Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Boyd, a prisoner at HMP Leeds, on 31 August 2021

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*

OGL

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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 Michael Boyd died in hospital on 31 August 2021, while in the custody of HMP Leeds. He was 70 years old. The cause of Mr Boyd's death was pneumonia due to COVID-19 pneumonitis. He also had several underlying health conditions. I offer my condolences to his family and friends.

4. Although Mr Boyd had been recalled to prison, he was taken directly from the police station to hospital and, therefore, was not physically present in the prison between his arrest and death. Given the incubation period of COVID-19 and the timing of his arrest, it is likely that Mr Boyd contracted the infection in the community.

5. Mr Boyd's care in hospital does not fall within the Ombudsman's remit, so the scope of the clinical review was confined to communication and information sharing between the prison healthcare team and hospital clinicians. The clinical reviewer was satisfied that the standard was consistent with that expected in the community and made no recommendations.

6. We are concerned that although Mr Boyd was a category C prisoner assessed as a low security risk, he was initially double handcuffed and restraints were used for most of his admission, despite his age, frailty and intravenous treatment. This was not proportionate to his risk, or compliant with Prison Service policy.

Recommendation

- The Governor 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 assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time;
    - staff do not double cuff category C prisoners unless the individual risk assessment indicates that this level of restraint is required and proportionate; and
    - managers carry out formal risk assessments when reviewing the use of restraints, to ensure informed and appropriate decisions.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Boyd's clinical care.

8. The PPO investigator investigated the non-clinical issues, including the security arrangements during Mr Boyd's admission to hospital and liaison with his family.

9. The Ombudsman's family liaison officer spoke to Mr Boyd's next of kin, his sister, to explain the investigation. She had no specific matters for the investigation to consider.

10. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

11. We sent a copy of our initial report to Mr Boyd's sister. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Leeds

12. Mr Boyd was nominally allocated to HMP Leeds and was the 24th prisoner to die since August 2019. Fifteen of the previous deaths were from natural causes (three related to COVID-19), seven were self-inflicted and one was drug-related. There have since been four deaths, three from natural causes (none apparently related to COVID-19) and one self-inflicted. There are no similarities between our findings in this investigation and those of the previous deaths.

COVID-19 (coronavirus)

13. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

14. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

Key Events

15. Mr Michael Boyd was remanded to prison in October 1975. On 4 February 1976, he was convicted of murder and sentenced to life imprisonment, with a minimum period to serve of 15 years. Mr Boyd was released on licence twice and had lived in the community since November 2014.

16. On 16 August 2021, Mr Boyd's licence was revoked again and he was recalled to prison. He was arrested that evening and held in custody at a police station.

17. The recall notification document indicated that Mr Boyd had several health problems and had been treated for cancer for several years but had avoided treatment in recent months. During the reception process, he reported bowel cancer, angina and dependence on alcohol.

18. At around 8.00pm, a nurse examined Mr Boyd in his cell but, due to his condition, was unable to take clinical observations or obtain information from him. The nurse confirmed that Mr Boyd was fit to be detained and stated he should be checked half-hourly. At 9.23pm, Mr Boyd was found to be unresponsive but breathing. When roused, he reported chest pains and was sent to hospital just after 11.00pm.

19. On 17 August, HMP Leeds accepted custody of Mr Boyd, with a view to him being discharged to the prison once he recovered. A security risk assessment concluded that he should be escorted by two prison officers and double handcuffed (where the prisoner is handcuffed and attached to an officer by a second pair of cuffs). Late afternoon, the restraints were reduced to an escort chain (a length of chain with a cuff at each end attached to the prisoner and a prison officer).

20. Prison healthcare staff obtained updates from the hospital. On 18 August, it was noted that Mr Boyd was being treated for shortness of breath, urinary retention (with a catheter inserted) and a pulmonary embolism (blocked blood vessel in the lungs). A later entry noted that he had recently undergone chemotherapy for chronic leukaemia.

