Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Mullen, a prisoner at HMP Leeds, on 30 November 2024

A report by the Prisons and Probation Ombudsman

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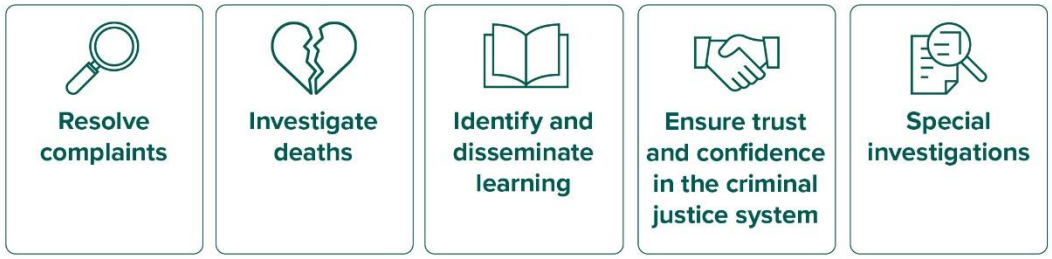
OUR VISION

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

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 His Majesty's Prison and Probation Service (HMPPS) 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 Steven Mullen died in hospital in the late evening of 30 November having been found hanging in his cell at HMP Leeds two hours earlier. He was 48 years old. I offer my condolences to Mr Mullen's family and friends.

Mr Mullen was the 14th prisoner to take his life at Leeds since November 2021.

Mr Mullen was in Leeds for little more than 24 hours by the time he was found hanging. I am satisfied that he received appropriate care in his brief time there and that staff had no reason to consider him at raised risk of suicide or self-harm. I make no recommendations.

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 **July 2025**

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Summary

Events

1. On 29 November 2024, Mr Steven Mullen was remanded to HMP Leeds charged with criminal damage, actual bodily harm and assault. His alleged victim was his wife.

2. During reception screening, Mr Mullen provided a positive urine test for methadone and opiates and he was prescribed a low dose of methadone starting that evening. He told reception staff that he had no thoughts of suicide or self-harm. He then moved to a shared cell on the induction unit.

3. CCTV shows that Mr Mullen came out of his cell during 30 November to receive his medication and to collect his meals.

4. Mr Mullen and his cellmate returned to their cell with their evening meals at 4.22pm and were locked in for the remainder of the day. Mr Mullen's cellmate said that he gave part of his meal to Mr Mullen as he was still hungry.

5. At around 9.25pm, Mr Mullen's cellmate woke from a brief sleep and saw Mr Mullen hanging by his belt from the window frame. He unbuckled the belt and Mr Mullen fell to the floor. The cellmate rang the cell bell and officers responded promptly. The officers believed that Mr Mullen was breathing and they placed him in the recovery position. Nurses arrived around a minute later. They found that Mr Mullen was not breathing and they began cardiopulmonary resuscitation (CPR). Ambulance paramedics arrived at 9.44pm and after they established a pulse they took Mr Mullen to hospital, where he died at 11.30pm.

6. Staff found a letter in the cell that Mr Mullen had written to his wife. He wrote that being in prison was the best place for him to be at that time and he asked her to send him some money. He gave no indication in the letter that he was thinking of taking his own life.

Findings

7. We are satisfied that staff at Leeds appropriately assessed Mr Mullen's risk of suicide and self-harm and that they could not reasonably have predicted or prevented his death.

8. The clinical reviewer concluded that Mr Mullen's healthcare at Leeds was equivalent to that which he could have expected to receive in the community.

The Investigation Process

9. HMPPS notified us of Mr Mullen's death on 1 December. 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.

10. The investigator visited Leeds on 11 December and spoke to three prisoners. He met the prison Governor and obtained copies of relevant extracts from Mr Mullen's prison and medical records.

11. The investigator interviewed five members of staff and two prisoners at Leeds on 18 February 2025.

12. NHS England commissioned a clinical reviewer to review Mr Mullen's clinical care at the prison. She and the investigator jointly interviewed five clinical staff by MS Teams on 20 February.

13. The investigator interviewed a further member of staff via Ms Teams on 3 March.

14. We informed HM Coroner for West Yorkshire Eastern District 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. We contacted Mr Mullen's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She said she had reported her concerns about her husband's risk to himself to the police the day before he went to court. She said that her friend also told police that if Mr Mullen could not contact her or she ended the relationship, he would take his own life. Mr Mullen's wife also said that on 31 October 2024 he had threatened to take his own life by jumping from a bridge. The police and community mental health team were aware of this. She believed that there would have been warning signs on the paperwork sent from court that the prison had either lost or ignored.

16. We shared our initial report with HMPPS and with Mr Mullen's wife via her solicitor. Mr Mullen's wife's solicitor identified an incorrect name in one of the report dossier documents, which we have amended.

