

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kien Vuong, a prisoner at HMP Leeds, on 10 October 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



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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.

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 Kien Vuong, a Vietnamese national, died in hospital on 10 October 2024, after he was found hanging in his cell at HMP Leeds earlier that day. He was 35 years old. I offer my condolences to Mr Vuong's family and friends.

Mr Vuong was the fifth prisoner to take his own life at Leeds in 12 months and there were four more self-inflicted deaths in the four months after Mr Vuong's death.

We are satisfied that Mr Vuong gave no indication to staff that he was at imminent risk of suicide and that they could not have foreseen his actions. However, Mr Vuong spoke little English and staff did not often use an interpreter to communicate with him, so the extent to which he was supported to express any concerns is questionable.

The clinical reviewer found that the care Mr Vuong received for his physical and mental health was not of the required standard and only partially equivalent to that which he could have expected to receive in the community. There were delays in him receiving care for his physical health and he was not adequately monitored after being prescribed antidepressant medication.

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 4 May 2024, Mr Kien Vuong, a Vietnamese national, was remanded in prison charged with drug offences. He was moved to HMP Leeds on 29 May. It was his first time in prison and he had limited English.
2. When Mr Vuong arrived at Leeds, reception staff noted that he had no medical issues and no thoughts of suicide or self-harm.
3. In June, Mr Vuong completed an application to see healthcare staff as he was tired. Blood tests were requested but not completed until 22 July due to the team's workload. The results (which were abnormal) were not uploaded to Mr Vuong's record until 15 September.
4. In August, Mr Vuong's behaviour deteriorated and his mood declined. Wing staff asked a nurse to see him and she referred him to the mental health team.
5. When Mr Vuong failed to attend work on 15 August, the workshop instructor went to find him and spoke to him on the exercise yard. Mr Vuong said he was stressed and unable to urinate. The next day, a nurse carried out a mental health assessment and arranged for a urine test and a GP referral. The GP prescribed antibiotics for the urine infection and an antidepressant to help with his mood.
6. Mr Vuong passed two kidney stones on 15 September and said he felt much better. On 26 September, during a GP review, Mr Vuong said he had taken his antidepressants for one week and then stopped. He agreed to restart and a GP re-prescribed antidepressants but Mr Vuong never collected them.
7. On 8 October, Mr Vuong attended court by video link. His case was adjourned to 23 October. An officer recorded that Mr Vuong did not speak English but he seemed ok with the outcome. She recorded that she had advised him of the support available. There is no evidence she used an interpreter.
8. Mr Vuong telephoned his family in Vietnam at 12.22pm on 10 October and spoke to his mother. He talked about his financial worries and said that he did not know how long he might be in prison for and was finding everything very difficult. He was crying by the end of the call.
9. At 3.09pm, an officer went to the cell to deliver a kettle (as requested by Mr Vuong and his cellmate). He opened the door and saw Mr Vuong with a ligature around his neck, suspended from the privacy curtain near the toilet. He shouted for staff. Staff quickly came to the cell and attempted resuscitation. Ambulance paramedics arrived and transferred Mr Vuong to hospital. However, at 4.24pm on 10 October, hospital staff pronounced life extinct.
10. After Mr Vuong's death, his cellmate said that Mr Vuong had tried to hang himself in September but he did not tell staff.

Findings

11. We are satisfied that Mr Vuong gave no indication to staff that he was at imminent risk of suicide and that they could not have reasonably foreseen his actions.
12. The clinical reviewer found that the care Mr Vuong received for his physical and mental health was not of the required standard and was only partially equivalent to that which he could have expected to receive in the community. She considered that he should have been monitored after being prescribed antidepressants and referred back to the mental health team when he reported that he had stopped taking them. She noted the long delay in uploading the blood test results and that multiple appointments had been postponed due to workload. She also noted that workshop staff had helped Mr Vuong to submit healthcare applications as these forms were available only in English.
13. Prison staff rarely used a telephone interpretation service to communicate with Mr Vuong. Records show that healthcare staff did use one for some assessments but not all. Sometimes they used another prisoner to act as interpreter, which is unacceptable for medical matters. We have identified this issue in a previous investigation into the death of a foreign national prisoner at Leeds. The prison accepted that the use of interpretation services needed to improve and were taking steps to address this.

