Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charles Pratt, a prisoner at HMP Leeds, on 9 January 2025

A report by the Prisons and Probation Ombudsman

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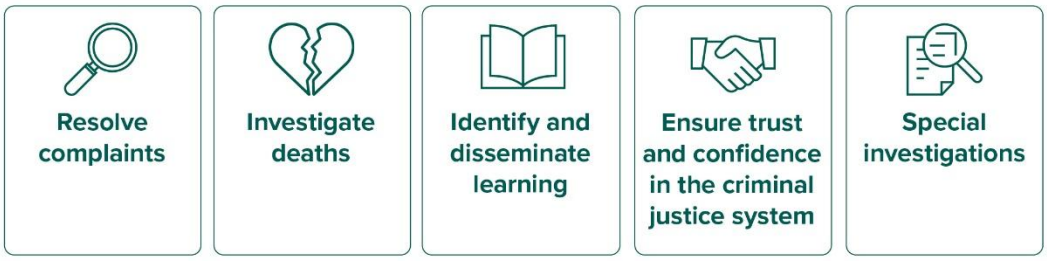
OUR VISION

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

1. 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.

2. 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.

3. In August 2024, Mr Charles Pratt was sentenced to 27 years in prison for sexual offences. He died in hospital of pneumonia, caused by Influenza A infection (a viral infection more commonly known as flu), on 9 January 2025, while a prisoner at HMP Leeds. He was 72 years old. We offer our condolences to those who knew him.

4. NHS England commissioned an independent clinical reviewer, to review Mr Pratt's clinical care at Leeds.

5. The clinical reviewer concluded that the clinical care Mr Pratt received at Leeds was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She noted that Mr Pratt declined a flu vaccine when healthcare staff offered it to him in October 2024. She found that a long-term conditions nurse had reviewed him, and healthcare staff had appropriately moved him to a social care wing due to his mobility issues. However, she also noted areas for improvement. These include recording information more clearly in the medical records, completing falls risks assessments, and referring prisoners with co-morbidities (more than one health condition) to multi-professional complex case meetings.

6. The clinical reviewer made five recommendations not related to Mr Pratt's' death, which did not impact her assessment of equivalence, that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Pratt's care. She found no non-clinical issues of concern directly impacting Mr Pratts' death and requiring a recommendation.

Governor and Head of Healthcare to note

8. On 30 November 2024, before taking Mr Pratt to hospital, prison staff completed an escort risk assessment, and a senior manager authorised restraining him with a single cuff (one wrist handcuffed to an officer's wrist). When Mr Pratt was due to be X-rayed, the prison officers with him in hospital asked permission from a prison manager to change the restraint to an escort chain (a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer). Mr Pratt then went into cardiac arrest, so staff removed the restraints but reapplied them when his condition stabilised. He remained restrained until 4 December. Although one senior manager authorised removing the restraints, another authorised reapplying them until Mr Pratt was discharged on 6 December and communication with the escorting officers was sub-optimal.

9. The prison told the investigator that they have introduced a quality assurance process to ensure escort staff receive updated risk assessments without delay following a change in the restraint level.

10. We are concerned that staff restrained Mr Pratt during his hospital admission despite his age, health condition and reduced mobility but are pleased note that he was not restrained when he returned to hospital on 7 January 2025 and so do not make a recommendation. The Governor and Head of Healthcare will want to consider the learning from this case.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman **September 2025**

Inquest

12. At the inquest held on the 28 January 2025, the Coroner concluded that Mr Pratt died from natural causes.

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