

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Vicky Thompson a prisoner at HMP Leeds on 13 November 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Vicky Thompson was found hanged in her cell at HMP Leeds on 13 November 2015. She was 21 years old. I offer my condolences to Ms Thompson's family and friends.

Ms Thompson was a transgender prisoner held in a male prison and therefore had particular vulnerabilities. Although she had been recognised as at risk of suicide and self-harm, I am concerned that Prison Service suicide and self-harm procedures were not operated effectively to protect her and did not take into account her specific needs. Ms Thompson complained that she experienced inappropriate and bullying behaviour from other prisoners but this was largely unaddressed.

I do not underestimate the challenge of managing transgender prisoners, but this investigation found that Leeds has more work to do to care for these prisoners appropriately. More generally, the allocation of transgender women to men's prisons is not straightforward and national policy, which is currently under review, should ensure that prisons focus on an individual assessment of risk and need, not simple legal status. In light of this, it is not clear that enough consideration was given to whether Ms Thompson's needs might have been better met in a women's prison.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2016

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Summary

Events

1. Ms Vicky Thompson was transgender and had been living with a female identity since she was ten. She did not have a gender recognition certificate to formalise her status. She had a history of suicide attempts and self-harm, mental illness and substance misuse. Ms Thompson had been in prison before and had been released from Leeds in April 2015.
2. On 19 October 2015, Ms Thompson was convicted of theft and other offences and remanded to Leeds until she was sentenced. While in police custody, she tried to harm herself by tying elastic around her neck and court staff noted that she had threatened to hang herself. When she arrived at the prison, staff began Prison Service suicide and self-harm prevention procedures (known as ACCT). At an initial health assessment, she said she had been bullied last time she had been in Leeds and had tried to hang herself. (There was no record of this.) She said she did not want to be in a male prison.
3. Ms Thompson began a 21-day methadone and alcohol/benzodiazepine detoxification programme. A mental health nurse assessed Ms Thompson but did not refer her for any further mental health support. On 27 October, a doctor prescribed Ms Thompson antidepressants without seeing her. No one obtained her community health records.
4. Ms Thompson was given a cell on E Wing, where she had been the last time she was at Leeds. Ms Thompson complained that other prisoners on the wing were abusive and behaved inappropriately towards her. She asked to be held separately from the general prisoner population and, on 20 October, was moved to A Wing, the prison's vulnerable prisoner unit, where she seemed to settle. Ms Thompson said that she did not want to move to a women's prison.
5. The equalities team held two multidisciplinary case conferences about how to manage Ms Thompson but no one considered the possibility of a move to a women's prison. Despite her particular needs as a transgender prisoner, no one from the equalities team or any healthcare staff attended Ms Thompson's ACCT case reviews. On 3 November, staff ended ACCT monitoring. On 8 November, Ms Thompson completed her methadone and alcohol detoxification programmes.
6. On 11 November, Ms Thompson appeared at court, but sentencing was adjourned until 30 November. Ms Thompson was worried about receiving a prison sentence, indicated she had thoughts of suicide, and court staff completed a suicide and self-harm warning form. Prison staff began ACCT procedures again but assessed her as a low risk of suicide. Staff checked her once an hour.
7. On 13 November, staff and other prisoners did not note anything concerning or different about her behaviour, but, in the afternoon, she told a nurse she was suffering withdrawal symptoms, as she was no longer receiving methadone. The nurse said she would arrange symptomatic relief but Ms Thompson did not receive any medication that day.

8. At about 8.00pm, an officer found Ms Thompson unresponsive with a ligature around her neck attached to the bed. Nurses and the paramedics tried to resuscitate Ms Thompson, but, sadly, this was not successful. At 8.48pm, the paramedics recorded that Ms Thompson had died.

Findings

9. Ms Thompson was originally sent to Leeds, a male prison, in line with existing national instructions, but this was not reviewed. We are concerned that a men's prison might not have been appropriate for a transgender woman who had lived with a female identify for ten years. Although Ms Thompson was not legally regarded as a woman, we consider that decisions about the location of transgender prisoners should be taken individually on their merits with the primary aim of the safety of the individual and others, rather than on blanket policies. Some aspects of the care and support offered to Ms Thompson as a transgender prisoner at Leeds were appropriate and consistent with national guidance, but we concluded that the prison and the National Offender Management Service need to do more to meet the needs and protect the safety of transgender prisoners.
10. Prison staff appropriately assessed Ms Thompson as at risk of suicide or self-harm but we found significant failings in the operation of ACCT procedures. Staff did not assess Ms Thompson's risk adequately at case reviews, there was no multidisciplinary attendance at case reviews, no continuity of management, observations were not carried out correctly, and the ACCT caremaps were inadequate.
11. We were concerned that, despite Ms Thompson's history of mental illness and her thoughts of suicide and self-harm, she received inadequate mental health assessment or treatment. We also found that Ms Thompson's complaints that prisoners were bullying her and behaving inappropriately went largely unaddressed, contrary to Leeds' local antisocial behaviour strategy.

Recommendations

- The Chief Executive of NOMS should ensure that all decisions about the location of transgender prisoners are based on an individual assessment of their needs and allow them to live safely in their acquired gender.
- The Governor should ensure that, in line with the Prison Service's commitment to diversity and equality, staff are aware of the specific needs of transgender prisoners and manage them in line with national Prison Service instructions to make sure those needs are met.
- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
 - ACCT case reviews should be multidisciplinary, with continuity of case management, and attended by all relevant people involved in a prisoner's care.
 - ACCT case reviews should fully consider and record the impact of bullying on the risk of suicide and take appropriate action.

- ACCT case reviews should assess the level of risk taking into account all risk factors. Levels of observations should reflect the risk and staff should carry out and record all required observations at the required intervals.
 - Case managers should set caremap observations which are specific and meaningful and aimed at reducing risk. Managers should review progress against caremaps at each review and set new actions when new issues arise.
 - Post-closure reviews should be held to assess whether there is any ongoing risk.
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- The Head of Healthcare should ensure that healthcare staff request relevant community health records for newly arrived prisoners, fully assess the needs of those who have been subject to mental health care in the community and that GPs review prisoners they have prescribed antidepressants without seeing them.
 - The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence or threats from other prisoners should be effectively protected.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator and the family liaison officer (also an investigator) visited Leeds on 24 November 2015. They obtained copies of relevant extracts from Ms Thompson's prison and medical records and interviewed two prisoners who knew Ms Thompson.
14. NHS England commissioned a clinical reviewer to review Ms Thompson's clinical care at the prison. The investigator and the family liaison officer interviewed 12 members of staff at Leeds in December 2015. The clinical reviewer joined them for interviews with healthcare staff.
15. We informed HM Coroner for West Yorkshire Eastern District of the investigation who gave us the results of the toxicology report. We have sent the coroner a copy of this report.
16. The family liaison officer contacted Ms Thompson's partner, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond and did not comment on the initial report.

