

**Investigation into the circumstances surrounding the death of a man at HMP Leeds on  
12 August 2004**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**April 2005**

This is a report of my investigation into the death of a man at HMP Leeds on 12 August 2004. He was on remand, and had been in prison for three days when he died. The purpose of the investigation was to establish the circumstances and events surrounding his death, including the quality of care provided by the Prison Service.

In April 2004, my office was passed the responsibility of investigating all deaths in custody. Under transitional arrangements, a Principal Officer in the Prison Service's Safer Custody Group was appointed to conduct the investigation on my behalf, with the assistance of a Governor from HMP Everthorpe. One of my colleagues acted as my representative on the investigation. I am grateful for all the assistance that the investigation team received from the Governor of HMP Leeds, and his staff, including the establishment's appointed Liaison Officer.

A key part of the investigation was also to make sure that the man's family had the opportunity to raise any concerns they had about his death. The investigation team was able to meet with his sister and brother in law. I am most grateful to them for having this meeting at what must have been an acutely difficult and distressing time for them.

The investigation has revealed serious gaps in information sharing between the West Yorkshire police and Leeds prison. Put bluntly, there was crucial police information about this man's risk of self harm that was simply not known by the prison. The policies and practices of the police are outside my terms of reference, but I have proposed that the Governor of Leeds discusses the findings of this report with the local police to try to ensure that no recurrence of the problems I have identified.

I offer sincere condolences to the man's family and friends in their sad loss.

**STEPHEN SHAW CBE  
PRISONS AND PROBATION OMBUDSMAN**

**APRIL 2005**

|  |             |
|--|-------------|
| <b>CONTENTS</b>                                | <b>Page</b> |
| <b>SUMMARY</b>                                 | 4-5         |
| <b>CONDUCT OF THE INVESTIGATION</b>            | 6           |
| <b>BACKGROUND INFORMATION:</b>                 |             |
| <b>The man</b>                                 | 7           |
| <b>HMP Leeds</b>                               | 7           |
| <b>EVENTS LEADING TO THE MAN'S DEATH:</b>      |             |
| <b>The arrest and charging of the man</b>      | 8           |
| <b>The man's time at Leeds</b>                 | 9-10        |
| <b>EVENTS AFTER THE MAN'S DEATH</b>            | 11          |
| <b>CONTACT WITH THE FAMILY AFTER THE DEATH</b> | 12          |
| <b>CLINICAL REVIEW</b>                         | 13          |
| <b>CONSIDERATIONS AND CONCLUSIONS</b>          | 14-15       |
| <b>RECOMMENDATIONS AND OBSERVATION</b>         | 16          |
| <b>OBSERVATIONS OF GOOD PRACTICE</b>           | 17          |
| <b>Annexes</b>                                 | 18-19       |

## SUMMARY

On 9 August 2004, this man was remanded into custody at Leeds accused of the murder of his wife on 6 August 2004. Between 6 August and 9 August, he had been held in police custody, where he was on constant watch. While there, he was interviewed by a forensic psychiatrist, who concluded that he seemed to be displaying an underlying paranoid illness and delusional thoughts about his wife. The forensic psychiatrist advised that the man was fit to be interviewed, but needed an appropriate adult to be present. On 9 August, the prosecution opposed bail. One of the reasons was that the man had already indicated that he had lost everything in life, and remanding him in custody would safeguard his own welfare.

When the man was transferred to Leeds, the information accompanying him from the police gave some indication that he was at risk of self harm, but did not include the information that he had been on constant watch, or the psychiatrist's brief note of his assessment. The Safer Custody Officer in reception, using the information from the police, undertook a Cell Sharing Risk Assessment to decide whether the man presented a risk to others in prison. His risk was assessed as low, and he was considered suitable for multi – cell location. The documents from the police were filed in the prison's security department. The man proceeded through the rest of the reception process. A nurse interviewed him and carried out a health screen, based on information he provided about his health. In the nurse's opinion, he did not present any suicidal or self-harming tendencies. She established that the man suffered from a heart condition. He was subsequently referred to the reception doctor, who prescribed appropriate medication for his physical condition.

