Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Burrows, a prisoner at HMP Leeds, on 15 May 2024

A report by the Prisons and Probation Ombudsman

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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

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Brian Burrows died in hospital on 15 May 2024, having been found hanged in his cell at HMP Leeds on 10 May. He was 43 years old. I offer my condolences to Mr Burrows' family and friends.

Mr Burrows was only in prison for six weeks before he took his own life. His main concern was a historical drug debt, which appeared to contribute to a deterioration in his mental health. My investigation found that staff missed opportunities to assess, communicate and manage Mr Burrows' risk of suicide and self-harm. They also failed to properly investigate Mr Burrows' claim that he was under threat or support him appropriately.

The clinical reviewer concluded that Mr Burrows' mental healthcare was not equivalent to what he could have expected to receive in the community as he never had a formal mental health assessment or a review of his medication despite being in crisis.

Mr Burrows' death was the fourth self-inflicted death in Leeds in a year and the thirteenth in three years. As a result, Leeds is being supported by the Yorkshire Prisons Group Regional Safety Team and the National Safety Team to improve the quality of ACCT management and support for those who feel at risk from others. This is much needed, and I hope has a positive, immediate impact on those being cared for at Leeds.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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Summary

Events

1. On 28 March 2024, Mr Burrows was sentenced to six months imprisonment for burglary and theft offences. He was sent to HMP Leeds. This was not his first time in prison. He was due to be released from custody on 13 May. He had a history of substance misuse, anxiety and depression. Mr Burrows was last monitored under prison suicide and self-harm procedures, known as ACCT, in 2010.

2. On 22 April, staff opened an ACCT after Mr Burrows cut himself as he said he was under threat due to an old drug debt. He was concerned about his mental health and said that he felt paranoid. Staff stopped ACCT monitoring the next day.

3. On 1 May, staff found Mr Burrows unconscious in his cell with a ligature around his neck. They opened an ACCT. Mr Burrows said that his actions were due to stress because of his historical drug debt. He again expressed thoughts of paranoia and said that he had started hearing voices. The nurse who treated Mr Burrows referred him to the mental health team. Staff found no evidence to support that Mr Burrows was under threat from other prisoners.

4. On 7 May, Mr Burrows made cuts to his arm twice in quick succession. Again, Mr Burrows said this was because he believed his safety was in jeopardy and he had heard threats against him. However, he wanted to remain on the same wing as he got on well with his cellmate. Staff increased his ACCT observations from once an hour to three times an hour.

5. On 9 May, staff asked Mr Burrows if he had the missing tie from his cellmate's laundry bag. Mr Burrows handed over the piece of string to staff, which he said he had resisted using to harm himself. Staff spoke to him but did not hold an ACCT review.

6. The next day at 1.52pm, Mr Burrows' cellmate left their cell to attend an appointment. At 2.43pm, an officer checked Mr Burrows and found him hanging from the bunk bed. Prison and healthcare staff provided emergency care. Paramedics arrived and took Mr Burrows to hospital. On 15 May, Mr Burrows died.

Findings

7. Mr Burrows had several risk factors for suicide and self-harm. He had a history of self-harm, substance misuse and anxiety and depression and appeared to experience paranoia. He had reported that he was also hearing voices. While staff placed more emphasis on Mr Burrows' belief that he was under threat due to his historical debt than his mental health, there was little investigation by prison or healthcare staff into either of these concerns.

8. Staff missed opportunities to adequately assess, communicate and manage Mr Burrows' risk. In particular, his first ACCT opened on 22 April, was closed prematurely after only one day, with the care plan actions not completed. No post-closure review took place as it should have done. When his ACCT was re-opened on 1 May, no mental health staff attended the review the next day and, despite

being referred for an urgent mental health assessment, this did not occur before he died. No ACCT review took place on 9 May, despite Mr Burrows handing over a cord that he said he had resisted using to harm himself. There were also some gaps in ACCT checks, most crucially for 51 minutes before Mr Burrows was found. We do not know when Mr Burrows hanged himself, but every minute is crucial in such life threatening situations.

9. The clinical reviewer found that Mr Burrows' physical care was equivalent to that he could have expected to receive in the community. However, they found that his mental healthcare was not equivalent. Mr Burrows should have had a formal mental health assessment and a review of his anxiety medication.

Recommendations

- The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure herself that there is not a systemic issue with false entries or missing checks.

- The NHS Commissioner should undertake a review of mental health referrals and assessments at HMP Leeds to assure themselves that prisoners are being assessed in a timely and appropriate manner.

- The Head of Healthcare should review the GP medication review waiting times and if a patient has had a number of incidents of self-harm, triage of their needs is undertaken, and an urgent medication review is facilitated.

The Investigation Process

10. HMPPS informed us of Mr Brian Burrows' death on 15 May 2024. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Burrows' prison and medical records, CCTV footage, phone records and body worn video camera (BWVC) footage. He also obtained the Ambulance Service records.

12. The investigator interviewed one prisoner and ten members of staff at Leeds in June 2024. He also interviewed a further three staff by video conference in July and August 2024.

13. NHS England commissioned a clinical reviewer to review Mr Burrows' clinical care at the prison. She and the investigator jointly interviewed staff.

14. We informed HM Coroner for West Yorkshire Eastern District of our investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's office contacted Mr Burrows' family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Burrows' family told us that Mr Burrows believed that his safety was in jeopardy due to a historic debt and that he would be harmed when he was released from prison. Mr Burrows' family also raised concerns about the breakdown in communication they experienced from HMP Leeds' family liaison officer. The Ombudsman discussed this with them directly and provided them with clarification. Leeds also addressed this matter with Mr Burrows' family directly.

