S PERIOD OF CUSTODY AT ALT COURSE

154. Here I examine the following issues:

- The communication of risk-related information between the custody staff at the Northern Custody Facility at Runcorn, GSL escort staff and reception staff at Altcourse.
- The assessment of the man's risk of suicide upon his arrival at Altcourse.
- Record keeping.
- The justification for transferring the man to Leeds.
- The passage of medical information between Altcourse and Leeds.

I make a number of recommendations and draw attention to two examples of good practice.

### **The communication of risk-related information between staff at the Northern Custody Facility at Runcorn, GSL escort staff and reception staff at Altcourse (see paragraphs 47 - 61 above)**

155. Information relating to the man's risk of self-harm or suicide was recorded in the following forms:

- a Prisoner Escort Record covering the man's journey from Runcorn Police station to a magistrates' court and onward to Altcourse on 2 October 2006.
- a suicide warning form opened by Prisoner Custody Officer (PCO 1) at the beginning of the above journey.
- a Form MG 5 used by the police as a summary of the criminal case against the man
- a one-page medical form completed by Primecare. (At consultation stage, Cheshire Police pointed out that PCO 1's evidence suggests that she saw more than one such form.)

### Prisoner Escort Record

156. The Detention Officer completed the front page of a Prisoner Escort Record (PER) before the man was escorted from the Northern Custody Facility at Runcorn to a magistrates' court on 2 October 2006. On it, he wrote, "Injury to right arm. Further serious charges likely. Very violent offender." The Detention Officer also ticked a box to indicate that the man presented a risk of suicide/self-harm. The Detention Officer later told an IPCC supervised investigation that he ticked this box because the man had told him that the injuries he had sustained to his hand were self-inflicted. It seems that the man may not have told the Detention Officer about his attempt to kill himself by injecting himself with heroin. No details of that event were entered on the PER. There is no evidence that the

Detention Officer saw the police case summary (Form MG5) in which these details of these events were recorded.

157. The PER was handed to Prisoner Custody Officer (PCO 1) when the man left Runcorn for the magistrates' court on 2 October. PCO 1 signed the form purely to record the fact that she had received the man into her custody for the purpose of escorting him to court. She knew nothing of the man's suicide attempt on 26 September. When PCO 1 arrived at the magistrates' court, she handed the man over to the court staff along with the accompanying paperwork, including the PER. PCO 1 then departed for other duties.
158. Once the man's court hearing was completed, he was taken to Altcourse under escort by PCO 2 who noted that the PER contained an indication that the man was at risk of suicide. However, like PCO 1, PCO 2 knew nothing of the man's suicide attempt on 26 September. PCO 2 said she handed the PER to the admissions staff upon her arrival at Altcourse.
159. The person to whom the PER was handed at Altcourse was the admissions manager. He told my investigator that, although he could not recollect the events of 2 October 2006, he was sure he would have received the PER. (In fact he had signed the PER to show that the man had been received from the escort.)
160. The PER was next seen by PCO 3 who administered the man's reception into Altcourse. PCO 3 did not know of the man's suicide attempt on 26 September as she had not seen the Form MG5.

#### Suicide/self - harm warning form

161. A suicide/self-harm warning form was opened by PCO 1 on 2 October because she was concerned at the man's state of mind. As required by the provisions of Prison Service Instruction (PSI) 51/2003, PCO 1 signed section 6 of the form to indicate the reasons for raising the form. When PCO 1 arrived at the magistrates' court, she handed the man over to the court staff along with the accompanying paperwork, including the warning form.
162. PCO 2 took receipt of the paperwork at the court prior to her departure to Altcourse with the man and five other prisoners. PCO 2 told my investigators she handed the paperwork, including the warning form, to the admissions staff at Altcourse.
163. PSI 51/2003 requires that section 7 of the warning form should be signed by whichever reception officer receives the prisoner. However, the man's warning form was not signed at section 7, indicating perhaps that it was not seen. The person to whom the warning form was handed was the admissions manager. He told my investigator he would have seen the warning form despite the fact that it was not signed to that effect.

164. The PSI also requires that the warning form should be passed to the reception healthcare screener, together with the PER, so that he or she can make a judgement as to whether it is necessary to open an ACCT form. The person who conducted the man's healthcare screen was a registered mental health nurse (RMN). However, she told my investigator she could not recall seeing the warning form. The registered mental health nurse (RMN) said that if she had seen the form she would probably have opened an ACCT plan.

#### Form MG5

165. An investigation conducted by the North Wales police in 2008 established that, on 17 October 2006, (15 days after the man arrived at Altcourse) a detective constable of the (Cheshire Constabulary) Force Major Incident Team received a telephone call from a detective constable of the North Wales Police Liaison Officer at Altcourse, asking for a copy of the police case summary – the Form MG5 – relating to the man's alleged offence of murder. At 1.25pm that day, the detective constable of the Cheshire Constabulary faxed the Form MG5 to the North Wales Police Liaison Officer at Altcourse. Included in the form was the following comment:

“At approximately 12.55pm on Thursday 28<sup>th</sup> September 2006, PC4256 was guarding [the man] whilst he was a patient at [a] hospital when he stated to a doctor in the presence of PC4256, ‘I murdered my girlfriend then took an overdose. I didn't expect to wake up in hospital. That wasn't the plan.’”