17. We have also amended several paragraphs in this report to reflect the information contained in the Person Escort Record which accompanied Mr Mullen from the police station to court. Despite several requests while the investigation was ongoing, we only received this information during the initial report consultation period.

Background Information

HMP Leeds

18. HMP Leeds is a local prison holding 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 and substance misuse services. Nurses are available 24 hours a day.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Leeds was in June 2022. Inspectors noted that the prison received into custody around 388 new prisoners every month. Inspectors found that Leeds was a well-led prison and managers were visible on the wings. However, inspectors also noted that the prison needed improvement in safety outcomes with at least eight self-inflicted deaths since the previous inspection in 2019. Inspectors found that the prison was working to address this major issue including developing positive early days in custody processes.

20. In July 2023, inspectors returned to Leeds to review progress since the previous inspection. Inspectors noted that there had been seven self-inflicted deaths in the previous 13 months and that Leeds had the second highest rate of self-inflicted deaths of any prison in England and Wales. Inspectors noted that unemployment and long periods locked-up at weekends were common factors in many of the deaths. Inspectors found that Leeds was capable of making progress, but there needed to be clearer, sharper and more sustained focus on what was needed to improve the well-being of prisoners.

Independent Monitoring Board

21. 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 2023, the IMB expressed its concern about the continuing high number of deaths at the prison, including high numbers of self-inflicted deaths. The IMB noted that Leeds had introduced new strategies for peer support for potentially vulnerable prisoners to boost the support already provided by Listeners (prisoners trained by the Samaritans to provide support to other prisoners). The IMB noted that staff and prisoner relationships were generally positive. However, they also found that many officers were newly qualified and often lacked experience in dealing with sometimes difficult and demanding prisoners. The IMB commented on the level of overcrowding at Leeds with prisoners having to share cramped cells.

Previous deaths at HMP Leeds

22. Mr Mullen was the 22nd prisoner to die at Leeds since November 2021. Of the previous deaths, 13 were self-inflicted, seven were due to natural causes and one was drug related. There were no similarities between Mr Mullen's death and the previous deaths.

23. Since Mr Mullen's death, there have been five further deaths at Leeds up to the end of April 2025. Three of these deaths were self-inflicted and two were due to natural causes.

Key Events

29 November 2024

24. In the late afternoon of Saturday 29 November 2024, Mr Steven Mullen was remanded to HMP Leeds charged with offences of criminal damage, actual bodily harm, controlling behaviour and assault committed between 1 June and 28 November. The alleged victim was Mr Mullen's wife. It was his first time in prison for around 15 years.

25. The paperwork that accompanied Mr Mullen to Leeds included a digital Person Escort Record (PER), a document that accompanies prisoners between police custody, courts and prisons and which sets out any risks. Mr Mullen's PER covered the period of his detention at court up to his handover to Leeds staff. It noted that he was not deemed at risk of suicide or self-harm. (The PER that earlier accompanied Mr Mullen from police custody to court noted that he suffered with depression, but also noted that he was not deemed to be at risk of suicide or self-harm. This PER was not seen by Leeds and we were only provided with a copy following issue of our initial report.)

26. Another prisoner told the investigator that he and Mr Mullen arrived in Leeds at the same time, and they spoke in the reception holding cell while waiting to be seen by staff. He said that he and Mr Mullen had similar problems with drug dependency and he asked staff if they could share a cell.

27. A nurse saw Mr Mullen for a reception health screen. Mr Mullen said that he had no issues with alcohol but had a history of crack cocaine misuse and was prescribed methadone. Mr Mullen said that he had no mental health problems and had no thoughts of suicide or self-harm. Mr Mullen provided a urine sample that tested positive for methadone and opiates. Mr Mullen's community healthcare records were not available to the nurse at the time of her assessment. These would have been requested the following Monday after obtaining Mr Mullen's consent.

28. A reception officer noted that he had a lengthy conversation with Mr Mullen. Mr Mullen said that he had been in prison before, knew what was expected of him as a prisoner and knew about support available through the Samaritans and Listeners. He said that he had no issues with being in prison and had no thoughts of suicide or self-harm.

29. A trainee advanced nurse practitioner noted that Mr Mullen was alert and orientated and prescribed him 10ml of methadone starting that evening. The doses were to increase over the following days in line with standard methadone prescribing procedures. Mr Mullen again said that he had no thoughts of suicide or self-harm.

30. From reception, Mr Mullen moved to cell D4-37, a cell on the fourth landing of D wing, the induction unit. He moved in with the prisoner he met in the reception holding cell. This prisoner told the investigator that he took the bottom bunk, and Mr Mullen took the top bunk.

31. As Mr Mullen was new in prison, staff made four welfare checks on him through the night and noted no concerns about him.

