Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dominic Comfort at HMP Leeds on 22 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*

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.

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

Mr Dominic Comfort was found hanged in his cell at HMP Leeds on 13 November 2017. He was taken to hospital, where he remained in intensive care until he died on 22 November 2017. He was 23 years old. We offer our condolences to Mr Comfort's family and friends.

Mr Comfort had a history of depression, personality disorder, illicit drug use, self-harm and attempted suicide. Although suicide and self-harm prevention procedures were in place, the investigation found that Mr Comfort did not receive appropriate mental health care while at Leeds. We are concerned that this is not the first time that we have found deficiencies in mental health provision at Leeds.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman August 2018

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Summary

Events

1. Mr Dominic Comfort had a history of chronic obstructive pulmonary disorder, personality disorder, illicit drug use, self-harm and attempted suicide. He had served a previous custodial sentence for a serious sexual offence and had been released on licence on 17 August 2010. On 7 November 2017, Mr Comfort appeared at Magistrates Court charged with possession of an offensive weapon. He was remanded into custody at HMP Leeds and next listed to appear in court on 27 November.

2. On Mr Comfort's arrival at Leeds, 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. On 13 November, at 6.50pm, an officer found Mr Comfort hanged in his cell. She requested an ambulance and began cardiopulmonary resuscitation. Officers and medical staff attended, and resuscitation continued until paramedics arrived. The paramedics took over emergency treatment and took Mr Comfort to the intensive care unit at hospital, where he was placed on life support. On 19 November, hospital doctors withdrew life support and on 22 November, at 2.00am, Mr Comfort was pronounced dead.

Findings

Management of risk of suicide and self harm

4. We found that ACCT procedures at Leeds were correctly conducted in line with mandatory national instructions. The first case review was multidisciplinary and the assessment of Mr Comfort's risk of self-harm was appropriate.

5. Mr Comfort made no attempts at self-harm until the events of 13 November and gave staff no indication that he had thoughts of suicide.

Clinical care

6. The clinical review concluded that the physical care provided to Mr Comfort was equivalent to that which he could have expected to receive in the community.

7. The investigation identified concerns with Mr Comfort's mental health care while in custody and the clinical review concluded that the mental health care provided to Mr Comfort was not equivalent to that which he could have expected to receive in the community. Although he was referred to the mental health team by the nurse and nurse prescriber in reception when he arrived at Leeds on 7 November, he had still not received a mental health assessment by 13 November.

8. The only contact Mr Comfort had with a qualified mental health professional was at his ACCT review. He did not receive a full mental health assessment.

Recommendations

- The Head of Healthcare, the healthcare commissioners and the Governor should review mental health care provision at HMP Leeds. The review should address the prison's capacity to deliver mental health assessments and ongoing interventions effectively, and its ability to support the ACCT process.

The Investigation Process

9. 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 prisoners responded.

10. The investigator visited Leeds on 23 November. He obtained copies of relevant extracts from Mr Comfort's prison and medical records.

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

12. The investigator interviewed five members of staff at Leeds in January. Two interviews were conducted jointly with the clinical reviewer.

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

14. One of the Ombudsman's family liaison officers contacted Mr Comfort's mother, to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Comfort's mother did not raise any concerns. Mr Comfort's mother received a copy of this report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Leeds

15. 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.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Leeds was conducted in November 2017. Inspectors found Leeds to be an unsafe prison, with levels of violence of every kind far too high. Illicit drugs were found to be 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 more often multidisciplinary. However, care maps were inadequate and recorded observations by staff lacked meaningful interaction with prisoners.

Independent Monitoring Board

17. 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 April 2018 the IMB were very concerned about the levels of self-harm and violence and of the ready availability of Psychoactive Substances (PS). The IMB commented that the level of health provision provided to prisoners fell well short of what is provided by the NHS in the community.

Previous deaths at HMP Leeds

18. Mr Comfort's death was the sixth self-inflicted death at Leeds since 2016. In other reports into deaths at Leeds we have made recommendations about mental health provision.

Assessment, Care in Custody and Teamwork (ACCT)

19. 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. As part of the process, a care map (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care map 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

20. Mr Dominic Comfort had served a five-year custodial sentence for a serious sexual offence and had been placed on the sex offenders register for life. Mr Comfort was released from custody on 17 August 2010. He had a history of depression, paranoia, personality disorder, illicit drug use, self-harm and attempted suicide.

21. On 7 November 2017, Mr Comfort appeared at Magistrates Court charged with possession of an offensive weapon (a knife). He was remanded into custody at HMP Leeds and listed to appear in court again on 27 November.

22. When Mr Comfort arrived at Leeds, a nurse saw him in reception. Mr Comfort said he was worried about how he would be treated in prison because of his previous sentence and that, although he had no immediate plans to self-harm, he was certain he would self-harm while in prison. She recorded that she had opened an ACCT. She also recorded that Mr Comfort suffered from depression, paranoia and personality disorder. He was prescribed mirtazapine (for depression) and promethazine (for insomnia). She referred Mr Comfort to the doctor and the mental health team.