A number of admissions the man made whilst in hospital appeared later in the report. These included confirmation that he intended to kill himself using heroin and that when he was arrested, the man ‘was on his way to kill himself’.

166. When, during the course of the police investigation, the North Wales Police Liaison Officer at Altcourse was interviewed, he said that although he knew he was on duty on 17 October, he could not recall requesting the form. He made the point that any request for a copy of the Form MG5 was for the purpose of assessing a prisoner's potential to escape rather than for the assessment of any health risks. He told his interviewer that he was aware that the man had not met the criteria for being made a category A prisoner and could not understand how this decision had been reached unless the Prison Service had been in possession of the Form MG5. (As I have pointed out in paragraph 65 above, PCO 3, on 2 October, notified the security department at Altcourse that the man had been charged with murder so that action could be taken to refer him to Prison Service Headquarters as a potential category A prisoner. Confirmation was received on 18 October that the man did not meet the criteria for category A.)

167. The police investigator noted that the decision not to place the man in category A was made the day after the fax was sent to Altcourse. My own investigator was unable to ascertain what information was available to the Category A committee at Prison Service Headquarters when they considered the man's case. The Directorate of High Security Prisons confirmed to the police on 19 November 2008 that they had no record of the man having been reported in as a potential category A prisoner during the month of October 2006.
168. During the course of their investigation, the police attempted to ascertain whether the Form MG5 had been filed in the man's prison record. They were told by staff at HMP Leeds that, after his death, his files had been sent to the Coroner to whom further enquiries were made. The police examined the files received by the Coroner and found that the Form MG5 was not amongst them.

#### One-page medical form

169. The Detention Officer, who supervised the man at Runcorn custody suite, told the police he thought it was essential for the staff who are assigned the task of escorting prisoners to court to be given as much information as possible about each prisoner. He said that a "short form" medical record, setting out brief details of any examination of the man and of any medication prescribed, raised by Primecare - the organisation responsible at the time for the medical oversight of prisoners in police custody - would have been included in the paperwork handed to the escorting staff.
170. PCO 1 was the person who was tasked to supervise the man and five other prisoners during the journey to the magistrates' court. At her interview, PCO 1 was able to recall that she saw a medical record that took the form of a one page document. She said this was stapled to the PER. She believed this document to be the one described by the Detention Officer. PCO 1 thought the form had been completed at 10.00pm on 1 October - the night before she escorted the man to court. She believed it contained information about the man's fitness to be detained and to travel as well as comments about his lack of eye contact and his state of depression at the time.
171. No such form, relevant to the man's period in police custody prior to his admission to Altcourse on 2 October 2006, was included with the medical documentation presented to my investigator during the initial stages of the investigation. However, the man's family solicitors later provided my investigator with a copy of the report of Operation Vogue, the IPCC supervised police investigation into the family's complaint about the passage of risk related information between the custody suite and the magistrates' court. My investigator's copy of the report contained four medical reports on the man completed by Primecare. The reports were timed and dated as follows:

- Report 1: 29 September, 8.30pm
- Report 2: 30 September, 9.30pm
- Report 3: 30 September, 10.25pm
- Report 4: 1 October, 4.35pm

172. The reports completed on 29 September and 1 October referred to the need for the man to be kept on a constant watch via closed circuit television. Whilst these reports seem to take the same form as those to which reference was made by the Detention Officer and PCO 1, none of them is likely to be the one described in paragraph 170 above.

### **Submissions from Cheshire Police**

173. At consultation stage, Cheshire Police submitted the following comments:

“PCO 1 in her account provides a weight of evidence to confirm she did indeed have sight of, and would have read in sufficient detail, the Primecare medical reports that she states were attached to the PER at the point of her taking responsibility for the escort of [the man].

“The Custody Record shows there were four separate occasions when Primecare examined the man while he was in custody. Following each of these examinations, Primecare produced 4 separate single page reports. The reports bear two dates: the date the man was assessed and the date the report was completed. The times referred to below are the times Primecare saw the man and not the times the reports were written:

- 2005hrs on 29 September
- 2130hrs on 30 September
- 2225hrs on 30 September
- 1630hrs on 1 October

“In her account, PCO 1 recalls a report dated from the previous night. This could possibly refer to either the third or the fourth medical report. PCO 1 specifically refers to her belief that the report/s contained information on fitness for detention and travel as well as lack of eye contact and depression. This detail is identical to the narrative on the second medical report. PCO 1 further states that she was aware of the specific suicide risk not only from her own observations of the man but also to her briefing from the notes attached to the PER. The only specific reference to suicidal intent is contained in the first medical report.

“Taking the Detention Officer’s and PCO 1’s recollections together, the weight of the evidence would suggest that all four medical reports were indeed attached to the PER by the Detention Officer and as a result they influenced PCO 1’s concern for the welfare of the man from the point of his transfer from custody until his arrival at the magistrates’ court.

“There is no reason therefore – from the Constabulary’s perspective – that those reports should not have accompanied the PER and any other documentation relating to risk from the court to the Prison Service.

