



**Investigation into the circumstances surrounding
the death of a man, a prisoner
at HMP Leeds, in July 2011**

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

September 2012

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Leeds. He was 28 years old when he was found hanging in his cell in July 2011. I offer my condolences to the man's family and friends.

The investigation was carried out by a Senior Investigator. An independent review of the man's healthcare was carried out by a clinical reviewer from Leeds Primary Care Trust (PCT). He has assessed whether the care that the man received in custody was comparable to that which he would have received in the community. A copy of this report was received on 1 March 2012.

I am grateful to the Governor of HMP Leeds and his staff for their co operation with my colleague's investigation. I apologise for the delay in completing this report.

The man had been recalled to prison for committing an alleged offence whilst he was on licence after being released following an earlier prison sentence. He was used to prison life and settled into the regime quickly and was well thought of by staff and other prisoners. He had many friends on the wing. When he was found hanging staff and paramedics attempted to resuscitate him but unfortunately they were unsuccessful. He was later pronounced dead by the prison doctor. My investigation has found no indication that the man was likely to take his own life, although a letter which he left in his cell intimated that he was struggling to come to terms with the sentence he thought he would get for the latest offence.

I make one recommendation in this report. This relates to staff following NICE guidelines.

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

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SUMMARY

1. The man was 28 years old when he died at HMP Leeds in July 2011. He had previously served a prison sentence and had been recalled to prison on 17 May 2011 after committing another offence which broke the terms of his release licence. He was due to appear for sentencing at a Crown court on 10 June although this hearing was later adjourned until 22 August.
2. The man was given a full healthscreen on his arrival at Leeds. He said that he was prescribed medication for acid reflux, and this was checked with his GP in the community.
3. He was next seen by a doctor on 6 July. He said that he had been having nightmares after being assaulted before his recall to prison. After a discussion about anxiety and its management he was prescribed anti anxiety medication.
4. On a day in July, the man took his lunch to his cell as normal. At 1.30pm, officers opened his cell door for him to go to education and found him hanging by a ligature made of bed sheets. Resuscitation attempts were made by discipline and healthcare staff who were nearby to the man's cell, and they were quickly joined by paramedics. Unfortunately the attempts were unsuccessful and the man was pronounced dead by the prison doctor at 1.50pm.
5. We make one recommendation. This relates to staff following the guidelines set out by the National Institute for Clinical Excellence (NICE).

THE INVESTIGATION PROCESS

6. The investigation into the man's death was opened on 3 August 2010, when a Senior Investigator visited HMP Leeds. She met with a Governor, the Primary Care Team Leader in the prison healthcare team, a Police Liaison Officer and a member of the Independent Monitoring Board. She was shown the cell and wing where the man lived before his untimely death. She also made a telephone call with the man's Offender Manager at Huddersfield Probation Office.
7. The Governor at Leeds was unavailable when the Senior Investigator visited the prison. She subsequently spoke to him on the telephone to discuss the response to the man's death. She was provided with copies of the man's prison and medical records and a copy of the letter which the police found in his cell.
8. The Senior Investigator attended Leeds again on 10 October when she interviewed staff who were involved in the resuscitation attempt and who found the man on the day of his death. She made a further visit on 8 February 2012 to complete another interview. She contacted a staff member who was unavailable for interview at that time by telephone on 10 February 2012. On completion of her interviews, she provided feedback to the prison both verbally and in writing.
9. The Senior Investigator also liaised further with the Primary Care Team Leader and was provided with a copy of the Serious Incident Investigation Report which had been completed on 14 October. (This is a report completed by all the healthcare staff present at the emergency response and who had previously treated the man whilst he was in prison.) This covered all the areas in which the healthcare team were involved.
10. A clinical review was commissioned by Leeds PCT and a clinical reviewer was commissioned to undertake this on their behalf. The review was received by this office on 1 March 2012 and this has impacted on the delay in completing this report as has the ill health of the Senior Investigator.
11. The Senior Family Liaison Officer working for the PPO contacted the man's family by telephone on 20 September 2011 to discuss the purpose and scope of the investigation and to provide them with the opportunity to raise any questions or concerns they may have about the circumstances surrounding his death. The family raised a concern. They wanted to know if their relative was being treated for anxiety and panic attacks.
12. The Senior Investigator wrote to the Coroner to inform them of the investigation and to request a copy of the post mortem report. At the time of writing this report this had not been received. A copy of this report will be sent to the Coroner to assist with the inquest process.
13. The man's family were sent a copy of the draft version of this report, and given the opportunity to comment. We have not received any further

comments. A response from NOMS to the recommendation has been added to the relevant section.

