

**Investigation into the circumstances surrounding the death of
a man at the local hospital in Coventry,
on 9 October 2004, whilst a prisoner at HMP Leicester**

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

June 2006

This is the report of an investigation into the death of a man at the local hospital in Coventry, on 9 October 2004, whilst a prisoner at HMP Leicester. The man, who was 64, was serving a four month sentence when he was attacked by his cell mate. He sustained the injuries from which he later died.

The investigation was carried out under interim arrangements agreed between my office and the Prison Service and that were in place during 2004. I am very grateful to the Governor of HMP & YOI Moorland, and her colleague, for conducting the investigation on my behalf. One of my investigators has edited her report into its current shape.

A clinical review was undertaken by the Eastern Leicester Primary Care Trust. I must also extend my thanks to the Governor of HMP Leicester, and his staff for their help during this investigation.

This report has been delayed as a result of the prolonged police investigation - initially into the murder of the man and then by a secondary investigation into other matters conducted at the request of the Crown Prosecution Service. Although any delay is to be regretted, it must be understood that the police have primacy in respect of all matters relating to a death in custody.

This report reveals a number of serious failings at HMP Leicester. I make eight recommendations in addition to those in the clinical review.

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Summary

1. The man who is the subject of this report was received into custody at HMP Leicester on 10 September 2004 after receiving a sentence of four months for aggravated assault and failure to surrender to bail.
2. He was located in the First Night Centre from 10 September until his relocation on 13 September to cell L3-028. He remained there for 10 days; during that period he shared the cell with eight different prisoners. There were no concerns noted and his shared cell risk assessment was low.
3. At 2.11 pm on 23 September 2004, he was again relocated to cell L3-055. The purpose of the cell move is unknown. He was joined at 2.39 pm by a cell mate. At 9.35 pm, the man was located in the Healthcare Centre after allegedly being assaulted by his cell mate.
4. The healthcare nurse contacted the prison doctor, who arrived at the prison at 9.45 pm. He assessed and gave treatment to the man and arrangements were made to attend the local hospital on the morning of the following day (24 September).
5. At 7.30 am on 24 September, the Acting Healthcare Manager, arrived at the prison, having been briefed by the nurse on the admission of the man to the Healthcare Centre the previous evening. He and his colleague, went directly to observe the man. The acting healthcare manager quickly formed the opinion that the man required urgent medical attention, and an ambulance was organised to attend the prison. Arrangements were put in place for staff to escort the man to Leicester Royal Infirmary. The prison had been informed that it would take approximately half an hour for the ambulance to arrive.
6. During this period, the Senior Medical Officer carried out further observations on the man and determined that he needed to go to hospital immediately. An ambulance was requested to attend as a medical emergency.
7. At 8.30 am, the man was transferred to the local hospital where he was admitted. On the afternoon of 24 September, the man was transferred to Walgrave Hospital Intensive Care Unit, where he remained until his death at 1.38 am on 9 October 2004.
8. The man's cell mate was convicted of his murder at Leicester Crown Court on 24 November 2005. He was sentenced to life imprisonment with a minimum term of 14 years.
9. The investigation reveals that, on two occasions prior to the attack on the man, Cell Sharing Risk Assessments on his cell mate should have been re-evaluated. It seems probable that, had this been done, he would have been assessed as high risk and required to occupy a single

cell. Another indicator of his cell mate's risk was not shared with discipline staff.

10. The response to the discovery of the man's injuries was not handled well. I am particularly concerned by the indications that the cell mate was enabled to clean up what was the scene of a serious crime.

Investigation Methodology

11. This investigation was conducted under the transitional arrangements agreed between the Prisons and Probation Ombudsman's Office and HM Prison Service and in place between April and December 2004. The investigation was carried out by the Governor of HMP & YOI Moorland and was coordinated by one of my investigators.
12. The investigation was formally opened at HMP Leicester on 12 October 2004. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation.
13. The investigation was put on hold to allow the police to conduct their enquiries. This included both the murder investigation and a secondary investigation. As a result, my investigation did not begin in earnest until May 2005. My investigator liaised throughout with the prison, the police, and representatives of the Crown Prosecution Service.
14. The Eastern Leicester Primary Care Trust was asked to carry out a Clinical Review of the medical care that the man received whilst he was in custody.
15. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
16. One of my family liaison officers contacted the man's sister. She did not wish to meet, but it was agreed that further contact would be made when the draft report was ready.

