

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert McLoughlin a prisoner at HMP Leeds on 25 February 2016

**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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

Mr Robert McLoughlin was found hanging in his cell at HMP Leeds on 20 February, and died in hospital five days later, on 25 February, never having regained consciousness. He was 32 years old. I offer my condolences to Mr McLoughlin's family and friends.

Although Mr McLoughlin was subject to Prison Service suicide and self-harm monitoring procedures at the time of his death, I am concerned that the prison did not properly address or mitigate his risk factors. Had the suicide and self-harm monitoring procedures operated more effectively, staff might have made more informed decisions about how best to support him.

I am concerned that I have repeatedly criticised the management of suicide and self-harm at Leeds and note that the Chief Inspector of Prisons has raised similar concerns. It is essential that the lessons from Mr McLoughlin's tragic death are quickly and effectively acted upon.

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**

**November 2016**

**Contents**

Summary ..... 1  
The Investigation Process ..... 3  
Background Information ..... 4  
Key Events ..... 6  
Findings ..... 13

# Summary

## Events

1. On 15 February 2016, Mr Robert McLoughlin was sentenced to 20 weeks imprisonment and was sent to HMP Leeds, from where he had most recently been released in April 2015. He had a history of self-harm and suicidal thoughts, and was dependent on alcohol.
2. Mr McLoughlin said he had depression, thoughts of self-harm and was worried about being bullied in prison. Reception healthcare staff began Prison Service suicide and self-harm monitoring procedures, known as ACCT, and referred him to the mental health team. They also prescribed a seven-day diazepam alcohol detoxification programme.
3. Staff assessed Mr McLoughlin as unsuitable to share a cell with another prisoner and gave him a single cell on the First Night Centre, where staff checked him once an hour.
4. On 16 February, Mr McLoughlin told a mental health nurse that he did not have any thoughts of suicide or self-harm, but felt under pressure and was worried about being bullied. The nurse arranged to review Mr McLoughlin in two weeks.
5. At the ACCT assessment interview later that day, an officer noted that the main trigger for Mr McLoughlin's risk was his fear of being bullied. Later, the officer and a manager carried out the ACCT review, without healthcare staff present, and assessed Mr McLoughlin as at a low risk of suicide and self-harm and left the frequency of checks at once an hour. They did not discuss his fear of being bullied. Later that day, Mr McLoughlin said he felt suicidal.
6. On 19 February, Mr McLoughlin cut his arms. The night manager increased the frequency of ACCT checks to twice an hour and asked another officer to update Mr McLoughlin's ACCT plan. He noticed that Mr McLoughlin's cell was very bare, and asked the officer to update the wing observation book for staff to investigate why he had few belongings. The officer did not update the ACCT plan, so staff continued to check Mr McLoughlin once an hour. He also did not update the wing observation book, so staff did not ask Mr McLoughlin why his cell was so empty.
7. On 20 February, staff checked Mr McLoughlin at 7.30am, but did not check him again until 11.50am when he cut his arm. Nurses examined him at 12.55pm, and he said he was upset his television had been stolen from his cell, and that he would kill himself. Not all of the staff present heard him say this and he remained subject to one check an hour. Another officer checked Mr McLoughlin at 1.30pm, and found him with a strip of sheet tied around his neck and to the window bars. Staff and paramedics resuscitated Mr McLoughlin and he was transferred to hospital. Sadly, he died on 25 February, never having regained consciousness.

## Findings

8. Staff appropriately began ACCT suicide and self-harm procedures when Mr McLoughlin arrived at Leeds, but we are concerned that the only ACCT case

review held during Mr McLoughlin's five days at the prison did not identify the full and dynamic range of Mr McLoughlin's risk factors, or set effective caremap actions to address his concerns and help reduce his risk. Staff clearly missed opportunities to investigate whether Mr McLoughlin was being bullied.