21. At 11.10am on 19 August, the escort officers recorded that Mr Boyd had tested positive for COVID-19 and was receiving treatment intravenously. Mr Boyd said he did not want his family to be informed he was COVID-19 positive, as they lived in Spain and he did not want to worry them. (It later came to light that his sister had returned to the UK.)

22. On 23 August, the central NHS digital team added an entry to Mr Boyd's prison medical record, confirming that he was at high risk of complications from COVID-19.

23. On 27 August, Mr Boyd's health deteriorated and he was admitted to the high dependency unit the next day. The escort chain was removed just before he was transferred. Mr Boyd said he did not want his next of kin to be informed. However, on 29 August, the prison asked the escort staff to try and obtain the contact details of Mr Boyd's next of kin, to be used in the event of his death.

24. Mr Boyd often refused food and drink. He also found it difficult to tolerate the oxygen mask and was warned that if he did not wear it, he was likely to die. He was assessed as having the mental capacity to make decisions about his care.

25. In the early hours of 31 August, a hospital doctor told the escort officers that there was only a small chance of recovery. The hospital began end of life care at around 6.00am and Mr Boyd died just before 2.00pm that day.

26. The coroner's officer, a serving police officer, traced Mr Boyd's sister and sent the details to the prison. After attempts to contact her on 24 and 25 September, the family liaison officer spoke to Mr Boyd's sister on 27 September.

27. Mr Boyd's funeral was held on 4 October. In line with national policy, the prison arranged and paid for the funeral, taking account of his sister's wishes.

Inquest

28. An inquest on 20 September 2021, confirmed that Mr Boyd's death was caused by pneumonia arising from COVID-19 pneumonitis. He also had underlying chronic lymphocytic leukaemia, ischaemic heart disease and chronic obstructive pulmonary disease, which did not cause but contributed to his death.

Findings

Clinical findings

29. After his recall to prison and arrest, Mr Boyd went directly from the police station to hospital. Prison healthcare staff were not responsible for his clinical care and this aspect of his management is therefore outside the Ombudsman's remit.

30. The focus of the clinical review was on the contact between healthcare and hospital staff. The clinical reviewer concluded that the communication was good and consistent with expectations in the community. She made no recommendations.

Restraints, security and escorts

31. 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.

32. 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 suffering from 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.

33. Prison Service Instruction 33/2015, External Prisoner Movement, defines the policy and guidance for the external escort of prisoners. It says that the normal practice is for category B and E-List prisoners to be double cuffed while on an escort and all other prisoners should be single cuffed unless a risk assessment indicates that double cuffs are required. Additionally, restraints will not normally be used when a prisoner's medical condition, advanced age or physical impairment renders restraints inappropriate.

34. Mr Boyd was a category C prisoner, who was assessed as low risk on each of the specific factors of concern on the security risk assessment. However, the initial level of restraint was double cuffing, normally applied to prisoners in a higher security category or where there are security concerns. The escort chain was removed three days before Mr Boyd's death, seemingly only because the escort staff were not permitted in the high dependency unit.

35. We consider that the use of double cuffs without justification was noncompliant with Prison Service policy. We are also concerned that prison managers who completed the management checks allowed the continuous use of restraints for 11 days, in spite of Mr Boyd's age, infirmity, low risk, catheterisation and intravenous treatment. We recommend:

The Governor 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 assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time;**
- **staff do not double cuff category C prisoners unless the individual risk assessment indicates that this level of restraint is required and proportionate; and**
- **managers carry out formal risk assessments when reviewing the use of restraints, to ensure informed and appropriate decisions.**

Contacting Mr Boyd's next of kin

36. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill.

37. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic, which states that if a prisoner is suspected of contracting COVID-19 (a formal diagnosis is not required), they should be asked if they want to inform someone and the prison should facilitate this.

38. Due to the unusual circumstances, Mr Boyd did not go through the normal reception and induction procedures in which his next of kin details would have been recorded. However, we are satisfied that prison staff were mindful of the need to obtain the information and Mr Boyd was given the opportunity for a relative to be notified of his illness after his diagnosis and again when his condition deteriorated.

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

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