HMP LEEDS

14. HMP Leeds is a category B local prison, holding just over 1,000 adult male prisoners from the West Yorkshire area. (Category B prisons hold those prisoners for whom the highest levels of security are not necessary but whose escape must be made very difficult.) It opened in 1847 and has undergone extensive expansion and refurbishment to improve the Victorian facilities.
15. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. For the past four published quarters, Leeds' performance has been judged "good" (with other possible assessments being exceptional, requiring development or serious concerns).

HM Chief Inspector of Prisons (HMCIP)

16. HMCIP last carried out an unannounced full follow-up inspection of Leeds in March 2010. The inspection report noted that the "close and effective" management of the prison had resulted in progress across all of the inspected areas. First night procedures were found to be good and staff-prisoner relationships had improved. Healthcare services had also improved. Regarding safer custody, the Chief Inspector said:

"Safety at Leeds remained a concern. As at previous inspections, first night arrangements were good, but they were let down by poor induction processes and ongoing support after the first night. More prisoners than at comparator prisons said they had felt unsafe. They did not report high levels of victimisation, but systems to investigate and monitor alleged incidents were weak. A great deal of attention had been given to suicide prevention strategies and procedures, following a large number of self-inflicted deaths, and in general support arrangements had improved, with especially good support on B1 landing for prisoners with a range of vulnerabilities. "

Independent Monitoring Board (IMB)

17. Each prison in England and Wales is also monitored by an IMB, the members of which are volunteers from the local community. Board members have access to every part of the prison and each prisoner held there. The IMB must produce an annual report, with the latest available for Leeds covering 2010.
18. The Board highlighted the significant improvements made across the establishment. However, they noted concern about overcrowding at the prison, writing that Leeds had been 100 per cent full for most of the reporting year. The IMB recognised the impact this had on prisoners held there.

Previous deaths in custody at Leeds

19. At the time of the man's death there had been 42 previous deaths at Leeds since this office took the responsibility of investigating deaths in prisons in 2004. There have been two more deaths since. None of these deaths have similar circumstances which relate to the recommendation made in this report, as a result of this investigation. However, many previous reports have made recommendations relating to suicide and self harm procedures. Nevertheless, on this occasion, the man clearly gave no signs to staff of his state of mind and his intention to harm himself. With regard to the evidence provided and the results of the investigation we can make no comparison of the recommendations made in respect of previous deaths at Leeds.

KEY EVENTS

20. The man was released from HMP Wealstun in July 2010, after serving a six year sentence for a violent offence. He was subject to licence conditions and because he was suspected of a further violent offence he was recalled to HMP Leeds on 17 May 2011.
21. At his healthscreen on his reception to the prison he told staff that he suffered from gastric reflux and was taking omeprazole, a drug for heartburn, which he said helped with his symptoms. He also said that he had been taking domperidone, a drug used to enhance digestion. This was thought to be linked with the heartburn. He told staff that he had not suffered from any mental health problems previously and he did not feel that he was likely to harm himself. He was subsequently prescribed 10mg domperidone to be taken three times daily for seven days and 20mg omeprazole to be taken once a day. The clinical record states that the domperidone should be stopped after one week. Prison healthcare staff contacted the man's doctor in the community and received verification that he had been prescribed the above medication on 20 May.
22. The man was given a cell on his own because he had previously had fights with other prisoners and was considered to be a risk to others. However, staff said that he was well liked by staff and other prisoners. He was familiar with prison routines and soon settled into prison life. Staff said he knew how to access support if he needed it as he was used to prison life. He attended the gym regularly and took part in educational and offending behaviour courses at prison.
23. On 9 June, the man asked healthcare staff for some cream for acne. He was given panoxyl cream. The day after on 10 June, he was examined by healthcare staff and found to be fit to attend court, which he did. The hearing was adjourned again until 22 August. A healthcare assistant (HCA) said that she spoke to the man about his court hearing a few days before his death. She said that he had told her that his solicitor had said he might get a longer sentence than he was expecting but that "he didn't come across as if he had any major concerns about it."
24. A doctor examined the man on 6 July. He told her that he had been threatened in January and since then he had suffered from sleeplessness and nightmares. He also said that he had pins and needles in his left arm. The doctor noted that he had an electrocardiogram (ECG, a test which measures electrical activity in the heart) before he came into prison and it had not indicated any heart problems and proved inconclusive. He told her that he felt anxious and suffered from panic attacks. She spent time discussing the relationship between stress and the mental and physical symptoms and self management of it and reassured him about his heart. She then prescribed him a trial period of propranolol 20mg to be taken at night. (Propranolol is a drug called a beta blocker which is used to reduce anxiety.) She also advised him to return if his symptoms did not settle quickly. Apart from a routine

repeat prescription for acne cream on 22 July, there are no further entries of note until the day of the man's death.

