

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Taylor, a prisoner at HMP Leeds, on 17 August 2020

A report by the Prisons and Probation Ombudsman



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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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 Taylor was found hanged in his cell at HMP Leeds on 17 August 2020. He was 52 years old. I offer my condolences to his family and friends.

Mr Taylor had only been at Leeds for five days when he died. It was his first time in prison, and he had recently received a long prison sentence for sexual offences.

While I recognise the challenges facing prison staff in busy local prisons and, of course, that my investigations have the benefit of hindsight, I am concerned that the assessment of Mr Taylor's risk of self-harm placed insufficient weight on known risk factors and too much on staff perceptions of his behaviour and demeanour and his assertions that he had no suicidal intentions.

As we have said many times before, although the professional judgment of staff is an essential ingredient in ensuring safety in custody, to be effective, risk assessment must also take account of known or readily available information associated with suicide.

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

September 2021

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings	10

Summary

Events

1. Mr Robert Taylor was remanded to HMP Durham on 3 April 2020, charged with sexual offences. He was a former school chaplain, and it was his first time in prison. He arrived with a suicide and self-harm warning form which noted that he had depression, anxiety and fleeting thoughts of suicide due to his situation. He was referred to the mental health team and prescribed antidepressants.
2. In June, Mr Taylor was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) for two days after he expressed suicidal thoughts.
3. On 12 August, Mr Taylor was sentenced to 14 years and nine months in prison and was transferred to HMP Leeds.
4. When he arrived at Leeds, Mr Taylor complained that he had anxiety and depression and was not sleeping well due to his current situation. He said he felt low because of the long sentence he had received but that he had no thoughts of suicide or self-harm. The mental health team assessed him, and he was prescribed antidepressants.
5. On the morning of 17 August, an officer found Mr Taylor hanging in his cell. The officer shouted for assistance, staff responded quickly and radioed a medical emergency code blue. Staff and then paramedics tried to resuscitate him but were unsuccessful, and Mr Taylor was pronounced dead.

Findings

6. Mr Taylor had a number of risk factors when he arrived at Leeds: it was his first time in prison; he had just received a long sentence; he was anxious and depressed; he had an outstanding mental health referral; and he had recently been managed under ACCT procedures after expressing suicidal thoughts.
7. We are concerned that staff placed too much emphasis on Mr Taylor's calm behaviour and his assertions that he had no suicidal intentions and did not give sufficient weight to his risk factors. We are also concerned that mental health staff failed to review all of Mr Taylor's risk information when he arrived at Leeds.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff conducting reception assessments and mental health assessments:
 - take into account all relevant information, including a prisoner's history, referrals or contact with mental health services and relevant prison documentation, including the Person Escort Record, to assess his risk factors for suicide and self-harm and his mental health needs; and
 - understand the need to consider a prisoner's risk factors and do not rely solely on what a prisoner says or how he presents.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with Nurse A and Nurse B, and that a senior manager discusses the Ombudsman's findings with them.

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. No-one responded.
9. The investigator obtained copies of relevant extracts from Mr Taylor's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Taylor's clinical care at the prison.
11. The investigator interviewed eleven members of staff and one prisoner, some jointly with the clinical reviewer. The interviews were completed by video and telephone because of the restrictions imposed due to the Covid-19 pandemic.
12. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
13. We contacted Mr Taylor's family to explain the investigation. Their solicitor asked for an account of the circumstances leading to Mr Taylor's death, including:
 - what risk information was passed onto HMP Durham and HMP Leeds when Mr Taylor arrived in custody and what risk assessments were completed by each prison;
 - whether Mr Taylor was considered a vulnerable prisoner and monitored under suicide and self-harm prevention procedures; and
 - whether he was prescribed any medication.We have addressed these concerns in this report.
14. The family was also concerned that Mr Taylor's wedding ring has never been returned and remains missing. We have addressed this in separate correspondence.
15. Mr Taylor's family's solicitor received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies in the report and accepted all recommendations.

Background Information

HMP Leeds

17. HMP Leeds is a local prison holding up to 1,218 prisoners who are 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.

HM Inspectorate of Prisons

18. The most recent full inspection of HMP Leeds was in November/December 2019. Inspectors found the levels of self-harm were significantly higher than other local prisons and since their last inspection. They noted that ACCT case management was not good enough despite PPO recommendations and that the safeguarding strategy was not effective in addressing risks or the needs of individuals in crisis.
19. HMIP also carried out a short scrutiny visit at Leeds in June 2020 to look at issues of key importance to prisoners during the Covid-19 pandemic. They found that the prison was calm and well-ordered, despite the continuing and severe restrictions to the regime. Although regime restrictions were accepted as being necessary early on in the pandemic and were, at that point, similar to those in the community, prisoners had become confused about why community restrictions were easing but restrictions in prisons were not. This, along with the lack of purposeful activity, meant many prisoners were bored and frustrated.