Background Information

HMP Leeds

17. HMP Leeds is a local prison holding up to 1,120 men. Leeds Community Healthcare Trust runs primary healthcare services and Leeds and York Partnership Trust provides mental health services for prisoners with severe and enduring mental health problems.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Leeds was in December 2015. Inspectors identified failings in reception and induction processes. They reported that more prisoners felt unsafe than at comparator prisons. The number of assaults was very high and investigations into these incidents were poor. Most vulnerable prisoners felt safe on their wing.
19. Levels of self-harm at the prison had increased significantly since the last inspection in 2013. Some ACCT plans included good assessments but overall, procedures needed to improve. More complex cases were managed well. The prison had structures to support transgender prisoners. Inspectors considered that primary mental health services were limited and focused on crisis management; secondary mental health services were more responsive and appropriate to needs.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2015, the IMB was concerned about prisoners' safety. Monthly safer custody meetings were held, but data collection was unreliable and incomplete. The IMB considered that ACCT documents were not well completed but believed that staff checked prisoners at risk appropriately. The IMB noted that a Gay, Bisexual and Transgender group was in its sixth year and still met occasionally.

Previous deaths at HMP Leeds

21. A previous investigation at Leeds regarding a man who died in May 2015, highlighted concern about the prison's ability to manage a prisoner's risk of suicide or self-harm. In three investigations into deaths at Leeds in 2014, and one in 2013, we identified failings in the management of the suicide and self-harm monitoring procedures. We have previously identified weaknesses in the identification and management of mental health problems.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Transgender prisoners

25. The care and management of transgender prisoners is covered in Prison Service Instruction (PSI) 07/2011. Gender reassignment is a protected characteristic under the Equality Act 2010, so prisoners must not be discriminated against or harassed because of it.
26. According to the PSI, prisoners should normally be held in prisons appropriate to their gender as recognised under UK law. This is normally the gender at birth, unless the individual has a gender recognition certificate, legally recognising their acquired gender. When a transgender prisoner without a gender recognition certificate asks to be held in a prison opposite to their legally recognised gender, a case conference must be convened to consider all relevant factors and make a recommendation to the appropriate senior manager. Case conferences, including a multidisciplinary risk assessment, should be completed to consider how best to manage a transgender prisoner's location if they remain in a prison reflecting their gender at birth.
27. The PSI requires that governors permit prisoners who consider themselves transgender and who want to begin gender reassignment, to live permanently in their acquired gender. This means that transgender prisoners must be allowed to dress in clothes appropriate to their acquired gender, adopt gender appropriate names and modes of address and have access to the items they need to maintain their gender appearance at all times.
28. Prisons must produce a management care plan, setting out how the individual will be managed safely and decently. Any risks to and from a transgender prisoner must be identified and managed appropriately, as for any other prisoner. The PSI notes that transgender prisoners should be considered as an 'at risk' group in terms of suicide and self-harm.
29. Since Ms Thompson's death, and a successful campaign by a transgender prisoner to be transferred to a women's prison, the National Offender Management Service (NOMS) has begun a review of policies for transgender prisoners. The PPO has commented on the consultation. Though we noted the challenge to prisons of meeting the needs of transgender prisoners, the law is clear that a transgender person should be treated according to the sex they identify with and that they should be permitted to live permanently in their

acquired gender, with access to appropriate clothes and other items. The risks to transgender prisoners should be properly managed.

Key Events

30. Ms Vicky Thompson was a transgender woman, who had been living in a female identity since she was ten years old. She had not had gender reassignment surgery or hormone therapy. Ms Thompson had previously been in Leeds prison and had been released from the prison, on bail, in April 2015. At that time, Ms Thompson told people that she was in a men's prison because she did not have a gender recognition certificate (which is necessary to obtain a new birth certificate recognising the acquired gender). Ms Thompson said she did not want the certificate because she knew who she was, and the cost was prohibitive.

October 2015

31. On 18 October 2015, the police arrested Ms Thompson for failing to appear at court to face charges of theft. She was held in police custody overnight. At 12.49am on 19 October, Ms Thompson cut her cheek with a metal press-stud from her trousers and rubbed her arms against the wall, causing reddening. At 1.03am, she tied some elastic from her waistband around her neck. When police officers intervened, Ms Thompson said, "Whatever happens tonight, I'm going to die". The police monitored her constantly from then and a doctor examined her. (The records from police custody do not show whether the doctor had any concerns about Ms Thompson, or prescribed any medication.)
32. Later on 19 October, Ms Thompson appeared at Crown Court and was convicted of theft, failure to surrender to court, and breach of a suspended sentence. Ms Thompson was remanded to HMP Leeds until November, when she would be sentenced. Court escort staff completed a suicide and self-harm warning form noting that Ms Thompson had scratches on her face and arms and had said she would hang herself and "be carried out in a box". She told the court escort staff that she had been sexually assaulted in prison before and was afraid to go back. There is no record that Ms Thompson had previously reported any sexual assault at Leeds.
33. Court escort staff telephoned the prison's equality advisor in advance and told her that Ms Thompson was on her way to the prison. The equality advisor spoke to the equality and diversity officer a prison manager, who had both met Ms Thompson when she was last at the prison. The equality advisor and the equality and diversity officer briefed reception staff about how to manage her specific needs as a transgender prisoner, when she arrived.
34. When Ms Thompson arrived, the equality and diversity officer met her in reception. He told the investigator that Ms Thompson said she did not want to go to a women's prison because other prisoners would be "bitchy". They discussed how she could obtain female clothing and make-up by ordering them from a nearby women's prison.
35. A reception officer began ACCT procedures in reception because of the scratches on Ms Thompson's arm and cheek, which she had been unwilling to discuss, and the information on the suicide and self-harm warning form. A Supervising Officer (SO) noted that Ms Thompson should have a safer cell (with reduced ligature points) with a suitable cellmate, and that staff should check her hourly until her risk of suicide and self-harm had been fully assessed. Ms

Thompson had not been regarded as at risk of suicide and self-harm during previous stays at the prison.

