

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Roy Glassford a prisoner at HMP Leeds on 26 August 2018

**A report by the Prisons and Probation Ombudsman**

## 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.

Mr Roy Glassford was found hanged in his cell at HMP Leeds on 26 August 2018. He was 59 years old. I offer my condolences to Mr Glassford's family and friends.

Mr Glassford arrived at Leeds on 14 June and was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) between 15 June and 12 July. He was not being monitored when he died.

I am concerned that staff stopped ACCT procedures prematurely on 12 July. Mr Glassford had appeared in court that morning and been told that police were investigating further offences, but staff failed to take this into account when deciding to stop ACCT monitoring. There were other deficiencies in the way the ACCT procedures were managed.

I am also concerned that Mr Glassford was not screened to assess his risk of suicide and self-harm when he returned to the prison after being questioned by police and charged with new offences. In addition, no one assessed Mr Glassford after he appeared in court by video link on 6 and 10 August, and was told he faced a lengthy sentence. I consider that staff failed to properly assess Mr Glassford's risk of suicide and self-harm and potentially missed an opportunity to put appropriate preventative measures in place.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**May 2019**

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# Summary

## Events

1. Mr Roy Glassford was remanded in custody on 14 June 2018 after breaching a Sexual Offences Prevention Order. He was sent to HMP Leeds.
2. Staff at Leeds started suicide and self-harm prevention procedures (known as ACCT) on 15 June. On 12 July, Mr Glassford appeared in court expecting to be sentenced but was told that the police were investigating further offences. Staff stopped ACCT monitoring later that day.
3. For around a week at the end of June, Mr Glassford refused food and fluids. On several occasions in June and July, he failed to collect his prescribed medication, which included antidepressants and painkillers.
4. On 31 July, police questioned Mr Glassford and charged him with further offences. He appeared in court by video link on 6 and 10 August, and was told to expect a lengthy sentence.
5. During a morning roll check on 26 August, an officer saw Mr Glassford hanging from the window bars in his cell. Mr Glassford showed signs that he had already died so staff did not start cardiopulmonary resuscitation. At 6.25am, ambulance paramedics confirmed Mr Glassford's death.

## Findings

6. We found that staff stopped ACCT procedures prematurely on 12 July. Mr Glassford had appeared in court that morning expecting to receive community service or a very short sentence but instead was told that police were investigating new offences. Staff stopped ACCT monitoring without considering whether this news increased Mr Glassford's risk of suicide and self-harm. There were other deficiencies in the way the ACCT procedures were managed.
7. Staff failed to assess Mr Glassford when he returned to Leeds on 31 July, having been charged with further offences. Also, no one spoke to him after his video link court appearances on 6 and 10 August, when he was told to expect a lengthy sentence.
8. Although the clinical reviewer was satisfied that the mental health care Mr Glassford received at Leeds was equivalent to that which he could have expected to receive in the community, she found that Leeds did not use a formal clinical risk assessment tool when assessing the risk of suicide and self-harm.
9. We found that staff did not implement their food refusal policy when Mr Glassford started refusing food.
10. There was a delay in responding to Mr Glassford's failure to collect his medication and staff did little to try to resolve the issue.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:
  - assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation; and
  - set caremap actions that are specific, meaningful and time-bound, aimed at reducing a prisoner's risks to themselves, and update them if additional needs are identified.
- The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison after a court appearance, police questioning or any other event that might increase their risk, are screened to assess their risk of suicide and self-harm and for potential health problems.
- The Governor should ensure that arrangements are in place to identify prisoners who may be at increased risk of suicide and self-harm, or require a healthcare assessment, following a court appearance by video link.
- The Head of Healthcare should ensure mental health staff receive formal in-house risk assessment and management of mental health training.
- The Head of Healthcare should ensure staff are aware of the Mental Capacity Act (2005) and how to use mental capacity assessments.
- The Governor and Head of Healthcare should ensure that all staff are aware of the management of food refusal policy and audit its use.
- The Head of Healthcare should ensure that there is a robust system in place to identify when prisoners do not collect their medication and that healthcare staff take appropriate action.