9. We are concerned the case review was not multidisciplinary, and no healthcare staff attended. Staff did not record in the ACCT plan information which indicated that Mr McLoughlin's risk of suicide had increased and did not consider holding a case review when Mr McLoughlin said he felt suicidal, or when he cut his arms. An instruction to increase the frequency of checks to twice an hour was not acted on and no one checked Mr McLoughlin between 7.30am and 11.50am on 20 February.
10. Healthcare staff carried out perfunctory alcohol withdrawal checks and did not routinely record physical observations or assess Mr McLoughlin's mental well being at a recognised time of increased risk.
11. We are concerned that the prison did not hold a debrief for staff after Mr McLoughlin died, and that some staff did not feel well supported.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
  - Holding multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews.
  - Discussing the impact of potential bullying on the risk of suicide at ACCT reviews, and taking action.
  - Recording all significant events which might indicate a raised risk of suicide or self-harm in the ACCT document.
  - Reviewing risk whenever an event occurs which indicates an increase in risk and holding a case review if required.
  - Setting clear responsibilities for undertaking ACCT observations as directed, which managers check to ensure they happen.
  - Setting caremap observations which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.
- The Head of Healthcare should ensure that detoxification assessments are clear, structured and encompass both physical and mental health issues.
- The Governor should ensure that all managers follow the national guidelines for dealing with a death or serious incident, including:
  - Offering staff involved appropriate support, and
  - Ensuring that a debrief is held promptly after the death of a prisoner and that all staff involved are invited.

## 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 visited Leeds on 2 March 2016. She obtained copies of relevant extracts from Mr McLoughlin's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr McLoughlin's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
15. The investigator interviewed ten members of staff and a prisoner at Leeds on 24 March and 19 April.
16. We informed HM Coroner for West Yorkshire (Eastern) about the investigation, who gave us the results of the post-mortem examination. We have given the Coroner a copy of this report.
17. A family liaison officer contacted Mr McLoughlin's family to inform them of the investigation and ask if they had any questions. Mr McLoughlin's mother asked how long her son had been in the cell before staff found him, and whether he had been assessed as at risk of suicide and subject to ACCT monitoring. Mr McLoughlin's family received a copy of the initial report. Their representative raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## Background Information

### HMP Leeds

18. HMP Leeds is a local prison holding up to 1,120 men. At the time of Mr McLoughlin's death, Leeds Community Healthcare Trust ran primary healthcare services, and Leeds and York Partnership Trust provided mental health services for prisoners with severe and enduring mental health problems. In April 2016, Care UK took over primary and mental health care.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Leeds was in December 2015. Inspectors identified failings in reception and induction processes and found that ACCT processes were poorly managed and many ACCT reviews were not multidisciplinary. Some ACCT plans included good assessments, but, overall, procedures needed to improve. Levels of self-harm at the prison had increased significantly since the last inspection in 2013, and there had been several self-inflicted deaths. Inspectors were concerned that some issues identified following previous PPO investigations into recent deaths still needed to be fully addressed.
20. Inspectors also found that violence had significantly increased among prisoners, and that New Psychoactive Substances (NPS) were a factor. A prisoner survey indicated that many prisoners felt unsafe at times. The Inspectorate concluded that fundamental issues around safety were destabilising the prison and needed to be urgently addressed.

### Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest report, for the year to December 2015, the IMB considered that ACCT documents were not well completed and that there was a shortage of ACCT assessors. They were also concerned about the level of violent incidents among prisoners.

### Previous deaths at HMP Leeds

22. Mr McLoughlin's was the seventh apparently self-inflicted death at Leeds since 2014, and two more prisoners have apparently taken their own lives at the prison since then. In previous investigations published in 2014, 2015 and 2016, we have raised concerns about staff at Leeds properly assessing risk, and the management of ACCT procedures.

### Assessment, Care in Custody and Teamwork (ACCT)

23. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner.
24. 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 multidisciplinary 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 on the caremap have been completed.

25. 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.

### **New Psychoactive Substances (NPS)**

26. NPS are an increasing problem across the prison and immigration detention estates. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.
27. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.
28. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

