Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Davies, a prisoner at HMP Leeds, on 10 June 2021

A report by the Prisons and Probation Ombudsman

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

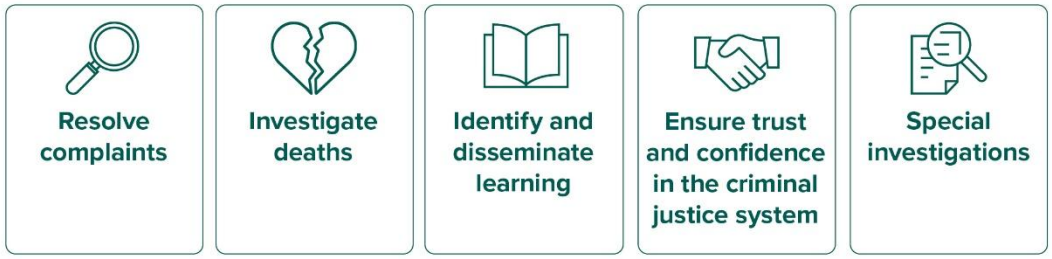
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Gary Davies was found hanged in his cell at HMP Leeds on 10 June 2021. He was 63 years old. I offer my condolences to his family and friends.

Mr Davies had been at Leeds for just four months when he took his life. During his short time in prison, Mr Davies sought minimal support from staff for his mental health and revealed nothing to suggest his intentions to take his life. However, the restricted regime in place during the pandemic and the limited nature of the wellbeing checks that took place, meant that staff were less able to detect signs of low mood or other problems.

I am concerned that when Mr Davies was initially found hanging in his cell, there was a short delay before staff provided medical assistance.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

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Summary

Events

1. On 1 February 2021, Mr Gary Davies was remanded to HMP Leeds, charged with supplying controlled drugs and conspiring to possess prohibited ammunition. He had a history of substance misuse.

2. When Mr Davies arrived at Leeds, he said he was devastated to be back in prison for the first time in 30 years. Staff assessed that he was not at risk of suicide or self-harm and he was offered support for his substance misuse.

3. Mr Davies appeared to settle. On 23 February, he moved to the Incentivised Substance-Free Living (ISFL) wing. He had contact with healthcare staff and the substance misuse team. At the end of April, he said he was stressed on the ISFL wing and wanted to move, but he gave no indication that he had thoughts of self-harm. On 11 May, he said he was settled on the ISFL wing and no longer wanted to move.

4. At approximately 8.00am on 10 June, an officer found Mr Davies hanging in his cell. The officer radioed a medical emergency code blue. Other staff responded quickly and tried to resuscitate Mr Davies until paramedics arrived and took over. They were unable to resuscitate him and pronounced that he had died.

Findings

5. Although we think that staff should have considered opening suicide and self-harm procedures when Mr Davies first arrived at Leeds, we are satisfied that they could not reasonably have been expected to foresee that Mr Davies was at risk of suicide at the time of his death.

6. However, the restricted pandemic regime and the limited nature of the welfare checks made on Mr Davies meant that staff were not well placed to identify any deterioration in his mood or other problems.

7. The officer who discovered Mr Davies hanging in his cell, did not provide immediate medical assistance. This led to a delay of one and a half minutes while the officer waited for colleagues to assist. Although early intervention might not have changed the outcome for Mr Davies, it could be critical in another emergency.

8. The clinical reviewer concluded that the clinical care that Mr Davies received at Leeds was of a good standard and at least equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff are given clear guidance about the purposes of welfare calls and checks, how to conduct them and how to follow up any concerns raised.

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.

- The Governor should share a copy of this report with Officer B and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Investigation Process

9. 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 obtained copies of relevant extracts from Mr Davies' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Davies' clinical care at the prison.

12. The investigator and clinical reviewer jointly interviewed seven members of staff at Leeds. The interviews were completed by video and telephone because of the restrictions imposed as a result of the COVID-19 pandemic.

13. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

14. We contacted Mr Davies' family to explain the investigation. Mr Davies' brother wanted to know the full circumstances leading to Mr Davies' death and whether he had received his letters. We have tried to address his concerns in this report and in separate correspondence.

15. Mr Davies' family received a copy of the initial report. They did not make any comments.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies in the report. All recommendations were accepted.

Background Information

HMP Leeds

17. HMP Leeds is a local prison holding a maximum of 1,218 prisoners who are on remand or have been convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group (previously known as Care UK) provides healthcare services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

18. The most recent full inspection of HMP Leeds was in November/December 2019. Inspectors found the levels of self-harm were significantly higher than at other local prisons and since their last inspection. They noted that ACCT case management was not good enough despite PPO recommendations and the safeguarding strategy was not effective in addressing risks or the needs of individuals in crisis. Inspectors found key work was developing well. They noted that all prisoners had a key worker, and staff and prisoners were reasonably positive about its value.

