

**Investigation into the circumstances surrounding the
death of a man in hospital in December 2006 whilst in the
custody of HMP Leeds**

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

October 2007

This is the report of an investigation into the circumstances surrounding the death of a man in hospital in December 2006. The man, who was aged 32 and was a prisoner at HMP Leeds. He had been remanded into custody on 24 September 2006, with a trial date of February 2007. The post mortem shows that he died as a result of a significant intracerebral haemorrhage.

I extend my sincere condolences to the man's family and friends for their sudden and sad loss.

A member of my office carried out the investigation. I wish to thank the then Governor of Leeds for making the necessary facilities and information available to my investigator, and for the assistance of the governor who acted as the prison's liaison officer.

Everyone spoken to during the course of this investigation was shocked to learn of the man's death. He was well liked in prison and had built good relationships with both his fellow prisoners and with staff.

The circumstances of the man's death are very sad, but I have found no evidence that staff at Leeds could have prevented it. I have made no recommendations but draw two matters to the attention of the Governor. I also highlight one example of good practice.

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SUMMARY

The man was remanded to HMP Leeds on 19 August 2006. He had been arrested following an argument with a friend. After two further court appearances, he was briefly released on bail. However, he returned to prison on 22 September, remanded to HMP Doncaster where he was subject to suicide and self harm assessment and observation procedures. Following an episode of self harm, the man moved back to Leeds on 15 November and appeared quite settled there.

On the evening of 4 December, he attended the medicine hatch to receive his medication. He spoke to the Primary Care Manager at Leeds, who was helping to give out medications. The manager knew the man and noticed that he seemed well and good-humoured.

The next morning, the wing officer was unlocking the wing so that prisoners could make their way to work. She unlocked the man's door and continued down the corridor unlocking each cell. She then returned to check on him as she had noticed he had not come out of his cell. She found him slumped on his bed and unresponsive.

The wing officer called to the staff nurse, who was also working on the wing, and they both went to the man's cell. The staff nurse knew the man was receiving medication and she was concerned that he might have taken an overdose. She found a pulse, but when she checked his pupils she realised he had had a cerebral bleed. She told the wing officer to get help and she made a code blue alarm call and asked for an ambulance.

Other staff members quickly attended and the ambulance arrived at 8.05. The man was taken to the local hospital and seen by a specialist. He had suffered a significant intracerebral haemorrhage. Sadly, his condition deteriorated and he died in the Neurology Intensive Care. His family were with him at the time. The man was aged 32.

This report makes no recommendations, but draws the Governor's attention to two matters and commends one example of good practice.

THE INVESTIGATION PROCESS

I was notified of the man's death on 5 December 2006. Notices were issued to staff and prisoners announcing the investigation and offering them the opportunity to contribute to it. My investigator visited the prison on 13 February 2007 and spoke with the relevant staff members. She also reviewed all the pertinent prison records and established a chronology of events.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment received by the man whilst in custody. I am grateful to the Consultant in Public Health Medicine, for his report.

One of my Family Liaison Officers contacted the man's family and explained the investigation process to them. They were invited to raise any concerns or questions for the investigation to consider. They did not raise any concerns about the way the man was looked after, or how they had themselves been treated by staff from Leeds prison. I am most grateful to them for talking to us at such a difficult time

HMP LEEDS

Leeds is a category B local prison accepting adult male prisoners from courts in the surrounding area. It is one of the largest local prisons in the country. The prison comprises six wings and a healthcare centre. It takes all adult male prisoners remanded from West Yorkshire until trial, and convicted prisoners for short periods following sentencing.

The healthcare centre at Leeds can accommodate up to 55 patients. It provides a 24 hour comprehensive primary care service, and has made provision for secondary care and treatment in a range of hospitals in the surrounding area.

Her Majesty's Chief Inspector of Prisons undertook an unannounced inspection of Leeds between 30 June and 4 July 2003. The report commented that Leeds presented as a typically overcrowded and pressurised local prison.

This is one of many deaths I have investigated at Leeds since taking responsibility for investigating all deaths in custody in April 2004. Several of those investigations are ongoing and a number of reports have yet to be published. However, there appear to be no issues from these other investigations of specific relevance to the circumstances of the man's death.

KEY FINDINGS

The man was arrested on 17 August 2006 following an altercation with a friend. The police risk assessment identified the man's risk areas as suicide, self harm, and mental health illness. It also showed that the man had some physical injuries for which he was treated.

Following an appearance at court, the man was remanded to HMP Leeds on 19 August.