## Key Events

29. On 15 February 2016, Mr Robert McLoughlin was sentenced to 20 weeks imprisonment for making a false bomb threat and threatening to destroy property, and arrived at HMP Leeds later that day. He had been at Leeds before, and had last been released in April 2015.
30. Included in paperwork which arrived with Mr McLoughlin was the police risk assessment report covering his time in police custody. It noted that Mr McLoughlin had previously self-harmed and that he had reported feeling suicidal in February and April 2015 while in prison, when he had threatened to hang himself. It also noted that Mr McLoughlin reported using a New Psychoactive Substance (Spice: a synthetic cannabinoid) in December 2015. A Person Escort Record (PER) accompanied Mr McLoughlin from court to prison. There was a note on the front page of the record saying that he had previously self-harmed (but did not record when or by what means), but that self-harm was no longer an issue. It noted that he was anxious and alcohol dependant.
31. A healthcare assistant began ACCT procedures in reception. She has since left Leeds and did not respond to requests for interview. She completed the concern and keep safe form, at the front of the ACCT document, and wrote that Mr McLoughlin said he had thoughts of self-harm, was alcohol dependant and said he had been bullied last time he was in prison.
32. Mr McLoughlin then saw a nurse, who completed the reception healthscreen. She also noted that Mr McLoughlin had thoughts of self-harm and was worried about being bullied. She noted that the healthcare assistant had already begun ACCT procedures. Mr McLoughlin said he had been diagnosed with depression in February 2015, but had not been prescribed any medication or received any further treatment since then. She referred Mr McLoughlin to the mental health team. She and Mr McLoughlin discussed how much alcohol he drank (but she did not record the amount) and he said he had last had alcohol the day before.
33. An Integrated Drug Treatment Service (IDTS) nurse saw Mr McLoughlin later for a routine IDTS assessment and discussed his alcohol use. Mr McLoughlin said he felt very low and had thoughts of self-harm. He said that he felt hopeless and had a history of self-harm. The nurse completed an alcohol use disorder identification test, widely used to identify those at risk from alcohol related problems. Mr McLoughlin said he drank at least ten pints of alcohol a day, and scored eight in the identification test, which indicated that he was at risk and needed further assessment or clinical intervention. The nurse referred Mr McLoughlin to the doctor and the substance misuse service.
34. Shortly after, Mr McLoughlin saw a prison GP, who prescribed a seven-day alcohol detoxification programme, which consisted of a reducing dose of diazepam prescribed across seven days. The GP also prescribed thiamine and vitamin B tablets, commonly prescribed to people who are dependent on alcohol.
35. A reception officer completed the Cell Sharing Risk Assessment (CSRA), but did not sign it, so we have not been able to identify them. Mr McLoughlin said he could not share a cell because of his mental health problems, and it appears that the officer assessed him as a high risk and unsuitable to share a cell based on

what he said. The IDTS nurse countersigned the assessment and noted that Mr McLoughlin was on an ACCT, but able to share a cell. A manager wrote that Mr McLoughlin was a 'high risk due to mental health issues' and crossed out that he was able to share a cell. She said she would not routinely overrule a nurse's assessment, but she was concerned about Mr McLoughlin's behaviour and presentation when she assessed him, as he seemed very agitated. Mr McLoughlin was allocated a single cell on F Wing.

36. A Supervising Officer (SO) completed the Immediate Action Plan in Mr McLoughlin's ACCT plan. He noted that Mr McLoughlin should stay in a single cell (in line with the CSRA), should be checked once an hour and have access to the dedicated Samaritans phone and Listeners (prisoners trained by the Samaritans to support other prisoners). He noted that he had emailed the prison's mental health team, but did not record what he had written.
37. During the night, a nurse checked Mr McLoughlin at 10.40pm, 2.58am, and 4.51am, as part of his detoxification observations, but did not record that she had taken his blood pressure or pulse, which is supposed to form part of the check. Mr McLoughlin apparently slept well and F Wing staff told her they had no concerns about him. Night staff also checked Mr McLoughlin once an hour throughout the night, in line with the ACCT Immediate Action Plan.
38. The next morning, 16 February, a mental health nurse assessed Mr McLoughlin following a previous nurse's referral. She remembered him from his previous times at Leeds. Mr McLoughlin was quiet, but said that he was all right because he was in a cell on his own. He said he had struggled in prison previously, because he had poor coping strategies and low self-esteem. They discussed how he had used alcohol to block these feelings.
39. Mr McLoughlin said he had no thoughts of self-harm at the time, but that this could change, as he currently felt under pressure. The nurse advised him to keep busy and seek employment, and said she would review him on 1 March.
40. Shortly after, another nurse carried out the second day physical health review. They discussed his depression and he told her his mother had cancer.
41. An hour later, Mr McLoughlin saw the IDTS nurse again as part of his IDTS review and said that he felt stable, with no shakes or tremors. He did not check Mr McLoughlin's blood pressure but took his pulse (which was within the normal range at 92 bpm) and blood oxygen level (also normal at 98 per cent). He told the investigator that he often did not have time to take a blood pressure reading during the IDTS review. He planned to review Mr McLoughlin again the next day.
42. Also that morning, an officer assessed Mr McLoughlin as part of the ACCT procedures. Mr McLoughlin told him that his problems stemmed from the death of his son earlier that month (Mr McLoughlin's family told us that he had not had a son) and that he was a heavy drinker. Mr McLoughlin said that he had begun harming himself by cutting aged 14, and that he always made superficial cuts. Mr McLoughlin said he had last harmed himself in April 2015. The officer noted that Mr McLoughlin was on a seven-day alcohol detoxification programme, was a high-risk prisoner in a single cell and said he had a history of being bullied. He

noted in the front of the ACCT that the trigger for Mr McLoughlin's risk was his fear of being bullied.

