

**Investigation into the circumstances surrounding the death
of a male prisoner at HMP Leeds in December 2005**

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

June 2006

This is the report of an investigation into the circumstances of the death of a male prisoner, in December 2005 at HMP Leeds. He was aged 37, and died of natural causes as a result of ischaemic and hypertensive heart disease.

My colleagues and I would like to extend our sincere condolences to his family and friends for their loss.

One of my investigators conducted the investigation. A clinical reviewer carried out a clinical review on behalf of Leeds West Primary Care Trust.

I am grateful to the Governor of Leeds and his staff for their full co-operation with my investigator. I am especially indebted to the prison liaison officer who ensured that all the necessary documentation was gathered. I would also like to thank the members of the Prison Officers' Association (POA) Committee who assisted my investigator by arranging interviews with staff, and suitable venues for these interviews to take place.

I have made no recommendations but have commented very favourably on the actions of staff after the prisoner was discovered. I would be grateful if the Governor would draw my comments to the attention of all his staff.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The prisoner died from natural causes in HMP Leeds in December 2005. He was aged 37 and was serving a sentence of 12 years imprisonment imposed at Leeds Crown Court just over two months earlier.

On arrival at Leeds prison, he had been given a reception health screen at which it had been identified that he suffered from sleep apnoea and had used a monitor. He was also found to be overweight and at risk of coronary heart disease. Clinical investigations were being carried out and he had started receiving treatment for hypertension.

In the small hours of 18 December, the prisoner's cellmate called for staff assistance as the prisoner had collapsed in their cell. The night staff attended the cell almost immediately, radioing for support from the night orderly officer and the nurses.

The night orderly officer arrived at the wing at the same time as the nurses. They joined other officers and entered the cell to attend to the man who was lying face down on the floor. One of the nurses asked for paramedics to attend the prison.

One of the night officers escorted the cellmate from the cell and took him to the Listeners Suite, which is situated on the ground floor, where he could be comforted.

The nurses commenced Cardio Pulmonary Resuscitation (CPR), assisted by the officers, which continued until the paramedics arrived. The paramedics stopped CPR, confirming that the prisoner had died and nothing further could be done.

One of my family liaison officers prepared letters for the prisoner's sister and partner to inform them of the Ombudsman's investigation, but unfortunately they did not receive them. Following the issue of the draft report another family liaison officer was able to make contact with his family and invited them to comment on the report and some changes were made as a result.

The post mortem report concluded that the prisoner died as a result of ischemic and hypertensive heart disease. I make no recommendations.

Investigation Methodology

1. All the initial indications were that this was a death from natural causes.
2. My investigator was given access to all the man's prison records, including his medical records.
3. Notices to staff and prisoners were sent to a governor, the liaison officer appointed by Leeds, to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.
4. My investigator conducted interviews with the prisoner's cellmate, as well as with wing staff and those involved in trying to resuscitate. The staff incident reports were also made available. The night patrol officer on the evening of the prisoner's, has since resigned from the Prison Service and was therefore unavailable for interview.
5. Leeds West Primary Care Trust (PCT) was invited to undertake a review of the clinical care the man received while in custody. A doctor was asked to carry out the review and it can be found in full as an annex to this report.
6. One of my family liaison officers made attempts to contact the prisoner's relatives, but unfortunately they were unsuccessful. Following the issue of the draft report another family liaison officer, did contact them and invite their comments on the report, since when some amendments have been made.

Background

Leeds Prison

7. The main part of Leeds prison was built in 1847. It is one of the largest local prisons in the country. The prison comprises six wings and a healthcare centre. It takes adult male prisoners remanded from the West Yorkshire area until trial, and convicted prisoners for short periods following sentencing.
8. Her Majesty's Chief Inspector of Prisons (HMCIP) undertook an unannounced inspection of Leeds between 22 and 26 August 2005. The report commented that Leeds is a large overcrowded prison, operating at 75 per cent above its certified normal accommodation, with a transient and usually short stay population.

Key Findings

Events leading up to the death of the prisoner

9. The prisoner was sentenced to 12 years imprisonment at Leeds Crown Court on 7 October 2005. He was then taken to Leeds prison. On arrival at Leeds, he was interviewed as part of the reception health screening process. This identified that he suffered from sleep apnoea and used a monitor. He was noted to be overweight and at risk of coronary heart disease. He was prescribed medication for hypertension.
10. The man was then allocated to a cell on E wing, and settled into the prison routine. On 1 December, he made an application to work in the prison kitchens as well as being a wing cleaner. However, he failed a drug test within the prison and his application was turned down.