16. Mr Burrows was also known as Mr Smith on prison records. Mr Burrows' family indicated that they would like him to be referred to as Mr Burrows in this report.

17. Mr Burrow's family received a copy of the initial report. They did not make any comments.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and this report has been amended accordingly.

Background Information

HMP Leeds

19. HMP Leeds is a local prison holding men who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health and substance misuse services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Leeds was in was in June 2022, which was followed up by a review of progress inspection in July 2023. From the initial inspection, it was reported that all incidents of violence were investigated but interventions that promoted changes in behaviour were limited. Challenge, support and intervention plans (CSIPs) were often developed without the involvement of the prisoner and targets were so broad that they lacked real purpose or clear outcomes. The mental health team worked closely with prison staff to make sure that those in urgent need or crisis received prompt support, with mental health practitioners available to participate in ACCT meetings.

21. The progress inspection reported that despite their previous concerns about the high number of prisoners who had taken their own lives, there had been a failure by leaders to make progress in reducing the rate of suicide, although the prison was making progress in some areas. Leeds had the second highest rate of self-inflicted deaths of any prison in England and Wales.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2022, the IMB reported that it considered Leeds prison to be a safe place for prisoners. However, they were concerned by the number of self-inflicted deaths which had occurred.

Previous deaths at HMP Leeds

23. Mr Burrows was the 28th prisoner to die at Leeds since May 2021. Of the previous deaths, 12 were due to natural causes, 13 were self-inflicted, one was drug related, and one is awaiting classification. Up to mid-October 2024, there had been one further self-inflicted death since that of Mr Burrows.

24. Of particular note is that there were three self-inflicted deaths between February 2024 and May 2024, of which Mr Burrows' was the third death. As a result, Leeds was identified as requiring additional support and monitoring from regional and national safety teams.

25. In previous investigations, we found that Leeds needed to improve their assessment and management of prisoners' at risk of suicide and self-harm. We

have also found that improvement was needed to mental health referral, assessment and treatment.

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

27. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Key Events

28. On 28 March 2024, Mr Brian Burrows attended court and was sentenced to six months imprisonment for burglary and theft offences. He was sent to HMP Leeds. This was not Mr Burrows' first time in prison. His earliest release date from custody was 13 May.

29. When he arrived, the Person Escort Record (PER – a document containing key information about a prisoner including their risk to themselves and others) that accompanied Mr Burrows indicated that he had no risks of suicide or self-harm, was not prescribed any medication and was not suffering from any alcohol withdrawal symptoms.

30. An officer completed Mr Burrows' reception screen interview. Mr Burrows told him that he was well accustomed to Leeds as he had been there before. The officer noted that Mr Burrows engaged well during his assessment and had no current thoughts of suicide or self-harm. Mr Burrows had last been monitored under suicide and self-harm procedures, known as ACCT, in 2010. The officer noted that Mr Burrows had said that a support worker for the Saviour Trust was his protective factor. Mr Burrows did not identify any emergency or next of kin contact details.

31. A nurse completed Mr Burrows' reception health screen. She noted that Mr Burrows kept falling asleep during the screening and had to be roused several times. Mr Burrows disclosed that he had anxiety and depression and was prescribed mirtazapine for these conditions. He said he had no thoughts of suicide or self-harm. She noted that Mr Burrows had a history of drug and alcohol misuse (he said he drank 18-24 cans daily) and tested positive for buprenorphine (a synthetic opioid often used to treat opioid addiction), cocaine and opiates. Mr Burrows confirmed that that he had taken crack cocaine and heroin prior to arriving in police custody that morning. He was under the care of the community drugs team and had been prescribed Espranor (a buprenorphine wafer which rapidly dissolves on the tongue), which he said he had last taken the day before. She contacted Mr Burrows' community pharmacy who confirmed this. She referred Mr Burrows to the substance misuse team.

32. An advanced nurse practitioner (ANP) saw Mr Burrows later that evening and noted his mental health and drug history and that he had no thoughts of suicide or self-harm. She noted that Mr Burrows had a history of abscesses in his leg muscle and was prescribed pregabalin (used to treat neuropathic pain). His left thigh was red and swollen. The nurse diagnosed Mr Burrows with cellulitis (a skin and tissue infection) and prescribed an antibiotic. Mr Burrows was also prescribed Espranor, pregabalin, and mirtazapine. She referred Mr Burrows to the substance misuse team, as well as the GP to review his leg. She noted that Mr Burrows' Espranor medication would be withheld that day, due to his presentation. Mr Burrows collected his medication from the following day.

33. An officer conducted Mr Burrows' induction interview. He had no concerns about Mr Burrows, and he was moved to D Wing, the Induction Wing.

34. On 29 March, a GP assessed Mr Burrows and concluded that he displayed no signs of alcohol withdrawal and should be monitored by the substance misuse team.

35. On 2 April, a recovery worker from the substance misuse team assessed Mr Burrows, primarily because he was prescribed opioid substitution therapy (OST) medication. She told us that she had no concerns about Mr Burrows' presentation, and he engaged positively. Mr Burrows said that he would like counselling. She agreed to refer him to the chaplaincy team. She created a care plan which noted that the substance misuse team would review Mr Burrows every six weeks.

36. On 3 April, Mr Burrows told a member of the resettlement team that when he was released, he hoped to return to his previous accommodation provided by the Saviour Trust. The resettlement officer noted that Mr Burrows would also be referred to the community drugs team.