43. Shortly after, Mr McLoughlin attended the first ACCT case review with a manager and an officer. No healthcare staff attended, contrary to national instructions, and despite Mr McLoughlin's alcohol dependence. The staff assessed Mr McLoughlin's risk of harm as low (from the options of low, raised and high) and left the frequency of checks unchanged at one an hour. They noted that Mr McLoughlin should remain subject to ACCT monitoring until he had completed the alcohol detoxification programme, and the officer noted this in the only entry on the caremap. The staff agreed that someone from the Drug and Alcohol Rehabilitation Service should be invited to the next review on 23 February.
44. Later, Mr McLoughlin met a drug and alcohol worker. They discussed his detoxification programme and plans for maintaining his recovery on his release. She explained to him the risks of drug use, particularly New Psychoactive Substances (NPS) (which he had said he had used in the community), while suffering anxiety and depression. She completed an alcohol audit and Mr McLoughlin scored 14, which indicated he was a hazardous drinker.
45. At 2.40pm, an officer unlocked Mr McLoughlin for association (when prisoners are allowed out of their cells to socialise with each other). Half an hour later, she asked if he was okay and Mr McLoughlin replied that he felt suicidal, that the silence in his cell was driving him mad and he wanted a television. At the time, televisions were in short supply on the wing and not every prisoner had one. Mr McLoughlin said he had tried to speak to somebody from the mental health team, but they had said that they did not have time to talk to him. She said she would phone them (but did not record whether she had or not), found him a television and made a note in the ACCT. Mr McLoughlin said he felt a bit better.
46. The officer unlocked Mr McLoughlin for association again that evening. He said he had no concerns, although he had felt a little down during the earlier association period. He asked to speak to a Listener, which he did, and afterwards said he felt better. She asked if he wanted to use the Samaritans phone (there is no record of his response).
47. Night staff carrying out ACCT checks, checked Mr McLoughlin at regular hourly intervals throughout the night and a nurse checked him three times, but recorded little detail of her checks.
48. On the morning of 17 February, a nurse assessed Mr McLoughlin for withdrawal symptoms. He told her that he felt well, was sleeping okay and eating and drinking appropriately. He said he was not experiencing any withdrawal symptoms. She completed a screening tool designed to measure any physical or emotional symptoms of alcohol withdrawal. Mr McLoughlin scored zero on every question, including symptoms of anxiety and agitation, indicating that he was not experiencing any withdrawal symptoms.
49. That morning, Mr McLoughlin preferred to stay in his cell during the association period, but did leave his cell in the afternoon. At lunchtime, he refused to take his prescribed diazepam. A pharmacy technician noted this in his medical record, but did not tell anyone else or record why Mr McLoughlin had refused it.

However, Mr McLoughlin took his diazepam that afternoon, and continued to take it as prescribed after that.