The subject of this report

17. The man, who was 64 when he was killed, was born and raised in Derby. He moved to Coventry for the purpose of employment. He obtained City and Guilds qualifications and worked in industry for most of his life.
18. Prior to his reception into HMP Leicester, the man had lived in rented accommodation, was retired and in receipt of state pension.
19. He was a diabetic that was medicine controlled. His pre-sentence report suggests that, although he consumed a moderate level of alcohol when he went out, his mental and physical health was considered to be good.
20. The man had previous convictions dating back to 1965. Most of his offences were dealt with by way of financial penalties. In 2000, he had received a police caution for pursuing a course of conduct which amounted to harassment. This involved a dispute with neighbours.
21. Prior to his conviction and four month sentence for aggravated assault and failure to surrender to bail in September 2004, the man was subject to a 24 month Community Rehabilitation Order (CRO) imposed by Coventry Magistrates in March 2004.

The man's family

22. The man told prison staff that he had no living family or close friends. He had no next of kin listed on prison records. Following his death, it was decided to advertise in the area for any relations.
23. On Monday 11 October, two days after his death, the prison chaplain was contacted by his niece. She gave the contact details for her mother, the man's sister.
24. The chaplain telephoned the man's niece on 13 October to offer support, and visited her and her mother on 16 October.
25. On 7 December 2004, the chaplain conducted the man's funeral at Derby Crematorium. At the invitation of the family, the chaplain went back to the house afterwards.

The cell mate

26. The cell mate was born in 1977 in Leicester. He was 27 years old at the time he murdered the man. He has a longstanding history of substance abuse and violence.
27. Although the cell mate had had contact with mental health services in the past, his last contact was in December 2002. At the time he killed the man, he was assessed as having no mental health concerns.
28. The Mental Health In-Reach assessor, stated in a report that there was no clinical indication for psychotropic medication, no self-harm ideation evident and the cell mate had not been on any prescribed medication for 2½ years. He had fallen out with his GP who he claimed had refused to give him any medication.
29. The cell mate was angry at being remanded instead of sectioned to Bradgate Mental Health Unit and losing his disability benefit. He had been barred from Bradgate Mental Health Unit due to his violent behaviour.
30. The cell mate was convicted of the murder at Leicester Crown Court on 24 November 2005. He was sentenced to life imprisonment. A minimum term of 14 years was set by the trial judge.

HMP Leicester

31. HMP Leicester is an early Victorian prison. The main living accommodation is a long rectangular cell block with four landings. Most cells have two occupants, although some cells have been converted into dormitories. In cell electricity is currently being installed in all living units. Whilst this investigation was taking place, some alteration work and electrification was taking place in the First Night Centre.
32. The prison was last inspected by Her Majesty's Chief Inspector of Prisons in July 2003 when it was noted that Leicester was three months into a five year action plan.
33. Since April 2004, there have been six deaths at Leicester, four apparently self inflicted, one from natural causes and one homicide. This man's death was the third since April 2004. Action plans drawn up as the result of the investigations into two of the deaths prior to this death have not yet been completed. Insufficient healthcare staff was cited by the healthcare manager as the main reason for the delay in implementation.
34. In the Prison Performance Ratings for the first quarter 2005/06, Leicester rated level 3 of 4. That level is defined as 'Meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime'.
35. Poor completion of cell sharing risk assessment forms has been highlighted in previous reports into deaths at Leicester.

Events prior to the man's death

36. On 10 September 2004 at Leicester Crown Court, the subject of this report was sentenced to four months imprisonment for an offence of aggravated assault.
37. The Court was concerned that this was the second offence of this type that he had committed in a very short period of time. The Court sentenced him to four months imprisonment and sent him to HMP Leicester.
38. His Cell Sharing Risk Assessment assessed him as a low risk, defined as no current indication/evidence of risk, suitable for multi-cell occupation. Comments made by the nurse on reception were 'prisoner has not expressed any suicidal or self harm thoughts during interviews'.
39. The nurse also completed a First Reception Health Screen document. In it, the man stated that he was an occasional drinker and smoked 10 cigarettes a day. He also indicated that he was a diabetic on medication, although he could not name it.
40. The man was located in cell B2-008 where he was issued with a smokers pack. He was offered a telephone call to contact a friend or member of his family which he declined. The following day, the man was visited by the prison chaplain.
41. On 13 September, an entry was made in the man's F2052A Prisoner Personal Record System, to say he had been seen by Probation, although with no summary of the interview. The same day he was re-located to cell L3-028. There is no explanation why.
42. The cell mate arrived at HMP Leicester from Leicester Crown Court on 17 September and was assessed as 'medium' risk for cell sharing. This meant: no immediate risk, but situation will need to be reviewed regularly.
43. On 18 September, the cell mate received a 'strike' [a warning under the prison's incentives scheme] for misuse of his cell bell. He wrote on his response that 'he nearly lost it' with his previous cellmate and almost hit him. Due to him threatening violence, his Cell Sharing Cell Risk Assessment should have been reviewed. This did not occur.
44. The following day, the cell mate was moved from B2 landing to the De-tox landing as he was suspected of being a cell thief.
45. On 20 September, the cell mate set fire to newspaper and pushed it under his door onto the landing. He refused to stop when instructed.

