INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP LEEDS IN MARCH 2006

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

This is the report of an investigation into the circumstances of the death of a man at HMP Leeds in March 2006. The man was found hanging in his cell. He was 29 years old.

I would like to offer my personal condolences to the man's family and to all those touched by his death.

The investigation was undertaken by two of my colleagues. Both of them and I would like to thank the management and staff at Leeds for their cooperation during the course of our inquiries. I am also grateful to the clinical reviewer for his review of the man's medical care while he was in prison.

Although the man who died had not come to notice as potentially at risk of self harm, he had a number of risk factors. He had received a life sentence four months prior to his death, and it is clear that he felt great remorse but found it difficult to accept the enormity of his crime and the impact it had on so many, including himself and his children. He was keen to move to a prison where he could start the work involved in a life sentence.

The man had turned to the illegal use of medication (buprenorphine), and he subsequently went though a detoxification programme which was completed days before his death. I am concerned by the evidence suggesting the increasing misuse of buprenorphine in prison.

Like many others in prison, the man was also suffering from depression. In the final week of his life, he was subject to threats and violence from other prisoners which led to his removal to the vulnerable prisoners unit. The relationship with his partner also came to an end.

I very much regret the delay in issuing this report, and would like to apologise both to the man's family and to the Prison Service.

I make seven recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2007**

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SUMMARY

The man was remanded into custody at HMP Leeds in April 2005, charged with murder. He settled into prison life, and was well liked by staff and fellow prisoners. He was convicted in November, having pleaded guilty, and sentenced to life imprisonment with a tariff of 12 and a half years.

The man attended the 'Fathers Inside' course, where he was highly regarded and was an active member of the group. Apart from this, he had little to occupy his time and was seeking a move to a prison with better provision for life sentenced prisoners.

The man began using buprenorphine (a drug used to maintain and detoxify those addicted to opiates) illegally in prison. He subsequently underwent a detoxification regime which he completed on 19 March 2006 only days before his death. In December 2005, he also saw the doctor as he was feeling depressed and began a course of antidepressants. The clinical review conducted as part of this investigation found that the treatment and monitoring of his depression was not in line with clinical guidelines.

After several wing moves, the man moved to B wing on 10 February 2006. His nephew was on the same wing. They were very close and spent much of their time together.

As time went on, the man and/or his nephew encountered problems with other prisoners. This culminated in an allegation by both men that on 19 March they were threatened in the showers by four other prisoners with blades. The allegation of bullying was not properly investigated, but both the man and his nephew applied to be moved to the vulnerable prisoners unit under prison rule 45 (this is where a prisoner is removed from the main prison population for their own protection). The man's nephew told my investigators that the man believed he would be transferred to another prison soon.

In addition to the threats and bullying to which he was subject, the man was frustrated by the limited regime in Leeds prison - particularly seeing other prisoners come and go while he was awaiting a place elsewhere.

In the final weeks of his life, the man had a number of other problems. He was upset by the death of his grandmother. He was undergoing detoxification from buprenorphine. And he believed that the relationship with his partner was over. (She was the mother of his third child, and the link to all three of his children as she brought them all to visit.)

The man spent two days in the vulnerable prisoners unit, during which time he did not receive his medication for depression. His nephew and other prisoners told my investigators he was upset and intermittently crying about the breakdown of his relationship and concerns about seeing his children.

On the morning of 23 March, the man's cellmate went to the gym, leaving the man alone in his cell. That morning, the fabric checks (checks to the security of the cell)

were not conducted in the man's cell. When his cellmate returned to the cell, he discovered the man hanging from the window bars in the toilet cubicle. Officers and healthcare staff acted quickly and appropriately in their efforts to save him. However, they were sadly unsuccessful in their efforts and the man was pronounced dead.

My investigation has revealed the man to be a committed and loving man for whom family was the focus. He found the length of his sentence daunting, but was eager to be moved to a prison that was able to address his needs as a lifer. Due to the increase in indeterminate life sentenced prisoners, the demand for lifer places has increased, and the man was one of many men waiting for a place to become available.

The investigation has also drawn attention to other unsatisfactory aspects of the man's care while in custody. As the murder of which he was convicted was motivated by his belief that his victim was a sex offender, there are questions around his transfer to the vulnerable prisoners unit where so many other prisoners are sexual offenders. The motivation for his crime was not recorded on any of the man's cell sharing risk assessments (CSRA).

Furthermore, the man was suffering from depression but was unable to obtain his medication during his final two days on the vulnerable prisoners unit. I have concerns about the management of those suffering from depression and similar issues are highlighted in the clinical review.

THE INVESTIGATION PROCESS

1. Two of my colleagues conducted the investigation on my behalf. They visited HMP Leeds where they had a meeting with the deputy governor and were given a tour of the prison, including the cell where the man had died. My investigators met with members of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB).

2. Notices were issued to both prisoners and staff, inviting anyone who might have information relating to the man who died to make themselves known to the inquiry. One of my Family Liaison Officers contacted one of man's sisters. One of the investigators and the family liaison officer visited the family and the man's former partner

3. The investigation team interviewed prison staff and prisoners, both formally and informally. The team examined the man's prison record, medical records and a series of prison documents. They also assessed the care that he received against Prison Service standards, orders and policies.

4. A clinical review of the man's healthcare in custody was commissioned from Leeds West Primary Care Trust. They appointed the Director of Public Health to undertake this on their behalf.

