Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerard Toner, a prisoner at HMP Leeds, on 6 August 2019

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 Gerard Toner died on 6 August 2019 of hepatic encephalopathy (changes in the brain that occur in patients with advanced liver disease) while a prisoner at HMP Leeds. He was 42 years old. I offer my condolences to Mr Toner's family and friends.

The clinical reviewer concluded that the healthcare Mr Toner received at Leeds was of an acceptable standard and equivalent to that which he could have expected to receive in the community.

We are not satisfied that the use of restraints was justified for the first few hours of Mr Toner's stay in hospital.

My investigation also found that there was too long a delay in telling Mr Toner's family that he was in hospital and seriously unwell.

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 **February 2022**

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Summary

Events

1. On 1 June 2019, Mr Gerard Toner was remanded to prison charged with being in possession of a bladed article in a public place. He was sent to HMP Leeds and subsequently received a five month prison sentence.

2. Mr Toner had a number of pre-existing medical conditions, including hepatitis C, epilepsy, diabetes and paranoid schizophrenia. He also had a 20-year history of substance misuse which affected his mental health and he had previously been sectioned under the Mental Health Act. When he arrived at Leeds, he was prescribed medication for his various conditions.

3. Mr Toner was suspected of being under the influence of psychoactive substances (PS) on eight occasions in June and July 2019 at HMP Leeds. On each occasion, he was found in his cell unresponsive and/or having a seizure. On each occasion, he was taken to hospital by emergency ambulance and the hospital diagnosed that he was suffering from the effects of PS. He was supported by the prison's mental health and substance misuse services.

4. Over the next two months, prison and healthcare staff became increasingly concerned that Mr Toner's mental and physical health were deteriorating. He was often confused and behaved strangely. He was seen by the visiting psychiatrist who considered that it was not clear if this was the result of Mr Toner's frequent use of PS or was caused by a brain injury or disease. He asked for Mr Toner to be referred to a neurologist.

5. At 8.15am on 3 August, an officer found Mr Toner unresponsive in his cell. A 999 call was made and at 8.30am paramedics arrived and took Mr Toner to hospital by emergency ambulance. His condition continued to deteriorate in hospital, and he died on the afternoon of 6 August.

Findings

6. The clinical reviewer concluded that the clinical care Mr Toner received at Leeds was of an acceptable standard and equivalent to that which he could have expected to receive in the community.

7. The clinical reviewer did, however, identify some concerns, although she did not consider that these affected the outcome for Mr Toner.

8. She was concerned that there was no effective system in place to ensure that prisoners receiving treatment for psychosis or schizophrenia had regular health checks, which was not in line with NICE guidelines.

9. The clinical reviewer was also concerned that the visiting psychiatrist did not directly refer Mr Toner to a neurologist to rule out an organic cause for his symptoms, but instead he chose to refer him via a prison GP.

10. We are not satisfied that the use of restraints was proportionate when Mr Toner was taken to hospital.

11. We found that there was too long a delay in telling Mr Toner's family that he was in hospital and seriously unwell.

Recommendations

- The Head of Healthcare and Lead Pharmacist should ensure that an effective system is in place to ensure that prisoners receiving treatment for psychosis or schizophrenia receive regular health checks, in line with the frequency outlined in NICE QS80, *Psychosis and Schizophrenia in Adults*.
- The Head of Healthcare should ensure that visiting psychiatrists are supported to refer patients onto secondary care when appropriate, to avoid delays in referrals.
- The Governor and Head of Healthcare should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.
- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.
- The Governor should write to Mr Toner's mother to tell her the outcome of the prison's investigation into the actions of some of the bedwatch staff.
- The Governor should ensure that all staff understand the need to behave with respect and sensitivity during bedwatches.

The Investigation Process

12. 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. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Toner's prison and medical records.

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

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

16. Mr Toner's next of kin, his mother, received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

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

Background Information

HMP Leeds

18. HMP Leeds is a local prison which holds up to 1,218 prisoners on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including clinical substance misuse and mental health services. The prison has 24-hour primary healthcare cover. There is a 16-bed complex needs unit which provides social and complex care.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Leeds was in December 2019. Inspectors found that the prison had continued to face significant challenges but had improved in many areas since the previous inspection. There was good local leadership of healthcare services and clinical records were of high quality. Health services were generally good, and governance was robust. A range of healthcare services were provided by a skilled staff group, and clinic waiting times were reasonable. Prisoners with long-term conditions and those with social and complex care needs received good support. There was a high demand for mental health services and access was prompt. Drug and alcohol dependent prisoners were treated promptly.