19. HMIP carried out a short scrutiny visit to Leeds in June 2020 to assess how well they had responded to the COVID-19 pandemic. Inspectors reported that the prison was calm and well-ordered, despite the severe restrictions to the regime. The prison had experienced a significant outbreak of the virus but had controlled it effectively. Prisoners reported being kept well informed. Inspectors noted that the key worker scheme at Leeds was targeted at those prisoners who had been identified as most vulnerable during the pandemic

Independent Monitoring Board

20. 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 annual report for the year ending December 2020, the IMB reported that the restricted regime brought about by the exceptional circumstances of the pandemic had meant fewer incidents of debt, bullying and violence among prisoners and staff reported that prisoners had generally felt safer.

Previous deaths at HMP Leeds

21. Mr Davies was the seventh prisoner to take his life at Leeds since June 2019. The prison has accepted and agreed to implement our previous recommendations about mental health provision, the key working scheme, suicide and self-harm monitoring and the emergency response.

Key worker scheme

22. HMPPS's policy document, Managing the Custodial Sentence Policy Framework, set out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual

introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

- All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.

- All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner. Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance, so it is important that they are sufficient.

23. Key work was formally suspended across the prison estate on 24 March 2020 due to the pandemic. In May 2020, the Prison Service issued an Exceptional Delivery Model for key work. This provided a framework of principles within which prisons must operate but left it to individual prisons to decide how to deliver key work safely during the pandemic. The Exceptional Delivery Model recommended that key work should continue for certain identified priority prisoner groups, including those prisoners at risk of suicide or self-harm and those who were clinically extremely vulnerable to COVID-19 and had been advised to shield.

Key Events

HMP Leeds

24. On 1 February 2021, Mr Gary Davies was remanded to HMP Leeds, charged with supplying controlled drugs and conspiring to possess prohibited ammunition.

25. The Person Escort Record (PER), which accompanied Mr Davies to Leeds, noted that he had a history of substance misuse (heroin and alcohol) and that he had been prescribed diazepam in police custody for alcohol withdrawal symptoms. Mr Davies arrived with two bottles of prescribed methadone (a heroin substitute).

26. An Operational Support Grade (OSG) started the reception screening process when Mr Davies arrived.

27. A nurse and a Healthcare Assistant (HCA) completed Mr Davies' initial and secondary health screens at the same time due to the COVID-19 restrictions in place. Mr Davies said that he was devastated that he had returned to prison after 30 years. He said that he had depression and anxiety, and that he had no history of attempted suicide or self-harm but had had suicidal thoughts in the previous 12 months. He said that he had seen a counsellor in the community which had been helpful. The nurse noted that Mr Davies would benefit from engaging with the mental health team.

28. Mr Davies also said he had a history of substance misuse. He tested positive for methadone, cocaine, cannabinoids and opiates. The nurse recorded that Mr Davies engaged well during his health screen and that she had no concerns about him. She referred him to the substance misuse team but did not refer him to the mental health team. We tried to interview the nurse, but she was unavailable.

29. Afterwards, an officer completed Mr Davies' reception and first night interview and Mr Davies was taken to the induction unit on D Wing where he was required to isolate for two weeks as one of the COVID-19 requirements.

30. Leeds was unable to provide Mr Davies' induction paperwork. We were told that Mr Davies' induction would have been conducted at his cell door due to the isolation regime. We were also told that prison staff would have given Mr Davies information about available support, regime activities, safety, healthcare and substance misuse.

31. On 2 February, a prison GP saw Mr Davies who said he was waiting for a hospital appointment for a knee operation. He said he usually drank ten units of alcohol daily and smoked heroin in the community but had been prescribed methadone. He had been given chlordiazepoxide (to treat alcohol withdrawal) while in police custody. The GP noted that Mr Davies showed no signs of alcohol withdrawal. He noted that the substance misuse team would monitor him and refer him back to the GP if he developed symptoms. He was unable to confirm the dose of chlordiazepoxide given to Mr Davies in police custody. He prescribed methadone and lansoprazole (used to treat indigestion and to prevent stomach ulcers).