The man was then located in the First Night Centre. He was allowed to make a phone call and rang his sister.

On 10 August, he was relocated to the induction unit and attended the first day of the induction programme. The next morning the man attended the gymnasium with his cellmate. The cellmate says the man told him he had assaulted his wife, and that she was in hospital. When the man returned to the wing he continued with the induction programme. During the association period that evening, he made a further phone call to his sister. On returning to the cell, he told his cellmate that his wife was dead.

At 7.20am on 12 August, an officer was unlocking prisoners for breakfast when the cellmate told him that he thought the man was dead. The officer entered the cell and alerted staff. A Senior Officer contacted control via the telephone to ring for an ambulance and to inform the duty Governor. Other staff were on the scene very quickly and three nurses diagnosed that there were no life signs present. The paramedics arrived at 7:35am and confirmed his death.

At 8.20am the residential governor telephoned the man's sister to tell her of his death. The governor offered to go and meet the family when they wanted this, but the man's sister says she was given no details about his death. The Governor subsequently apologised to the family for the way in which the prison broke the news of his death.

I have made a number of recommendations and observations. These include recommendations about the use of information about prisoners by the prison, the transfer of information from the police, the need for prisons routinely to observe prisoners charged with serious offences, and the arrangements for telling the next of kin about the death. I have concluded that the emergency procedures, once the man was discovered in his cell, worked well. I have also identified two areas of good practice by the prison.

## **CONDUCT OF THE INVESTIGATION**

The investigation was conducted by a Principal Officer from the Prison Service's Safer Custody Group and a Governor from HMP Everthorpe. One of my investigators was the lead for the Prisons and Probation Ombudsman.

During the course of initial inquiries, the investigation team were shown around the prison and visited the cell where the man died. They also reviewed all the relevant documentation and established a chronology of events.

Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing to it.

One of my Family Liaison Officers contacted the man's family and offered them the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. A meeting took place on 21 September 2004 with the man's sister and brother-in-law.

The investigation team contacted the Chairman of the local Prisons Officers' Association (POA), and the Chair of the Independent Monitoring Board (IMB) to tell them about the investigation. Six members of staff and one prisoner were interviewed during the course of the investigation. All members of staff were offered the opportunity of being accompanied by a work colleague or Trade Union official. All the interviewees have been given a copy of the transcript of the interview.

The investigation team also contacted Her Majesty's Coroner to tell him of the nature and scope of the investigation. The Coroner provided the investigation team with a copy of the Post Mortem Report of 29 September 2004. This recorded the cause of death as 'incised wound to left side of neck and ligature strangulation'. The report said that the distribution of the injuries and ligature strongly indicated that they had been self-inflicted.

A doctor from Leeds Primary Care Trust, undertook a clinical review of the healthcare provided to the man while at Leeds.

## **BACKGROUND INFORMATION**

### **The man**

This man was born on 7 September 1963, and was 40 years old when he died. He was married and they had two children. He was remanded in custody at Leeds on 9 August 2004, accused of murdering his wife on 6 August 2004. He had no previous convictions, and had never been in prison before. He suffered from a heart condition, cardiomyopathy, for which he was taking medication and had a pacemaker fitted.

The man's sister told the investigation that the man had become depressed following the diagnosis of his illness which had forced him to change jobs. He was struggling to come to terms with being on medication at a relatively young age. The man's sister said that she had been concerned about his wellbeing for some months before his wife's death, and in particular about his paranoid behaviour. She said that she discussed her concerns with the man's GP who told her that he was probably depressed about his illness. She explained that the man's employer had also become concerned about him and had referred him to the occupational health department at work. In her view, her brother and his wife had always had a volatile relationship but they could not live apart. She said that when her brother was arrested she told the police about her concerns for his mental health and she gave them his medication.