Independent Monitoring Board

20. 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 report for the year to December 2018, the IMB expressed concern that, unlike other comparable prisons, HMP Leeds did not have a dedicated mental health facility. Those prisoners who had been identified as having significant mental ill health issues were cared for in either the Segregation Unit, or the complex care unit, often resulting in disturbance to other prisoners. The IMB urged NHS England to conduct an urgent needs assessment into the provision, and delivery, of mental health services at HMP Leeds.

Previous deaths at HMP Leeds

21. Mr Toner was the 20th prisoner to die at Leeds since August 2017. Of the previous deaths, eight were self-inflicted, one was a homicide, eight were from natural causes and two were drug-related. There have been eight further deaths at Leeds since Mr Toner's death, four self-inflicted, three from natural causes and one drug-related death. There were no similarities between Mr Toner's death and the previous deaths.

Psychoactive Substances (PS)

22. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a significant problem across the prison estate. They are difficult to detect and can affect people in a number of 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.

23. There are many types of PS, including synthetic cannabinoids, often referred to as “Spice”.

Key Events

June 2019

24. On 1 June 2019, Mr Gerard Toner was remanded to prison charged with being in possession of a bladed article in a public place. He was sent to HMP Leeds. He was subsequently sentenced to five months in prison.

25. A prison officer opened ACCT procedures (the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm) in Reception after Mr Toner said he was having suicidal thoughts and had self-harmed three days earlier.

26. Mr Toner had an initial health screen with a nurse. She noted that he had hepatitis C, epilepsy, diabetes and paranoid schizophrenia, and that he had arrived with a prescription for methadone (an opiate used to treat heroin addiction). Mr Toner said he had a 20-year history of substance misuse which also affected his mental health, and that he had misused alcohol, crack cocaine and heroin on a daily basis in the community. In 2018, he had been sectioned under the Mental Health Act and had spent time in psychiatric hospitals. He told the nurse that while he felt supported by his family, they were not prepared to visit him in prison, which had left him feeling low in mood, although he said he had no thoughts of self-harm.

27. The nurse reviewed Mr Toner again the following day. She referred him to the prison's drug and alcohol treatment services (DART) and the mental health in-reach team (MHIRT) because he was displaying signs of poor mental health. He was prescribed several medications, including methadone, olanzapine (an anti-psychotic) and pregabalin (an anti-epilepsy drug).

28. Also, on 2 June, Mr Toner was reviewed by DART and MHIRT. Care-plans were created to manage his recovery and care. DART and MHIRT staff saw him regularly to offer support and encouragement.

29. On 8 June, Mr Toner was seen by a visiting psychiatrist. He noted that Mr Toner struggled to remember his full health history.

30. The ACCT was closed on 11 June after Mr Toner said he no longer felt suicidal and was engaging with DART. ACCT procedures were begun again on 15 June but were closed the following day after Mr Toner admitted having used PS and agreed to continue working with DART.

31. On 15, 24 and twice on 30 June, Mr Toner was suspected of being under the influence of psychoactive substances (PS). On each occasion he was found slumped in his cell, unresponsive and/or having a seizure. There was also evidence of razors being found in his vomit. When he regained consciousness, his behaviour was often erratic, his speech was slurred, and he presented as being confused. On each occasion, prison staff used a medical emergency code to alert healthcare staff, an ambulance was called immediately, and he was taken to hospital.

32. After being taken to hospital on 30 June, Mr Toner had a CT and MRI scan. The results showed no abnormalities but there was evidence of long-standing thickening of the top part of his skull. The scans also showed a build-up of fat in his liver, excess fluid in his abdomen and an inflamed spleen. His condition was noted to be serious, and he was moved to the intensive care unit at the hospital and placed under sedation. Hospital staff diagnosed his symptoms as 'suspected cannabinoid intoxication' and liver cirrhosis (scarring of the liver). An appointment was arranged for him to see a hepatitis specialist at the prison.

July 2019

33. On 5 July, Mr Toner was discharged from hospital and returned to Leeds. He was reviewed twice daily by both healthcare and DART staff. Prison staff were concerned that Mr Toner was sleeping on the floor of his cell and that he appeared to have difficulty following simple commands. He was also unkempt, and his cell was extremely untidy.

34. On 11 July, a nurse saw Mr Toner, and noted he was able to maintain a conversation but that he could not remember his recent admission to hospital. She raised her concerns with the MHIRT.

35. Mr Toner was again suspected to be under the influence of PS on 12 July, although he denied it.

36. On 16 July, a prison GP saw Mr Toner and recorded that he had 'wet brain' (irreversible brain damage caused by long-term alcoholism which has symptoms similar to those of dementia). The GP referred him to DART and arranged further tests and an appointment with the psychiatrist. The following day, Mr Toner refused to attend his appointment with the psychiatrist.

37. Mr Toner was again found under the influence of PS on 19 July and was admitted to hospital with reduced consciousness levels. As a result, he missed his re-booked appointment with the psychiatrist.