## The Investigation Process

11. 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. One prisoner responded.
12. The investigator visited Leeds on 30 August 2018. She obtained copies of relevant extracts from Mr Glassford's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Glassford's clinical care at the prison.
14. They interviewed seven members of staff and a prisoner at Leeds on 17 September, and the investigator interviewed three staff members on 18 September.
15. We informed HM Coroner for West Yorkshire Eastern District of the investigation. The results of the post-mortem examination were not available when we issued our initial report but have since been provided. We have sent the coroner a copy of this report.
16. We contacted Mr Glassford's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any issues.
17. We shared our initial report with the Prison Service. They did not find any factual inaccuracies and their action plan is annexed to this report.
18. The clinical reviewer has revised her report. This version is attached.
19. We provided a copy of our initial report to Mr Glassford's son. He did not raise any further issues or comment on the factual accuracy of the report.

## Background Information

### HMP Leeds

20. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.
21. In August 2018, Leeds was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focussing on improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

### HM Inspectorate of Prisons

22. The most recent inspection of HMP Leeds was conducted in November 2017. Inspectors found Leeds to be an unsafe prison. They found the levels of self-harm were significantly higher compared to those of other local prisons. Inspectors found initial ACCT assessments were generally good, and reviews were often multidisciplinary. However, caremaps were inadequate and observations recorded by staff lacked meaningful interaction with prisoners. Inspectors considered that healthcare services remained reasonable, but triage clinics for mental health were not effectively used.

### Independent Monitoring Board

23. 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. The IMB report for the year ending December 2017, acknowledged the work of the prison’s Safer Custody unit in addressing self-harm issues, but noted that there had been a 13% rise in prisoners harming themselves.

### Previous deaths at HMP Leeds

24. Mr Glassford was the 22nd prisoner to die at HMP Leeds since August 2015. Of the previous deaths, nine were self-inflicted, nine were from natural causes, one was a homicide, one was drugs related and one is awaiting classification. There have been four deaths since, three from natural causes and one self-inflicted. We have previously made recommendations about the assessment of prisoners’ risk of suicide and self-harm, management of ACCT procedures and mental health care.

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

25. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide and 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. 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 carried out at irregular intervals to prevent a prisoner

anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

26. As part of the process, a caremap (a 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. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## Key Events

27. Mr Roy Glassford was remanded in custody on 14 June 2018 for breaching a Sexual Offences Prevention Order. He was sent to HMP Leeds. This was not his first time in prison.
28. When Mr Glassford arrived at Leeds his Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons that sets out the risks they pose) noted he had previously self-harmed and had anxiety and depression. Staff carried out a cell sharing risk assessment (CSRA) and noted he was a vulnerable prisoner (VP) who should not share a cell due to the nature of his offences. A nurse carried out the reception health screening and noted that Mr Glassford had chronic arthritis, chronic obstructive pulmonary disease (COPD – a collection of lung diseases including chronic bronchitis and emphysema) and a history of depression. He told her he had a history of attempted suicide and self-harm, although had not self-harmed in the past year. The nurse had no concerns about Mr Glassford and he was allocated a cell on the First Night Centre (FNC).
29. During a second health screening on 15 June, Mr Glassford told a nurse that he was thinking about hanging himself or taking an overdose to end his life. He said he had self-harmed many times in the past and felt he had no support in the community. She started suicide and self-harm prevention procedures (known as ACCT) and put Mr Glassford on constant watch until his ACCT assessment.
30. Around an hour later, an officer conducted Mr Glassford's ACCT assessment interview. She noted that Mr Glassford was reluctant to engage, was shaking, and was saying that he had nothing to go out to and wanted to die. He said he would probably hang himself. The officer noted that Mr Glassford needed to see the mental health team and needed pain relief for back problems.
31. A custodial manager (CM), chaired Mr Glassford's first ACCT case review later that afternoon, with a nurse and an officer in attendance. The CM noted that Mr Glassford engaged fully. Mr Glassford said he had not received his prescribed medication for back pain, was concerned that he was still unable to contact his son (his son had to give permission for his telephone number to be disclosed) and was waiting for a mental health review. Staff added these issues to his caremap and assessed his risk of self-harm as low. They set his observations at five an hour throughout the day and night, and three constructive conversations a day.
32. The same day, 15 June, a prison GP prescribed Mr Glassford amitriptyline (a painkiller), atorvastatin (for high cholesterol), bisoprolol (to treat high blood pressure), sertraline (an antidepressant) and tramadol (a painkiller).
33. A CM held a second case review with Mr Glassford on 18 June. A nurse also attended. Mr Glassford said he had been prescribed his medication and felt better now that he was no longer in pain. The CM noted that a mental health assessment was still needed and that contact with Mr Glassford's son would be addressed once he was settled on F Wing (the VP Wing). (Mr Glassford was moved there later that day.) Staff assessed that Mr Glassford's level of risk

remained low and reduced his observations to three an hour, with three constructive conversations a day as before.