36. At an initial health screen, Mr Thompson told a healthcare assistant that she had tried to hang herself at the prison in March 2015. (There was no mention of this in her medical record.) Ms Thompson said that in the community, she had been prescribed mirtazapine for depression and methadone to treat opiate addiction. The healthcare assistant thought Ms Thompson appeared depressed and vulnerable. Ms Thompson told her that she did not want to be in a men's prison because she had been bullied last time she was in Leeds. She did not pass on Ms Thompson's concerns about bullying to anyone else or that she had said she did not want to be in a men's prison, as she believed Ms Thompson would be supported through ACCT procedures.
37. Ms Thompson told reception officers that she was willing to share a cell with a suitable cellmate and did not want to be on her own. She was assessed as suitable to share a cell.
38. A mental health nurse recorded that Ms Thompson had been prescribed a daily dose of 30mls of methadone in the community, but had not attended a recent appointment and had not collected her methadone for the last ten days. Ms Thompson said that she had been using her partner's methadone and benzodiazepines (tranquilisers) and had been drinking up to 12 cans of strong lager daily.
39. Ms Thompson said she had been diagnosed with bipolar disorder five years earlier, and had been prescribed mirtazapine, but had not taken any for the past ten days. Ms Thompson appeared anxious about being in prison and that she would be bullied. Ms Thompson said she had self-harmed the night before, when she was in police custody. She told the nurse that she had been bullied and sexually assaulted in prison before, and was afraid about being back at Leeds. Again, there is no record that the nurse shared Ms Thompson's concerns with any other staff or took any action, apart from recording what she had said in her medical record.
40. Ms Thompson gave a urine sample, which tested positive for methadone, cocaine, benzodiazepines and opiates. The nurse referred Ms Thompson to the doctor and the Integrated Drug Treatment Service (IDTS).
41. A GP examined Ms Thompson and noted that she had been injecting heroin into her groin and taking diazepam (a benzodiazepine drug). He prescribed Ms Thompson a 21-day methadone detoxification programme and an alcohol detoxification programme with a reducing dose of diazepam to treat symptoms of alcohol withdrawal and her withdrawal from benzodiazepines. He also prescribed thiamine and vitamin B tablets, which are also often prescribed to patients who misuse alcohol. He noted that Ms Thompson looked well, but did not comment on her mental health and did not prescribe mirtazapine (which was not prescribed until 27 October). A nurse from the IDTS completed a basic detoxification care plan with Ms Thompson. This included instructions for staff to confirm Ms Thompson's prescribed medications with her community GP, carry out observations for the first night and day, book Ms Thompson a GP

- appointment, and use the Clinical Opiate Withdrawal Scale (COWS) to check her for signs of methadone withdrawal.
42. Ms Thompson went to a cell in the prison's first night centre, which she shared with someone she had previously shared with. A prisoner diversity representative, who had met her before, spoke to her for about 20 minutes. Ms Thompson said she wanted to move to A Wing (the vulnerable prisoners unit) when she left the first night centre as she had previously been bullied on E Wing. She said this was "bog standard" bullying which he thought meant that other prisoners had bullied her because she was transgender.
 43. Between 11.50pm and 6.00am on 20 October, staff checked Ms Thompson at regular intervals, on the hour. There is no record that anyone checked her between 6.30am and 9.05am on 20 October.
 44. At 9.05am, a nurse assessed Ms Thompson's mental health. Ms Thompson said she had been diagnosed with bipolar disorder and had been admitted to a psychiatric hospital previously. She said she had a history of sexual abuse and drug use, and that she had been bullied the last time she had been at Leeds. She said that she was happy to share with her current cellmate.
 45. Ms Thompson told a nurse that she felt life was not worth living and was tearful during their meeting. Although she had identified a need for someone to get Ms Thompson's community mental health records no one had requested them and neither did the nurse. She did not refer Ms Thompson to the secondary mental health team (known as the inreach team) for a further mental health assessment but noted that she would see her again in two weeks.
 46. Later that morning, Ms Thompson saw a nurse from the IDTS team to discuss her drug use. Ms Thompson appeared a little shaky, but said she felt well. He did not use the COWS to measure Ms Thompson's withdrawal symptoms and arranged to review her again in a month. (Another nurse did a COWS assessment when she checked Ms Thompson later that day.)
 47. The equality and diversity officer met Ms Thompson that day to agree her management care plan, including searching, showering, accommodation, dress code, and employment. Ms Thompson agreed the plan. Again, he told Ms Thompson that she could buy make up and other feminine items through a local women's prison, and her orders would be sent to her at Leeds.
 48. Later on 20 October, an officer assessed Ms Thompson as part of the ACCT process. She noted that Ms Thompson had a long history of being abused. She had been diagnosed with bipolar disorder, but had not been taking her medication. Ms Thompson said she had tried to tie a ligature around her neck when she was in police custody, and talked about difficult personal relationships. She said that she had tried to kill herself many times in the community, including by lying on train tracks, trying to hang herself and drinking nail varnish remover. Ms Thompson said she felt ugly as she had no make-up and could not style her hair properly. She said she wanted to die and did not feel she would get the help she needed. The officer recorded that Ms Thompson needed to be prescribed medication for her bipolar disorder and that she thought Ms Thompson would continue to self-harm.