38. Mr Toner continued to be reviewed by DART and MHIRT. He denied using PS, but he also told staff that other prisoners were offering him illicit substances and that he felt like a 'guinea pig'. He said that he was willing to work with DART to address his substance misuse issues. He continued to tell staff that he was being 'spiked' with illicit substances and he asked to move to a different wing. Staff completed an incident report and passed it to the prison's security department.

39. On 23 July, Mr Toner was the subject of a multi-disciplinary complex care meeting, where it was agreed he would benefit from a move to the prison's complex care unit for additional support prior to his upcoming release on 16 August. Staff were concern about his pending release because he was vulnerable and appeared unable to care for himself.

40. On 25 July, a nurse saw Mr Toner. When she arrived at his cell, he was slumped on the floor and she noted that the cell was extremely untidy and there was evidence of faeces on the floor. She took his observations, which were normal and made an urgent referral to the MHIRT.

41. On 26 July, a nurse carried out an MHIRT assessment. Prison officers told her that they had seen Mr Toner eating his faeces with a spoon earlier that day. She asked Mr Toner about this and he said that he felt that he was losing his mind and could not control what he was doing. She considered his behaviour could have an organic cause (that is, could be caused by injury or disease affecting the brain) and was not necessarily caused by the use of PS. She referred him to the prison psychiatrist, and he was moved to the prison's complex care unit to receive an increased level of care and observation.

42. The psychiatrist saw Mr Toner on 27 July. He noted that Mr Toner's physical and mental health had deteriorated since he last met with him. He considered it was possible that this was due to substance misuse but noted that it was "imperative to rule out an organic factor". He noted that he would discuss a neurological referral with a prison GP.

43. The prison GP reviewed Mr Toner on 30 July and requested urgent blood samples to confirm a possible diagnosis of hepatic encephalopathy (confusion caused by liver failure).

44. On 31 July, Mr Toner had a seizure, although the effects were evident on just one side of his body and he did not lose consciousness. The psychiatrist reviewed Mr Toner again on 31 July and 1 August. He considered that an urgent referral to a neurologist was required, together with an urgent social care assessment.

45. A prison GP reviewed Mr Toner on 2 August and recorded that he looked better and was less confused, and that he would review him again when the blood test results had been received.

Events of 3 August 2019

46. At 8.15am on 3 August, a nurse went to Mr Toner's cell to give him his medication. She found him unresponsive and shaking on the floor of his cell and thought he may be having a seizure. She immediately used her radio and called a code blue (an emergency medical code indicating a prisoner is unconscious or is having difficulty breathing). The control room called an ambulance.

47. At 8.30am, paramedics arrived at the cell. They attempted to stabilise Mr Toner, but he continued to deteriorate. Mr Toner was taken to St James Hospital, Leeds, accompanied by two prison officers, and restrained using 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.)

48. At around 1.45pm, Mr Toner was moved to the intensive care unit of the hospital and placed into an induced coma. The escort chain was removed, and he remained unrestrained. Hospital staff found pieces of paper lodged at the back of his throat which they considered might have been impregnated with PS. They telephoned prison healthcare staff to tell them that Mr Toner had tested positive for PS and about the paper they had found in his throat. They asked that a search be carried out of Mr Toner's cell to look for evidence of possible substance misuse to assist with their diagnosis. A nurse searched his cell and

found prison library books with parts of pages torn out, but no evidence of any illicit substances.

49. The following day, 4 August, hospital staff carried out a CT scan. The results showed that Mr Toner had damage to the frontal lobe of his brain (likely to have been caused by seizures) and swelling to the brain. They told prison healthcare staff that he could suffer lasting brain damage if he regained consciousness. Mr Toner remained sedated in intensive care.

50. Mr Toner's condition continued to deteriorate, and he died at 4.20pm on 6 August.

Contact with Mr Toner's Family

51. On the morning of 5 August, the prison appointed a Family Liaison Officer (FLO). She visited Mr Toner's next of kin, his mother, at her home to inform her that Mr Toner was seriously ill in hospital. She subsequently met Mr Toner's mother at the hospital and offered support. She maintained contact with Mr Toner's family, offering support and information.

52. Mr Toner's funeral was held on 30 October. The prison contributed to the costs of Mr Toner's funeral in line with national policy.

Support for prisoners and staff

53. The prison posted notices informing other prisoners of Mr Toner'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 his death.

54. After Mr Toner's death, a prison manager debriefed the staff who were involved giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

Post-mortem report

55. The post-mortem report gave Mr Toner's cause of death as acute on chronic (sic) hepatic encephalopathy (changes in the brain caused by advanced, acute or chronic liver disease) caused by hepatitis c and alcoholic liver disease.

