Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm Carney, a prisoner at HMP Leeds, on 5 November 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Malcolm Carney died in hospital on 5 November 2020, while a prisoner at HMP Leeds. He was 81 years old. The cause of his death was COVID-19. He also had underlying lung cancer, ischaemic heart disease and chronic obstructive pulmonary disease. I offer my condolences to Mr Carney's family and friends.

4. It seems likely that Mr Carney contracted the virus at Leeds, as he had not left the prison for several months before his death.

5. The clinical reviewer concluded that the clinical care Mr Carney received at Leeds was equivalent to that he could have expected to receive in the community. Full details of the findings are in the clinical review report.

6. The clinical reviewer made recommendations about the failure to follow up a hospital discharge recommendation to refer Mr Carney to a Cancer of Unknown Primary clinic and the need for care plans and regular review of prisoners with fluctuating mental capacity. We endorse her views. She also made additional clinical recommendations, which the head of healthcare will need to address.

7. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that hospital discharge recommendations and referrals are acted on and documented in prisoners' medical records.

- The Head of Healthcare should ensure that there is a care plan in place for patients with impaired mental capacity and that they are formally reviewed at appropriate intervals.

The Investigation Process

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

9. The PPO's investigator investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Carney's location; the security arrangements for his admission to hospital; liaison with his family; and whether early release was considered.

10. The investigator and clinical reviewer interviewed the acting head of healthcare on 14 January 2021. The interview was conducted by telephone due to the restrictions in place during the COVID-19 pandemic.

11. The PPO family liaison officer wrote to Mr Carney's next of kin, his partner, to explain the investigation. Mr Carney's daughter replied on her behalf, raising several issues about Mr Carney's care throughout his time at the prison. Those relating to more recent events and the cause of death included:

    - Concerns that staff might not have noticed Mr Carney's weight loss.
    - Actions taken to address his numerous falls.
    - Mr Carney's family did not agree with the 'do not attempt resuscitation' order and thought that Mr Carney had changed his mind.
    - Mr Carney did not move to the prison's palliative care unit.
    - Mr Carney's family were not informed that Mr Carney had been moved from St James's University Hospital to Leeds General Infirmary.

    The PPO's role is to investigate the care that Mr Carney received in relation to his cause of death, and those issues within our remit have been addressed in either this report, or in the clinical review.

12. Mr Carney's family also had concerns about his overall clinical care at Leeds. These concerns are outside our remit and we agree with the clinical reviewer that they would be best addressed through the Practice Plus Group formal complaints process.

13. Mr Carney's wife and daughter received a copy of our initial report. They made no comments.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). They accepted our recommendations and found no factual inaccuracies. The HMPPS action plan is annexed to this report.

Previous deaths at HMP Leeds

15. Mr Carney was the 20th prisoner to die at Leeds since November 2018. Of the previous deaths, seven were self-inflicted, one drug-related and one awaiting classification. The remainder were due to natural causes, none linked to COVID-19. There have since been seven further deaths, four from natural causes (of

which two were apparently COVID-19 related), two self-inflicted and one awaiting classification.

16. There are no similarities between our findings in the investigation into Mr Carney's death and those of the previous deaths.

HM Inspectorate of Prisons

17. In a report on short scrutiny visits to local prisons issued in June 2020, HM Chief Inspector of Prisons noted that the initial outbreak of COVID-19 at Leeds was before national restrictions had been implemented. In response to this, managers at Leeds had quickly devised and put in place a local model to minimise the spread of the virus. Healthcare COVID-19 contingency plans had been reviewed after the early outbreaks and Inspectors considered that they had been stronger as a result.

COVID-19 (coronavirus)

18. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

19. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

    In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-received prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

20. Mr Malcolm Carney was convicted of sexual offences on 19 December 2014 and sentenced to 20 years in prison. He was sent to HMP Leeds.

21. Mr Carney had several existing medical ailments. These included a previous stroke, chronic obstructive pulmonary disease (COPD), type 2 diabetes, heart disease, heart failure, angina, kidney disease and spinal problems. He used walking aids to get around. Due to his poor physical health, Mr Carney was allocated a cell in the prison's healthcare inpatient unit.