37. On 10 April, Mr Burrows called the support worker. She told us that Mr Burrows said he was okay and was counting down the days to his release. He had asked her to send him some money so that he could purchase items from the prison shop, which she did. On 12 April, Mr Burrows moved to A Wing, a standard wing.

38. At 8.18pm on 14 April, Mr Burrows phoned the support worker and left a voicemail. He said that there was another prisoner on the wing that he had had trouble with over 20 years ago. He said that prison staff planned to let this prisoner out of his cell that night to hurt him. Mr Burrows said that he was just letting her know in case something happened to him. The next day, 15 April, Mr Burrows moved to B Wing, a standard wing. This was a coincidental move and not connected to Mr Burrows' fears.

39. On the same day, staff submitted an intelligence report (IR) noting that there was a possibility that Mr Burrows was under threat from an identified prisoner because of a debt gained in the community years ago. The debt involved a substantial amount of money (the exact figure was not noted). The report noted that Mr Burrows had not been in custody since 2017 and, so far, the information reported was uncorroborated (we surmised that Mr Burrows had provided the intelligence himself). It noted that Mr Burrows would be moved to E Wing and a challenge, support, and intervention plan (CSIP) referral was submitted. (Individuals at risk of violence in prisons may be supported through a CSIP.)

40. On 16 April, Mr Burrows moved to E Wing. Staff concluded that CSIP procedures were not necessary as they hoped that Mr Burrows would no longer feel under threat. There is no record that staff discussed this with Mr Burrows. It was also confirmed that he would be released on 13 May.

41. On E Wing, Mr Burrows shared a cell with a cellmate. The cellmate told us that when Mr Burrows arrived, he was anxious, crying and disclosed that he owed another prisoner a debt from "ten years ago".

42. On 18 April, Mr Burrows attended a video-link appointment with his community offender manager (COM). Afterwards, Mr Burrows told staff that he had no concerns. An officer checked on Mr Burrows in the afternoon. He said that he was fine and had no problems. During the evening routine check, Mr Burrows again raised no concerns to staff.

43. On 19 April, a Custodial Manager (CM) from the Safer Custody Team emailed the E Wing manager and asked him to check Mr Burrows because he had previously

reported feeling under threat. Staff checked on Mr Burrows and had no concerns about him.

44. On 22 April, an officer spoke to Mr Burrows at his cell to follow up on concerns that had been raised by the CM. Mr Burrows told the officer that he had no current thoughts to harm himself, but his mood was low. He said he got on well with his cellmate and this helped him. The officer noticed that Mr Burrows had a wound on his arm. Mr Burrows said that it was an old wound that he thought may have got infected. The officer agreed to get a member of the healthcare team to see him. He was also Mr Burrows' allocated key worker and said he would arrange a key worker session with him soon and reminded him of the support available to him in the prison. Mr Burrows said that he would tell staff if he had any concerns.

45. On the same day, a prison offender manager (POM) opened an email that had been sent to him four days earlier (on 18 April), from Mr Burrows' COM. (He worked part-time and so saw the email on his return to duty.) The COM's email noted that he had just completed a video-link meeting with Mr Burrows, at which he had disclosed that he was under threat in prison due to a historic drug debt. Mr Burrows refused to identify the alleged perpetrator(s) but stated that they had made serious threats of violence towards him, and that he would be assaulted if he was not relocated. Mr Burrows had showed his COM self-inflicted cuts that he had made to his arm two days previously. He said that he had seen a member of the healthcare team but believed that he should be monitored under ACCT procedures. The COM requested that the POM pass this information onto prison staff. The investigator found no evidence in Mr Burrows' medical record that he was seen by any member of the healthcare team in relation to self-inflicted cuts.

46. The POM went to E Wing and spoke to Mr Burrows. Mr Burrows said that the threat against him had followed him to E Wing. He said his mood was low and he wanted to apply for Vulnerable Prisoner (VP) status. The POM spoke to the E wing manager, and they agreed to start ACCT procedures.

47. A Supervising Officer (SO) completed the ACCT immediate action plan. Mr Burrows said he had no current thoughts of suicide or self-harm. The SO set ACCT observations at once per hour with staff required to have three conversations with Mr Burrows each day. Another SO was allocated as the ACCT case manager.

48. An officer gave Mr Burrows a VP application form to complete. Staff noted that Mr Burrows would remain in his shared cell on E Wing and had access to Listeners and an in-cell phone.

49. An officer spoke to Mr Burrows and completed a key work session with him and further explained the ACCT process. Mr Burrows said he understood and raised no further concerns.

50. On the morning of 23 April, an officer completed Mr Burrows' ACCT assessment with him. Mr Burrows spoke about his mental health and said that he felt paranoid. Despite taking his medication (for anxiety), he felt that he was "on edge" all the time. He attributed this to his drug debt from 20 years ago. Mr Burrows said he had no thoughts of suicide or self-harm. He disclosed that when he had self-harmed the previous week, he had done so because he had moved wings and was worried about his drug debt. Prior to this, he said he had last self-harmed ten years ago, in

the community. He wanted to be relocated to the VP Wing or in a single cell. It was noted that a member of the mental health team should attend his first ACCT review.

51. Afterwards, the ACCT case manager chaired an ACCT review with a mental health nurse and Mr Burrows. An officer provided a verbal input beforehand. Mr Burrows said that he had been approached by a prisoner on A Wing about his drug debt. He was vague about this incident and gave no details. While he stated that he had not had any similar issues on E Wing, he was not comfortable leaving the wing and therefore would not be able to be assigned a prison job. He said he preferred to stay in his cell where he felt safe, watching television. While Mr Burrows had applied for VP status, the case manager explained that it was unlikely that his request would be approved because he did not meet the criteria to be relocated onto this wing. The case manager agreed to provide Mr Burrows with in-cell distraction packs.