Recommendations

- The Head of Healthcare should ensure that those individuals who are newly prescribed antidepressants due to low mood are monitored and if compliance is poor, a referral to the mental health team is considered.
- The Head of Healthcare should ensure that medical investigation results are reviewed in a timely manner and that this is audited on a regular basis to ensure test results do not get delayed in being actioned.
- The Head of Healthcare should ensure that the workload of clinical teams is reviewed and that if demand is impacting on completion of reviews, that this is escalated and also a plan is put in place to deal with the increased demand.
- The Head of Healthcare should ensure that healthcare applications are available in other languages, particularly those that are spoken widely within the prison.

The Investigation Process

14. HMPPS notified us of Mr Vuong's death on 10 October 2024.
15. 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. No one responded.
16. The investigator visited Leeds on 17 October 2024. She obtained copies of relevant extracts from Mr Vuong's prison and medical records.
17. The investigator interviewed five members of staff and one prisoner at Leeds in October and December 2024.
18. NHS England commissioned an independent clinical reviewer to review Mr Vuong's clinical care at the prison and she conducted joint interviews with the investigator.
19. We informed HM Coroner for Wakefield of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
20. The Ombudsman's office contacted Mr Vuong's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
21. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. Practice Plus Group provided an action plan which is annexed to this report.

Background Information

HMP Leeds

22. 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.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Leeds was in June 2022, which was followed up by an Independent Review of Progress (IRP) inspection in July 2023. In June, inspectors noted that the prison needed to be safer and there needed to be more purposeful activities for prisoners as they reported the number of deaths at Leeds was high. They found that leaders had good oversight of the action plan drawn up following PPO investigations into these deaths, which they reviewed frequently to ensure recommendations were implemented and learning embedded. Inspectors found the number of self-harm incidents had reduced and was continuing to fall but some incidents had been very serious. They concluded that measures to improve the well-being of prisoners should be a priority.
24. The IRP reported that there had been a failure by leaders to make progress in reducing the rate of suicide at Leeds, although the prison was making progress in some areas. Leeds had the second highest rate of self-inflicted deaths of any prison in England and Wales.

Independent Monitoring Board

25. 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 31 December 2023, the IMB reported that they were concerned about the number of deaths in the prison over the past 12 months, leading to Leeds being designated a 'cluster' site. The IMB noted that prisoners could make healthcare appointments and could be seen within a few days, or more quickly if it was an emergency.
26. The IMB reported that a new key worker strategy had been planned for 2024 with the aim of a key worker remaining with a prisoner to try to build good, meaningful working relationships and continuity for prisoners.

Previous deaths at HMP Leeds

27. Mr Vuong was the 22nd prisoner to die at Leeds since October 2021. Of the previous deaths, seven were due to natural causes, 13 were self-inflicted and one was drug related.
28. Mr Vuong's death was the fifth self-inflicted death in the 12 months to October 2024. There were four further self-inflicted deaths between October 2024 and

February 2025. As a result, Leeds has been receiving additional support and monitoring from regional and national safety teams.

29. In previous investigations, we found that improvement was needed to mental health referral, assessment and treatment. We also found a lack of use of interpretation services for prisoners with limited English.

