Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Brady, a prisoner at HMP Leeds, on 15 September 2020

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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Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Robert Brady died in Wheatfield Hospice, Leeds, on 15 September 2020 of lung cancer while a prisoner at HMP Leeds. Mr Brady was 79 years old. I offer my condolences to Mr Brady's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Brady received at Leeds was good and equivalent to that which he could have expected to receive in the community. She made four recommendations. We have combined two of her recommendations in this report to make three recommendations.

5. We found no non-clinical issues of concern. We make no recommendations.

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

Recommendations

- **The Head of Healthcare should ensure that staff use appropriate risk assessment tools for prisoners at risk of malnutrition, skin integrity and falls prevention in accordance with NICE guidelines.**
- **The Head of Healthcare should ensure that care plans are created and fully documented in prisoner's medical records to allow effective continuity of care.**
- **The Head of Healthcare should liaise with Care UK's regional data analyst and North Leeds Specialist Commissioning Group for an update on the unavailability of Mr Brady's care plans and risk assessments.**

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Brady's clinical care at HMP Leeds.

8. The PPO investigator has investigated non-clinical issues, including Mr Brady's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Brady's next of kin, his niece, to explain the investigation. She did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Leeds

11. Mr Brady was the 18th prisoner to die at Leeds since September 2018. Of the previous deaths, eight were from natural causes, seven were self-inflicted deaths and two were drug-related deaths. There are no similarities between our findings in the investigation into Mr Brady's death and our investigation findings for the previous deaths.

Key Events

12. On 11 September 2019, Mr Brady was remanded to HMP Durham on charges of sexual offences. He transferred to HMP Leeds on 30 September. On 15 June 2020, he was sentenced to 19 years in prison for sexual offences.

13. Mr Brady had a number of pre-existing medical conditions including mild COPD (chronic obstructive pulmonary disease), diabetes, diverticulitis (a form of bowel disease) and osteoarthritis (a joint disease which results in pains in the joints).

14. On his arrival at Leeds, Mr Brady had an initial and secondary reception health screen. The nurse noted his medical conditions and no areas of concerns were identified. No care plans were created to manage his long-term conditions.

15. In February 2020, Mr Brady complained of a productive cough. The GP referred him for a chest X-ray and the results indicated that he might have cancer. As a result, the GP made a two week wait referral for suspected cancer. Following test results completed in June, a respiratory hospital consultant diagnosed Mr Brady with incurable lung cancer. Mr Brady had six radiotherapy sessions until 1 July.

16. On 12 June, Mr Brady said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

17. Mr Brady's condition deteriorated. On 14 September, prison staff at Leeds began the process of applying for early release on compassionate grounds on Mr Brady's behalf.

18. Mr Brady told staff that he wanted to die in a hospice, and, on 15 September, prison healthcare staff arranged for his transfer to Wheatfield Hospice. Mr Brady died there later that evening at 8.00pm.

Inquest report

19. An inquest into Mr Brady's death was held on 5 October. The Coroner concluded that Mr Brady died of synchronous small cell lung cancer and non-small cell lung cancer.

Lisa Burrell

Assistant Prisons and Probation Ombudsman June 2021

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