

**INVESTIGATION INTO THE CIRCUMSTANCES  
SURROUNDING THE DEATH OF A MAN  
AT HMP LEEDS IN AUGUST 2005**

**REPORT BY THE PRISONS AND PROBATION  
OMBUDSMAN FOR ENGLAND AND WALES**

**MARCH 2007**

This is the report of an investigation into the death of a man at HMP Leeds in August 2005. He was discovered hanging in a sitting position in his cell in the prison's segregation unit, suspended by a bed sheet tied to the top of his bunk bed. He was pronounced dead in his cell. His death has also been investigated by the local police who are satisfied that no-one else was involved.

I offer my sincere condolences on their loss to the man's family and friends. I hope that this report answers their questions, but recognise that it may not alleviate their distress or lessen their grief. They describe him as an intelligent young man, who was furthering his education and had huge potential.

This report has taken significantly longer than most conducted by my office, and I appreciate his family's patience throughout. A key objective of the investigation has been to give his family every opportunity to raise any concerns they had about his death. One of my Family Liaison Officers, alongside investigation colleagues, met representatives of his family, a family friend, and their solicitors, and we have done all we can to answer their questions. Information has been shared with the family's solicitor throughout the investigation.

Ten weeks before he died, the man had appeared at the Crown Court for failing to answer a criminal charge and was sentenced to 28 days imprisonment. He was also remanded in custody to stand trial for the original offence. This was the first time he had been in prison in England. His death was the eighth I had investigated at HMP Leeds since I was given responsibility for investigating all deaths in prison custody in April 2004, and the third that was apparently self-inflicted.

The investigation was undertaken on my behalf by four investigators from my office. I would like to express my thanks to the Governor of Leeds and his staff for the help and active co-operation that my investigators received throughout the investigation.

Recognising the significance of diversity matters and the use of control and restraint to this investigation, I obtained advice from two experts. I am grateful to them both for their assistance. Where I have differed from the diversity expert's assessment in particular, it is because his comments about religious discrimination concern events which happened before such attitudes and behaviours were made clear to the Prison Service by the Mubarek public enquiry.

I have also been assisted by Her Majesty's Chief Inspector of Prisons (HMCIP), whose most recent inspection of Leeds, by coincidence, took place in the week that this investigation was opened. I commissioned a clinical review from the local Primary Care Trust, and am grateful to the reviewer for his assistance. I also thank the local police, in particular the detective sergeant who assisted my investigators in many ways and willingly shared information and documentation.

The scale of this investigation was larger than most undertaken by my office. This was determined at an early stage because of the family's concerns about the circumstances of their relative's death. He was a committed Muslim. The period he spent at Leeds prison included the week in July 2005 when bombs exploded in London, and the unsuccessful bombing attempts later in the month. Previous events at Leeds had, rightly

or wrongly, given the prison a reputation for racial intolerance, and his family have been understandably worried that his death might in some way have had a racial element. They have also been concerned because he died in the segregation unit, where he had been held following an incident when he was alleged to have assaulted officers and when a staff member had been used to restrain him.

During the investigation, over 50 people have been formally interviewed and over 120 documents have been examined and considered. The time taken by the investigators has substantially increased as significant information has come to light at later stages, and additional interviews have been arranged. Specialist information was provided from the Commission for Racial Equality (CRE) and the Diversity and Race Equality Adviser to the Prison Service.

The time taken on this investigation meant that it was about to be completed as the report of the Zahid Mubarek inquiry was published. Zahid was also a Muslim who died within a prison, although in very different circumstances. The Mubarek inquiry report considers the experiences of Muslim prisoners as a whole, and I have taken it into account in reaching my own conclusions. In May 2006, more than one in eight of the prisoners at Leeds were Muslims. I hope that this report will help HMP Leeds to address their specific needs, as well as more general issues.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**March 2007**

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## Summary

1. The man moved from his home country, with his family, to Leeds in 1994, and then changed his name to an English name, which is the name he used when he was held at HMP Leeds. I understand from his family that he was a full time student when first taken to the prison in June 2005. He had been sentenced to 28 days imprisonment for failing to appear to answer a criminal charge, and had also been remanded in custody on the original charge. His family and other prisoners describe him as a devout Muslim.
2. Shortly after arriving at HMP Leeds, the man expressed some feelings of depression and was placed overnight with another prisoner who had been trained by the Samaritans as a Listener (a prisoner who helps other prisoners in distress).
3. He moved on to F wing and was held in normal location. There was an incident in June when he and another prisoner had a fight over the pool table and he was moved to another wing. On 19 June, his sentence expired, and he became an unconvicted prisoner held on remand, rather than a convicted prisoner.
4. On 15 July, a week after the four terrorist bombs exploded in London, his cellmate alleged that the man offered to show him how to make a bomb. The allegation was reported to the police who had no concerns, and the incident was dealt with as a security matter. The man was moved to the prison's segregation unit for two nights, held under prison rule 45, Good Order or Discipline. Other prisoners taunted him as he left the wing. When his cell was searched, letters were found - some written in English and others in Arabic - which refer to the next life being better than this life.
5. The man left the segregation unit and went to a different wing, where he remained until Thursday 18 August when two significant events occurred. In the morning, an officer saw him wearing blood stained clothing. He was quickly assessed by a psychiatric nurse and his case discussed by a multi disciplinary team. It was not considered that he was at risk of harming himself or that he was suffering from mental illness and it was decided that the nurse would continue to work with him. The identified risk was to staff and prisoners, rather than to himself, and the nurse assessed him as preferring to be on his own.
6. The second event was at the evening roll check when officers found the man alone in his cell, which was in darkness. When they opened the door, one of the officers was hit and the man was alleged to have carried out the assault. The other drew his staff and used it on the man. Control and restraint methods were used to take him to the segregation unit where he was placed in the special cell, his clothes were cut off and he was strip searched. He remained there until early the following afternoon when he was put in a normal segregation unit cell with bunk beds. His family came to visit him that day, but were told the visit would not take place.

7. The man remained in the segregation unit. He attended an adjudication hearing on Saturday 20 August when he was charged with assaulting staff. The alleged offence was referred to the police for investigation.
8. On Sunday morning, his cell was opened as usual where he was found hanging from the bunk beds. The officer opening the cell door thought that the man had died, and no attempt was made to remove the ligature or lay him on the floor (in contravention of prison policy). When healthcare staff arrived, the nurses also considered that he had died. His death was confirmed by a doctor later that morning.

## The investigation process

9. This investigation was conducted by four investigators from my office, two of whom visited Leeds to open the investigation on 24 August 2005, three days after the man's death.
10. Notices were issued to staff and prisoners telling them of the investigation and its terms of reference, and offering them the opportunity to participate. Letters were written to staff and prisoners who knew the man but had since left the prison. My investigators examined the cell in the segregation unit where he died, and were given a tour of the prison.
11. My investigators obtained the records relating to the man's imprisonment, and further records were subsequently provided. They received full cooperation from the local police who supplied video and DVD footage of his time in the prison's segregation unit. Although the police have not completed their investigation, they have concluded that no-one else was involved in his death, and no other staff or prisoners went into his cell in the segregation unit in the 24 hours before he died.
12. Tape recorded interviews were conducted with prisoners and staff who had significant contact with the man. All those interviewed have been asked to sign the transcript and indicate any corrections, and the majority have been signed. Over 50 staff were interviewed and, though they were not asked to declare their ethnicity, all except one appeared to be White British and no-one indicated that they shared the man's faith. Thirteen prisoners were interviewed, of whom a third were from a black ethnic minority background. As well as interviewing staff, a meeting took place with the officer and Imam who were responsible for liaison between the prison and the man's family. A further meeting was held with all three Imams in July 2006.
13. My investigators have also had access to the reports written following the deaths of prisoners at Leeds in 2004 and 2005, and to the reports of inspections by Her Majesty's Chief Inspector of Prisons (HMCIP). Coincidentally, the Inspectorate was carrying out an unannounced follow up inspection of the prison in the week that this investigation was opened. Their findings are of great importance, and have been used throughout this report particularly in the section dealing with the issues identified.
14. An independent clinical review of the medical care he received in HMP Leeds has been provided by the local Primary Care Trust.
15. After the majority of the interviews had been conducted, the investigation team identified two specific aspects of the man's imprisonment, diversity and the use of control and restraint, as warranting expert opinion. Two expert advisors were appointed, and provided with the draft report, and relevant prison records and interview transcripts. Because they were appointed at a late stage of the investigation, neither expert had the opportunity to contribute to the interviews.

16. The first expert analysed the use of control and restraint, comparing it with the standards of the Prison Service. The second provided an expert opinion of the diversity issues raised in the report. He met the investigators in June 2006, and his advice and expert opinion have influenced the presentation of the material in this report. In particular, the second expert has researched the community anxieties about the man's death, and provided invaluable interpretation of a Muslim's understanding of the man's treatment during his imprisonment. Following the expert's advice, the meeting took place with the Imams working at the prison. Because the expert advisors were appointed after interviews with staff and prisoners had taken place, the second expert in particular has expressed that his "advice is qualified in the context of limitations within the investigative process around race and Muslim issues."
17. One of my family liaison officers arranged a meeting on Monday 26 September 2005 with one of the man's brothers, and the family solicitors. They also met one of his friends. My investigation attempts to answer the questions posed by the man's brother, the friend and those representing the family.
18. The following concerns were raised:
  - during one visit, the man told his brother that he was being bullied by staff. He also mentioned being jumped on by another prisoner after a game of pool after which he had moved wings. His brother said he could see the fear in the man's eyes when some prisoners with trusted jobs in the prison came into the visiting room to deliver food.
  - at another visit his family say that staff said, in the man's hearing, that he was going to let off a bomb. This was the only example of racism mentioned by the family.
  - on another occasion three days later, two of his brothers went to the prison to visit the man but were told by staff at the gate that he had been involved in a fight which had resulted in him breaking an officer's arm. They were also told that the man was not speaking to anyone, and was praying to calm himself and that the visit would not take place. His brother would like to know what happened.
  - the family want to know why the man was in a single cell in the segregation unit which had a bunk bed.
  - his brother asked whether prisoners should have bed sheets.
  - he said that his brother sent three visiting orders/letters to family members that were not received.
  - since the man's death, the police have shown the family letters found in his cell some time before he died. His brother was not given any copies of those and would like some.
  - his brother would like to know if the man submitted any written complaints during his time in the prison.
  - his brother is aware of an incident that took place on 18 August when the man barricaded himself into his cell. He would like more information about the incident including whether he was alone in the cell, whether he was medically assessed and whether appropriate care was given after the incident.

- the man complained to his brother that he was not getting enough food, and his brother thought he looked unhealthy. The man had ordered some biscuits (canteen) and these did not arrive until after his death. His brother asked when he had ordered them and why they had taken so long to arrive.
  - the man was concerned because he had not had any contact with his solicitor for some time and his brother would like the investigation to clarify whether this was the fault of the solicitor or if any fault is with the prison.
  - the post mortem report states that there were some cuts to the man's body and arms and the family want to know how they occurred.
  - his brother has heard a rumour that someone entered his brother's cell in the segregation unit.
  - the family friend believed that, when he saw the man on his last visit, his eyes looked as though he had taken drugs. He asked if the man had been given any drugs.
  - the friend also asked why the man was not on an open suicide watch.
  - the general issue of racism in Leeds prison was raised and the family friend asked why, if HMP Leeds has a problem of racism (as he believes it does), the man remained there.
19. Since the publication of the first draft of the report, the investigators have considered the feedback from both the family and the Prison Service, and factual inaccuracies have been corrected. The investigators have also viewed the closed circuit television (CCTV) coverage of the segregation unit for the days when the man was present. The evidence of the CCTV coverage is woven throughout the report, and has resulted in changes from the first draft. The coverage does not include a sound track. The Governor at Leeds has been advised of the significance of the evidence of the CCTV coverage, and has requested a copy for his own viewing.

## **HMP Leeds**

20. HMP Leeds is predominantly a Victorian prison. The four original wings (A, B, C and D) were built in 1847. Two more wings (E and F) were opened in 1994, together with new kitchens, gymnasium and healthcare centre. It is a category B local prison for adult male prisoners from West Yorkshire. The certified normal accommodation in August 2005 was 806, the operational capacity was 1,254. On 21 August 2005, 1,225 prisoners were held.
21. In August 2005 there were 369 new prisoners and 968 separate prisoner movements through reception. The average stay for a prisoner was 29 days.
22. A wing consists of four landings, the top three entirely populated by vulnerable prisoners (those who must be protected from others). The bottom landing, A1, contains the segregation unit which is known as S1. Other wings hold convicted and unconvicted prisoners, and D wing is the induction wing.

### ***Segregation Unit***

23. There are 22 single cells in the segregation unit, including two special cells and two cells for prisoners on dirty protest. The special and dirty protest cells are fitted with closed circuit television (CCTV) and 12 additional cameras continuously film the landing. At the time of the man's death, there were no segregation unit cells which met the Prison Service's definition of a safer cell. However, two cells were converted to the standard in October 2006. At the time of the man's death, and when this investigation began, most of the cells were furnished with bunk beds. I am pleased to note that, following correspondence after a visit I made myself to Leeds, they have now been removed.
24. Each cell is equipped with an internal bell, located alongside the light switch, which prisoners may use to alert staff. An electronic buzzer sounds in the office when the bell is pressed, and a light outside the cell flashes to show which bell has been used. There is no record of bells being used. The bells are reset by pressing a cancel button, located outside the cell alongside the call light.
25. The special cell also has a light switch on the wall adjacent to the call bell. However, as the special cell lights are left permanently on in order that the CCTV cameras can function, the switch does not control the lights.
26. When staff predict that force will be required to restrain a prisoner, arrangements are made for planned control and restraint removals to be video taped.
27. The special cell is sparsely furnished, with a built in sleeping plinth. It has a toilet, but no hand washing facilities or running water. It has closed circuit television coverage with two cameras which contemporaneously record the

28. Meals are brought to each cell at midday and evening time and left at the door, together with a flask of hot drinking water. Each door is opened in turn to permit the prisoner to collect their tray, and the routine is repeated when the used plates and flasks are removed. Prisoners are given a breakfast pack at the same time as they are given their evening meal.
29. The staffing levels in the segregation unit remain the same regardless of the number of prisoners in the unit. During the day, the unit is managed by a senior officer and six prison officers who are all specialist segregation unit staff and have been through a selection interview. At night, unlike other wings which are staffed by a mix of prison officers and operational support grades (OSGs), the segregation unit is staffed solely by an OSG from the pool of OSGs, rather than a specialist on the unit. The OSGs do not have specialist knowledge of the requirements for a segregation unit and are not selected for the role. During the day their duties are in other parts of the prison, and the only time they work on the wings is at night time. Their information about the prisoners is obtained from wing staff when they take over. The OSGs interviewed for this investigation had not attended training courses relevant to the care of prisoners, including suicide and self harm awareness. (However, I am pleased to note that, since this investigation began, the night OSGs have been replaced by officers.)
30. During the night, as in other parts of the prison, staff have a routine known as pegging which requires them to go to pre-determined parts of their wing at pre-set times and use the pegging gun to log their presence. The purpose of the pegging routine is to ensure that all parts of the wings are patrolled regularly through the night. There are two pegging points in the segregation unit.
31. When prisoners are first located in the segregation unit, they are given an information booklet about the unit's rules, the daily regime, and how to make applications or a complaint. The booklet also acts as a compact between the prisoner and unit staff on agreed behaviour and entitlements. The compact is expected to be given to prisoners within 24 hours of their arrival, but there is no system which ensures that this happens.
32. Prisoners have to be dressed by 7:30am, when they are unlocked briefly and are allowed to make any applications. If prisoners are not fully dressed when the cell is unlocked, they are not allowed to make an application later in the day. As well as applying for the range of matters available to all prisoners, those in the segregation unit have to apply for items available as a right for other prisoners, including telephone calls, showers and exercise. Prisoners who want any information are expected to ask at application time, which is the time when they have most contact with staff, although they can ask at other times. Prisoners can ask to talk to the Listeners and use the Samaritans mobile telephone. When this investigation began, the

33. It is a mandatory requirement that prisoners held in a segregation unit are visited daily by the duty governor, chaplain, and doctor. A member of the IMB visits each prisoner every week day. The visits are to ensure that prisoners are being treated fairly and decently and to give them an opportunity to raise any concerns.
34. As well as looking after prisoners in the unit, including monitoring their mail, segregation staff are responsible for the administration of adjudication hearings (prison disciplinary hearings) including preparation of paperwork, collecting and returning prisoners, and being in attendance throughout.