Key Events

30. On 4 May 2024, Mr Kien Vuong, a Vietnamese national, was remanded in prison, charged with drug offences. He was moved to HMP Leeds on 29 May. It was his first time in prison. He had limited English.
31. An officer carried out a reception interview with Mr Vuong and completed a first night reception form using Google Translate to help with the conversation. He noted that Mr Vuong spoke no English, was unable to read or write in English and requested help with learning. The officer noted that Mr Vuong said he did not have any current thoughts of suicide or self-harm, but had taken an overdose two years ago. He said he did not have any medical issues.
32. A nurse completed the reception health screen and noted that an interpreter was needed (but did not indicate if one was used). She noted that Mr Vuong did not have any medical conditions.
33. On 30 May, an officer completed a prisoner induction meeting with Mr Vuong. She gave him details about the prison regime including how to access education, employment and healthcare services. She made no mention of using any interpreting services for this discussion or translated documents.
34. Mr Vuong had a court hearing by video link on 31 May. His case was adjourned until 4 June. An officer noted that she was unable to communicate with Mr Vuong due to the language barrier but he seemed well.
35. The first record of staff using an official interpreting service to speak to Mr Vuong was on 5 June, when an officer used it to discuss the English language learning plan with him.
36. On 9 June, an officer completed an introductory key worker session with Mr Vuong. She noted that his cellmate acted as an interpreter for the ten-minute meeting. She told us that another officer, was Mr Vuong's allocated key worker. The other officer never had any key worker meetings with Mr Vuong.
37. On 12 June, Mr Vuong submitted an application for a healthcare appointment as he felt tired. He was referred for blood tests but these were not completed until 22 July. (Several appointments were postponed and rearranged due to the primary care team's workload.)
38. From 21 June, Mr Vuong worked in a workshop in the mornings and had English lessons in the afternoons. He received several positive entries in his record about his high quality of work, input during his English language lessons and being polite and respectful to others.
39. From August, staff noted a change in Mr Vuong's demeanour. On 14 August, an officer made a negative behaviour entry in his record. She described his behaviour as "bizarre" as he appeared under the influence of something, had pushed past staff and was unable to answer questions. At the request of wing staff, a nurse reviewed Mr Vuong. She spoke to him with the assistance of another Vietnamese prisoner. She noted he was low in mood and referred him to the primary care mental health team.

40. On 15 August, Mr Vuong did not attend the workshop so one of the specialist textile instructors, went looking for him. At interview, the instructor said that he saw Mr Vuong on the exercise yard so he went to speak to him. He asked another prisoner to act as interpreter. He was aware that Mr Vuong had a urinary tract problem and had been feeling down. He opened a Challenge, Support and Intervention Plan (CSIP) for support as he was concerned about Mr Vuong's failure to engage. The CSIP noted that the workshop instructors were concerned that Mr Vuong appeared visibly sad and withdrawn. Other Vietnamese prisoners had said he was feeling stressed and fearful about being in prison. Through the unofficial interpreter, Mr Vuong said he was overwhelmed and stressed and had some health problems. He was unable to urinate and this was making him feel down. Wing staff said that a healthcare referral had been submitted and healthcare staff were providing support.
41. On 16 August, a nurse completed a mental health assessment using Language Line (a telephone interpreting service available to all staff at Leeds). Mr Vuong told her he was worried about debt, family issues and how long he might be in prison. The nurse noted that Mr Vuong said he had no thoughts of suicide or self-harm. She made a GP referral for consideration of prescribing mirtazapine (an antidepressant).
42. An officer added an entry to Mr Vuong's CSIP on 20 August. She said that he had assaulted staff on the wing on 14 August and she thought a contributory factor might have been illicit drug use (which she said was not yet confirmed). Prison managers interviewed Mr Vuong on 23 August using another Vietnamese prisoner as interpreter. They noted that there was a language barrier and the described events were not a pattern of behaviour for him. They concluded that there was no reason to progress the matter to a CSIP.
43. On 22 August, a prison specialist textile instructor noted that Mr Vuong told her that he was unable to urinate and was in pain. She said she contacted healthcare but a nurse said she was too busy to see him. She noted she emphasised Mr Vuong needed to be seen so the nurse scheduled an appointment and arranged for a sample urine pot to be delivered to Mr Vuong so he could have a test for a possible urine infection.
44. On 29 August, a GP at Leeds completed a review and used Language Line to speak to Mr Vuong. She agreed to prescribe antibiotics for the urine infection and antidepressants.
45. On 15 September, Mr Vuong passed two kidney stones and reported to healthcare staff that he was feeling better. On the same day, Mr Vuong's blood test results (from the sample taken on 22 July) were entered on his record. These were abnormal and it was noted that this was not unexpected given his urine infection.
46. On 26 September, a GP reviewed Mr Vuong and she used Language Line to ask Mr Vuong how he was feeling about taking antidepressants. Mr Vuong said he had taken the tablets for one week and then stopped. He agreed to restart. The GP re-prescribed the antidepressants, but Mr Vuong never collected them.
47. On 8 October, an officer noted that Mr Vuong had another video link court hearing and the matter was adjourned until 23 October. She noted he could not speak English but had understood the proceedings and was ok with the outcome. She