“The PER identified that [the man] was at risk of suicide/self-harm. The medical notes attached to the PER do make a specific reference to [the man] taking a heroin overdose 12 days ago, if not the circumstances of that overdose. I would submit there was sufficient information on the PER form for any reasonable person to conclude [the man] was considered at significant risk of suicide/self-harm throughout his period of detention and that in itself was sufficient evidence to inform ongoing assessments of risk once received into the care, custody and control of the Prison Service. Prison Custody Officer (PCO 2) confirms that she saw the PER and the suicide warning form made out by PCO 1. If the four medical reports were attached to the PER the additional information contained in those reports reinforced the information contained on the face of the PER.

“It is accepted that the purpose of the MG5 Case Summary that the detective constable of the Cheshire Constabulary faxed to the prison, at the request of the North Wales Police Liaison Officer at Altcourse, was to assist the Prison Service in allocating suitable category status to [the man]. The MG5 did include information of [the man’s] alleged attempt to commit suicide shortly before his arrest. It may be suggested that Recommendation 4 might equally apply to the MG5.

“My final observation is that [the man] entered the prison system on 2 October 2006. He committed suicide shortly thereafter. The suggestion that the man’s death may have been prevented if Cheshire Constabulary’s PER had contained more information about the risk to the man of suicide/self-harm would carry more weight if the man had committed suicide shortly after his arrival at Altcourse. The risk of the man committing suicide or harming himself may have changed and the risk increased or decreased during his period in prison as a result of a variety of factors. The responsibility for reviewing and updating the assessment of the risk of the man committing suicide in the period between him entering the system and his death lies with the Prison Service.”

## Conclusions

174. I do not call into question the veracity of the evidence submitted by the police with regard to the information faxed to Altcourse on 17 October. I also take note of the above submission from Cheshire Police. However, it remains my view that the full details of the man’s alleged crime and of his attempt at suicide during the course of his arrest should have been available to the GSL staff who escorted the man to Altcourse and subsequently to the reception staff at the prison on the day of the man’s arrival at Altcourse when the initial assessment of his risk of self-harm or suicide was first undertaken. I do not hold Cheshire Police responsible for the man’s death. In raising my concerns about the passage of risk

information between the police and the Prison Service, I seek to draw attention to the importance I attach to the need for the highest standards of communication between agencies to be preserved. In making recommendation 1 below, I hope that the Director of Altcourse and Cheshire Police will work together to explore ways of improving inter-agency communication systems and procedures where risk information is concerned.

175. The fact that the man had allegedly killed his girlfriend was likely to result in his imprisonment for life had he been found guilty of murder. The nature of the killing, allegedly committed at a time when the man was on parole licence from a sentence imposed for causing Actual Bodily Harm to the same person, was apparently so brutal that it is highly probable he would have been given a very long tariff by the judge. The man was likely to have known this. Prisoners who find themselves facing the consequences of such crimes (brutal murders in a family or other close relationship) are statistically amongst those who present the highest risk of suicide in prison. The man's attempt to kill himself by injecting himself with heroin during the course of his arrest is clear evidence that he was in that category.

#### **The assessment of the man's risk of suicide upon his arrival at Altcourse**

176. Those staff at Altcourse who were interviewed told my investigator that the man did not present as being at risk of suicide when he arrived. The admissions staff based their assessment of that risk on the scant information contained in the Prisoner Escort Record, the self-harm warning form - if, indeed, they saw these forms - and on what the man told them. The man was likely to have been at a higher risk of suicide than he was prepared to admit. Had staff known the full details of what had led to his arrest, his failed suicide attempt and his admission that he could not live with himself after having killed his girlfriend, they might have judged his risk differently. The assessment of the man's risk of suicide should have been informed by the whole picture and not just part of it.
177. The doctor who was the author of the clinical review of the management of the man's health needs, writes on page 5 of his review:

“At HMP Altcourse, [the man's] symptoms were initially ascribed to a situational response to the crime he had committed. The injection of heroin was categorised as an impulsive action and much weight is placed on [the man's] denial of suicidal thoughts or intentions. Surprisingly, his use of cocaine appears not to have been considered as a possible cause. When cocaine is stopped or when binge drinking ends, a crash follows almost immediately. Symptoms include:

- depressed mood
- fatigue
- generalised malaise
- vivid and unpleasant dreams
- agitation and restless behaviour.

“The depression can last for months following cessation of long-term heavy use (particularly daily). Withdrawal symptoms can also be associated with suicidal thoughts in some people. There is a risk of suicide or overdose. Since at least 50% of people addicted to cocaine have a co-existing mental disorder (particularly depression and attention-deficit disorder), these conditions should be treated aggressively.

“It is not clear how the severity of his symptoms or the level of risk were assessed at Altcourse and no special measures were introduced. However, had the suicide screen used at first reception in HMP Leeds been applied to the man at this stage,(i.e at Altcourse) it is likely that he would have hit the trigger point for further intervention, including opening an ACCT (Assessment, Care in Custody and Teamwork) form.”

178. The doctor who was the author of the clinical review makes the following recommendation:

“HMP Altcourse Healthcare Service should review the assessment and management of suicide risk and depression.”

### **Recommendation 1**

**The Director of Altcourse should explore, with his police counterparts, methods of ensuring that vital information about the risk of suicide presented by prisoners in police custody is properly and comprehensively recorded on the PER and effectively communicated to private security organisations and to the Prison Service.**

**(I understand that since 2006, the format of the PER may have been changed.)**

### **Record keeping**

179. The suicide and self-harm warning form completed by PCO 1 who escorted the man from Runcorn police station to a magistrates’ court on 2 October 2006 was not signed by either admissions or healthcare staff at Altcourse. This significant omission adds further doubt about what information was given to relevant staff about the man’s risk factors during transit from police to prison custody.

