Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Liam Deane a prisoner at HMP Leeds on 12 November 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Deane was assaulted and killed by his cellmate in the vulnerable prisoners unit at HMP Leeds on 12 November 2017, and had already died when he was found by prison officers. He was 22 years old. I offer my condolences to Mr Deane's family and friends.

The perpetrator was convicted of Mr Deane's murder. I am satisfied that there was no information that suggested that the perpetrator was a risk to other prisoners in general or to Mr Deane. It follows that I do not consider that prison staff could have predicted the perpetrators actions on 12 November.

However, I am concerned that the mix of prisoners in the vulnerable prisoner unit at Leeds was a challenging one, and that there is no evidence that staff in the unit were sufficiently alert to the possibility that Mr Deane might be at risk because of his offence. Mr Deane told officers and nursing staff that he had been threatened and abused, but there is nothing to suggest that any action was taken.

I note that the perpetrator was able to assault Mr Deane because Mr Deane was incapacitated by effects of using a psychoactive substance (PS). I am concerned that PS were apparently readily available in Leeds at the time and I repeat my view that the Prison Service needs to issue advice and guidance to prisons on the best ways of combatting the serious problem of illicit drugs.

Sue McAllister CB
Prisons and Probation Ombudsman **April 2019**

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Summary

Events

1. Mr Liam Deane had been at HMP Leeds since 13 August 2017, and was serving a life sentence for the murder of his two-day old daughter.

2. The perpetrator had been at Leeds since March 2017, after transferring from HMP Hull, and was serving a sentence for a sexual offence. The perpetrator had previously displayed poor behaviour and had been found under the influence of illicit substances in prison. In August 2017, the perpetrator had been attacked by a previous cellmate at Leeds who had thrown boiling water in his face.

3. Mr Deane and the perpetrator began sharing a cell in the vulnerable prisoner wing on 19 October 2017. Cell sharing risk assessments (CSRAs) were completed appropriately for both men. There was no information that indicated either Mr Deane or the perpetrator were a risk to other prisoners.

4. At approximately 5.30am on 12 November, the emergency cell bell was pressed in the cell occupied by Mr Deane and the perpetrator. An Operational Support Grade (OSG) responded. When the OSG reached the cell, the perpetrator told him that he thought Mr Deane had self-harmed, that there was blood and that Mr Deane was not breathing. The OSG used his radio to call a medical emergency code to summon help.

5. Healthcare staff responded immediately. They examined Mr Deane and agreed that resuscitation attempts were futile as he was clearly dead. Paramedics attended and at 6.03am, they confirmed that Mr Deane had died.

6. The perpetrator was arrested by police later that morning on suspicion of murder. On 2 August 2018, the perpetrator was found guilty of the murder of Mr Deane. He was sentenced to life in prison with a minimum term of 19 years.

Findings

7. We are satisfied that Cell Sharing Risk Assessments (CSRAs) were appropriately carried out on both prisoners and that there was nothing to suggest that the perpetrator posed a risk to other prisoners generally or to Mr Deane specifically.

8. We do not consider that staff could reasonably have been expected to foresee that the perpetrator would murder Mr Deane.

9. We are, however, concerned that although Mr Deane told a nurse that prison staff were aware that he was being abused and threatened by other prisoners because of his offence, there is record of this in his prison records and nothing to suggest that any action was taken to safeguard him.

10. Mr Deane's offence had attracted a lot of media attention locally and staff in the vulnerable prisoners unit (VPU) should have been aware that this might put him at risk. We are concerned that staff working in the VPU were either not aware that Mr Deane was at risk because of his offence, or that they were aware and

took no action under the prison's violence reduction policy to investigate and support Mr Deane.

11. Mr Deane had, a psychoactive substance (PS), in his system before his death and was incapacitated by it when the perpetrator assaulted him. Despite the prison's efforts to tackle the supply of drugs, we are concerned about the easy availability of PS at Leeds. More needs to be done to reduce both the supply and the demand for PS. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service.