52. Mr Burrows also said that he did not think his medication was effective as he felt more anxious. He said that he had self-harmed to release stress and used this a coping mechanism, something he had done for many years. However, he said he had no current thoughts to harm himself. A nurse agreed to refer Mr Burrows to the GP to review his medication. Staff noted that Mr Burrows showed very clear future planning throughout their interview as he talked about his upcoming release on 13 May and the accommodation he had waiting for him. Mr Burrows also said he was supported by his mother and support worker in community. The review panel agreed that ACCT monitoring would be stopped. The ACCT care plan noted that Mr Burrows' VP application had been submitted and he had been referred to the GP for a medication review. These were the only two actions on Mr Burrows' care plan.

53. Mr Burrows' ACCT was placed into a post-closure period whereby he should have been checked daily for seven days with a post-closure review taking place on the seventh day. Staff did not complete these checks or the post-closure review.

54. On 26 April, Mr Burrows phoned the support worker. Mr Burrows said he was okay, got on well with his cellmate and asked for a further loan of money. She agreed to send this to him.

55. On 30 April, Mr Burrows phoned the support worker. Mr Burrows told her that he was worried that prisoners were talking about him and would hurt him by throwing hot water over him. He also spoke about his release accommodation. She contacted Mr Burrows' COM and raised Mr Burrows' concerns. Mr Burrows' COM assured her that she had recently raised her concerns about Mr Burrows and staff had opened an ACCT (she was not aware ACCT monitoring had ended).

56. The next morning, an officer told us that he spoke to Mr Burrows, who was in a jovial mood, and they shared a few jokes, along with his cellmate.

57. That afternoon, the cellmate returned from work at 4.00pm. When he got to his cell and looked through the observation panel, he saw Mr Burrows lying on the floor in an unnatural position. As the cell door was locked, he alerted an officer. The officer attended the cell and found Mr Burrows unconscious with a strip of bedding material tied around his neck and attached to the bed rail on the top bunk. He radioed a code blue (used when a prisoner is unconscious or has breathing difficulties). He used his anti-ligature knife to cut the ligature from Mr Burrows' neck. Upon doing

this, Mr Burrows took a sharp intake of breath and regained consciousness. A nurse attended, took over Mr Burrows' care and treated him. An ambulance, which had been called, was cancelled. The nurse referred Mr Burrows to the mental health team by sending an urgent task email on the medical system.

58. The officer reopened Mr Burrows' ACCT. Mr Burrows was crying and attributed his actions to his historical drug debt of £100. He told staff that he did not want to kill himself but saw no other way out of his current situation. The cellmate told staff that he had not seen or heard any evidence that Mr Burrows was under threat. Mr Burrows also said that he had recently started hearing voices which had got worse, and he had no vapes. The officer provided Mr Burrows with a packet of vapes.

59. A SO completed the ACCT immediate action plan and placed Mr Burrows on four observations an hour. For the remainder of the evening, staff raised no concerns about Mr Burrows. When an officer checked Mr Burrows at around 7.00pm, Mr Burrows said that he regretted his earlier actions as it could have been sorted out with a conversation.

60. At 9.40am on 2 May, the ACCT case manager chaired an ACCT review with a member of the offender management unit (OMU) attending. No healthcare staff attended. The case manager noted that he had invited the OMU member to attend to address any concerns Mr Burrows had about his release. Mr Burrows said that despite tying the ligature, he had not wanted to hurt himself or die and his actions were a cry for help. He said he had built up stress because of his debt issue. He said he felt much better now that he had spoken to staff and had now chosen to self-isolate (not take part in the prison regime and remain in his cell). He said he would continue to collect his medication, but staff agreed he could shower alone. The case manager said that he would ensure E Wing management were aware of this and added this as an action on the ACCT care plan. Mr Burrows said he got on well with his cellmate.

61. The case manager noted that Mr Burrows had been informed (no date) that his VP application had been declined (because the VP Wing was full). They discussed whether he could move to the VP Wing overflow cells, located on E Wing 5s landing but concluded he might be targeted by other prisoners if they identified him as a VP. Staff felt his current location was the best place for him. The case manager noted that Mr Burrows appeared paranoid that people might harm him in the community when he was released. Mr Burrows said he intended to take a taxi home rather than public transport. The case manager scheduled an ACCT review for 13 May and said that his POM would also see him before he was released. Staff reduced Mr Burrows' ACCT observations to one per hour.

62. Mr Burrows later collected his medication and had a shower. He told an officer that he felt much better and apologised for his previous actions. He said that he had no current thoughts to harm himself and was looking forward to being released from prison.

63. At 10.20am, the duty mental health nurse (who monitors the mental health email inbox), triaged a nurse's urgent referral. She noted that Mr Burrows had been referred to the mental health team because he had tied a ligature and was hearing voices (which met the criteria for an urgent referral). However, she assumed that a

mental health nurse had attended Mr Burrows' ACCT review to assess him and therefore took no further action.

64. The cellmate told us that the closer Mr Burrows got to his release, the more anxious he got and the more voices he said he heard. He said that he had not heard anyone threaten Mr Burrows and neither had he heard any rumours that his safety was in jeopardy because of a historical drug debt. Mr Burrows had told him that he believed his head was playing games with him.

65. Between 3 May and 6 May, staff raised no concerns about Mr Burrows. While Mr Burrows had told staff that he preferred to remain in his cell, he continued to leave his cell to collect his meals and medication.