### *Cell sharing risk assessment*

180. The second section of the cell sharing risk assessment form asks ten questions, one of which is, "Does the prisoner have any previous convictions for the following: murder, sex offence, kidnapping, manslaughter, false imprisonment, GBH, ABH (and other offences). In the man's case, the "no" box was ticked. In fact, the man was already serving a sentence for Actual Bodily Harm.
181. The third section asks questions about the prisoner's mental condition and has to be completed by a member of healthcare staff. The user must judge from a medical standpoint what level of risk a prisoner presents of harming others. In this man's case, the section was completed by a nurse who judged that the risk was low.
182. The form also requires the author to comment as to whether any self-harm issues have arisen. The nurse ticked neither of the two boxes available. At interview, she could not account for why she did not do so.

### **Recommendation 2**

**The Director of Altcourse should take urgent steps to remind his staff of the importance of accurate and comprehensive completion of all documents relating to prisoners, especially the suicide and self-harm warning and cell sharing risk assessment forms. The Director should address any staff training needs in this regard.**

### **The justification for transferring the man to Leeds**

183. When my investigator opened the investigation, he was told that the man might have been transferred from Altcourse to Leeds as part of an overcrowding draft - a means by which overcrowding at one prison is relieved by sending prisoners to other prisons where there are vacancies. The investigation found that this was not the case.
184. The Head of Operations at Altcourse explained that the man was moved on security grounds. On 25 October 2006, the man was caught using a mobile phone in his cell. Two days later, a distressed woman telephoned the prison to report that she had received a threatening phone call from the man on his mobile phone. It was thought the woman was likely to be a witness at his forthcoming trial. At about this time, it also became apparent that the man had sent a friend to the cell of another prisoner whose sister was likely to be a prosecution witness. On the man's instructions, the friend told the prisoner that he was a "grass" and that he would be assaulted.
185. The Head of Operations at Altcourse described the man as a very influential prisoner who "had a finger in every pie". He said the move to Leeds was

arranged primarily because of his use of the mobile phone on 25 October and the intelligence about threatening the brother of a potential prosecution witness. The Head of Operations at Altcourse stressed that the transfer was a temporary measure - "a respite" - and that the man would have been returned to Altcourse for his trial.

186. While it is usually better for prisons to manage any threats to security and order without recourse to transfer, I am conscious that the stability of a prison can be threatened by the presence of those who bring pressure to bear on others. The man was evidently regarded as such a prisoner. In my view, the apparent attempt to threaten prosecution witnesses was a not improper reason for arranging his temporary transfer. However, such a transfer was far from the only course of action. Indeed, it was possible for the man to threaten those he thought would give evidence against him from Leeds as well as from Altcourse. (In fact, the man was caught using a mobile phone while he was in Leeds.) As things turned out, the man made it clear to staff at Leeds that he resented being there. I believe this contributed in part to his poor attitude and aggressive behaviour.

### **The passage of medical information between Altcourse and Leeds**

187. When the man was transferred to Leeds on 10 November 2006 his core prison record was taken by the escorting staff, along with his medical record. The medical file for the man presented to my investigator had initially been opened at Altcourse in April 2005 at the outset of the man's previous period of custody. This file was a traditional paper record, known as the Inmate Medical Record (IMR). It contained numerous notes and documents relating to the man's time at Altcourse and Acklington. However, at the time of his next admission to Altcourse, on 2 October 2006, the system for recording the details of prisoners' medical history was in the process of changing from the IMR to an electronic system known as System One. On the day of his transfer, no print-out of the electronic record for the man for the period he was at Altcourse was inserted into the paper file that travelled with him to Leeds.

### **Recommendation 3**

**The Director of Altcourse, in liaison with Medacs, the contractor responsible for the delivery of healthcare, should ensure that before any prisoner is transferred to another prison the prisoner's complete medical record is assembled. This function should be regularly audited by an appropriate manager.**

188. The doctor who was the author of the clinical review also touches on this issue in his clinical review. He recommends as follows:

“The Prison Service should review the systems for transferring important information between forensic medical services and prison healthcare and transferring clinical information held on computers.”

## **Good practice**

### *First night watch*

189. My investigator was told that, as matter of routine, all prisoners undergoing their first night at Altcourse are placed in the First Night Centre and are observed at regular intervals - normally half hourly - throughout the night. Observations do not cease until approximately 10.00am the next day. My investigator was also told that if, after that period, any prisoner were to demonstrate that he was having difficulty in coping, observations would continue or, if necessary, self-harm monitoring procedures would be implemented.

### *Self-harm communication form*

190. My investigator was told that the self-harm communication form is normally raised at Altcourse in respect of prisoners about whom staff are concerned, but whose condition is not such as to warrant the initiation of formal self-harm monitoring procedures. The expectation was that the form would normally be open for no more than 48 hours. If staff considered it necessary to keep the form open beyond that period, formal self-harm monitoring procedures would be started if appropriate.

