PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Leeds in November 2013

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man in November 2013, at HMP Leeds. He had been suffering from lung cancer. He was 50 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Leeds was undertaken. The prison cooperated fully with the investigation.

The man had been sentenced to life imprisonment in January 2000 and was released on life licence in November 2011. In February 2013, he was recalled to prison after being charged with further offences and was sent to HMP Leeds. He had been diagnosed with lung cancer during his previous time in prison and had been receiving treatment in the community. He initially refused food and treatment at Leeds, but two weeks later started to eat and take pain relief medication. He declined any other active treatment. In October, a scan showed that the cancer had spread to his spine and he was given a single dose of palliative radiotherapy. He made it clear that he did not want any active treatment or to be resuscitated if he had a cardiac or pulmonary arrest.

In November, the man collapsed in his cell after suffering a massive bleed. After some initial delay in entering the cell, because not all night supervisory staff can access cells even in emergencies, healthcare and other staff attended, but did not attempt to resuscitation in line with his wishes. Paramedics arrived and confirmed that he had died.

The investigation found that the man received mostly prompt and appropriate medical care while he was at Leeds and I am satisfied that his death could not have been prevented. However, I am concerned that there were sometimes delays in him receiving pain relief. I also do not consider that the use of restraints when he was taken to hospital was always justified by fully considered risk assessments, a matter I have raised before with HMP Leeds.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

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SUMMARY

1. The man was released on licence from a life sentence in November 2011. On 19 February 2013, he was recalled to prison after being charged with further serious offences and was taken to HMP Leeds.

2. The man was 50 years old and had been diagnosed with terminal lung cancer in 2011. In the community, he had been under the care of a consultant oncologist at hospital and had undergone a course of palliative treatment.

3. When he arrived at HMP Leeds, the man refused to take any food or medication, except pain relief, despite the efforts of healthcare staff. On 26 February, after discussions with a prison GP, he signed a do not attempt cardiopulmonary resuscitation order. On 8 March, he started eating again, but continued to refuse any medication, other than pain relief. Healthcare staff monitored and reviewed his condition frequently.

4. A chest X-ray on 12 August showed his cancer had progressed. Throughout August and September, healthcare staff continued to monitor the man and a hospice nurse advised on his care.

5. On 9 October, the man had an MRI scan which showed the cancer had spread to his spine. He moved to the prison's healthcare centre as an inpatient on 17 October. On 5 November, he received a single course of palliative radiotherapy at hospital.

6. Towards the end of November, a night patrol officer responded to the man pressing his cell call button and found him bleeding profusely from his mouth. The officer radioed for emergency assistance and a nurse and other staff responded. He was unresponsive, but in his line with his wishes staff did not attempt to resuscitate him. The nurse administered oxygen to help alleviate any pain or distress. Paramedics arrived shortly afterwards and confirmed that he had died.

7. The clinical reviewer concludes that the man's medical condition was generally well managed and care was equivalent to that he could have expected to receive in the community, except there were some occasions when he did not receive pain relief promptly.

8. The man was in very poor health and later had reduced mobility which meant he sometimes relied on a wheelchair. Despite this, he was restrained by handcuffs when he attended hospital without fully considered risk assessments. Although staff opened his cell and went in relatively quickly after the emergency was called, we are a concerned that not all night patrol officers carry keys in a sealed pouch to allow immediate access in an emergency. We make three recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.

10. The investigator obtained copies of the man's relevant prison and prison medical records. He interviewed three members of staff at Leeds on 30 January 2014. He gave the Governor initial feedback about the investigation and followed this up in writing.

11. NHS England commissioned a clinical reviewer to assess the man' clinical care at the prison.

12. We informed HM Coroner for West Yorkshire of the investigation, who provided the results of the post-mortem. We have sent the Coroner a copy of this investigation report.

13. The man's son received a copy of the draft report. He raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP LEEDS

14. HMP Leeds is a local prison holding up to 1120 adult male sentenced and remand prisoners.

15. Healthcare services are commissioned by NHS England (York and Humber) and provided by Leeds Community Healthcare NHS Trust. During the day there is full healthcare cover, including a doctor. At night there is nurse cover. There is 19 bed inpatient unit.

