Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald McKean, on 28 May 2023, following his release from HMP Leeds

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

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 detained people 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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

4. Mr Donald McKean died from pneumonia in hospital on 28 May 2023, following his release from HMP Leeds. Mr McKean was 60 years old. We offer our condolences to his family and friends.

5. Mr McKean had a difficult life, and his problems were exacerbated by learning difficulties and alcohol. He returned to prison in March 2023, after a long period in hospital where his behaviour became unmanageable and ultimately led to a new sentence for the assault of hospital staff. Mr McKean's family raised questions about the suitability of imprisonment and the adequacy of societal support for him over a long period of time. Unfortunately, these are not questions that the PPO can answer as they are outside our remit. We found no issues of concern relating to the input from Leeds and the Probation Service in the period leading up to his death, and we make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr McKean's death on 12 June 2023.

7. The PPO investigator obtained copies of relevant extracts from Mr McKean's prison and probation records.

8. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the non-invasive post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's family liaison officer contacted Mr McKean's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He raised issues relating to his brother's brain damage in infancy and the subsequent lack of adequate support for him during his life which are outside the remit of the PPO's investigation. He also said that he was concerned about Mr McKean's care at Leeds prior to his discharge and that his pneumonia was not diagnosed before he went into a care home. This is discussed in this report. A further issue regarding the prison's contact with Mr McKean's brother while he was in hospital at the beginning of 2023 is addressed in separate correspondence.

10. The initial report was shared with Mr McKean's brother. He did not reply to the PPO, but his comments forwarded by the Coroner have been addressed in separate correspondence.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found a factual inaccuracy regarding the attendees of a meeting, which has been corrected in this report.

Background Information

HMP Leeds

12. HMP Leeds is a local prison holding around 1,100 men with a high turnover. It has a mix of remand and convicted prisoners, and a wide range of sentenced prisoners. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services, and there is 24-hour coverage. Midlands Partnership Trust provides psychosocial substance misuse services.

HM Inspectorate of Prisons

13. The most recent full inspection of HMP Leeds was in June 2022. HMIP inspectors reported that the prison was well led and staffing levels were better than in many other prisons. Inspectors said that there were clear governance structures for healthcare leaders to review the quality of patient provision, and that there was evidence of good partnership working between healthcare and prison staff. Patients with long-term conditions and complex care needs were identified at reception and reviewed. HMIP reported that there was good social care provision for those prisoners who needed it and there was liaison with the local authority and other agencies to plan for the release for these prisoners.

Probation Service

14. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

15. Mr Donald McKean had an extensive offending history, frequently relating to his behaviour in public and linked to his use of alcohol. This included numerous breaches of the peace, assaults and threatening and disorderly behaviour. He also had a long history of non-compliance with his licence conditions. A Probation Service risk assessment for Mr McKean at the end of 2020, said that all his offences reflected his difficulties relating to other people along with anti-social attitudes, and that heavy alcohol use was a significant factor in his offending. The risk assessment also noted that because of the extent of Mr McKean's offending behaviour, he had been barred from working with most organisations that might help him to improve the quality of his life.

16. On 19 December 2022, Mr McKean was convicted of assaulting paramedics who had gone to his aid on 16 November and was sentenced to a 12-month community order. However, following the assault of another emergency worker, on 3 January 2023, he was remanded in custody and sent to HMP Leeds.

17. On arrival at Leeds, Mr McKean complained of an injury to his arm which he said had happened in a fall the day before (but from ambulance and hospital records it appears the injury was sustained on 1 January). Healthcare staff were concerned that he may have fractured a bone and wanted him to be checked at hospital. Because of Mr McKean's behaviour difficulties, he needed three officers to escort him to hospital and these were not initially available, and when they were, Mr McKean refused to go. Eventually he agreed and he was taken to hospital on 8 January, where a fracture was confirmed. Mr McKean returned to the prison on the same day, but before he did, he had had an epileptic seizure in hospital (epilepsy was a pre-existing health condition). His clinical record noted that following his hospital visit, Mr McKean was using a wheelchair.

