Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Brown, a prisoner at HMP Leeds, on 4 March 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

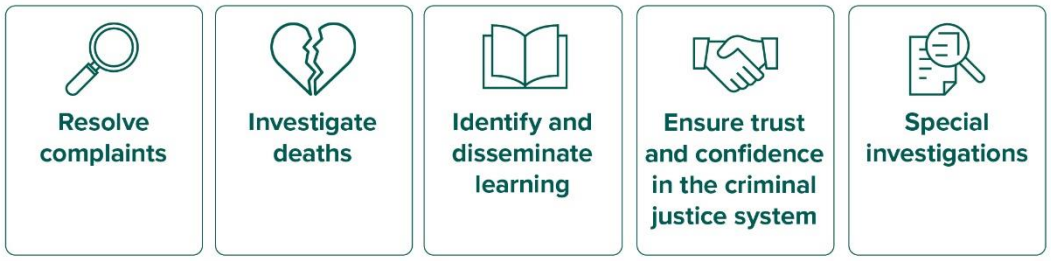
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Michael Brown died on 4 March 2023 of a stroke at HMP Leeds. He was 72 years old. We offer our condolences to Mr Brown's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Brown received at Leeds was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. The care provided to Mr Brown was of a good standard and we found no non-clinical issues of concern.

The Investigation Process

6. We were notified of Mr Brown's death on 4 March 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Brown's clinical care at HMP Leeds.

8. The PPO investigator investigated the non-clinical issues relating to Mr Brown's care, including Mr Brown's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Brown's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of our report.

10. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

11. We also shared the initial report with Mr Brown's sister. She did not identify any factual inaccuracies and expressed her thanks to prison and healthcare staff who had cared for Mr Brown.

Previous deaths at HMP Leeds

12. Mr Brown was the 32nd prisoner to die at Leeds since March 2020. Of the previous deaths, 17 were from natural causes, 12 were self-inflicted, one was from drugs, and one is awaiting classification. There are no similarities between our findings in the investigation into Mr Brown's death and our investigation findings for the previous deaths.

Key Events

13. On 10 December 2022, Mr Michael Brown was remanded to HMP Leeds for murder.

14. At the initial health screening, staff identified that Mr Brown had advanced dementia. Healthcare organised for Mr Brown to have a room on the prison healthcare unit, which could better support his needs. Mr Brown was referred to the mental health in-reach team for support with the symptoms of his dementia, which included confusion, aggression and difficulty holding conversations.

15. Mr Brown's reception screening identified several other existing medical conditions, including epilepsy (a common condition where sudden bursts of electrical activity in the brain cause seizures or fits), angina (chest pain caused by reduced blood flow to the heart muscles, and hypertension (high blood pressure). Mr Brown was also hard of hearing. Mr Brown took several medications for these conditions, which were re-prescribed on the day he arrived at Leeds. He was referred to social care, who provided a package to help with personal hygiene and ensure his cell was kept clean. Prison and healthcare staff created care plans to manage falls and to encourage and support Mr Brown with his daily living, recognising the need for 24-hour support.

16. Mr Brown ate very little and began to lose weight rapidly after arriving at Leeds. Healthcare staff monitored his food and fluid intake, encouraged him to eat and drink, and conducted regular malnutrition assessments, but this made little difference. Healthcare staff created a care plan to monitor Mr Brown's weight.

17. Healthcare staff quickly identified that a secure hospital would be a more suitable place for Mr Brown, whose dementia was difficult to manage in a prison environment. On 16 December, a prison psychiatrist made an urgent referral to Newton Lodge, a medium secure hospital in Wakefield. A doctor from Newton Lodge assessed Mr Brown on 19 December but deemed him not suitable. Mr Brown's medical records do not contain an assessment outcome.

18. On 16 December 2022, prison staff started Prison Service suicide and self-harm procedures, Assessment, Care in Custody and Teamwork (ACCT), after Mr Brown was seen with cuts on his wrist. Healthcare and prison staff were not sure if the cuts were deliberate. The ACCT was used primarily to manage Mr Brown's safeguarding needs arising from his dementia and was reviewed regularly by a multi-disciplinary team. A mental health nurse put up signs in Mr Brown's cell to help him identify his surroundings and added guidance for treating people with dementia to his ACCT document and medical notes.

19. On 3 January 2023, Mr Brown was assessed by a doctor from St Magnus low secure unit in Surrey. The same day, an officer noted that Mr Brown had a cut on the back of his head. Due to Mr Brown's confusion, he would not let healthcare staff dress it. In the evening, officers found Mr Brown on the floor of his cell, having fallen from his bed. Prison and healthcare staff called an ambulance, which arrived soon after and took Mr Brown to hospital. Hospital staff found that he had fractured his hip, which they operated on. Mr Brown's ACCT was closed on 12 January, during his stay in hospital.

20. On 2 February, St Magnus confirmed Mr Brown was suitable to move there once a bed became available. The next day, Mr Brown returned to prison where healthcare put close clinical observation in place.

21. On 8 February, because of his dementia and advanced health problems, a prison doctor made a clinical decision in Mr Brown's best interests, that resuscitation would not be appropriate in a critical cardiac or respiratory event.

22. Mr Brown was taken to hospital on 15 February after falling and receiving a cut above his eye. The hospital had no cause for concern and Mr Brown was returned to prison the same day.

23. Mr Brown's health began to decline rapidly after he returned from hospital. He was reviewed by the prison GP on 20 February and diagnosed with end stage dementia. The palliative care team made arrangements to ensure Mr Brown's care and comfort in the final stages of life.

24. A bed became available at St Magnus on 22 February, but there was a delay in the transfer while HMPPS considered reducing Mr Brown's security status.

25. On 28 February, healthcare staff determined that Mr Brown's condition had deteriorated so significantly that transfer to the secure hospital would cause him too much distress and pain. The transfer was cancelled.

26. On the same day, the Governor approved an open-door policy (a policy where the prisoner's cell door is open 24 hours a day) so that Mr Brown could more easily access the support and company of prison and healthcare staff.

27. In the early hours of 4 March, Mr Brown died.

Post mortem report

28. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Brown's cause of death as cerebral infarction (a loss of oxygenated blood to areas of the brain resulting in brain tissue destruction) caused by cerebrovascular atherosclerosis (blockages to the arterial blood supply to the brain). Vascular dementia (loss of normal brain function due to a lack of sufficient blood flow) was an underlying condition which contributed to but did not cause the death.

29. The inquest, held on 22 March 2023, concluded that Mr Brown died from natural causes.

Findings

30. Mr Brown was very unwell when he arrived at Leeds on remand. Staff quickly identified that the prison was not a suitable environment for a person with his considerable health needs, and in particular his advanced dementia which made prison a very challenging environment. Although their efforts to move him to a more suitable setting did not ultimately happen because of the abrupt decline in Mr Brown's health, prison and healthcare staff at Leeds did their best to accommodate his needs while he was there, and his requirements undoubtedly made demands on Leeds' staffing resources.

31. The clinical reviewer found that Mr Brown's clinical care at Leeds was equivalent to that which he could have expected to receive in the community.

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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