23. A supervising officer saw Mr Comfort after the nurse had opened the ACCT and completed the immediate action plan. Mr Comfort said he was worried about his previous serious sexual offence and wanted to be located with other sex offenders away from the main prisoner population. He also said he wanted help with his mental health issues. She gave Mr Comfort the form to complete to be granted vulnerable prisoner status. She assessed Mr Comfort as being at raised risk and his level of observations was set at hourly throughout the day and night until the first case review.

24. That evening, a nurse prescriber saw Mr Comfort following the nurse's referral. She recorded that Mr Comfort had arrived in custody with his prescribed medication. She noted that Mr Comfort was on an ACCT as he had stated he would harm himself while in prison. She issued a repeat prescription for mirtazapine and promethazine and referred Mr Comfort to be seen by the mental health team.

25. On 8 November, at 9.10am, an officer assessed Mr Comfort as part of ACCT procedures. Mr Comfort said he had a number of mental health issues; he suffered from depression, paranoia and personality disorder. He said he was prescribed an anti-depressant and something to help him sleep. Mr Comfort said he had never self-harmed in prison before but had taken three overdoses in the past while in the community, the last occasion being three years ago. He said he had no current suicidal thoughts but it was always at the back of his mind. Mr Comfort said he would feel much better once he had been granted vulnerable prisoner status. She recorded that Mr Comfort had mental health issues, wanted to be granted vulnerable prisoner status and was due back in court in three weeks' time.

26. At 11.35am, a custodial manager held the first ACCT case review with a mental health nurse and Mr Comfort present. The custodial manager recorded that the officer had given verbal input into the review. Mr Comfort said that due to his

previous sexual offence, he was worried about where he would be located. She told Mr Comfort that his vulnerable prisoner application had been granted and he would move from the induction unit to the vulnerable prisoner wing as soon as a space became available. Mr Comfort said he had abused cannabis and alcohol in the past but had not had any for several months. He said he had no current thoughts of self-harm and did not use any Psychoactive Substances (PS). Mr Comfort asked the mental health team to contact his sister to let her and his mother know that he was in prison. He gave the nurse his sister's mobile phone number.

27. The custodial manager and the mental health nurse assessed Mr Comfort as being at low risk of suicide and self-harm, and reduced the level of observations to two conversations during the day and four observations during the night. The custodial manager completed the ACCT care map, which contained three actions: for Mr Comfort to be granted vulnerable prisoner status, which she signed as completed; for Mr Comfort to work with the substance misuse team; and for the mental health team to make contact with Mr Comfort's mother. The next case review was set for 15 November.

28. The mental health nurse recorded in Mr Comfort's medical record that she had attended the ACCT review. She noted that she had left a message on Mr Comfort's sister's phone to say her brother was in prison, he was receiving support from staff, and had asked his sister to contact the mental health team. She also recorded Mr Comfort's history of depression, paranoia, personality disorder and his prescribed medication. She referred Mr Comfort to the substance misuse team.

29. The mental health nurse told the investigator that prisoners referred to the mental health team should be seen for an initial assessment no later than five working days, or within 24 to 72 hours if the referral is deemed urgent. Mr Comfort's medical records show he had no other interventions with healthcare staff after he saw her as part of the ACCT review.

30. Later that afternoon, resettlement case worker saw Mr Comfort. Mr Comfort said he was unemployed before he came into prison, claimed state benefits and had no fixed address. He said he suffered from depression and had a personality disorder. She recorded that Mr Comfort had been referred to the mental health team and she had made him aware of the support services on offer at Leeds and how to access these. She noted that another team member would be Mr Comfort's resettlement worker.

31. Mr Comfort's prison records show that he moved from a single cell on the induction unit to a single cell on fifth landing on E Wing on 9 November. The custodial manager told the investigator that F Wing was the vulnerable prisoner wing, but that the fifth landing of E Wing was used as an extension of F Wing if there were insufficient spaces on F Wing. She said any vulnerable prisoners on E wing were escorted onto F Wing to collect any medication, all meals and have their association periods. The vulnerable prisoners on E wing did not mix with the rest of the prisoners on that wing and Mr Comfort would have been moved from E Wing to F Wing as soon as a place became available.

32. On 12 November, following a death of a prisoner at Leeds, in line with national instructions all prisoners who were on an ACCT were reviewed by staff. At 10.30am, a custodial manager held a review with Mr Comfort. No one else was present. Mr Comfort said he had heard that a fellow prisoner had died but he was not affected by what had happened. The custodial manager recorded that he assessed Mr Comfort to be at a low risk of self-harm, that the level of his observations remained unchanged and the next review was scheduled for 15 November.

Events of 13 November

33. An officer recorded in Mr Comfort's ACCT document that she checked on him ten times between 8.15am and 6.00pm. She told the investigator that the prisoner in the adjoining cell to Mr Comfort was also on an ACCT. Although he was on more frequent observations than Mr Comfort, she said she decided to check Mr Comfort at the same time as the other prisoner.