**I regard both these systems as examples of good practice.**

## **ISSUES RELATING TO THE MAN'S PERIOD OF CUSTODY AT LEEDS**

191. Here I examine the following issues:

- Were the man's mental health needs and risk of self-harm properly identified and managed at Leeds?
- Was his prospective move to Dovegate properly handled?
- Were the regime restrictions placed upon him justified?
- Was it appropriate to keep him in a single cell?
- Was the response to the discovery of the man hanging prompt and effective?
- The handling of the man's letters found in his cell after his death.

I also examine whether the proper courtesies and support were offered to the man's family in the aftermath of his death and I provide answers to the concerns his family expressed through their solicitor.

### **Were the man's mental health needs and risk of self-harm or suicide properly identified and managed at Leeds?**

192. I have already expressed the view that had the full details of the man's history between 19 September and 2 October 2006 been available at the point of the man's reception at Altcourse, the assessment of his risk of suicide at that stage might have been different. That said, there was little to indicate he was at risk of suicide when he arrived at Leeds on 10 November. The PER for the journey from Altcourse carried no notation of any such risk. The man was seen by a doctor who noted a history of depression but recorded that the man did not appear to be suicidal. He was referred for a mental health assessment. This was due to take place on the day he died. The doctor prescribed Buspirone to reduce anxiety and Paroxetine (an anti-depressant).

193. However I am alarmed by the fact that crucial risk-related information sent to the Sentence Planning office at Leeds on 20 November 2006 seems not to have been acted upon (see paragraph 113 above). The man's Probation Officer had the presence of mind to draw attention to his concerns that the serious nature of the charge his client was facing was such as to render the man at risk of self-harm. Whilst it does not follow that, had the information been acted upon, there would have been a different outcome, the likelihood that the information was simply 'filed and forgotten' represents, in my view, a significant and unacceptable systemic failure which reflects badly on the approach by the then staff of the Sentence Planning Unit to their duty of care for prisoners.

#### **Recommendation 4**

**The Governor must take immediate steps to ensure that systems are put in place to guarantee that risk-related information received from outside agencies about prisoners is acted upon immediately.**

194. Between his arrival at Leeds and the eve of his death, the man demonstrated no obvious signs that he was contemplating suicide. However, it is clear that his reading of the prosecution letters passed to him by his solicitor on 5 December had a profound impact on him. During the exercise period that afternoon, one of the officers supervising D wing exercise asked the man why he was back in D Wing. The man replied:

“Don’t ask. I went down to reception last week to go to Forest Bank [as noted earlier, it is assumed that he meant Dovegate] and sat in reception all morning. They then twisted me up [slang for being restrained] and took me to the seg. I then came back on here as basic high risk [i.e on the basic regime and considered to present a high risk of harming others]. I have also been told I am getting charged with conspiracy to murder as well as murder and stuck here until 22.12.06 so I am now f\*\*\*ed.”

195. The officer later told my investigator he thought the man seemed his usual self. He emphasised that at no stage did the man appear to him to be suicidal.
196. However, the evidence later given to the police and to my investigator by one of the prisoners in the adjacent cells gives a closer insight into the man’s state of mind at that time. The prisoner told the police that the man had intimated to him on the exercise yard one day that, before being arrested, he had intended to kill himself. The prisoner also said the man told him that he could not face up to a long prison sentence and that since 13 November when he was placed in the next cell, the man, in his view, became more and more depressed. The prisoner disclosed to the police that the man felt he should have killed himself after he had killed his girlfriend.
197. During his interview with my investigator, the prisoner in one of the adjacent cells disclosed that the man told him on the exercise yard one day that he was going to kill himself before being arrested. The prisoner said,
- “He didn’t say he would do it in here...he didn’t to me personally that he was going to do it in here but he did contemplate doing it outside before he came in.”
198. The prisoner in one of the adjacent cells said he thought the trigger for the man’s suicide was his realisation of the full force of the prosecution case against him.

199. In a telephone call to his family later that day, the man said:

“I’ve got nothing to look forward to because they’re never going to let me out. I don’t want to upset everyone but I can’t do this forever, do you know what I mean?”

200. The family member who took the call did not read anything significant into the man’s words because he often spoke in those terms. She did not pass on the contents of the call to anyone at HMP Leeds. Despite the nature of that call, the man still did not show any obvious signs to staff that he was contemplating suicide. The two prisoners in the adjacent cells during the night of the man’s death told my investigator that they talked with the man about topics such as football. They said at no stage did the man say anything about wanting to kill himself or give them an impression that he was in a frame of mind to do such a thing.

201. Whilst he was at Leeds, the man’s overt behaviour suggested to staff that he was, in their view, an aggressive and truculent man. However, it would seem that the man managed to hide his real feelings. Although it was clear to staff his morale was low, he gave them no obvious signs that he was contemplating suicide. Indeed, from the available evidence, it seems possible he did not become actively suicidal until the day before his death. Even then, his manner was not such as to give staff reason to believe he was about to kill himself. It is difficult to identify specific ways in which staff at Leeds could have intervened to prevent his death.

202. However, the doctor who was the author of the clinical review suggests that the depression protocol at Leeds was not followed and recommends that the healthcare department should reconsider the approach to screening risk in prisoners who have committed serious crimes and who have been transferred from other prisons. I agree.

**Was the man’s prospective move to Dovegate properly handled?  
Were the regime restrictions placed upon him justified?**

203. On 21 November 2006, the man was placed on closed visits after being caught with a mobile phone. Between 23 and 27 November, he was given a number of warnings about his behaviour. He was advised he would be reduced to the basic regime level, resulting in a loss of privileges, if his behaviour did not improve. Despite this, genuine efforts were made to give the man a fresh start by transferring him to C Wing on 28 November. I applaud this decision.