50. A nurse checked Mr McLoughlin three times in the early morning of 18 February, and noted no concerns. None of the three detoxification night checks over the three nights recorded detailed information about how Mr McLoughlin presented. Again, night staff checked Mr McLoughlin hourly, at regular intervals throughout the night, as part of his ACCT observations.
51. At 10.23am on 18 February, the IDTS nurse saw Mr McLoughlin again. Mr McLoughlin did not display any withdrawal symptoms and said he felt stable. The nurse did not record anything about Mr McLoughlin having missed a dose of medication. At interview, he said that it was not unusual for prisoners to miss medication and that, had he known, he would have tried to find out why this was.
52. At 9.00am on 19 February, Mr McLoughlin attended an Alcoholics Anonymous meeting. On his return to F Wing, he joined the wing's association period and collected his lunch. He left his cell for association again that afternoon.
53. Shortly before 9.30pm that evening, a night patrol officer, who was carrying out ACCT checks, saw that Mr McLoughlin had scratched his left arm. He radioed for help and a nurse, the night manager and the assistant night manager arrived shortly after. The night manager unlocked Mr McLoughlin's cell and the nurse dressed the scratches.
54. The night manager recognised Mr McLoughlin from a previous sentence, and asked him how he was feeling and why he had self-harmed. Mr McLoughlin said he felt a little low. He asked how he could help and Mr McLoughlin said he needed some support.
55. The nurse noted in the medical record that Mr McLoughlin had asked to speak to a Listener, but was told that this would not be possible at that time of night, because he had been assessed as high-risk in the Cell Sharing Risk Assessment. At interview, the night manager could not recall this, and said he would have arranged a Listener for Mr McLoughlin had he asked.
56. The night manager noticed that Mr McLoughlin's cell was bare, apart from a television and furniture, and that he had no kettle and few personal belongings. He brought him two cups of hot water and tea packs. He asked Mr McLoughlin why his cell was empty, but Mr McLoughlin could not explain. He asked Mr McLoughlin if he would like staff to check him twice an hour and he said he would. He made a note of the incident in the ACCT, but was then called to another part of the prison, so asked his assistant to note the increased observations on the front page of the ACCT. He also asked his assistant to make a note in the wing observation book about Mr McLoughlin's empty cell, for staff to investigate the next day. The assistant did not make an entry in the wing observation book or update the observations on the front of the ACCT.

### **Saturday 20 February**

57. A member of staff checked Mr McLoughlin at 7.30am and recorded that he was asleep. There are no other entries in the ACCT until 11.50am.

58. Officer A was responsible for carrying out ACCT checks on Mr McLoughlin's landing (5's landing) that morning, however, as soon as he came on duty, he had to help with an incident on D Wing and nobody carried out the ACCT checks in the officer's absence.
59. During the morning, the IDTS nurse saw Mr McLoughlin (there was no entry for 19 February in Mr McLoughlin's medical record) and noted that he was due for release on 24 April, and would require housing support. He planned to review him again in three weeks. He recorded no concerns about Mr McLoughlin.
60. At about 11.50am, Mr McLoughlin pressed his cell bell and an officer responded. She saw that he had scratched his arms again and asked healthcare staff to come and check him. She noted details of the incident in the ACCT plan. When an officer arrived to cover the lunchtime period on F Wing, she told him about Mr McLoughlin.
61. A prisoner told the investigator that he had seen Mr McLoughlin that morning and noticed some faint scratches on his arm. He asked him if he was all right and Mr McLoughlin replied that he had some personal issues. He asked whether other prisoners were giving Mr McLoughlin any problems, and Mr McLoughlin said they were not. A little later, Mr McLoughlin told him that his television had been stolen. Shortly afterwards, the prisoners were locked in their cells for lunch.
62. At 12.55pm, Officer B and two nurses went to Mr McLoughlin's cell. He initially refused help and seemed quite agitated, but Nurse A persuaded him to clean the multiple scratch wounds himself and she dressed them. She told him to use his cell bell if he wanted any further healthcare assistance. She asked Mr McLoughlin why he had self-harmed and he said that he was upset that his television had been stolen that morning, and that he would kill himself. The officer told the investigator that he did not hear Mr McLoughlin say any of this. Nurse A recalled that Mr McLoughlin kept trying to engage the officer in conversation about his television. The other nurse was absent from work on sick leave during the investigation and could not be interviewed.
63. Nurse A asked Mr McLoughlin if he had seen a mental health nurse since arriving at Leeds, but he was not sure. He said he would like to speak to someone from the mental health team.
64. Nurse A radioed the duty mental health nurse and asked him to assess Mr McLoughlin. In interview, she said that she told the mental health nurse that Mr McLoughlin had said he would kill himself if he was not given a television. The mental health nurse replied that he might not be able to see him immediately, as he was busy. She noted her actions in the ACCT and the wing observation book. The officer continued to patrol F Wing and did not see Mr McLoughlin again.
65. The mental health nurse told the investigator that he was the only mental health nurse on duty at the time and had been busy that morning. He said he was writing up notes during his lunch break when Nurse A contacted him. He said that he did not know that Mr McLoughlin was on an ACCT and that he did not think that Nurse A was asking him to see Mr McLoughlin urgently. He said that he had thought he would have time to see Mr McLoughlin at some point that day.