He was removed from his cell under restraint and located in the Segregation Unit.

46. On 22 September, the cell mate appeared on a Governor's Adjudication charged under Prison Rule 51, para 16, for burning large amounts of paper. He received a punishment of 14 days stoppage of pay at 75%, 14 days loss of canteen/use of private cash, and 14 days loss of association. He was moved to cell L2-16. Again, no Cell Sharing Risk Assessment took place. It seems likely he would have been assessed as 'high' risk. If so, this would have resulted in him being required to occupy a single cell.
47. Leicester's anti-bullying strategy states that the Cell Sharing Risk Assessment document remains live and must be re-visited whenever a prisoner is relocated.
48. At 11.00 am on 23 September, the cell mate was interviewed by a nurse. The cell mate made it clear he wanted to be moved from prison to the Bradgate Unit at Glenfield Hospital, an institution from which he was barred due to his violent behaviour. When the nurse said it was unlikely he would be sectioned under the Mental Health Act when he appeared at court, he replied, 'Do I have to go out and kill someone in order to do so?' A Security Information Report was not completed or submitted until after the events of 23/24 September, nor did the nurse inform any other staff member or make any comments in either the cell mate's Wing File or in any Observation Book.
49. At 2.11pm on 23 September, the subject of this report was moved to cell L3-055. At 2.39 pm, the cell mate was moved in with him.

Events surrounding the man's death

50. At 9.30 pm on 23 September, the man pressed the emergency cell bell. An officer attended cell L3-055 and observed that the man was lying on his bed. He had a swollen right eye and blood was streaming down onto his T-shirt. The cell mate was sitting cross-legged on his bed reading his book.
51. The man said to the officer, 'I've been hit, get me out of here.' The officer asked the cell mate what he had been doing, but he cannot recollect his response. The officer went to the bottom of the stairs and told the Senior Officer that the man had been assaulted. The officer called two other officers. I conclude that the initial officer left the scene of an alleged assault to call for staff when in fact he should have used his radio or whistle to call for staff assistance.
52. The officers returned to the cell and entered it. The man was standing at the back of the cell. Two officers sat him down in a chair. One officer got a wet towel from inside the cell and began to mop up some blood from the man's face.
53. A short while later, the man was trying to put some trousers on but appeared to be struggling and seemed to have lost his coordination. The staff were unsure whether this was normal for him or not. They assisted him to put his trousers on.
54. An officer put some toiletries and legal papers in a bag. While he was doing this, the cell mate - who had been lying on his bed throughout - asked for some hot water. That request was denied. The cell mate also said, 'I only hit him twice', and something like, 'he bounced off the wall.'
55. The cell was checked for weapons but none was found. The cell had blood on the bed and floor but showed no other signs of disturbance.
56. It is usual for prisoners to be asked whether they wish the police to be involved following an apparent assault, or whether they are content for the prison to deal with the matter internally. That would probably have happened the following morning, but by that time the man had been sent to hospital. Leicester does not have a specific contingency plan for dealing with in-cell assaults.
57. Staff helped the man out of his cell and had to support him as he seemed unsteady on his feet. He was walked to the Healthcare Centre where the nurse was on duty. An officer took five photographs of the man's injuries. The nurse called for a doctor to see the injured man.
58. During this time the man had said, 'He's mad, he just kept hitting me.'