34. The officer said that Mr Comfort declined to go to F Wing for morning association at 10.20am, and refused both his lunch and evening meal. When she asked Mr Comfort why he did not want his meals, he just asked her to close the door. She said that at other times during the day Mr Comfort was seen lying on his bed reading. There were no other concerns.

35. The officer told the investigator that she went to Mr Comfort's cell at 6.50pm to do an ACCT check. She opened the observation panel and saw Mr Comfort hanging from the window bars by a ligature made from bedding. She shouted for staff and immediately entered the cell and supported Mr Comfort's body. Two officers immediately responded. One officer then supported Mr Comfort's body while another cut the ligature and they lowered Mr Comfort to the floor. An officer radioed an emergency code blue, which indicates a prisoner is unable, or having difficulty breathing. Two officers began cardiopulmonary resuscitation (CPR). The control room log shows the code blue was called over the radio at 6.50pm and an ambulance was called immediately.

36. Nursing staff immediately responded to the code blue call. The nurses continued with 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 nurses continued with CPR.

37. Paramedics arrived at 7.05pm and took over Mr Comfort's care. They continued CPR and, after a period of treatment, paramedics transferred Mr Comfort to the intensive care unit at the hospital, where he was placed on life support. Mr Comfort did not regain consciousness.

38. Healthcare staff at Leeds maintained daily contact with the hospital for updates on Mr Comfort's condition. On 19 November, the hospital informed healthcare staff that life support had been withdrawn. On 22 November, at 2.00am, hospital doctors pronounced Mr Comfort dead.

Contact with Mr Comfort's family

39. On 13 November, Leeds asked West Yorkshire Police for assistance in informing Mr Comfort's mother that her son had been taken to hospital. The family liaison

officer met Mr Comfort's mother and sister at the hospital at 3.25am, to offer support. In the days that followed, she maintained contact with Mr Comfort's mother and Mr Comfort's family continued to visit him in hospital. Mr Comfort's family were with him when he died on 22 November, and she met them at the hospital to offer condolences. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

40. The Head of Operations 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.

41. The prison posted notices informing staff and prisoners of Mr Comfort'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 Comfort's death.

Post-mortem report

42. A post-mortem examination confirmed that the cause of Mr Comfort's death was hanging. It noted that the toxicology results confirmed that Mr Comfort was not under the influence of alcohol or any illicit drugs at the time of his death.

Findings

Management of risk of suicide and self harm

43. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* sets out the Prison Service's framework for delivering safer custody procedures. It lists a number of risk factors and potential triggers for suicide and self-harm. These include first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially the start of a trial or 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.

44. Staff correctly opened an ACCT on 7 November, immediately on Mr Comfort's arrival at Leeds. We consider that Leeds correctly assessed Mr Comfort's level of risk and the level of observations was appropriate. Mr Comfort was reviewed on 12 November, in accordance with the instructions contained in PSI 64/2011, following the death of another prisoner at Leeds.

45. Mr Comfort gave no indication to staff or prisoners that he had any suicidal thoughts in the days immediately before 13 November. It is impossible to know whether staff at Leeds could have predicted that Mr Comfort intended to take his own life or therefore done anything to prevent his actions.

Clinical Care

46. The clinical reviewer considered that the physical care that Mr Comfort received from healthcare staff at HMP Leeds was equivalent to the care he would have received in the community.

47. However, the clinical reviewer has serious concerns about the standard of mental health care and considered that this was not equivalent to the care Mr Comfort would have received in the community.

48. The clinical reviewer commented that new referrals should be seen for assessment within five working days, with urgent cases seen within 24 to 72 hours. Mr Comfort's medical record confirms he was referred to the mental health team by both the reception nurse and nurse prescriber on his arrival at Leeds on 7 November 2017. However, he was only seen on one occasion by a qualified mental health professional, at an ACCT review held on 8 November 2017. Mr Comfort should have had a full mental health assessment by 12 November.

49. The clinical reviewer judges the assessment carried out by the mental health nurse was in the context of an ACCT review and was not a comprehensive, full mental health assessment. He comments that the National Institute for Health and Care Excellence (NICE) Guidance NG66, *Mental health of adults in contact with the criminal justice system*, states that the Correctional Mental Health Screen for Men (CMHS-M) should be considered, along with the use of General

Anxiety Disorder – 7 (GAD-7) and Patient Health Questionnaire -9 (PHQ-9), which are the standard assessments in primary care for the assessment of anxiety and depression to support clinical opinion and management of risk. He found that she did not use of any of these assessment tools to support her clinical opinion.

50. We agree with the clinical reviewer that the mental health care that Mr Comfort received was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare, the healthcare Commissioners and the Governor should review mental health care provision at HMP Leeds. The review should address the prison's capacity to deliver mental health assessments and ongoing interventions effectively, and its ability to support the ACCT process.

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