66. At 1.59pm on 6 May, Mr Burrows phoned the support worker. Mr Burrows told her that he would not get out of prison because he would be stabbed. She asked Mr Burrows for more information about why he believed this. Mr Burrows said that he just knew he would, and it was the person that he had trouble with 20 years ago. He said that he was being monitored by ACCT procedures, but staff had not been checking him. He ended the call by saying that he would not be getting out of prison. She contacted the prison to raise concerns about Mr Burrows.

67. As a result, an officer spoke to Mr Burrows. Mr Burrows said that although he was in debt to one prisoner, it felt as if it was the whole wing, as the prisoner had a lot of influence. Mr Burrows said he intended to keep himself to himself until his upcoming release date, after which he believed that the debt would no longer be a problem. While he said that his mental health could be better, Mr Burrows said he had no thoughts of suicide or self-harm.

68. On 7 May at 8.30am, an officer radioed an emergency code red after he had responded to Mr Burrows' cell bell and found that he had self-harmed by cutting his arm. A nurse attended and treated his wounds. Mr Burrows refused to engage with staff. Staff increased his ACCT observations to two per hour. At 9.15am, when checked by the officer, Mr Burrows had reopened his wounds. The nurse again attended to treat him.

69. A Custodial Manager (CM) chaired an ad-hoc ACCT review in Mr Burrows' cell, in response to his self-harm. The officer attended. (The nurse told us that she was present but only to treat Mr Burrows' wounds and did not contribute to the ACCT review). Mr Burrows told the CM that he had self-harmed due to his historic drug debt. He believed others were talking about him on the wing, and despite the officer's attempts to reassure him that this was not the case, Mr Burrows was adamant that he had heard threats against him. When asked if he wanted to move to another wing, Mr Burrows said he wanted to remain on E Wing as he got on well with his cellmate. He said he would stay in his cell until his release in six days' time. The CM noted that Mr Burrows gave staff his razors and said he had no current thoughts of suicide or self-harm. He noted that Mr Burrows had a positive rapport with the officer and his cellmate, who would both help to support him. He increased Mr Burrows' ACCT observations to three per hour with staff required to have three conversations with him each day. Staff documented this review in his prison computer records but not in his ACCT document.

70. On 8 May, staff noted that Mr Burrows' mood appeared to be better. He left his cell to collect his medication and took a shower. In the evening, the officer on duty noted in Mr Burrows' ACCT log that he was unable to check him regularly between 5.47pm and 6.21pm due to staff resources.

71. The next day, 9 May, staff described Mr Burrows' mood as low and lethargic. In his statement, Officer A noted that Mr Burrows was polite when he interacted with him but seemed disinterested. With some encouragement from the officer, Mr Burrows mixed with other prisoners outside his cell.

72. That afternoon, the cellmate told Officer A that the tie string from his laundry bag was missing. The officer asked Mr Burrows (he was outside his cell on the landing at the time) if he had taken the string and had it in his possession. Without hesitation, Mr Burrows produced the string from his pocket and handed it over to the officer. The officer described Mr Burrows' actions as very "nonchalant" and so took Mr Burrows to the wing office to have a private conversation with him.

73. Officer A noted that Mr Burrows was not very forthcoming, but he did engage in conversation. Mr Burrows denied that he had intended to harm himself with the string and said although his mood was low, he had no thoughts to harm himself and talked enthusiastically about this release. He said that his concerns centred around an unpaid drug debt, accumulated in HMP Wealstun, around six years ago. He said that no one had threatened him or even mentioned the debt since he had been at Leeds (this statement was in contradiction to what Mr Burrows had previously said multiple times about the debt) and he did not think that there was anyone currently on E Wing that was from Wealstun. The officer offered Mr Burrows reassurances about his safety on the wing. While Mr Burrows had not expressed that he had any current thoughts of suicide or self-harm and he showed some future planning, the officer was still concerned about him and spoke to a SO.

74. The SO spoke to Mr Burrows, who said that he was looking forward to being released from prison, was positive and intended to return to Wakefield and spend time with his family. Mr Burrows talked about his history of self-harm and admitted that, on this occasion, he had managed to control himself and had handed over the string to Officer A before wanting to harm himself. Mr Burrows said he had no current thoughts of suicide or self-harm. The SO noted that Mr Burrows clearly showed future planning and presented with no increased risk at the time. He decided his ACCT observations should remain at three per hour. He reminded Mr Burrows of the support available to him. After the meeting, Mr Burrows collected his evening meal.

Events on 10 May

75. On 10 May, during the morning routine check and ACCT checks, staff raised no concerns about Mr Burrows. At 8.02am, CCTV shows staff unlocked Mr Burrows' cell to allow the cellmate to leave and attend work. At 8.26am, Officer B unlocked Mr Burrows for exercise. Mr Burrows left his cell and went onto the exercise yard. Staff noted that Mr Burrows did not interact with anyone else while he was there.

76. At 9.16am, Mr Burrows left the exercise yard and collected his medication from the medication hatch. Between 9.21am and 10.32am, Mr Burrows was on the wing landing, watching other prisoners at the pool table. During this time, Officer C spoke

to Mr Burrows twice to check how he was. He told Mr Burrows that it was nice to see him out of his cell and asked him if he was looking forward to his release from prison in three days' time. Mr Burrows said that he was and wanted to get away "from the system". The officer had no concerns about Mr Burrows.

77. At 10.32am, Mr Burrows returned to his cell. Officer B had a brief conversation with Mr Burrows before locking his cell door. Mr Burrows said he was okay and started to watch television.