### **HMP Leeds**

Leeds is a category B local prison in the Yorkshire and Humberside area. Its main function is to receive those people committed to custody by the courts. It takes all adult male prisoners remanded from the West Yorkshire area until trial, and convicted prisoners for short periods following sentencing. Most sentenced prisoners are allocated to a training prison within 72 hours of being sentenced, and are transferred out of Leeds as soon as spaces become available.

The prison was built in 1847. Two new wings were opened in autumn 1994, and a new gate complex was opened in September 2002. The accommodation consists of six wings with 680 single cells, mostly occupied by two prisoners in each cell. New prisoners on induction are located on D Wing which holds up to 217 men.

The local strategies for the care of prisoners at risk of self-harm at Leeds are in accord with national policy. The local policy for the prevention of suicide is published within the prison and is available to both staff and prisoners.

The suicide prevention policies and procedures received a 'good' rating in the Standards Audit which took place at Leeds in April 2003. The Head of Residence heads the Suicide Prevention Team at Leeds. The team meets monthly and the minutes of the meetings show good attendance and indicate an understanding of national policy and a commitment to its effective implementation at Leeds. Staff training in Suicide Prevention procedures is an

integral part of the prison's current training programme and has been delivered to the majority of staff at Leeds.

There have been seven deaths in Leeds in the past two years. Two were from apparent natural causes, four were apparently self inflicted, and there has been one homicide.

## **THE EVENTS LEADING UP TO THE MAN'S DEATH**

### **The arrest and charging of the man**

In the early hours of 7 August, the ambulance service called the police about a domestic incident at the home of the man and his wife. The man's wife had received fatal injuries, and the man was arrested on suspicion of her murder. He was placed in a police cell under constant supervision, and this was maintained throughout the whole period he was in police custody. This is detailed in the police custody detention record. In the early afternoon of 7 August, he saw a doctor about his heart condition. The doctor said that he was fit to be interviewed. The police then made arrangements for a psychiatrist to attend the station.

A forensic psychiatrist came to the station later that afternoon and interviewed him. He advised the police that, although he appeared coherent and plausible, the man was possibly showing signs of mental illness. This involved possible delusional ideas against his wife, as part of a syndrome of morbid jealousy. He said that the man was fit to be detained and interviewed, but advised the presence of an appropriate adult, ideally an approved social worker with experience of mental health problems. His view was that the man could be processed through the criminal justice system, but that further psychiatric evaluation would be required at a later stage.

The psychiatrist agreed to prepare a report for the police, which he did on 11 August. The report provided a detailed account of his examination of the man, and noted that he had no suicidal ideas. This report had not been forwarded to Leeds by the time of the man's death on 12 August.

The police made arrangements for a social worker to attend the station. By this time, the man also had legal representation. In the evening of 7 August, after the social worker had arrived, the police formally interviewed him. During the police interviews, the man said that he had not intended to kill his wife.

On 8 August, the man was charged with the murder of his wife. On 9 August he appeared at Huddersfield Magistrates Court. The prosecution opposed bail on a number of grounds. One of the reasons was that he had already indicated that he had lost everything in life, and that remanding him in custody would safeguard his own welfare. These reasons were set out in writing on the police remand application form MG7. The man's police custody detention record also noted, in relation to any possible bail application, that he was suffering from depression and there was the possibility of self-harm. The detention record, however, was not forwarded to Leeds.

The Prisoner Escort Record (PER) that accompanied him to court stated that he had a serious heart condition and was on medication, that he had a pacemaker fitted and that his

medication could make him depressed. The boxes indicating that the prisoner might be suicidal or likely to self harm were not ticked.

