

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Brook, a prisoner at HMP Leeds, on 24 April 2024

A report by the Prisons and Probation Ombudsman

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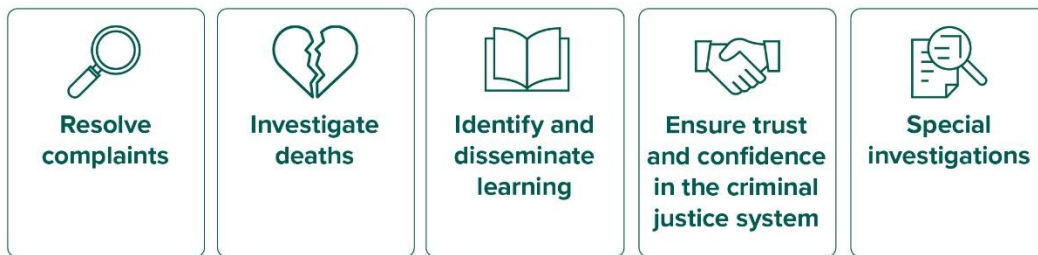
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OUR VISION

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



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Summary

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. Mr Peter Brook died in hospital of heart disease on 24 April 2024, while a prisoner at HMP Leeds. He was 70 years old. We offer our condolences to Mr Brook's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Brook received at Leeds was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer found that readings taken at Mr Brook's reception health screen, which showed he had high blood pressure and a fast heart rate, were not followed up.
5. We found that the decision to restrain Mr Brook when he was taken to hospital was not justified given his age, health and poor mobility. We bring this to the Governor's attention.

Recommendations

- The Head of Healthcare should ensure patients with hypertension and/or tachycardia (fast heart rate) identified at the reception screen are followed up appropriately in line with NICE NG57 guidelines.

The Investigation Process

6. HMPPS notified us of Mr Brook's death on 24 April 2024.
7. NHS England commissioned an independent clinical reviewer to review Mr Brook's clinical care at Leeds.
8. The PPO investigator investigated the non-clinical issues relating to Mr Brook's care.
9. The Ombudsman's office contacted Mr Brook's sister to explain the investigation and to ask if she had any matters, she wanted us to consider. She had one question relating to Mr Brook's medical care. She asked why he had died when he was about to be discharged from hospital. This has been addressed within the clinical reviewer's report.
10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. Following representations made by Practice Plus Group, the clinical reviewer removed the second recommendation from his report. The revised clinical review report is annexed to this report. Practice Plus Group provided an action plan addressing the remaining recommendation, which is also annexed to this report.
11. We sent a copy of our initial report to Mr Brook's sister. She raised some further queries which have been addressed in separate correspondence.

Previous deaths at HMP Leeds

12. Mr Brook was the 27th prisoner to die at Leeds since April 2021. Of the previous deaths, 11 were from natural causes, 13 were self-inflicted, one was drug related and one is awaiting classification.
13. We have previously made recommendations to Leeds on the use of restraints during transfers to hospital. We were told that the prison had delivered training to authorising managers on the appropriate use of restraints.