66. At 1.30pm, Officer A returned to F Wing and Officer B told him what had happened to Mr McLoughlin at lunchtime. Officer A and Officer C went straight to Mr McLoughlin's landing to carry out ACCT checks and unlock prisoners for work.
67. At about 1.45pm, Officer A reached Mr McLoughlin's cell. He looked through the observation panel but the cell was in darkness and he could not see Mr McLoughlin. He called Officer C to help him and they unlocked the cell. They found Mr McLoughlin at the back of the cell with a piece of torn bed sheet tied around his neck and attached to the window bars. Officer A cut the sheet and laid Mr McLoughlin on the floor, while Officer C radioed an emergency code blue (which normally indicates a prisoner is unconscious, not breathing or is having breathing difficulties). According to prison logs, Officer C radioed the code blue at 1.46pm. Officer A felt for a pulse in Mr McLoughlin's neck but could not find one, so he put him into the recovery position.
68. Officer B had heard Officer A's call for help and ran up to the landing, where he could see Mr McLoughlin's cell door was already open. He also checked Mr McLoughlin for breathing and a pulse, but could not find either, so started cardio-pulmonary resuscitation. Officer A took over chest compressions while Officer B delivered rescue breaths.
69. Five nurses responded to the emergency code blue and arrived at the cell with an emergency bag, oxygen and a defibrillator. The nurses took over the resuscitation efforts and, at one point, regained Mr McLoughlin's pulse, but quickly lost it again.
70. The paramedics arrived at the prison gate at 1.53pm and at the cell a minute later. They assessed and treated Mr McLoughlin and, at 2.52pm, transferred him to the ambulance and took him to hospital.

#### **Contact with Mr McLoughlin's next of kin**

71. At about 3.45pm, the safer custody manager arrived at Mr McLoughlin's mother's address. She accompanied his family to the hospital, where they visited Mr McLoughlin in the Intensive Care Unit. The next day, she appointed an officer as the family liaison officer. He visited the hospital and met Mr McLoughlin's family.
72. On the afternoon of 25 February, hospital staff withdrew Mr McLoughlin's life support and he died at 3.40pm, without ever regaining consciousness. His family were with him.
73. The officer remained in contact with Mr McLoughlin's family after his death and the prison contributed to the cost of Mr McLoughlin's funeral, in line with Prison Service policy.

#### **Support for staff and prisoners**

74. The prison did not hold a debrief for staff after Mr McLoughlin died, which is contrary to national instructions.
75. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr McLoughlin's death.

## Post-mortem report

76. The post-mortem report concluded that Mr McLoughlin died from a hypoxic ischaemic brain injury, caused by hanging, and that he had bronchopneumonia. Mr McLoughlin had a number of scars on both forearms and on the back of his right hand, some of which were consistent with the cuts he had made five days before he died.
77. A toxicology report determined that Mr McLoughlin had taken diazepam before he died, in line with his prescribed alcohol detoxification programme. The examination also detected traces of New Psychoactive Substances (NPS), in particular a synthetic cannabinoid, but the amount was too small to measure and it was not possible to say when he had last used NPS.

# Findings

## Managing Mr McLoughlin's risk of suicide and self-harm

78. Mr McLoughlin was identified as at risk of suicide and self-harm on the day he arrived at Leeds, 15 February, and was being managed under ACCT procedures when he was found hanging in his cell only five days later. The investigation identified some failings in how Mr McLoughlin's risk was managed and the operation of the ACCT process, which meant that he did not always receive an appropriate level of support.
79. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and triggers that might increase prisoners' risk of suicide or self-harm. Several of these applied to Mr McLoughlin, including early days in prison, previous self-harm and suicidal thoughts, substance misuse, low self-esteem, fear of violence or intimidation and a mental illness diagnosis. Although, Mr McLoughlin was identified as at risk of suicide, there is no record that any member of staff considered all of the risk factors that applied to him.
80. On 16 February, staff held Mr McLoughlin's first and only case review, but no member of the healthcare team, the Integrated Drug Treatment Service (IDTS), or the drug and alcohol recovery service attended. It is a mandatory requirement that a member of healthcare attends the first case review. The lack of multidisciplinary attendance at Mr McLoughlin's review is particularly troubling given his history of alcohol use and his participation in a seven-day alcohol detoxification programme.
81. Prison Service Instruction (PSI) 64/2011, which covers safer custody, instructs that ACCT caremap actions should be detailed and time-bound, and aimed at reducing risk. They should reflect prisoners' needs, level of risk and the triggers of their distress and cover issues accordingly. Mr McLoughlin told healthcare staff and an officer during the ACCT assessment interview that he was worried about being bullied at the prison, and this was noted as the only trigger to his risk. However, the ACCT case review notes and the caremap contained no reference to this, or how staff might support Mr McLoughlin on F Wing. The only entry in Mr McLoughlin's caremap related to his ongoing alcohol detoxification programme.
82. In addition to planned case reviews, PSI 64/2011 instructs that a case review should be held when there are additional concerns. We consider that staff should have considered holding a case review later on 16 February, when Mr McLoughlin said for the first time that he felt suicidal, and again after he cut himself on 19 February. The night manager spent some time checking Mr McLoughlin was all right that night and agreed to increase the frequency of checks to twice an hour. He also raised some concerns about how empty Mr McLoughlin's cell was. However, he did not hold a case review and instead asked his assistant to update Mr McLoughlin's ACCT plan and the wing observation book, neither of which happened. Clearly, staff missed important opportunities to investigate further whether Mr McLoughlin was being bullied.
83. According to the ACCT plan, Mr McLoughlin was still subject to hourly checks on 20 February. However, he was not checked between 7.30am and 11.50am,