### **The man's time at Leeds**

The court remanded the man in custody, and later that day he arrived at Leeds. A Cell Sharing Risk Assessment was carried out by a prison officer, who that day was working as a Safer Custody Officer. She came to the conclusion that there was a low risk that the man might assault a cellmate, and that he could be placed in a shared cell. In coming to this view she took account of the following documents received from the police:

- **The Prisoner Escort Record (PER)** form that accompanied the man to court.
- **Form MG1**, West Yorkshire Police File Front Sheet, giving the man's name and details of his offence.
- **Form MG4**, charge sheet, which indicated that the man's reply to the charge was that he had not intended 'for it to go that far'.
- **Form MG5**, giving a summary of the case.
- **Form MG7**, remand application, which explained that the risk of self-harm was one of the reasons for opposing bail.
- **Form MG16**, custody record covering sheet giving personal details.
- **Medical Record Sheet**, record of the man's heart condition and details of medication.
- **West Yorkshire Police Prisoner Risk Assessment**, which said that the man had been assessed as being charged with a serious offence, and having both a physical and mental condition or illness. It noted that the man denied that he suffered any mental health problems or depression, or that he would attempt self-harm or suicide while in custody, but that the man said the medication could make him depressed.

The man's prison core record cover was completed by a Senior Officer. The information envelope from the police was placed in a security tray for collection by the security department.

The medical reception assessment was then carried out by a nurse using a document called the Modified Reception Health Screen. The assessment was conducted without the information from the police, and relied on the answers that the man gave about his medical condition. The assessment recorded the man's heart problems. The nurse noted on the form that the man had no obvious mental health problems at the time of the report. She confirmed at interview that he did not appear to have any mental health issues, but that he was obviously very upset about what he had done.

The assessment also considered suicide risk factors. The man said that he was not suicidal, but that he was pessimistic about the future. The boxes relating to previous psychiatric history and the presence of physical illness were both ticked 'no'. On the basis of the assessment, he was given a score of 6. A score of 10 or more is taken to indicate that a prisoner is at risk.

Following the reception assessment, the man was referred to a doctor for his physical health who prescribed appropriate medication for his condition.

The man was located in the First Night Centre. An officer interviewed him and told him about prison procedures. He issued the man with a basic smoking pack and PIN phone telephone credit so that he could make a telephone call. The man was then placed in cell D1-19 and allowed to make a telephone call. He rang his sister.

The F2052A Prisoner History sheet had no entries other than the reception onto the First Night Centre recorded by the officer and that the man was issued with his first night pack.

On 10 August, the man was relocated to cell D4-36, a landing three floors above the ground floor. Later that same day he was moved to cell D2-10 on the ground floor, due to his heart condition. On the morning of 11 August, the man attended the gymnasium with his cellmate. When he returned to the wing, he continued with the induction programme. In his statement to the police, the cellmate said that the man had told him he was in prison for 'beating his wife' and that 'his wife was in hospital and was in quite a mess from the incident'. The cellmate said in his interview with the investigation team that, after they returned from the gymnasium, the man kept asking for a cigarette and pressing the cell bell. The cellmate said the man kept 'moaning' and 'wondering' about what was going to happen to him. The cellmate tried to reassure him that he still had his children to see and think about. The cellmate said that, after tea, the man asked for some razor blades saying that he wanted a shave, and that staff gave him some. He said that, at about 8pm, he and the man were locked in the cell. The cellmate said the man told him that during the association period that evening he had made a telephone call to his sister about selling his house. The man also told said that he had telephoned the hospital and they told him his wife had died, and that his life was finished now. The cellmate said that he was surprised at how little that news appeared to have affected the man and he did not seem upset. But he also said that the man had a bottle of tablets in the cell and told him that if he took all the tablets he would not wake up. He said that the man had mentioned taking all the tablets on 10 and 11 August but did not appear serious. The post mortem report confirms that toxicology evidence was negative. The cellmate said that during the evening he watched some television and 'crashed out' at about 10pm.