HM Inspectorate of Prisons

16. The last inspection of Leeds was in January 2013. The Inspectorate found that the standard of healthcare was good with some innovative practice. There was a good range of health services and prisoners being able to see a nurse every day. Waiting times to see a GP were reasonable. Prisoners with long term medical issues were well managed, but inspectors noted that some prisoners experienced delays in receiving prescribed medication. There were effective links to Macmillan nurses and a local hospice where patients in the terminal stages of illness could receive care. Training in end of life care had started and a policy was being developed.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community who help to ensure prisoners are treated fairly and decently. In its latest published report for the year to December 2012, the IMB said that outpatient care was well administered with reasonable waiting times to see a doctor. Prisoners were positive about healthcare provision and the Board had received no complaints in the reporting year. Prisoners requiring mental health services received regular and sufficient professional care and support.

Previous deaths at HMP Leeds

18. Since the start of 2012, there had been three other deaths from natural causes at HMP Leeds, before that of the man’s. We have raised the issue of inappropriate use of restraints before.

KEY EVENTS

19. The man had been sentenced to life imprisonment in January 2000 for a sexual offence. He was released on life licence from prison on 3 November 2011. On 19 February 2013, he was recalled to prison after being charged with further offences. He was taken to HMP Leeds. He had been diagnosed with lung cancer during his previous time in prison and was under the care of oncologists at hospital.

20. A nurse carried out an initial reception health screen at Leeds. She noted that the man had been diagnosed with lung cancer before he was released on licence and had completed a course of radiotherapy. He also suffered from type two diabetes and asthma. She recorded that he smoked 30 cigarettes a day. He had been offered smoking cessation advice a number of times, but had always refused to give up smoking.

21. The man told the nurse that he wanted to die in prison and would refuse to take any prescribed medication and planned to go on hunger strike. She opened an ACCT document (Assessment Care in Custody Teamwork – the Prison Service procedure for managing prisoners at risk of suicide and self-harm) and referred him to a mental health specialist at the prison.

22. The mental health specialist saw the man later that day. She noted that he had attempted to take an overdose of prescribed medication in 2011. She referred him to a psychiatrist who runs clinics at the prison.

23. A prison GP saw the man the same day and reviewed his blood pressure, diabetes and pain relief medication. He noted that he said he was due to attend hospital for a scheduled appointment with the oncology department, but did not know the date. The man said that he had completed both radiotherapy and chemotherapy treatment. The doctor discussed his decision to refuse food and medication with him, but he still refused both.

24. On 21 February, a prison GP saw the man and discussed his decision to refuse food and medication and the impact this would have on his health and future treatment options. He was clear that he still intended to refuse both.

25. The doctor discussed the possibility of an advance directive with the man (this is a statement explaining what medical treatment the individual would not want in the future, should they lack mental capacity). He said he would think about this. Healthcare staff regularly checked him who, despite refusing food and medication, remained stable. He was managed in line with guidance for prisoners who refuse food.

26. A doctor discussed the man’s medical history and treatment options with a consultant oncologist at hospital. The oncologist confirmed that the man had recently had a course of palliative radiotherapy for lung cancer. She did not consider his death was imminent but his prognosis was poor.

27. On 22 February, a prison GP saw the man and noted that he was still refusing all food and treatment and had signed a form to indicate that he had refused medication. He asked him whether he wanted resuscitation to be attempted if

he had a cardiac or respiratory arrest. He said he wanted to have pain relief and to be treated with "comfort and dignity", but he would not want to be resuscitated. He did not sign a formal order about resuscitation at the time.

28. A nurse discussed the man's cancer and poor prognosis with him later that day. The nurse referred him to the City Wide team (a team of nurses who specialise in the care of patients who have suffer from lifelong conditions, including diabetes, lung disease, heart disease, epilepsy and kidney disease). He also referred him to the end of life lead at the prison for assessment.

29. Healthcare staff saw the man daily, took his observations and offered him medication and food. Although he was refusing food and medication, he was taking liquids.

30. The end of life lead examined the man on the afternoon of Sunday 24 February and noted the presence of ketones in his urine (these are usually present when the body is not getting enough glucose for energy). She contacted an out of hours GP, who agreed that the cause was likely to be his food refusal. He advised that he should be monitored every four hours and a GP should examine him the next day.