49. At 2.00pm on 20 October, a Supervising Officer (SO) held the first ACCT case review with Ms Thompson but there were no other members of staff present. He noted that he had spoken to an officer about her assessment before the meeting, but there was no healthcare staff representation at the review and neither the equality advisor nor the equality and diversity officer were invited. Ms Thompson told the SO that she had seen staff from a number of agencies, including the mental health team, had talked to the equality and diversity officer, and now felt calmer. She said she felt less fearful and happy to live on E Wing. There is no record that she told the SO that she had been bullied or sexually assaulted when she was last at the prison. Ms Thompson said she would take any medication she was prescribed.
50. The SO assessed Ms Thompson as at a high risk of suicide or self-harm. He left the frequency of checks unchanged at once an hour and arranged the next case review for 27 October. He made two entries on the ACCT caremap, noting that Ms Thompson should live on E Wing in a shared cell with a cellmate she felt comfortable with (which she was) and that working might help her. (In fact, Ms Thompson said she did not want to work and had signed forms to acknowledge that she would not be paid if she did not work.) He noted that the mental health team had already seen Ms Thompson, so he did not refer her again.
51. At 10.00pm, a nurse checked Ms Thompson in her cell. Ms Thompson said she had no withdrawal symptoms and the nurse noted she showed no visible signs of withdrawal, although she did not record the COWS score. Ms Thompson was upset because she had not been able to shave since arriving at Leeds and the nurse advised her to raise this with an officer the next morning. (Ms Thompson asked an officer the next morning, who told her that prisoners are not usually allowed to have razors while in the first night centre. The Head of Safer Custody told the investigator that prisoners are not allowed a razor on their first night in the prison, but if they spend longer in the first night centre, they might be allowed one under staff supervision.)
52. Staff checked Ms Thompson throughout the night at hourly and predictable intervals. These continued until 9.00am on 21 October, when there was a three and a half-hour gap until the next recorded check at 12.30pm. The next check was at 2.30pm. There was then a gap until 5.00pm, when the next check was recorded.
53. On 21 October, Ms Thompson had an IDTS review with a nurse and discussed her drug use. Ms Thompson told her that she had visited a gender reassignment clinic in London, but had not followed up the appointment. She acknowledged that she would not be able to pursue gender reassignment until her lifestyle was more stable and she was clear of the hepatitis C virus. (This is the first reference to Ms Thompson having the hepatitis C virus, although the records from her last time at Leeds also mentioned it.)
54. Ms Thompson said that she wanted to shower at a different time from other prisoners on the wing, in line with her compact. The nurse said she would try to arrange this for her when she moved from the first night centre to another wing later that day. Ms Thompson said that other prisoners had shouted abuse at her when she went to collect her medication. Although the nurse noted this, she took

no further action to alert wing staff or the nurses responsible for dispensing medication.

55. Later that day, the equality and diversity officer, the Head of the mental health team, an offender manager and an officer from Catch 22 (a housing agency), the nurse and the E Wing manager (who formed the equalities team), met for a case conference to discuss Ms Thompson. Ms Thompson knew about the meeting, but was not present. The group decided that Ms Thompson should focus on her detoxification and managing her drug and alcohol issues before she pursued gender reassignment. The group planned to meet again in two weeks. They discussed which wing Ms Thompson should be moved to and considered that it would not be appropriate for her to move to the vulnerable prisoners' unit on A Wing, because many of the prisoners were sex offenders and she might be subject to more harassment or unwanted attention there than on other wings.
56. The equality and diversity officer told the investigator that he was aware that other prisoners made comments about Ms Thompson, and to her, but she had said she could cope with this, as she had experienced it almost her whole life. Ms Thompson moved to E Wing that afternoon. At 11.00pm, a nurse assessed her and noted that she had no signs of withdrawal symptoms.
57. At 10.37am the next day, 22 October, Ms Thompson phoned her partner and told him that E Wing had changed since she had last been at the prison. She said she hated being there and was going to ask to move.
58. Later, Ms Thompson asked the equality and diversity officer if she could move to A Wing. He told her he was concerned that, as she was a sex worker in the community, prisoners on A Wing might take advantage of her. Ms Thompson said she did not like being on E Wing, and said that other prisoners made comments about her. She said she felt unsettled and unsafe and did not want to mix with other prisoners on E Wing.
59. That day, Ms Thompson's community GP faxed the prison her community medical records, confirming that she had been prescribed mirtazapine, methadone and an antibiotic for acne. A nurse scanned the notes onto Ms Thompson's medical record and noted her existing prescriptions, that she had a history of low mood and self-harm and that she had the hepatitis C virus.
60. On 23 October, Ms Thompson was upset when she saw the IDTS nurse and said that other prisoners on the wing had verbally abused her. They discussed the problem at length and she told Ms Thompson that little could be done about this unless staff witnessed the abuse. She told Ms Thompson that she should tell wing staff when this happened. She walked back to Ms Thompson's cell with her and a prisoner shouted at Ms Thompson. She challenged the prisoner about his behaviour. She noted that Ms Thompson had settled well on E Wing the last time she had been at the prison and Ms Thompson agreed that she might feel uncomfortable for a few days, but that the situation should improve. Ms Thompson said that wing staff were supportive.
61. The IDTS nurse told Ms Thompson how to order toiletries and arranged for her to have some shampoo. She suggested that Ms Thompson should ask her partner to send her money for more toiletries. They spoke about the scratches on Ms

Thompson's arm and strategies for managing thoughts of suicide or self-harm. She recorded their conversation in the ACCT document. She went back to see Ms Thompson a little later and thought Ms Thompson seemed more settled. She did not report to wing staff the abuse she had witnessed, or complete a security report about it and the other abuse Ms Thompson had reported.

62. The IDTS nurse told the investigator that she had asked for Ms Thompson to be moved to the healthcare inpatient unit during the case conference because she did not think the main prison was the right location for her. There is no record of this request or that anyone considered it.
63. On 24 October, Ms Thompson cut the right side of her face with a sharp object and a nurse treated the cut. Ms Thompson told her that prisoners on the wing were bullying her and that she hated her face because she looked like a man. Ms Thompson said that a prisoner had put a card under her cell door, inviting her to spend the night with him and that she had passed the card to wing staff. The nurse noted this in her medical record and completed a self-harm and injury form. Wing staff spoke to the prisoner Ms Thompson thought had sent the card, but he denied it. No further action was recorded.
64. Later on 24 October, a SO and an officer held another ACCT case review. No member of healthcare staff or anyone from the equalities team attended. Ms Thompson said she felt very low and would leave the prison in a box. The SO assessed Ms Thompson as at a raised risk of suicide (lower than previously when her risk had been considered as high) but increased the level of observations to twice an hour. The SO did not add any further actions to the caremap. The next case review was scheduled for 26 October.
65. Ms Thompson phoned her partner later that morning and told him about the card a prisoner had put under her door and that she had cut her face. She told him that staff had refused to allow her to move wings. Later that day, she made shallow cuts to her wrist and arms. A nurse treated the cuts.
66. On 25 October, Ms Thompson applied to be treated as a vulnerable prisoner so she could move to the vulnerable prisoner unit on A Wing. Ms Thompson wrote that, since being on E Wing, prisoners had made derogatory comments and she could only cope by self-harming. Staff on E Wing endorsed the application, and noted that, although she had coped well on E Wing when she was last in the prison, this time, prisoners were less accepting of her and this was affecting Ms Thompson's mental state.
67. On 25 October, Ms Thompson phoned her partner again and said that prisoners on E Wing had called her names and she expected to move to A Wing. Her partner told her to behave herself this time or he would end their relationship. Ms Thompson said she had been self-harming and her partner told her to stop.
68. On 26 October, a SO and an officer held the third ACCT case review. Ms Thompson repeated that she was not happy on E Wing and had applied to be treated as a vulnerable prisoner. The staff did not consider there had been any change in her level of risk but decided to reduce the frequency of observations to once an hour. No changes were made to the caremap. The next review was arranged for 4 November.