### ***Diversity***

35. At the time of the man's death the prison did not employ a dedicated Diversity Manager, and responsibility for diversity issues was one of several roles carried out by a governor who was interviewed for this investigation. In the months since then, a diversity team has been appointed in line with the recommendations of the CRE and HMCIP. There are three full time members of the team, including a senior manager plus the Co-ordinator of the Multi Faith Chaplaincy team.
36. The Diversity Manager describes his role as to provide a strategic input to the senior management team, so that race and diversity are emphasised throughout all the prison's functions. He has provided information about developments since his appointment, including the investigation of all racist complaints, which are evaluated by a Scrutiny Panel that has prisoner and community members. A mediation programme has been established and the recruitment of visible ethnic minority staff has increased.
37. The prison's multi faith co-ordinator and Muslim Chaplain has provided information about the number of Muslim prisoners at Leeds, compared with Muslims in the general prison population and the wider community. The 2001 census records that in the wider community, 2.9% of the population are Muslim. The 2005 annual census of religion in prisons, carried out by HM Prison Service Chaplaincy, states that 9.2% of prisoners are Muslims. The May 2006 race relations statistics collected at Leeds report that 13.5% of the prison's population are Muslims.
38. Muslim prayers take place every Friday and I am told that approximately 60% of Muslim prisoners attend. Islamic study classes are held on each wing during evening association every week, but the number of places is restricted so not all prisoners can attend. The class is described as a social and informal occasion, which includes a faith based talk.
39. According to the Imams, the main focus of attention for Muslim prisoners at Leeds is the provision of suitable halal food. They describe some improvements to the regime, such as prisoners being allowed to wear caps

40. I am unaware of any consideration having been given to the wider aspects of prison life and their particular impact for Muslims. Focusing on events in this man's imprisonment, examples are the absence of water for washing and drinking in the segregation unit's special cell, and the short length of the rip proof clothing provided in the cell, both of which prevent proper preparations for Muslim prayers.

### ***Deaths in custody***

41. Between April 2004, when I took responsibility for investigating deaths in custody, and August 2005 when the man died, there were seven deaths at Leeds prison. Of these three were apparently self inflicted deaths, and the others were either due to natural causes, substance misuse or homicide. All three of the men who apparently took their own lives were white, two of them died in the normal wings and the third in the segregation unit. Only one of the inquests has taken place and the report has yet to be published. Two of the reports make recommendations which are relevant to this investigation. In one case, I was concerned that officers did not cut the ligature and lay him on the floor as soon as he was found, and so I reminded the Governor about the importance of complying with PSO 2710 when discovering an apparent death. In the case of another man, who also attached a ligature to a bunk bed in the segregation unit, I recommended that the Governor remove ligature points and provide a safer cell in the unit.

## **HMCIP inspections**

### ***Inspection of HMP Leeds August 2005***

42. Her Majesty's Chief Inspector of Prisons (HMCIP) undertook an unannounced inspection of Leeds between 22 and 26 August 2005. The inspection followed up recommendations made at their previous visit and considered any changes made. Many of their findings are relevant and significant to this investigation, and so I make extensive reference to the report here.

### ***Race relations***

43. The inspectors were concerned about safety at the prison, particularly for black and ethnic minority prisoners of whom 43% of those surveyed said they felt unsafe at times. The inspectors said that race relations at Leeds had been under the spotlight for some time, following the murder of a prisoner, the investigation of a dossier of complaints and a visit by the Commission for Racial Equality. Although complaints structures and monitoring had improved, black and ethnic minority prisoners reported 'under-cover' racism and discriminatory treatment by staff. Prisoners surveyed said that they had no confidence in the complaints system, although they did report improvements in the previous six months, and a diversity officer was about to be appointed.
44. HMCIP repeated recommendations about wing staff investigating racist incident complaints. They also highlighted the failure to investigate prisoner complaints of staff racism, which are followed by the member of staff making their own complaint about the complainant. Additional recommendations concerned:
- staffing the diversity posts
  - extending the race advisory group to be a genuine forum for consultation with prisoners
  - monthly meetings of the diversity group
  - including interviews of all involved parties in the investigation of racist incident complaints.

### ***Visits***

45. HMCIP repeated their recommendation about providing visitors with easy access to an efficient booking system. Although the visiting hours were good and there was a new visitors' centre, the staffing of the telephone lines was insufficient to cope with demand and the problems were aggravated by delays issuing visiting orders and the absence of a system for prioritising applications.

### ***Use of force***

46. The inspectors noted a high and mechanistic use of force, with at least one incident per day and records indicating that, in some situations and

47. Further recommendations were made:
- the officer certifying correct completion of use of force forms should not be involved in the incident or give authority for the use of force
  - the quality check of the forms should not be done by a manager who was involved in the incident
  - a duty manager and healthcare staff should attend all planned cell removals.
48. All prisoners taken, under a full re-location to the special cell, are strip searched to ensure that they do not have any objects which could be used to harm themselves or others. The investigators were told that the search routinely includes cutting their clothes off, rather than taking them off, and this happens whether they are wearing their own or prison clothes. Prisoners are provided with a rip proof garment to wear.

### ***Bullying***

49. Prisoners surveyed by the inspectors reported bullying and intimidation by prisoners and staff, and said that it was not reported because of lack of confidence in the system. The inspectors noted that there was an appropriate anti-bullying policy, but its implementation was patchy and there were no planned interventions for working with victims.
50. A previous recommendation that all staff should be encouraged to inform the bullying coordinator of all cases of suspected or confirmed bullying had not been achieved and was repeated. Further recommendations were made concerning:
- staff training and use of reporting systems
  - attention to discrepancies between the reports made by each wing
  - training for anti-bullying liaison officers.

### ***Suicide and self harm***

51. The inspectors found that a pilot multi-disciplinary safer custody programme was making an impact, and there was a valuable and effective Listener scheme although the lack of a Listener in the segregation unit was a serious deficiency. (Listeners are prisoners who volunteer to be trained by the Samaritans and provide confidential support for others who are at risk of self harm or suicide.) Prisoners in the segregation unit were supposed to use the services of the Listener located in the Vulnerable Prisoners wing, even though they might not wish to do so. The prison also had dedicated

### ***Segregation unit***

52. The inspectors were concerned about the management of the segregation unit, considering that it was run in a militaristic fashion. They found that the special cell was used excessively, proper records were not kept, and it was sometimes used as a punishment for relatively minor disciplinary offences by prisoners already in the unit.
53. Although prisoners relocated to the segregation unit should only be strip-searched with a duty manager's authorisation, the inspectors found that this was routine practice. The HMCIP report commented that the length of time spent by prisoners in the special cell was high, and they were not removed at the earliest opportunity when they complied with instructions.
54. The inspectors noted poor procedural practice regarding the duty governor's authorisation of the special cell, and also many examples where the doctor's authorisation was completed long afterwards. They observed little meaningful interaction between staff and prisoners, and observations of prisoners were carried out at predictable intervals. The only prisoners who were checked at night time were those deemed to be at risk of harming themselves or held under cellular confinement (which is a sentence imposed at an adjudication hearing).
55. Additional recommendations were made:
  - all use of the special cell should be recorded
  - special cells should not be used solely for searching prisoners
  - the special cell should not routinely be laid out with strip clothing
  - a duty manager should always authorise the use of the special cell
  - quality assurance systems should be introduced for the use of special accommodation records
  - the doctor's authorisation of use of the special cell should be obtained as soon as possible and not when the prisoner has returned to a normal segregation unit cell
  - staff should maintain regular contact with prisoners while they are in the special cell and record their interaction.

### ***HMCIP thematic review of race relations in prisons***

56. In December 2005 HMCIP published *Parallel Worlds*, a thematic review of race relations in prisons. Their research included survey material from 5,500 prisoners of all racial groups. It is a comprehensive document which finds that much progress has been made and processes for addressing racism and discrimination are in place. However, it also finds that there is no shared understanding of race issues within prisons. Prisoners from visible minorities in all the prisons surveyed reported poorer experiences than white prisoners and overwhelmingly reported that they felt less safe, less respected and reported poorer access to the regime and facilities.

## **The man's imprisonment at HMP Leeds**

**6 June – 14 July 2005**

*First night centre, cell D1:07*

57. The man appeared at the Crown Court in June 2005, charged with failing to appear to answer a criminal charge and was sentenced to 28 days imprisonment. The court further remanded him in custody pending trial for the original offence.
58. Prison escort contractors took him to HMP Leeds and he passed through reception to the first night centre (FNC) where an officer interviewed him to complete the first part of a cell sharing risk assessment (CSRA). The officer recorded that the man was of low risk of harm to others and that he was suitable for multi cell location. He was clean shaven when he was photographed for the prison records.
59. A nurse in the first night centre, who was the only member of staff interviewed for this investigation from a visible ethnic minority, medically assessed the man and completed the First Reception Health Screen Form. She also indicated on the form that there were no current indications of risk, and that he was suitable for multi cell location. The FNC nurse asked the man a number of predetermined questions. He told her that he had a regular place to live, that he had not seen a doctor recently, and that he was not on medication nor had suffered any recent injuries. He said that he did not suffer with asthma, diabetes, epilepsy or fits, chest pains or allergies, and that he had no concerns about his physical health. The nurse observed that he had a good colour, was well built and did not abuse alcohol or drugs.
60. The man also told the FNC nurse that he had suffered intermittently from depression since childhood, but had never consulted a doctor. In response to the question, "have you ever tried to harm yourself?" he replied that two years previously he had thought of harming himself. The nurse noted that the man appeared a bit subdued and preoccupied with a girl he knew from college. She recorded that he did not feel like harming himself and that he was not suicidal. She considered that he was fit for normal location and work, and both of them signed the form.
61. The man was located in cell D1:07 in the first night centre, which he shared with another prisoner. An FNC officer completed the induction log with him, informed him of the prisoners' telephone system, and gave him a personal identification number to use to access the telephone. He was also informed about the Listeners scheme, how to send visitor's orders, and other aspects of prison life and regimes. (The officer told the investigators that her interview with someone like the man who died, who was in custody for the first time, would last about 20 minutes.) He also had a routine meeting with the chaplain and with gym staff.

*Cell D3:16*

62. The next day, 7 June, the man left the first night centre and was relocated to cell D3:16 which he shared with a second prisoner. Two days later, an officer on D recorded in the wing observation book that the man felt low but stated that he was not suicidal. A senior officer (SO) told investigators that his recollection was that the entry was made at 8:00pm. The SO immediately went to see the man in his cell, finding him sitting on his bed with a towel over his head. The SO said that he tried to talk to the man, but found him reluctant to talk. He was sufficiently concerned about his welfare that he arranged for him to move into the Listeners cell overnight, with a Samaritan trained prisoner for company. The SO advised the night Orderly Officer and night staff, asking them to check during the night. He did not open an Assessment, Care in Custody and Teamwork (ACCT) document, which is the prison's suicide and self harm monitoring procedure.

*Cell F4:19*

63. There were no occurrences of note during the night and the next day the man was located back to a normal cell. He did not return to his original cell, but was moved to F4:19. He signed a voluntary drug testing compact, and telephone records indicate that he attempted to make three telephone calls.
64. The man shared cell F4-19 with a third prisoner. His cellmate kept a diary and has a good memory of the short period that they spent together. He described the man as a nice lad, who was a bit difficult to understand although his standard of English was good. He told the investigators that the man could be a bit annoying when they were watching television as he was always asking questions. He said they had heated theological discussions, and he described the man as prickly when there was news about Iraq.
65. On 12 June, prison telephone records show that the man attempted to make a further telephone call.
66. At 10:10am on Monday 13 June, the man and a white prisoner, the incident prisoner had an argument at the pool table on the wing resulting in a fight in which pool cues were used. The incident was reported on Prison Service incident report forms and the officers and prisoners who were present have been interviewed for this investigation.
67. In his interview, the incident prisoner stated that the man had jumped the queue for the pool table which caused the fight. He thought that it was possibly his first time in prison and that he might not have understood the rules. After the fight, he said that he remained on the wing and the man was moved. He said that they subsequently met on E wing and they got on well. The incident prisoner said that the man was a good pool player and, as the winner of a game would continue to play, he often played for long periods. He said that the man kept himself to himself in relation to both staff and prisoners. He described him sitting by himself and praying in the

68. Another prisoner on the wing, intervened to break up the fight. In interview, the intervening inmate said that he was playing pool when he heard a commotion. He was hit in the head with the tip of the man's pool cue and intervened to break up the fight between him and the incident prisoner.
69. Officers arrived and restrained the man, the incident prisoner and the intervening inmate.. A Physical Education Officer (PEO) was on F wing and he heard staff shouting for assistance and went to restrain the man. An officer was on F wing and went to assist the PEO and another officer to restrain the man, whilst other colleagues restrained the incident prisoner. Another officer was on F wing and witnessed the fight. She observed that the prisoner that she had seen doing most of the hitting ran off down the landing, and she thought that the man had been defending himself.
70. The second officer assisted her colleagues to restrain the man, and said that he complied with the officers. As his arms were already held, the officer said that it is routine practice for the head to be held to prevent it being injured and she took that role. The man was told by the PEO that he was going to be taken down on to the floor. The PEO described the man as a bit dazed, but said that he did what the officers told him to do and no force was used. The second officer said that little was said to the man during the incident, other than to shout what was going to happen next. After he was laid on the floor, the second officer said that they recognised that he complied with their orders and so they immediately released their hold. The man got to his feet and stood with his back to the wall of the landing.
71. Both the man and the incident prisoner were taken to see the senior officer and placed on a disciplinary charge.
72. The third prisoner recalled returning to his cell from work that day at midday. He said that the man told him he had been involved in a fight at the pool table, and had a headache. A nurse (not the same one that he had seen in the FNC) saw the man in the cell. He has not been interviewed for the investigation and no longer works at the prison. The medical record indicates that the nurse's assessment was that there was nothing abnormal and the man should be observed. According to his cellmate, the nurse thought the man was partially concussed. His cellmate stayed off work that afternoon to monitor the man's condition, which he said was fine. He offered to attend the adjudication with the man the following Tuesday. The first officer who witnessed the fight was the reporting officer at the hearing in front of a governor. Both the man and the incident prisoner were cautioned for their behaviour, as it could not be established who started the fight.
73. His cellmate said that the man slept on the top bunk in their cell. He had few possessions other than the Qur'an, which he read either sitting on his bunk or the chair. The man ate his meals sitting on his blanket on the floor at the end of the bed. He said that he did not see any tension, either racial