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. The IMB report for the year ending December 2018 found that prisoners were treated with humanity and respect, given staff constraints.

Previous deaths at HMP Leeds

21. Mr Taylor was the eighth prisoner to take his own life at Leeds since August 2018. During this period there were also 10 deaths from natural causes, two drug-related deaths and one death where the cause is as yet unidentified. We have previously made recommendations about staff under-estimating prisoners' risk of suicide, about staff responsibilities during emergency responses and about mental health provision at Leeds.
22. Since Mr Taylor's death, there have been two more self-inflicted deaths at Leeds and five deaths from natural causes.

Key Events

HMP Durham

23. On 3 April 2020, Mr Robert Taylor was remanded to HMP Durham, charged with sexual offences against children. He was a former school chaplain and had been arrested after he went to a police station and admitted his offending, despite the fact there had been no complaints about him. It was his first time in prison.
24. The Person Escort Record (PER) which accompanied Mr Taylor from court to prison noted that he had ‘no known risks’, but that he had depression and anxiety. A suicide and self-harm warning form also noted that Mr Taylor had fleeting thoughts of suicide. However, Mr Taylor told escort staff that he was “too soft and weak” and had no intention of acting on these thoughts.
25. A prison reception officer completed Mr Taylor’s reception interview. He reviewed the SASH form and spoke to Mr Taylor. Mr Taylor denied thoughts of suicide and self-harm but asked to live on the vulnerable prisoners’ (VP) wing (for men deemed vulnerable to bullying due to their presentation or offence history).
26. A nurse completed Mr Taylor’s initial health screen. She reviewed the risk information that Mr Taylor had arrived with, including the PER. Mr Taylor told the nurse that it was his first time in prison, and he felt low due to his offences, but that he had no thoughts of suicide or self-harm. He said that he had had suicidal thoughts in the past but denied that he would act on these. He had been prescribed mirtazapine (an antidepressant) and sleeping medication in the community. The nurse referred him to the mental health team.
27. Afterwards, the prison GP assessed Mr Taylor and prescribed promethazine to help him sleep. She noted that Mr Taylor said he had no thoughts of suicide or self-harm, no history of substance misuse and no mental or physical health issues.
28. Mr Taylor was sent to the VP Wing, where staff started his induction. The prison chaplain also saw him and offered support.
29. Mr Taylor said he was worried that people would find out about his offence. His key worker reassured him that he was safe on the VP Wing. A mental health nurse assessed Mr Taylor who said that he felt low but denied thoughts of self-harm. The nurse noted that Mr Taylor did not need secondary mental healthcare but referred him to the mental health team for cognitive behavioural therapy.
30. On 2 June, the chaplaincy team started ACCT procedures after Mr Taylor expressed suicidal thoughts, was distressed, anxious and felt low. He said he regretted his offences and was paranoid that other prisoners were talking about him.
31. At a multidisciplinary ACCT review panel the next day, Mr Taylor said he was not sleeping well. He hoped that once he had attended court for his trial, he would be transferred to a prison near his home. He said that his job as a cleaner on the wing helped him. When asked about thoughts of self-harm, Mr Taylor said he was “too soft” to harm himself but if there was “a button he could press, he would”. However,

Mr Taylor said that he would not want to put his family through that as they were very supportive towards him.

32. The panel and the ACCT caremap noted that the mental health nurse agreed that the mental health team would support Mr Taylor and the prison GP prescribed mirtazapine. It was agreed that ACCT monitoring would stop.
33. On 18 June, Mr Taylor declined a mental health assessment. He told the nurse that he did not believe cognitive behavioural therapy would change his situation. Following a discussion, the nurse advised Mr Taylor that he would be discharged from the mental health caseload.
34. On 1 July, the Safer Custody Team received a phone call from Mr Taylor's wife, who was concerned that he had not contacted her. When staff told Mr Taylor, he said that he sometimes felt anxious about ringing his wife but would do so.
35. On 10 July, Mr Taylor told a mental health nurse that he wanted counselling support to address his feelings of guilt. He was having 'good and bad days' but said he had no suicidal thoughts. Mr Taylor agreed to a further mental health assessment. Mr Taylor's medical record shows that he did not attend a scheduled mental health appointment for counselling on 12 August. (This is probably because he attended court that day.)