59. The cell mate remained unsupervised in the cell which had a certain amount of fresh blood on the floor and elsewhere. That gave him the opportunity to clean up the 'crime scene'.
60. After approximately 30 minutes, the doctor arrived. The man had swelling around his right eye and two cuts adjacent to the eye. He also had a bruise on his chest. The doctor administered six sutures to his cuts and arranged for x-rays to be taken the following day.
61. The doctor gave instructions to the nurse to 'keep a close eye' on the man, that he should be placed into a shared cell, and that the doctor should be contacted should the man's condition deteriorate. The man was placed into a three man dormitory, with two other prisoners. The healthcare unit was staffed that night by the nurse and an officer support grade (OSG). (Observation into the dormitory cell is through a hatch in the door.)
62. At 11.15 pm, one of the other prisoners reported that the man had fallen whilst trying to get out of bed. A security officer happened to be in the healthcare unit at the time and the nurse was able to enter the dormitory and carry out an examination. The man was complaining of leg and back pain. The nurse found no evidence of new injury or of any injuries to his legs or back. The nurse decided to place the man's mattress on the floor to try to prevent further falls, and gave him a bottle to use as a toilet facility.
63. The nurse maintained observations regularly during the night but did not enter the dormitory again. She observed that the man was restless and saw that he got up on two more occasions. He was more unsteady on his feet than before, although she was able to converse with him.
64. At 6.00 am on 24 September, the nurse saw that the man was more settled and took the opportunity to write up her notes. At 7.25 am, when she checked him again, she saw that he was rolling off his mattress. She asked why he was doing that and he replied, "I can't help it miss." At 7.30 am during the handover, it was found that he was difficult to rouse. The Acting Healthcare Manager requested an ambulance to transfer him to hospital. The prison was told that an ambulance would take approximately 30 minutes to arrive.
65. At the same time, the night duty SO briefed the day staff about the night's events. He gave instructions that the cell mate should be kept separate from other prisoners and the cell should be treated as a potential crime scene. At 7.45 am, cell mate was unlocked from his cell by an officer who had not been at the morning briefing, allowing him to clean his cell in preparation for his court appearance later that morning.

66. At about 8.00 am, the man was examined by a doctor who asked for the ambulance to be chased up. The ambulance arrived at 8.30 am and he was transferred to the Leicester Royal Infirmary.
67. The assault was reported to the local police at 9.00 am. When the investigating officers arrived at the prison, they found that some potential evidence had been eliminated from the cell by the cell mate.
68. At 3.00 pm that day, the man was transferred to the local hospital where he remained until his death on 9 October 2004. His death was certified at 1.38 am.

Clinical Review

69. A clinical review was undertaken by the Eastern Leicester Primary Care Trust.
70. The report highlights his concerns regarding medical observations during the patrol state (i.e. during the period when the prison is secured and staffing levels are reduced).
71. He makes seven recommendations with which I concur. The report also draws attention to two areas of good practice in relation to the man's diabetes medication and control. The recommendations are:
- a. A clear protocol for the management of head injury needs to be established that is in keeping with the NICE good practice guidance.
 - b. As part of this protocol, there needs to be clarity about the circumstances under which closer contact with the patient than that afforded by observation through the hatch is required and when re-assessment by a doctor is indicated.
 - c. The prison, in conjunction with healthcare, need to consider the practicalities of providing support for regular observations during patrol status when required. The PCT should be assured of the safety of such arrangements.
 - d. Unless it is possible to safely maintain a patient within healthcare by allowing access at sufficiently frequent intervals, then a patient with a head injury should not be kept in the prison overnight.
 - e. The competences of staff need to be formally recorded in relation to the range of issues for which they will be responsible overnight in healthcare. Healthcare needs to have clear contingencies should the competency of supervising healthcare staff not meet the healthcare needs of the patients requiring overnight observation.
 - f. There is a general issue that clinical care is provided by a variety of individuals, many of whom are not permanent staff. The issue of clear clinical leadership and overall responsibility for patient management is of particular importance. The healthcare unit in conjunction with the PCT Clinical Governance team should review this situation as a matter of urgency.
 - g. Clinical notes need to fully and appropriately capture the relevant clinical findings and observations and management plans. This is particularly important when many clinical staff may be involved in the care of a patient. The PCT and the

healthcare unit need to establish whether the issue represents a training need.

The following areas were considered to represent good practice.

- h. The man was in receipt of medication but he was not entirely sure of their purpose. This was established by contact by the healthcare unit with his GP and recent blood results in relation to both his diabetes and his raised cholesterol for which he was also on treatment were acquired.
- i. Review of both his diabetes control and a concern over possible diabetic neuropathy led to a request for urgent review by the specialist unit.