*Cell E3:09*

74. On 14 June, following the fight at the pool table, the man was relocated to E wing cell E3:09, where he shared a cell with a fourth cellmate. The telephone records indicate that the man attempted to make three telephone calls that day at 2:35pm, 2:37pm and 2:39pm.
75. Five days later, on 19 June, the man's sentence expired and he was held on remand, awaiting trial for the original offence. It appears that the prison was not aware of the change of status. There is no record of his change of status, any change to the conditions under which he was held or of a referral to the prison's bail application systems. At the outset of this investigation, both my investigators and the prison found it difficult to establish the basis for the man's imprisonment and it was subsequently confirmed that his change of status had not been noted by the prison. His criminal solicitors have since told me that the man did apply for bail, but the judge refused his application.
76. The following day, a fifth cellmate moved into the cell with the man, and they remained together until 8 July when the fifth cellmate was transferred. He recalled being on the exercise yard when he said that the man pointed out another prisoner to him, saying that he was the one he had fought with which had resulted in him being moved to a different wing.
77. His fifth cellmate described the man as a person who did most of the talking. His cellmate said that the man came from Iraq and had lived in Germany and Saudi Arabia. He thought that the man had possibly been in prison in Germany, and that this was his first time in custody in this country. He said that the man read the Qur'an and used to preach to him. He talked of an ex girlfriend who lived in Germany, his parents and his grandmother, and asked how to send out a visiting order. His cellmate recalled the man writing letters in his cell in his native language, and that at times he struggled to understand what people were saying although his own spoken English was good.
78. His fifth cellmate said that the man had no problems with staff or other prisoners, and kept himself to himself. He described him as a negative person, who made remarks about life being pointless. He said that the man was self contained on the wing, and did not have a good relationship with his family. Whatever the subject of their conversation, it would turn into one about religion and the man would preach to him about right and wrong. This behaviour increased during the time that they shared a cell, and his cellmate described him as hard to get on with. He was surprised to have learnt that the man had died, as he had not hinted that he felt suicidal. The man had explained that the people who set off the London bombs were regarded as martyrs, but that anyone else who took their own life would go to Hell.

79. The man's fifth cellmate described relationships between prisoners and staff as "them and us", and that it was harder to have a friendlier relationship in a remand prison. He said that neither staff nor prisoners treated the man differently after the London bombs, and he did not speak to him about any racial tension.
80. About three weeks after the fight at the pool table, the other prisoner involved, the incident prisoner, also moved on to E wing, where he got a job in the servery. He said that he came across the man on several occasions, and they got on well. He thought that the fight occurred because he was unfamiliar with prison routines, and there was no hostility when they saw each other again. He also said that he used to see the man praying in the exercise yard, and that he tended to keep himself to himself.
81. The investigators established that the man used the prisoners' telephone briefly on the following dates, although none of the calls lasted more than a few seconds:
- 17 June, two occasions
  - 19 June, three occasions
  - 22 June, one occasion
  - 23 June, one occasion
  - 26 June, two occasions
  - 27 June, once
  - 28 June, once
  - 29 June, once.
- Like the other telephone calls, these lasted seconds, he was not connected and no conversation took place.
82. On 7 July four bombs exploded in London, causing loss of life and substantial injuries to many people. These events were of considerable national interest, and were of great local significance as it transpired that three of those responsible were from the Leeds area. The Governor of the prison was asked to be alert for tensions within the prison and to ensure that there were no repercussions.
83. The B wing observation book contains a photo copy of a State of Alert update issued by the Home Office at 11:45am on 8 July 2005. It states that:
- "Governors should ensure that any incidents or indications of tension within establishments, which may be linked to yesterday's events, are reported immediately to National Operations Unit (NOU) via the single incident number. This may include tensions around Muslim Friday prayers; any intelligence from this, or any related issue, should be passed to NOU as above."*
84. On 9 July, the man signed a wing compact which sets out the wing rules and informs prisoners what is expected of them. The compact was explained to him by a wing officer, but his signature was counter-signed later by another officer as part of his routine administrative tasks. Between

85. On 14 July, the seventh cellmate moved into cell E3:09 with the man. He said that initially they got on together. His cellmate described him as a quiet person, who read the Qur'an and talked about a girl friend, but that he had not telephoned her since coming into prison. He said that the man stayed in his cell during association and kept himself to himself on the exercise yard, but did attend Muslim prayers.
86. The Imams at the prison knew the man by sight as he attended Friday prayers. Two of their team also knew him as he regularly went to the Islamic study class. The dates that he attended were not recorded, but there were six to eight occasions. No change to his mental health was observed over this period, and he was described as strong and sociable. The Imams described the man as an active participant in the classes, with a strong faith which they said was based on the teaching of the Qu'ran rather than the prophets. They also said that he did not believe in praying five times daily, as is the norm for Muslim prisoners, but prayed at any time even if it was at a time or place which singled him out. I understand that his beliefs and depth of knowledge are unusual amongst Muslims generally, and especially for prisoners, and his level of education may have made him less likely to engage with others.

### **15 – 17 July 2005**

87. On the afternoon of 15 July, the man received a visit from members of his family. His seventh cellmate described him as excited afterwards, because his visitors had told him about an incident in Iraq when American soldiers had been killed. He said that the man watched all the television coverage of the London bombings. The man told his cellmate that he was upset by the death of a suicide bomber and, in his distress, had damaged a television. He went on to say that the man offered to show him how to make bombs after they were released. His cellmate became uncomfortable and on 15 July told the wing SO of their conversations.
88. In interview, the SO told the investigators that following his cellmate's comments the man was treated as a security risk, and the SO reported the matter to the security SO and governor from the prison's security department. The governor and the security SO went to the wing just before 8:00pm and the SO escorted the man from the cell to the wing office where he could talk to him. The security SO told the investigators that other prisoners were still out of their cells. He confirmed that hostile threats and abuse were directed at the man whilst they walked to the wing office. The security governor said that he believed that other prisoners were aware of the man's views about the events in London and shunned him. The verbal abuse was not recorded and no action was taken against those making the threats. The security governor said this was because so many prisoners were unlocked that those responsible could not be identified. Despite the

89. The security governor and SO interviewed the man, who denied the conversations alleged by his cellmate but did say that he knew people who would know how to make bombs. The governor was concerned for the man's own safety, because of what his cellmate had said, and also because of the reaction of other prisoners. He did not think it would be safe for him to return to normal location on E wing, but that he would be safe in the segregation unit overnight after which he would arrange for him to be relocated. The allegations about the man were recorded on a Security Information Report (SIR), which was passed to the local police for their attention. The police force employs police liaison officers to work within the prison. The security governor was not aware of any concerns being expressed by the police and no more action was taken.
90. The wing SO said that the man asked to be moved from the cell, went willingly to the segregation unit, and did not appear to be especially concerned about anything else. He recalled that, when he collected his belongings, there was little to move and he was wearing prison issue clothing.

*Cell S1: 11*

91. The security governor and SO escorted the man to the segregation unit, and described him as calm and compliant. They located him in cell S1:11, which is a normal cell, where they explained the procedures and issued him with the paperwork to clarify why he was there.
92. In interview, the security governor was asked about his assessment of the man and whether he consciously thought about whether he was safe from other prisoners and himself. He said that both he and the nurse on duty, who also assessed him, felt confident that he was safe. He described the man as calm, compliant and lucid and said that he did not say anything about how he was being treated by other prisoners or by staff.
93. The security governor was responsible for completing the authorisation documentation required to hold the man in the segregation unit. He was segregated under prison rule 45, Good Order or Discipline, (GOOD), for his own safety. In addition to authorising his segregation, the governor completed the segregation unit algorithm, which is a document used to assess the level of risk to staff and self. As the reason for segregation, the governor recorded, "Own interest claims that prisoners on the wing are hostile and aggressive has them believe he has terrorist connections."
94. The nurse completed the healthcare section of the algorithm. In interview, she said that she did not recall assessing the man. She said that she usually asked prisoners about any mental health problems, medication or ACCT monitoring in order to complete the questions about the likelihood of self harm. She thought that the interview would last a couple of minutes,

95. After the man moved to the segregation unit, cell E3:09 was searched by the wing SO and another officer. They found correspondence written in both English and Arabic. The SO did not recall where the papers were found, but did remember that they had toothpaste on the back which suggested to him that they had at one time been stuck on the notice board.
96. No copies of the correspondence were kept in the prison, and the originals were passed to the local police who arranged their translation. The security governor said that he read the English section of the correspondence and made no arrangements to translate the Arabic text within the prison. He did not consider that the words in the letters signified that the man presented a risk to others or himself. Instead, he thought that he might be at risk from other prisoners for expressing views which could be thought to show that he sympathised with the bombing campaign. The correspondence written in English read as follows:

*Good life is after the bad life so the real life is after we die then wake up for the rustlet [sic] of what we have expressed of this low life.*

97. The correspondence written in Arabic was translated as follows:

*I do seek refuge with God from the rejected devil in the name of Allah, most gracious, most merciful.*

*Who wants the real life has to work hard for it and have faith in God and has to be a Muslim and a believer*

*Travelling and socialising with people. All Muslims should hold the rope which Allah stretches out for you and you should not be intimidated by anything or anyone. Muslims should help each other financially and in respect to getting married to Muslims and believers. And Muslims should not surrender to barriers in life. God would like to test us, and wants to show us how present and what the difference is between the real life that God wants for us and to strengthen our faith in God.*

*Back to hope*

*Back to the faith*

*Adam and Eve*

I am advised that these are the conventional words of a Muslim expressing his devotion and they do not contain anything of individual significance.

## **17 July – 17 August 2005**

### *Cell B3: 15*

98. After two days, the man left the segregation unit and was relocated to cell B3:15, which he shared with his eighth cellmate until 16 August. A segregation unit officer completed the Cell Sharing Risk Assessment in preparation for the man's return to the wing. He assessed the risk presented by the man as medium, but did not recall the reason why he increased it from the original reception assessment and did not record the basis for his decision. He recalled him as quiet, not interacting very much with staff, and he did not recall him making any applications.
99. His cellmate was interviewed for this investigation using the services of an Arabic speaking prisoner as an interpreter. He said the man did not speak to him at all, and that every time he tried to speak to him he told him to leave him alone. He said that the man stayed on his bed all day long, and he did not see him praying.
100. An Arabic speaking prisoner, said in interview that he met the man at Muslim prayers and sometimes on the exercise yard. The man told him that he had come to prison because he had killed an Englishman and was due in court on 14 September, when he thought he would be sentenced to between six to ten years imprisonment. The prisoner said that the man told him that he was unhappy with prison and had said "I am happy to kill myself. It is better than staying in this prison."
101. The man's family visited him again on 2 and 14 August.
102. The instructor in the prison's sewing workshop recalled the man working in workshop three on 15 August, when she tried to teach him to use a sewing machine. She said that the man sat at the front of the workshop. He was very quiet, keeping himself to himself, and she did not see him speak to any prisoners or other members of staff. As she was training him, the instructor said that he did not give any feedback and did not appear to listen to her instructions. The instructor gave him sewing tasks, but she said he did not do them. On one occasion, she saw him go to the back of the workshop, remove his foot wear and wash his feet in the sink before getting to his knees. She knew that this occurred at approximately 11:25am as it was the end of the morning session and he was the last prisoner to leave.
103. On 16 August, a ninth cellmate moved into the cell with the man. He said that, when he arrived, the man was sitting in the cell which he said was "quite mucky. Everything was scattered about." They introduced themselves and he thought that the man seemed like a decent fellow, but not very chirpy. There was no television in the cell, and the man said that they did not need one, as he had been without a television for a week or more. He said that the man told him that he had been in trouble, which was why he did not have a television, although there is no record of his television being withdrawn.

104. His cellmate thought that they should have a television and went to request one from the staff, but without any success. He said that the man “had bibles” and every time they had a cigarette he would pray to say sorry to God for having a cigarette. It was his impression that the man did not have anyone in his life and he thought that his family had disowned him. The man told him that he had been working in the sewing shop and had not slept for three nights. His cellmate said that the two men drank tea, smoked and talked together. He told the man about himself and what he had been through. He said that the man asked questions and seemed quite interested, and the cellmate was pleased to have someone who listened to him.
105. Whilst the man washed himself, his cellmate saw what he described as deep cuts on his left wrist, which he believed were self inflicted. The man told him that he cut himself whilst he was with another cellmate, another Asian fellow, who was asleep at the time. He said that his cellmate woke up and put the light on, which alerted staff. His cellmate wrapped towels around the man’s wrist to control the bleeding. When the officers came to the door, the men said that everything was alright.
106. The cellmate told investigators that he tried to make the man laugh, but he would reply that there was “nothing to cheer up about. I am sick of life. I don’t like it anymore. All I want to do is go to sleep tonight and not wake up.” The cellmate to make him realise that he could make a life for himself, even without any family support. He asked if there was anything the man liked to talk about; he replied that he liked to talk about not wanting to live. The next morning, he said he told the wing senior officer of the cuts on the man’s left wrists. The cellmate asked for and was granted a change of cell, remaining on the wing and seeing the man at association. He thought that he was alright, but did suggest that he should talk to someone about his problems. He told the investigators that he thought the man was not prepared to talk about his issues, and someone would have had to have approached him to do so.
107. Another prisoner on the wing who knew the man said that he was aware of problems between the man and wing staff before 18 August, as he said that he was in the habit of covering the observation spy hole in his cell door. He said that sometimes the man would put furniture in front of his door and, on a couple of occasions, staff had to force the door. On other occasions he saw a member of staff sit with the man, and he described them as good staff who would try to help prisoners.

*Cell B3:24*

108. The tenth cellmate moved into cell B3:15 on 17 August, and at 1:56pm the same day the man was moved to cell B3:24 which he shared with his eleventh cellmate. A wing officer knew both prisoners and said that there were no reports of any issues between them. The officer did not know the

109. When he was interviewed for the investigation, he said that he remembered the man showing him marks where he had harmed himself.
110. The wing PO also remembered the man, and recalled that on one occasion he interviewed him as he refused to go to work. The PO did not remember when the interview took place, but did say that afterwards the man agreed to go to work. (As the man had been held on remand since 19 June, he should not have been required to go to work.)