5. The lead investigator contacted Her Majesty's Coroner by letter to inform him of the nature and scope of the investigation, and to request a copy of the post mortem report. A copy of this report will be sent to the Coroner to assist him with his inquiries.

HMP LEEDS

6. Leeds is one of the largest local prisons in the country. The four original wings (A, B, C and D) were built in 1847. Two further wings (E and F) were opened in 1994, together with new kitchens, a gymnasium and a healthcare centre. Leeds takes adult male prisoners remanded for trial from the West Yorkshire area, and holds convicted prisoners for periods following sentencing.

7. B Wing consists of four landings. The man was first located in a cell on the third landing, and then moved up to the fourth landing where he briefly shared a cell with his nephew. The man then moved to A wing where vulnerable prisoners (VPs) are housed.

8. Her Majesty's Chief Inspector of Prisons (HMCIP) undertook an unannounced inspection of Leeds between 30 June and 4 July 2003. The report commented that Leeds presented as a typically overcrowded and pressurised local prison. At the time of the inspection, Leeds held 60 per cent more prisoners than it was designed for, and almost all of them were two to a cell built for one. In one month, over 400 new prisoners had to be settled into the prison. Reception staff dealt with 150 prisoner movements a day in "cramped and unsuitable conditions". The average stay for a prisoner was 12 weeks.

9. Since I took on the responsibility for investigating deaths in prisons in April 2004, there have been a number of deaths in Leeds both before and after the death of this man. Many of those investigations are ongoing and several reports have yet to be issued. However, I am concerned that in this report I have to repeat some recommendations of an earlier investigation regarding cell sharing risk assessments.

KEY EVENTS

10. The man was remanded into custody on 27 April 2005. The prisoner escort record (PER) for the day before at court showed that he had previously self harmed and had been given medication from the doctor for detoxification from alcohol. This is not recorded on the PER on 27 April when the man transferred from court to the custody of HMP Leeds.

11. The man settled into Leeds and began work in the kitchens. The only concern was that he had to be kept separate from two co-defendants until his trial. The man pleaded guilty to the charge of murder. Alcohol had played a large part in his offending behaviour, as it had in the false belief that his victim was a paedophile. The man was remorseful for his crime and the impact it had on his family.

12. In November 2005, the man was sentenced to life imprisonment with a tariff of 12 and a half years. The first and the second SO spoke to the man about his sentence and discussed how he was feeling. He asked to be given a single cell while he adjusted to the news. They recorded that he had no thoughts of self harm at that time. They conducted a cell sharing risk assessment (CSRA) review which concluded he was a medium risk of harming others. They agreed him having a single cell for a few weeks, as long as population pressures allowed.

13. On 14 December, the man received a letter from his solicitors saying that they could not appeal against his sentence. The following day he went to see the prison doctor. The man had previously been prescribed tramadol to relieve pain from the stump of an amputated finger, but this had recently stopped. He insisted that tramadol was the only medication that had helped in the past. The doctor prescribed tramadol for a period of two weeks. The man told the doctor that, since he had been sentenced to life, he had low moods and crying episodes. The doctor noted in the man's clinical record that he was not suicidal and started him on trazodone, an antidepressant. The man was to be reviewed again in two weeks.

14. On 19 December, the man saw a counsellor. The counsellor described him as calm, articulate and intelligent. The man said that he still felt a degree of shock at his sentence, but was starting to accept it. He told the counsellor about his family, and said that they were a huge source of support to him. He also said that he saw his children regularly and this gave him comfort.

15. The counsellor noted that the man felt some prisoners wanted to prove themselves against him. He said he had not been threatened, but had a gut feeling about it. The man also mentioned that he wanted to transfer to another prison as soon as possible. He also talked about his offence. He felt it had been fuelled by alcohol, and that many of his personal problems had alcohol at their root. He discussed how he intended to spend his time in custody, and that he was considering studying a psychology course. They agreed to meet again, and an appointment was made for 10 January 2006.

16. The following day, the man went to see a second prison doctor. The doctor's entry in the clinical record notes that the man saw him because of a "depressive episode", did not feel the antidepressants were working, and felt drowsy in the mornings. The doctor advised him that antidepressants took time to work. The man was also noted to be suffering from eczema and was prescribed medication to treat it.

17. On 29 December, the man saw again the first prison doctor about the pain he was experiencing in his finger stump. The man said that he was not in as much pain now, but that he had given up smoking and had developed a particularly bad cough. The doctor diagnosed bronchitis and prescribed antibiotics. There was no mention of his depression or antidepressant medication during this consultation.

18. The man was not giving any cause for concern on the wing. He asked to be promoted to enhanced status (the top level) on the Incentives and Earned Privileges scheme (IEP) under which prisoners can earn additional privileges through good behaviour. Staff agreed to look into it over the next couple of weeks. He also underwent another cell sharing risk assessment review. (These reviews are necessary when someone is classified as a medium or high risk.) The review does not record if the level of risk was deemed to have changed.

19. Throughout his time in Leeds, the man received a huge amount of correspondence and regular visits from his partner and family members. He also telephoned them often. It was clear that his family was important to him and he was very much loved by them. A letter from his partner in early January mentioned her concern for the man as he seemed down when she had spoken to him on the phone. The man was worried that she would not wait for him. She reassured him and said that she would visit that weekend.

20. In January 2006, the man began a 'Fathers Inside' course. His course tutors noted that he made an excellent start to the course, that he had a good attitude and was a key contributor.

21. The man did not attend the appointment with his counsellor on 10 January. Staff reported that he said he did not want to attend. He also missed both a dental and medical appointment on 19 January.