69. On 27 October, the IDTS nurse saw Ms Thompson, who had cropped a prison jumper so that it showed her midriff. Other prisoners were commenting on this. The nurse advised the wing manager that dressing in that way might cause negative attention and the manager said she would speak to Ms Thompson. The nurse thought that Ms Thompson appeared in high spirits and happy because she thought that she would be moving to A Wing.
70. Later that day, a prison manager refused Ms Thompson's application to be held separately from the main prison population as a vulnerable prisoner. He noted that the equality advisor needed to consider the request, but that he felt that Ms Thompson would be at greater risk on a wing with sex offenders. He thought they should consider moving Ms Thompson to the segregation unit, for her own protection.
71. The officer from Catch 22 spoke to Ms Thompson, who was upset about the decision and also complained that her tobacco had been stolen. Ms Thompson threatened to harm herself and the officer and two friends of Ms Thompson spent some time trying to calm her, and encouraged her to come out of her cell. The officer said she would help Ms Thompson get her make-up. A SO and the officer held an ACCT case review, assessed Ms Thompson as at a raised risk of suicide and increased her observations to twice an hour. They did not update the caremap or record any actions about the missing tobacco, harassment, bullying or the possibility of a move.
72. Afterwards, the equality advisor and equality and diversity officer spent two hours with Ms Thompson, talking about why she was so desperate to move wings. Ms Thompson said she had not had a shower since being on E Wing. She said that she wanted to kill herself because of her situation and because she was finding it difficult to contact her partner.
73. They noticed that Ms Thompson had padded out her bra with socks and cropped her jumper. They challenged her about the way she was dressing, which was not in line with the compact she had signed and Ms Thompson agreed to follow the guidance. By the end of their conversation, they thought Ms Thompson seemed happier. They agreed to find a job for her in the prison and arrange for her clothes to be sent in. They agreed again that they would arrange for her to order items such as a make up through the women's prisons as no one appeared to have done anything about this. The equality advisor advised some E Wing staff about how they should manage and support Ms Thompson, including reminding them to use 'her' and 'she' when talking about her.
74. Also on 27 October, a prison GP prescribed Ms Thompson mirtazapine for depression and mecycline for acne, in line with her community prescription. He did not see Ms Thompson in person.
75. On 28 October, Ms Thompson applied again to be treated as a vulnerable prisoner and said she frequently received sexual comments from other prisoners on E Wing. The equality advisor spoke to the governor, who approved her application that day.
76. On 30 October, Ms Thompson moved to single cell on A Wing. An officer and the equality and diversity officer explained the wing compact about cosmetics

and appropriate clothing and Ms Thompson agreed to it. An A Wing officer told the investigator that Ms Thompson seemed to settle well on the wing and had a small circle of friends.

77. Later on 30 October, a SO held an ACCT case review with no other member of staff present. Ms Thompson said she was happy to be on A Wing and thought she would feel much more settled. She said she had no thoughts of suicide or self-harm. The SO continued to regard her as at raised risk of suicide and self-harm, but reduced the frequency of observations to once an hour.
78. The prisoner diversity representative also lived on A Wing and spent some time with Ms Thompson. He said that Ms Thompson said she was not happy about being in prison, but was not worried about being in a men's prison. He said Ms Thompson had told him and other prisoners that she did not want to move to a women's prison. He said that Ms Thompson appeared to get on well on the wing. He said he knew some of the signs that someone was contemplating suicide, such as giving away their possessions, becoming withdrawn or not eating. He said Ms Thompson did none of these things. He saw no signs that she was not coping, or that she had suicidal thoughts. On 31 October, Ms Thompson phoned her partner and told him she had moved to A Wing and that it was a lot better there.
79. On 3 November, Ms Thompson declined to see a mental health nurse. It is not clear what the appointment was for, but Ms Thompson said she did not need to see her as she had regular input from the diversity team, and her only concern was that she was not able to dye her hair. The same day, a SO and an officer held an ACC T case review. Ms Thompson said she was happy on A Wing and that all of her problems had stemmed from being on E Wing. The staff assessed her as at a low risk of suicide and ended ACCT monitoring. They scheduled a post-closure review for 10 November. (This did not happen.)
80. On 5 November, the equality advisor and equality and diversity officer chatted to Ms Thompson on A Wing. The equality advisor thought that Ms Thompson looked well.
81. On 6 November, Ms Thompson phoned her partner. She said she was unsure about her status and did not know whether she was still on remand. She had not spoken to her solicitor, who had not been at court when she was remanded to the prison. Ms Thompson told him she preferred being on A Wing, but said there were a few "weirdos" there. Ms Thompson said that when she was on E Wing, she had carved her partner's initials into her wrist and this had left a scar. He told her that was not a good thing to do. On 8 November, Ms Thompson finished her methadone and alcohol detoxification programmes.
82. On 9 November, the IDTS nurse saw Ms Thompson who said that she felt quite positive about completing the detoxification programmes the day before, although said she was having trouble sleeping. The nurse said she would arrange for her to be prescribed zopiclone (a sleeping tablet). Ms Thompson said she had settled well on A Wing and got on well with other prisoners. She said she was due in court on 11 November, and was sure she would be released. After the meeting, the nurse arranged for a GP to prescribe zopiclone for three nights.