The night patrol officer said that nothing untoward happened during the night. She said that she was doing her last wing check at 5.30am, and when she looked in cell D2.10 she saw two people who appeared to be asleep.

On the morning of 12 August, an officer was unlocking prisoners for breakfast. The cellmate said that he jumped off the top bunk and saw the man on the bottom bunk covered in blood. He went outside and alerted the officer. The officer entered the cell at 7.20am and alerted other staff. A Senior Officer contacted control via the telephone to ring for an ambulance and to inform the duty Governor. Other staff were on the scene very quickly and three nurses diagnosed that there were no life signs present. The paramedics arrived at 7.35am and confirmed that he was dead.

## **EVENTS AFTER THE MAN'S DEATH**

A Governor sealed the cell at 7.46am. The police arrived at 8am. During the course of the morning, Scenes of Crime Officers examined the cell. The man's body was removed at 1.22pm.

A hot-debrief was undertaken during the morning with staff involved in the discovery of the man. The night patrol officer, was not invited to the meeting. The Senior Officer who contacted the control room, visited the officer who was first on the scene at home later that day. The Governing Governor visited the wing during the day to talk to the staff and to offer his support. The care team also offered support and counselling to any member of staff involved. A Principal Officer spoke to, and offered support to, the prisoners in the cells adjacent to D2-10.

Residential unit managers reviewed all prisoners who had F2052SH forms (self harm forms) closed within the three weeks prior to the man's death, by means of a short interview. Full multi-disciplinary reviews were also carried out that day on all prisoners with open F2052SH forms. .

The prison completed a contingency action plan checklist. However, this does not make clear who carried out certain actions.

## **CONTACT WITH THE FAMILY AFTER THE DEATH**

At 8.20am, the residential governor telephoned the man's sister, to tell her of her brother's death. The man's sister was at home with her husband, the man's mother, and the man's two children. The residential governor noted that the man's sister appeared to take the news relatively calmly. The man's sister said that she already had a family liaison officer, from Huddersfield Police, in relation to the murder charge. The residential Governor left his details and those of the prison Chaplain. He offered to go and meet the family when they wanted this.

At 9.30am, the residential governor telephoned the family's police liaison officer. The police liaison officer said that he had spoken to the family since the residential governor's telephone call, and was to visit the family that morning.

At 3pm, the residential governor visited the man's sister's home, together with the Chaplain, and two police liaison officers. The man's sister was there with her mother, and brother. The residential governor explained the circumstances in which the man was discovered, the investigation procedures, and arrangements for handing back his property. The Chaplain offered support and help with the funeral arrangements, and ongoing contact if this would help. The family were invited to visit the prison and see the man's cell if they wished to do so. The residential governor handed a letter to the man's sister from the Governing Governor, expressing condolences from the prison to the family.

The man's sister queried the appropriateness of the initial contact to the family by telephone. The residential governor agreed this was not ideal but explained that he wanted to tell the family promptly and avoid notification from other sources, such as other prisoners and the media. If the prison had known of the police Family Liaison Officer, he agreed that it would have been better for the bad news to have been broken by the police. Later that day, the Governing Governor wrote to apologise for not using the police family liaison team, and adding to the family's pain at such a difficult time.

The investigation team visited the man's sister and brother-in-law on 21 September to give them an opportunity to raise any issues for the investigation. The man's sister said that she told the police about her concerns about the man's mental health, and he had been put on a 24 hour watch at the police station. She could not understand why he was then put on normal location at the prison.

The man's sister was still very angry at the way the prison had told her of the man's death. She said that when the residential governor telephoned her that morning she had asked about how her brother had died, but was told that she would be given the details in a visit that afternoon. She had received the governing Governor's letter of apology, but still felt

outraged at the way the prison had handled her brother's death. She said the Chaplain had been helpful when he visited.