HMP Leeds

36. On 12 August, Mr Taylor was sentenced to 14 years and nine months in prison. He was transferred to HMP Leeds. The PER noted that he had no thoughts of self-harm but had previously been monitored under ACCT procedures which had been closed on 3 June. It noted that Mr Taylor had no physical or mental health concerns and had been approved to live on the VP Wing.
37. In reception, an officer noted Mr Taylor's offence, that he could share a cell with another prisoner and that he would live on the VP Wing.
38. Nurse A from the mental health team told us that a Reception manager contacted him to complete a mental health risk assessment for Mr Taylor due to his long prison sentence. He said that he did not see a reception screen entry in Mr Taylor's medical record before he saw him. He said that he did not know that it was Mr Taylor's first time in prison, and he had not seen his medical record before seeing him. His assessment was based on what Mr Taylor told him. He said that he would not always see prison documentation such as the PER or suicide and self-harm warning forms and, in this case, he did not. He was also not aware that Mr Taylor had previously been monitored under ACCT procedures at Durham.
39. Nurse A used recognised health and mental health screening tools to assess Mr Taylor and noted that his presentation and state of mind gave him no indication that Mr Taylor was at risk of suicide or self-harm. Mr Taylor appeared settled, positive and talked about having good family support. The nurse noted that Mr Taylor felt low and had mild anxiety but no signs of psychosis.
40. Nurse B saw Mr Taylor and completed a full initial health screen afterwards. She told us that she would usually review any medical record entries made immediately

before a prisoner's transfer. Mr Taylor told her that he had anxiety and depression due to his situation and was shocked at the length of his sentence. However, he said that he had no thoughts of suicide or self-harm. She noted that Mr Taylor had no alcohol or drugs issues and referred him to the prison GP to review his medication.

41. An officer completed Mr Taylor's first night interview. Mr Taylor raised no concerns and identified his wife as his next of kin. She noted that Mr Taylor had last been monitored under ACCT procedures in June. It was agreed that Mr Taylor would live on F Wing, the prison's VP Wing. He was allocated a cell on his own.
42. That evening, a prison GP completed a virtual review of Mr Taylor. He told us that he reviewed Mr Taylor's electronic medical records, including his medical history, previous prescriptions and the reception and mental health nurses' entries. He prescribed promethazine and mirtazapine.
43. The prison GP said that he was aware of Mr Taylor's sentence length but that this in itself was not a reason for him to see him in person. He said he was confident that there were no mental health risks or clinical issues from the record or reception screen which warranted a face-to-face assessment.
44. In her police statement, an Operational Support Grade (OSG) said that she checked on newly arrived prisoners that evening. She opened Mr Taylor's cell observation panel and introduced herself. She said they had a short conversation and Mr Taylor asked how he could make phone calls from his cell. She provided instructions and said that Mr Taylor appeared okay and quite "chatty".
45. On the morning of 13 August, a prisoner orderly, who lived on F Wing, saw Mr Taylor to complete a prisoner induction session. He said that Mr Taylor appeared generally okay but that he was concerned for his safety in prison and was worried about media coverage about him and about other prisoners finding out about his offences. Mr Taylor said that he had not spoken to his wife and was unsure if she knew he had been moved to Leeds. The orderly told him how the phone system worked and reassured him that he would be safe. He said that he told a landing officer about Mr Taylor's concerns afterwards.
46. Later that morning, an officer completed further elements of Mr Taylor's prison induction. Due to Covid-19 restrictions and social distancing requirements, she gave him information and booklets at his cell door. She noted that Mr Taylor raised no concerns.
47. At 10.54am, an officer, who had been appointed as Mr Taylor's key worker, recorded in prison records that he had spoken to Mr Taylor at his cell door to conduct a welfare check and to introduce himself and that Mr Taylor had raised no issues.
48. A prison investigation after Mr Taylor's death identified that the key worker had not in fact had any contact with Mr Taylor. He said that his entry had been made prematurely, as he had intended to visit Mr Taylor, but this had not happened. (The prison took disciplinary action against him.)

49. That afternoon, an officer phoned Mr Taylor's wife and told her that he was at HMP Leeds and was 'okay'. She explained that he would be able to call her once the security team had approved his phone contacts' list due to public protection issues as a result of Mr Taylor's offences.
50. On 14 August, the prison orderly asked a prison officer to unlock Mr Taylor's cell door so that he could check on him again. The orderly reiterated the concerns he had previously raised with him. He said that he told an officer about these concerns. The officer told us that he had no recollection of this. Healthcare staff completed Mr Taylor's secondary health assessment that day.
51. On 15 August, Mr Taylor phoned his wife.