204. However, on 30 November, the man was taken to reception in order to prepare for a transfer that day to Dovegate. After spending several hours waiting in reception, he was told Dovegate would not accept him.

205. Even though the man was apparently content to transfer to Dovegate, I am not sure there were good grounds for sending him there. More to the point, the fact that he had to wait in reception for several hours, only to be told the transfer would not proceed, is an example of poor prisoner management. It is perhaps understandable that the man reacted badly. It would have been more appropriate for his transfer to have been agreed or rejected before he was taken from the wing. Although the man would still have been disappointed had this happened, he would not have had his hopes dashed after a wait of about four hours in reception.
206. The sudden cancellation of the man's transfer was followed by a decision to re-locate him to D Wing rather than return him to C Wing and to take him, at least part of the way, under restraint. Whilst I accept that, given the man's behaviour, it was necessary to restrain him, the fact that it became necessary at all stemmed from what had happened in reception.
207. None of the staff interviewed at Leeds knew why the man was due to be transferred to Dovegate. (It is highly unusual for any prisoner to be transferred to a training prison before he has been tried, convicted and sentenced, especially if he is facing a life sentence as was this man.) Neither was my investigator able to establish why the transfer was cancelled. However, it is most likely that it was due to the fact that the man was still awaiting trial. Had the option of transferring the man to Dovegate not arisen, this particular episode would have been avoided.

## **Recommendation 5**

**The Governor should take immediate steps to ensure that decisions as to allocations or transfers are communicated to prisoners in a manner that is both timely and in keeping with the Prison Service's policy of decency.**

208. The next day, the man was placed on the basic regime because of the earlier warnings he had been given about his conduct. No doubt his behaviour the previous day was also taken into account. His reduction to the basic regime meant he could not watch television in his cell, the number of letters he could send out each week was reduced, and the number of visits per month were decreased.
209. It is, of course, most unfortunate that, at a time when the man was already under great pressure, these regime restrictions were imposed. They could not have helped his morale. However, I believe that, aside from the comments I have made about the man's cancelled move to Dovegate, it was reasonable for staff to impose sanctions given his behaviour.

### **Was it appropriate to keep the man in a single cell?**

210. A cell sharing risk review held on 1 December resulted in the decision to keep the man in a single cell until after his court appearance due on 22 December. It is easy, with the benefit of hindsight, to judge that the man should not have been kept in a cell on his own. However, at the time this decision was made, the man had not manifested any obvious signs he was contemplating suicide and was therefore not subject to self-harm monitoring procedures. Furthermore, his aggressive and uncooperative behaviour, whatever the cause, suggested he presented a risk of harming others. I therefore raise no criticism of the decision to keep the man in a single cell.

### **Was the response to the discovery of the man hanging prompt and effective?**

211. The officer principally responsible for patrolling D2, D3 and D4 landings, and the first person to discover the man hanging, said he was reluctant to enter the cell on his own as he knew that in the past staff had been taken hostage when entering a cell alone in response to what seemed to be a genuine emergency. There is no evidence that this reluctance resulted in any undue delay in entering the man's cell once other staff had arrived. The officer principally responsible for patrolling D2, D3 and D4 landings could not be certain that the man was dead before he entered the cell. He could not have known at that stage whether the man still had a pulse. That said, it became clear as soon as staff entered the cell that the man was beyond recovery. However, any reluctance to enter a cell in response to a life threatening situation carries with it the possibility that a delay might occur with the result that a life could be lost.

### **Recommendation 6**

**The Governor should ensure that his staff are properly advised about the need to enter a cell as swiftly as possible in the event of the discovery of a life threatening situation and that considerations about personal security is weighed against the need to preserve life.**

212. The officer principally responsible for patrolling D2, D3 and D4 landings was critical of the quality of the scissors provided to staff for cutting through materials used as ligatures (as noted earlier, he described them as similar to those provided in kindergartens). He said he had some difficulty in cutting through the ligature used by the man. Whilst there is no evidence that the difficulty the officer said he experienced affected the outcome in the man's case, it is imperative that all emergency equipment is fit for purpose.

## **Recommendation 7**

### **The Governor should procure and issue staff with serviceable cut down tools.**

213. Both the nurse who had attached the defibrillator to the man's chest and the officer principally responsible for patrolling D2, D3 and D4 landings told my investigator of their disappointment at the lack of care offered to them in the aftermath of their response to the emergency.

## **Recommendation 8**

### **The Governor should satisfy himself that appropriate arrangements are in place to provide care and support for staff, including members of the care team, who have been involved in the discovery of prisoners who have taken, or have attempted to take, their own life.**

#### **The handling of letters found in the man's cell after his death**

214. My investigation found no evidence of any correspondence left by the man at the time of his death indicating his intention to take his own life. However, a number of documents found in the man's cell after his death were seized by the West Yorkshire police for use in their separate investigation. In a report submitted by West Yorkshire police to the Coroner on 2 March 2008, the Detective Inspector in charge of the police investigation wrote:

"There was a note found in the subsequent search of the cell occupied by [the man]...I am of the opinion that this in no way can be referred to as a 'suicide note' and my initial report reflected this point."

