

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Leach, a prisoner at HMP Ashfield, on 10 October 2023

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



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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 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.
3. On 29 April 2021, Mr David Leach was sentenced to eight years in prison for sexual offences.
4. He died of metastatic hepatocellular carcinoma (liver cancer which spread to other parts of the body) on 10 October 2023 while a prisoner at HMP Ashfield. He was 85 years old. We offer our condolences to Mr Leach's family and friends.
5. The PPO family liaison officer contacted Mr Leach's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
6. NHS England commissioned an independent clinical reviewer to review Mr Leach's clinical care at HMP Ashfield.
7. The clinical reviewer concluded that the clinical care Mr Leach received at Ashfield was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Leach's care was well documented, and staff were mindful of his needs leading up to, and during the terminal phase of his illness. The clinical reviewer made recommendations not related to Mr Leach's death that the Head of Healthcare will wish to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Leach's care. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. Oxleas NHS Foundation Trust pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer, who amended their report.
11. At the inquest held on 29 May 2024, the coroner concluded that Mr Leach died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

April 2024

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