## **CLINICAL REVIEW**

In accordance with procedures agreed with the NHS, the investigation team advised Leeds West Primary Care Trust (PCT) of the man's death. The PCT then put in train arrangements to undertake a clinical review of the healthcare provided to the man while at Leeds. A doctor from Leeds Primary Care Trust, undertook the review. Before he did so, he wrote to say that he was concerned that his could not be an independent investigation, as Leeds West PCT employed a number of staff at Leeds prison, and he was the line manager of the Head of Healthcare at Leeds.

The reviewer's report is attached. His report refers to a psychiatrist's report of 11 August 2004. This is in fact the report of the consultation of 7 August 2004 arranged by the police, written up on 11 August and not available to Leeds before the man's death on 12 August. The doctor concluded that there was nothing in the medical notes that suggested that the man's death could have been predicted or prevented. However, he said that the notes in the Inmate Medical Record (IMR) were inadequate. He recommended that the processes immediately after a death in custody be reviewed to allow clinical staff to make appropriate entries in the IMR.

## **CONSIDERATIONS AND CONCLUSIONS**

In the two days that the man was in police custody he had been subject to a 24 hour watch. The man had already said that he had lost everything in life, and it is clear from the prosecution opposition to bail that they had concerns about his welfare. The reasons for opposing bail were set out in writing on the police remand application form MG7, and sent to the prison. Leeds used this information to complete a cell sharing risk assessment. But in accordance with procedures within the prison, this information was then forwarded to the Security Unit. It was not available to healthcare staff to complete their assessment.

The prison health care assessment was completed within the required 24-hour period following reception into Leeds and appropriate medication was prescribed for the man's physical health. Health care staff did not consider him to be at risk of self-harm or suicide. This assessment was based on his answers about his physical and mental health and without the relevant police documentation.

In my view it was quite wrong for the prison to use the police information for the cell sharing risk assessment, but then file it with security documents. The crucial information that the man had been remanded in custody partly because of the court's fears about self harm was not therefore available for healthcare to undertake the initial healthcare screening.

**Recommendation: Information regarding a prisoner from the police, or any other source, should be made available to all parties during the reception process. The information should be seen by all the staff carrying out risk assessments. It should not be forwarded to other departments before it has been seen by all those involved in undertaking these crucial assessments.**

However, yet more significant than the information on the MG7 was the fact that the police had been sufficiently worried about the man to put him on a 24 hour watch. The prison did not know this. It is evident from the investigation that all the information about the risk of self-harm on the police custody detention sheet was not transferred to the PER form which accompanied him to Court. The man was also referred to a psychiatrist while in police custody. The psychiatrist concluded that the man might have had paranoid delusional thoughts concerning what had happened and required further psychiatric assessment. This was noted on his police custody detention record. This information was also not forwarded to Leeds.

**Reccomendation: The Governor of Leeds should discuss the findings of this report with West Yorkshire police with the aim of ensuring that the police pass on all relevant information about a prisoner.**

The man was seen by many staff during his short period in Leeds, and had many opportunities to voice his concerns over his wellbeing but did not do so. Yet when he arrived at the prison, he was almost bound to be in turmoil about what he had done. I am concerned that there are no specific arrangements to care for newly received prisoners charged with the serious offences of murder, rape, and arson. My view is that it would be reasonable for prisoners charged with the most serious offences and new to custody to be routinely observed more closely for the first few days of their period of custody either by admission to healthcare or by monitoring through use of the F2052SH.

**Recommendation: Safer Custody Group should consider whether prisoners charged with murder, rape, and arson and new to custody should be routinely observed more closely for a short period of time after reception, either by admission to healthcare or by monitoring through the F2052SH document.**

Emergency procedures at the prison worked well and post incident response was good. However, I found that the contingency action plan checklist did not clearly indicate who had carried out certain actions.

**Recommendation: Contingency documentation should clearly show what action has been taken and by whom. Specific action sheets for staff should be reintroduced to show a clear audit trail.**

While of no direct bearing on the death of the man, the F2052A Prisoner History Sheet had no entries other than the reception onto the First Night Centre recorded by an officer and the man being issued with his first night pack.