31. A GP saw the man the next morning and discussed the impact food refusal was having on his health. He was unhappy that healthcare staff were monitoring him every four hours. The doctor explained that this was necessary because of his condition. He had experienced some haemoptysis (coughing up of blood) and the doctor asked whether he would want to be treated if he experienced a large haemoptysis, which can be fatal. He said he would accept treatment for any distress or pain, but did not want any active treatment. The doctor recorded that his end of life care plan would be put in place after a review by a psychiatrist. He said he planned to contact his solicitor to help with an advance directive.

32. Later the same day, the psychiatrist saw the man and discussed his decision to refuse both medication and food. The psychiatrist concluded that he had the mental capacity to refuse treatment and understood the consequences.

33. On 26 February, after further discussion with a doctor, the man signed a DNACPR order. (DNACPR this means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.) Healthcare staff were informed of his decision.

34. The man had an appointment with the oncologist on 5 March, but does not appear to have attended. His medical records show that, on 5 March, he had experienced chest pains, but refused an electrocardiogram (ECG) test. (An ECG measures the electrical output of the heart and is used to investigate the possible cause of chest pain.)

35. On 8 March, the man said he was now eating small amounts of food. On 26 March, the ACCT document was closed as he was eating normally. Although he continued to refuse medical treatment, it was noted that his mood had improved. Healthcare staff continued to monitor him regularly.

36. On 27 March, a nurse saw the man, who had complained of chest pain which he believed was due to stress. However, he refused to see a doctor.

37. A nurse was carrying out routine observations on the man on 1 April and noted that he had intermittent pain in his ribs. He did not wish to see a GP, but asked about his rescheduled appointment with his oncologist. The nurse said she would follow this up. She also noted that he was now eating three meals a day.

38. On 10 April, a doctor saw the man after he complained of pain in the right side of his chest. He said he did not want any treatment for the pain. The doctor reminded him that he could request treatment at any time should he change his mind.

39. On 8 May, the oncologist saw the man at hospital. She noted he appeared well, his chest sounded clear and, although he had been experiencing some chest pains, he had not suffered any further haemoptysis. She also recorded that he did not report any problems with mobilising. She noted that he said that he had been told before he had been recalled to prison that he had already outlived his life expectancy and that he should get his affairs in order. She reassured him that, as he was already two years past the date his condition had been diagnosed, it was possible that he could continue in reasonable health for the foreseeable future. She discussed the palliative treatment options available to him and recorded that he refused any treatment.

40. On 14 May, a prison GP examined the man after he had complained of pains in his chest. The doctor changed his pain relief medication and asked a nurse to arrange a referral to Macmillan Care.

41. On 15 May, the end of life lead saw the man after he again complained of pain in his chest which radiated to his neck and arms. He also had shortness of breath. She referred him to a prison GP, who decided to send him to hospital the same day. He was diagnosed with pericarditis (an inflammation of the fibrous sac surrounding the heart). He was discharged back to the prison after an overnight stay.

42. A doctor reviewed the man the next day and discussed the effectiveness of his pain relief and his symptoms. He told the doctor he had submitted a complaint as he had been left for two days without pain relief in prison. He was also concerned that a promised referral to the Macmillan nursing team had not been followed up. The doctor prescribed him with a daily dose of morphine. He also prescribed oral morphine that he could take if he experienced any breakthrough pain. The same day the doctor followed up the referral to the Macmillan nursing team at a local hospice.

43. On 20 May, the man attended hospital for a chest X-ray. The oncologist wrote with the results on 4 June, saying the X-ray showed a gradual worsening of his condition and that his pericarditis would be an indication of this. Healthcare staff continued to monitor and review him frequently.

44. On 15 July, the man appeared at Crown Court in relation to the further charges for which he had been recalled to prison. The next day, a prison GP

saw him. He was concerned that his pain relief was not as effective as it had been and the doctor increased the dose of his morphine.

45. Later that day, the end of life lead noted that the man had not received the increased dose of pain relief as the task requesting the increased dosage had not been sent to the pharmacy. She also recorded that the previous day the judge at his trial had been concerned about his pain relief and had contacted the prison about this. She spoke to a doctor, who prescribed a covering dose for that day. The correct dose was in place the next day.

46. On 17 July, a doctor reviewed the man. He discussed with him his palliative care and his prognosis (the records do not show what this was considered to be). He recorded that he had a full understanding of his condition and the treatment options, but continued to refuse any active treatment.

47. On 18 July, the man was found not guilty in respect of the charges against him. As his licence had been revoked when he was recalled to prison, he had to remain in prison until the Parole Board directed his release on licence.

48. On 23 July, a clinical nurse specialist based at the hospice saw the man and became his dedicated Macmillan nurse for the remainder of his illness. She saw him regularly and advised healthcare staff at Leeds about his care.

49. A doctor reviewed the man on 29 July and discussed his prognosis and end of life arrangements. He said that he would prefer to be cared for in a hospice and die in hospital. The doctor mentioned the possibility of applying for release on compassionate grounds and said that he would request a report from the oncologist. He thought it unlikely it would be granted at this point as his prognosis was unclear, but it would make a later consideration easier. (He appears later to have decided to wait for the Parole Board's decision about his release.) The doctor offered him a move to the healthcare centre, but he declined as he wanted to stay on the wing for as long as possible.

50. On 1 August, a doctor contacted the oncologist and they discussed concerns about the possibility of the man developing metastatic bone disease (caused when cancer spreads from the original organ site to bone). A bone scan and chest X-ray were scheduled for 6 August. Unfortunately, he was unable to attend the appointment as it coincided with a visit from his legal representative.

51. The man attended hospital for a bone scan and X-ray on 9 August. He was escorted by two officers and restraints were used. (The records do not show what level.) A doctor discussed the results of the X-ray with him on 12 August and noted that the lung cancer had become more aggressive. He reviewed his palliative care plan.

52. On 2 September, the results of the bone scan showed no evidence that the cancer had spread to the man's bones. On 6 September, the end of life lead spoke to the clinical nurse specialist about his abdominal and lower back pain. The clinical nurse specialist supplied a heat pack and advised that his pain relief should be reviewed. The end of life lead recorded that she had asked a doctor to review his medication, but there was no record that this took place.

53. On 13 September, a nurse asked the man to consider a move to the healthcare centre. He refused and said he wanted to remain living on his wing for as long as possible. She told him he could change his mind at any time.

54. On 17 September, a multidisciplinary team meeting was held at Leeds to review the man's care. The oncologist, clinical nurse specialist, end of life lead and the man attended. They discussed problems with delays in him receiving his medication, his abdominal pain and weight loss. He also stated he had not been able to open his bowels for a week. The oncologist examined him the same day and recommended an MRI scan to check for any spread of the cancer. She also recommended additional pain relief and a laxative and emphasised the importance of giving his pain relief at the correct time.

55. On 27 September, a nurse recorded that the man continued to experience delays in receiving his pain relief medication because of a late ward round. She noted this on a handover sheet to ensure other healthcare staff were aware of the problem.

56. On 9 October, the man attended a NHS Treatment Centre for an MRI scan. He was escorted by two staff and restrained using double handcuffs. (Double cuffing is when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) His restraints were removed during treatment but double handcuffs were reapplied as soon as his scan was completed.

57. The next day, a doctor received the results of the MRI scan which showed the presence of at least three bone metastases. He discussed the results with the oncologist and she advised that he be referred to a specialist oncologist at another hospital, in order that a course of radiotherapy could begin as soon as possible. She also advised a prescription of dexametasone, a drug used to reduce bone pain and inflammation. The doctor arranged the referral and prescription. The original appointment was for 17 October, but the man was too ill to attend and he agreed to move to the healthcare centre that day. His appointment was rescheduled for 1 November.

58. On 1 November, a specialist oncologist saw the man at hospital. He was in a wheelchair and was escorted by two officers and restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

59. The man returned to hospital on 5 November to undergo a single radiotherapy treatment to his spine. He was escorted by two officers and restrained, but the records do not show the type of restraint used. However, a prison GP reviewed him on 8 November and noted that he appeared reasonably well, but had been upset at being double cuffed when he was taken to hospital. The doctor noted that this was against his expressed advice and advised him to raise the matter with the Independent Monitoring Board. The doctor had emailed the prison's senior management team with concerns about the use of restraints.

60. The man complained that his pain relief medication was late on 17 and 19 November. Records show that a nurse met him and assured him that appropriate steps had been taken to prevent his pain relief being late in future.

