

**Investigation into the circumstances surrounding the death of
a man at HMP Leeds on
26 August 2004**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

July 2006

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Leeds on 26 August 2004. He was 33 years old and serving a four year sentence for attempted robbery.

I offer sincere condolences to this man's family and friends in their sad loss. A key objective of all my investigations is to make sure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. In this case, the investigation team was able to meet with the man's family who expressed some concerns which they wanted to be investigated. I am most grateful to them for agreeing to hold this meeting at what must have been a very difficult and distressing time.

As Ombudsman, I took over responsibility for investigating deaths in prison custody in April 2004. Under transitional arrangements in force until 30 November 2004, a senior investigating officer (SIO) was appointed by the Prison Service to report to me. In this case, the SIO was a Principal Officer and member of the Prison Service's (now NOMS's) Safer Custody Group. He was assisted by a Principal Officer from HMP Lindholme. I am grateful to them for all the work that they have done and their report is of a high standard. One of my colleagues oversaw the investigation.

I am grateful for all the assistance that the investigation team received from the Governor of Leeds, and his staff, including the establishment's Liaison Officer.

I am also grateful to the doctor appointed by Leeds West Primary Care Trust, for the helpful clinical review he conducted into the medical care provided to the man.

This report makes a total of six recommendations.

**STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN**

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OMBUDSMAN'S SUMMARY

INTRODUCTION

The man was born in March 1971, and was 33 years old when he died at HMP Leeds on 26 August 2004.

The man had been convicted of various offences dating back to 1990. Sentences had included Community Service Orders, Supervision Orders, a Community Rehabilitation Order and financial penalties.

The man was previously in prison custody in 2001. On 7 May 2001, he was located in Leeds and the first reception health screen noted that he had a history of depression and had previously taken an overdose and that he also had a history of cocaine use. He was placed on a Suicide and Self Harm Warning form (F2052SH). On 15 June 2001, he returned to Leeds after a court appearance but the reception health screen did not note any previous psychiatric history. He was described as 'a happy soul.' On 3 August 2001, he was transferred to HMP Lindholme. He said that he was feeling suicidal and an F2052SH was opened; this was closed on 7 August 2001. It was then noted that he had a history of depression for 12 years. On 12 September 2001, the man arrived at HMP Hatfield, and the prison noted his previous history of cocaine use and that he had been under the care of a Community Psychiatric Nurse (CPN) for depression and had previously been on a F2052SH. On 18 October 2001, when he was again transferred to Lindholme, he was described as being tearful in reception. The man's history of self harm was noted as was his suicide attempt. The current risk of self harm or suicide was considered to be low and he was not placed on an F2052SH. Finally, on 1 November 2001, he arrived at HMP Ranby and it was noted that he had taken an overdose 12 years previously and that he was a 'polydrug' user. This information was available when the man was subsequently remanded to HMP Leeds in January 2004.

The man was remanded in custody on 24 January 2004 by Bradford Magistrates' Court, charged with attempted robbery, to appear at Bradford Crown Court on 2 February. During the First Reception Health Screen no issues with drug misuse were noted, and he was not identified as being at risk of suicide or self harm. The man described himself as a 'social drinker.'

On 2 February, the man appeared before Bradford Crown Court where he was remanded to appear again on 15 March. He returned to custody at Leeds. On 18 February, a pre-sentence report was completed and was included in his core record. That report identified that the man's offences of violence and aggressive behaviour were triggered by heavy alcohol use with an observation that he would benefit from access to alcohol and drug counselling services if sent to prison. It is not clear when the prison received this report. The man was never referred to any counselling service for drug or alcohol problems while in Leeds. On 15 March, he appeared before Bradford Crown Court and was convicted but not sentenced. He again returned to

Leeds. On 26 April, the man appeared before Bradford Crown Court where he was sentenced to four years imprisonment. He returned to Leeds and was located in cell D4-27.

On 27 April, the man was relocated to cell F4-46 and then to F5-46 as he smashed up his cell furniture and TV. He said that he did that because he did not want to share a cell with an Asian prisoner. A cell sharing risk assessment was then completed by an officer to decide whether the man presented a risk to others in prison. The man's risk was assessed as low to medium. He was not seen as an immediate risk, but the situation would need to be reviewed regularly. At 6.30pm, an officer tried to enter the cell and was obstructed by the man. Other staff attended and the man was apparently restrained using approved control and restraint techniques (C&R). The man was then escorted to the segregation unit unaided. On 28 April, his Incentive and Earned Privilege (IEP) status was reviewed and he was reduced from standard to basic regime.