34. A CM held a third case review with Mr Glassford on 25 June, with an F Wing manager, and a nurse in attendance. Mr Glassford said he was focusing on his court case and was unsure what to expect, and was still waiting for permission to have his son's telephone number. His refusal to collect his medication was not discussed. Staff agreed to keep the ACCT open as there were still outstanding issues on the caremap. They reduced the observations to one an hour during the day, three during the night and one constructive conversation a day.
35. On 26 June, Mr Glassford refused to collect his medication, refused all his meals and did not attend work. This was noted in Mr Glassford's prison record, but there was no record it was followed up. On 28 June, staff noted in Mr Glassford's medical record that he had not eaten or drunk any water since 23 June. Staff noted that she would inform the mental health team. There is no record of this, but a nurse saw Mr Glassford on 2 July, for a mental health triage. Mr Glassford said he felt nervous about an upcoming court date, had no support in the community and continuously had suicidal thoughts. The nurse referred him for grief counselling and noted he should continue to be monitored by the ACCT process. She made no reference to Mr Glassford's food refusal.
36. A CM held Mr Glassford's fourth case review on 2 July, with an F Wing manager and a nurse in attendance. Staff noted that Mr Glassford was unhappy about not receiving the goods he had ordered (known as canteen), which had affected all F Wing prisoners, and said he had started a hunger strike. Staff noted that this had been reported to healthcare staff. Mr Glassford said he was attending court on 4 July, and believed he may get community service, or a very short sentence. Staff noted that the ACCT should remain open pending Mr Glassford's court appearance.
37. A nurse and other members of the mental health team discussed Mr Glassford at a mental health meeting on 4 July. They agreed that Mr Glassford should be discharged from triage and that the mental health team would continue to follow up through the ACCT process.
38. A CM held Mr Glassford's fifth case review on 5 July, with a nurse in attendance. Mr Glassford told staff he had been mistaken about his court date and was unsure of the date. The CM noted that Mr Glassford had been given the opportunity to contact his solicitor to get the correct date and to get his son's telephone number or his address, so he could make contact. He noted that this completed the caremap actions but staff decided to keep the ACCT open until Mr Glassford knew his court date.
39. Mr Glassford attended Leeds Crown Court for sentencing on 12 July, where he was informed that police were investigating further offences. This meant that Mr Glassford could not be sentenced for the original breach, and his case was adjourned until 10 August.
40. A CM held Mr Glassford's sixth case review that afternoon. A F Wing manager and a nurse also attended. The CM noted that Mr Glassford was in a talkative mood with good eye contact and posture. Mr Glassford said he now knew when

he was attending court and his son had given him permission to make contact. He said he felt he had adequate support in place and had no thoughts of suicide or self-harm. The CM noted that all the caremap actions had been addressed and staff decided to close the ACCT. Staff held a post-closure ACCT interview with Mr Glassford on 19 July, and decided the ACCT should remain closed.