when he cut himself again. Nurse A heard Mr McLoughlin say that his television had been stolen that morning and that he would kill himself. Officer B, who was also present at the time, said he did not hear Mr McLoughlin say this. She did not record details of what she had heard in the ACCT plan, and the staff did not discuss what Mr McLoughlin had said. Although he had apparently expressed an intent to kill himself, the staff present did not consider increasing the frequency of checks.

84. Nurse A asked the duty mental health nurse to see Mr McLoughlin. The mental health nurse, who was the only mental health nurse on duty, had not had time to do so before Mr McLoughlin was found hanging 35 minutes later.
85. We consider that staff failed to identify and consider all of Mr McLoughlin's risk factors, or to take a holistic approach to managing his risk. As a result, they missed the signs that his risk of suicide was increasing. We make the following recommendation:

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

- **Holding multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews.**
- **Discussing the impact of potential bullying on the risk of suicide at ACCT reviews, and taking action.**
- **Recording all significant events which might indicate a raised risk of suicide or self-harm in the ACCT document.**
- **Reviewing risk whenever an event occurs which indicates an increase in risk and holding a case review if required.**
- **Setting clear responsibilities for undertaking ACCT observations, which managers check to ensure they happen.**
- **Setting caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.**

## **Detoxification**

86. The clinical reviewer found that Mr McLoughlin's medical record contained limited information about his alcohol detoxification or well-being during it. She concluded that the IDTS reviews were perfunctory at what is recognised as a high-risk time for prisoners withdrawing from alcohol. Healthcare staff checked Mr McLoughlin during the night, as part of detoxification observations, but did not take blood pressure or pulse readings. The required number and frequency of checks was not specified, meaning sometimes Mr McLoughlin was not checked for long periods of time.
87. There was no clear case management system within the IDTS, and so nobody was aware (other than the pharmacist) that Mr McLoughlin had missed a dose of his detoxification medication, checked the reason why, or his well-being. We make the following recommendation:

**The Head of Healthcare should ensure that detoxification assessments are clear, structured and encompass both physical and mental health issues.**

88. Mr McLoughlin's post-mortem toxicology examination found traces of NPS, specifically a synthetic cannabinoid, in his body, but the amount was too small to measure or identify when he had last used it. Mr McLoughlin had said that he had used NPS in December 2015, before coming back to prison. In our Learning Lessons Bulletin on NPS, published in July 2015, we highlighted growing concerns about the use of NPS in prisons and the possible links to suicide and self-harm. However, there was no particular evidence to suggest that Mr McLoughlin had used NPS at Leeds or that staff should have taken any action.

#### **Post incident care**

89. PSI 64/2011 instructs that managers must hold a debrief for staff involved in a death in the prison, to offer support and discuss what happened. Leeds did not hold a debrief after Mr McLoughlin died and some staff we interviewed felt that they had not received adequate support. We make the following recommendation:

**The Governor should ensure that all managers follow the national guidelines for dealing with a death or serious incident, including:**

- **Offering staff involved appropriate support, and**
- **Ensuring that a debrief is held promptly after the death of a prisoner and that all staff involved are invited.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations