Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Waller, a prisoner at HMP Leeds, on 15 July 2018

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*

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 Robert Waller died on 15 July 2018 after being found hanged in his cell at HMP Leeds. He was 48 years old. I offer my condolences to Mr Waller's family and friends.

Mr Waller had only been in prison for around ten hours when he died. He had a significant history of illicit drug use, anxiety, depression and attempted suicide. It is deeply concerning that an officer falsified records and did not conduct a check under suicide and self-harm procedures in the three hours before Mr Waller was found hanged. I note that the officer concerned has now been dismissed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **November 2020**

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Summary

Events

1. Mr Robert Waller had a significant history of illicit drug use, anxiety, depression and attempted suicide. He had served previous prison sentences and had been released from his last sentence on 29 March 2018. On 14 July, Mr Waller appeared at Leeds Magistrates Court charged with robbery and was remanded into custody at HMP Leeds.

2. When Mr Waller arrived at Leeds at 1.45pm, staff immediately monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT) as he had said he was certain he would self-harm while in prison.

3. At 11.46pm, an officer found Mr Waller hanged in his cell. He requested an ambulance and officers and medical staff attended, and began cardiopulmonary resuscitation which continued until paramedics arrived. The paramedics took over emergency treatment, but at 0.17am on 15 July, the paramedic doctor pronounced Mr Waller had died.

Findings

Management of risk of suicide and self-harm

4. Although staff appropriately opened ACCT procedures when Mr Waller arrived at Leeds, we are concerned that they assessed his risk of suicide and self-harm on the basis of his presentation.

5. We found that ACCT procedures at Leeds were not conducted in line with mandatory national instructions as one member of staff did not conduct hourly checks after 9.00pm as required. The Operational Manager of HMP Leeds held an internal investigation and the member of staff was dismissed.

Illicit Substances

6. Mr Waller used illicit drugs and tested positive for opiates when he arrived at Leeds. Toxicology results confirm that Mr Waller had used illicit drugs before he arrived at Leeds and was prescribed therapeutic levels of medication after he arrived at Leeds.

Clinical care

7. The clinical review concluded that overall the care provided to Mr Waller was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Operational Manager and Head of Healthcare should remind staff that they must actively assess a prisoner's level of risk based on the information and documents available to them, and that observations should be set according to this assessment, balanced with his presentation.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

9. The investigator visited Leeds on 23 July. He obtained copies of relevant extracts from Mr Waller's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Waller's clinical care at the prison.

11. The investigator interviewed five members of staff and two prisoners at Leeds in August. Mr Waller's cellmate spoke very limited English and was released three days after Mr Waller's death and so, was unavailable for interview. It was also not possible to interview a Supervising Officer (SO) who was on long-term sick leave at the time of the investigation.

12. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigator contacted Mr Waller's mother, to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Waller's mother raised a concern which was outside of the remit of this investigation. This has been addressed through separate correspondence.

14. Mr Waller's mother and daughter received a copy of the initial report. Mr Waller's daughter pointed out an omission. This report has been amended accordingly. Mr Waller's mother did not make any comments.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Leeds

16. 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. CareUK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

17. 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 involved. The project is focusing on improving reducing violence, living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons (HMIP) carried out an inspection of Leeds in November 2017. Inspectors found Leeds to be an unsafe prison, with high levels of violence. Illicit drugs were easily available. Inspectors considered that the healthcare services outcomes for prisoners remained reasonable but triage clinics for mental health were not effectively used. Inspectors found the levels of self-harm were significantly higher compared to those of other local prisons. Inspectors found initial ACCT assessments were generally good, and reviews were generally multidisciplinary. However, caremaps were inadequate and recorded observations by staff lacked meaningful interaction with prisoners.

Independent Monitoring Board

19. 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 annual report, published in May 2019 the IMB were very concerned about the availability of psychoactive substances (PS) and the impact this had on prisoners' wellbeing and the prison regime. The IMB were also concerned about the provision and delivery of mental health services.

Previous deaths at HMP Leeds

20. Mr Waller's was the tenth self-inflicted death to occur at Leeds since January 2015. In previous self-inflicted deaths we made recommendations about the management of suicide and self-harm procedures. Since Mr Waller's death there have been five self-inflicted deaths at Leeds. In the report into one of those deaths, issued in November 2019, we escalated our concerns over the management of suicide and self-harm procedures at Leeds directly to the Prison Group Director. We have not therefore escalated again on this occasion.

Assessment, Care in Custody and Teamwork (ACCT)

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm.

Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

22. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

23. Mr Robert Waller had been in prison several times since 1985. He was most recently released on 29 March 2018. Mr Waller had a history of illicit drug use while serving previous sentences. He was diagnosed with diabetes, asthma, depression and ischaemic heart disease following a heart attack in 2010.

24. On Saturday, 14 July, Mr Waller appeared at Leeds Magistrates Court charged with robbery and burglary. He was remanded into custody at HMP Leeds until his appearance at Bradford Crown Court on 13 August.

25. A Police Custody Officer (PCO) had completed a Person Escort Report (PER) and a Suicide and Self-Harm Warning (SSHW) form. These documents are intended to alert staff in all criminal justice agencies who come into contact with a prisoner about their risk of suicide and self-harm. The PCO noted on the forms that Mr Waller said he would kill himself in prison. He also noted that in June Mr Waller had attempted to hang himself, had deliberately jumped in front of cars and had self-harmed by cutting. The PER and SSHW form accompanied Mr Waller to Leeds.

26. A Supervising Officer (SO) assessed Mr Waller when he arrived in reception at 1.45pm. The SO signed the PER and SSHW forms and immediately opened an ACCT. The SO noted that Mr Waller had a partner for support but that he was concerned that she would not stay with him while he was in prison. The SO assessed that Mr Waller was low in mood and asked when he would receive his medication. The SO noted that Mr Waller wanted to be on a small unit where he could "get his head down". The SO recorded that Mr Waller did not seem to have an immediate plan to harm himself. The SO set Mr Waller's level of observations at hourly throughout the day and night until the first assessment. Mr Waller was allocated a double cell on the first night centre.

27. A nurse saw Mr Waller in reception. The nurse recorded that Mr Waller was on an ACCT, had a history of self-harm but had no current suicidal thoughts. The nurse recorded that Mr Waller tested positive for opiates, and suffered from diabetes, asthma, depression and ischaemic heart disease. The nurse referred Mr Waller to the doctor and the mental health team.

28. An advanced nurse practitioner saw Mr Waller following the nurse's referral. The advanced nurse practitioner recorded that Mr Waller had arrived in custody with his prescribed medication. Mr Waller said he spent £80 a day on drugs and had last used drugs two days before his arrival at Leeds. He said he had no thoughts of self-harm. She noted that Mr Waller was on an ACCT as he had stated he would harm himself while in prison. She told the investigator that Mr Waller's presentation gave no indication he was at of risk of suicide and she agreed that hourly observations were appropriate.

29. The advanced nurse practitioner repeated Mr Waller's prescribed medication of bisoprolol (for high blood pressure), glyceryl trinitrate (for angina), monomil XL (for angina), ramipril (for high blood pressure), atorvaststin (for high cholesterol), mirtazapine (an antidepressant), gabapentin (for nerve pain) and aspirin. She also prescribed one 15ml dose of methadone (an opiate substitute) until Mr Waller saw the substance misuse doctor the next day.

30. Mr Waller's security records show that he had a history of illicit drug use since 2014. The investigator found there was no evidence or intelligence that Mr Waller used drugs, was in debt or was bullied after his arrival at Leeds on 14 July.

31. Staff recorded in the ACCT document that they observed Mr Waller at 2.30pm, 3.20pm and 4.23pm. An officer recorded that he observed Mr Waller at 5.00pm, 5.23pm, 6.10pm, 6.30pm, 7.20pm and 8.15pm. The officer told the investigator there were no issues or concerns about Mr Waller at the times he checked on him. The officer said Mr Waller helped his cellmate who had very limited understanding of English.

32. A prisoner who was a Samaritan-trained Listener, told the investigator his role as a Listener on the first night centre was to offer support to newly arrived prisoners. The prisoner said he knew Mr Waller from previous sentences at Leeds. He said Mr Waller appeared fine and gave no indication that he had any issues or problems.

33. CCTV footage shows that an officer went to Mr Waller's cell at 9.00pm. The officer recorded that he had introduced himself as the night duty officer and there were no concerns. The officer also recorded that Mr Waller knew the officer's father, an officer at another prison where Mr Waller had served a previous sentence.

34. At 9.55pm, a substance misuse nurse recorded that she had checked Mr Waller and saw he was in bed, appeared asleep and that she was able to see breathing movements.

35. At 10.08pm, the officer recorded in the ACCT document that he had checked on Mr Waller and that he was lying on the bed watching television. However, the CCTV footage of the first night centre shows that the officer made no checks on Mr Waller after 9.00pm.

36. At 11.46pm, CCTV footage shows, an operational support grade (OSG) arrived on the wing. He responded to screams for help coming from Mr Waller's cell. Mr Waller's cellmate had woken, found Mr Waller hanging from the window bars and screamed for help.

37. The OSG told the investigator that he opened the observation panel and, using his torch, saw Mr Waller hanging from the window bars in his cell by a ligature which appeared to be made from bedding. The OSG said Mr Waller's cellmate was sitting on the top bunk and screamed for someone to help. The OSG immediately radioed a code blue emergency, which indicates a prisoner is unconscious or having difficulty breathing.

38. The control room log shows the OSG called the code blue over the radio at 11.46pm and an ambulance was called immediately.

39. CCTV footage shows that the officer had also arrived at the cell within 20 seconds of Mr Waller's cellmate's screams. He entered the cell and cut the ligature, causing Mr Waller to fall to the ground with some force. The officer moved Mr Waller out of the cell and onto the landing and began cardiopulmonary resuscitation (CPR).

40. At 11.48pm, a Custodial Manager (CM) and a nurse arrived at Mr Waller's cell. The nurse and the CM continued with the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the nurse and the CM continued CPR.

41. Paramedics arrived on the first night centre 11.56pm and took over Mr Waller's care. They continued with CPR and, after a period of treatment, at 0.17am on 15 July, paramedics pronounced Mr Waller had died.

Contact with Mr Waller's family

42. At 2.00am on 15 July, an officer was appointed as family liaison officer (FLO). The FLO, along with the Duty Operational Manager, went to the prison and liaised with police to verify the contact details for Mr Waller's next of kin, his sister. At 6.00am, they visited Mr Waller's sister at her home address, to break the news of her brother's death and offer condolences. In the days that followed, the FLO maintained contact with Mr Waller's family and in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

43. A custodial manager held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

44. The prison posted notices informing staff and prisoners of Mr Waller's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Waller's death. Mr Waller's cellmate was moved to another cell and was supported by staff.

Post-mortem report

45. A post-mortem examination confirmed that the cause of Mr Waller's death was hanging. The pathologist noted that Mr Waller had a fractured lower spine which most likely occurred when Mr Waller fell to the ground after the officer cut the ligature. The toxicology results indicated previous cocaine use or exposure. In addition, analysis confirmed a sub-therapeutic level of methadone, and therapeutic levels of mirtazapine and gabapentin. The drugs detected were all at relatively low concentrations and unlikely to have had a significant effect on Mr Waller's thoughts or behaviour.

Findings

Management of risk of suicide and self-harm

46. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

47. Mr Waller had said he would kill himself in prison and had made suicide attempts in the month before he arrived at Leeds on 14 July. Although staff appropriately opened an ACCT immediately on Mr Waller's arrival at Leeds, we are concerned that both prison and healthcare staff assessed his risk on the basis of his presentation, rather than also taking his risk factors into account. If they had considered his risk factors, they may have concluded that he should be observed more frequently than once an hour.

48. We recommend:

The Operational Manager and Head of Healthcare should remind staff that they must actively assess a prisoner's level of risk based on the information and documents available to them, and that observations should be set according to this assessment, balanced with his presentation.

49. In previous self-inflicted deaths we made recommendations about the management of suicide and self-harm procedures. In the report into one of those deaths, issued in November 2019, we escalated our concerns over the management of suicide and self-harm procedures at Leeds directly to the Prison Group Operational Manager. We have not therefore escalated again on this occasion.

50. The hourly observations were correctly conducted and documented up to and including 9.00pm. However, the officer failed to undertake any checks on Mr Waller after that. He also made a false entry in the ACCT document to say he had checked Mr Waller at 10.08pm.

51. The Operational Manager of HMP Leeds, suspended the officer on 23 July and conducted an internal investigation into his actions, which resulted in the officer's employment with the Prison Service being terminated.

Clinical care

52. The clinical reviewer judged that the care Mr Waller received from healthcare staff at HMP Leeds was equivalent to the care he would have received in the community.

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