22. On 11 January, the man underwent a mandatory drug test. This showed that he had taken buprenorphine, a drug used to treat those having an opiate addiction. The man was not prescribed this medication and opted to have the sample re-tested. (The illicit trading and use of buprenorphine in prisons has been noted in a number of recent annual reports from Independent Monitoring Boards.)

23. It would appear the man was bored in his cell, only attending the 'Fathers Inside' course. He completed the course at the end of January, the tutors

reporting that he was a strong and reliable member of the group and had played a prominent role.

24. The man often tried to stretch time out of his cell, and staff would have to ask him to hurry up. At times this led to him receiving warnings. When he asked staff about the possibility of becoming an enhanced prisoner on 19 January, they told him it would not be possible as at that time he had lost association. It is not clear from the available records why this punishment had been imposed.

25. Population pressures meant that the demand for cells had increased. The man was asked to share a cell, and on 24 January was placed on disciplinary report for refusing to move cells. He was angry about this. This further delayed the possibility of him becoming enhanced.

26. At the end of January, the man sent a letter to his children. He explained that he missed them and was sorry about how long they would be apart. However, he said he was going to make the most of the time, particularly in education, to try and make a better life once he was out of prison.

27. On 3 February, the man moved to C wing. He moved again to B wing on 10 February. My investigators were unable to ascertain the reasons behind the moves.

Time spent on B wing

28. On 12 February, the lifer officer on B wing, introduced herself to the man. Lifer officers work on each wing to support those prisoners sentenced to life imprisonment. The lifer officer explained to my investigators that unless they were preparing reports on individuals, the lifer officer may in fact not have much to do with an individual prisoner. This may explain why the man does not appear to have had much interaction with any lifer officer other than this particular one.

29. The man received a letter around this time from the Lifer Review and Recall Section in the Home Office. This explained that, taking account of his time on remand, his minimum term was 11 years and 331 days, which would expire on 27 October 2017. This meant the first opportunity the man would have to move to open conditions would be 1 October 2014.

30. On 13 February, staff undertook another cell sharing risk assessment review. In the risk minimisation plan, it stated that the man should “share with a suitable padmate”. The man applied to attend the substance misuse triage clinic and was placed on a waiting list.

31. On 15 February, the man attended another appointment with the counsellor. He told the counsellor that he had developed a buprenorphine habit over the previous four months. He then elaborated that he had been bartering and dealing to maintain his habit. The man told the counsellor he no longer wanted to take buprenorphine and had applied to see the specialist doctor. He spoke

of his desire to “get back to normal” for the sake of his family and that he was aware he was on a “slippery slope”.

32. The lifer officer met with the man again a few days later. She noted that he seemed to be settling on the wing quite well and had started working as a cleaner. Over these two weeks, the man did not always collect his tramadol medication. It is not clear why he did not attend or how or if this was followed up.

33. On 20 February, the man’s partner visited with his three children. The man gave the children gifts prepared during his ‘Fathers Inside’ course. These included a tape recording of the man reading a story which he gave to his youngest child.

34. The following day, the man attended the substance misuse clinic. He told the clinic nurse that he had been taking buprenorphine illegally on the wing. The nurse referred him to the specialist substance misuse doctor.

35. On 27 February, the lifer officer again met with the man to complete a lifer report. At this point, the man said that he would be content to move to Wakefield prison to be close to his family. He was keen to move to another prison so he could progress in his sentence and complete offending behaviour courses. The lifer officer said they spoke at length about his offence. She said that the man had said he was drunk, but did not blame the drink. The man had a hatred of sex offenders, and had believed his victim had committed sex offences against children (this belief was incorrect). They also discussed the man’s family and the relationship with his partner. He spoke fondly of his partner, but was very clear that he expected to lose her at some point. He seemed to accept that his partner could not wait for him.

36. At this time, the man shared a cell with a fellow inmate. They appeared to get on well, so much so that when a single cell became available the man said he was happy to remain in the shared cell.

37. The following day (28 February 2006), the man met the specialist substance misuse doctor and told him that he had been using buprenorphine every day for the past four months. The man gave a urine sample which tested positive for buprenorphine. The doctor prescribed a 19 day buprenorphine detoxification programme and decided that the man should stop using tramadol as it was an opiate painkiller. He would review him in three weeks. The doctor also referred the man to a drugs therapist to provide some psychosocial support. The man took his first prescribed dose of buprenorphine the same day.

38. Over the next week, the man received a visit and letters from his partner that enclosed photographs of his children. In a letter dated 10 March, his partner commented on how down he had sounded on the phone.

39. The same day, the man saw the drugs therapist. The man told him that he felt his main problem was being held in Leeds and that his future as a lifer at Leeds was “grim”. The man felt that, if he moved to another prison where he could

progress, his drug taking would cease. The therapist arranged to see him again the following week.

40. On 13 March, the man was subject to an adjudication relating to the failed mandatory drug test. He pleaded guilty. The punishment was 50% loss of his earnings for 14 days, the forfeiture of canteen and private cash for 14 days, and no association for 10 days. There is little mention in any available records about him for the next week. The medical record notes that he took his last prescribed dose of buprenorphine on 14 March.

41. The man's nephew, who was also serving a sentence at Leeds, told my investigators that he was on B wing with the man for about a month prior to his uncle's death. The man and his nephew both described their relationship as being more like brothers, and they were very close both inside and outside of prison.