78. The cellmate returned to the cell at 11.25am. At 11.49am, an officer unlocked Mr Burrows to collect his lunch and he returned to his cell three minutes later. Staff completed appropriate ACCT checks until 12.26pm.

79. While CCTV shows an officer attended Mr Burrows' cell to conduct ACCT checks at 12.59pm and 1.25pm, he recorded in the ACCT log that he had checked him three times, at 12.59pm, 1.15pm and 1.32pm. At interview, the officer told us that this was a genuine mistake.

80. At 1.32pm, Officer B went to Mr Burrows' cell and unlocked the cellmate so that he could attend a visit. She saw Mr Burrows and had no concerns about him. The cellmate said that when he left the cell, Mr Burrows was just staring into a cup of coffee he had made. This was not unusual behaviour for him.

81. At 1.52pm, Officer B did an ACCT check on Mr Burrows. Mr Burrows was sat in his chair, and she recorded no concerns about him. This was the final ACCT check carried out before Mr Burrows was found unresponsive.

Emergency response

82. At 2.43pm, Officer D went to Mr Burrows' cell to do an ACCT check. When he looked through the observation panel, he saw Mr Burrows slumped by the side of his bed face down, with a shoelace tied around his neck and around the top bunk bed. He opened the cell door and radioed a code blue at 2.44pm. Staff in the control room called an ambulance immediately and instructed healthcare staff to go to Mr Burrows' cell. He cut the shoelace with his anti-ligature knife and removed it from Mr Burrows' neck. Officer C arrived, and they laid Mr Burrows on the floor.

83. Mr Burrows showed no signs of life. Officer C started cardiopulmonary resuscitation (CPR) and rotated this with Officer D and another officer who had arrived.

84. A nurse arrived within three minutes of the code blue call, followed by further healthcare staff a minute later. She checked Mr Burrows for signs of life and took over his care, continuing chest compressions with the aid of emergency equipment that had been brought to the cell.

85. The first paramedics arrived at 2.48pm and took over the care of Mr Burrows. The paramedics had already been on site at Leeds dealing with another emergency incident. After approximately 30 minutes of CPR, the paramedics established a pulse and took Mr Burrows to hospital.

86. At 5.10am on 15 May, the hospital confirmed that Mr Burrows had died.

Contact with Mr Burrows' family

87. After Mr Burrows was transferred to hospital on 10 May, the prison appointed a family liaison officer (FLO). As Mr Burrows had not identified any recorded next of kin, the FLO liaised with the offender management unit and the police liaison officer and got the contact details for Mr Burrows' mother. The FLO phoned Mr Burrows' mother to inform her that Mr Burrows was in hospital. She met his mother and other family members at the hospital.

88. On 13 May, a SO and FLO visited Mr Burrows in hospital and spoke to his family. They issued Mr Burrows' family with his release from custody documents. Mr Burrows' family informed them that it was unlikely that Mr Burrows would recover.

89. Due to unforeseen personal issues, the FLO had to step down from FLO duties around a week after Mr Burrows' death. Mr Burrows' sister said that she had last spoken to the FLO around 22 May, when she had returned some of Mr Burrows' personal belongings. After this, Mr Burrows' sister said she made several unsuccessful attempts to contact the FLO and the prison.

90. Another FLO took over the role on 31 May. On this day, she contacted Mr Burrows' sister and apologised for the delay that had occurred in contacting her. Mr Burrows' family provided the contact details of the funeral directors and questioned why the family had not received all of Mr Burrows' personal property back yet, which included letters that the family said they had sent him. The FLO agreed to look into this. She had further contact with Mr Burrows' sister on 3 June, 5 June, 10 June and 12 June. She told the family that some of Mr Burrows' property had been located. She confirmed that that she had contacted the funeral directors and that the prison would contribute towards the cost of Mr Burrows' funeral in line with national policy. She also informed Mr Burrows' family that she was due to take some leave and another FLO would take over FLO duties. She informed the family that the other FLO was on leave until 16 June and would be in touch after this. This did not happen.

91. On 20 June, the Prisons and Probation Ombudsman contacted Mr Burrows' sister (as is routine with all self-inflicted deaths). Mr Burrows' sister raised concerns about the inconsistent family liaison they had received from Leeds. The Ombudsman raised this with the prison. As a result, the Head of Safety visited Mr Burrows' family on 1 July at their home. He apologised that the prison had not fulfilled its obligation of keeping in contact with the family following Mr Burrows' death. He gave them Mr Burrows' outstanding property and answered the family's questions.

Support for prisoners and staff

92. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

93. After Mr Burrows' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

94. The prison posted notices informing other prisoners of Mr Burrows' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Burrows' death. They also deployed Listeners to the wing to offer support to prisoners when Mr Burrows died.

Post-mortem report

95. The pathologist gave Mr Burrows' cause of death as hypoxic ischaemic encephalopathy (damage to the brain due to loss of blood supply) caused by hanging. No toxicological analysis was undertaken.

Findings

Assessment and management of risk of suicide and self-harm

96. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

97. When Mr Burrows arrived at Leeds, he had a number of significant risk factors for suicide and self-harm: he had a history of self-harm, mental health issues (depression and anxiety) and a history of substance misuse.

98. Throughout his short time at Leeds, although Mr Burrows had self-harmed on more than one occasion (most seriously by tying a ligature around his neck which caused him to be unconscious), he told staff that he had no thoughts to take his own life. However, he remained highly anxious about a real or perceived risk to his safety from an unnamed prisoner to whom he said he owed a historical drug debt. He also sometimes said that he was concerned about his safety when he was released. We found no evidence that this perceived threat was real, though it is evident that Mr Burrows experienced a deterioration in his mental health because of this. It is also striking that he took his own life three days before he was due to be released.

ACCT opened on 22 April 2024

99. Mr Burrows was supported under ACCT procedures on two separate occasions. Firstly, we have concerns about how the ACCT was managed when it was opened on 22 April. Mr Burrows had self-harmed (four days earlier by making cuts to his arm) and stated that he felt under threat due to a historic debt and wanted to apply for VP status. ACCT monitoring was subsequently stopped the next day.

100. PSI 64/2011 states that an ACCT can be closed when the risk of harm has been reduced to a level where it is no longer considered raised, and all support actions have been achieved. Mr Burrows' care plan actions had not been completed when the ACCT was closed. His application to relocate to the VP Wing was still outstanding and he had not yet seen the GP for a review of his anxiety medication.

101. We consider that the ACCT was closed prematurely. Mr Burrows had a history of self-harm, anxiety and depression and was prescribed antidepressant medication. The issues that had caused him to self-harm in the first place still existed and very little appeared to be known about his alleged debt issue.

102. PSI 64/2011 also states that after the closure of ACCT procedures, a post-closure review should be held. This review should take into consideration how the prisoner is feeling, their access to support and their progress since ACCT monitoring stopped. The first post-closure review must be completed as soon as is practically possible following a seven-day post-closure monitoring period, and a seven-day post-closure monitoring form must be completed during this time (and up until the post-closure review takes place).

103. Staff did not complete any daily checks or the seven-day review. Had staff done this, they may have identified that Mr Burrows' concerns still existed and appeared to have exacerbated. This was a missed opportunity.

ACCT re-opened on 1 May 2024

104. ACCT procedures were appropriately re-opened on 1 May when Mr Burrows tied a ligature around his neck and stated that he was hearing voices. At the ACCT review that took place the next day, no one from the general or mental healthcare teams was invited to attend. This is not in accordance with PSI 64/2011.

105. At interview, the ACCT case manager, the ACCT case manager stated that he would not have invited the mental health team as Mr Burrows' issues related to a historic debt and his release from prison, and not his mental health. Mr Burrows had made a serious attempt to take his life the previous day, and he had also reported that he was hearing voices. The case manager told us that he was unaware that Mr Burrows had reported that he was hearing voices, despite this information being recorded on prison and healthcare records when the ACCT was reopened. This was a missed opportunity to address Mr Burrows' mental health concerns and for a member of the mental health team to have been present during the review.

106. At the review on 2 May, staff set the date for the next review as 13 May. Given that Mr Burrows had been found unconscious the day before, we consider that the amount of time between reviews was too long. This is an issue we have previously raised with Leeds. In addition, 13 May was the day Mr Burrows was due to be released and we consider it would have been prudent to hold a review ahead of his release to see how he was feeling and also so that the review was not time pressured due to his impending release.

107. On 9 May, Mr Burrows was found in possession of a cord that he handed over to staff when asked. Two members of staff spoke to him individually. He told the first, that he had not taken the cord to harm himself but gave a different account to the second saying that he had managed to control his urges to harm himself with it. This, in itself, should have raised staff suspicion suggesting Mr Burrows was not always entirely honest with them about his plans to harm himself. We accept that Mr Burrows presented as positive and was planning for the future. However, staff should have held an urgent ACCT review to properly assess whether Mr Burrows' risk to himself had increased. This is particularly in light of the ligature he had tied eight days earlier which had caused him to be unconscious. Staff were overly reliant on Mr Burrows' presentation and what he said rather than considering all his risk factors.

108. PSI 64/2011 states that during ACCT reviews, staff should discuss and identify potential sources of support with the prisoner. Sources of support can include any person or services that the prisoner can use and speak to, to help them keep safe and can include staff members (such as chaplaincy) peer support, or outside support (such as family, friends or guardians). Leeds should have considered whether they could have involved the support worker in the ACCT process, as a source of support for Mr Burrows, and to be involved in his care. This was a missed opportunity.

ACCT observations and record keeping

109. We found several omissions in the completion of Mr Burrows' ACCT documentation which included:

- No information relating to Mr Burrows' risk, triggers and protective factors when the ACCT was reopened on 1 May;
- On 3 May, no supervisor check recorded and no observations recorded between 4.00pm and 5.00pm;
- On 4 May, no evening summary/conversations recorded;
- No details recorded of the ACCT review that took place on 7 May in the ACCT document.
- On 8 May, no checks recorded between 5.47pm and 6.21pm (noted as due to short staffing) and no checks recorded between 8.00pm and 9.00pm; and
- On 10 May, an ACCT entry between 12.59pm and 1.32pm appeared to be falsified and no observations recorded from 1.52pm and 2.43pm (when Mr Burrows was found unresponsive) - a 51 minute gap between checks, despite Mr Burrows being on three checks an hour.

110. PSI 64/2011 states that ACCT observations and conversations must be documented immediately after they take place. We referred the issue of falsified ACCT checks to the police. They are currently considering whether to investigate further this and concerns about missing ACCT checks from previous deaths. The missing/falsifying of ACCT checks are also the subject of an ongoing internal investigation. Given that we have identified inconsistencies with staff completing ACCT checks, we make the following recommendation:

The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure herself that there is not a systemic issue with false entries or missing checks.