25. At interview, an officer said that, on the day of his death, the man took his lunch into his cell, as normal. He explained that between 11.30 and 12 noon prisoners attended the servery where they get a meal, which is then taken to their cells. They are then locked in their cell to eat lunch and at 1.30pm their cells are re-opened for them to attend education or work or the gym, depending on the timetable.
26. The officer said at interview that, as part of his normal duty, he was unlocking prisoners at 1.30pm following lunch. When he came to the man's cell, he opened the door and was moving on to unlock the next cell when he realised there was something wrong. He returned to the cell and immediately saw the man hanging by a ligature from the window bars. He noticed that the ligature was made of torn bedsheets. He immediately shouted for staff and then went into the cell and held the man's body up to relieve the strain on his neck. He then shouted a code blue emergency over the radio. (A code blue emergency call is used when there is a prisoner having breathing problems and is a potentially life threatening situation.)
27. A second officer told the investigator that he heard his colleague's shout for help and his subsequent call for a code blue. He said he was about five seconds away from the man's cell but did not have a radio and could therefore not shout the call over the prison network. However, a third officer also heard his colleague and he also made another code blue call over the radio.
28. The second officer immediately went into the cell and used his anti ligature knife to cut the bedsheets from the window bars. (An anti ligature knife is a specially designed knife to use to cut ligatures. All officers have them on their belts.) He told the investigator that once the ligature was cut, the sheets unravelled from the man's neck. Both officers tried to lay the man on the floor. However, the second officer said that the man's head banged on a chair whilst they were trying to lay him on the floor but the man did not react to this in any way. He described the man as being blue in colour, and also said that his tongue was swollen.
29. The second officer said that he was not first aid qualified and did not know how to find a pulse but said he knew he had to do something. Just then a third officer entered the cell. As she had previously been a nurse, she immediately started to give cardiopulmonary resuscitation (CPR) to the man. She could not remember how many compressions she gave but said that healthcare staff arrived almost immediately.
30. Two nurses had been at the other side of the landing when the emergency call was shouted over the radio. They immediately responded and were at the man's cell within a minute. They requested an emergency ambulance and then took over CPR from the third officer. Almost immediately other healthcare staff arrived with emergency equipment. One of the nurses

attached a defibrillator to the man. (A defibrillator is a machine which measures electrical impulses in the heart. If the defibrillator finds electrical activity it gives an electrical shock to enable the heart rhythm to correct itself. It can only do this if electrical activity is indicated. If not it advises the user to continue with CPR). The nurse said, in her statement, that it advised her to continue with CPR, which she did.

31. At 1.35pm the prison doctor arrived in the man's cell and three minutes later paramedics arrived. The nurses continued CPR until 1.50pm when the doctor pronounced that the man had died according to the clinical notes provided by the prison. The clinical reviewer in his review stated that the time of death was pronounced at 1.52pm. Having asked him about this discrepancy he said,

“personally I do not think that there is any significant difference regarding the timing of declared death. I think my 1.52 came from the reports of the trust post event....”

32. A hot debrief was completed by a Governor (a hot debrief is a meeting held to ensure that any relevant learning is captured following an incident). The Governor said that nothing of note was raised but staff were reassured and offered the services of the duty care team. All prisoners on the wing who were subject to suicide or self harm risk procedures were reviewed and the others informed of the man's death and offered the support of Listeners or the Samaritans telephone. (Listeners are prisoners who have been trained by the Samaritans to offer support.)

33. All deaths in prison custody are investigated by the police, as well as the Prison and Probation Ombudsman. As part of the police investigation, the man's cell was examined. The police found a letter in his cell indicating that he was going to take his life.

34. A trained family liaison officer from the prison and the governing Governor visited the man's girlfriend's address later that afternoon to tell her of his death. She was his nominated next of kin. However, when they arrived, they were told by a neighbour that she was on holiday. The governing Governor decided to contact her over the telephone and then informed her of her boyfriend's death. They were then given the man's mother's details and went to her address to inform her.

35. The prison continued to liaise with the man's family to arrange the funeral. They also paid the full cost of the funeral. The family liaison officer attended the funeral on behalf of the prison and also arranged for the man's girlfriend and his family to visit the cell where he died and look at the book of remembrance. The man's property was returned to his mother.