Findings and conclusions

72. On two occasions prior to the assault, Cell Sharing Risk Assessment forms should have been re-evaluated for the cell mate as required by the local strategy. Had that been done, the decision would almost certainly have been that he should occupy a single cell.
73. The nurse did not communicate the details of her interview with the cell mate on the morning of 23 September until after he had assaulted the subject of this report. Although he was in a single cell at the time of her interview, she should have foreseen the possibility of his sharing in the future and ensured that prison staff were aware of what he had said. *(The Prison Service have responded as follows: An SIR was not completed on the day as the cell mate had made no direct threat to a specific named individual. The SIR was completed the day after the assault took place on the advice of a governor. It should be noted that non-specific threats of violence are made by some prisoners when goal-directed intentions are held by them. It is not routine, due to clinical confidentiality, to communicate details of mental health assessments with non-clinical staff unless there are treatment implications or clinical findings which have a bearing on this. There were no clinical symptoms to suggest that the cell mate had mental illness problems and this would be verified by the psychiatrist a few days later when he was seen at HMP Woodhill. Given his behaviour prior to being interviewed, i.e. 2 episodes of fire setting, it would have been reasonable to assume that this would have already been flagged by landing staff and he would already have been risk assessed for single cell status. That he had no current cellmate when interviewed reinforced the impression that he had already been risk assessed by staff who had had previous dealings with him, prior to being interviewed by In-Reach.)*
74. I believe that the nurse could have communicated the *relevant* information to the wing staff without breaching clinical confidentiality. The cell mate had already shown himself to be a disruptive prisoner and was then talking about killing someone to get what he wanted. I agree that there had been two previous occasions when cell sharing risk assessments should have been completed, but were not. However, this was new information, and there is no record of a new risk assessment being considered.
75. The incident response was not handled at all well. The first officer on the scene should not have left the cell door to call for assistance, but should have used his radio or whistle. The cell mate should not have remained in the cell after the man was taken to the healthcare unit. The cell was contaminated by blood, presenting a bio-hazard, and it was believed that the cell mate was responsible for the assault. The cell mate should have been put into a single cell, his clothes bagged for evidential purposes and the original cell sealed until released either by the police or the Governor. There is currently no contingency plan for

dealing with in-cell assaults. (*The Prison Service have responded to the issue of our draft report as follows: Para 51 and para 74 - refer to the comment that 'The first officer went to the bottom of the stairs and told the Senior Officer that the man had been assaulted'. There is a conclusion that the officer was wrong to leave his post at the cell and should have called for help via the radio or by whistle. The officer has been spoken to and disputes the accuracy of this statement. He feels that in the circumstances, shouting to the Senior Officer from the top of the stairs was the quickest way of getting help. He supports this by stating that he could see the Senior Officer from his position outside the cell and felt that this meant he was near enough to call for and was away from the cell door for a matter of seconds only. He feels that to use the radio would have delayed help arriving for the injured man. It is felt that the statement made in the report regarding this matter is possibly misleading and does not reflect the layout or physical environment of HMP Leicester.*)

76. Whilst I accept that the distances involved may not have been great, I believe that the man's best interests would have been served by the officer remaining at the cell. The officer told the Police in a sworn statement and my investigating officers, that he went to the bottom of the stairs to summon help, whilst confirming that he did have a radio with him at the time.
77. If the man had been at an outside hospital, his pulse, blood pressure and other vital signs would have been checked on a regular basis. Due to the restrictions imposed during the night patrol state, it was not easy for the nurse to carry out those checks. In fact, her observations were carried out through the dormitory cell hatch over a distance of a few metres.
78. The sight lines within the ward were poor and observation of patients in the dormitory was particularly difficult. That was identified as a risk in the July 2003 report by Her Majesty's Chief Inspector of Prisons.
79. When the day shift staff came on duty, the handover briefing was not sufficiently comprehensive to encompass all of the new staff. That resulted in one member of staff being unaware of the assault and unlocking the cell mate from his cell. A simple notice placed on the cell door would have alerted staff not to open the cell door.

Recommendations

- The Governor should implement First on Scene training for staff incorporating a policy to bag and tag all items of clothing from victims and alleged perpetrators to ensure all evidence is preserved.
- The Governor should include Preservation of Evidence training in the Training Plan, paying particular attention to Senior Officers.
- The Governor should implement a policy to ensure a cell is isolated immediately after a serious incident, ensuring the cell cannot be accessed by any member of staff, before the cell is officially handed back by the police.
- The Governor should re-visit security training for non-uniformed staff, paying particular attention to the reporting of information on Security Information Reports.
- The Governor should include Shared Cell Risk Assessments on the training plan.
- The Governor, in conjunction with the PCT, should ensure that arrangements are in place for medical staff to carry out physical observations during periods of the patrol state.
- The Governor should implement procedures to improve communication between staff, especially during handover periods.