Recommendations

- The Governor should ensure that:
  - supervision of vulnerable prisoners in the VPU means that they are safe and free from bullying and intimidation;
  - staff consider the risk to individual prisoners and must not assume that are safe simply because they are in the VPU; and
  - whenever bullying or intimidation is identified or reported, staff must follow the procedures set out in the prison's Violence Reduction policy.
- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

The Investigation Process

12. The investigator, issued notices to staff and prisoners at Leeds, informing them of the investigation and inviting them to contact him if they had relevant information. No one responded.

13. The investigator visited Leeds in November 2017, and obtained copies of Mr Deane's and the perpetrator's prison and medical records. NHS England commissioned reviews of Mr Deane's and the perpetrator's clinical care at the prison.

14. In accordance with the Ombudsman's terms of reference, the investigation was suspended while West Yorkshire police conducted a criminal investigation into the circumstances of Mr Deane's death and then during the subsequent criminal proceedings.

15. Following the conclusion of the court proceedings, the investigator reissued the notices to staff and prisoners at Leeds. No one responded.

16. The police conducted interviews as part of the criminal investigation into Mr Deane's death. The transcripts of these interviews were made available to the investigator, and, this report has been written based on documentary evidence and information taken from these transcripts.

17. We informed HM Coroner for West Yorkshire of the investigation. The coroner gave us the results of Mr Deane's post-mortem examination and toxicology tests. We have sent the coroner a copy of this report.

18. The investigator wrote to Mr Deane's family to explain the purpose of the investigation and to ask them if there were any issues that they wished the investigation to consider. Despite the letter being sent to the family at the correct address, the investigator was told that this had never been received. We apologise for any inconvenience this caused.

19. Mr Deane's family received a copy of the initial report. Their appointed representative contacted us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence on these matters.

20. HMPPS received a copy of the initial report, they responded and accepted all recommendations that were made.

Background Information

HMP Leeds

21. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

22. In August 2018, Leeds was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons. The project is focused on improving living conditions, preventing drugs from entering the establishments and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Leeds was in October and November 2017. The HM Chief Inspector reported that levels of violence of all kinds were far too high. The inspection found that not only did prisoners feel no safer than at the last inspection, the harsh reality was that they were indeed less safe. Violence, self-harm and the use of force were all high. The inspectors also said it was particularly troubling that since the last inspection, there had been four self-inflicted deaths, with another occurring while the inspection team were at the prison. The day after the inspection ended, Mr Deane was murdered.

    The inspectors reported that a number of prisoners expressed frustration at what they perceived to be the inability of many newer staff to relate to them and to complete all aspects of their role effectively.

24. The inspectors also expressed concern about the arrangements for vulnerable prisoners, and found that vulnerable prisoners on E and F wings felt particularly unsafe and intimidated and there was little discussion about this group at the safer custody meetings. Prisoners said that verbal abuse and bullying sometimes went unchallenged by staff. F wing was exclusively used for vulnerable prisoners, about 20% of whom were there for their own protection. The inspection found that other prisoners were unhappy about sharing a wing with sex offenders and that the combination of these groups was challenging.

25. Despite efforts to tackle the supply of drugs, the inspection found that they were still too easily available. 63% of prisoners said it was easy to get illicit drugs in the prison.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2017, published in April 2018, the board said that significant issues had been reported in the 2016 IMB annual report, and the board remained concerned that many prisoners felt unsafe, particularly those on recall or in the vulnerable category.

27. The IMB recognised that the new Safer Custody Team had been actively addressing these issues with efforts being made to reduce the incidence of self-harm and suicide.

Previous deaths at HMP Leeds

28. Mr Deane was one of seven prisoners to die at Leeds in 2017. There were no similarities with the other deaths.

Vulnerable prisoner units

29. Prisoners who are regarded as vulnerable can be held separately from other prisoners for their own protection in Vulnerable Prisoner Units (VPUs). Prisoners might be considered vulnerable because of the nature of their offence, or due to problems such as debt or bullying on standard wings. The mix of prisoners in VPUs can, therefore, be very complex.

30. Our investigations into homicides in prisons have highlighted the need to be aware of potential conflicts between individuals with different vulnerabilities in VPUs, and to manage prisoners appropriately who might need to be held separately from the general prisoner population but who also pose a significant risk to other vulnerable prisoners.

Homicides in prison

31. Homicides in prison remain mercifully uncommon. Prisons contain many people who pose a serious risk of harm to others, but very few kill in custody. Learning can be slow to emerge from these deaths because of the need to build, and then not prejudice, a criminal case against those responsible.

32. The PPO can only complete an investigation once the criminal process has finished. Unlike a criminal investigation, the PPO’s remit is to examine the circumstances surrounding the death and establish whether anything can be done to help prevent similar tragedies in the future.

33. To that end we have published two Learning Lessons Bulletins on homicides in prison. The first, published in December 2013, noted a common theme that staff did not always have access to or fully consider all relevant information in a prisoner’s record. As a result, staff were not always aware of the information held about the risk a prisoner posed. We said that staff should be made aware of a prisoner’s history of violence. We also noted that VPUs often hold a complex mix of prisoners and there needs to be a clear strategy to manage prisoners in VPUs who are a risk to other vulnerable prisoners.

34. In a further Learning Lessons Bulletin, issued in September 2016, we identified the need to better manage violence and debt in prison, not least that associated with the use of psychoactive substances. We said that when a prisoner is identified as potentially at risk of harm from others, action should be taken to ensure they are appropriately protected and located in a safe place.

Cell sharing risk assessments

35. Prison Service Instruction (PSI) 20/2015, *Cell sharing risk assessment*, says that a prisoner's suitability to share a cell must be assessed whenever it is proposed to locate him or her with one other prisoner. It sets out the process to be followed based on research into risks where two prisoners are located together in a locked cell. The purpose of the risk assessment tool is to help staff to identify prisoners at risk of murdering or very seriously assaulting another prisoner in a closed space.

36. The PSI says that the CSRA should be seen as a live document and all staff should be encouraged to report changes in a prisoner's behaviour which affects one of the CSRA risk issues.

Psychoactive Substances (PS)

37. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a genuine problem across the prison estate. They are difficult to detect and can affect people in several ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

38. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

39. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Assessment, Care in Custody and Teamwork

40. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Mr Liam Deane

41. On 13 August 2017, Mr Liam Deane was remanded to HMP Leeds charged with assault on his two-day old daughter. This was Mr Deane's first time in prison.

42. On his arrival at Leeds, an initial health screen was completed by a healthcare assistant, and a nurse. They recorded that Mr Deane had no significant medical history, was not taking any regular medication and did not report any physical health issues. Mr Deane said that he had no previous mental health issues or previous contact with mental health services. He said that he had no thoughts or intent to self-harm and denied any current or previous substance misuse. The nursing staff reported that Mr Deane engaged well during the health screening.

43. The nurse completed the healthcare section of the cell sharing risk assessment (CSRA), which is designed to assess the risk of violence a prisoner poses to a possible cellmate. She recorded that none of the standard risk factors (psychosis, extremely disturbed behaviour, failure to engage with the reception process, agitation or aggressive attitudes and behaviour) were present and there was no increased risk of sharing a cell. Mr Deane said that he was willing to share a cell and raised no concerns.

44. Because of the nature of his offence, Mr Deane was given vulnerable prisoner status and located in the vulnerable prisoner unit (VPU).

45. On 15 August, Mr Deane was told by a member of the chaplaincy team, in the presence of a supervising officer (SO), that his daughter had died because of the injuries she had sustained. The chaplaincy team offered Mr Deane support and started suicide and self-harm prevention procedures (known as ACCT) as a precautionary measure. Mr Deane was reviewed by a mental health nurse the following day, prior to an ACCT review.

46. In her written police statement, the mental health nurse said that Mr Deane did not show any signs of emotional distress. She said that he was quiet but not withdrawn. He engaged appropriately with the staff and showed good eye contact. She also said she had not completed a full mental health assessment at that time, because there was no requirement to do so, but advised Mr Dean how to self-refer if his mood changed. The mental health nurse said that she had no concerns about Mr Dean and there was no follow up appointment planned.

47. During the ACCT review, it was recorded that Mr Deane had not presented with any identified risks of self-harm. Mr Deane said that he was aware that he could access a wing Listener (a Samaritans-trained prisoner who can provide emotional support). Mr Deane told the review that he had another child and he needed to be alive to care for her. He also said that he was nervous about the response from other prisoners. Staff reassured him that he would be safe. Mr Deane was encouraged to socialise more and it was agreed that the ACCT would be closed.

48. On 5 October 2017, Mr Deane was found guilty of murder and was sentenced to life imprisonment. On his return from court, he was assessed by the mental

health nurse who had seen him previously. She completed a one-to-one assessment of Mr Deane's mood, risk and coping strategies. She said that Mr Deane was quite composed and he was not distressed or tearful in any way. She said that they spoke about his sentence and Mr Deane said he had been expecting a life sentence so he had had time to get used to this. The mental health nurse said that from the conversations that she had had with Mr Deane, it was clear that his mother and older daughter were protective factors against suicide for him.

49. Mr Deane raised no concerns about his metal state or his mood. However, he told the mental health nurse that he had received indirect threats from other prisoners because of his offence, that he believed wing staff were aware of it, and that he kept to himself. There is no evidence that prison staff, or the nurse took any action in response to Mr Deane's concerns.

50. A fellow prisoner, told the police that he was Mr Deane's friend. The prisoner said when Mr Deane first arrived at Leeds, he shared a cell with him for four months. He said that he continued to speak to Mr Deane after they stopped sharing a cell, and had asked him if he got on with his new cellmate. Mr Deane said, 'He's awake all night and asleep all day.' The prisoner also said that in November, Mr Deane asked him if he would share a cell with him again, but that he felt this was because they got on well, rather than that Mr Deane was not getting on with his current cellmate.

The perpetrator

51. The perpetrator was serving an indeterminate sentence for raping and seriously assaulting a woman in 2008 when he was aged 19. He had previous convictions for assault, sexual assault and indecent exposure. He had been released on licence and had been remanded into prison custody after breaching a Sexual Offences Prevention Order (SOPO) in the community. He arrived at Leeds on 9 March 2017, having transferred from HMP Hull where he had been on remand.

52. On his arrival at Leeds, it was recorded that he had a history of illicit drug use. He had been found under the influence of drugs numerous times at other prisons. Staff referred him to drug and alcohol services (DARS) but he chose not to engage.

53. The perpetrator's medical records did not indicate that he had any formal mental health conditions, although there was reference to previous involvement with PIPE (Psychological Informed Prison Environment) at Hull, suggesting he might have a personality disorder. He had been prescribed Sertraline (an antidepressant) for low mood since 2016, although he did not have a formal diagnosis of depression.

54. The perpetrator's CSRA was reviewed when he arrived at Leeds. There was nothing recorded that suggested he had been aggressive or violent to staff or other prisoners in custody. The CSRA was completed and assessed him as able to share a cell.

55. Although there was nothing of a violent nature in the perpetrator's prison record, his behaviour was poor in terms of failing to comply with prison rules, including

regularly refusing to attend work. This had resulted in him being placed on a basic regime for much of his time at Leeds (which meant that he had less time out of his cell).

56. In May, the PIPE unit at HMP Hull wrote to healthcare staff at Leeds. They said that the perpetrator had previously been a resident on the PIPE unit prior to being deselected due to problematic behaviour, and that they had received a ‘strange’ letter from him saying that one of the PIPE unit officers was his 'disowned brother'. They said that the perpetrator had previously had substance misuse issues and had some ‘vulnerability issues’. They said that he had had a mental health assessment in April 2017 after sending a similar letter, and that no issues had been raised. The perpetrator had said he did not remember sending the letter. There is no evidence that any further action was taken by healthcare staff at Leeds or that prison staff were made aware.

57. On 9 July 2017, the perpetrator was found to be under the influence of an illicit substance, believed to be PS, and needed healthcare treatment. The perpetrator did not tell staff what he had taken, but he was advised on the dangers of PS use. He declined any additional support.

58. On 25 August 2017, he was assaulted by his then cellmate who threw boiling water over him, resulting in first and second degree burns to his face. The perpetrator was treated by nursing staff, but refused to go to hospital. Nursing staff encouraged him to attend hospital, but recorded that he had the mental capacity to refuse treatment. The perpetrator’s cellmate told staff that he had assaulted him because he was a sex offender.

59. On 19 October, the perpetrator began sharing a cell with Mr Deane. There are no records of any problems between the perpetrator and Mr Deane while they were sharing a cell and no suggestion that either was at risk from the other.

Events of 12 November 2017

60. At approximately 5.30am on 12 November, Mr Deane and the perpetrator’s emergency cell bell was activated. An operational support grade (OSG), answered the bell. When he looked into the cell through the observation panel, the perpetrator said, ‘I think my cellmate has self-harmed.’ The OSG asked why he thought that, and the perpetrator said, ‘I can see blood.’ The OSG asked the perpetrator whether Mr Deane was breathing, and he said ‘no.’ The OSG used his radio to call a medical emergency code blue (indicating that a prisoner is either unconscious or having difficulty breathing) before entering the cell.

61. A nurse responded immediately. She said in her police statement that it took her around two minutes to get to Mr Deane’s cell. On her way there, a call came over the radio changing the emergency code blue to a code red, indicating blood loss. When she arrived, she said the OSG was in the cell, together with the perpetrator. The nurse said that she asked the perpetrator to leave the cell. She then placed a chair next to the bunk, so that she could stand on it to gain access to Mr Deane on the top bunk.

62. The nurse said Mr Deane’s injuries looked serious and she asked the OSG to help her roll him onto his back so that she could assess him properly. The nurse

said Mr Deane had mottled skin, was cold to the touch and his limbs were stiff. There was blood on his chest but she could not see any obvious injuries. The nurse said that from her assessment, she believed any attempts at resuscitation would be futile as Mr Deane had clearly been dead some while.

63. Another nurse also responded. She said that when she arrived, she saw Mr Deane lying chest down on the top bunk with his face towards the wall. She said her colleague rolled Mr Deane towards her, and she could see that he had a large amount of blood on the front of his T-shirt and a large amount of congealed blood on the mattress. She could not hear a heartbeat. The nurse checked for a pulse and could not find one. The second nurse said she could not see any injuries to indicate where the blood was coming from, but after discussing with her colleague, they agreed that it would be futile to carry out resuscitation.

64. Paramedics attended at approximately 5.55am. At 6.03am, the paramedics confirmed that Mr Deane had died. All staff left the cell to preserve the scene.

Contact with Mr Deane's family.

65. Due to the nature of Mr Deane's death, the police appointed a family liaison officer to support Mr Deane's family. The police also informed the family of Mr Deane's death. A prison officer was appointed by the prison as family liaison officer, but due to the police involvement, he had no direct contact with the family.

Support for prisoners and staff

66. After Mr Deane's death, a duty manager, debriefed the staff involved in the incident to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

67. The prison posted notices informing staff and prisoners of Mr Deane's death, and offering support. Prisoners assessed as being at risk of suicide or self-harm were reviewed in case they had been adversely affected by Mr Deane's death.

Post-mortem

68. A post-mortem examination established that Mr Deane died from head and neck trauma. Toxicology results also indicated that he had used PS before his death.

Police investigation and trial

69. The perpetrator was arrested later on the morning of 12 November on suspicion of murder. The perpetrator initially indicated to officers that he wanted to admit to what he had done. However, during several hours of police questioning, the perpetrator consistently replied, 'No comment' to all questions and pleaded not guilty when charged with Mr Deane's murder.

70. It was established at the trial that while Mr Deane was incapacitated due to using PS, the perpetrator used a broken bottle to inflict three wounds, one to the back of Mr Deane's head and two to his left cheek, together with other minor cuts and abrasions. The judge said that he had inflicted the wounds while kneeling behind Mr Deane on the top bunk. He then asphyxiated him, first by strangulation and then by covering his mouth or pushing his face into the bedding.

71. Neither injury killed Mr Deane immediately, and he would have remained alive for several minutes after the initial assault. The judge said if the perpetrator had chosen to call assistance immediately after the assault, it is very likely Mr Deane would have lived.

72. The reason the perpetrator gave for his attack on Mr Deane was that Mr Deane was a sex offender – he was not. The judge said that it was impossible to know whether he had killed Mr Deane 'for his own satisfaction' or to 'curry favour with others' or because others had encouraged him to do so.

73. On 2 August 2018, the perpetrator was found guilty of the murder of Mr Deane and was sentenced to life imprisonment with a minimum term of 19 years.

Findings

Clinical care

Mr Deane's clinical care

74. The clinical reviewer who reviewed Mr Deane's clinical care concluded that the clinical care he received at Leeds was of an acceptable standard and equivalent to that which he could have expected to receive in the community.

75. The clinical reviewer noted that Mr Deane had no history of physical or mental health problems.

The perpetrator's clinical care

76. The clinical reviewer who reviewed the perpetrator's clinical care concluded that the care he received prior to the events 12 November 2017, was appropriate.

77. The clinical reviewer found that his medical notes indicated no historical risk to others in custody.

78. The clinical reviewer said that the perpetrator might have shown symptoms indicative of drug misuse and considers that this was managed appropriately. The perpetrator did not engage with drug and alcohol services (DARS) although this was offered to him and was revisited with him on several occasions.

79. The clinical reviewer found that the perpetrator did not appear to interact socially with others and that his engagement and co-operation were limited. This was evident throughout his prison and healthcare notes and on looking at the transcripts of police interviews following the attack. The clinical reviewer said that this might be part of his inherent personality, with no obvious signs of a formal mental illness.

Cell sharing risk assessment

80. Mr Deane had a cell sharing risk assessment completed when he arrived at Leeds. The assessment took into account Mr Deane's known risk factors, although little was known other than his index offence. In the responses he gave there was nothing that suggested he was a risk or threat to other prisoners, and he was assessed as a standard risk and suitable to share a cell.

81. The perpetrator's cell sharing risk assessment was appropriately reviewed when he arrived at Leeds in March 2017 after being recalled to custody. Although The perpetrator had convictions for assault, these dated back to 2008 and involved elderly women. He had a poor record of behaviour in terms of not complying with prison rules, but this did not include violence towards other prisoners, and nothing in his prison record indicated that he was a risk of harm to others.

82. We are satisfied that CSRAs were appropriately carried out on both prisoners and that there was nothing to suggest that the perpetrator posed a risk to Mr Deane or any other cellmate.

Violence reduction/vulnerable prisoners

83. Leeds' local Violence Reduction Strategy, dated 2017' states that all incidents of violence, both verbal and physical, must be thoroughly investigated and actions taken and support provided must always be documented.

84. The perpetrator and Mr Deane were vulnerable due to the nature of their offences. As a result, they were located on the vulnerable prisoner wing on their arrival at Leeds. There was no information to suggest that the perpetrator and Mr Deane were a risk to others.

85. The perpetrator was attacked by his previous cellmate in July 2017, and the prisoner who carried it out, told staff that he had done so because the perpetrator was a sex offender. Following the incident, the perpetrator was offered support and medical intervention, but declined both. His cellmate was removed from the wing and later transferred to another prison.

86. Mr Deane's offence had attracted a lot of local media attention. When he first arrived at Leeds, Mr Deane told prison staff that he was worried about the reaction of other prisoners, and staff reassured him that he was safe.

87. After he was convicted in October, Mr Deane told a nurse that other prisoners, including some on the vulnerable prisoner wing, had verbally abused and indirectly threatened him because of his offence. He said that prison staff were aware of the threats and abuse. However, there is nothing recorded in Mr Deane's prison records to indicate that staff were aware that he was being threatened or what, if any, action was being taken to safeguard him.

88. Apart from what he said to the nurse, there is no evidence in Mr Deane's prison records he was being abused or threatened by other prisoners. However, given the local notoriety of his offence, it would not have been surprising if he had attracted some hostility and staff should have been aware of this possibility. There is also no record that Mr Deane told staff he was being abused and threatened.

89. We are concerned that staff working in the VPU were either not aware that Mr Deane was at risk because of his offence, or that they were aware and took no action under the prison's violence reduction policy to investigate and support Mr Deane. Staff in VPUs need to be particularly alert to the possibility of bullying and proactive in tackling it. We note that in their last inspection HMIP expressed concern about the arrangements for vulnerable prisoners at Leeds, and found that this group of prisoners felt particularly unsafe and intimidated, that there was little discussion about them at the prison's safer custody meetings, and that prisoners in the VPU said that verbal abuse and bullying sometimes went unchallenged by staff.

90. Having said that, we have seen nothing to suggest that the perpetrator posed a risk to others generally or to Mr Deane specifically, or that that staff could reasonably have been expected to foresee that he might murder Mr Deane.

91. We make the following recommendation:

The Governor should ensure that:

- **supervision of vulnerable prisoners in the VPU means that they are safe and free from bullying and intimidation;**
- **staff consider the risk to individual prisoners and must not assume that are safe simply because they are in the VPU; and**
- **whenever such bullying or intimidation is identified or reported, staff must follow the procedures set out in the prison's Violence Reduction policy.**

Psychoactive Substances

92. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS use has a profoundly negative impact on physical and mental health, and can also lead to debt, violence and intimidation. Prisoners under the influence of PS are also vulnerable to humiliation for the enjoyment of other prisoners. PS use has also been linked with precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

93. Mr Deane was not identified as having a drug misuse problem. He told staff that he had no current or previous substance misuse and no further action was taken. However, toxicology tests showed that Mr Deane had PS in his system at the time of his death. Staff had not identified Mr Deane as a PS user but the perpetrator said at his trial that Mr Deane had taken Spice (a PS) repeatedly in the previous week. The clinical reviewer was satisfied however, that Mr Deane did not have a known or suspected substance misuse problem.

94. Substance misuse was an ongoing issue for the perpetrator. He had a history of drug misuse and in July 2017, he was found to be under the influence of an illicit substance. Staff tried to encourage the perpetrator to engage with DARS on several occasions, but he chose not to.

95. The perpetrator and Mr Deane took PS on the night of 11 November. We cannot know whether the mind-altering effects of PS played any part in the perpetrator's decision to assault Mr Deane. However, the trial judge found that PS played a significant part in Mr Deane's death in two ways. First, although Mr Deane was a larger man than the perpetrator, it rendered him incapable of resisting the perpetrator's attack on him, Secondly, the wounds Mr Deane suffered would not have been sufficient to kill him were it not for the fact that the PS had the effect of inhibiting 'his body's ability to adjust to the major, but not necessarily fatal, blood loss'.

96. This illustrates some of the many ways in which PS poses a serious risk to the safety of prisoners and staff.

97. Leeds is taking active steps to reduce the availability of drugs. The prison has introduced machines to test all mail and property entering the prison for illicit substances. The process for searching both domestic and legal visitors has been reviewed, and increased searching, patrols and joint initiatives with local police have also been introduced. Managers are looking at other ways in which

funding from the 10 Prisons Project can be used to reduce the supply and demand for illicit drugs and plan to update their local drugs strategy in March.

98. Nevertheless, we are concerned that drugs were easily accessible to prisoners at the time of Mr Deane's death.

99. Leeds is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on the best measures to tackle the problem.

100. In a number of recent investigations, we have recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive told us that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (March 2019), this strategy has still not been issued, although we have been told that this will happen 'shortly'. We therefore repeat the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

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