Events of the morning of his death in December 2005

11. At approximately 1:55 am on the morning in December, the prisoner's cellmate rang the cell bell. This was answered by an Operational Support Grade (OSG) who was told that he had collapsed. The OSG immediately contacted two Night Patrol Officers, who in turn called the Orderly Officer to say that a prisoner was reported to have collapsed in cell E 504. (The Orderly Officer is the duty Senior Officer who is in charge of the prison for the night period.) The Senior Officer (SO) and another officer answered the radio call to attend E wing. While the SO was on his way to the cell, he called on the radio for medical staff to attend. The SO and the other officer arrived on the wing at the same time as the medical staff. They were joined by the two Night Patrol Officers and they all made their way to cell E 504.
12. The cell door was unlocked by the SO, allowing the Night Patrol Officers along with a nurse to enter the cell. They gave immediate attention to the prisoner who had collapsed and was lying face down on the floor. They found that he had stopped breathing and could not find a pulse. The Night Patrol Officers assisted the nurse to place the man on to his back, and his pulse and breathing were checked again.
13. At this point, the cellmate was taken from the cell and the other officer decided that he should be placed in the PALS Suite. A governor, Head of Corporate Business at the prison, explained that PALS is the term for the prison's Prisoner Active Listener Scheme. There is a PALS Suite, which is a large cell containing three beds in which two prisoners, trained as Listeners, are located. A Listener is a prisoner trained by the Samaritans in the counselling. He also explained that a prisoner, deemed to be in a crisis, will be placed in the suite, and allocated the third bed. One of the Listeners will remain awake, working in shifts, to talk to them. The governor appointed by Leeds

as a liaison officer said that there are many advantages, the main one being that constant counselling can be given without a huge impact on the prison, especially whilst on night state.

14. At 2:04am, the nurse instructed the SO to call for an ambulance. She also requested extra medical equipment which was collected by another nurse and a Healthcare Officer (HCO).
15. The nurse commenced Cardio Pulmonary Resuscitation (CPR) assisted by the Night Patrol Officers. They were re-joined by the other nurse and CPR continued until the paramedics arrived.
16. At 2:10am, the paramedic car arrived at the prison. The paramedic was collected from the prison gate and taken straight to E wing by an officer. He returned to the gate to collect the ambulance that arrived at 2:15am. At 2:20am, the paramedics decided to stop CPR, confirming that the prisoner had died and nothing further could be done.
17. At 2:25am, all staff left the cell, which was sealed, awaiting the arrival of the police. The paramedics left the prison at 2:50am. The police arrived at the prison at 3:30am, and the Scenes of Crime Officer (SOCO) arrived at 4:30am. The cell was unlocked to allow the SOCO to take photographs and then relocked.
18. At 5:30am, the funeral directors sent two female staff to remove the prisoner's body from the prison. Because he was a heavy man, the assistance of eight prison staff was needed to take him down the two floors to the ground floor of the wing. The staff involved said that they found this to be extremely distressing and tiring. As they reached ground level, they felt physically and emotionally exhausted.
19. The governor appointed by Leeds as a liaison officer visited the home of the prisoner's sister, who was his nominated next of kin, to tell her of his death. The visit took place at 9:35am and this governor was accompanied by the prison's family liaison officer (an SO), and a lady from the chaplaincy.
20. The post mortem examination concluded that the prisoner had died as a result of ischaemic and hypertensive heart disease.

The care of the prisoner's cellmate

21. My investigator visited Leeds to interview the cellmate on 21 February to ask about the care and support he had received. In the interview a number of concerns were expressed:
 - He felt that he had not been given adequate support by the prison;
 - The Listener he was placed with also suffered from a heart complaint;

- Whilst he was with the Listeners, the observation flap on the cell door was left open and staff checked him every 20 minutes throughout the night which he found disruptive;
- He found it distressing that, when the prisoner's body was brought down stairs, it was placed on the floor at the bottom of the stairs in full view of himself, who was in the PALS suite;
- Prior to a visit to the cell by the prisoner's family, the cellmate said that he was told to clean the cell and make it ready for them to visit. He also found this very distressing and asked a friend to assist him.

22. My investigator spoke to an SO, who is one of the wing Senior Officers. He was asked what support had been offered to the cellmate following the prisoner's death. This SO said that he along with his staff had offered support on the days following, all of which was recorded in the cellmate's history sheet. However, he said that the cellmate declined all the offers of help. He said that the cellmate was also seen by the lady from the chaplaincy, who offered additional support. This too had been declined.
23. My investigator uncovered no supporting evidence for the allegation that the cellmate was told to clean the cell before the family visit.

Clinical Review

24. A doctor completed a clinical review into the care of the prisoner at Leeds. During the course of the review, he interviewed the Head of Prison Healthcare and the Clinical Director of General Practice Development.
25. In his review, the doctor says that there is nothing to suggest that the medical care the prisoner received was inappropriate, or that any appropriate interventions had not been taken. He concludes that the medical records were clear and detailed, and staff actions and interventions were appropriate.
26. The doctor does not make any specific recommendations arising from the death of the prisoner. He says that healthcare staff should continue to identify prisoners at risk of coronary heart disease and take appropriate steps to address this.

Conclusions and Recommendations

27. The prisoner died of natural causes as a result of ischaemic and hypertensive heart disease. The clinical reviewer concludes that the medical records were clear and detailed, and that the staff actions and interventions were appropriate.
28. My investigator found no additional evidence to substantiate the claims by the cellmate that he was unsupported in the days following the prisoner's death or that he was asked to clean their cell in preparation for the family visit. It was appropriate and commendable that the cellmate was placed with Listeners after leaving his own cell whilst staff tried to resuscitate the prisoner.
29. Neither have I been able to substantiate the claim that the cellmate's door flap was left open while staff continued to manage the situation. However, it is clearly good practice for staff to check that all cell flaps are closed in such circumstances, not least to provide dignity for the deceased.
30. I commend the actions of the staff involved in trying to resuscitate the prisoner. I also pay tribute to the assistance they gave to the undertakers and the distressing circumstances in which this took place.
31. I make no recommendations.