36. After his death, a prisoner from the next cell to the man's made a complaint to the prison police liaison officer. The investigator was unable to see the prisoner because he had been discharged from Leeds when she visited the prison. However, the investigator interviewed the police liaison officer and

asked him about this complaint. He explained that he had seen the prisoner immediately after the man's death and ascertained that there was nothing substantive that required further investigation. He said that the prisoner made comments about the prison officers' actions that were unfounded and after he had interviewed him the prisoner retracted his comments.

37. Another prisoner who had since been released from prison contacted the investigator. He was invited to put his concerns in writing but has not done so at this time.

ISSUES

Clinical care

38. The man's clinical records stated that his GP had noted that he had suffered from some "mental/behavioural problems" in 1997. There were no further details available. At this time he would have been 13 or 14 years of age. The clinical reviewer concluded that these difficulties did not translate into a significant mental health problem in the man's adulthood because there were no further entries about such issues after this time.
39. The clinical reviewer stated that the prescriptions for omeprazole and domperidone were appropriate. He explained that the decision to stop the domperidone after one week would have been to see if the man's symptoms returned on stopping the domperidone initially and then both drugs. He said that there was a plan then to do a further simple test (the h.pylori test) if symptoms recurred. This would have helped diagnose the root cause of the reflux and allow more targeted treatment to be prescribed. In the clinical reviewer's opinion this was an entirely reasonable approach and certainly the stopping of these drugs would have had no significant detrimental effect on him other than perhaps some acid reflux coming back.
40. Three weeks before the man's death, he was examined by a doctor. He told her that he had been suffering from panic attacks and anxiety, after being assaulted in January. The doctor reassured him and prescribed a low dose of propranolol, a beta blocker. She explained that she did not think that a referral to the mental health team was appropriate at this stage. However, she said that if the symptoms persisted then she would review him at a later date.
41. In the Serious Incident Review completed by the PCT, it states that propranolol is an effective treatment for anxiety under National Institute of Clinical Excellence (NICE) guidelines. (NICE guidelines set the standard for high quality healthcare). The clinical reviewer commented on this statement, saying that:
- "In fact there is no mention of the use of beta blockers [such as propranolol] as an effective treatment in the latest NICE guidelines. The appropriate first step according to these guidelines is education about anxiety and active monitoring of the condition, before any medication is contemplated. However having said this, the use of propranolol in patients presenting with anxiety is still seen in primary care and this drug can have some effects on certain potentially distressing physical symptoms which can occur in anxiety."
42. The clinical reviewer makes it clear in his review that the prescribing of propranolol for anxiety is not in line with NICE guidelines. He also questions the assertion in the PCT review that he was offered more than equivalent care than that which he would have received in the community, stating that his conclusion is that he received "at best equivalent but no more than that in

terms of what would have been expected in the community at this time.” However, he clarifies this by saying that he did not believe that there was a missed opportunity to identify or treat any mental health problems suffered by the man.

43. The clinical reviewer makes no recommendations in his review. However, we believe that it is important that healthcare staff follow the NICE guidelines, as this will lead to better outcomes for the health of prisoners. We make the following recommendation to the Head of Healthcare.

The Head of Healthcare should ensure that all healthcare staff work in accordance with NICE guidelines

Emergency response

44. We have found that there was a swift and appropriate response to the emergency situation, when the man was found in his cell. Staff responded immediately, holding his body up, releasing him from the ligature and then providing CPR, which continued until the doctor pronounced him dead. The ambulance response time was 12 minutes from the initial call to contact with the man and the prison facilitated this fast response effectively.

CONCLUSION

45. The man was used to prison life and had settled into the regime. He was aware of how and where to get support should he require it. He was being treated for anxiety and was due to be reviewed by the prison GP if the symptoms continued.
46. Although the clinical reviewer has highlighted that propranolol is not the best treatment for anxiety according to NICE guidelines, it would seem that it was appropriate in the circumstances. There were no other signs to suggest that the man was considering taking his own life, and a different outcome would have been unlikely had he been prescribed different medication.

RECOMMENDATION

1. The Head of Healthcare should give consideration to the information relating to NICE guidelines, which is contained in the clinical review and ensure staff are clear about the guidelines.

NOMS have accepted this recommendation. They said, “A monthly clinical governance meeting has been established with all prescribers to review and monitor all current and new NICE guidelines.

The clinical governance group is cascading information and ensuring effective implementation of new guidelines within teams.