The adjudication hearing was heard on 29 April for the incidents committed on 27 April. He pleaded guilty to both offences and he received four days cellular confinement for obstructing an officer and for smashing his cell furniture, 50% of his earnings were stopped for 28 days and he lost canteen and TV privileges for 14 days. The man was compliant whilst in the Segregation Unit.

On 2 May, the man returned to normal location, on basic regime in cell C2-04. Another cell sharing risk assessment was carried out, this time by a Senior Officer. The man's risk was assessed as low, and he was considered suitable for multi-cell location. At 2.20pm, he smashed the windows of his cell after being told that he would be staying on C Wing. He was returned to the Segregation Unit, totally compliant, having surrendered to the two members of the C&R Team. At the following adjudication hearing, he pleaded guilty and he lost canteen privileges for 14 days and 50% of his earnings were stopped for 14 days.

On 25 May, the man refused to be relocated on normal location. The adjudication hearing was heard on 26 May. He pleaded guilty and received seven days cellular confinement, seven days loss of canteen facilities, association, tobacco and TV.

On 26 May, the man's IEP level was to be reviewed to upgrade to standard, but this did not take place because he refused again to be located on normal location pending a transfer to HMP Ranby on 1 June 2004. The man was again placed on report and he remained on basic regime. The adjudication hearing was heard on 27 May and he pleaded guilty. He received a caution.

On 28 May, the man asked to speak to a specific officer. He told that officer that he had refused to relocate to ordinary location and he had smashed his cell because of his medical condition. He said that he suffered from depression and panic attacks but had not told the prison healthcare staff about this. The officer made an entry in the man's Core Record F2052A: 'This man has asked to speak to me today. He has told me that he refused to

leave the Seg Unit and return to the wings. Indeed the reason he smashed up in the first place is down to a medical condition. He claims to suffer from depression and panic attacks, but states that he has not informed the prison healthcare of this. I have now done so, and enquiries are being made with his outside GP.' There is no evidence in his Medical Record that the man's GP was consulted. He eventually saw a locum GP on 11 August.

On 1 June, he was relocated to cell D2-07 from the Segregation Unit. A further cell sharing risk assessment was undertaken and the man's risk was assessed as high, he was now not considered suitable for multi-cell location.

On 14 June, an entry in the man's Medical Record shows that he was fit for transfer. The entry does not mention where he was to be transferred to.

On 11 August, he saw the locum GP. The man was described as being depressed for the previous year, and that he suffered from insomnia and was irritable although not suicidal. The man was to be reviewed in three to five weeks. He was prescribed medication to help, Lofepamine 70mg and Zopiclone 7.5mg. There was no objective assessment of the level of depression and there appears to have been no referral made to the Mental Health Inreach team.

A Senior Officer said in interview that the man had approached him a number of weeks before 25 August when he was told that he was going to be transferred to Lindholme, which he was not happy about. The Senior Officer said he telephoned the Observation, Classification and Allocation (OCA) Department to ask them to see the man about his transfer to Lindholme. The man was seen by the department on 25 August, and a Senior Officer in the OCA Department told the man that he was going to be transferred to Lindholme on 26 August. The man objected to being transferred to Lindholme and told the Senior Officer from OCA that he would not be able to handle being on the spurs there. The man had generally indicated that he preferred to be on his own in a single cell. He had previously been in Lindholme from 3 August 2001 to 12 September 2001 and from 18 October 2001 to 1 November 2001 and records show that he had been located in D and E Wings during that time (initially he had been in a two man cell and then in a single cell). He also spent some time in the Segregation Unit there. His prison records from Lindholme also confirm that he had been on an F2052SH between 3 and 7 August 2001.

The Senior Officer in OCA told the man that she could not see any valid reason why he could not go to Lindholme and that he would be going to Lindholme on 26 August. He was seen by a nurse who agreed that the man was fit for transfer. The nurse made an entry in his Medical Record, 'states he will be unable to handle spurs at Lindholme, does not cope well with sharing a cell. Currently on treatment for depression.' She then stamped the Medical Record with a standard stamp - 'Fit for transfer. No outside hospital appointments. Not suicidal or depressed' - despite the fact the man was on medication for depression which she had noted.

The man returned to the Wing and told a Senior Officer there that he was not happy with OCA's decision to transfer him to Lindholme and he reiterated his concerns about the move. That Senior Officer then spoke to the Senior Officer in OCA about the transfer issue. The Senior Officer in OCA told the Senior Officer on the wing that OCA had not received his call which he had made to them a number of weeks earlier. After some discussion they decided that they should consult the Duty Governor. The Senior Officer on the wing then spoke to the Duty Governor and explained the situation and the Duty Governor in turn spoke to the Senior Officer in OCA. The Senior Officer in OCA told the Duty Governor that the man had not given her any valid reason why he should not be transferred to Lindholme and he had been medically assessed by a nurse. This was considered by the Duty Governor and he decided, on the basis of the information from the Senior Officer in OCA, that he could see no reason to reverse the decision to transfer the man to Lindholme. He did not review the man's paperwork.