**Recommendation: The Governor of Leeds should remind staff about the importance of updating all relevant paperwork about a prisoner.**

Not all staff who were involved following the discovery of the man were at the hot-debrief.

**Recommendation: The Governor of Leeds should remind senior colleagues that all staff on duty who are involved in such an incident should be seen for a hot-debrief before going off duty.**

There were few entries on the IMR and nothing to say that the man had died. The clinical review recommended that processes immediately after a death in custody should be reviewed to give clinical staff the opportunity to make appropriate entries in the IMR.

**Recommendation: Processes immediately after a death in custody should be reviewed to enable clinical staff to make appropriate entries in the IMR.**

I am concerned that the prison told the man's sister on the telephone of the death of her brother, and did not explain the circumstances of the death. I can understand her upset at the way the prison dealt with this. She was not only left to break the news alone to her mother and her brother's children, but she had no details about what had happened. This news came only days after the horror of the death of the man's wife.

**Recommendation: The Governor of Leeds should review its procedures for informing the next of kin of a death. The review should ensure that whoever is in first contact with the next of kin gives them as much information as is known at this stage, and**

**says who the family can contact for outside support.**

**Finally I turn to the matter raised by the doctor concerning the clinical review. I think that he makes a good point about independence relevant to all PCTs. Whilst it was entirely appropriate for the PCT to undertake the clinical review. It would have been better for the PCT to have identified an alternative clinician to undertake it. This would have avoided potential conflicts of interests that could have arisen as a result of the doctor directly managing the Head of Healthcare.**

#### **RECOMMENDATIONS:**

**Information regarding a prisoner from the police, or any other source, should be made available to all parties during the reception process. The information should be seen by all the staff carrying out risk assessments. It should not be forwarded to other departments before it has been seen by all those involved in undertaking these crucial assessments. The Governor of Leeds should discuss the findings of this report with West Yorkshire police with the aim of ensuring that the police pass on all relevant information about a prisoner.**

**Safer Custody Group should consider whether prisoners charged serious offences of murder, rape, and arson and new to custody should be routinely observed more closely for a short period of time after reception, either by admission to healthcare or by monitoring through the F2052SH document.**

**Contingency documentation should clearly show what action has been taken and by whom. Specific action sheets for staff should be reintroduced to show a clear audit trail.**

**The Governor of Leeds should remind staff about the importance of updating all relevant paperwork about a prisoner with relevant entries.**

**The Governor of Leeds should remind senior colleagues that all staff on duty involved in such an incident should be seen for a hot debrief before going off duty.**

**Processes immediately after a death in custody should be reviewed to enable clinical staff to make appropriate entries in the IMR.**

**Local recommendation: The prison should review its procedures for informing the next of kin of a death. The review should ensure that whoever is in first contact with the next of kin gives them as much information as is known at this stage, and says who the family can contact for outside support.**

**(The Prison Service says that they do not consider that the prison's action in informing the man's sister by telephone, of her brother's death was incorrect or inappropriate as it was done to ensure she was informed speedily. However, they do accept that the prison should have given her more detail in this case.)**

## **OBSERVATION:**

**Whilst it was entirely appropriate for the PCT to undertake the clinical review, it would have been better for the PCT to have identified an alternative clinician to undertake it. This would have avoided potential conflicts of interest that could have arisen as a result of the doctor directly managing the Head of Healthcare.**

## **OBSERVATIONS OF GOOD PRACTICE:**

All prisoners who had F2052SH forms closed three weeks before the man's death, were reviewed by means of a short interview. Full multi-disciplinary reviews were completed for those with open F2052SH forms. This was very good practice.

The Senior Officer demonstrated concern for staff by visiting the night patrol officer, as she had not been present at the hot-debrief, to tell her of the incident and to see if she required support. He should be commended for this.