83. Later on 9 November, the equalities team held a second case conference about Ms Thompson, but she was not invited to attend. They considered Ms Thompson seemed to have settled on A Wing and had integrated with other prisoners. However, they noted that prisoners in the segregation unit, which was on the landing below, frequently shouted abuse at her. Ms Thompson seemed to be coping with this, but the equality advisor spoke to the segregation unit manager about this on 12 November. (The vulnerable prisoner unit has since been moved away from the segregation unit.)
84. After the conference, the equality and diversity officer gave Ms Thompson information about support groups who could support her in the community after she was released. He said he had arranged for Ms Thompson's make-up to be delivered by the end of the week and noted that she was waiting for her partner to send some clothes into the prison. The Catch 22 officer was also making enquiries about whether Ms Thompson could start a hairdressing course in the prison.
85. On the evening of 10 November, Ms Thompson phoned her partner. They talked about a visit he had booked on Saturday 14 November, and that he would bring some new clothes for her. She told her partner that other prisoners were being decent to her when he asked if she was getting any trouble from them. Her partner said that Ms Thompson could ask to move to a women's prison and said he would put the details in a letter to her. Ms Thompson did not say anything about this.
86. On 11 November, Ms Thompson appeared at court, but sentencing was adjourned until 30 November. Her solicitor was not present. Ms Thompson returned to the prison.
87. At court, Ms Thompson told court escort staff that, if she was sentenced to a period of imprisonment, she would leave prison "in a box" and the escort staff had completed a suicide and self-harm warning form. A healthcare assistant assessed Ms Thompson in reception when she got back to the prison. He asked about the information on the warning form and Ms Thompson said that she would kill herself if she received a long sentence. She said she had no suicidal thoughts at that time and threatened that she would "do something" if he began ACCT proceedings. However, he began an ACCT plan and asked for a mental health review. Staff were instructed to check Ms Thompson twice an hour at irregular intervals, until she had been assessed.
88. On 12 November, an officer assessed Ms Thompson as part of the ACCT process. Ms Thompson said she did not currently feel like harming herself but was worried about her sentence. She said that she could cope with a short sentence but did not know how long she would get. She said she was looking forward to seeing her partner when he visited on Saturday, although she was nervous about receiving unwanted attention from other people in the visits area.
89. At 4.30pm on 12 November, a SO and an officer held the first ACCT case review. No member of healthcare staff or anyone from the equalities team attended. The SO noted that Ms Thompson was nervous about her court appearance and outcome but said that she had no thoughts of suicide or self-harm. They assessed her as at low risk of suicide and set the frequency of checks at once an

hour. They set no caremap actions. They scheduled the next review for 19 November.

90. The mental health nurse assessed Ms Thompson again on 12 November, after the healthcare assistant's referral. Ms Thompson was shaking and said she had found it difficult to put on eyeliner that morning. She said even with the zopiclone, she had been having trouble sleeping since she had completed the detoxification programme. She said that she had been taunted at court, could not face spending Christmas in prison, and was already upset about missing her partner's birthday. The nurse noted that Ms Thompson was already being monitored under ACCT procedures, which should continue. The nurse did not refer Ms Thompson for any further mental health assessment or treatment.
91. The equality advisor went to see Ms Thompson on A Wing later. When she got there Ms Thompson was laughing and chatting to other prisoners so she decided not to interrupt her, as she seemed happy.

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92. The prisoner diversity representative told the police that he and Ms Thompson had talked on the morning of 13 November. She had told him that she was due in court soon and talked about what outfit she would wear. He thought she had seemed happy and had no concerns about her.
93. At 9.25am, at an ACCT check, an officer noted Ms Thompson was in her cell, curling her hair. Ms Thompson told the officer that her sentencing had been adjourned and that she was fine. The officer checked Ms Thompson again at 10.25am and 11.25am. At 12.00pm, she collected her lunch. At 1.30pm, the officer recorded that Ms Thompson was in her cell, watching television. At 3.15pm, Ms Thompson was unlocked for an association period, when prisoners have free time to mix with each other. Staff saw her chatting with other prisoners and no one recorded any concerns about her.
94. At 4.25pm, Ms Thompson asked to speak to a nurse and told her that she was struggling to cope with withdrawal symptoms since she had stopped receiving methadone. The nurse did not make a detailed note of her examination or record whether Ms Thompson showed any sign of withdrawal symptoms. Ms Thompson said that she did not want to take methadone again and the nurse suggested some medication to relieve the symptoms of withdrawal. Ms Thompson seemed content with this. The nurse arranged for a doctor to prescribe Ms Thompson medication, but there is no indication that she received any that day. The nurse recalled that Ms Thompson looked well; she had curled her hair, put make up on, and seemed in good spirits.
95. At 5.45pm, a SO went to check Ms Thompson. She was lying on the bottom bunk but had put a tee shirt over the end of the bunk bed, which made it difficult to see her. She removed the tee shirt when he asked her.
96. An officer checked Ms Thompson at 6.00pm and again at 7.00pm, when she was lying on the bed watching television. At about 8.00pm, he checked her again. At first, he could not see Ms Thompson, but then realised that she was sitting on the

floor with a ligature made from a tee shirt tied around her neck and attached to the bed frame. She did not respond when he called her.

97. The officer tried to radio a medical emergency, but there were problems with the radio network. He went into Ms Thompson's cell and pressed his personal alarm to alert other staff. He cut the ligature from around Ms Thompson's neck but she did not appear to be breathing.
98. A SO, who was in an office on A Wing, responded immediately to the officer's personal alarm. At 8.05pm, he radioed a code blue emergency and the control room called an ambulance at 8.06pm.
99. The SO was unable to get a response from Ms Thompson and noticed that Ms Thompson had cuts on her left arm. He thought that nurses had arrived within 20 seconds of the code blue call.
100. A nurse had been working in reception with two colleagues when they heard the code blue emergency call. The three nurses immediately went to A Wing, less than a minute away. One nurse collected an emergency bag on their way to the wing.
101. A nurse checked Ms Thompson, found no signs of life, and began cardiopulmonary resuscitation. They attached a defibrillator, which found no shockable heart rhythm, so the nurses continued resuscitation. At 8.20pm, paramedics arrived at Ms Thompson's cell and took over emergency treatment. At 8.48pm, the paramedics recorded that Ms Thompson had died.

Contact with Ms Thompson's family.

102. The equality and diversity officer, who was not on duty at the time, was asked to act as the prison's family liaison officer, and arrived at the prison at 9.46pm. Ms Thompson had listed her partner as her next of kin, and there was initially some confusion about the correct address (although this was recorded in full in the ACCT document and in Ms Thompson's medical record). After contacting the police, he and a prison manager arrived at Ms Thompson's partner's house at midnight. They informed him of her death and offered condolences and support. The prison contributed to the cost of Ms Thompson's funeral in line with Prison Service policy.