42. The man's cellmate on B wing told my investigators that the man had a lot of friends in the prison, and that he was chatty and witty. He said they had discussed serving a long time in prison and, although this sometimes got the man down, he could be cheered up. They also spoke about how it was unreasonable to expect partners to wait for them to be released. The man told his cellmate he wanted to move to a prison that dealt with first stage lifers.

43. On 20 March, the man was in his cell with his nephew when the prison officer walked past. They asked him if they could be moved to the vulnerable prisoners' wing under prison rule 45 as one of them had been accused of stealing a chain. They also said that someone with whom the man had problems outside of prison had come into Leeds, and the man had been told there was a price on his head. This had escalated and the previous day, having been confronted in the showers, they had had to fight their way out. They told the prison officer that they had been told they would be assaulted if they went to education that day.

44. The prison officer told my investigators that he suggested that the perpetrator could be moved instead. The man replied that he had been 'warned' by prisoners on other wings and would only feel safe on the vulnerable prisoners' wing. The man said he did not want to get into fights for fear of damaging his chances of eventual release on life licence.

45. The man's nephew told my investigator that he and his uncle were in the shower and four other prisoners came in, one with a tool with a razor blade attached to it. He and his uncle wanted to leave and had to fight their way out. The man's nephew showed my investigator a scratch from the razor he said he had received in the struggle. When asked if staff were on hand, he said there was one member of staff on the landing above. After the fight, they went back to the cell to discuss their position. Originally, they thought about a transfer to the segregation unit but were told this was not an option. The man's nephew did not have long left to serve, but was conscious that the man would be left on his own. They spoke to the lifer officer who said that she was confident the man would be transferred in a few weeks. With that in mind, the man's nephew

said they decided to request a move to A wing as they were concerned that there was a real danger of being attacked again.

46. The lifer officer discussed the request with the man. She was concerned that, with so long to serve, it would be difficult to lose the label of being a vulnerable prisoner. (Many sex offenders are held on the vulnerable prisoner wings due to the nature of their offences, and potential bullying from other prisoners. This often means that other prisoners located on VP units for their own protection are also labelled as sex offenders.) The man said that he did not want to get into fights. He knew it was a big decision but one he felt he needed to take.

47. The application for rule 45 was completed. The man wrote: "we have been approached and they had blades and stuff and they wanted to take me in the showers over a chain that's been stolen, and one inmate has come in the jail that has put a price on my head and I fear for my safety. I need to move ASAP as I know it's no joke."

48. The application was approved. However, there were no spaces available on the unit that evening. The man and his nephew were therefore moved into a cell together until the transfer could be arranged. Staff were briefed that if any prisoner asked about the move, they would say they were having family problems and needed some time together.

Time spent on A wing - the vulnerable prisoners unit

49. The following day the man and his nephew moved to the vulnerable prisoners unit. The man was located in cell A4 12 with another prisoner, prisoner A, and his nephew was placed in a cell with prisoner B.

50. That afternoon, the man made four telephone calls. His nephew told my investigator that the previous week the man's grandmother had died and they had both found this upsetting. He also said that the man had spoken to his girlfriend a few days previously and they had broken up, although this was not unusual. The relationship had been turbulent and they sometimes argued but always made things up. His nephew said that the man seemed more upset about this argument and was concerned it would stop his partner bringing his children to see him.

51. In a phone call to his partner that evening, the man told her he was on protection, and that there was "no getting off it once he was on it". He was very worried about seeing his daughter, and his partner reassured him that the man's sister could take her to visit him regularly. The man said that could not happen now he was on protection and the visits he received from her and their daughter kept him going. (It may be that the man did not think his children would be able to visit if he was attending visits at the same time as sex offenders, or that he did not want them to visit in that situation.) The man's partner said she could not personally visit, as it would just upset him further. The man jumped from subject to subject in the conversation, and seemed angry and upset. Despite her denials, he believed his partner was seeing

someone else. However, he did speak with his daughter who sang to him over the phone.

52. Prisoner A told my investigators that, on the day the man moved into his cell, he had asked him how people manage to hang themselves in the cells. Prisoner A said that he told him how to make a noose and attach it to the window. He said he knew this as he had previously shared a cell with someone who had killed himself.

53. On the morning of 22 March, the man went to the wing medication hatch to collect his medication but it was not there. The staff nurse was on duty and, when she had finished, she went to the pharmacy to find out about the man's medication. They said that it had been dispensed and should be on the wing. The staff nurse checked the other wings, but could not find the medication or the man's prescription chart. She eventually located his clinical record and took the prescription chart back to the pharmacy. They then agreed to re-dispense it. The pharmacy does not dispense medication immediately, so the staff nurse returned to the wing and left a note for the nurse on duty the following morning to explain what had happened and that it should be delivered to A wing.

54. That afternoon, the man approached the wing officer. He asked about the possibility of having some clothes brought into the prison, as he said he had fallen out with his girlfriend and had nowhere to store them. He also complained that he had not had his medication that morning. The wing officer contacted reception to ask them about the clothing, and then spoke to a nurse who agreed to resolve the problem surrounding the man's medication.

55. The man made several phone calls that day. He arranged for a family member to go and collect his clothes from his partner. He also spoke to his sister about being on protection and the threats he had received. The man told his sister how upset he was about the break-up with his partner and that he was worried he was not going to see his daughter. He told her it was killing him and that he was crying himself to sleep at night. He also told her he was expecting to be moved to Gartree prison. The man then phoned his partner and spoke to his young daughter, telling her that he loved her. When he spoke to his partner, he again asked if she was seeing somebody else and they began to argue before they were cut off.