### **18 August 2005**

111. Another SO working on B wing remembered the man's time on the wing. She remembered him as a quiet person, who was courteous to her as she carried out wing duties such as unlocking his cell for work and association.
112. Early in the day, an officer observed blood stains on the elbows of the man's prison issue tracksuit top which he was wearing inside out. The officer passed the information to another B wing officer, the SO and then to another officer who is a trained ACCT assessor. When the SO was interviewed for this investigation, she initially said that she had no recollection of concerns about the man harming himself or of any injuries, such as cuts on his arms. Subsequently the SO amended her interview transcript and confirmed that the officer had made her aware, and then the ACCT assessor was asked to speak to the man.
113. The ACCT assessor went to see the man and found him sitting on his top bunk. He asked the man if he had any concerns, but he did not reply. The assessor tried to engage him in conversation, but he said that the man continued to be unresponsive and stare at the floor. The assessor went on to ask the man to get off the bunk so that he could see whether there were any cuts on his arms, but again said that he did not get a response. The assessor contacted the healthcare centre to ask a mental health nurse to come and see the man and his request was passed to a Registered Mental Health Nurse (RMN).
114. Approximately five minutes later, the RMN arrived and saw the man, spending about 20 minutes with him in his cell whilst the assessor waited outside out of hearing. The nurse said that, at first, the man would not speak to her and was very hostile, so she was quiet for a long time before he eventually spoke. Initially, he lay on his bed, but sat up later on in the interview.
115. At first the man said that there was nothing she could do to help him. They then talked about his family and the reasons he was in prison. She said that the man referred to events in his background, which she did not think were caused by psychiatric delusions. She said that she could not be certain whether or not he had a mental illness as, in the early stages, it

116. The RMN was aware of the cuts on the man's arms, but said that the man paid little attention to them, saying that they were not important. She described them as openly visible and that they were scratches, rather than cuts. The RMN said that she respected the man's refusal to speak about them. She recalled that he might have said to her that the marks were not actually deliberate.
117. The RMN said that they talked about how he was coping in prison, as she had been told that he was isolated on the wing. He told her that he did not like people very much, whether inside or outside prison, and spoke of his desire to hurt his peers and the officers. The RMN said that the man also referred to religious and political matters, which she said she could not discuss as they were outside her remit. Her impression was that the man had no intention of harming himself, but just wanted to get out of prison. She felt that any threats were to staff and prisoners, rather than to himself. At one point in the interview, the RMN said that the man tried to close the cell door, which she prevented, and the ACCT assessor came to check that she was alright. She said that the man was unhappy about the door being open, but accepted that it had to be.
118. Whilst the RMN was with the man, she began to complete the RMN initial assessment, which is used to screen prisoners for the mental health clinics. He denied any history of psychotic illness, psychiatric treatments or involvement with specialists such as psychiatrists or psychologists. Completion of the form included assessing risk of suicide or self harm, and the RMN described how she included it in the conversation without using direct questions. In interview, she confirmed that she did not consider that the man presented any risk to himself, but that he did to others.
119. At the end of their interview, the RMN told the man that she would come back to see him and would refer his concern about his sister to her colleagues. She then spoke to one of the wing officers, in the presence of others, to tell them about her interview. The RMN made the following entry in the wing observation book.
- (The man) hostile in presentation verbalizing hatred towards uniform staff. Feels volatile and unable to control himself at times. Not wanting a cellmate as it increases his stress levels. Please be aware of potential for violence and impulsiveness.*
120. Later that day, the RMN discussed her assessment with colleagues at the Single Point Referral meeting. It was decided that the man should be included on her case load and also be referred to the chaplaincy team. She said that the assessment form was placed in the medical records room, to be filed in his medical records.

121. The record of the Single Point Referral meeting was made available to the investigation team in December 2005, some four months after the investigation began. Neither the RMN's notes, the RMN initial assessment, or the record of the meeting, were included in the man's medical records and so none were available to the various nurses or doctors who subsequently assessed him. (None of the documents have been made available to the investigation team.) The clinical reviewer, who assessed the man's treatment as part of this investigation, confirms that there is no indication that concerns about him were brought to the attention of healthcare staff before 18 August.
122. There was an acting senior officer in charge of the wing on 18 August. At approximately 3:00pm, a wing officer told the acting SO that the man's, eleventh cellmate, had been putting his cellbell on continually all day. (Each cell is equipped with a bell for prisoners to summon emergency assistance from staff, and which lights up when it is used.) The officer told the acting SO that, when staff went to see the man's cellmate, he verbally abused them.
123. The acting SO, the officer and a second officer went to the cell and a third officer was close by. The acting SO opened the cell door to speak to the man's cellmate, who was in the cell alone. When interviewed for this investigation, the acting SO said that, before he had chance to speak, the man's cellmate punched him in the eye. The staff present responded immediately and took him, using control and restraint methods and handcuffs, to the segregation unit. The operation took place under the supervision of the duty governor for the day. The duty governor said that there had been earlier concerns about order and control on B wing during August, although none of these appears to relate to the man who died.
124. In his police statement, the wing officer said that he spoke to the man as well as to his cellmate. The officer told the police that the man was lying on his bed, talking incomprehensibly and behaving strangely. The officer dealt with the man's cellmate, and left the cell.
125. Later in the day after the cellmate went to the segregation unit, the third officer, who was present when the inmate was removed, went to the cell to talk to the man. She recognised him from the wing, mainly seeing him when his cellmate rang his cellbell, and had not met him previously. She said that as he had not presented any problems, he had not come to her attention. The man asked if someone was going to move in or if his cellmate was coming back, saying that he wanted to be on his own. The officer reassured him that it was unlikely that he would have anyone in the cell with him that night. She said that she thought he was depressed and down, but that he did not seem suicidal and was fine after she reassured him that he was likely to remain on his own. She thought he was tired of sharing the cell with his eleventh cellmate, and previously she had thought that he was fine. She said that he was talkative and she found him polite and well mannered. When asked generally about his interaction with other

126. At approximately 8:00pm during the evening roll check, and after the tea meal was served, the wing officer called the second officer (who was involved when the man's cellmate was removed) to cell B3:24. The cell was in darkness, and the officer could not see the occupants. He called out but did not receive an answer, and then unsuccessfully tried to switch on the cell light. He saw that a blanket had been placed over the window at the back of the cell, which was in darkness. The second officer also attempted to make verbal contact with the man but got no reply. He shouted to the acting SO, who was on the middle of the wing collecting the wing roll, to tell him that the cell was blacked out and he could not see inside. The acting SO went to the cell, and on his way, asked the wing officer to bring ligature scissors. The acting SO was aware that the man was alone and feared that he might be trying to harm himself.
127. The acting SO unlocked the door and went into the cell with the second officer. In interview, the acting SO said that the man grabbed hold of him and hit him with an object, continuing to do so until both fell to the floor. He remembered other staff arriving and restraining the man. The second officer described the man appearing from the dark cell and hitting the acting SO with an object in his right hand. A struggle followed in which the second officer described the man as being too strong for him to restrain. He said that the man continued to hit the acting SO with an object and ignored his own shouts to stop. The officer said he was afraid for their safety and so drew his stave, hitting the man on his left arm before he himself fell to the ground. The wing officer was present when the stave was used, although he heard it rather than saw it in use. The second officer said that he hit the man a second time on his left forearm.
128. The second officer said that, as he got to his feet, he saw the acting SO on his back, with the man crouched over him still hitting him. The officer told him to stop fighting and attempted to hit his right thigh, but because of the cramped conditions, he said the blow was ineffective. The officer grabbed the man in what he described as a bear hug from behind, trapping both his arms and pulling him backwards. He said that he managed to maintain a grip on the man's right wrist as he continued to struggle. Then other officers entered the cell and took over restraining him. The officer and the acting SO left the cell to seek medical attention, and took no further part in the incident.
129. A fourth officer was one of those who went to the cell and saw the struggle between staff and the man. Whilst his colleagues restrained the man in arm locks (a physical control and restraint technique), the fourth officer held the man's head to prevent any injury.
130. The first wing officer also attended the incident and saw the man struggling violently with staff. He noticed that the cell was dark and took hold of the man's left arm. An SO arrived at the same time to see the second officer

131. The SO was followed into the cell by another officer, who had just finished locking up prisoners on A wing. He went to cell B3:24 and saw an officer trying to move a chair out of the cell doorway. He noticed that the cell was dark, something was across the window and the light was smashed. He saw an officer standing by the sink and other people on the floor, went in and took towels down from the window.
132. The officer who had just finished locking up prisoners on A wing saw another officer on the floor with a prisoner, and he put the prisoner into an arm lock on the right arm and followed the instructions of the officer holding his head. In interview, he said that he thought it strange that there was no shouting from anyone and the prisoner was not making any noise at all. He said he was worried as the man continued to be silent, showed no sign of pain and did not flinch or struggle. He recalled that the man understood what was being said and complied with the instructions throughout the walk to the segregation unit. He said that the man was calm, and was lifted to his feet and moved into the segregation unit. The wing officer was aware of the man's wrists being handcuffed behind his back by the SO, using the handcuffs passed to him by the Principal Officer (PO).
133. In interview for this investigation, the SO said that the man was non-compliant, which he described as being sullen with staff and not saying anything. The SO said that, because the man did not speak, it was not possible to gauge his mood and so he continued to be treated as non-compliant even though he did what officers told him to do and did not struggle. The SO said that the an officer continued to hold the man's head as they left the wing. The officer said that the man struggled throughout, and pushed from side to side, which he considered meant that he was not complying with orders. The staff interviewed for the investigation said that when C & R was used to escort a prisoner to the segregation unit, prisoners would be told what was happening, but no other conversation would take place.
134. The PO was on duty as orderly officer when there was an alarm call for assistance on B wing and he went to cell B3:24. He saw two members of staff in each corner of the cell who appeared to be injured, and others restraining a prisoner on the floor. The PO said that he first became aware that a stave had been used when he was told this by the officer on the left hand side of the cell. He said that the officer repeated it two or three times and was distressed, and the PO told him to calm down. The officers told the PO that the man was violent and "non compliant", and he oversaw his removal from the wing, checking that the situation was under control and procedures were being followed. The PO said that he walked in front of the

135. A segregation unit officer was on duty at the time of the incident and responded to the alarm. He went to B wing, looked into the cell and heard orders being given. He realised that the situation was under control and judged, from the damage to the cell, that the prisoner would be brought to the segregation unit and would be “non compliant” with officers. The segregation officer left B wing and returned to the unit to make sure that the special cell was ready. A second segregation officer, who had been on duty when the man was taken to the unit on 15 July, also left the unit and went to the wing. He said that he saw five or six officers outside the cell, and others locking prisoners into their cells. He did not know who was in charge, but recognised that enough staff were present and so he also returned to the unit.
136. Although a different wing officer had little to do with the incident, he made the entry in the B wing observation book at 8:05pm as the officers who were involved had left the wing:
- (The man) sat in the dark hiding when doing roll check. The acting SO opened the door to check the inmate was okay. He was attacked by (the man). Controlled and restrained to segregation unit. Two staff off injured.*
137. The man's ninth cellmate was locked in his cell, B3:40, when he heard the alarm and saw staff responding. He described a prisoner, whom he later learned was the man who died, being removed from cell B3:24. The person was bearded, wearing track suit bottoms, a top, no shoes and was handcuffed.
138. Another prisoner knew the man from the exercise yard and association, and he was in a cell directly opposite on B wing. He recalled that a member of staff asked the man to unblock his spy hole and then two officers tried to open the door and gain access. As the door opened, the inmate said that one officer was hit with an object and he heard him scream in pain. Other officers arrived and entered the cell and he saw someone he believed to be the man being physically removed. In his opinion, “no excess violence” was used on the man and he remembered that a principal officer was directing the course of events.
139. Another prisoner said that he knew that the man had fought with an officer. He heard shouting, which he did not understand, and saw through a gap at the side of his door that the man had handcuffs on. He described one of the officers involved in restraining the man as wearing glasses.
140. After the man left the cell, it was sealed and taken out of use pending being restored to order. Any of his property remained there and was not taken to the segregation unit.

*Cell S1: 33*

141. The man was taken to the segregation unit, walking there in handcuffs and with three officers continuing to hold him. He was placed in cell S1:33, which is the special cell.
142. The duty governor became aware of the incident on B wing and made his way to the segregation unit. He was told that the man was not complying with staff and was not communicating with them. The governor said that he was responsible for assessing the information about him and deciding whether he should be held in the unit and in the special cell.
143. At 8:10pm, three officers were working in the segregation unit when the man was brought there under restraint. The CCTV coverage indicates that the man did not resist the officers as he was taken to the segregation unit. The second officer said that they were informed by radio that the man was on his way down. The wing staff placed him face down on the floor of the cell and segregation unit staff replaced them, the three officers holding either an arm or his head. A fourth officer said that the man was quiet and complied with instructions. The second officer said that segregation unit staff always assume that prisoners are brought under control and restraint because they are not complying with orders, and on this occasion wing staff said that the man was tensing his muscles.
144. The duty governor explained that the replacement staff relieved wing staff who might be tired. The arrangement also offered alternative staff who might be better able to interact with the prisoner. The second officer took over control of the man's head, the first officer took control of his right arm and the third took control of his left arm. The SO was present and removed the handcuffs and assisted to strip search the man by cutting the clothing from his body. The second officer said that the man struggled whilst being strip searched. He said that he held the man's head with one hand, and his other hand was free. He confirmed that this meant the man's head was in contact with the floor and was not protected by his hand. The first officer recalled that the man struggled with the officers and did not say anything throughout.
145. A different nurse was present when the man was walked by staff to the unit, and her statement to the police says that he was angry and shouting loudly.
146. The prison statements completed by the SO and other staff state that they acted on the authority of the duty governor, who explained that this did not necessarily mean that he was present at the time. The governor said that the strip search was justified because of the risk that the man could have a weapon which he could use to harm staff or himself. The nurse stayed outside the cell whilst the man was searched.
147. A towel was placed over the lower part of the man's body and a blue rip proof gown was left for him to wear. One at a time the officers released their hold and retreated from the cell. The last member of staff to leave

148. In his police statement, a second SO said that the trousers the man was wearing were soiled with faeces. The CCTV coverage shows the officer removing his trousers, pausing to put on protective gloves, before completing the strip search. After the clothing was removed from the man, it was placed in a bag outside the cell and taken away the following day by one of the prison orderlies.
149. Each prisoner held in a special cell must be assessed by healthcare staff and the first SO said that this was done after the man was locked in S1:33. The RMN who assessed the man earlier in the day said that she was still on duty and heard the radio call when the man was taken to the segregation unit. However, she was not called to the emergency and did not share her knowledge with her colleague. In interview for this investigation, the RMN said that she would not have been concerned about his removal to the segregation unit, as she thought that he preferred to be quiet and on his own, rather than on a noisy wing.
150. The segregation nurse completed the segregation safety algorithm at 8:10pm and the report of injuries form (F213) at 8:20pm. She recorded the marks on the man's arms on form F213, but did not do so on the algorithm. Her police statement records that the man was angry, and so she spoke to him through the observation panel. The CCTV coverage shows that two nurses stood at his cell door for about 15 seconds at 8:20pm, and he went to the door, appearing to stand quietly, with his arms outstretched. The nurse told the police that she asked the man whether he had any mental health problems or was subject to self harm, to which he replied with verbal abuse. She noticed small lacerations to his left wrist, but did not know how they were acquired. The nurse said that the man would not have anything to do with her, and she thought he was angry and was not mentally disturbed. She said that she did not consider him to be subject to self harm or suicide, and checked with officers whether he was subject to ACCT.
151. The duty governor said that he considered all the available information and decided that, because of the man's violence and uncooperative behaviour he should be segregated and held in the special cell. His decisions were recorded on the algorithm. The governor said that the evidence of the man's non-compliance was that he did not communicate and so staff could not evaluate his attitude. The governor also said that he saw the man struggle with staff.

