

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Benjamin Hyland, a prisoner at HMP Leeds, on 11 December 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

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.

If my office is to best assist HM Prison and Probation Service in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Benjamin Hyland was found hanged in his cell at HMP Leeds on 11 December 2022. He was 29 years old. I offer my condolences to his family and friends.

Mr Hyland died less than 48 hours after he arrived at Leeds. Although he had several significant risk factors for suicide and self-harm and had been identified as at risk by the police in his escort record, prison staff who interviewed him on his arrival chose not to start Prison Service suicide and self-harm prevention procedures.

My office has shared concerns with the Governor of Leeds and the Prison Group Director for Yorkshire about deficiencies in identifying and assessing risk factors for suicide and self-harm in newly arrived prisoners and it is troubling that I have had to raise these issues again in this report.

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

Adrian Usher
Prisons and Probation Ombudsman

August 2023

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	9

Summary

Events

1. On 9 December 2022, Mr Benjamin Hyland was remanded to HMP Leeds, charged with terrorism offences. Police staff recorded in his escort record that he was at risk of suicide and self-harm and had banged his head on a door frame while in their custody. They also disclosed that he had a history of depression and anxiety. It was Mr Hyland's first time in prison.
2. An officer interviewed Mr Hyland on his arrival at Leeds, recording that he said that he banged his head out of "frustration" and had no thoughts of suicide and self-harm. The officer told us that he chose not to start Prison Service suicide and self-harm prevention procedures (known as ACCT) because Mr Hyland interacted well and appeared settled. Other staff who spoke to Mr Hyland on his first night reached similar conclusions.
3. Prison staff provisionally identified that Mr Hyland was at high risk of inflicting violence on a cellmate and allocated him a single cell.
4. At 9.50am on 11 December, an officer unlocked Mr Hyland's cell but could not see him in the cell. She spoke to a colleague, who had not seen Mr Hyland. Despite the uncertainty about Mr Hyland's whereabouts, neither officer took any further action.
5. At 11.58am, the same officer unlocked Mr Hyland's cell for lunch. This time, she went into the cell and found him hanged behind the toilet privacy curtain. Prison and healthcare staff began cardiopulmonary resuscitation, but shortly after they arrived, paramedics confirmed that Mr Hyland had died.

Findings

Identifying the risk of suicide and self-harm

6. Mr Hyland had risk factors for suicide and self-harm when he arrived at Leeds and had been highlighted as at heightened risk in his escort record. Nevertheless, staff who interviewed him relied on his body language and what he said to them when considering whether to start ACCT procedures, rather than considering his range of risk factors. This is an issue that we have previously highlighted to the Prison Group Director for Yorkshire.

Other learning

7. Mr Hyland's cell sharing risk assessment was not reviewed on his second day in custody, as it should have been. His potential to share a cell was not therefore reconsidered. Sharing a cell might have been a protective factor against his risk of suicide and self-harm.
8. On the morning of his death, wing staff did not check on Mr Hyland's whereabouts and wellbeing when they did not know where he was.

9. Prison and healthcare staff should not have tried to resuscitate Mr Hyland when rigor mortis was established.

Recommendations

- The Prison Group Director for Yorkshire should meet the Ombudsman to discuss what action she intends to take to improve the identification of risk of suicide and self-harm at HMP Leeds.

The Investigation Process

10. On 11 December 2022, HM Prison and Probation Service notified us of Mr Hyland's death. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Leeds on 20 December 2022. He obtained copies of relevant extracts from Mr Hyland's prison records.
12. The investigator interviewed five members of staff from Leeds in person and by video conference between 6 February and 1 March 2023.
13. NHS England commissioned a clinical reviewer to review Mr Hyland's clinical care at the prison. They jointly interviewed healthcare staff.
14. We informed HM Coroner for West Yorkshire (Eastern) of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Hyland's sister and former partner to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Hyland's former partner asked why his head was bruised and whether he should have been watched more closely in prison, given the impact this might have had on his mental health. We have addressed these concerns in this report.
16. We shared the initial report with HM Prison and Probation (HMPPS). They did not identify any factual inaccuracies. We have attached their action plan as Annex 7.
17. We also shared the initial report with Mr Hyland's sister and former partner. They did not respond.