A Prisoner Escort Record (PER) accompanies every prisoner as they move between police custody, the courts and the prison system. It is used to highlight any staff concerns about the prisoner in their care, and the information is passed to the next agency who may deal with the prisoner. The man's PER form highlighted the self harm and mental health issues as previously assessed by West Yorkshire Police.

A further risk assessment was carried out as part of his reception screening at Leeds. It noted that the man had said he had self-harmed in the last month. It also recorded that he suffered from schizophrenia, and that he used alcohol and drugs.

The man attended court hearings on 22 and 29 August. On the second occasion, he was released on bail. However, when he next appeared before the court on 22 September, he was again remanded to prison. This time he was taken to HMP Doncaster.

Nothing noteworthy happened until 14 November when the man cut himself with a razor blade. He told staff that it was a cry for help as he wanted to be moved out of Doncaster. He said he was having difficulties with some other prisoners there. An ACCT document was opened that day to observe and monitor him. (The Assessment, Care in Custody and Teamwork (ACCT) procedures are used by staff to raise concerns about the welfare of any prisoner. This process allows for closer observation, assessment and support of an individual prisoner.)

The man's record shows he was transferred from Doncaster to Leeds the next day. His PER on transfer showed that he was subject to the ACCT procedures, and the self harm box was ticked making others aware of his risk areas. It also again detailed his mental health problems and schizophrenia. The Cell Sharing Risk Assessment completed at Leeds documents that the man was a drug user and that he was subject to ACCT monitoring. Records show that his ACCT document was closed on 16 November. A post closure interview should have taken place on 23 November but did not.

The Primary Care Manager at HMP Leeds told my investigator that, on the evening of 4 December, they were short staffed so she helped give out the evening medications. She said she knew the man and was aware that he had a history of mental health difficulties. She said they were friendly and he would call her by her first name and she called him by his first. She said he came to collect his methadone and they had a chat and a laugh. She said the man was joking with her about working in the treatments room as that was usually a role for the nurses and not members of the management team. She said the man also spoke to her about

reducing his methadone prescription. She advised him to see the drug misuse worker first and discuss his plans with her. The man agreed to do this. She said the man seemed well mentally and in good spirits, and "he was his usual polite and pleasant self".

The first wing officer and the second wing officer were on duty on B wing on the morning of 5 December 2006. The first wing officer explained to my investigator that she began unlocking the cells at about 7.20 am to allow prisoners to attend the workshops. She said that she unlocks each cell door and says good morning to the occupants. Most prisoners are up and ready to start the day at this time, 'though some require a second shout'. After she has unlocked all the cells on the landing, she then begins a second round of checking each cell and its occupants. When she returned to the man's cell, she went in and saw that he was sitting up on the bed, fully dressed but appearing to be asleep. She estimated it to be 7.45am by this time.

The first wing officer said she shook the man's leg in an attempt to wake him. Although he was snoring loudly, she could not rouse him. She was aware that he had been subject to a cell search earlier that week and foil, which can be used for smoking drugs, had been found in his cell. At the time, he said it was not his and must have belonged to the previous occupant. No charges were brought against him but the suspicion remained. The first wing officer said this information was in the back of her mind when she found him. When she could not wake him, she worried that he might have taken something. She told my investigator that she remembered that the television was on and the man was dressed in fresh clothes for the day ahead. She knew the staff nurse was on the wing so she went across the landing to her office to fetch her.

The staff nurse had come on duty at 7.15 am and was in the treatment room on the landing, opposite the man's cell. The first wing officer asked her if the man was on any medication that would make him drowsy as she could not wake him up. The staff nurse knew that the man was on three doses of temazepam a day (he received this as one pack in the morning). When interviewed by my investigator, the staff nurse said that she did initially thought that the man might have taken a day's supply all at once.

She went to the man's cell with the first wing officer who again tried to wake him. The staff nurse said the man was sitting up on his bed, with his back against the wall and his head slumped to one side. She said he was fully clothed, dribbling and breathing noisily. She knew from what she could observe that something was not quite right and was concerned that he might have overdosed. She told the first wing officer to get help and she made a code blue alarm call to the communications room and asked for an ambulance to be called.

The staff nurse said she did not know the man well, but had seen him the previous morning when he had collected his medication. She shouted to him to try and rouse him. She felt his pulse and it was strong. She then checked his eyes and immediately realised that he had had a bleed. She said two nurses then arrived with oxygen and they put the oxygen cylinder and mask on him to assist his breathing. They continued until paramedics arrived.

The ambulance arrived at the prison at 8.05 and left the prison at 8.38, arriving at the hospital's Accident and Emergency Department at 8.40. The man was admitted, accompanied by two officers carrying out the bed watch duties. When the man was examined by the consultant at the hospital at 9.15, he asked for the handcuffs to be removed. The officers, who were conducting the bed watch duty, sought the approval of the duty governor at the prison. The duty governor agreed to this request and the handcuffs were removed. The staff involved in the bed watch duty then waited outside the man's room.

While the man was on his way to the hospital, one of the prison's family liaison officers (FLOs) contacted his next of kin (his wife). He explained the situation to her and urged her to attend the hospital as soon as possible. He also offered to arrange transport, but the wife said she would make her own way. He then travelled to the hospital with the imam. They were both present when the family, including his wife and his ex-wife, arrived at the hospital at about 1.30pm. They spent several hours there and then left briefly to take a break. The man's brothers arrived to visit at 6.00pm, and at 7.00pm his wife and ex-wife returned. The man's condition deteriorated and he was pronounced dead at 8.25pm with his family present.

After the man's death

The Governor wrote to the man's wife, offering his condolences and providing contact details to enable the family to get in touch with the prison. He also offered the family the opportunity to visit the prison if they so wished. They decided not to do so.

The prison FLO maintained close contact with the man's wife and provided support to her during the first few weeks after the man's death. His money, clothes and personal effects were returned to his wife on 3 January 2007. His funeral was held on 11 January, and the FLO helped the man's wife make the arrangements. The costs were met by the prison.

Following any death in custody, it is important that staff feel supported and that appropriate systems are in place to allow anyone affected to share their concerns and feelings. The prison's Care Team made themselves available to any member of staff wishing to speak to them. Staff on duty at the time of the man's death, although shocked and upset, told my investigator that they did feel properly supported.

ISSUES

The man had a history of mental illness, as well as a record of drug and alcohol misuse. He had spent previous periods in prison and, it seems, was not daunted by the experience.

It appears that all appropriate risk assessments were carried out both in police custody and in prison. This included ACCT monitoring and observations. The man's ACCT document was closed on 16 November, and a post closure interview should have taken place on 23 November. I suggest that the new Governor reminds his staff of the importance of undertaking such interviews. However, I acknowledge that this omission did not impact on the care given to the man while he was in Leeds.

When the man was first taken to hospital, he was cuffed to an officer in accordance with the local security arrangements. I appreciate the need to ensure any risks to the public are minimised, but have to question the appropriateness of this action in this case. The man was clearly unconscious and required emergency care. Once at the hospital, staff had to contact the prison to get permission to remove the cuffs. Whilst I do not make a formal recommendation, I urge the Governor to ensure that due consideration is taken of all the presenting factors when decisions about cuffing arrangements are made.

During consultation on the draft report, Leeds commented on the above, as follows:

"A full risk assessment is undertaken prior to an escort. Sending a prisoner out to hospital uncuffed because they are "obviously" unconscious is a risky thing to do, especially when the prisoner concerned is in custody for a violence related offence, as was the case with the man who died.

This is reviewed once medical advice has been sought and once the consultant had assessed the man he requested that the cuffs be removed, permission was sought and the cuffs were removed.

I am concerned about the comment "the staff had to contact the prison to get permission to get the cuffs removed". The decision to change the initial risk assessment in the light of new information is made by a governor grade. It would not be appropriate to authorise escorting staff to make decisions of this nature."

The clinical reviewer notes that the man had a history of mental health problems, drug misuse and self harm. However, he concludes that these had been managed appropriately. He points out that the man suffered a significant intracerebral haemorrhage which could not have been foreseen. When this occurred, the response was swift and appropriate.

Many staff members who met my investigator said they regretted that the man had not recovered in hospital. However, they took some comfort from the fact that they found him while he was still breathing and got him to the hospital so that his family could say their goodbyes. It is to her credit that the first wing officer checked each cell a second time that morning. This ensured that the man was discovered as soon as possible and enabled his speedy transfer to hospital.

The first wing officer should be commended for her good practice in double checking on prisoners in her care, ensuring any emergency is quickly recognised and dealt with.

I note that the family told my FLO that they had been told to apply to the social fund for help with funeral expenses and that the prison would assist if this was unsuccessful. This is not in line with PSO 2710 'Follow up to deaths in custody', which makes clear that the prison should offer funeral assistance without reference to other sources. I draw this to the Governor's attention.

GOOD PRACTICE

The first wing officer should be commended for her good practice in double checking on prisoners in her care, ensuring any emergency is quickly recognised and dealt with.