152. The duty governor confirmed that the man would be placed on a 15 minute watch, as is standard for the special cell. This meant that he was to be observed every 15 minutes and his actions noted, and the frequency of observation continued throughout the time that he was in the special cell. The PO looked through the cell door to check the man, and then went to the office where the camera monitors are located and where he could continue to observe him. He was confident that the man was in a good state of physical health and there was no risk of him collapsing. He then checked the two injured staff who were distressed, and advised them to go off duty and seek hospital treatment. The PO also ensured that all officers involved in the incident completed the required paperwork.
153. The man was observed by staff at 15 minute intervals throughout the night, praying, walking round his cell and lying on his bed. In interview, the Operational Support Grade (OSG) on duty that night said that he was working in the segregation unit when the man arrived, saw him being brought in and remained on duty throughout the night. At 1:30am, the OSG recorded that the man flushed the toilet and drank water from the toilet. The OSG recorded this event, but did not report it and no action was taken. The OSG was relieved for part of the night by a second OSG, who recalled seeing the man praying. Both OSGs said that they mainly observed the man on the camera monitors, but occasionally by physically checking him through the cell door.
154. The CCTV coverage shows that the man was unsettled throughout the night, and lay on his bed for barely 40 minutes, between 5.00am and 5.40am. Throughout the night he was constantly on the move, kneeling to pray on his mat, pacing the cell, and standing at the toilet. He appeared to drink water out of the toilet nine times, between 9.28pm and 1.42am. On four occasions between 10.53pm and 2.44am he appears to use the toilet water for washing or to wet his hands and face. He repeatedly went to the wall where the light switch and cell bell are located. He appears to use the light switch, and look back into the cell to see if the light has gone off.
155. The times recorded on the CCTV do not tally consistently with those in the log. At the time recorded in some entries, the CCTV coverage indicates that staff had left the unit.
156. The investigators were told that the man did not use his cell bell to summon staff during the night. There is no electronic record of cell bells being rung, and the CCTV coverage is unclear. The first OSG said that he would have spoken to the man once or twice, but he had no recollection of receiving a reply.

### **19 August 2005**

157. The second segregation SO was in charge of the unit on Friday 19 August. Prisoners in the unit at tea time the previous day would have received a breakfast pack when their tea meal was served. The CCTV coverage shows that no food or drink was taken to the man's cell at breakfast time.

158. The SO said that he went to the special cell in the morning to collect the man's applications. He said that he also asked if he wanted to leave the special cell, but he replied that he wanted to remain there. The SO said that the man was lying on his mattress and did not get up or make any threat to staff. He described him as being very angry and he did not want to talk to staff. The man remained in the special cell.
159. On 19 August the following entries were made in the segregation wing history sheet:
- A.M. Still in strip cell at apps (applications) no problems.*
- P.M. Visits informed segregation unit that (the man) was required for a visit. Informed that (the man) had just been showered and relocated to a standard cell (still in the segregation unit) but was not talking to staff. Spoke with (duty governor) that I had asked (the man) if he wanted his visits and he stated no and remained in bed. )*
- E.D. (Evening duty) Evening meal served no issues.*
160. There are no other entries in the history sheet, which the segregation unit staff interviewed for this investigation say reflects the fact that there were no concerns about him. There are brief records of the observations which continued at 15 minute intervals until the man moved out of the special cell. The CCTV coverage indicates that officers had little contact with him.
161. In interview, the first OSG recalled that he checked all the prisoners at about 6:00am before the day staff came on duty. Another officer arrived and took over from the OSG who told him that the man was in the special cell. The officer continued the 15 minute observations at 6:45 and 7:00am, either through the cell observation flap or on camera, but had no conversation with him. He said that throughout the day he tried to engage the man in conversation, without success, though his response was not aggressive.
162. Records show that at 9:15am, the prison doctor saw the man and reported that there were no problems. At the time that the man was held in the segregation unit, the doctor worked Monday to Fridays, 8:30am to 4:30pm, as a locum doctor. He started his working day in the segregation unit where officers take him to each prisoner individually. An officer stands each side of the doorway, and the prisoner is called to either the door or the observation panel (if opening the door would present a risk) to speak to the doctor. The doctor said that an officer informs the prisoner that he is present and asks if they have any medical needs, so that prescriptions can be prepared as necessary. He would rely on the officers to draw a specific prisoner to his attention, and he said that this did not happen in the man's case. If a prisoner asked to speak to the doctor, the doctor said that a room would be identified and it would be possible for him to interview and, occasionally, carry out a physical examination. The prisoner's medical

163. In interview for this investigation, the doctor said that he does not usually examine prisoners who have been brought to the segregation unit under restraint. He said that the usual routine is for them to be examined by a nurse who decides whether the doctor needs to see them. If the doctor does need to see them, it is usually done within 24 hours. If a doctor's assessment is not required, he said that he is only asked to confirm that he has seen the medical record completed by the nurse.
164. The doctor confirmed that the same day, he signed the Report of an Injury to Inmate Form for the man which was completed by the nurse when she saw him the previous day. However when interviewed for this investigation, the doctor did not recall seeing the man.
165. However the CCTV coverage indicates that the doctor and three officers stood in the doorway of the man's cell for less than one minute. It does not appear that the man spoke to any of them.
166. At 10:15am, one of the prison Imams made the routine visit by the chaplaincy team to the segregation unit. He had not met the man previously, and was unaware that his colleagues knew him from the Islamic study classes. The Imam saw the man through the observation panel in his door and asked if he was alright, to which he replied that he was okay. No further conversation took place between them.
167. However the CCTV coverage shows that the Imam's visit to the wing lasted for four minutes. He went to each cell, accompanied by two or three officers. The CCTV shows that the man's door was opened, but it is not apparent whether or not he spoke to the Imam.
168. At 12:00pm, officers said that the man refused his lunch, and also said that he refused to leave the special cell. His refusal of the meal was recorded in the prison's Food Refusal book. The CCTV coverage shows that a meal was offered at 12.16pm, and immediately taken away. After lunchtime, the second SO said that he went back to the special cell and told the man that he would have to come out into a normal cell. The officer who said he spoke to the man earlier recalled the officers discussing the man, as at some time since coming to the unit he had been incontinent of faeces and they thought that he should have a shower.
169. However the CCTV coverage indicates that the man's behaviour whilst he was in the special cell was neither violent nor aggressive.

S1:25

170. At 1:45pm, the SO returned to the cell with two more officers, the sixth and seventh in the unit to date, and they spoke to the man again. One of the officers said that at first the man did not move. Eventually, he did get up,

171. One of the officers completed the Segregation Compact with the man, which is a ten page document explaining the segregation unit rules to prisoners, including the arrangements for prisoners of different faiths. He has no recollection of the interview with the man or when it took place, but believes it was within 24 hours of his arrival. The officer said that he would stand in the cell doorway to carry out the interview, and the other officer was present as well. The officer who completed the Compact said he checked that the man could read the document, and explained it to him in an interview which he thought would have taken about five minutes. The man refused to sign it and the officer recorded this, leaving it with him afterwards.
172. The CCTV coverage shows an officer putting a document through the man's door at 1.36pm. The document appears to be an A4 booklet, with a loose section enclosed. The man picked up the document, and then lay on his bed reading it. There is no evidence that the document was discussed with him.
173. Other than the officer's signature on the Compact, there is no record of the interview and the officer had no recollection of the man's manner or wellbeing. The other officer recalled that the man was surly and not talkative, but was calm throughout and appeared to understand what was being said to him. He returned to talk to him after lunch, but he sat at the rear of the cell and made no response.
174. Although copies of the Qu'ran are available on application by prisoners in the unit, the man does not appear to have asked for one. The CCTV coverage suggests that he did not have one.
175. The CCTV shows that at 1.52pm, officers went to the man's cell and he came out, walking alone to the opposite side of the unit where the showers are located. A second prisoner was brought into the same area at 2.05pm, the officers left and shortly afterwards the man came out wearing normal prison clothes.
176. Another SO manages the visits centre. He was interviewed for this investigation and explained the visitors' procedure. He stated that during the man's stay at Leeds six visits were booked. However, only four took place as, on two occasions, the visitors did not arrive. The visits SO recalled the occasion when he telephoned the segregation unit to inform them that the man was due to have a visit that afternoon.
177. The officer who had been present when the man had his shower told him that he had visitors, but he lay on his top bunk and said that he did not want

178. However the CCTV coverage shows that at 3.40pm, four officers went to the cell and remained for less than a minute.
179. Another OSG works in the gatehouse at the prison. He recalled a Friday when he received a telephone call stating that the man had been involved in an incident and subsequently placed in the segregation unit. He was told that he would not talk to anyone, and so the visit would not take place. He was informed that the decision had been taken by one of the prison governors. The gatehouse OSG remembered the visitors arriving and informing them that the man had assaulted someone. He could not recall the exact words he used, but thought he might have said the visit would not take place. He said that he did not say whether this was a decision of the man or the prison. Another OSG was also on duty at the time. She remembered the man's family as she had met them on previous visits, and recalled that they made several visits a week when he was held on remand. She said that at the time she did not know why the visit had been cancelled.
180. At 4.03pm the CCTV coverage shows that a prison orderly put flasks of drinking water outside the cells, but not outside the one occupied by the man. Between 4.30 and 5.00pm, the first officer on the scene carried out a check of prisoners in the unit. He recalled that the man was sitting at the back of the cell, and answered when he spoke to him.
181. Shortly before 6.00pm the CCTV coverage shows the prison orderly serving meals to the cells. Officers are seen going to the man's cell, but no food is passed to him. None of the staff interviewed recall anything of significance occurring during the rest of the day.

### **20 August 2005**

182. On 20 August, the following entries were made in the wing history sheet:

*A.M. Applications made no problems. (Compact officer)*

*P.M. Plastics removed after dinner meal. (Officer)*

*E.D. Given pack tea meal no problems. (Officer)*

183. The duty officer on that weekend said that, as far as staff were concerned, the man was not a troublesome prisoner. By this he meant that he did not bang his door or put his cell call light on, and so the only dealings he had with staff were when they were serving meals. The duty officer described the man as polite and quietly spoken.
184. The CCTV coverage indicates that officers had little contact with the man during the day. At 11.11am the CCTV coverage shows three officers taking him out of his cell, and being given a rub down search. The man then went into an office, and came out shortly afterwards. The first officer on the scene can be seen on the CCTV talking to the man, who then remains sitting on a chair outside. The man returns to the office at 11.22am, leaving eight minutes later.
185. The Governor's recollection was that the adjudication hearing took place at 1:30pm on 20 August, which he chaired in the adjudications room within the segregation unit. The charge was that "at approximately 8:00pm on 18 August 2005 in cell B3:24 you [the man] assaulted the acting SO". A second senior officer (SO) and the first officer on the scene were present at the hearing.
186. The man told the Governor that he did not understand the adjudication procedures, and so the hearing was adjourned to enable the first officer to explain them to him. The man returned to the room, and was asked if he wanted to explain what happened. He said that "they had been playing me around and I didn't want them to come into my cell. So I blocked the door with table chair and cupboard just pushed behind the door. They then kept knocking on the door and pushing it to get in and they were just calling my name. Then when they came in I threw the bin at one of them and the other one started hitting me with his stick."
187. The Governor asked the man where he was at that time and he said "I was on the floor; the staff were on the floor and trying to cuff me. Then they took me away." The first officer recalled the man saying that he wanted to be legally represented as he had been assaulted, and the Governor adjourned the hearing pending a police investigation.
188. The second SO described the man as cooperative throughout the hearing, and said that he no longer seemed angry but did seem reserved. The first officer thought that he was calm, collected and confident and did not show signs of nervousness. He said that the man still did not interact with officers, but was no longer as surly and seemed to be more settled.
189. After the adjudication hearing the man returned to cell S1:25, shown on the CCTV coverage at 11.30am. At 12.26pm the cameras show meals being handed to prisoners, but it does not appear that one was given to the man. The CCTV coverage indicates that officers had limited contact with him during the afternoon.

190. The first officer said that he went to the man's door a few times during the afternoon to try to get him to communicate, and each time, the man was lying or sitting on the blanket at the rear of the cell, and grunting or speaking out of earshot in response. He told him that his canteen food order would not be delivered on Saturday because he had moved from the wing where it had been ordered, but that it should arrive on Sunday. Canteen was delivered to prisoners who changed location a day after other prisoners, and so his canteen would arrive on Sunday morning.
191. The second SO recalled the man returning to his cell after the hearing, coming to his door later to collect his meal but having no conversation with staff. None of the staff interviewed recalls whether he had any property with him, other than a copy of the Qur'an. The compact officer was on duty in the evening and he said that there were no concerns about him.

### **21 August 2005**

192. During the evening and night of 20 August, the first night OSG was designated as the OSG on duty in the segregation unit. Halfway through the night he was relieved by a second OSG, who had been working on D wing. Although the shift was allocated to one OSG, it is apparently common practice for OSGs to swap locations during the night to maintain their awareness.
193. The first OSG physically counted all the prisoners on the unit and, prior to going off duty just after 6:00am on Sunday, recalled seeing the man sitting on the floor of his cell at the end of his bunk bed furthest away from the door. The first OSG said that he could see his legs sticking out from the end of the bunk bed on the floor, and thought that something such as a towel or a sheet was over the end of the bed. He said that it was quite common for prisoners to hang something at the end of their bunks, as it prevented the daylight coming in through the window and helped them sleep longer.
194. At 6:45am, the first officer commenced his duty in the segregation unit. The first OSG told him about another prisoner who had caused concern, before the officer went to carry out a roll check of the prisoners. He said that he opened the observation panel of cell S1:25 and saw the man lying at the rear of the cell on a blanket between 6:45 and 6:50am.
195. The first officer returned to the cell between 8:00 and 8:30am (the CCTV shows 8.44am) to put the man's canteen order outside his door. The canteen had been ordered by the man when he was on B wing, and he had purchased two packets of biscuits. The first officer said that he thought to himself that the biscuits might be an opportunity to engage the man in conversation. He placed them outside the cell door ready for it to be unlocked for applications, and said that he did not look into the cell at the time.
196. At approximately 8:45am, the second SO the first officer, the compact officer, the duty officer and another officer, commenced their morning

197. He unlocked the cell and went in, followed by the compact officer. He saw that the man was almost in a sitting position, suspended from a ligature made from a sheet tied to the top bedpost, and his legs were blue. He was leaning on his left side with his right arm wrapped around the lower bars of the bottom bunk. The first officer said that, through his experience in the armed services, he believed that he had been dead for some time. He told the investigation team that his first aid qualification was out of date, but he had some medical knowledge from his military service. He touched him and spoke his name several times. When he touched the body he found that it was cold and, in his opinion, rigor mortis had started and the man had been dead for some time.
198. The first officer on scene said that he took charge of the situation and told his colleagues, including the second SO, to leave the cell. He said that they wanted to preserve evidence and also to preserve the man's dignity. He asked the other staff to use the radio to send a Code Blue call for emergency assistance. (A Code Blue call is used when a prisoner is not breathing.)
199. The second SO said that three radios are held in the segregation unit. Another attending officer said that he attempted to use his radio, but found that the battery was flat. The second SO ran the few yards to the office to telephone the control room to ask them to summon healthcare staff. The CCTV shows that two officers ran out of the cell at 9.04.40am, less than 30 seconds after the door was opened. The other officer on scene left at the same time, first going upstairs to the wing treatment room where he knew that a nurse would be carrying out treatments. He found a nurse and alerted her to the emergency, before going on to collect a new battery for his radio.
200. The first officer said he went back into the cell to see what he could do for the man, trying to lift him, but decided that he could not do anything and went back out again. He did not ask the other officers to go back in with him, but waited at the door for the nursing staff to arrive. A Governor said that she responded to the radio call and went to the unit where she saw the first officer outside the cell. She said that the nurse went in to the cell with the first officer, and she restricted other staff from going in with them.
201. The first officer on scene remembered that the nurse from the treatment room arrived first and they went into the cell together, preventing other staff coming in with them. The CCTV coverage shows that the nurse arrived at 9.06.26am. They tried to lift the man so that they could cut the ligature, but