Action taken since Mr Burrows' death

111. Since the self-inflicted deaths of three prisoners (including Mr Burrows) in a matter of weeks in 2024, Leeds has introduced various measures to improve the quality of ACCT management. These include increased risks and triggers training and additional suicide and self-harm training for prison staff. A new ACCT quality assurance process was developed in May 2024 to better identify and manage individuals' risks and identify staff who need support.

112. Leeds has also introduced a detailed project plan which highlights all recommendations from early learning reports, PPO reports and actions identified internally by the prison as risks. This is then used to record progress against actions and evidence quality checks of all safety related processes. The Yorkshire Prisons Group Regional Safety Team and the National Safety Team have also provided more extensive guidance and resources to support the Leeds' safer custody team. While we make no recommendation to reflect the ongoing work at Leeds, we are

concerned that Leeds received additional support after a high number of deaths in 2023 and many of the same issues have been identified in this investigation.

Challenge, Support and Intervention Plans (CSIP)

113. Individuals at risk of violence in prisons may be supported through a CSIP. CSIP referrals were mentioned three times in Mr Burrows' records, on 15 April, 18 April and 22 April, but he was not monitored under CSIP processes while at Leeds. While initially it was felt that a move to a new wing would have resolved or at least reduced the fear of his safety, Mr Burrows later told staff that the debt had followed him to E Wing.

114. We found little evidence that staff conducted a thorough investigation to validate or determine the extent of this threat and identify a set of actions that could have been taken to reduce any risk of violence towards Mr Burrows or make him feel supported. The Head of Safety and the Yorkshire Prisons Group Regional Safety Team identified this as an issue in their Early Learning Review. As a result, the prison has introduced a more robust quality assurance process of CSIPs and has educated staff about the need for thorough CSIP investigations and plans. We therefore make no recommendation.

Clinical care

115. The clinical reviewer found that the physical healthcare that Mr Burrows received was equivalent to that he could have received in the community. However, they found that the mental healthcare received by Mr Burrows was not of an acceptable standard and was not equivalent to that which he could have expected to receive in the community.

Referrals to the mental healthcare team

116. After Mr Burrows was found unconscious with a ligature around his neck on 1 May, a nurse made an urgent referral for him to be assessed by the mental health team. This was sent via an urgent red flag task to the mental health team email inbox, which is reviewed daily by the duty mental healthcare worker. The urgent referral was considered by a nurse on 2 May. However, Mr Burrows was not assessed by the mental health team before he died and no one from the mental health team attended Mr Burrows' ACCT review on 2 May.

117. The Head of Healthcare told us that ACCT case managers should tell the mental health team about ACCT assessments and reviews. The safer custody and mental health teams then jointly agree which reviews mental health staff will attend. This did not happen for Mr Burrows because the SO had made that assumption that his issues related to his impending release from prison and not his mental health.

118. Irrespective of this, the urgent red flag task should have triggered an urgent mental health assessment for Mr Burrows, due to the ligature incident on the 1 May. However, the nurse who triaged the referral assumed that a senior mental health nurse had been allocated to attend Mr Burrows' ACCT review. The Head of Healthcare told us that, following the ACCT review, Mr Burrows should then have been seen for an individual mental health assessment.

119. The Head of Healthcare told us that following Mr Burrows' death, the healthcare team reviewed the urgent referral process and set up a system to avoid this error happening again and to improve healthcare's attendance at ACCT reviews. However, we are concerned that following two self-inflicted deaths in 2023, we found that prisoners' mental health was not assessed appropriately. We were assured by the healthcare provider at the time that they had taken action to prevent this from re-occurring, yet the following year Mr Burrows died, again without a vital assessment by the mental health team. We make the following recommendation:

The NHS Commissioner should undertake a review of mental health referrals and assessments at HMP Leeds to assure themselves that prisoners are being assessed in a timely and appropriate manner.

Referral to the GP

120. Following the ACCT review on 23 April, Mr Burrows was referred to the GP for an appointment for a medication review as he stated his medication for his anxiety and depression was not effective. At interview, healthcare staff told us that there was a wait of up to six weeks for a GP appointment. As Mr Burrows was due to be released from prison on 13 May, his medication review would not have occurred before this date. This is very concerning as, despite Mr Burrows self-harming on four occasions (one of which included using a ligature), there appeared to be no effort made to bring forward his GP appointment as urgent to review his medication. We make the following recommendation:

The Head of Healthcare should review the GP medication review waiting times and ensure that, if a patient has self-harmed, a triage of their needs is undertaken, and an urgent medication review is considered and facilitated where necessary.

Family liaison

121. No FLO support was available to Mr Burrows' family between 22 May and 31 May and from 12 June to 30 June. During this time, Mr Burrows' family were trying to get information about arrangements for his funeral and had outstanding queries. There was also a delay of over six weeks before all of Mr Burrows' personal property was returned.

122. The inconsistent FLO support provided to Mr Burrows' family was due to an unfortunate set of individual circumstances as well as a shortage of fully trained FLO staff. Since Mr Burrows' death, Leeds has increased the number of trained FLOs they have so that a back-up FLO is always allocated following a death. They have also set up a new central FLO communication system where information, including FLO logs of contact, can be shared, so that information is more readily accessible. We also note that the Head of Safety personally met with Mr Burrows' family to apologise for the service they had received. Given the actions already taken to provide effective and consistent support for bereaved families, we make no recommendation.

Inquest

123. An inquest was concluded on 1 September 2025, that the cause of Mr Burrow's death was from hypoxic ischaemic encephalopathy (damage to the brain due to loss of blood supply) caused by hanging.

124. The coroner concluded the circumstances of Mr Burrow's' death was due to suicide.

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