32. A Probation Service Officer completed Mr Davies' basic custody screen by contacting him on his in-cell phone. She recorded information about his housing,

accommodation on release, finance and family concerns. Mr Davies told her that he had been prescribed methadone for 36 years and was prescribed a 50ml dose in the community. He was concerned that he had only been prescribed 15ml in custody. He said that he had alcohol misuse issues but had not been prescribed any detoxification medication, though he said that the substance misuse team were monitoring him.

33. That morning, the prison pharmacist confirmed with Mr Davies' community pharmacist that he was prescribed 50ml of methadone. This information was passed to a substance misuse assistant.

34. Due to the COVID-19 pandemic and isolation rules, the Probation Service Officer was asked to complete a wellbeing check with each prisoner by in-cell phone once a week. She phoned Mr Davies and completed his wellbeing check that day. She answered Mr Davies' questions about the prison regime and visits.

35. That evening, a nurse recorded that Mr Davies had complained that he was experiencing withdrawal symptoms and wanted an increased methadone dose. She noted that Mr Davies displayed no overt signs of withdrawal and put in place a care plan.

36. On 3 February, a substance misuse worker saw Mr Davies after reviewing his referral to the team. Mr Davies confirmed that he had a history of alcohol and crack cocaine misuse and said he had started using substances at the age of 22. She provided drug intervention advice. Mr Davies said that he had no suicidal or self-harm thoughts and was aware that he could speak to staff if he needed support.

37. On 9 February, an officer completed Mr Davies' second basic custody screen by in-cell phone.

38. On 10 February, a prison GP conducted a telephone consultation with Mr Davies about his knee. Mr Davies was offered and accepted a steroid injection. (The GP saw Mr Davies again on 10 March. Mr Davies declined the steroid injection and said that he did not feel that he needed it.)

39. On 15 February, Mr Davies was moved to C Wing (a standard wing) as he had completed his initial two weeks of isolation.

40. On 23 February, the substance misuse worker saw Mr Davies and reviewed his care plan. Mr Davies wanted to live on A Wing, the prison's Incentivised Substance-Free Living (ISFL) wing which supports those with substance misuse issues. He was moved there later that day.

41. An officer completed a welfare call to Mr Davies on 28 February and recorded that he raised no concerns. Another officer completed a key worker session with Mr Davies on 30 March. He told her that he had settled at Leeds, had a good support network and wanted to live drug-free.

42. On 16 April, the substance misuse worker saw Mr Davies and reviewed his substance misuse care plan. He had completed his in-cell relapse prevention work. He wanted to move to another wing as he felt the ISFL wing posed too much temptation for him. He did not explain more. She said that she would try to get him moved to C Wing. Mr Davies said that he was still taking his methadone.

43. On 27 April, an officer phoned Mr Davies and completed his wellbeing check. Mr Davies said that he had felt stressed since his move to the ISFL wing and wanted to return to C Wing as he was settled there and felt it had more "consistency". He also said he had received some bad news about his father's health. The officer reminded Mr Davies that the chaplaincy offered support.

44. On 11 May, the substance misuse worker completed a 13-week care plan and substance misuse review with Mr Davies. She reported that Mr Davies was settled and despite his earlier concerns, he now wanted to remain on the ISFL wing. He wanted to remain drug-free, denied being bullied on the wing and said he had no concerns or thoughts of self-harm. He talked about his father's illness. Mr Davies had completed all his intervention exercises.

45. An officer completed further wellbeing checks by phone on 5 May, 8 May, 17 May, 25 May and 1 June. She recorded each time, "No issues or concerns raised regarding welfare".

46. On 5 June, Officer A, the night patrol officer recorded just after midnight, "Checked on during night state, no issues".

47. On 9 June, CCTV footage shows that Mr Davies collected his evening meal at around 5.18pm.

48. The prison told the investigator that Mr Davies had used his in-cell phone to call his brother on the evening of 9 June. During this call, Mr Davies had become agitated, upset and had said that his head was "battered". Mr Davies also told his brother that he was worried that he may lose his home on release from prison. (Staff were not aware of this call until after Mr Davies' death.)

49. That evening and night, prison staff raised no concerns about Mr Davies. CCTV footage shows that Officer A, the night patrol officer, checked on Mr Davies at 9.30pm. She raised no concerns about him.

Events on 10 June

50. On the morning of 10 June, CCTV footage shows that Officer A conducted the morning roll check and looked into Mr Davies' cell at 6.13am. She said that Mr Davies appeared asleep and that she had no concerns about him. She described the cell as well-lit due to the early rising of the sun.