56. The second wing officer had not previously met the man, but knew his nephew. When he was unlocking the prisoners for the evening meal, he made small talk with the nephew who told him that his uncle was on the wing and had received an upsetting phone call similar to a "Dear John letter". The second wing officer said he would see the man later. After they had served the evening meal, the officer went round to collect the food trays. The man asked if he could go in with his nephew for a while. The officer said that the man seemed all right at this time. Having been alerted to the background by his nephew, he told the man that he could see a Listener (a prisoner trained by the Samaritans) if he wanted. The man declined, and said he would rather speak to his nephew. The officer said it was not unusual for prisoners to want to speak to relatives if

they were in prison together, and he took the man to his nephew's cell just a few doors away.

57. The nephew and his cellmate sat and talked to the man. He was angry, upset and crying. His nephew recalled that this was unusual, as he had only ever seen the man cry twice before. The nephew said that the man had always known that the relationship would end, but that his partner would always allow their daughter to visit. However, this particular evening he was not rational and it was as though he had his heart set on her waiting for him. When the second wing officer went back to the cell, the man thanked him. He did not seem upset and had stopped crying.

58. Prisoner A said that the man seemed generally all right, but at other times would cry. The evening of 22 March was one of these times. The man had talked a great deal about his girlfriend and children, the fact that he and his girlfriend had broken up, and his worry that he would not see his children again. Prisoner A also recalled the man talking about how long he was going to be in prison and the reality of his life sentence seemed to be hitting home. He remembered the man saying something about not feeling he could do the sentence and that he was not really coping.

23 March

59. The nephew told my investigators that on the morning of 23 March, at approximately 7.15am, he was on his way to work and spoke to the man through his cell door. The man had said how he thought they would be put in a cell together but the nephew replied that it might not happen that day. The nephew's understanding was that prisoner A was due to be released the following day, and then there would be space for them to be able to share. The nephew told my investigator that the man had said: "I might just pretend to hang myself or something, maybe they will get in touch with [his partner] and tell her I've done it and she might come and see me and then maybe they will take notice." The nephew said that he thought the man was joking around, as they were both laughing and he never believed it was something that his uncle would actually do.

60. At about 8.30am, the landing officer unlocked the cells on A4 landing. He remembered that the man went to the nursing station. The senior nurse was on duty. The senior nurse told my investigators that the staff nurse who had been on duty the previous day had left a note saying that she had located the man's prescription chart. The senior nurse said that at the time the note did not mean much to her, as she did not know the man. When he arrived to collect his medication, it was again not there. The senior nurse told him she did not have his prescription chart and would try to chase it up once she had finished the morning treatments. As he left the treatment hatch, she heard him swear. She told him she would try to help and asked him not to swear.

61. At some point after this time, the second landing officer conducted the cell fabric checks. This involves checking the general fabric of the cell, and the security of the locks and bars on the windows. The officer had been the only

officer conducting the checks. At interview, she said she did not have time to check every cell so carried out random checks. She did not recall seeing the man, and therefore believed she did not check his cell.

62. At approximately 10.20am, the first landing officer went to the man's cell to unlock so prisoner A could go to the gym. He recalled that prisoner A was waiting with his gym kit. He did not see the man, but had no reason to check that he was there at that point and did not go in to look for him. Prisoner A said that the man had seemed all right that morning, but he did not really speak to him before going to the gym.

63. The nephew said that he came back to the wing from work at about 11.20am. Soon after, he went to his uncle's cell. He knocked on the door but got no response. He could see that a green sheet was up over the toilet cubicle. He kicked the door, and shouted, "Are you ignoring me or something", then officers told the nephew to go back to his own cell.

64. Prisoner A returned to the wing from the gym at approximately 11.35 am and the first landing officer took him back to his cell. The officer could not see the man and noticed the green sheet hung up at the doorway into the toilet cubicle. The officer asked prisoner A if the man was in the toilet area. Prisoner A looked and replied, "He's hanging boss." The officer looked himself and saw the man hanging from the window. The first landing officer shouted for assistance and went in. Along with the second prison officer, he supported the man's body while the wing SO cut the ligature using an anti-ligature knife. The man was laid on the floor and staff started Cardio Pulmonary Resuscitation (CPR). An emergency call was made over the radio to alert healthcare staff to the situation. A code "blue" was called. This alerted staff that the patient was potentially not breathing. The senior nurse arrived quickly and took over CPR. Shortly afterwards, other healthcare staff arrived to assist and the control room called for an ambulance. Healthcare staff attached an external automatic defibrillator to the man. It instructed them not to shock as there was no activity in his heart but to continue with CPR.

65. The paramedics arrived quickly and they took over the resuscitation. They continued for approximately 25 minutes to try to revive the man. Their attempts were sadly unsuccessful and they pronounced the man dead at 12.16pm.

Action following the man's death

66. All contingency plans were actioned and thorough. The deputy governor held a staff hot debrief whilst the family details were located. The deputy governor and the appointed prison family liaison officer visited the man's sister to break the news of his death.

ISSUES

Buprenorphine

67. The man was not a drug user outside of prison, but became addicted to buprenorphine whilst in custody at Leeds. (Buprenorphine is a drug licensed for the safe maintenance or detoxification of those with opiate addiction.) Prisoners and staff interviewed by my investigators were aware that the illegal use and trading of buprenorphine was a big problem at Leeds. This was something of which management were well aware and my investigators were told that action was being taken to help minimise its availability.