30 November 2024

32. The investigator watched CCTV footage and body worn video camera footage (BWVC). He also obtained information from Yorkshire Ambulance Service. The following account is based on these sources as well as statements and interviews with staff and the cellmate.

33. At just before 9.00am on 30 November, an officer unlocked Mr Mullen, and he came out of his cell and spoke to other prisoners. Mr Mullen had a further 10ml dose of methadone at 9.32am. (The cellmate said that he and Mr Mullen should have had their doses earlier that morning, but they had both lost their identity cards, so these needed to be replaced before they could have further doses.)

34. At just after 10.00am, an officer went to cell D4-37 to give Mr Mullen and his cellmate some general information about prison life. She gave them prison induction booklets and asked if they had any questions about being in prison. She asked Mr Mullen if he wanted her to inform his family that he was in prison and he asked her to contact his wife. She telephoned Mr Mullen's wife to tell her that Mr Mullen was in Leeds and that he was okay. She noted that Mr Mullen's wife raised no concerns. (As Mr Mullen's wife was the victim of his alleged offence, he was not allowed to contact her directly.)

35. A substance recovery worker reviewed Mr Mullen that morning. She noted that Mr Mullen engaged well and said that he had no thoughts of suicide or self-harm. She noted that Mr Mullen said that he had a history of depression and had been prescribed an antidepressant in the past but he had not taken the medication for a long time. She told Mr Mullen about the process for booking a GP appointment.

36. At just before midday, Mr Mullen and his cellmate collected their lunches and returned to their cell which staff locked.

37. At 2.18pm, Mr Mullen received a further 10ml dose of methadone and he then returned to his cell, and an officer locked it at 2.23pm.

38. CCTV shows that two prisoners separately went to Mr Mullen's cell several times that afternoon. One prisoner said that he went to the cell to speak to the cellmate, as they had served sentences together at HMP Wealstun. He said that when he went to the cell Mr Mullen was lying in bed and he did not speak to him. The other prisoner said that he knew the cellmate from the community and had gone to the cell to ask him for some sugar as he had none. He said that he did not see Mr Mullen.

39. At 4.18pm, an officer unlocked cell D4-37 and Mr Mullen and his cellmate walked downstairs to collect their evening meals. They returned to their cell with their meals at 4.22pm and another officer locked the door. All prisoners were locked in at around this time and they remained locked in for the rest of the day. The officer told the investigator that he had seen Mr Mullen engage with the regime during the day and he had appeared positive and well. When he locked the cell that afternoon, he asked Mr Mullen and his cellmate if they had everything they needed for the night, and they said that they did.

40. At 4.47pm, another officer looked into cell D4-37 and checked that the door was locked (she checked all the cells on the landing). She told the investigator that due to the number of prisoners on D wing, they were unlocked at different times during the day for the various aspects of the regime. She said Mr Mullen stuck in her mind as he had a distinct mark under his right eye. She said that she recalled interacting with Mr Mullen and his cellmate throughout the day. She said that Mr Mullen engaged appropriately with the regime and nothing arose to cause her any concern.

41. At 8.44pm, an officer made a routine check on all the cells. She told the investigator that she could not recall what Mr Mullen and his cellmate were doing at the time of her check, but said that she would have taken action had she noticed anything of concern.

42. The cellmate said that he ate some of his evening meal but gave one of his sandwiches to Mr Mullen as he was still hungry. Mr Mullen had said nothing at any time in the day to suggest that he was thinking of harming himself. He said that he and Mr Mullen watched television in the evening, and he believed that he fell asleep at around 9.00pm. He said that he woke up a short time later and got out of bed to make a cup of tea. As he got up, he saw Mr Mullen hanging from the window frame. He lifted Mr Mullen's body, unbuckled the belt he had used as a ligature, and Mr Mullen fell to the ground. He then pressed the emergency cell bell and checked to see if Mr Mullen had a pulse, but he could not find one.

43. CCTV shows that the cell bell light for the cell illuminated at 9.27pm. Officer A reached the cell at 9.28pm. He told the investigator that when he reached the fourth landing he heard knocking from cell D4-37 which suggested an emergency. He said that when he opened the observation panel Mr Lawson was standing at the door and he pointed to the back of the cell where Mr Mullen was lying on the floor partly obscured by the toilet privacy screen. He radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). As there were two prisoners in the cell and the circumstances were unclear, he waited for other staff to arrive before going into the cell. Officer B reached the cell 22 seconds after Officer A. CCTV then shows Officer A looking over the bannisters to check where other staff were and, with two more officers climbing the stairs, he unlocked the cell at 9.29pm. As he went into the cell, the cellmate told him that Mr Mullen had hanged himself with a belt.