51. At 8.02am, Officer B unlocked Mr Davies' cell door and shouted inside to ask if he wanted to go out for exercise. Mr Davies did not respond. The officer noticed that Mr Davies was not in his bed and so he opened the door completely and entered the cell. He saw that Mr Davies was hanging from a ligature, made from a bed sheet tied to the toilet window bars. He immediately stepped out of the cell and radioed a medical emergency code blue, indicating a life-threatening situation. The control room log recorded that this occurred at 8.02am and that they called an ambulance.

52. CCTV footage shows that Officer B remained outside the cell door for nearly one and a half minutes until Officer C arrived. The two officers entered the cell together. Officer C supported Mr Davies' body while Officer B used his cut-down knife to cut

the ligature. They then lowered Mr Davies' body to the floor. Officer C checked Mr Davies for signs of life but found none.

53. A nurse and a HCA were working nearby when the emergency code was called. The nurse arrived at Mr Davies' cell at 8.03am, 15 seconds after the officers had entered the cell. She took over Mr Davies' care and immediately started cardiopulmonary resuscitation (CPR). The HCA had gone to collect the emergency medical bag and arrived at the scene at 8.06am with another nurse. The nurses continued resuscitation attempts with the assistance of medical equipment. A Custodial Manager (CM) also arrived at Mr Davies' cell

54. Healthcare staff continued CPR until paramedics arrived at 8.14am and took over. At 8.45am, the paramedics stopped resuscitation attempts and pronounced Mr Davies' death.

55. A suicide letter, written by Mr Davies, was found in his cell. It said that he was sorry, he loved his family but that he could not handle the "pressure" he was getting in prison and that he had no fight left in him and could not take any more.

Contact with Mr Davies' family

56. After Mr Davies died, an officer was appointed as the prison's family liaison officer. Due to the COVID-19 restrictions in place, the officer phoned Mr Davies' next of kin, his brother, at 9.15am and broke the news of Mr Davies' death.

57. The prison provided ongoing support and contributed towards the costs of Mr Davies' funeral in line with national instructions.

Support for prisoners and staff

58. After Mr Davies' death, the duty governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Davies' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Davies' death.

Post-mortem report

59. The post-mortem report concluded that Mr Davies died from hanging. No toxicology tests were conducted.

Information received after Mr Davies' death

60. The prison told us that Mr Davies had received a letter from his brother on 23 April, saying that Mr Davies had been sent £800. The prison confirmed that a balance of approximately £494 remained in his account. Mr Davies' records showed that he had periodically spent money on canteen (purchases from the prison shop) and no money had been sent from his account. Many of the items that Mr Davies had bought (such as a radio, DVD player and two pairs of trainers) were found in his cell after he died.

Findings

Identifying the risk of suicide and self-harm

61. Mr Davies left a note saying he could not handle the "pressure" he was getting in prison anymore. He did not say whether the pressure was mental or whether it took a physical form (such as being bullied).

62. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and the procedures (known as ACCT) that staff must follow when they identify a prisoner at risk.

63. Mr Davies arrived at Leeds with a number of these risks: he had a significant history of substance misuse - he had been prescribed methadone for 36 years - and he had not been in prison for over 30 years and said he was devastated to be back in prison. He also said he was suffering from depression and anxiety, that he had had suicidal thoughts in the last 12 months and that he had received counselling in the community.

64. In these circumstances we are surprised that a nurse did not refer Mr Davies to the mental health team and consider opening ACCT procedures or make a record of why she decided it was unnecessary. (We were unable to interview the nurse and therefore could not ask her.) However, Mr Davies appears to have settled at Leeds after this, so if ACCT procedures had been opened, it is likely that they would soon have been closed.

Staff engagement with prisoners

65. On the basis of the information available to them we do not consider that staff had any reason to consider that Mr Davies was at imminent risk of suicide at the time of his death. However, the information available was limited. The restricted pandemic regime meant that prisoners spent less time out of their cells and staff therefore had less time to engage with them or to observe how they interacted with other prisoners. As a result, signs of deteriorating mood or of problems with other prisoners that might normally have been picked up, may have been missed.

66. At Leeds prisoners who did not meet the criteria for key work sessions during the pandemic received a weekly welfare call on their in-cell phone. During his four months at Leeds, Mr Davies received one key worker session (on 30 March) and 14 well-being checks conducted by phone, nine of which were conducted by an officer. He also received occasional welfare checks carried out by night patrol staff, the last of which took place on 5 June.

67. The records of the earlier welfare calls were fairly detailed and provided evidence that staff had had a discussion with Mr Davies. However, after recording on 27 April that Mr Davies was feeling stressed about his wing move, an officer simply recorded that Mr Davies had raised no issues at the remaining five welfare calls between 5 May and 1 June. The officer told us that this was a typical pattern for all prisoners, not just Mr Davies. She said that initially prisoners had a lot of issues to

raise, but that as the pandemic and the restricted regime continued, they tended to have much less to say.