68. As noted earlier, there is evidence that the illicit use of buprenorphine is a growing problem in prison.

69. Once the man asked for help, he was dealt with appropriately and offered a detoxification regime along with counselling. The man completed the detoxification programme on 19 March 2006. It is widely understood that detoxification can be a difficult time for prisoners. Sometimes, drugs are used as a coping mechanism and, once complete, detoxification may reveal the problems that drug use was masking.

Bullying

70. The man and his nephew were transferred to A wing on 21 March, following an incident in which they said that they had been threatened with blades by prisoners in the showers and feared for their safety. There are several issues that relate to this incident, although not all are directly relevant to the man's death.

71. The first prison officer completed a Security Information Report (SIR) detailing that the man and his nephew had some problems with people outside of prison which had escalated inside. The officer reported that the two men had told him they had received threats, had to "fight their way out of the showers," and had been threatened with assault if they went to education. This SIR did not name the people that the man and his nephew had accused.

72. The lifer officer also completed a SIR. She wrote that the man and his nephew had been "threatened to be sliced with a razor in the showers or on their way to education". They had named the four prisoners concerned and the lifer officer had written the names on the SIR. She signed and dated the form on 20 March at 11.00am. The procedure is that the SIR is then examined for other intelligence relating to the incident and the security manager makes comments. Finally, a governor examines and makes comments on the form. The duty governor signed this SIR on 21 March and wrote, "wing to raise BIR forms and challenge behaviour of those who are threatening."

73. The following day, a Bullying Information Report (BIR) was raised. The lifer officer completed the first section which requires a brief explanation of concerns. The officer wrote that the man and his nephew were being

threatened by four named prisoners. She noted that this was partly due to a chain having been stolen on the wing. There is no mention of the incident in the showers, or of bladed weapons. The lifer officer also completed the victim support plan which refers to the threat of assault on the way to education or in the showers.

74. The second part of the BIR requires the unit manager to fill in the "Report of investigation by unit manager" (to include who, what, why, when and where bullying incident occurred). The PO wrote that he interviewed both the nephew and the man on 21 March in the afternoon. He wrote: "… agreed to move them both into the same cell to offer support to each other. At the time of interview they were vague as to why they were fearful and were unwilling to name names. Subsequent information has been received that there may have been some pressure from the above prisoners re a missing gold chain."

75. The PO signed and dated the BIR on 23 March. He told my investigators that the interview was conducted on the basis of limited information at the end of that day. He said: "…and when I did interview them, they were extremely vague and they were unwilling to come forward with any information and they just wanted to go on VP status. At that stage I was concerned to the extent that I agreed to keep them together and then move them to A wing the following day." The PO's priority was to keep the man and his nephew safe. In interview, he said that he was not aware that the man and his nephew had told staff they had been threatened with a bladed weapon. (The man had written that they had been threatened with "blades" in his application for vulnerable prisoner status, but the PO had not seen this.)

76. My investigators interviewed the second PO, the bullying coordinator for B and H wings. The second PO explained that it was the role of the wing manager to conduct a minor investigation into a bullying incident when a BIR had been raised. Where a prisoner has named the alleged perpetrators, there was an expectation that these prisoners would at least be interviewed. The PO believed that would be the role of the anti-bullying coordinator.

77. The second PO explained that his role was to log the BIRs (of which he received between 10 and 15 per week). Ideally, he should quality check them but had found he did not have the time to do this as he was a full time PO on a wing and was not allocated sufficient hours to complete the role fully. The second PO said he felt the role had not been given the profile it required. However, he acknowledged that this was improving and was beginning to receive more attention.

78. No investigation into the allegations made by the man and his nephew took place at the time. My investigators looked at the wing files of the four alleged perpetrators and found that one of the four was suspected of bullying behaviour. By chance, his cell had been searched the day after the incident and a bladed article was found in his cell. None of the wing records cited the alleged incident in the showers on 20 March.

79. My investigators were concerned that no investigation had taken place, and that wing managers may not be aware of their responsibilities to conduct these investigations. If true, this would mean that bullying activity could take place without being challenged. My investigators suggested to the Governor that he look into the matter and remind all wing managers of their investigation responsibilities. An investigation was subsequently completed, but the accused prisoners had by then moved to other prisons.

80. At the time, a governor had only recently been placed in charge of "safer custody" within Leeds. I hope that he is given sufficient resources to tackle this area, and ensure time is taken to quality check information and provide feedback to staff. Moreover, the Governor must be confident that his staff understand their role and what is expected of them in dealing with bullying incidents. I therefore recommend:

A mechanism should be put in place for a senior manager to regularly check the quality of Bullying Information Reports and act on any deficiencies identified.

Cell sharing risk assessments

81. The Prison Service introduced a national cell sharing risk assessment system in 2002. Its origins lay in a judgement by the European Court of Human Rights in a case brought by the parents of a murdered prisoner, Christopher Edwards. The court found that the Prison Service was in breach of article 2 of the European Convention on Human Rights (ECHR) in that it failed to have in place an adequate risk assessment procedure. The murder of Zahid Mubarek by his cellmate in 2000 was a further tragic reminder of weaknesses in the Prison Service's ability to assess risk and to track potentially violent prisoners who should not share cells with others. I have personally had cause to examine the issues surrounding risk assessments in a number of my own investigations, including that into a murder in HMP Leeds in April 2004.