44. Officers moved Mr Mullen away from the corner of the cell and, after checking him, they believed he had a pulse and was breathing so they moved him onto his side (the recovery position). A nurse arrived at 9.31pm and was followed by a colleague. After checking Mr Mullen, the nurse said that Mr Mullen was not breathing, and her colleague started CPR. Officers took turns in giving CPR while the nurses gave oxygen and periodically checked Mr Mullen with a defibrillator.

45. Control room staff called an ambulance when the code blue call was made, and paramedics arrived at 9.44pm. They took charge of the efforts to resuscitate Mr Mullen. The paramedics established a pulse and at 10.59pm they took Mr Mullen to hospital. Mr Mullen died in hospital at 11.30pm.

46. Mr Mullen had left a letter in his cell in which he told his wife that being in prison was the best place for him to be at that time for both their sakes, He wrote that he would do anything to get back what he had lost but, if he did not hear back from her,

he would understand. He asked her to send him some money from his savings. He gave no indication in the letter that he was thinking of taking his own life.

Contact with Mr Mullen's family

47. The Duty Governor telephoned Mr Mullen's wife at 10.59pm to tell her that Mr Mullen had been taken to hospital and was in a serious condition. Mr Mullen's wife went to the hospital to see him. One of Leeds' family liaison officers telephoned Mr Mullen's wife on 2 December. Leeds contributed to the cost of Mr Mullen's funeral in line with national instructions.

Support for prisoners and staff

48. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners to identify prisoners most affected by the death.

49. A Custodial Manager (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.

50. The prison posted notices informing other prisoners of Mr Mullen'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 Mullen's death. Listeners were deployed to speak to other prisoners and staff started prison suicide and self-harm support procedures for Mr Lawson.

Post-mortem report

51. The pathologist gave Mr Mullen's cause of death as pressure on the neck consistent with hanging.

52. Mr Mullen's toxicology report found the presence of methadone at a level consistent with therapeutic use.

Findings

Assessment of risk of suicide and self-harm

53. Assessment, Care in Custody and Teamwork (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. There should be regular multidisciplinary review meetings involving the prisoner. In determining whether to start ACCT procedures, staff are expected to consider any potential risk factors in addition to any overt actions or words suggesting risk.

54. Mr Mullen had a number of potential risk factors. His alleged offences were against his wife, whom he would not have been allowed to contact, and he appeared to have no other external support in the community. He had problems with drug use and had not been in prison for a number of years. Despite these potential risk factors, nothing occurred in Mr Mullen's very brief time at Leeds to indicate that he was thinking about taking his own life. He consistently told staff that he had no thoughts of suicide or self-harm, and he had quickly formed a level of friendship and support with his cellmate. In addition, Mr Mullen's unsent letter to his wife suggested that he was thinking of the future with hopes of rekindling their relationship.

55. Mr Mullen's wife told us that both the police and the community mental health team were aware of recent events that might have suggested that he was at risk. Following issue of our initial report we obtained a copy of the PER that accompanied Mr Mullen from police custody to court. The PER noted that Mr Mullen suffered with depression but also noted that he was not considered to be at risk of suicide or self-harm. (Leeds did not receive a copy of this PER.)

56. We have found no reason for staff at Leeds to have believed that Mr Mullen was at risk and in need of any additional support through ACCT procedures.

Emergency response

57. Leeds' staff information notice on entering cells titled *'Entering a cell – Dynamic Risk Assessment'*, explains that staff have a duty of care to prisoners, to themselves and to other staff. The notice states that preservation of life must take precedence over security concerns although staff should not take action that they feel would put themselves and others in danger. The notice makes clear that there are many different incidents that can occur in prison so it is difficult to be prescriptive about the actions to be taken in any particular set of circumstances.

58. When Officer A responded to the cell bell from cell D4-37, he found the cellmate standing at the door, and he indicated there was a problem with Mr Mullen, who was lying at the back of the cell partly obscured by the toilet privacy screen. He radioed a code blue but, as there were two prisoners in the cell and the situation was unclear, he made the decision to wait for further support before entering the cell. Officer B arrived 22 seconds after Officer A, and when Officer A saw further

officers approaching, he and Officer B went into the cell. They went in 46 seconds after Officer B first attended the cell. Officer A told the investigator that he understood the need for a dynamic risk assessment and in other circumstances he might have gone into the cell at an earlier point.

59. We consider that Officer A made a reasonable decision in line with the staff information notice and the information before him at the time.

Clinical care

60. The clinical reviewer found that Mr Mullen's care at Leeds was of the required standard and was equivalent to that he could have expected to receive in the community. The clinical reviewer made one recommendation that was not directly delated to Mr Mullen's death.

Inquest

61. An inquest into Mr Mullen's death held between 22 and 26 June 2026, concluded that his cause of his death was suicide by hanging. The inquest jury found that the outcome might have been different if information known to the police about Mr Mullen's mental health had been known to the prison.

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