16 and 17 August 2020

52. On 16 August, Mr Taylor collected his meals during the core day and had time out of his cell.
53. CCTV footage shows that OSG A completed the night roll check on F Wing at 8.43pm. She said that when she checked on Mr Taylor, he was lying on his bed (the bottom bunk) with his head towards the far end of the cell. Mr Taylor appeared to be asleep and so she did not disturb him. She said that when she had checked on Mr Taylor on previous evenings, she had had short conversations with him. She described him as 'pleasant'.
54. During the night, OSG A monitored the prisoner next to Mr Taylor's cell hourly under ACCT procedures. She said she heard nothing unusual from Mr Taylor's cell.
55. On the morning of 17 August, CCTV footage shows that OSG A completed the morning roll check at 5.55am, using a torch when she looked into each cell. Although she did not remember checking on Mr Taylor, she said she was confident that she had no concerns about him and said he must have been in his bed as he was not visible in any other part of the cell.
56. At 7.01am, just before OSG A's night duty ended, she completed an ACCT check on the prisoner next door to Mr Taylor. As she was next door, she decided once again to check on Mr Taylor. When she looked through Mr Taylor's cell observation panel, she saw him kneeling at the side of his bed. There was a blue, prison-issue towel wrapped around his neck, which was connected to the metal bars of the top bunk. She knocked on the cell door, but Mr Taylor did not respond.
57. OSG A said that the battery was flat on her radio and so she shouted downstairs to Officer A that a prisoner had tied a ligature around his neck and asked him to call a medical emergency code blue, indicating a life-threatening situation. The control room log recorded that a code blue was called at 7.01am and an ambulance was called a minute later.
58. OSG B was nearby and heard OSG A's shout for assistance. CCTV footage shows that he arrived on F Wing in approximately 40 seconds. He saw that OSG A had not yet gone into Mr Taylor's cell. As he approached Mr Taylor's cell, he removed his cut-down tool from his pouch and told OSG A to open the cell door. He allowed

Officer A to run past him to open the cell door as OSG A was struggling to get her cell key out of her sealed pouch. Two more officers also responded to the emergency.

59. Once in the cell, OSG B saw that Mr Taylor had tied a ligature from the top bunk bed rail and his knees were barely touching the cell floor. He lifted Mr Taylor and supported his body weight. He then passed his cut-down tool to Officer A to cut the ligature. However, the ligature was extremely thick and wrapped tightly around Mr Taylor's neck which made it difficult to remove. An officer helped OSG B and Officer A to remove it. OSG B noticed that Mr Taylor had blood all over his hands and wrists which appeared to have come from his nose and mouth.
60. Once the ligature was removed, prison staff laid Mr Taylor on the floor. An officer started cardiopulmonary resuscitation (CPR). She noticed that Mr Taylor was not breathing, his face was grey, and his skin was warm to touch. OSG B then took over CPR until healthcare staff arrived.
61. Two nurses arrived at 7.05am, and immediately took over Mr Taylor's care and continued CPR. Within 10 seconds, more healthcare staff arrived, including a nurse who brought medical emergency equipment. Healthcare staff administered oxygen and used a defibrillator. No shock was advised. A nurse noted that Mr Taylor's skin was mottled and pale, but he had no signs of rigor mortis (a stiffening of the body after death). Healthcare staff continued CPR until paramedics arrived at 7.22am and assessed Mr Taylor. At 7.25am, they pronounced his death.

Contact with Mr Taylor's family

62. After Mr Taylor's death, staff identified that his wife was his next of kin. The prison appointed a Senior Officer (SO) as the prison's family liaison officer and the Head of Safety as her deputy. At 8.20am, they visited Mr Taylor's wife and daughters and broke the news of Mr Taylor's death. The prison provided ongoing support and contributed towards the costs of Mr Taylor's funeral in line with national instructions.

Support for prisoners and staff

63. After Mr Taylor's death, the Head of Residency debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
64. The prison posted notices informing other prisoners of Mr Taylor'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 Taylor's death.