18. On 10 January, Mr McKean moved to the prison's dedicated social care unit, where more support was available to him. When Mr McKean arrived at Leeds, he was incontinent and had slurred speech and right sided weakness. On 13 January, a GP at Leeds thought that Mr McKean may have had a stroke and asked for his hospital scan results from 8 January. When healthcare staff received the scan results, they did not give any indication that Mr McKean had recently had a significant stroke.

19. On 19 January, Mr McKean became very unwell and was taken back to hospital. Due to his behaviour towards staff, they called the police. The next day, Mr McKean was diagnosed with aspiration pneumonia and admitted to hospital. A scan on 25 January also showed he had suffered a stroke. Leeds did not have the capacity to do stroke rehabilitation and Mr McKean remained in hospital.

20. On 22 February, the Crown Prosecution Service (CPS) decided to discontinue the case against Mr McKean because of his health issues, and he was released from prison. He remained in hospital as an ordinary patient. However, his continual difficult behaviour with hospital staff escalated to assault and, on 14 March, staff called police. Mr McKean returned to Leeds on remand on 16 March. On 17 April, Mr McKean was sentenced to 20 weeks imprisonment for assault and harassment.

21. Following Mr McKean's return to Leeds, he was again accommodated in the social care unit, where he received daily input from healthcare staff for his continence, showering and other needs. Mr McKean was frequently abusive to staff and although this caused considerable issues at times, his difficulties were well known to staff at Leeds, who often made great efforts to accommodate his requirements.

Pre-release planning

22. On 25 April, a multi-agency meeting considered plans to manage Mr McKean's risks in the community and support needs, including accommodation on his release from prison. The planning for Mr McKean's discharge was led by his social care worker with input from many others, including probation and prison staff.

23. On 17 May, Mr McKean's social care worker visited the prison and held a meeting with his prison offender manager (POM) and healthcare staff. They engaged Mr McKean in the discussions and told him that it was likely that he would go to a care home on release. Leeds said that he could continue to use his prison wheelchair and they would arrange transport on discharge. The meeting also agreed the support of a substance misuse worker for Mr McKean when he was released.

24. Following the meeting, on 19 May, Mr McKean's community offender manager (COM) confirmed that his assessed needs were too great for alternative accommodation such as an approved premises (AP). Mr McKean's POM was concerned about release without suitable accommodation. Following her enquiries, she confirmed that it was not legally possible for him to stay in prison past his release date. Healthcare staff wrote a report outlining Mr McKean's needs and behaviours so that an accommodation provider would have advance knowledge of his requirements.

25. On 20 May, Mr McKean's social care worker confirmed that there was a care home place available for him and that he would be provided with 24-hour one to one support. He also said that a place in a care home closer to one of his brothers might become available in a few weeks.

26. Mr McKean was released from prison on 24 May, and he was met at his care home by his COM, his social care worker, and his substance misuse support worker.

Circumstances of Mr McKean's death

27. On 27 May, Mr McKean became ill at his care home and was taken to hospital, where he died the following day.

Post-mortem report

28. A non-invasive post-mortem report concluded that Mr McKean died from pneumonia. A cerebrovascular accident (commonly known as a stroke, which is serious condition where the blood supply to part of the brain is cut off) was given as a factor which contributed to, but which did not cause the death.

Findings

29. Mr McKean's brother was concerned that Mr McKean may have been released to a care home with established pneumonia that had not been diagnosed. He was seen on a daily basis by prison and healthcare staff, by a doctor at the prison two days before his release, and by a nurse at reception on the day of his release. They had no concerns and there is nothing in his prison or clinical notes leading up to his release that would give any indication that Mr McKean had become unwell or that there was a suspicion of pneumonia. We did not find any shortcomings in his care and make no recommendations.

Good practice

30. Mr McKean often required a lot of staff attention and was frequently angry and abusive to both prison and healthcare staff at Leeds. He was assessed by probation staff as being a high risk of serious harm to the general public and very high risk of serious harm to staff when in custody. However, despite being very challenging, staff at Leeds treated Mr McKean with understanding in the period leading to his discharge from prison in May. Mr McKean's social care worker had a very good appreciation of Mr McKean's difficulties and included him in the decision making about his future, and worked closely with the prison staff and his COM in the lead up to his release from prison to ensure that he had appropriate accommodation with sufficient support.

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

Inquest

31. The inquest into Mr McKean's death concluded in October 2024 and found that he died of natural causes.

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