Key Events

14. On 2 April 2024, Mr Peter Brook was sentenced to 20 months imprisonment for sexual offences. He was sent to HMP Leeds.
15. A nurse completed Mr Brook's reception health screen. She took his blood pressure and pulse rate and noted that he had hypertensive (high) blood pressure, and a tachycardic (fast) pulse rate. No plan was made with Mr Brook to take follow up readings or to review these medical observations. The nurse also noted that Mr Brook had type 2 diabetes. He told the nurse that this was diet controlled and that he was not on any prescribed medication.
16. Mr Brook had his secondary health screen on 8 April. The nurse did not retake Mr Brook's blood pressure or pulse rate.
17. On 16 April, Mr Brook told his key worker that he felt unwell. He said he was finding it difficult getting up and down the stairs to his cell, and that he thought he was going to collapse. He also said he had not eaten for a few days. The key worker noticed that Mr Brook had an appointment slip to see a GP and told him to raise these issues with the GP.
18. On 18 April, a nurse saw Mr Brook on the landing and noticed that he appeared pale and short of breath. The nurse took medical observations which showed that Mr Brook had a high blood-sugar level. Later that day, a GP at Leeds advised that Mr Brook should be transferred to hospital for further tests. Mr Brook was taken by ambulance to Leeds General Infirmary.
19. Two officers escorted Mr Brook to hospital and they used an escort chain (a chain with a cuff at each end, one attached to the prisoner's wrist and the other attached to an officer's wrist).
20. On 19 April, while in hospital, Mr Brook had a heart attack. A prison manager agreed for the escort chain to be removed in case medical staff needed to use a defibrillator.
21. Over the next few days, Mr Brook remained in hospital and his health continued to deteriorate.
22. In the early hours of 24 April, Mr Brook was found unresponsive in his hospital bed. Hospital staff tried to resuscitate him but they were unsuccessful. At 5.05am, a doctor pronounced that Mr Brook had died.
23. As Mr Brook had not nominated a next of kin when he arrived at Leeds, the prison did not inform anyone that he was in hospital. The prison appointed a family liaison officer (FLO) at 6.30am on 24 April. The FLO contacted the police who provided details of a relative. The FLO telephoned them and broke the news of Mr Brook's death.

Post-mortem report

24. The post-mortem report concluded that Mr Brook died of ischaemic heart disease.

Inquest

25. The inquest, held on 12 December 2024, concluded that Mr Brook died from natural causes.

Findings

Clinical care

26. The clinical reviewer concluded that the care Mr Brook received at Leeds was equivalent to that which he could have expected to receive in the community. He noted that Mr Brook had limited interaction with healthcare staff. Apart from his reception and secondary health screens, he did not require any healthcare intervention until he became unwell on 18 April 2024.
27. The clinical reviewer found that Mr Brook received a thorough reception health screen and a timely second stage assessment while at Leeds. Although he was identified as having very high blood pressure and a fast heart rate at the reception screen, there were no plans made for follow up or review. The secondary screen would have been a good opportunity to review these observations and plan for follow up in line with NICE guidelines. We recommend:

The Head of Healthcare should ensure patients with hypertension and/or tachycardia (fast heart rate) identified at the reception screen are followed up appropriately in line with NICE NG57 guidelines.

Restraints, security, and escorts

28. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
29. Before Mr Brook was taken to hospital on 18 April, prison staff completed an Escort Risk Assessment (ERA). This included a medical assessment completed by healthcare staff. A nurse indicated on the form that Mr Brook had health and mobility issues that would affect his ability to escape. The nurse noted that Mr Brook was "very breathless and having difficulty with his mobility". The ERA said that Mr Brook was assessed as posing a low risk of harm to others and a low risk of escape.
30. The authorising manager indicated on the ERA that he had taken the prisoner's current health into account when assessing the level of restraint to be used. However, he added no comments. The authorising manager told the investigator that he had considered all the available risk information and referred to the Graham judgment before making the decision to follow the "Cat C protocol". (Mr Brook was a Category C prisoner and standard cuffing arrangements for Category C prisoners is a single cuff.)

31. We found that the medical information on the ERA was not fully considered by the authorising manager, who seemed to focus solely on Mr Brook's security category and made no reference to Mr Brook's health or mobility when authorising restraints. We consider that the level of restraint used on Mr Brook was not necessary or proportionate.
32. In 2022 and 2023, we made recommendations to Leeds about this issue. We were told that training had been delivered to authorising managers on the appropriate use of restraints, including application of the Graham judgment. However, this case demonstrates that managers are not always properly considering the current health and mobility of the prisoner before authorising the level of the restraint to be used. Given that we have not identified issues with the inappropriate use of restraints at Leeds since 2023, we do not make a recommendation, but bring this to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman

December 2025

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