82. A wing in Leeds is used to house prisoners subject to prison rule 45, i.e. those prisoners housed separately for their own protection. This separation can be required for a number of reasons including bullying, but a large proportion of such prisoners have been charged with sex offences. My investigators were concerned about the man's transfer to A wing. This appeared to be a major decision for him, given that he had an intense hatred for sex offenders and the motive for his offence was that he thought the victim was a paedophile. The lifer officer told my investigators in interview that: "He detested sex offenders and I mean, when you spoke to the man about them, it wasn't he didn't like them, you could tell in eyes, his face, he really, really detested them and this is how this had all happened. He'd got word from someone that this man, I mean he knew this man, he had been chatting at his house, that he got word this man had a previous conviction for sex offences on a child and that's how this all started."

83. The lifer officer told my investigators that she warned the man that the label of becoming a vulnerable prisoner would likely continue throughout his prison sentence. Given the man's feeling towards sex offenders, he may have found this difficult. It appears from his phone calls that the man did not want his children to visit, or think they would be able to visit, whilst he was subject to rule 45. The man's nephew told my investigators that the man had not appeared too worried, as he believed that he would be moving to a lifer prison shortly.

84. This episode raises serious security concerns. The motivation for the man's offence had not been identified in his original Cell Sharing Risk Assessment (CSRA) and was not picked up subsequently. Therefore, the 'movements' officer was not aware of this when allocating his cell on A wing. On his initial CSRA, the officer who completed the form noted that he had the Prisoner Escort Form, the warrant and a list of pre-convictions. The rest of the information had been gathered from the man himself.

85. On 1 December 2005, the lifer manager completed the form LSP (lifer sentence planning) 1B, "Recommend initial allocation to first stage prison". He wrote, "…murdered … because he wrongly believed [the victim] was a sex offender."

86. When the lifer officer completed the LSP 3E, "Progress report by personal officer" on 22 February 2006, she wrote that the man had said at some point: "[the victim] was a known sex offender and that he deserved it."

87. The man's CSRA was reviewed on 3 August 2005, 1 December 2005, 4 January 2006 and 13 February 2006. None of the assessments mentions the motivation for the man's offence. The risk minimisation plan only contains the note, "to share with suitable padmate" (what suitable means is not defined). The quality of these reviews was poor and warrants further consideration from the Governor.

88. I accept that, when the man first entered Leeds, the officer completing the CSRA was dependent on his answers to measure his risk. However, there were opportunities to add further information at subsequent reviews. The lifer officer said she was concerned that the man might have been angered by the offences of some of the prisoners on A wing and have lost his temper. She said she took her concerns to the lifer manager who told her to complete a security incident report. The lifer officer admitted that she forgot to do this.

89. Whilst on A wing, the man was troubled by a number of issues and it appears that he was not in fact bothered about the offences of others at this time. However, I am concerned that the circumstances of his offence and his views on sex offenders were not taken into account when he applied to become a rule 45 prisoner.

90. In my report on the murder of one prisoner by another in Leeds in April 2004, I made several recommendations concerning Cell Sharing Risk Assessments. It is necessary for me to repeat two of these:

The Governor must satisfy himself that he has in place appropriately robust management checks that Cell Sharing Risk Assessment forms are completed in full at all times.

The protocol being developed, which ensures the use of all available documentation when completing Cell Sharing Risk Assessment reviews, should be brought into operation as a matter of the highest priority.

Treatment for depression

91. The following extracts are from the clinical review conducted by the PCT:

> "On the 5th December 2005, the man was noted to have a low mood and crying episodes. He was judged not to be suicidal. He was started on an antidepressant. However, depression is not recorded in the notes and there is no assessment of symptoms recorded at that time. Depression was recorded at a visit to the MO on the 20th December. Subsequently there is apparently no reassessment of the symptoms of depression or review of medication. The man remained on an antidepressant treatment, although it appears for 24-48 hours prior to his death it may not have been dispensed, equally it is not clear if he was taking the medication.
>
> "According to the National Institute for Health and Clinical Excellence (NICE) guidelines on depression, patients started on antidepressants who are considered to present an increased suicide risk or are younger than 30 years (because of the potential increased risk of suicidal thoughts associated with the early stages of antidepressant treatment for this group) should normally be seen after 1 week and frequently thereafter as appropriate until the risk is no longer considered significant. The man was under 30. Patients started on antidepressants who are not considered to be at increased risk of suicide should normally be seen after 2 weeks. Thereafter they should be seen on an appropriate and regular basis, for example, at intervals of 2-4 weeks in the first 3 months and at longer intervals thereafter, if response is good. In this case the guidelines were not followed and no clear evidence is recorded as to why they should have been ignored. A number of depression rating scales are available but none were used in this instance. However, they are not routinely used in General Practice but it would be worth considering their use in the prison setting. Although counselling was provided this did not appear to be specifically related to supporting the depression.
>
> "The man had a depressive illness but it is not clear from the clinical notes that this was being managed appropriately; the NICE guidelines were not followed. He also had a substance misuse problem which appeared to be managed appropriately … Whilst there is considerable evidence of "Discontinuation Syndromes" on withdrawal of antidepressants, there is little evidence from the literature indicating that an abrupt reduction in the dosage or discontinuation of antidepressants of any chemical class produces symptoms of major depression within 2-4 days, although one case series has suggested this. Consequently it is not possible to say

from the information examined if his depressive illness or related medication was the key factor resulting in the final incident."

I endorse the following recommendations made by the clinical reviewer:

Prison Healthcare should review the management of depression, including recording of symptoms, follow up and support arrangements and approach to monitoring progress.