202. The nurse from the treatment room was working on A wing when she heard the radio call for Hotel 3, which is the call for healthcare emergency assistance. She collected the resuscitation kit from the treatment room and ran to the segregation unit. When she got there she saw officers standing outside the man's cell, and they pointed her in the right direction. She saw that he was suspended at the end of his bunk bed with the ligature round him made of a green blanket or sheet. She and the first officer on scene began to cut the ligature, the nurse holding the torso and the first officer using the scissors. At that point, she said that another nurse joined them and supported the man's lower body so that the ligature could be cut properly.
203. The second nurse on scene said at approximately 9:00am he heard a Code Blue call over the radio and went to the segregation unit, where he was directed to a cell and saw an officer and his colleague. He said that he saw the man suspended at the end of the bed. He said that they cut the ligature, manipulated the man's arm from where it was trapped in the bed and placed him on the floor.
204. The second nurse on scene commenced a physical examination and found that rigor mortis had set in. He checked his blood pressure, pulse and pupils and saw that blood had pooled in the peripheries. He found no pulse or blood pressure and he said that the man's body was freezing cold. The second nurse on scene listened for breathing with a stethoscope from the emergency equipment bag and decided not to commence cardio pulmonary resuscitation (CPR). The first officer said that the second nurse on scene asked whether he and his colleague were in agreement, which he understood meant whether or not to commence CPR. He said that they attempted to lay the man's body out as well as possible, covered him up and then left the cell. The second nurse on scene said that the principal officer advised that they should leave the cell, in order to preserve the evidence.
205. The second SO and the compact officer returned to the cell doorway and remained outside. The second SO said that he was satisfied that the situation was being dealt with properly and the compact officer waited to see if further assistance was required.
206. The principal officer (PO) in charge arrived at the prison for duty at 8:20am. His duties included ensuring that management checks took place, addressing any staffing issues and managing any serious occurrence in the prison. He went to his office at the start of his shift and was there when he was telephoned by the control room and informed of the emergency in the segregation unit. He had not heard the alarm over his radio and said that

207. The PO went to the segregation unit where he found that the duty governor and another governor were present and two nurses were attending to the man. The PO was informed that the paramedics were on their way.
208. The paramedics arrived, shown on the CCTV at 9.23am, and were briefed by the second nurse on scene before going into the cell alone. They left before the arrival of the doctor who formally pronounced that the man had died. The PO appointed a log keeper to stand at the cell doorway, and the security SO undertook the task until another officer took over. The PO went on to discuss the running of the establishment for the day with the duty governor. The second governor took responsibility for events in the unit, whilst the duty governor went to the control room to implement the contingency plan and visit the family. The PO gave instructions that cells S1:25 and B3:24 should be sealed pending the police investigation.
209. The following times and events were recorded in the Control Room Incident log for 21 August:
- 8: 57am Blue call (emergency call) Segregation Unit
  - 8:57am ambulance required
  - 9:08am ambulance arrives
  - 9:13am paramedics arrive in the Segregation Unit
  - 9:58am police and paramedics arrive
  - 10:20am doctor arrives and directed to the Segregation Unit
  - 10.30am doctor pronounced that the man had died.
210. The PO said that both he and the second governor were unsure who was responsible for the man's body, and who would take responsibility for its removal as the contingency plan did not provide relevant information. He said that the paramedics advised them that the Coroner's Officer would take this responsibility.

## Events after the man's death

211. After the paramedics arrived, the first officer and the nurses dealt with them, whilst other staff wrote their statements and returned to their normal duties. The compact officer said that the prisoners at the far end of the unit were unaffected by any change in routine, but the regime for those near to cell S1.25 was disrupted. The second SO said he was instructed by the other governor to run the usual daily regime, but said that this was not possible whilst the police were present and the man's body was still in the cell. The prisoner in the cell opposite was moved so that he no longer faced the door, and one exercise period took place.
212. Other prisoners in the unit were told individually about the man's death, and were also spoken to by a member of the Independent Monitoring Board and the Suicide Prevention team. The local branch of the Samaritans was informed of his death and they were asked to come into the prison after notices had been put up and prisoners had been informed. The HMCIP inspection began the day after the man died and the report comments on the inspectors concern about the support of the prisoners in the aftermath.
213. The duty Coroner's Officer arrived at the prison at 11:23am, followed by the undertakers at 2:00pm. They left the prison at 2:35pm.
214. The duty governor went to the man's family home at midday to tell them of his death. He was accompanied by one of the Imams and a family liaison officer. They met the man's mother and several of his brothers and sisters. The family was distraught and the duty governor said that they accused the prison of killing their son and brother. The duty governor invited the family to visit the prison but no specific arrangements were made. The visit ended at 1:00pm.
215. An OSG was on duty in the gatehouse at approximately 1:30pm when the man's relatives arrived asking to see their brother. The OSG was aware that something had happened in the night concerning the man, but did not know that he had died. He asked the control room to make someone available to come and speak with them, as they were very angry and upset. One of the prison chaplains happened to be visiting the gate when the man's family arrived and staff called him to speak to them.
216. The family wished to view his body but the reverend told them that this was not possible as the body was the responsibility of the Coroner, the cell had been sealed, and the undertaker would shortly be taking the body to the mortuary at the local hospital. The reverend assured the family that the police would contact them when the body could be seen. He told the investigation team that the man's mother was angry. He said he told them that he understood their concerns and gave further reassurances before the family left. They accepted the invitation to return to the prison at a later date, when they were able to ask questions and receive more information.

217. One of the inmates was in the segregation unit at the same time as the deceased. He wrote a letter in response to my notice about this investigation and said that he could tell that there was something wrong with the man as he often refused his meals. My investigators examined the paperwork relating to refusal of food, and noted that he refused one meal. The inmate also stated that, during the evening of 20 August, he heard a female officer go to the man's cell door and tell him to remove something which was obstructing the view into the cell. He said that the man did not speak to any of the other prisoners in the segregation unit. He also provided background information about the prison's regime, stating that he had not witnessed any racist or bullying behaviour by staff and did not personally know the man.
218. Representatives of the prison's staff care team went to the segregation unit after the man's death and spoke to staff members together to offer their support.
219. A de-brief meeting took place in the afternoon which was chaired by the second governor. The meeting reviewed the action taken after the man's body was discovered and whether any staff had questions or wanted to speak to the care team.

## First Post Mortem and Toxicology

220. The Consultant Forensic Pathologist carried out a post mortem at the mortuary of the local hospital between 3:10pm and 4:30pm, on 21 August. His statement of 23 August says that the circumstances surrounding his death and the appearance of his body are all consistent with him having died as a result of hanging. Hanging is likely to have caused compression of the carotid arteries which will either have deprived the brain of its blood supply or caused reflex cessation of the activity of the heart.
221. The consultant also commented on the number of bruises on the right arm. These were only vaguely visible externally, but on internal examination there were clearly a number of discrete areas. He considered it most likely that each of the bruises would have been caused by a separate blow, except that on the elbow which could be the result of a fall. He stated that the other bruises are more likely to have been caused by blows from a solid object such as a baton, which is consistent with the story that has been given. The consultant did not consider that these injuries had contributed directly to the man's death.
222. The post mortem further noted that there are superficial scratches over the front of the man's left wrist and on both elbows, which have the appearance of having been deliberately self inflicted. None of the scratches penetrates particularly deeply, and the doctor states that they will not have contributed to the cause of death. Their appearance indicates that they were likely to have been present for at least a day and possibly longer before the man died, so it is possible that their presence could have alerted those around him to the potential for self harm. Finally, the consultant confirmed that there was no natural disease that was likely to have contributed in any way to causing the man's death.
223. A Consultant in Clinical Chemistry and Toxicology and Professor of Forensic Toxicology, carried out the toxicology tests on blood obtained from the man at the post mortem. His statement is dated 8 September and he found that there were no significant toxicological findings.

## Second post mortem

224. The man's family requested a second independent post mortem. This was conducted on 30 August 2005 by a second doctor at the local hospital. He noted the following:

### i) Ligature mark

*The ligature mark comprised a dried parchmented more or less horizontal band over the front and left lateral side of the neck. It was at the level of the larynx (voice box). At autopsy there was little patterning, but on examination of the photographs of the first autopsy some vague patterning was present. The ligature mark sweeps posteriorly over the left side of the neck, towards the posterior mid-line. The ligature mark was fainter over the right side of the front of the neck and disappeared over the posterior right neck. The ligature mark was irregular in width, but on the whole was 2cm in diameter.*

### ii) Other external signs of injury

#### *Head and Neck*

- *yellow bruise measuring 2 x 1 cm, on the lateral aspect of the right upper eyelid*
- *parchmented abrasion measuring 1 cm in diameter over the outer right eyebrow.*

#### *Right Upper Limb*

- *two parallel crusted linear abrasions, measuring 3.5 and 2.5 cm long and 0.1 cm wide, over the antero-lateral aspect of the right antecubital fossa*
- *abrasion measuring 0.6 x 0.2 cm, on the dorsal-medium right wrist, with minor associated bruising*
- *close to the anatomical snuff box of the right hand, a linear injury measuring 1.5 x 0.1 cm*
- *over the dorsal aspect of the left distal forearm, a pair of tangentially orientated parallel linear injuries measuring 1 x 0.1 cm.*

#### *Left Upper Limb*

- *horizontal crusted linear wound measuring 3 cm long and 0.2 cm wide, on the antero-lateral aspect of the left antecubital fossa*
- *five more-or-less horizontal and parallel linear superficial crusted injuries measuring 3.5 cm long by 0.1 cm wide on the front of the left wrist and distal left forearm.*

#### *Deep bruising*

*At the first autopsy and clearly visible on the autopsy images were deep bruises as follows:*

- *On the distal medial right forearm, 5 cm in diameter*
- *On the proximal medial right forearm, 4 cm in diameter*
- *Over the dorsal mid right arm, 3 cm in diameter*
- *Covering the right deltoid up to 5 cm in diameter*

*These bruises were, at second autopsy, visible externally.*

*Death was caused by pressure to the neck, exerted by means of a ligature. From the autopsy photographs provided, the ligature was some sheeting. The ligature mark found upon the body was consistent with being caused by this ligature. A suspension point was present over the right side of the neck. The history described the deceased almost in a sitting position when found hanging. The common lay view of hanging is that full suspension, with the weight of the body putting pressure on the neck. However, enough pressure can be exerted readily in low suspension to bring about death. Thus hanging in a sitting position, or even a lying position, with just the weight of the head exerting pressure on the neck, can be sufficient to bring about death. Thus this male could have hanged himself in the position described in the history. The precise mechanism of death by hanging is not fully understood. It is thought to be a combination of factors, including blockage of the airways, blockage of the blood supply to the neck and irritation of nerves which supply the heart. Unconsciousness may be rapid, within even a few seconds, followed by death within a few minutes.*

*Estimation of the time of death is difficult at autopsy, and somewhat inaccurate. Rigor mortis (stiffening of the body) can develop between 3-8 hours and lasts up to a few days. The temperature of the body tends to stay stable for an hour or so following death, with gradual cooling (a degree an hour) following this, to ultimately ambient temperature. As a commonly used "rule of thumb" those bodies which feel cold and are stiff (ie have rigor) have been dead between 8 - 36 hours. In a draft statement, provided only to assist me at autopsy, the consultant forensic pathologist who completed the original post mortem says that by the time of his autopsy at 1510 on 21 August 2005, rigor mortis was present and the body had cooled to ambient temperature. This would probably mean that death had occurred 8 to 36 hours previously (prior to his assessment). However, I must emphasise the inaccuracy of time of death estimation. In this case, it appears that the history is more significant in determining when death actually occurred.*

*The history described death as occurring at 0916hrs. For clarity, this is the time of death declared by a doctor (or suitable qualified person), and is merely a declaration so that the process of death investigation and certification can take place. It is not necessarily the time that physical death of the person occurred.*

*The pattern of hypostasis was consistent with suspension by the neck. Hypostasis is pooling of the blood after death in dependent parts of the body. Typically in hanging cases, the blood pools in the forearms, hands and feet, as seen in this instance.*

*Away from the ligature mark upon this male's neck, there were no defensive injuries. In ligature strangulation, the victim may attempt to pull the ligature away from their own neck. This can produce fingernail injuries and additional neck bruises. None of these were present. There were no apparent injuries*

*to the fingernails although it is unclear whether they were clipped at the first autopsy.*

*Away from the ligature mark there were several other injuries. The linear parallel marks could have been caused by a relatively sharp-edged object, although not necessarily a knife. The nature of these injuries (linear parallel) and their location were suggestive of self infliction. They have not directly caused or contributed towards death. They do show some features of healing, although it was difficult to determine how old precisely these injuries were. I would estimate that they were a day or so old. They would not have affected this male's capability of moving his limbs.*

*Several deep injuries were identified at the first autopsy, although by the time of the second autopsy they had come to the skin surface and were visible. There were bruises, about the right upper limb. I note that prior to him being placed in the segregation cell he was involved in an incident where he received a number of blows with a blunt object. These bruises could have been caused by this mechanism. However, other causes of blunt trauma cannot be excluded. These injuries were relatively minor, and have not caused or contributed towards death.*

*There was no pathological evidence of restraint. There were no injuries from for instance handcuffs or bindings about the hands or ankles. Restraint by these mechanisms cannot be excluded. Sometimes restraining ligatures may not leave an injury, if they are soft or broad, or if there is little resistance to their application. Injuries may disappear with time during life (although they are unlikely to disappear following death for a considerable period).*

*I have not yet examined the toxicology in this case. I would gladly do so if required. I am not a toxicologist however. Without toxicology results one cannot exclude chemical restraint of the deceased.*

*There were no natural disease processes which have contributed towards death.*

## Issues considered in the investigation

### *The man's health and wellbeing*

225. When the man arrived at Leeds prison, his physical health was described as good and the only concern noted was that he had previously suffered from depression, although without requiring any treatment. Although a Muslim he had taken a Western name. He was placed overnight with a Listener before being moved onto normal location and no other action was taken. The photograph taken at reception shows that he was clean shaven.
226. In the first weeks of his imprisonment he presented as someone who was quiet, but who played pool and socialised to some extent. He generally accepted prison discipline, did not come to the attention of staff for breaking rules, and was described as well mannered and polite. The records provide little information about his wellbeing, but his cellmates recall that his faith became increasingly obvious and important to him. One of them confirms his family's view that he was a man who kept his troubles to himself and did not seek out anyone to share them with. The majority of his conversations turned to his faith, and his other main interest was events concerning his country. By July, when the bombs exploded in London, his cellmates describe him as being obsessed. On 15 July, letters were found, which the prison assumed were written by him, which state that he thought that the "next life was better than this life", but the staff who read the English text only considered the security perspective of risk to others, and did not consider whether they indicated any risk to himself.
227. Any deterioration to his state of mind seems to have been from the middle of August. On 16 August, his cell mate noticed that he had injured himself by cutting his arms. An officer thought that he was not suicidal, but was depressed because of the behaviour of his cell mate. The sewing room instructor said that he was unable to concentrate on simple instructions, and wing staff were concerned about him and referred him to the Mental Health In-reach team. The nurse identified that the man presented a risk to staff, and it is alleged that the very same day he assaulted staff and was then removed to the segregation unit. She considered whether there was a risk of him harming himself, and decided that there was none.
228. Segregation unit records and staff interviews provide evidence of the last two days of his life. In that time, he barely spoke to anyone, did not see his family, had nothing to occupy himself with, and no copy of his religious text, the Qu'ran. He received nothing to eat or drink whilst in the special cell. The CCTV confirms that he barely rested that night, and ceaselessly prayed or paced the cell. On the other hand, he was able to conduct himself clearly and confidently in front of the governor and staff at the adjudication hearing the day before he died.
229. Other than the incident at the pool table and the assault on staff on 18 August, he is described as a quiet man, who kept himself to himself, and

- Had those responsible for locating him in the segregation unit been aware of the marks on his arms, (whether from a proper physical examination or from sight of the records) and the concerns of the psychiatric nurse, they might have arranged for him to be placed on the suicide and self harm monitoring arrangements.
  - If the nurse's comments had been included in his medical record, and been available to the nurse who completed the segregation unit safety algorithm, he might have been paid more attention.
  - Had the daily healthcare monitoring been conducted properly, the doctors and nurses might have observed his growing distress.
  - If the Imam had been aware of his colleague's knowledge of the man he might have paid more attention to him during his chaplaincy round.
- Regrettably, none of these happened.