The Senior Officer on the wing told the man that OCA would not reverse their decision and he would be going to Lindholme the next day. The man replied that he was sorry but he would fight staff in the morning. The Senior Officer on the wing made an entry in the Wing Observation Book, 'Staff are to be advised that the man in D207 will be going to Lindholme on 26 August. He does not want to go and has informed me that he will fight staff. Be careful when opening cell. He has resigned himself to going in a body belt.' He also left a note for the Principal Officer in the morning. The information was not entered in the Duty Governor's log.

The Senior Officer on the wing communicated this information to a Principal Officer (PO) and the Orderly Officer and to the Duty Governor. He also left a note on another Principal Officer's (D Wing Principal Officer) keys for the following morning.

In interview, the Senior Officer in OCA explained that due to the length of the man's sentence he could not stay in Leeds. The options available to her were to transfer the man to either HMP Moorland, HMP Wealstun or Lindholme. The man said he would transfer to Everthorpe or Wealstun but not to Lindholme. HMP Ranby and HMP Everthorpe were no longer accepting prisoners from Leeds. The Senior Officer in OCA and the Duty Governor did not consider Wealstun appropriate due to the man's adjudication history and their knowledge of Wealstun's regime (Leeds were having a lot of problems with Wealstun accepting prisoners). HMP Moorland was ruled out as it was considered this would have been a backwards step for the man. Lindholme was therefore considered the most suitable prison for him.

EVENTS AFTER THE MAN'S DEATH

On the morning of 26 August at 6.10am, the man was found hanging in his cell by an officer who immediately called for assistance. Another officer arrived and raised the alarm by calling the Emergency Control Room (ECR) using the first officer's radio. A nurse arrived within seconds of the alarm call and the second officer opened the cell for her to go in. The nurse called for the ligature scissors to cut the man down from the ligature, which was attached to the cell window. On examining the man, the nurse determined that he had died and said, 'there's no need for scissors, he's obviously dead'. She then left the cell.

A Senior Officer, the Night Orderly Officer, had also attended and asked everyone to leave and treated it as a crime scene. A few moments later, another nurse arrived and the night orderly officer asked him to check if the man had a pulse. That nurse entered the cell with him and checked for a pulse. He told the night orderly officer that there was no pulse and they both left the cell. The night orderly officer told the Emergency Control Room that they had a death in custody and an officer rang the emergency services and was told, incorrectly, that an ambulance was not needed and that he should contact the coroner.

At 8.10am, a Detective Inspector Police Liaison Officer arrived on the Wing. At 8.15am, all staff who had been involved attended a briefing session, a 'hot debrief.'

At 8.20am, a doctor arrived at the cell and joined the Detective Inspector and Police Liaison Officer. All three entered the cell, leaving three minutes later.

At 9.05am, two Senior Scene of Crime Officers (SOCOs) arrived, entering the cell five minutes later. Over the next 50 minutes they gathered evidence and took photographs. At 10.00, the Detective Inspector, Police Liaison Officer, and the two SOCO's, cut the man's body down from the ligature. This was nearly four hours after he had been discovered hanging.

A governor and one of the prison's chaplains, visited the man's mother and broke the sad news of her son's death at around 10.30am.

All F2052SH forms closed in the previous three weeks were reviewed to ensure that the man's death had not adversely affected those other prisoners. Reviews were also carried out on all prisoners on open F2052SH forms in the prison.

FAMILY CONCERNS

The man's mother was concerned that her son had been trying to talk to a member of staff for a number of weeks about being transferred to Lindholme. She was also concerned that his objections to being transferred were not taken seriously by the prison and no action was taken by them in response. She was also worried that her son had been prescribed antidepressants but was going to be transferred before the medication had a chance to take effect. Finally, she did not initially receive all of her son's property from Leeds, that is a new pair of trainers, a radio cassette player, house keys and clothing which he had worn when he was initially taken into custody.

One of my Family Liaison Officers, my supervising investigator, and the Coroner's Officer all contacted the prison on several occasions on behalf of the man's mother about the property. They were all assured that the property would be returned to the man's mother. Eventually she wrote a letter to the Governing Governor on 27 January 2005 about the property. Following this, the property was returned to her. This delay in returning the man's property caused his mother unnecessary stress and upset.