61. On 25 November, a prison GP saw the man and noted that, despite complaining of lower back pain, he had said he felt quite well. They discussed his upcoming Parole Board hearing (which we understand was due to held within the next two weeks). They were both optimistic he would be released. However, the hostel that had been identified as a release address had now indicated that they would not be able to accommodate him because of his deteriorating health.

62. Later on 25 November, the end of life lead saw the man and noted he appeared well, although he had complained of swelling to his left foot. She asked for a doctor to examine him at the earliest opportunity.

63. At 9.00pm the man pressed his emergency cell call bell (which activates an alarm in the wing office and a red light on the outside of the cell to alert staff). An operational support grade (OSG), the night patrol officer responded. When she looked into the cell, he was standing with his back to the door and she asked him what was wrong. When he turned she noticed he had blood around his mouth. She radioed an emergency code red. This indicates a life threatening situation when a prisoner is bleeding and requires control room staff to call an ambulance immediately. The duty nurse responded that she was on her way.

64. While she waited for the duty nurse to attend, the OSG asked the man what had happened. He tried to respond, but as he did so he appeared to vomit a considerable amount of blood and fell to the floor. She was unable to get through to duty nurse by radio as there was too much radio traffic. She was unable to open the cell to help him as operational support staff at Leeds do not carry cell keys in a sealed pouch to use is an emergency at night. She therefore ran to the office and telephoned the control room, who contacted the duty nurse.

65. The duty nurse arrived at about 9.02pm and saw that the man was lying face down in a pool of blood against the cell door. A custodial manager arrived a few seconds later with another manager and an officer, and opened the cell door.

66. The duty nurse went into the cell and turned the man onto his side. She noted that his pupils were fixed and dilated, his face and neck were blue and blood was still coming from his mouth. As he had indicated that he did not want active treatment or resuscitation to be attempted in these circumstances, the nurse administered oxygen to help alleviate any pain or distress. Paramedics arrived at 9.14pm and confirmed that he had died.

Family liaison

67. The man had nominated one of his sons as his next of kin. At 11.00pm, the prison family liaison officer and an officer went to his home to inform him of his father's death. He was not there at the time and they were unable to

contact him by telephone that night. The next day they went to his home again at 12.05pm and told him that his father had died.

68. The funeral was held on 10 December and representatives from the prison attended. The prison contributed to the cost of the funeral in line with national guidance.

Support for staff and prisoners

69. Staff and prisoners were informed of the man's death by a Governor's notice. There was an appropriate debrief for those involved in the emergency and staff were offered support. Prisoners at risk of suicide or self-harm were reviewed in case they had been affected by his death.

Post-mortem report

70. A post-mortem examination established that the cause of death was massive haemoptysis with pneumonia due to metastatic bronchial squamous cell carcinoma.

ISSUES

Clinical care

71. The clinical reviewer has made a number of observations and recommendations on clinical matters. We do not repeat them all in this report, but bring them to the attention of the Head of Healthcare.

72. The clinical reviewer noted that the man's medical conditions were generally well managed at the prison. The response to, and management of, his illness was mostly appropriate, timely and at least comparable to what could be expected in the community setting.

73. However, we agree with the clinical reviewer that the man's pain relief was not always effectively managed.

The man's pain relief

74. The man complained a number of times about his pain relief. In May 2013, he said he had been left for two days without any pain relief. The Head of Healthcare responded to his complaint and arranged for him to see a GP to review his pain relief medication.

75. On 15 July, the judge in the man's trial contacted the prison as he was concerned that he had appeared to be in pain when he was at court. His medication was reviewed and the doctor prescribed an increased dose on 16 July. The same day, a nurse noted that this had not been actioned as the task had not been sent to the pharmacy. The doctor had to prescribe a covering dose to ensure he received appropriate pain relief that day.

76. On 17 September, at a meeting where the man's pain relief was discussed, the consultant oncologist stressed the importance of giving pain relief on time. Yet on 27 September, records show that there had been further delays in him receiving his medication because of a late ward round.

77. In November, the man complained again that his pain relief was late. Records show that there had been a delay in providing him his pain relief. A nurse went to see him to assure him that steps had been taken to ensure the delay did not recur.