### ***The prison's knowledge and understanding of the man's well being***

230. It has already been said that this investigation has been more extensive than most undertaken by my office. This is due in part to the high level concerns expressed by this man's family at an early stage. But it is also because his records were so sparse, and provided so little information about the short time he spent at the prison. The investigators wanted to find out all there was to know about his imprisonment, and could only achieve their goal by carrying out far more interviews with staff and prisoners than is usually the case.
231. The timescale for the investigation has also been extended because significant information, for example about the blood stained clothing and assessment by the mental health nurse, only came to light some four months after the investigation began. The Mental Health In-reach Team responded promptly to the concerns of wing staff on 18 August. The man was assessed by a nurse the same day, followed by a discussion of his needs at a review panel. The nurse made a brief note in the wing observation book to alert staff, but there is no evidence that her concerns were communicated to segregation unit staff or included in his medical records.

**I recommend that there should be an information sharing protocol between the prison and the Mental Health In-reach Team to ensure that information is shared speedily, especially in an emergency and when prisoners change location.**

**I recommend that all clinical staff should be reminded of their duty to keep contemporaneous records of contacts with patients and ensure that these are available in their medical records.**

232. Quite apart from the serious matter of delaying production of this report, my main concern is that no-one at Leeds prison had all this information about the man until reading it here. Therefore, no-one would have been able to

## ***Diversity***

233. In the course of extensive interviews with staff and prisoners at HMP Leeds, we detected no evidence of overt racist attitudes, though they would hardly be likely to be displayed to an investigator. We acknowledge our debt to the expert on diversity matters and particularly his insights into a Muslim perspective on prison life. Because he was appointed at a relatively late stage of the investigation, his knowledge was not available when it began. Had it been available, it is likely that more questions would have been asked of staff and prisoners about how the treatment of this man compared with the treatment of non-Muslim prisoners.
234. The prisoners we spoke to appeared to be sensitive and tolerant of this man's individuality, even when his actions – such as praying during exercise – singled him out from others. Numbers of staff demonstrated positive attitudes and referred to the benefits of their recent diversity training, although this is no indication of whether or not racist discrimination exists. The number of complaints of racism was low, but have increased since the appointment of the Diversity Manager, which the prison consider is due to increased awareness of the issues. Although staff thought that few complaints were made – and the man made none – they expressed the opinion that staff would meet the needs of individual prisoners, whether arising from race, faith or otherwise. As these complaints are now always investigated by the diversity team, prisoner's confidence in the system should increase.
235. Notwithstanding the extensive provision of diversity training, it is apparent that there is limited understanding of the requirements of Muslim prisoners, and the man's treatment was insensitive to his cultural and spiritual values. It failed to meet the standards for best diversity practice. The Mubarek inquiry report recommends that training should stress the need for staff to put themselves in the position of ethnic minority prisoners and see things from their point of view.
236. Although his religious habits were said to differ from the norm amongst other Muslim prisoners, if they were noticed by staff, no action was taken. When the man arrived at Leeds in June 2005 he was clean shaven, but by the time of his death he had grown a full beard. The prison's Imams describe the act of growing the beard as a challenge for any prisoner, and especially a Muslim in July 2005. It was a very visible change, which may

237. The reasons for his change of habit are unknown, but the change was visible, and there is no evidence that they were questioned. Consideration should have been given to taking pro-active steps to understand his reasoning. The changes may or may not have been a sign of his growing distress and emotional disturbance, but they either went unnoticed or were ignored. Observers who were more aware of a range of evidence of worsening mental health, and with greater insight into his faith, might well have given more thought to their significance.
238. There were several occasions when the diversity aspect of an incident does not appear to have been considered. One example was the occasion when it was the man, rather than a white prisoner, whose wing was changed. After the incident at the pool table, when the man and another prisoner were fighting, officers could not decide which prisoner was responsible for beginning the fight but it was the man who changed wing rather than the white prisoner.
239. A second example of the diversity perspective being ignored was the letters found in his cell on 15 July which were only dealt with as a threat to security. One prisoner's word was the basis for a referral to the police. No thought was given to translating the letters, seeking advice or considering other interpretations. The prison's Imam would have been an obvious source of assistance. Even at a time of considerable unrest in the country following the London bombs, the prison did not consider that a Muslim prisoner might feel vulnerable. A translation might have led the reader to consider that they were written by someone at risk of harming himself, and advice from another Muslim would have been that their faith does not permit suicide. (Of course, in this case, this would have meant that suicide prevention would not have been considered.)
240. The third example was that no action was taken after he was taunted by other prisoners as he was escorted from the wing on 15 July, other than to raise the assessment of risk on the Cell Sharing Risk Assessment from low to medium. Prisoners were out of their cells and directed hostile threats and abuse at him. The description of the incident is disturbing, particularly at a time when sensitivities were high and staff had been asked to be mindful of any incidents. Whether or not those responsible could be identified, the incident should have been recorded and responded to. It can only be seen as a racist incident, and even Islamophobic, but no action was taken. It was ignored, other than to remove the man from the wing, and no consideration was given either to identifying those responsible or reporting it as a racist occurrence. The only interpretations can be that either hostile, verbal taunts were tolerated within the prison, or that their significance was not noticed.

241. Fourthly, we are concerned that no attempt appears to have been made to understand how the man, a devout Muslim, might have interpreted his experiences in prison and the treatment he received there. He was removed from the wing and shunned by other prisoners, but no thought was given to protection from risk other than removing him to the segregation unit.
242. Finally, aspects of his treatment during the second period in the segregation unit, especially drinking and washing from the toilet bowl, would be degrading to anyone of any faith or ethnic background. For a Muslim to have to drink from an unclean place is particularly humiliating, as it conflicts with hygiene rituals which are a basic tenet of the faith. The man's mental state may well have been affected by the level of desperation which forced him to relieve his thirst in this way. As well, washing is an essential part of the preparation for Muslim prayers, and the only water available to him was what he could scoop out of the toilet bowl.
243. Although no racist attitudes and behaviour were expressed in any of the extensive interviews with staff or prisoners who came into contact with him, we are aware of the concerns that have been expressed by the Commission for Racial Equality, HM Chief Inspector of Prisons and by the Prison Service's own diversity experts. We are also aware that both the prison and the Prison Service take these concerns seriously, and have put an action plan into place. We recommend that the Governor continues to implement the action plan. The Governor should acknowledge that racism may occur in any of the prison's operations, and ensure that staff consider the diversity perspective in all their contact with prisoners. In particular, the Governor should ensure that the objectives of the prison's diversity and suicide and self harm awareness training are linked, with recognition of mental health issues in the first and cultural issues in the latter.

**I recommend that the Governor should continue to implement the prison's action plan for dealing with racism, and acknowledge how it may be evident in any of the prison's contact with a prisoner.**

**I also recommend that the Diversity Action Plan should be reviewed in the light of this report, and its scope extended to include my findings. In particular, the objectives of diversity and suicide and self harm awareness training should be harmonised, rather than seen in isolation.**

244. The report of the inquiry into the death of Zahid Mubarek refers to the increase in the number of Muslim prisoners, and the suggestion that they may experience religious intolerance as a result of an increased level of Islamophobia in society. The report notes that the definition of racism adopted by the earlier inquiry into Stephen Lawrence's death did not include discrimination because of a person's religion. It suggests that Home Office considers recognising the concept of institutional religious intolerance. It also recommends that the pastoral role of prison Imams is developed to be consistent with that of other faiths. The adoption by Leeds of both of these

**I recommend that the Governor considers the recommendations of the Mubarek inquiry report, in particular in respect of institutional religious intolerance and the extension of the role of the prison's Imams to include pastoral as well as religious support.**

***Use of force***

245. All the staff interviewed for the investigation confirmed that their training in control and restraint was up to date. Staff whom we interviewed, but who were not involved in its use on the man, also confirmed that they were only aware of approved methods being used in the prison. Although a stave was used on the man during the incident on 18 August, we are satisfied that staves are not used routinely at Leeds. Equally, we accept that the staff who went to his cell on 18 August were injured.
246. Although the use of a stave is happily rare, I cannot say it was disproportionate in the circumstances that staff encountered on 18 August. I judge that the way in which the man was treated that day was no different from how any other prisoner would have been treated in the same circumstances. However, I am concerned about aspects of the use of control and restraint.
247. It is not apparent on either occasion when control and restraint methods were used on the man that any attempt was made to calm and defuse the situation by talking to him, as required by PSO 1600, other than to issue instructions. Control and restraint guidance requires that the officer at the prisoner's head acts as the lead, giving instructions and communicating with the prisoner.
248. Staff described the man as non-compliant, but gave different definitions of the meaning of the term. Even when he cooperated with instructions, some staff described him as non-compliant because he did not speak to them. Others reported that he was non-compliant because they said that he struggled and pushed from side to side. Because he was defined as non-compliant, force continued to be used. The man had a good understanding of English and spoke it well, but this definition of compliance is particularly worrying for other prisoners without his ability.

**I recommend that the Governor should remind staff to use the minimum force necessary in resolving a situation, and dialogue with prisoners should be encouraged.**

249. We accept that prisoners should be moved to a special cell in order to prevent them harming themselves, others, damaging property or creating a disturbance, and we accept that the man should have been located there for a short period after he was taken to the segregation unit, though not for the number of hours which ensued. However its use should be at a minimum,

250. We also accept that prisoners in the special cell should be searched to ensure that they are not concealing anything with which to cause damage. However the search should be conducted according to prison service guidance and it should not be routine practice for a prisoner's clothing to be cut off as appears to be the case at Leeds. It should only be done as a last resort, and should follow continuing attempts, led by the officer at the head, to diffuse the situation. Every prisoner should be treated as an individual, and each incident should be treated on its own merit.

**I recommend that a prisoner's clothing should only be cut off as a last resort.**

### ***The segregation unit***

251. I have referred already to the findings of HMCIP, and the August inspection, with which I concur. There are additional aspects of the operation of the segregation unit which I am concerned about, particularly for prisoners at risk of suicide or harming themselves.
252. Prisoners on the segregation unit must make applications for matters which are basic rights for all other prisoners. Application time is an established daily routine, which often coincides with the daily visits by the governor, doctor and chaplain. This brief interaction is the time of day when prisoners have most contact with anyone else, and the rest of the day they are alone. It is not apparent that the personal officer arrangements apply to prisoners in the segregation unit, meaning that there are fewer opportunities for prisoners to relate to staff. Unless a prisoner is on ACCT, in the special cell or held under cellular confinement, he is not observed by staff at any time during the night.
253. The duty governor, the chaplain and a member of the Independent Monitoring Board must visit each prisoner every day as a safeguard. Each of them has very different roles, and prisoners may have individual needs which they would not wish to share with the others. However, I understand that the visits are often carried out collectively at the same time as applications are received, and in the company of all the officers on duty. The number of staff members in attendance may well be intimidating to prisoners who should not be required to disclose personal matters in front of others.

254. The daily visits appear to be carried out as a routine, without any attempt to gather insights into a prisoner's wellbeing or frame of mind. It is especially disappointing that, even when the daily chaplaincy visit was carried out by someone of the man's own faith, no attempts were made to engage with him. Two of the Imams' colleagues knew the man well, but their insights did not appear to have been contributed to the daily visit. The CCTV coverage demonstrates that the contact was woefully limited.
255. The daily record of the man's conduct in the unit is inadequate, and much of the information in the report has been obtained from interviews with staff. It does not state whether he spoke to staff or they to him, and it does not provide information about the efforts made to transfer him out of the special cell.
256. The Prison Service Order which sets the standards for managing a segregation unit states that staff working there must be selected specifically for the work. However, the OSGs, who at the time of the man's death worked in the unit at night, had not been specially selected for the role and had not received any training related to the care of prisoners. All the prison's OSGs work a fixed rota over a ten week period - the bulk of which is worked during the day in parts of the prison where they have no contact with prisoners such as the Visits Centre. For one or two weeks of the rota, each OSG works during the night on the segregation unit. The only knowledge the OSGs have in relation to the prisoners is what is handed over to them when they come on duty. Nor did they attend courses such as ACCT training.

**I recommend that the Governor reviews all aspects of the operation of the segregation unit, paying specific attention to the matters identified earlier in my report.**

#### ***Provision of food and drink whilst in the segregation unit***

257. The man was taken to the segregation unit on 18 August after the team meal and next day's breakfast pack were served on B wing. He did not take any property with him, and was not provided with an additional pack for 19 August. The CCTV coverage indicates that food was proffered at lunch time, but not accepted or left behind to be eaten later. Flasks of hot water were put outside other cells in the afternoon, but the man's was omitted. Officers went to his cell when tea was being delivered, but no food was left for him. Breakfast is unclear, and again no food was given at lunch time on 20 August. The weekend tea pack and breakfast pack were left outside his cell later that day.
258. There was no provision of drinking water in the special cell. No provision was made even when he was seen drinking water from the toilet bowl, although I understand that flasks have been made available since my investigators drew the matter to the Governor's attention. One member of staff saw the man drink out of the toilet, but did not report the action as unusual or take steps to provide a drink. He merely recorded the incident.

259. The records and CCTV coverage suggest that it is doubtful whether he was supplied with food and drink during his second stay in the segregation unit.

**The Governor should ensure that food is left for prisoners who refuse meals, or it is offered again later.**

***Suicide and self harm awareness by segregation unit staff***

260. The National Offender Management Service's Safer Custody Group has advised me that national training in ACCT suicide and self harm awareness does not include specific guidance for staff in segregation units. Since my office became responsible for the investigation of deaths in custody, I have been very troubled by the number of deaths occurring in segregation. Leeds is no exception as this man's death was the second death in segregation since April 2004, and a third has occurred since. These examples confirm my view that segregation is inimical to the care and support of potentially suicidal prisoners.