41. Mr Glassford's medical record shows that he did not collect any of his prescribed medication, including pain relief and antidepressants, on 23, 25 and 29 June, or generally after 13 July (although he told a nurse on 23 August that he had last taken amitriptyline on 24 July). A pharmacy technician, discussed this with Mr Glassford on 29 July. Mr Glassford said that he was either not unlocked to collect it, or there were no staff at the medication hatch on the wing. The pharmacy technician told Mr Glassford he could ring his cell bell if he was not unlocked, but Mr Glassford said he would not do that. Mr Glassford remained unhappy and continued to refuse to collect his medication. The pharmacy technician made a note on SystemOne (the electronic medical record) to alert the doctors and nurses who managed long-term conditions.
42. Police interviewed Mr Glassford at a Police Station on 31 July, and charged him with further offences. A nurse assessed Mr Glassford's physical fitness for the police interview before he left, but there is no evidence anyone in the prison saw him on his return. On 6 August, Mr Glassford appeared at a Magistrates' Court by video link. Mr Glassford said he would plead guilty and his case was referred to the Crown Court.
43. Mr Glassford applied to see a member of the mental health team on 7 August, and a nurse saw him two days later. Mr Glassford said that he had a lot of childhood issues he wanted to talk about and was on a list for grief counselling. A nurse told Mr Glassford that it would be more appropriate to discuss his issues with them. Mr Glassford asked the nurse if he could move to a cell on a lower floor, because he had difficulty walking up and down the stairs. The nurse arranged for a follow up mental health review and for Mr Glassford to move to the floor below.
44. Mr Glassford appeared at court by video link on 10 August. The court told him that the additional charges were serious and that it was likely he would receive a lengthy sentence. The case was adjourned to 7 September.
45. Mr Glassford's solicitor met with him on 17 August. He told her that he intended to plead guilty and understood the implications. Mr Glassford's solicitor told the investigator he seemed relaxed and spoke openly, and the only problem he raised was difficulty in accessing his medication.
46. On 20 August, Mr Glassford applied to see a member of healthcare staff because he had severe back pain. A nurse saw him three days later, on 23 August. Mr Glassford told her that he had been prescribed amitriptyline but had not collected it for almost a month because he found the medication hatch was frequently closed. He thought his medication should be brought to his cell. She requested a doctor's appointment for him and advised him to request paracetamol in the meantime. There is no record that Mr Glassford asked for paracetamol or saw a doctor before he died.

47. Shortly after starting his shift on F Wing at around 8.15pm on 25 August, an officer carried out a roll check. He told the investigator he vaguely recalled Mr Glassford standing in his cell but they did not speak to each other. He said there were several ACCTs open on the wing, including one for the prisoner in the cell next to Mr Glassford. He carried out ACCT checks throughout the night, but had no reason to check Mr Glassford.
48. Mr Glassford telephoned his son four times on 25 August, and eventually managed to speak to him at 11.06pm. Mr Glassford told his son that he was not going to be around anymore and was going to join his mother. His son did not reply. Mr Glassford said he felt agitated as he did not have any coffee, his family had disowned him, he had no money and was in pain. Mr Glassford told his son, 'Tell your mother I'm sorry and I love her despite what I did.' His son did not respond. The call lasted a maximum of ten minutes, during which there were many periods of silence. (Mr Glassford's son told the prison's family liaison officer that he had not reported the contents of this telephone call to the prison, because his father had spoken and written about no longer being around on several occasions.)
49. At approximately 6.07am on 26 August, an officer started a morning roll check on F Wing. When he reached Mr Glassford's cell, he saw Mr Glassford suspended from the window bars. The officer radioed an emergency code blue and control room staff called an ambulance. Another officer who had been working on E Wing, responded to the code blue immediately. The two officers went into Mr Glassford's cell. An officer cut down Mr Glassford and laid him on the cell floor. They noted that Mr Glassford was not breathing and felt stiff, so did not start cardiopulmonary resuscitation (CPR).
50. A nurse responded to the code blue call and arrived at Mr Glassford's cell almost immediately. The nurse noted that Mr Glassford had no pulse, felt stiff and his limbs appeared mottled. She concluded Mr Glassford had been dead for some time and CPR would be inappropriate.
51. Paramedics arrived at Mr Glassford's cell at 6.20am and at 6.25am they confirmed Mr Glassford had died.

### **Contact with Mr Glassford's family**

52. A Supervising Officer (SO) and an officer visited Mr Glassford's son to break the news of his father's death. In the days that followed, the SO maintained contact with Mr Glassford's son and the prison contributed to the cost of the funeral, in line with national guidance.

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

53. After Mr Glassford's death, a manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
54. The prison posted notices informing other prisoners of Mr Glassford's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Glassford's death.

### **Events after Mr Glassford's death**

55. A prisoner wrote to the investigator following Mr Glassford's death. He said that Mr Glassford had been verbally abused, bullied and intimidated by other prisoners on the wing, because of his offence. He said prisoners in trusted positions and jobs, such as those working on the servery, lost Mr Glassford's canteen menus, which meant he was unable to select his meals. There is no evidence to support this.