Support for prisoners and staff

103. After Ms Thompson's death, a manager debriefed the staff involved in the emergency response. No one identified any immediate issues. He offered his support and that of the staff care team.
104. The prison posted notices informing other prisoners of Ms Thompson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Ms Thompson's death.

Post-mortem report

105. At the time of issuing this report, we had not received the post-mortem report. A toxicology report detected therapeutic levels of mirtazapine and low concentrations of methadone and diazepam consistent with Ms Thompson's detoxification programmes. The toxicology report also detected traces of new psychoactive substances (NPS) in Ms Thompson's body, indicating that she had used some before she died. The prisoner diversity representative told the police that Ms Thompson had once used 'Spice', a synthetic cannabinoid, about a week before she died.

Findings

Ms Thompson's location in a men's prison

106. Ms Thompson had been living as a transgender woman for most of her life. She had been at HMP Leeds before, when she had continued to live as a woman. According to PSI 07/2011, transgender prisoners who do not have a gender recognition certificate should usually be placed in prisons appropriate to their legally recognised gender, which would normally be their birth gender. Ms Thompson did not have a gender recognition certificate, and her legal gender remained male. She was therefore sent to Leeds from court.
107. The PSI says that if a transgender prisoner asks to be located in a prison opposite to the gender which is recognised under UK law, a case conference must be convened to consider the matter. The case conference will consider all relevant factors and make a recommendation to a relevant senior manager, senior to the Governor, who will make the final decision.
108. At an initial health assessment when she first arrived at Leeds, Ms Thompson said that she did not want to be in a male prison but there is no evidence that anyone advised her that she could ask to move to a woman's prison or that anyone considered her location, without an application. Ms Thompson appeared to be under the impression that a move to a women's prison would not be possible without a gender recognition certificate. We recognise that Ms Thompson seems to have been equivocal about her location and also apparently said that she would not have wanted to move to a women's prison, but nevertheless the most appropriate location should have been considered.
109. At the same time that Ms Thompson was at Leeds, another transgender woman prisoner, who did not have a gender recognition certificate, publicly and successfully campaigned to serve her sentence in a women's prison. On 30 October, she was moved to a women's prison from a men's local prison. We consider that staff at Leeds and centrally in NOMS, who would have been aware of the change in approach and practice, should have considered and recorded whether, in the light of that decision, Ms Thompson's needs and safety would have been better met in a women's prison. We consider that someone should have formally consulted Ms Thompson on arrival at Leeds about her preferences.
110. The PSI sets out that there must be case conferences to consider how best to manage the prisoner's location. Staff at Leeds convened two multidisciplinary case conferences about Ms Thompson but did not involve her. The case conference focused on her internal location in the prison, and did not consider whether a women's prison might be better to meet her needs, protect her safety and that of the good order of the prison.
111. A Prison Service representative, speaking after the other transgender prisoner moved to a women's prison, said that decisions about where to locate transgender prisoners should involve medical experts, such as psychologists and healthcare professionals. There is no evidence that any expert opinion was sought in Ms Thompson's case. Since Ms Thompson's death, NOMS has begun a review of the policies covering transgender prisoners. We consider that all decisions about the location of transgender prisoners should be based on an

individual assessment of their needs and not based on blanket policies. We make the following recommendation:

The Chief Executive of NOMS should ensure that all decisions about the location of transgender prisoners are based on an individual assessment of their risks and needs, so that they can live safely in their acquired gender.

Support for Ms Thompson as a transgender prisoner at Leeds

112. Staff at Leeds convened two multidisciplinary case conferences about Ms Thompson but did not involve her. PSI 07/2011 requires the prison to devise a management care plan. Leeds developed a management care plan but we consider it was basic and did not fully consider or meet her needs.
113. According to PSI 07/2011, transgender prisoners must have access to gender appropriate clothes and other items they need to maintain their appearance. Ms Thompson's access to women's clothing and make up was limited, as she did not have a prison job. She had to rely on her partner sending her money and bringing in clothes and had no access to alternative supplies of women's clothes, which are usually provided in women's prisons through donated clothing or other sources. (Women prisoners are entitled to wear their own clothes.) There were delays in providing Ms Thompson the opportunity to order feminine products.
114. Most staff appeared to have referred to Ms Thompson appropriately, although Ms Vickerman had to advise some wing staff about how to address her appropriately as a woman. We found at least one entry in ACCT documentation and a number in her medical record, which referred to Ms Thompson as 'he'.
115. Ms Thompson was not happy on E Wing and wanted to move to the vulnerable prisoners unit on A Wing. We understand that finding the most appropriate, safe place to house a transgender prisoner in a men's prison can be difficult. However, we were concerned (although this did not happen), that one prison manager considered that the segregation unit would have been a suitable location for Ms Thompson.
116. The equality advisor and equality and diversity officer offered some good support to Ms Thompson, but as we note below, were not involved in any of her ACCT case reviews. While some aspects of the care Ms Thompson received as a transgender prisoner at Leeds was thoughtful and appropriate, the prison needs to do more to meet the needs of transgender prisoners. We make the following recommendation:

The Governor should ensure that, in line with the Prison Service's commitment to diversity and equality, staff are aware of the specific needs of transgender prisoners and manage them in line with national Prison Service instructions to make sure those needs are met.

Assessment of risk and management of ACCT procedures

117. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action.

When Ms Thompson arrived at Leeds on 19 October, she had been convicted but not sentenced, had a history of attempted suicide and self-harm, a history of mental health problems and of substance misuse. PSI 07/2011, which covers transgender prisoners, indicates that transgender prisoners should be considered a high risk group for suicide. Ms Thompson arrived at Leeds with a suicide and self-harm warning form because she had said she would not leave the prison alive. Although staff rightly began ACCT procedures when she arrived, we do not consider that her level of risk was always properly assessed.