56. Post-mortem toxicology tests found no evidence of illicit drugs. However, the toxicologist reported that specimens were obtained three days after Mr Toner's death, and therefore any evidence of illicit drugs may have been excreted within that time.

Findings

Clinical care

57. The clinical reviewer concluded that the care Mr Toner received at Leeds was of an acceptable standard and equivalent to that which he could have expected to receive in the community. She found that Mr Toner received timely support from the DART and mental health teams. She also found that Mr Toner was transferred to the prison's complex care unit for closer observation when staff became concerned about his presentation, and that his condition was tracked via the multidisciplinary team process. She noted that the decline in Mr Toner's ability to complete day to day tasks might have been due to a number of causes, including frequent use of PS, drug induced psychosis and his history of extensive alcohol misuse.

58. The clinical reviewer did, however, identify some concerns, although they did not affect the outcome for Mr Toner.

59. She found that although Mr Toner received some health checks for unwanted side effects of his anti-psychotic medications, these were not completed as regularly as they should have been, in line with NICE guidelines (Quality Standard 80, *Psychosis and Schizophrenia in Adults*). We recommend:

The Head of Healthcare and Lead Pharmacist should ensure that an effective system is in place to ensure that prisoners receiving treatment for psychosis or schizophrenia receive regular health checks in line with NICE QS80, *Psychosis and Schizophrenia in Adults*.

60. The clinical reviewer also said it was unclear why the visiting psychiatrist did not directly refer Mr Toner to a neurologist to rule out an organic cause for his symptoms, instead of choosing to request this via a prison GP. However, she said that it was unlikely that Mr Toner would have received an appointment prior to his final admission to hospital on 3 August even if the psychiatrist had referred him directly. We recommend:

The Head of Healthcare should ensure that visiting psychiatrists are supported to refer patients onto secondary care when appropriate, to avoid delays in referrals.

Security risk assessments and the use of restraints

61. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility.

62. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the

prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

63. This is reinforced in Prison Service Instruction (PSI) 33/2015, External Escorts. This says that the normal practice is for Category C prisoners (like Mr Toner) to be single cuffed when they are escorted outside the prison, but that handcuffs will not normally be necessary if a prisoner's mobility is severely limited, for example, due to advanced age or disability, unless the prison has grounds to believe that an escape might be made with external assistance.

64. The medical section of the risk assessment for Mr Toner's last journey to hospital was ticked to indicate that his medical condition did not restrict his ability to escape unaided and that there were no medical objections to the use of restraints. However, it also recorded that, although Mr Toner could normally walk unaided, he was currently unresponsive and was prone to seizures and convulsions.

65. The security assessment noted that Mr Toner was assessed as a low risk to the public and a low risk of escape. However, he was assessed as medium risk to hospital staff, because on a previous visit to hospital on 15 June, Mr Toner had become aggressive while under the influence of drugs and had to be restrained by prison staff and the police. A prison manager decided that, for the journey and treatment/consultation, Mr Toner should be accompanied by two escorting officers and restrained using an escort chain.

66. We recognise that many factors have to be taken into account in determining the level of restraints. Mr Toner was a relatively young man and he had behaved aggressively to prison and hospital staff on a previous visit to hospital. However, he was unconscious when he was taken to hospital as an emergency on 3 August and we, therefore, question whether the use of an escort chain was proportionate, given he was escorted by two officers. However, we are satisfied that the escort chain was appropriately removed when Mr Toner was placed in an induced coma. We recommend:

The Governor and Head of Healthcare should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

Liaison with Mr Toner's family

67. Prison Rule 22 says that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health, an appropriate member of prison staff should engage with their next of kin to provide information and support.

68. Mr Toner was taken to hospital by emergency ambulance on the morning of 3 August. At about 1.45pm, he was moved to the intensive care unit and placed in an induced coma. Prison staff were informed on 4 August that he could have suffered lasting brain damage if he recovered. Mr Toner remained sedated in

intensive care. However, the prison did not appoint a FLO or inform Mr Toner's next of kin (his mother) that he was seriously ill until the morning of 5 August.

69. Although the FLO immediately visited Mr Toner's mother at her home, we consider that the prison should have appointed a FLO and contacted Mr Toner's family much sooner when he was admitted to hospital on 3 August and was moved to intensive care. We make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

70. Mr Toner's family complained about what they considered to be disrespectful and insensitive behaviour by some of the bedwatch staff. The prison's Family Liaison Officer apologised on behalf of the prison and told the family that the Governor would be commissioning an investigation. We recommend:

The Governor should write to Mr Toner's mother to tell her the outcome of the prison's investigation into the actions of some of the bedwatch staff.

The Governor should ensure that all staff understand the need to behave with respect and sensitivity during bedwatches.

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