215. However, at a later date, the man's family solicitor noticed that private letters were visible in one of the photographs of the contents of the man's cell that had been taken by the police on the night of his death. The solicitor therefore asked for copies of every document seized by the police. Amongst these documents were found numerous letters written by the man to various members of his family and to friends in which he expressed his sorrow for the pain he had caused them and bade them his farewell.
216. This tardy discovery was a source of much distress to the man's family and a matter that will no doubt have been regretted by West Yorkshire Police. (West Yorkshire Police have since accepted this criticism, advised relevant staff regarding their conduct and apologised to the man's family.)

## **FAMILY CONCERNS**

217. Here I provide responses to the concerns raised by the man's family.

***What action did the police take to prevent the man killing himself (e.g. constant watch)?***

218. These matters are dealt with in paragraphs 37 - 48.

***What action was taken by those responsible for escorting the man from Runcorn police station to a magistrates' court and later to Altcourse prison to prevent him from killing or harming himself? What handover did they have from the police and what handover did they provide at Altcourse?***

219. These matters are considered principally in paragraphs 49 – 77 and 156 – 173.

***Was the man on a suicide watch on his admission to Altcourse? When did it cease and why?***

220. These matters are dealt with in paragraphs 62-89.

***Was the man placed on a suicide watch at Leeds? If not, why not? Is it true that Leeds would not have accepted him if he had been on such a watch?***

221. The man was not placed on any self-harm monitoring procedures at Leeds where he manifested to staff no indications that he was at risk of self-harm or suicide. The investigation found no evidence to suggest that Leeds does not accept at risk prisoners from other prisons.

***Why was the man transferred from Altcourse to Leeds? Was it because he had to be kept apart from another prisoner whose girlfriend was in the same flat as his partner on the night she died?***

222. The man was transferred to Leeds for security reasons. This matter is dealt with in paragraphs 104 – 107 and 182 - 185.

***What assessment was made of the man's mental state from his arrest to his death, and what treatment, if any, did he receive?***

223. This is covered in the main body of the report and in the clinical review written by the clinical reviewer on behalf of Leeds Primary Care Trust.

***Did the man suffer panic attacks prior to his release from Acklington prison in August 2006? Were his medical records from that period of imprisonment available when he returned to custody in September 2006?***

224. As the clinical reviewer points out in his clinical review, no medical records for the period the man spent at Acklington were available. It has therefore not been possible to confirm whether the man experienced panic attacks at Acklington.

***As the man was already on parole licence when he was arrested a month later, should he have been given the same prison number at Altcourse as he had at Acklington?***

225. This is covered in paragraph 64.

***Is it true that the man was placed on the basic regime at Leeds following an incident when he had been made to wait in reception for approximately four hours for transfer to Dovegate only to be told that the transfer had been cancelled?***

***Why (in his state of mind) he was made to wait so long in reception?***

***Why he was going to be moved to Dovegate?***

***Why the transfer did not take place?***

***Why he was restrained and what happened next?***

***Whether he was placed on disciplinary charges.***

***Whether he was placed on the basic regime in relation to this incident.***

226. These matters are covered at various points in the report.

***Is it true that on another occasion the man was taken for a legal visit but made to wait all afternoon when the visit had been cancelled by his solicitor by phone or letter? The family believe that this contributed to his distress and have asked the Ombudsman to investigate the incident.***

227. The investigation could find no evidence in relation to this matter.

***Is it true that the man was not allowed to have writing paper? (He sent a letter to the family apologising for having to write on the back of a letter that they had sent him because he had no paper.)***

228. The investigation found that on 30 November the man's privilege level was reduced from standard to basic. One of the consequences of that reduction was that his entitlement to letters was reduced from three per week to two. These restrictions were still in force when he died. It has not been possible to prove

whether there was any other reason why he chose to write on the back of a previous letter.

***Why was the man in a cell on his own?***

229. This matter is covered in paragraphs 123 - 126 and 209.

***Has any risk assessment been conducted of the provision of bunk beds in cells of single occupation in the main prison? Was the man's cell a single cell or a double cell in single occupancy? If the latter, why?***

230. The man occupied a cell in which two beds were provided as bunks. My investigator was told by the wing manager that the operational requirement at Leeds for the provision of accommodation is such that two beds are normally required to be kept in every cell on normal location. The policy for the provision of beds in the segregation unit was different. The wing manager told my investigator that a management decision had been made some time earlier to remove spare beds in the segregation unit partly because they were not needed and partly because of the added risk two beds could pose.

***The family understands that the man's cell was opposite the staff room and that his cell light was left on all night when he died. Who had control of the light switch (inside or outside the cell)? Were any staff in the staff room overnight? Could they have noticed that his cell light was on all night? Should this have raised any concerns?***

231. I have found no evidence to prove that the man's cell light was switched on all night. However, the member of staff who was on duty in D Wing that night, and who was first to discover him hanging, noticed as he approached the man's cell at 5.50am on the morning of the man's death that the cell light was indeed on. It is not unusual for some prisoners to leave their light on all night: this tends to happen, for example, when they fall asleep while watching television.

232. It is of course known that the man hanged himself by attaching a ligature to the conduit carrying electricity to the light in his ceiling and then falling backwards from the top bunk. It is likely that, in order to be able to see what he was doing as he attached the ligature in this way, he needed to have the cell light on. Thus, the light would have remained on from whenever he began the process.