118. Ms Thompson was managed under ACCT procedures for almost all of her time at Leeds, including at the time of her death. We found a number of deficiencies in the management of the ACCT process. PSI 64/2011 requires ACCT reviews to be multidisciplinary where possible. It is a mandatory requirement that the first case review should be attended by a member of healthcare staff and others who will be involved in the prisoner's care.
119. None of Ms Thompson's ACCT case reviews were multidisciplinary. No member of healthcare staff attended any of Ms Thompson's reviews, despite her history of mental health problems, her referrals to the mental health team, and her substance misuse problems. Two case reviews, the first on 20 October and the third on 30 October had only one member of staff present. Even when multidisciplinary attendance is not possible, it is implicit that ACCT case reviews, which are based on teamwork, should involve more than one member of staff. Despite the identified increased risk for transgender prisoners, no one invited the equality advisor nor the equality and diversity officer, who were working closely with Ms Thompson as a transgender prisoner, to any of the ACCT case reviews.
120. Each of the six ACCT case reviews at Leeds, were chaired by a different case manager. PSI 64/2011 notes that the ACCT process operates most effectively when there is continuity in the attendance of staff. As Ms Thompson had more complex needs as a transgender prisoner, we consider that the lack of continuity of case manager seriously weakened the effectiveness of the support procedures.
121. Although Ms Thompson was generally assessed as at a raised or high risk of suicide, the frequency of required checks was never higher than two an hour. Checks were more often once an hour, even when risk was assessed as high. We consider this was a low level of observations for someone assessed as at a raised or high risk of suicide. We are also concerned that staff did not always follow the required frequency of observations set out on the front of the ACCT document. Many of the observations were carried out at regular and predictable intervals. There were some periods when staff made no entries at all in the ACCT ongoing record.
122. Two days before her death, Ms Thompson had appeared at court and sentencing was adjourned. She said that she was anxious about the sentence she would receive and staff began ACCT procedures. Despite this, staff assessed that she was at a low risk of suicide and checks were at once an hour. Hours before she died, she mentioned problems sleeping and some methadone withdrawal symptoms. We cannot say whether more frequent checks would have prevented Ms Thompson from taking her life. However, we are concerned that staff did not consider the weight of Ms Thompson's combined risk factors. They relied too

much on her statement that she had no thoughts of suicide or self-harm, when just the day before she had said she would kill herself if she got a longer than expected sentence.

123. PSI 64/2011 instructs that the ACCT caremap must reflect the prisoner's needs, level of risk and the triggers of their distress. Each entry must reflect the identified issues, be tailored to meet the individual needs of the prisoner and be aimed at reducing their risk. Staff made almost no entries in either of Ms Thompson's caremaps, including when she raised clear concerns about bullying and inappropriate behaviour from other prisoners (which we discuss in more detail below) and about anxieties about court appearances.
124. Ms Thompson's first ACCT was closed on 3 November (without any multidisciplinary representation). An ACCT post-closure review, scheduled to take place a week later, did not happen.
125. A PPO publication on the self-inflicted deaths of prisoners being managed under ACCT procedures, published in April 2014, found that too often staff failed to identify appropriate actions in caremaps to minimise or resolve the reasons for distress. Safety checks were not at the required intervals (or were too predictable) and ACCT reviews often did not include input from a multidisciplinary team. We found many of these weaknesses repeated in the management of Ms Thompson's ACCT plans. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **ACCT case reviews should be multidisciplinary, with continuity of case management, and attended by all relevant people involved in a prisoner's care.**
- **ACCT case reviews should fully consider and record the impact of bullying on the risk of suicide and take appropriate action.**
- **ACCT case reviews should assess the level of risk taking into account all risk factors. Levels of observations should reflect the risk and staff should carry out and record all required observations at the required intervals.**
- **Case managers should set caremap observations which are specific and meaningful and aimed at reducing risk. Managers should review progress against caremaps at each review and set new actions when new issues arise.**
- **Post-closure reviews should be held to assess whether there is any ongoing risk.**

Clinical care

126. A mental health nurse from the primary care team saw Ms Thompson on 20 October. Ms Thompson suffered depression and also said she had been diagnosed with bipolar disorder. Her medical record showed that she had been admitted to psychiatric hospitals for treatment in the past. She had attempted suicide numerous times and said that she did not want to live and that life was not worth living after all she had been through. After she had assessed Ms

Thompson, the nurse did not record whether she needed any further assessment, which the prison's standard operating procedures require. Nor did she refer her for a fuller assessment by the mental health inreach team, as we would have expected for a patient who had been diagnosed with bipolar disorder. PSO 2050 (Continuity of Healthcare for Prisoners) requires prisons to obtain information from a prisoner's GP and other relevant health services prisoners have been in contact with. Although the prison obtained her GP records there is no indication that anyone requested Ms Thompson's community mental health records.

127. The clinical reviewer noted that a GP did not examine Ms Thompson before prescribing her mirtazapine on 27 October, and did not make a follow up appointment to see her. He also noted that mirtazapine is usually administered at night as it causes drowsiness and can aid sleep, but Ms Thompson was given hers during the day.
128. The clinical reviewer concluded that Ms Thompson's methadone and benzodiazepine/alcohol detoxification programmes were appropriately managed. However, he also concluded that, because of the lack of any comprehensive assessment of Ms Thompson's mental health and the lack of healthcare staff input into the ACCT process, the standard of clinical care Ms Thompson received at Leeds was not equivalent to that she could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff request relevant community health records for newly arrived prisoners, fully assess the needs of those who have been subject to mental health care in the community and that GPs review prisoners they have prescribed antidepressants without seeing them.

Bullying

129. In the Ombudsman's annual report for 2014-2015, it was noted that bullying was sometimes a significant factor in self-inflicted deaths. In our learning lessons bulletin issued in July 2014, which examined the self-inflicted deaths of young adults aged between 18-24 years old, we found that this was particularly prevalent. In our sample, 20% had experienced some form of bullying from other prisoners in the month before their deaths, compared to 13% of older prisoners. Too often, prisons do not identify the links between bullying and the risk of suicide and do not take appropriate action.
130. Ms Thompson complained that she was experiencing name-calling, abuse and inappropriate behaviour from some prisoners. She said that during a previous stay at the prison, she had been sexually assaulted yet no one made further enquiries into this very serious allegation. On 24 October, she told a nurse that she had cut her face because she was being bullied on the wing. Three days later, she told the Catch 22 officer that her tobacco had been stolen. Little was done to follow this up.
131. Some staff seemed to believe that they could not take action to support or protect Ms Thompson unless they witnessed bullying, or she could name who was responsible for the behaviour. We are concerned that staff did not take Ms Thompson's concerns seriously. For example, no one completed a security

report when Ms Thompson reported abuse or bullying and no one began victim support procedures, contrary to the local antisocial behaviour policy. It is important that staff should be vigilant about any signs of potential bullying, particularly for vulnerable groups such as transgender prisoners. They should actively challenge and promptly deal with any antisocial and threatening behaviour. We make the following recommendation:

The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence or threats from other prisoners should be effectively protected.

**Prisons &
Probation**

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