Background Information

HMP Leeds

18. HMP Leeds is a local prison holding up to 1,218 men who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services. Midlands Partnership Trust provides psychosocial substance misuse services.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Leeds was in June 2022. Inspectors reported that the number of prisoners arriving each week was very high and that reception processes were delivered well and early days work to support prisoners was robust. They found that every new arrival had a custody care plan that aimed to address previous weaknesses in assessing the risk of self-harm, which they identified as an important improvement.
20. However, inspectors also reported that the induction process was not comprehensive. They found that only 73% of prisoners surveyed said that they received an induction and, of those, less than half found that it covered all that they needed to know.
21. Inspectors reported that the number of deaths was high, including eight self-inflicted deaths since their last inspection (in November 2019). However, they found that the number of self-harm incidents was lower than at their last inspection and in similar prisons.

Independent Monitoring Board

22. 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 2020, the IMB reported that they had raised concerns with the Governor about a first-time prisoner on a long sentence who had died within five days of arrival to the prison. The IMB reported that they were informed that such prisoners, and those on remand and awaiting trials for serious offences, would be targeted by keyworkers to build a relationship and to identify risks of self-harm.

Previous deaths at HMP Leeds

23. Mr Hyland was the twenty-eighth prisoner to die at Leeds since December 2019. Of the previous deaths, eight were self-inflicted. Another prisoner took their life on the same day as Mr Hyland, a few hours later. In four of the previous self-inflicted deaths, we identified deficiencies in identifying and assessing risk factors for suicide and self-harm in newly arrived prisoners.
24. In our report into the death of a prisoner in March 2022, we recommended that the Prison Group Director (PGD) for Yorkshire write to the Ombudsman to set out what action she had taken to satisfy herself that meaningful improvements had been

made to the assessment and management of the risk of suicide and self-harm at Leeds. The PGD responded in October 2022, saying that the national safety team had completed a full review of reception and first night processes at Leeds, including exploring how the risk of harm is recognised and shared. She identified that a recent quality assurance of this process found that relevant information was shared and that prisoners who had evident risks were being supported appropriately.

25. Since Mr Hyland's death, six more prisoners have taken their lives at Leeds (including the prisoner who died on the same day). As a result, Leeds is receiving additional support and monitoring from regional and national safety teams.

Assessment, Care in Custody and Teamwork

26. 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. 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.
27. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions 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.

Key Events

9 December 2022

28. On 9 December 2022, Mr Benjamin Hyland was remanded to HMP Leeds, charged with multiple terrorism offences. It was his first time in prison. Police staff recorded in the Person Escort Record (PER, which accompanies prisoners on all journeys between police stations, courts and prisons to communicate risk factors) that Mr Hyland was at risk of suicide and self-harm. They recorded that he had banged his head on a door frame in police custody and had punched walls in the past. Police staff also recorded that Mr Hyland had a history of depression and anxiety.
29. At around 3.50pm, Mr Hyland arrived at Leeds. An officer interviewed him in Reception. He wrote on the PER that:

“[Mr Hyland] interacted well on reception interview – said the head banging incident was borne out of frustration. Denies ever having had thoughts of suicide/self-harm ... ACCT not opened.”
30. The officer recorded on the prison case management system that Mr Hyland arrived with a suicide and self-harm warning. He noted that he interviewed Mr Hyland “at length” in Reception and that he “interacted well throughout”. The officer also repeated his remarks from the PER about Mr Hyland’s motivation for banging his head and denial of thoughts of suicide and self-harm.
31. The officer told us that Mr Hyland said that he banged his head because “them bastards [referring to the police] were winding me up, they did my head in”. He said that Mr Hyland appeared “very well” and was chatty, forthcoming with answers and had good body language. The officer said that Mr Hyland’s main concern was that he did not want to be on the same wing as a particular individual. (Mr Hyland did not spend any time on the same wing as this prisoner.) The officer said that he chose not to start ACCT procedures because of Mr Hyland’s “manner, his confidence, he was very settled with his peers ... very outgoing, very jovial”.
32. A nurse completed an initial health screen. She recorded that it was Mr Hyland’s first time in prison. The nurse recorded that Mr Hyland had a wound on his head, which he said was from banging his head on a door frame out of frustration. She noted that Mr Hyland said that he had not done that before and that he denied thoughts of suicide or self-harm. The nurse also recorded that Mr Hyland said that he had anxiety and depression and felt that he should be on medication. She referred him to the mental health team.
33. An officer completed a cell sharing risk assessment (designed to assess the risk of violence a prisoner poses either to or from a cellmate) and recorded that the nature of Mr Hyland’s offence meant that he was not suitable to share a cell. A Custodial Manager (CM) reviewed the cell sharing risk assessment and recorded that a second day assessment was required because information about previous convictions from the Police National Computer was not available at the time. He noted that Mr Hyland would be allocated a single cell as a high-risk prisoner on his first night in custody. There is no record that the second day cell sharing risk