The Governor and Head of Healthcare should consider the contents of the clinical review and potential changes that need to be made.

Life sentenced prisoners at Leeds

92. Leeds is not a suitable prison to hold for any protracted period of time those prisoners who have been sentenced to life imprisonment. There are no offending behaviour programmes, and insufficient opportunities for education and work. The man was anxious to progress to a first stage lifer prison. There are numerous references from those dealing with the man that this was a particular issue for him. The average stay for all prisoners at Leeds is 12 weeks, and it must have been difficult to see others leaving the prison while knowing he would be there for a long time.

93. Delays in transferring life sentenced prisoners is an issue across the Prison Service. The rise in use of short tariff indeterminate sentences (IPP) means that those on short tariffs have to be prioritised for moves to complete the necessary work before they can reasonably be released on licence. In turn, this means those such as the man with longer tariffs have to wait longer as there are simply not enough spaces.

The National Offender Management Service must review the number and location of prisons that are able to work with those serving a life sentence with a view to increasing available places as quickly as possible. Delays in transferring someone to a suitable prison where they can start to work towards their sentence plan targets must be minimised.

Fabric checks

94. On the day of the man's death, the cell fabric checks had not been fully completed although they were signed off as such. The officer described the fabric checks as: entering the cell, checking the bolt, lights and cell bell are in working order, checking around the door and walls of the cell, checking that the bed is attached to the wall. Then going in to the toilet area, flushing the toilet, checking the cistern and also checking the windows and bars. If the officer saw green sheeting up by the toilet cubicle she said she would remove it. She estimated that on average it would take about four or five minutes to check one cell. Sometimes, if there was excess kit or posters in the wrong place, these would have to be removed. Also, if there was a security problem, it would have to be reported which could take up a lot of time.

95. Ordinarily two officers would be assigned to this task, but on this day the second landing officer conducted the checks single-handedly. She therefore decided to conduct random checks but did not record which cells had been checked, or tell the senior officer of the ones that had not been checked. She signed to say that they had all been checked. It is Prison Service policy that all cells must be checked everyday. The second landing officer was reprimanded by her senior officer for not checking all cells and not telling the senior officer at the time.

96. There is no way of knowing whether the man would have been found sooner had his cell been checked. However, this was clearly of concern and this finding was fed back to the Governor during the course of the investigation so that all staff could be reminded of the importance of completing cell fabric checks on every cell every day. Proper completion of these checks is endorsed by this report.

    All staff must be reminded of the importance of completing cell fabric checks on all cells every day and informing managers immediately if for some reason they are unable to complete the task.

The man's mental state

97. Whilst it is not possible to identify exactly what may have caused the man apparently to take his own life, he had faced a number of problems in the days and weeks running up to his death. He had recently completed a detoxification programme, having become addicted to illegally obtained prescribed medication. He had also lost his grandmother. He believed that his relationship had broken down, and was unclear as to the impact this would have on the relationship with his children. Furthermore, he had received threats within prison and had moved to the vulnerable prisoners unit. He was frustrated with being at Leeds, and only had access to a limited regime. Any or all of these factors could have contributed to his depression and left him feeling negative about the future.

RECOMMENDATIONS

A mechanism should be put in place for a senior manager to regularly check the quality of Bullying Information Reports and act on any deficiencies identified.

The Prison Service accepted this recommendation and said a "System will be created to ensure Head of Residence carries out quality checks of BIRs and takes action where necessary."

The Governor must satisfy himself that he has in place appropriately robust management checks that Cell Sharing Risk Assessment forms are completed in full at all times.

The Prison Service accepted this recommendation and said "A new Cell Sharing Risk Assessment (CSRA) will be delivered to managers shortly. This includes instruction on appropriate management checks. System will be created to ensure robust management checks are carried out."

The protocol being developed, which ensures the use of all available documentation when completing Cell Sharing Risk Assessment reviews, should be brought into operation as a matter of the highest priority.

The Prison Service accepted this recommendation and said "In conjunction with the new CSRA package being implemented, the new policy will identify that staff should liaise with relevant departments (OMG/custody, security) when conducting CSRA reviews to gain relevant information relating to risk."

Prison Healthcare should review the management of depression, including recording of symptoms, follow up and support arrangements and approach to monitoring progress.

The Prison Service partially accepted this recommendation and said, "We are currently piloting a new assessment tool for use in primary care mental health. We are also working towards the implementation of The Stepped Care Approach for Primary Mental health in line with current NICE guidance once funding has been secured"

The Governor and Head of Healthcare should consider the contents of the clinical review and potential changes that need to be made.

The Prison Service partially accepted this recommendation and said, "Clinical care and re-design of services are a constant element of any healthcare organisation endeavouring to meet the requirements of the patient and constantly evolving guidance from NICE and other researched based information that is validated by both the service and the PCT. The department is NICE guidance compliant having recently audited the Depression treatment."

The National Offender Management Service must review the number and location of prisons that are able to work with those serving a life sentence with a view to increasing available places as quickly as possible. Delays in transferring someone to a suitable prison where they can start to work towards their sentence plan targets must be minimised.

The Prison Service accepted this recommendation and said, "The Chief Executive of NOMs has commissioned a Service Review of the systems and services for indeterminate sentence prisoners which is scheduled to report in August 2007."

All staff must be reminded of the importance of completing cell fabric checks on all cells every day and informing managers immediately if for some reason they are unable to complete the task.

The Prison Service accepted this recommendation and said "Guidance to be issued to staff via Staff Information Notices to ensure compliance with LSS"