68. We acknowledge the significant pressures faced at Leeds around the time of Mr Davies' death because of low staff numbers, and therefore their inability to conduct weekly key worker sessions. We recognise that Mr Davies did not fall into the category of a priority prisoner for key worker sessions and that he received regular welfare calls. However, while the wellbeing phone calls are good practice, they are a poor substitute for the face-to-face interaction and opportunity to get to know prisoners that the key worker scheme is designed to provide. The officer had never met Mr Davies in person and told us that, although he had told her on 27 April that he was feeling stressed on the ISFL wing, she did not know much about what happened on the wing in relation to drug misuse and therefore why Mr Davies might be feeling stressed there.

69. We do not criticise the officer, who was doing the job she had been asked to do and who gave us other examples of how her welfare calls had contributed to prisoners' wellbeing. However, we consider that the staff making welfare calls and checks need to be given clear guidance about their purpose: is it simply to ask prisoners if they have any issues to raise or is to give prisoners the opportunity to talk generally (for example, about their family or what they are doing to keep occupied) in an attempt to assess their mood and their concerns.

70. We also consider that staff making the calls need guidance on what to do in response to any concerns that are raised. For example, when Mr Davies said he was feeling stressed, we think this should have been explored and followed up.

71. We recognise that many prisoners may not choose to open up during a phone call with an officer they have never met, and we cannot say that such calls would necessarily have made any difference to the outcome for Mr Davies. Nevertheless, we make the following recommendation:

The Governor should ensure that staff are given clear guidance about the purposes of welfare calls and checks, how to conduct them and how to follow up any concerns raised.

Bullying

72. We do not know what Mr Davies meant when he wrote that he could not handle the "pressure" he was getting in prison and that he was too old to fight any more, or when he said he was feeling stressed on the ISFL wing. We have considered whether there was any evidence that he was being bullied.

73. Mr Davies' brother sent him £800 on 23 April and, when Mr Davies died seven weeks later, he had approximately £500 in his account. The records show that Mr Davies had made a number of purchases while he was in prison and that these items were found in his cell after his death. If Mr Davies had been being bullied for money (for example, to pay drugs debts) we would have expected that he would no longer have had money in his account and that he would no longer have had expensive possessions such as a DVD player or trainers in his cell.

74. This suggests he was not being bullied for money, although it is still possible he was being bullied in other ways (for example, into trading his prescribed medications). There is insufficient evidence for us to be able to reach a conclusion. This is the kind of issue that staff would have been better place to spot prior to the pandemic.

Clinical care

75. The clinical reviewer noted that overall, the healthcare that Mr Davies received was of a good standard and was equivalent to that which he could have expected to receive in the wider community.

Mental health

76. During his reception screen on 1 February, Mr Davies said that he had received counselling in the community before coming into prison. He had never tried to harm himself but had admitted to having suicidal thoughts a year earlier, although he had not acted on these. He had no other known history in relation to his mental health. Although the reception nurse noted that Mr Davies would benefit from being referred to the mental health team, we found no evidence that this happened. However, the clinical reviewer notes that Mr Davies was regularly seen by the substance misuse team who reviewed his risks. When Mr Davies attended his last review with the substance misuse team on 13 May, he denied any thoughts of suicide or self-harm.

Emergency response

77. When Officer B discovered Mr Davies hanged in his cell, he immediately left the cell and raised the alarm. However, it is evident from CCTV footage that the officer did not then return to the cell to cut Mr Davies down and provide medical assistance, and instead waited for colleagues to assist. This took approximately one and a half minutes. This is a concern as there was no evidence to indicate that he believed Mr Davies posed a high risk or that he was concerned for his personal safety. The officer told the investigator that he had learned in training that officers should not enter a cell on their own. He said that he panicked when he saw Mr Davies hanging.

78. We recognise that it can be difficult for staff in challenging circumstances to make instant decisions but when there is a potentially life-threatening situation, it is critical that staff act quickly and exercise sound judgement. In emergencies, delays can have a significant impact on a person's chance of survival and early intervention may change the outcome. We make the following recommendations:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.

The Governor should share a copy of this report with Officer B and arrange for a senior manager to discuss the Ombudsman's findings with him.

Inquest

79. The Coroner's inquest held on 31 January 2023 determined the medical cause of death to be hanging. The jury returned a narrative conclusion, stating that Mr Davies died as a result of suicide.

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

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

T I 020 7633 4100