261. There does not appear to be any focussed suicide and self harm awareness training for segregation unit staff. The staff interviewed for this investigation were asked about their awareness of suicide and self harm issues. They said that it was difficult to detect those prisoners who were at risk as there were few opportunities for conversation, prisoners did not socialise together and usually spent short periods of time in the unit. The expectations of staff appeared to be limited to prisoners already identified as at risk, and the monitoring required for them. The records of observations of prisoners suggest that contact is limited to observing whether they are still alive, and staff do not have any meaningful interactions with them. Staff understanding did not include what they should look out for in order to identify any other prisoners who might be at risk. Neither did they have any knowledge of the specific needs of Muslim prisoners who were at risk.

**I recommend that the Governor should take advice from the National Offender Management Service Safer Custody Group and ensure that suicide and self harm training includes awareness of issues arising from:**

- **prisoners' individual circumstances, including their ethnicity**
- **prisoner's location, especially the segregation unit.**

262. I realise that his cell was not a safer cell, and it contained several ligature points (such as window bars, sink taps and heating pipes), as well as the bunk beds. However, despite the earlier death in the segregation unit, bunk beds remained in place until after this man had also taken his life. I am

263. The Listener for the unit is from the Vulnerable Prisoners wing, and may not be acceptable to segregation unit prisoners. When the man was in the unit, it was known that the signal for the Samaritans mobile telephone was poor. (This has now been improved.)

***The role of clinical staff within the segregation unit***

264. Prison Service Order 1700 applies throughout the prison service. It places specific responsibilities on medical and nursing staff in respect of all prisoners in a segregation unit, and additional responsibilities for those located in the special cell. The man's records state that the duties were carried out. However, it appears they were performed purely as administrative tasks and, in my view, they did not fulfil the intended function of promoting a prisoner's health, safety and wellbeing. The CCTV coverage confirms that little time was spent with prisoners.

**The healthcare manager should ensure that all clinical staff carry out the daily checks of segregation unit prisoners in a proper manner.**

265. All prisoners admitted to the unit must quickly be assessed by a nurse who must be satisfied that they are fit to be detained. Although the assessment happens and is recorded, the nurse stands at a distance, sometimes outside the cell, or sees and speaks to the prisoner through the observation flap. Whilst staff must be safe, every effort should be made to enable the nurse and prisoner to have face to face contact. Unfortunately, the nurse who assessed the man has not made herself available for interview for this investigation.

266. The CCTV coverage suggests that the man appeared to show the marks on his arms to the nurse, who recorded the injuries on one form, later countersigned by the doctor. She did not record the marks on the segregation safety algorithm, which was seen by the governor, but did note there that he was not at risk of harming himself.

267. The clinical reviewer comments that clinical staff should assess whether there are underlying medical reasons leading to the prisoner's removal to the unit, and not restrict their assessment to whether any injuries have occurred in the course of the removal. Although the algorithm records the injuries to the man's arms, it is not apparent that they were taken into account when his safety was considered.

268. The reviewer refers to the forms countersigned by the prison's doctor, which state that the man had no injuries and there was no medical reason to prevent admission to the unit. The doctor did not see the man for himself, but simply confirmed the nurse's assessment. I concur with the clinical reviewer's description of the process as being regarded as "purely

**I recommend that healthcare staff should re-examine their input into the process of removal to the segregation unit to ensure that any underlying medical issues that might have precipitated the removal are also considered, as well as considering any injuries occurring during the removal.**

269. Finally the reviewer also comments that a prisoner's medical record may not be available in the unit and, in this case, his contact with clinical staff is not included in the record. Neither does the record include reference to the man's assessment by the Mental Health In reach Team nurse. (Since the publication of the first draft of this report, I have become aware of the Leeds Interagency Protocol, which should deal with this situation.)

**I recommend that healthcare staff should re-examine how information about a prisoner's medical condition is collated and added to the medical record.**

***Policy for dealing with an apparent death***

270. The policy in HMP Leeds for responding to a prisoner who appears to have died is derived from national Prison Service guidance in PSO 2700. Staff members are required to summon help and request emergency medical assistance, and enter the cell as soon as possible. If a ligature has been used, staff should support the prisoner, cut the ligature and place the body on a flat, solid surface. They should check for signs of life, and if the prisoner is not breathing, resuscitation should be attempted unless the prisoner is clearly dead. In the absence of any clear sign of death such as rigor mortis, the policy instructs that resuscitation should commence and be maintained until the arrival of healthcare staff. Only a doctor or licensed paramedic can certify the death of a prisoner, and so resuscitation must be attempted until such time as death is pronounced or healthcare professionals assume responsibility for their care.
271. My investigations into other deaths at Leeds have found that the policy has been followed on those occasions. Unfortunately, that was not the case when the man was discovered. Although at least four staff were present when the cell door was opened, all but one person immediately left and no attempt was made to remove the ligature and lay him on the floor until the nurses arrived. The first officer to go into the cell did not have an up to date first aid qualification and was not a trained nurse. He alone decided that the man had died, and ushered other staff including the senior officer out. No attempt was made to resuscitate him. Healthcare staff subsequently confirmed the decision that resuscitation should not be attempted.

272. Whilst these omissions might not have affected the outcome for this man, in other circumstances they could be of vital importance and it is essential that the prison's procedures are followed. These matters have separately been drawn to the attention of the prison's governor, and I am pleased to note that he has already issued an order reminding staff of their responsibilities.

**I recommend that the Governor should remind staff of the requirements of the local policy in responding to the apparent death of a prisoner.**

### ***Bullying***

273. The man's family report that he complained to them that he was bullied. We have found no records to show that he was bullied, although numbers of staff interviewed have acknowledged that prisoners can be reluctant to make a complaint. However we are very aware that the man was isolated by virtue of his education, his race and his faith, and was certainly vulnerable to being bullied. He was not protected by his peers or by perceptive staff intervention.

### ***The man's contact with his family and solicitor***

274. The prison indicated that six family visits were booked for him – he clearly knew how to request the visiting orders – but only four took place. The system for booking visits changed in August and only those records are now available. The record shows that visits were booked for 14, 19 and 24 August. The first took place, the second did not happen and he had died by the time that the third was due.

275. My investigators have found no record in the prison of letters being written and sent out by the man. The only correspondence recorded as received by him was the letters from the solicitors representing him in relation to his court appearance. The solicitors were asked to provide information about their knowledge of the man, and have confirmed that they visited him the day he moved to the segregation unit for the second and last time. This information has been forwarded to the local police, who are considering whether to interview the man's legal representatives.

### ***The man's change of status***

276. When the man arrived at Leeds he was convicted of failing to appear at court and sentenced to 28 days imprisonment. He was also remanded in custody pending trial for the original offence. The sentence expired on 19 June and a trial date had not been fixed. There was no evidence that he was treated differently when the sentence expired and he had the status of an unconvicted prisoner. For example he did not wear his own clothes, have additional visits or telephone calls, or additional private cash. He continued to be located with convicted prisoners, and on at least one occasion was punished for refusing to go to work.

277. Neither was there any evidence that the prison was aware of his change of status or that his rights had been explained to him. There is a system at Leeds whereby remand prisoners are assisted to apply for bail but it had not been identified as appropriate for him.

**I recommend that the Governor should review procedures to ensure that a change of status from convicted to unconvicted prisoner is noted and acted upon.**

### ***Procedures for searching cells***

278. On 15 July, the man was taken from the wing for his own protection and, the duty governor ordered that his cell was searched. Correspondence was found which was recorded as security information and, again quite rightly, was passed to the police to investigate. This information was only shared with my investigators by the police and was not communicated by prison staff.

279. There are aspects of the cell search that do not comply with prison procedures. A search document should have been completed, recording those present, which member of staff gave authority for the search and what, if anything, was removed. The correspondence was not securely bagged and no attempts were made to check whether it had been written by him, but action was taken on the assumption that the letters were his property.

280. The prison had no record of the letters, did not inform the investigators of the search. The investigators were informed by the police. The letters were written in English and Arabic, but no attempt was made by the prison to translate them. Neither the referral to the police or the property which they handed over was recorded, and there was no record of the outcome of events or the opinion of the police.

**I recommend that cell searches should comply with the requirements of local security procedures.**

### ***Shift swaps during the night***

281. The name of each member of staff working each shift in the prison is recorded on the Detail, which should be an accurate record of which individual is responsible for each duty. However, it is apparently custom and practice for the OSGs working at night to swap duties half way through the night. This continues with the knowledge of the senior staff on duty at the time who permit the movement through the prison and record their management checks.

282. CCTV coverage of the segregation unit indicates that, not only did the OSGs swap their duties, but that on several occasions, no-one was present including times when records state that observations were made. For

**I recommend that the Governor should carry out his own investigation of night staff movements in the segregation unit.**

**I recommend that the Governor should review procedures to ensure the record of staff on duty is accurate and up to date.**

***Radios***

283. I am told that the failure of an officer's radio is a regular occurrence and they cannot be relied upon as a means of summoning urgent assistance. I understand that the matter has been discussed at a high level within the prison, but the problem has not yet been resolved.

**I recommend that the Governor should review procedures to ensure staff have fully functioning radios in all parts of the prison.**

***Other family concerns***

284. The man's family said that the police had shown them letters which he had written, and which were found in his cell some time before he died. I assume that they are referring to the letters found on 15 July, which remain in the possession of the police. Since the report was first published, I have been assured by the Prison Service that no letters are in their possession.

## Conclusions

285. The man who is the subject of this report was a young man, whose family believed had a promising future ahead of him. He entered the prison as a clean shaven, college student with a girlfriend. His only criminal conviction was for failing to appear at court to answer charges. He served a short sentence, but continued to be held when bail was refused and he was not moved to remand conditions, as was his right. Whether remanded or sentenced, the prison had a duty to keep him safe, which they were sadly unable to do.
286. His imprisonment coincided with significant events for people of his nationality and, unsurprisingly, the man seems to have been preoccupied by them. Some may conclude that his experience in prison led to his radicalisation and the deterioration of his emotional and mental health. The prison and medical records provide little insight into his wellbeing and much of what we have learnt is from extensive interviews with staff and other prisoners. Consequently, we know that he rarely came to the notice of staff apart from on some exceptional occasions.
287. Thursday 18 August was a significant day in his period in custody. First, and positively, wing staff recognised his deteriorating health and their referral for psychiatric assessment was quickly responded to. The nurse did not identify any risk to himself but did identify that he presented a risk to others. Later that day he obstructed his cell and, when it was unlocked, it is alleged that he assaulted two officers. In the course of controlling the situation, one officer used his stave and hit him. I am satisfied that using a stave is a very rare occurrence and that, in the circumstances, the officer's use of the stave was not disproportionate. However, I am concerned that the nurse's assessment was not incorporated into the standard healthcare processes when a prisoner is taken to the segregation unit, and especially to the special cell.
288. The man's family have raised important concerns about the extent of racism at HMP Leeds. I am pleased to note that, in the course of many hours in the prison and free access throughout, my investigators have not witnessed any racist attitudes or behaviour from either staff or prisoners.
289. However, others such as HMCIP and the CRE, with greater expertise and resources than my own, have identified racism at Leeds. Their criticisms are accepted by the Prison Service and action plans have been put in place. Sadly, as far as this man was concerned, those plans were inadequate as they did not ensure that he was treated in a culturally sensitive way. Some events during his imprisonment might have been dealt with differently had he been from a different faith or ethnic group, and a diversity perspective should have been brought to bear on all aspects of his imprisonment, especially when his mental health deteriorated and when he was in the segregation unit.

290. I recognised the value of expert advice on diversity matters, and am grateful to the expert on diversity matters for his assistance. His knowledge and experience have informed my comments. I conclude that the man was the recipient of unwitting ignorance by staff, of his religion and its requirements. I have borne in mind here that he died before the publication of the Mubarek report, before its comments on religious discrimination were drawn to the attention of the Home Office, and before its suggestion that the concept of institutional religious intolerance should be recognised. I also conclude that the lack of insight by the prison contributed to the deterioration of his frame of mind, but cannot be certain how it contributed to his death.
291. My concerns about the segregation unit are wide-ranging, and not restricted to discipline staff. The man's clothes were soiled with faeces when he arrived in the unit, but he was left without water to drink or wash with. He did not eat for at least 24 hours. He had nothing to occupy himself with, and no copy of his religious text.
292. I am pleased that the bunk beds have now been removed and the Samaritans telephone has been improved. It should not have taken another death for these things to have happened. And it is worrying that segregation unit staff appear to have little understanding of what to look for in a prisoner who is at risk of harming themselves. It is equally worrying that the medical oversight, which is supposed to be a safeguard, seems to be a futile, administrative exercise. The limitations of the daily visits by healthcare staff are graphically illustrated by the CCTV coverage.
293. Finally, I have already made the Governor aware of deficiencies to the first response to the man's death. I am pleased that he has already taken steps to ensure that the lessons are learned.
294. The man died a lonely death in the segregation unit of the prison in the city where he and his family had made their home. No issue has caused me more concern since I became responsible for the investigation of all deaths in prison custody two years ago than deaths in segregation. Like all too many prisoners who end up in segregation units, he presented a discipline problem but was increasingly vulnerable himself.

## Recommendations

### Local

- 1 The Governor should take advice from the National Offender Management Service Safer Custody Group and ensure that suicide and self harm training includes awareness of issues arising from:
  - prisoners' individual circumstances, including their ethnicity
  - prisoner's location, especially the segregation unit.
- 2 The Governor should continue to implement the prison's action plan for dealing with racism, and acknowledge how it may be evident in any of the prison's contact with a prisoner.
- 3 The Diversity Action Plan should be reviewed in the light of this report, and its scope extended to include my findings. In particular, the objectives of diversity and suicide and self harm awareness training should be harmonised, rather than seen in isolation.
- 4 I recommend that the Governor considers the recommendations of the Mubarek inquiry report, in particular in respect of institutional religious intolerance and the extension of the role of the prison's Imams to include pastoral as well as religious support.
- 5 The Governor should remind staff to use the minimum force necessary in resolving a situation, and encourage dialogue with prisoners, in accordance with the requirements of PSO 1600.
- 6 A prisoner's clothing should only be cut off as a last resort.
- 7 The Governor should review all aspects of the operation of the segregation unit, paying specific attention to the matters identified earlier in my report.
- 8 The Governor should ensure that food is left for prisoners who refuse meals, or it is offered again later.
- 9 The Governor should review procedures to ensure that a change of status from convicted to unconvicted prisoner is noted and acted upon.
- 10 Cell searches should comply with the requirements of local security procedures.
- 11 There should be an information sharing protocol between the prison and the Mental Health In-reach Team to ensure that information is shared speedily, especially in an emergency and when prisoners change location.
- 12 The Governor should carry out his own investigation of night staff movements in the segregation unit.
- 13 The Governor should review procedures to ensure the record of staff on duty is accurate and up to date.

- 14 The Governor should remind staff of the requirements of the local policy in responding to the apparent death of a prisoner.
- 15 The Governor should review procedures to ensure staff have fully functioning radios in all parts of the prison.

### **Healthcare**

- 16 The healthcare manager should ensure that all clinical staff carry out the daily checks of segregation unit prisoners in a proper manner.
- 17 All clinical staff should be reminded of their duty to keep contemporaneous records of contacts with patients and ensure that these are available in their medical records.
- 18 Healthcare staff should re-examine their input into the process of removal to the segregation unit to ensure that any underlying medical issues that might have precipitated the removal are also considered, as well as considering any injuries occurring during the removal.
- 19 Healthcare staff should re-examine how information about a prisoner's medical condition is collated and added to the medical record.