***Why was the man kept in D wing, the induction unit for so long? Is it true that the facilities and regime in that wing are not as wide ranging as on other wings?***

233. My investigator was told that prisoners are not kept on the induction wing for a specified period. Some are moved onto other wings after a few days, while others stay for a much longer period. The decision as to how long prisoners remain on the wing is determined by individual needs and circumstances. In

general terms, prisoners on D Wing do not go to work, whereas those in other wings do. As a result, those on D Wing are likely to spend more time in their cells. As this report shows, the man's time on D wing was interrupted briefly on 28 November when he was moved to C wing to see if he could settle there. Two days later he was returned to D wing. I take the view that the man was not kept on D wing for an unusually long time.

***What contact did the man have with other prisoners and staff during the night of the man's death?***

234. The man was in cell D2-41 when he died. The adjacent cells were occupied by two prisoners, both of whom were interviewed during the course of the investigation. Both have said that during the eve of the man's death they had short, sporadic conversations with the man about football and other general topics. They both confirmed that at no stage did he mention whether he was depressed or that he may have been contemplating suicide.
235. However, one of the prisoners in the adjacent cells said that on the eve of the man's death, after the man had seen his solicitor, who passed him the prosecution papers, he seemed to be very red faced as if he had been crying. The prisoner also said that he saw the man walking slowly along the landing with his head down. The prisoner was persuaded that the man was deeply affected by what he read in the prosecution papers and that this may have triggered his demise. (See also my comments at paragraph 134 above.)
236. Both prisoners in the adjacent cells said that at some stage during the night they heard a noise coming from the man's cell, rather like a chair falling over. However, neither thought it significant or reported it to staff.
237. The officer on duty in D Wing that night confirmed that he had spent some time during his shift in the office on the landing on which the man's cell was located. The officer also confirmed that the office is opposite that cell. The officer told my investigator that at no stage during the night did he remember hearing any conversations between the man and the prisoners in the neighbouring cells.

## **LIST OF RECOMMENDATIONS**

**To the Director of Altcourse**

### **Recommendation 1**

**The Director of Altcourse should explore, with his police counterparts, methods of ensuring that vital information about the risk of suicide presented by prisoners in police custody is properly and comprehensively recorded on the PER and effectively communicated to private security organisations and to the Prison Service. (A copy of this report has been provided to the Cheshire police.)**

**(I understand that since 2006, the format of the PER may have changed.)**

### **Recommendation 2**

**The Director of Altcourse should take urgent steps to remind his staff of the importance of accurate and comprehensive completion of all documents relating to prisoners, especially the suicide and self-harm warning and cell sharing risk assessment forms. The Director should address any staff training needs in this regard.**

### **Recommendation 3**

**The Director of Altcourse, in liaison with Medacs, the contractor responsible for the delivery of healthcare, should ensure that before any prisoner is transferred to another prison the prisoner's complete medical record is assembled. This function should be regularly audited by an appropriate manager.**

### **Good practice**

#### ***Automatic first night watch***

My investigator was told that, as matter of routine, all prisoners undergoing their first night at Altcourse are placed in the First Night Centre and are observed at regular intervals - normally half hourly - throughout the night. Observations do not cease until approximately 10.00am the next day when the oncoming shift have had an opportunity to observe each prisoner themselves. My investigator was also told that if, after that period, any prisoner were to demonstrate that he was having difficulty in coping, observations would continue or, if necessary, self-harm monitoring procedures would be implemented.

## **Self-harm communication form**

My investigator was told that the self-harm communication form is normally raised at Altcourse in respect of prisoners about whom staff are concerned but whose condition is not such as to warrant the initiation of formal self-harm monitoring procedures. The expectation was that the form would normally be open for no more than 48 hours. If staff considered it necessary to keep the form open beyond that period, formal self-harm monitoring procedures would be started if appropriate.

**I regard both these systems as examples of good practice.**

**To the Governor of Leeds**

### **Recommendation 4**

**The Governor must take immediate steps to ensure that systems are put in place to guarantee that risk-related information received from outside agencies about prisoners is acted upon immediately**

### **Recommendation 5**

**The Governor should take immediate steps to ensure that decisions as to allocations or transfers are communicated to prisoners in a manner that is both timely and in keeping with the Prison Service's policy of decency.**

### **Recommendation 6**

**The Governor should ensure that his staff are properly advised about the need to enter a cell as swiftly as possible in the event of the discovery of a life threatening situation and that considerations about personal security are weighed against the need to preserve life.**

### **Recommendation 7**

**The Governor should procure and issue staff with serviceable cut down tools.**

### **Recommendation 8**

**The Governor should satisfy himself that appropriate arrangements are in place to provide care and support for staff, including members of the care team, who have been involved in the discovery of prisoners who have taken, or have attempted to take, their own life.**

(At consultation stage, the Prison Service accepted all the above recommendations.)

***Summary of recommendations made in the clinical review***

**The Prison Service should review the systems for transferring information between forensic medical services and prison healthcare and transferring clinical information held on computers between prisons.**

**HMP Altcourse Healthcare Service should review the assessment and management of suicide risk and depression.**

**HMP Leeds should review the lack of adherence to the depression protocol and reconsider the approach to screening risk in prisoners transferred from other prisons but who have committed major crimes.**