noted that she had advised him of the support available including the Samaritans, Listeners (prisoners trained by the Samaritans) and healthcare staff.

48. Mr Vuong's cellmate told the investigator that they worked and attended English courses together. He said he heard telephone conversations when Mr Vuong rang his family and Mr Vuong had told him about his journey to the UK, how he had ended up in prison and that he was in pain and felt useless and depressed. Sometimes Mr Vuong would cry through the night and not leave his cell. They supported each other. He said that around a month earlier Mr Vuong had tried to hang himself with a rope in their cell but changed his mind as he did not want his cellmate to find him. They had not reported this to anyone. Mr Vuong was also upset due to his ongoing urinary problems. A nurse had given him medication which had helped but he was still having issues.

Events of 10 October 2024

49. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to the telephone calls and staff radio communications from 10 October. She also obtained information from Yorkshire Ambulance Service NHS Trust.
50. CCTV shows that on the morning of 10 October, Mr Vuong left his cell at 8.11am and returned to his cell at 11.27am. His cellmate returned at 11.33am. CCTV shows Mr Vuong collected his lunch and returned to his cell. An officer completed a routine roll check at 11.53am.
51. Mr Vuong telephoned his family in Vietnam at 12.22pm and the telephone call lasted for 12 minutes. The investigator arranged for the translation of his conversation from Vietnamese to English. Mr Vuong spoke to his mother. He said he was feeling homesick and tired. He said she should sell property to clear a debt. He said that he did not know how long he would be in prison for and he was finding everything very difficult. He said that he was unable to pursue establishing a nail shop business. He said that things were hard for him and he had a lot of debt. He said he was not as strong as others. He said that his trial had not begun so he was not sure the length of his sentence or possible release. He was worried that his family would face bankruptcy as even if he was released, he may not be able to secure work. He said his situation was complicated. The call ended with Mr Vuong saying that it was very hard! He was crying.
52. Mr Vuong's cellmate said he was in the cell when Mr Vuong used the telephone. At 1.54pm, Mr Vuong's cellmate left the cell to attend English classes. Mr Vuong remained in the cell. He briefly left the cell at 2.26pm and then returned and closed the cell door at 2.29pm.
53. In his police statement, an officer said just after 3.00pm, he went to the cell to give the occupants a kettle as they had requested. CCTV shows at 3.09pm, the officer opened the cell door and entered the cell. He saw Mr Vuong with a ligature around his neck, suspended from the privacy curtain rail near the toilet. He shouted for staff. A second officer was the first to arrive. She supported Mr Vuong as the officer cut the ligature and they placed him on the floor. They started CPR. Within seconds, a third officer entered the cell and she radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff in the control room immediately called an ambulance at 3.09pm.

More prison staff attended and four healthcare staff also went to the cell at 3.12pm to assist with the resuscitation attempt with the aid of emergency equipment that had been brought to the cell.

54. Paramedics arrived at 3.20pm. They were joined by a critical care paramedic and a second ambulance crew. Paramedics transferred Mr Vuong to hospital. However, Mr Vuong did not regain consciousness and at 4.24pm, hospital staff pronounced life extinct.