Post-mortem report

65. The post-mortem report concluded that Mr Taylor died from hanging.

Findings

Risk assessment on arrival at Leeds

66. PSI 64/2011 on safer custody requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and that they manage prisoners identified as at risk under ACCT procedures. The PSI lists several risk factors and states that potential triggers should be continually assessed.
67. PSI 07/2015 on early days in custody is clear that staff should examine all newly arrived prisoners on their arrival and share, review and act on information, including person escort records, where necessary. NICE guidelines state that initial health screens in reception should ensure continuity of care for people transferring from one custodial setting (including courts) to another by accessing relevant information from the patient clinical record, PER, cell-sharing risk assessments, medication prescriptions and outstanding medical appointments.
68. We have considered whether staff at Leeds should have recognised Mr Taylor as at risk of suicide and started ACCT monitoring.
69. When Mr Taylor arrived at Leeds on 12 August, he had a number of risk factors: it was his first time in prison; he had just received a long sentence; he had been monitored under ACCT procedures about two months earlier because he had expressed suicidal thoughts; he said he was feeling depressed and anxious; and he had an outstanding mental health assessment. We recognise that Mr Taylor had been in prison on remand for four months at this point, but we consider that there is a difference between being on remand and facing the reality of a long sentence, and we note that Mr Taylor told Nurse B in Reception that he had been shocked by the length of his sentence.
70. A prison manager appropriately asked a mental health nurse to assess Mr Taylor in Reception because of the heightened risk he may pose after receiving a long sentence. Nurse A assessed Mr Taylor using recognised mental health screening tools, which was good practice. However, we are concerned that he did not look at Mr Taylor's medical record or PER, both of which contained risk and mental health information. He was therefore not aware that it was Mr Taylor's first time in prison or that he had previously been managed under ACCT procedures as recently as June 2020. The nurse said his assessment was based on what Mr Taylor told him.
71. Nurse B, who completed Mr Taylor's general health screen in Reception after Nurse A, did record his risk factors in his medical record, but made no reference to the PER in her entry. Neither nurse referred to Mr Taylor's recent referral to the mental health services at Durham, which remained outstanding.
72. Although Mr Taylor was also reviewed by a GP when he arrived, this was simply a paper review and the GP did not see Mr Taylor in person.
73. We are concerned that staff did not give sufficient weight to Mr Taylor's risk factors and placed too much emphasis on his calm, polite behaviour and his assertions that he had no suicidal intentions. While the judgement of staff based on a prisoner's

apparent mood and state of mind is important, prisoners will often try to hide their distress, particularly in a strange setting and with people they do not know. Assessments based on immediate behaviour must, therefore, be balanced against the available information about known risk factors.

74. We consider that staff at Leeds, who did not know Mr Taylor at all, should have recognised that he was vulnerable because of his long sentence, the nature of his offences, and his anxiety and depression.

The Covid-19 regime

75. We are also concerned that there is no evidence that staff had any meaningful contact with Mr Taylor during the five days he spent at Leeds. The Covid-19 regime restrictions meant that he spent around 23 hours a day alone in his cell and that his induction was delivered by an officer standing outside his cell. His key worker who should have seen him, did not do so and made a false entry saying that he had seen him.
76. The only meaningful interaction Mr Taylor had was with another prisoner, an induction orderly, with whom he shared some of his concerns. The prisoner says he told staff about Mr Taylor's concerns, but staff say they do not remember him doing so.
77. We consider that this isolation may have contributed to Mr Taylor's state of mind when he took the decision to take his life.

Clinical care

78. The clinical reviewer concluded that the general clinical care that Mr Taylor received was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.
79. However, she raised concerns about the mental healthcare Mr Taylor received, particularly the lack of shared information about the referral to the mental health team before his transfer to Leeds. If Nurse A had reviewed the available risk and medical records, including details of Mr Taylor's referral to the mental health team at Durham, he may have referred Mr Taylor for mental health support. This was a missed opportunity to consider Mr Taylor's risk factors
80. This aspect of Mr Taylor's care was not of the required standard and not equivalent to that which he could have expected to receive in the community.
81. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff conducting reception assessments and mental health assessments:

- take into account all relevant information, including a prisoner's history, referrals or contact with mental health services and relevant prison documentation, including the Person Escort Record, to assess his risk factors for suicide and self-harm; and

- understand the need to consider a prisoner's risk factors and do not rely solely on what a prisoner says or how he presents.

Learning Lessons

82. We have identified some concerns in this report and consider it is important that staff learn from our findings. We therefore recommend that:

The Governor and Head of Healthcare ensure that a copy of this report is shared with Nurse A and Nurse B, and that a senior manager discusses the Ombudsman's findings with them.

Inquest

83. The inquest into Mr Taylor's death was held in June 2023. The conclusion was that Mr Taylor's death was due to suicide.

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