78. Although the man's complaints were dealt with as they arose and his immediate issues resolved, it is apparent that there was no effective process to ensure he received his medication promptly. For various reasons, including late ward rounds and poor allocation of tasks, his pain relief was delayed a number of times. It is not acceptable that someone with such a serious medical condition should have to wait for pain relief. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners diagnosed with cancer and other serious illnesses have immediate access to effective pain relief medication when required.

Use of restraints

79. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

80. On 9 August, the man had an appointment at hospital for a bone scan and X-ray. The healthcare part of the assessment was not fully completed and simply stated that he suffered from asthma, diabetes and blood pressure. It did not indicate how his health conditions affected his risk. He was assessed as being a low risk of escape and medium risk to the public or hospital staff. The Head of Operations and Security decided that two staff should escort him and restraints should be used. The records do not indicate what type and level of restraints were used.

81. On 9 October, when the man attended hospital for an MRI scan there was again no healthcare assessment of how his medical condition impacted on his risk, but he was assessed as low risk in all areas. Despite this, the deputy governor decided that restraints were to be used. The assessment does not show the type of restraint authorised, but the escort record shows that he was restrained with a single handcuff when he left the prison reception area and that double cuffs were applied when he was in the escort vehicle.

82. On 1 November, the man had an appointment with the oncologist, by this time he was in a wheelchair. Again there was no information on how his medical condition impacted on his risk. A manager again instructed that two members of staff should escort him and that he should be restrained using an escort chain. There was again no assessment of his health and its impact on his risk of escape when he was taken to hospital on 5 November for radiotherapy, although restraints were used. (A GP noted in the medical that healthcare staff had emailed their views about restraints, but this does not appear in the assessment.) This time he was assessed as medium risk of escape, although previously he had been regarded as low risk.

83. The assessments of the man's risk were inconsistent, with very little input from healthcare staff as the court judgement requires. We are not satisfied that there was sufficient information to justify the use of restraints on him, a terminally ill prisoner with reduced mobility. We are particular concerned that

on at least one occasion he was subject to the use of double handcuffs while being escorted.

84. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like the man the Prison Service requires that reasons should be recorded in writing. There is no evidence to support this decision and we can see no reason why it would be justified.

85. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are not satisfied that the decisions were justified by a fully considered risk assessments that took into account the man's medical condition at the time as required by the 2007 High Court judgement. This is a matter we have raised with HMP Leeds a number of times before. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

Cell entry in an emergency

86. The man rang his cell bell at 9.00pm on 26 November. This was answered by an operational support grade night patrol officer. She was unable to go into the cell immediately as operational support grades at Leeds do not carry a cell key in a sealed pouch for use in an emergency at night.

87. At night, custodial managers at Leeds carry keys and prison officers have a cell key in a sealed pouch to be used in an emergency. However, we are concerned that operational support grades who act as night patrol officers on their own on wings at Leeds are not able to open a cell in an emergency. While in this case it would not have affected the outcome for the man, in other emergencies, such as when a prisoner is found hanging, a delay of four minutes before a cell is opened as happened here, could make the difference between life and death. We make the following recommendation:

The Governor should ensure that all staff on duty at night are able to access a cell quickly in an emergency.

PRISONS AND PROBATION OMBUDSMAN for England and Wales
Independent Investigations

ACTION PLAN:

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners diagnosed with cancer and other serious illnesses have immediate access to effective pain relief medication when required.	Accepted	Dedicated primary care nurses are now assigned to manage patients with serious illnesses and will maintain oversight of their medication. Care pathways are also developed in consultation with the NHS palliative care team for prisoners requiring end of life care.	Completed The Head of Healthcare	
2	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	In January 2014, further guidance was issued by NOMS to all Governors and Directors about the use of restraints. Training will be provided for all staff completing risk assessments at HMP Leeds to ensure they understand the legal position regarding the health needs and actual risks presented by prisoners being escorted to hospital. The risk assessment form used at the prison will also be updated to include specific instructions regarding the recording of the reasons for decisions made in relation to restraints.	30/6/14 The Governor, HMP Leeds	
3	The Governor should	Accepted	The availability of cell keys during the night	30/9/14	

	ensure that all staff on duty at night are able to access a cell quickly in an emergency.		duty period will be reviewed to ensure that all staff are able to access a cell quickly in an emergency.	The Governor, HMP Leeds	