Contact with Mr Vuong's family

55. The prison appointed an officer as the family liaison officer (FLO) when Mr Vuong was found unresponsive in his cell and a second officer as her deputy.
56. The FLO noted that she had tried to call the number listed for Mr Vuong's family in Vietnam, but the number did not connect. She contacted Mr Vuong's solicitor to see if they had any family contact information. They did not. She contacted the Vietnamese Embassy and was waiting for a response.
57. On 15 October, the deputy FLO tried the number for Mr Vuong's family listed on his prison telephone account and used a telephone interpreting service to speak to Mr Vuong's mother. Mr Vuong's mother said she already knew her son had died as another Vietnamese prisoner had contacted her. The deputy offered her condolences and support.
58. The Prison Service contributed towards the cost of Mr Vuong's funeral in line with national policy and arranged for his ashes to be sent to his family in Vietnam.

Support for prisoners and staff

59. When Mr Vuong was found unresponsive in his cell, a senior manager went to break the news face to face with his cellmate and arranged for his cellmate to be relocated.
60. 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 and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
61. After Mr Vuong's death, a prison 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.
62. The prison posted notices informing other prisoners of Mr Vuong'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 Vuong's death. They also deployed Listeners to the wing to offer support to prisoners when Mr Vuong died.

Post-mortem report

63. The post-mortem report gave Mr Vuong's cause of death as hanging.

Findings

Assessment and management of Mr Vuong's risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in force at the time of Mr Vuong's death, listed risk factors and potential triggers for suicide and self-harm. It said all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. (The PSI has been superseded by the Prison Safety Policy Framework though ACCT procedures remain broadly the same.)
65. Mr Vuong did not have any significant risk factors for suicide and self-harm when he arrived at Leeds, beyond the fact it was his first time in prison. There would have been no reason to start ACCT procedures at that time.
66. A few months later, Mr Vuong's behaviour deteriorated and his mood declined. He was reviewed by the mental health team and prescribed antidepressants. However, he said he had no thoughts of suicide or self-harm and gave no indication that he was at risk. Again, we consider that there would have been no need for ACCT procedures.
67. According to his cellmate, Mr Vuong tried to hang himself in September. Clearly this should have triggered ACCT procedures had staff known about it. However, Mr Vuong's cellmate said they told no one. We are satisfied that, in the context of Mr Vuong's limited ability to communicate with staff, he gave no indication to staff that he was at imminent risk of suicide in the lead up to his death and that staff could not have foreseen his actions.

Clinical care

68. The clinical reviewer concluded that Mr Vuong's physical and mental health care was not of the required standard and was only partially equivalent to that which he could have expected to receive in the community.

Mental health

69. On 29 August, a GP prescribed antidepressants to Mr Vuong for low mood. When the GP reviewed him on 26 September, Mr Vuong said he had taken the antidepressants for only one week and then stopped. The clinical reviewer considered that the GP should have referred Mr Vuong back to the mental health team for short-term monitoring of the antidepressant effects and of Mr Vuong's mood. We recommend:

The Head of Healthcare should ensure that those individuals who are newly prescribed antidepressants due to low mood are monitored and if compliance is poor, a referral to the mental health team should be considered.

70. Mr Vuong never collected the antidepressants prescribed on 26 September. This was not identified at the time. The Head of Healthcare told the clinical reviewer that there was now a new process in place where the healthcare team reviewed any non-collection of medication and decided on next steps.

Physical health

71. The clinical reviewer noted that there had been a long delay in entering Mr Vuong's blood test results from 22 July, which were not entered until 15 September, and that appointments had been moved several times due to workload. She also noted that workshop staff had helped Mr Vuong to complete healthcare applications as the forms were available only in English. We recommend:

The Head of Healthcare should ensure that medical investigation results are reviewed in a timely manner and that this is audited on a regular basis to ensure test results do not get delayed in being actioned.

The Head of Healthcare should ensure that the workload of clinical teams is reviewed and that if demand is impacting on completion of reviews, that this is escalated and also a plan is put in place to deal with the increased demand.