### **Post-mortem report**

56. Mr Glassford's post-mortem reported he died as a result of hanging.

# Findings

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

57. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm from self, from others and to others (Safer Custody)*, sets out the factors that might increase a prisoner's risk of suicide and self-harm. Several factors applied to Mr Glassford, including a history of self-harm, a history of mental illness, a chronic physical health condition (arthritis and COPD), relationship problems and lack of social support.
58. Staff started ACCT procedures on 14 June, the day after Mr Glassford arrived at Leeds, and stopped them on 12 July. We are concerned that staff stopped the ACCT procedures prematurely. On the morning of 12 July, Mr Glassford appeared in court and was told the police were investigating further offences. At the ACCT case review that afternoon, no one sought to find out what had happened at court and no one discussed the possibility of new charges with Mr Glassford. Staff decided to stop ACCT procedures. We consider that staff failed to consider all the risk factors and triggers that applied to Mr Glassford when they decided to stop ACCT monitoring.
59. Given that Mr Glassford had told staff at a previous ACCT review that he expected a community service or a very short sentence, we consider that the news that he was likely to face further charges would have had a significant impact on him. We consider the ACCT procedures should have remained open until it was clearer what charges and sentence Mr Glassford might face. We consider there were other issues affecting Mr Glassford's risk of suicide and self-harm that were not addressed as part of the ACCT procedures. At his third ACCT review on 25 June, Mr Glassford's failure to collect his medication was not discussed. His reasons for not collecting his medication, which included antidepressants and painkillers, should have been explored with him to try to resolve the issue.
60. At his fourth ACCT review on 2 July, Mr Glassford said he had started a hunger strike. Staff failed to fully discuss the reason why, and took no action other than noting that it had been reported to healthcare staff. Mr Glassford had again refused to collect his medication and had not attended work, but neither issue was addressed.
61. PSI 64/2011 states that completion of a caremap is an integral part of the ACCT process and that it, *'must reflect the prisoner's needs, level of risk and the triggers of their distress. Each action on the caremap must be tailored to meet the individual needs of the prisoner, be aimed at reducing the risk to themselves and must be time bound. At each case review, the case review team should consider whether the prisoner displays any additional needs that may require the caremap to be updated'*.
62. At Mr Glassford's first ACCT case review on 15 June, three issues were added to his caremap: medication for back pain, contact with son, and mental health assessment. No further issues were added to the caremap during the subsequent five case reviews. This is despite further issues emerging during the reviews, namely Mr Glassford's court appearance and his food refusal. Clearly

staff identified Mr Glassford's court appearance as an issue for him as they noted they would keep the ACCT open until he knew the date, but no one updated the caremap. We make the following recommendations:

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

- **assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation; and**
- **set caremap actions that are specific, meaningful and time bound, aimed at reducing the prisoner's risk to themselves, and update the caremap actions if additional needs are identified.**

63. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events such as attending court, sentencing at court, or being questioned by police, are factors that might have a significant impact on the health of a prisoner. For those prisoners passing through reception, prisons are required to have protocols in place for screening them to identify any potential healthcare or suicide and self-harm issues. PSI 07/2015, *Early Days in Custody*, states that the PER and any other available information must be examined by reception staff and the prisoner must be interviewed to assess their risk of suicide and self-harm.
64. Mr Glassford was questioned by police at a Police Station on 31 July, and charged with further offences. PSI 64/2011 lists further charges as a potential trigger for suicide and self-harm.
65. There is no evidence that Mr Glassford was screened when he passed through reception on his return to the prison after being charged with new offences. Staff said there was no routine assessment of prisoners returning after a temporary absence when they came through reception, unless they were alerted by police or the escort contractors. We are concerned that despite raising this issue in a previous investigation at Leeds two years ago, there is still no process to identify prisoners who might be at risk following their return to prison after police questioning or a court appearance. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison after a court appearance, police questioning or any other event that might increase their risk, are screened to assess their risk of suicide and self-harm and for potential health problems.**

66. Mr Glassford appeared in court by video link on 6 and 10 August, when he was told there were serious further charges against him and he faced a lengthy sentence. As Mr Glassford did not leave the prison, he did not pass through reception on these occasions.
67. Nevertheless, PSI 07/2015, *Early days in custody*, states that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link. There is no evidence that anyone spoke to Mr Glassford following his court appearances to assess whether

his risk of suicide and self-harm had increased or whether he needed to see healthcare. We make the following recommendation:

**The Governor should ensure that arrangements are in place to identify prisoners who may be at increased risk of suicide and self-harm, or require a healthcare assessment, following a court appearance by video link.**

### **Mental health care**

68. The clinical reviewer was satisfied that overall, the mental health care Mr Glassford received at Leeds was equivalent to that which he could have expected to receive in the community. However, she noted some concerns. She found that healthcare staff at Leeds did not use any formal clinical risk assessment tools to assess a person's risk of suicide and self-harm. Also, when a nurse assessed Mr Glassford on 9 August, following his self-referral, and he told her he had lots of issues about his childhood he wanted to talk about, she did not explore this further with him and just said he was on the waiting list for counselling. In addition, healthcare staff did not carry out a mental capacity assessment when Mr Glassford refused food and stopped collecting his medication.

69. We make the following recommendations:

**The Head of Healthcare should ensure mental health staff receive formal in-house risk assessment and management of mental health training.**

**The Head of Healthcare should ensure staff are aware of the Mental Capacity Act (2005) and how to use mental capacity assessments.**

### **Food refusal**

70. Leeds has a local policy for managing prisoners who are refusing food and fluids, dated January 2017, in line with NICE guidelines and PSI 64/2011. The policy says it is essential that any prisoner who refuses (or claims to refuse) food or fluids is identified and procedures are put in place to deal with their clinical management. The policy sets out the process that should be followed. This includes a full medical assessment and weekly clinical assessments if food refusal continues. Leeds did not follow this policy when Mr Glassford started to refuse food and fluids.

71. While this may have had no impact on the eventual outcome, it is important that Leeds follows its own policy when prisoners refuse food and fluids to ensure that the prisoner receives appropriate care and support. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff are aware of the management of food refusal policy and audit its use.**

### **Medication and pain management**

72. If a prisoner does not take prescribed medication, especially for pain management or mental health conditions, this can affect their ability to cope.

Failure to collect medication may also be an indication that a prisoner is being bullied and does not, therefore, want to leave his cell.

73. Leeds follows Care UK's not in-possession medication protocol. One of its aims is to improve the delivery of medication and develop and improve the supply and administration of medication. Leeds also has a local operating policy for managing omitted doses of medication. It says that staff should be aware of the harm a missed dose of medication can cause and prioritise critical medications with prompt follow up to ensure prisoner harm is minimised. There are a number of principles to apply when assessing a missed medication, including how long has the medication been omitted, is it safe to recommence, does the prisoner need further medical help, will the omission or delay cause any side effects, and will omission cause a deterioration of a condition. The operating policy gives a non-exhaustive list of medications that are considered critical, these include mental health medicines including antidepressants. There is no evidence that any of this was considered in Mr Glassford's case.
74. The PPO's Learning Lessons Bulletin on Prisoner Mental Health, published in January 2016, says that prison and healthcare staff have a responsibility to talk to prisoners who fail to collect or take their medication and to try to ascertain why they have chosen not to comply and to encourage them to begin taking it again. Prison healthcare leads should ensure that there is a robust system in place for flagging non-compliance and clear guidance for healthcare staff about the management of medication and dealing with non-compliance.
75. Mr Glassford did not collect his medication at least three times during June, including antidepressants and painkillers. He later told a nurse on 23 August that he had last taken amitriptyline (for pain management) on 24 July. It took a further 15 days before, a pharmacy technician spoke to him about it. The pharmacy technician said he sent a note to the doctors and long-term condition nurses on SystmOne to inform them that Mr Glassford was not taking his prescribed medication. Another pharmacy technician, also spoke to Mr Glassford about not collecting his medication and told the investigator she had made a note on SystmOne. Despite this, Mr Glassford continued to not collect or take his medication and no further action was taken. His medical records do not show which days Mr Glassford did and did not collect his medication, and no pharmacy records were available. Staff did not follow this up as they should have done.
76. The prison should have a better system in place for identifying, and addressing, prisoners' failure to collect their medication. We make the following recommendation:

**The Head of Healthcare should ensure that there is a robust system in place to identify when prisoners do not collect their medication and that healthcare staff take appropriate action.**

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