assessment took place. Prison staff allocated Mr Hyland a single cell on D Wing (the first night and induction unit).

34. An officer conducted a first night interview. She recorded that Mr Hyland said that he did not have any immediate concerns about being in prison for the first time. The officer also noted that Mr Hyland did not report any current or historic thoughts of suicide and self-harm, although he reported a history of anxiety and depression. She noted that Mr Hyland engaged well and concluded that ACCT procedures were not required as there were "no concerns".

10 December 2022

35. The night patrol officer recorded that Mr Hyland slept through the night and that there were no issues.
36. An officer conducted Mr Hyland's induction, as part of a group of new prisoners. She recorded that this included information about the prison regime, healthcare services and support avenues.

11 December 2022

37. At 9.50am, the officer looked through the observation panel of Mr Hyland's cell and unlocked the door so that he could come out for domestic activities. She then spent around two minutes standing on the wing landing with her back towards Mr Hyland's cell.
38. At 9.52am, the officer looked through the observation panel, opened the door and put her head inside. She told us that she could not see Mr Hyland in the cell, so she shouted in case he was on the toilet behind the privacy curtain at the back of the cell. The officer said that there was no response. She then locked the cell and walked further down the landing. The officer told us that she assumed that another officer, who was helping her unlock the landing, had already unlocked Mr Hyland's cell.
39. The officer said that she then asked the other officer whether she had unlocked Mr Hyland's cell, and that the other officer could not remember. The other officer told us that the first officer asked her if Mr Hyland had come out of his cell, and that she said that she did not know as she had not been looking in that direction. Neither officer returned to check Mr Hyland's cell.
40. At 11.57am, the first officer began unlocking cells on the landing for lunch. At 11.58am, she arrived at Mr Hyland's cell and looked through the observation panel. The officer then spoke to the other officer, who was on the landing near her. She told us that she asked the other officer whether anyone had moved from the cell that morning, and that the other officer said "no".
41. Around 20 seconds after arriving, the officer unlocked the cell. She found Mr Hyland hanged from a ligature behind the toilet privacy screen. The other officer cut the ligature and radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance.

42. An officer began cardiopulmonary resuscitation (CPR) on rotation with colleagues. At 12.00pm, two nurses arrived at the cell and took over the resuscitation. A nurse recorded that rigor mortis appeared to be present around Mr Hyland's mouth.
43. At 12.10pm, paramedics arrived at Mr Hyland's cell. At 12.11pm, they stopped the resuscitation and confirmed that Mr Hyland had died.
44. Mr Hyland left a note in his cell addressed to his son, the content of which appeared to indicate that he intended to take his life.

Contact with Mr Hyland's family

45. Mr Hyland named his solicitor as his next of kin when he arrived at Leeds. Police officers subsequently identified Mr Hyland's former partner and notified her of his death.
46. A Supervising Officer (SO), the prison's family liaison officer, told us that the police asked prison staff to wait before they contacted Mr Hyland's family. He said that he was unsure why this was but thought that it might relate to the nature of Mr Hyland's offence.
47. On 15 December, the family liaison officer was given permission to contact Mr Hyland's family, and subsequently spoke to his sister to explain the sequence of events and how prison staff could support the family in the upcoming weeks, including with funeral costs. He also contacted Mr Hyland's former partner.

Support for prisoners and staff

48. After Mr Hyland's death, a CM 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.
49. Prison staff checked the welfare of prisoners who lived in cells near to Mr Hyland. They conducted additional case reviews for all prisoners who were being monitored under ACCT procedures. On 12 December, Samaritans attended Leeds to help Listeners provide support to those prisoners who had been affected following two self-inflicted deaths on the same day.