The Head of Healthcare should ensure that healthcare applications are available in other languages, particularly those that are spoken widely within the prison.

Staff interactions with Mr Vuong and lack of use of interpreting services

72. There is no evidence in the records that interpreting services were used to communicate with Mr Vuong when he arrived at Leeds and for his first month there. After that they were used sporadically.
73. Mr Vuong attended court by video link on 31 May and 8 October. Both times, the officer recorded that Mr Vuong could not communicate in English and there is no evidence that an interpreter was used.
74. Prisoners should be reviewed after a court appearance, including one by video link, to check that there has been no change in their risk of suicide and self-harm. The prison told us that all prisoners receive a welfare check following a video link court appearance. There is a printed sheet available with questions in Vietnamese, which includes, "What happened in court today?" and "Are you OK?". While Mr Vuong could have maybe answered "Yes" or "No" in English to some of the questions, we are not confident that he could have communicated effectively in the absence of an interpreter. The value of the printed sheet for non-English speaking prisoners is therefore questionable.
75. The officer who conducted Mr Vuong's key worker session also did not use a telephone interpreting service but instead relied on his cellmate to interpret. This is not acceptable.
76. There was evidence that some healthcare staff used Language Line to communicate with Mr Vuong but not all. There were occasions where another prisoner was used as interpreter. This is not appropriate for health matters.

77. We identified the lack of use of interpreting services in a previous investigation into the death of a foreign national at Leeds. The Head of Safety and Equalities and the Head of Healthcare accepted that use of interpretation services could be improved. They said that work was ongoing to increase the number of telephone handsets available to staff and to improve guidance on using the telephone interpretation service.
78. The Head of Safety and Equalities provided an update to the investigator in May 2025. He said that all prisoner facing areas had been issued with handsets to access the Language Line services. However, the current arrangements for access were not ideal as there were issues with real-time access, excessive wait times, frequent disconnections, unavailable languages and no access outside of normal hours.
79. The issue of staff's failure to use formal interpreting services is not singular to Leeds. We have raised our concerns in a number of investigations across a number of prisons. HMPPS has commissioned a trial of a handheld translation device and Leeds has requested to be included in the pilot. Leeds has provided confirmation that they are working to improve staff use of interpreting services. As a result, we do not make a recommendation on this occasion, but the Governor must maintain focus on this area and demonstrate progress is being made.

Key worker scheme

80. HMPPS's Manage the Custodial Sentence Policy Framework requires that all prisoners should be allocated a prison officer key worker to engage, motivate and support them throughout their time in custody. Key workers should spend an average of 45 minutes each week per prisoner on key work duties, including individual time with each prisoner. This did not happen for Mr Vuong who had only one ten-minute key worker session during his five months at Leeds.
81. Prison managers at Leeds told us that from 12 May 2024, their focus had been on ensuring that new arrivals had a key worker session within five days. Mr Vuong had his session on day 11. Managers said staffing levels had impacted on their ability to meet the five-day target.
82. Managers said that the intention was for prisoners to have a key worker session every 28 days. A group of 20 staff were now being utilised as key workers when on duty and they each had 56 prisoners. The plan was to give them 42 hours a month to see each prisoner on their caseload. However, staffing levels and redeployments meant that it was a challenge to consistently deliver key work. The Governor should be aiming for full delivery as soon as possible so that all prisoners can benefit from key work.

Governor to Note

83. There was a delay in the prison FLO contacting Mr Vuong's family in Vietnam. It is unclear why it took five days to check the number listed on Mr Vuong's telephone account. We bring this to the Governor's attention.

Good practice

84. The two workshop instructors were proactive in trying to help Mr Vuong. They were the first to identify Mr Vuong's deteriorating physical and mental health and alerted staff. They also helped Mr Vuong to complete healthcare applications. We wanted to highlight the help and support they provided to Mr Vuong.

Inquest

85. At the inquest, held on 14 April 2026, the jury concluded that Mr Vuong died by suicide.

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