CLINICAL REVIEW

In accordance with procedures agreed with the NHS, the investigation team advised Leeds West Primary Care Trust (PCT) of the man's death. The PCT then arranged to undertake a clinical review of the healthcare provided to him while at Leeds. A doctor from Leeds West PCT, undertook the review. His report is attached as an annex. It makes a number of recommendations which are in line with my own conclusions and views.

The clinical review also highlights an issue in respect of healthcare staff completing paperwork. In particular, the review says that the Medical Record was not well organised, forms were not always fully completed with no indication why, and they were not always numbered in sequence. Entries were often difficult to read with illegible signatures.

CONSIDERATION AND CONCLUSIONS

When the man arrived in Leeds, healthcare issues relating to previous custodial periods do not appear to have been referred to by healthcare staff. During the first reception health screen, the man said he only drank socially but the pre-sentence report noted that this crime was drink related and during his previous sentence in 2001 he said he was a polydrug user. The pre-sentence report specifically recommended that the man should be put on a drug and alcohol programme if he received a custodial sentence. The man was not put on any drug or alcohol programme. Even if the pre-sentence report was not available on reception, it should have been communicated to healthcare and reviewed when it was available. A system must be put in place to ensure that pre-sentence reports are copied to healthcare in a timely manner.

Recommendation:

Healthcare staff should ensure that reference is taken of previous custodial records and issues communicated by external health and social care agencies at the earliest opportunity.

Whilst the fact of a prisoner being prescribed anti-depressants does not in itself preclude transfer, it is important that the sending prison is confident that the receiving establishment has appropriate healthcare provision to meet the prisoner's clinical needs. I do not feel that the assessment of the man's refusal to transfer to Lindholme was correctly handled. I am particularly concerned about the failure of the nurse appropriately to assess the man's fitness for transfer. I note that she 'stamped' his medical record with a standard stamp, in direct contradiction of known medical information. Furthermore, this resulted in the governor and OCA being given misinformation on which to base their decision making. However, I suspect this may be symptomatic of a collective failing from all staff involved with assessing 'fitness for transfer'.

Recommendation:

A training needs analysis should be carried out to identify training needs for healthcare staff in all the reception processes.

Recommendation:

A review of the use of stamps in medical records should be undertaken to ensure prisoners are assessed according to clinical need and do not have their medical record 'stamped' as a matter of course.

On entering the cell, staff did not cut the man down. Whilst it is acceptable to make a reasoned clinical decision not to resuscitate, it is difficult to see how a full clinical assessment to support such a decision can be made of a patient who remains suspended by a ligature. On discovering an apparent death, staff should support the prisoner, cut the ligature and place the prisoner onto a flat solid surface before checking for signs of life and, if appropriate, attempting resuscitation.

I note that the man was in fact left hanging for four hours after the discovery of his body. While conscious of the need to protect potential evidence, I do not believe this was respectful.

Recommendation:

The Governor should remind staff of their need to comply with PSO 2710, Chapter 2 on discovering an apparent death.

All of this man's property should have been returned to his mother immediately. It should not have been necessary for her to have written a letter to the Governor to request the return of the rest of his property.

Recommendation:

The Governor should remind staff that all property belonging to a deceased prisoner should be returned to the appropriate person in a timely and sensitive manner.

The clinical review has highlighted issues regarding healthcare staff completing paperwork. Specifically, the review says that the man's Medical Record was not well organised and forms were not always fully completed with no indication why. Forms were not always numbered in sequence and entries were often difficult to read with illegible signatures.

Recommendation:

Healthcare staff should be reminded of the need for clear, concise and contemporaneous record keeping in accordance with the Nursing and Midwifery Council (NMC) guidelines for records and record keeping. A clinical audit system must be put in place to monitor compliance with standards for records and record keeping.

RECOMMENDATIONS:

OPERATIONAL:

Recommendation:

The Governor should remind staff of their need to comply with PSO 2710, Chapter 2 on discovering an apparent death.

Recommendation:

The Governor should remind staff that all property belonging to a deceased prisoner should be returned to the appropriate person in a timely and sensitive manner.

HEALTHCARE:

Recommendation:

A training needs analysis should be carried out to identify training needs for healthcare staff in all the reception processes.

Recommendation:

Healthcare staff should ensure that reference is taken of previous custodial records and issues communicated by external health and social care agencies at the earliest opportunity.

Recommendation:

A review of the use of stamps in medical records should be undertaken to ensure prisoners are assessed according to clinical need and do not have their medical record 'stamped' as a matter of course.

Recommendation:

Health care staff should be reminded of the need for clear, concise and contemporaneous record keeping in accordance with the NMC guidelines for records and record keeping. A clinical audit system must be put in place to monitor compliance with standards for records and record keeping.

The Prison Service has accepted all the recommendations.