Post-mortem report

50. A post-mortem examination confirmed that Mr Hyland died of hanging. The post-mortem report identified a partially healed superficial abrasion on the centre of Mr Hyland's forehead near the hairline. The pathologist recorded that this was in keeping with a reported self-inflicted injury.
51. It is likely that this is the bruising to which Mr Hyland's former partner referred in her correspondence with us, and which was seemingly caused by him banging his head in police custody.

Findings

Identifying the risk of suicide and self-harm

52. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Leeds should have identified Mr Hyland as at risk and begun ACCT procedures to support him.
53. Mr Hyland had some significant risk factors for suicide and self-harm when he arrived at Leeds. It was his first time in prison. He was charged with multiple terrorism offences and likely to receive a long sentence if found guilty. He had harmed himself in police custody and had identified a history of depression and anxiety. PSI 64/2011 also recognises that prisoners are at increased risk of suicide and self-harm in their first days in custody.
54. The PER identified these risk factors and highlighted that Mr Hyland was at risk of suicide and self-harm. The reception officer told us that he chose not to start ACCT procedures because Mr Hyland denied having any further thoughts of harming himself and that his manner indicated that he was not at risk. The officer who conducted the first night interview also concluded that there were no concerns about Mr Hyland's risk.
55. We have said repeatedly in our reports that staff should consider an individual's range of risk factors, rather than just what they say or how they present. Mr Hyland was identified as at risk in police custody and harmed himself the day before he was sent to prison, yet staff chose not to start ACCT procedures.
56. We have previously expressed concerns about staff identifying the risk of suicide and self-harm at Leeds. In September 2022, we made a recommendation to the Prison Group Director (PGD) for Yorkshire asking her to set out the actions she intended to take in response to our concerns. The PGD responded in October 2022, saying that the national safety team had completed a full review of reception and first night processes at Leeds, including exploring how the risk of harm is recognised and shared. She identified that a recent quality assurance of this process found that relevant information was shared and that prisoners who had evident risks were being supported appropriately. Nevertheless, this investigation has again highlighted poor risk assessment. We make the following recommendation:

The Prison Group Director for Yorkshire should meet the Ombudsman to discuss what action she intends to take to improve the identification of risk of suicide and self-harm at HMP Leeds.

Governor to note***Cell sharing risk assessment***

57. x PSI 20/2015 instructs that the cell sharing risk assessment must be completed as part of the reception process when prisoners are first received into custody. It states that “if the Police National Computer record is not available on the first day in custody, this must be checked so that the risk assessment is finalised the next working day”.
58. Mr Hyland did not receive a ‘Day 2’ cell sharing risk assessment and therefore remained provisionally high risk for cell sharing and in a single cell. We do not know what the outcome of a ‘Day 2’ risk assessment might have been and it is possible that it might have concluded that he could share a cell. Sharing a cell is usually a protective factor for those at risk of suicide and self-harm and it is important that assessments are completed promptly and appropriately.

Events of 11 December

59. The officer could not see Mr Hyland in his cell when she unlocked it at 9.50am. Although she spoke to another officer about Mr Hyland’s potential movements, it is apparent from both officers’ accounts of this conversation that they were not certain where he was at the time. Neither took any further action to establish where Mr Hyland was or to check his wellbeing.
60. Mr Hyland was found hanged behind the privacy curtain in his cell a little over two hours later, with rigor mortis beginning to establish. While we cannot be sure, it is possible that he was in this position when the officer looked into the cell earlier in the morning. A more thorough earlier check on his whereabouts and welfare might have led to a different outcome.

Cardiopulmonary resuscitation

61. European Resuscitation Council Guidelines 2015 state that, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. A nurse identified the presence of rigor mortis and told us that she did not consider stopping the resuscitation as she thought that it had to continue until paramedics arrived. She said that she was not aware of the guidelines about when not to perform cardiopulmonary resuscitation.
62. The clinical reviewer highlighted that rigor mortis is a sign of irreversible death and that its presence means that resuscitation should not be attempted.

Inquest

63. The inquest into Mr Hyland’s death concluded on 10 June 2024, and recorded a verdict of hanging.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100