22. At an assessment with a Macmillan nurse in January 2015, Mr Carney firmly stated that he did not want to be resuscitated if his heart or breathing stopped. It was noted that his family agreed to this and the decision was regularly reviewed. From 2017 until shortly before his death, entries in Mr Carney's medical record noted periods of confusion and poor memory.

23. Palliative care specialists monitored Mr Carney from 2018, in consultation with prison healthcare staff. On 2 January 2018, a prison family liaison officer was assigned to support Mr Carney and his family.

24. In June 2019, after reporting persistent back pain and weight loss, Mr Carney had tests for suspected cancer and was referred to a specialist. Initially, he was thought to have myeloma (a blood cancer), but tests excluded this and his consultant suggested a referral to the Cancer of Unknown Primary (CUP) clinic. (CUP is a rare disease in which cancer cells are found in the body but the place where the cancer began is not known.) This was not followed up.

25. Mr Carney had a fall on 1 November and was admitted to hospital. A week later, he was diagnosed with lung cancer. Hospital doctors discussed the diagnosis with Mr Carney and his family and decided not to offer treatment because of his age and other medical conditions. He was kept under review in palliative care meetings and the Multi-Professional Complex Case Committee. Medical records show that in late 2019 and early 2020, Mr Carney was offered the opportunity to move to the prison's palliative care suite, but he declined.

26. On 30 March 2020, an application for early release on compassionate grounds was refused, as there was insufficient evidence that Mr Carney was likely to die within three months and that adequate provision had been made for his care in the community. The Prison Service Public Protection Team advised the Governor to keep the case under review and resubmit the application if there was a change of circumstances.

27. Mr Carney had been assessed as clinically extremely vulnerable. He applied for release under the Release on Temporary Licence (ROTL) on Compassionate Grounds Scheme for those considered medically vulnerable to COVID-19. After assessing his application on 18 May, the ROTL Board considered him unsuitable for release.

28. In May, Mr Carney was given a letter covering the recommendations on shielding for those at higher risk due to underlying medical conditions. On 21 May, his key

worker explained the contents and Mr Carney agreed to shield in his cell for 12 weeks, only going out for showers or medical reasons.

29. On 9 June, Mr Carney decided that he no longer wished to shield and signed a disclaimer to this effect. This meant that he resumed exercise and other domestic activities with other prisoners, albeit in line with the policy restricting numbers and social distancing.

30. Mr Carney had a longstanding cough due to COPD. However, on 17 October he began to cough continuously for long periods. A swab was taken and, while waiting for the results, he was isolated and monitored for symptoms of COVID-19.

31. On 21 October, the prison was deemed a COVID outbreak site due to the number of staff who had either tested positive, or had been in contact with others who had tested positive for COVID-19.

32. During an early morning welfare check on 23 October, Mr Carney was short of breath, with chest pain and low oxygen levels. Paramedics attended but decided not to take him to hospital. They suggested that a prison GP review him.

33. At 6.00am on 24 October, Mr Carney coughed continuously during a welfare check. His condition worsened during the day. A nurse examined him late afternoon and, while reviewing his records, she noticed that his test result said positive for COVID-19. Mr Carney was taken to hospital by emergency ambulance, escorted by two prison officers wearing PPE and no restraints were used.

34. Healthcare staff obtained regular updates on Mr Carney's condition. The family liaison officer and Mr Carney's family kept in touch and shared information with each other. His family were also given the contact details for the hospital so they could maintain contact and request information independently. An operational manager authorised hospital visits.

35. Mr Carney's condition did not improve. He was placed on end of life care and died on 5 November. The family liaison officer notified Mr Carney's family shortly afterwards.

36. The duty governor debriefed the escort officers and offered support. A member of the care team also spoke to them.

37. Mr Carney's funeral was held on 2 December. In line with national policy, the prison contributed to the funeral expenses.

Cause of death

38. There was no post-mortem examination as the Coroner accepted the hospital's certification that Mr Carney had died from COVID-19. Mr Carney also had underlying lung cancer, ischaemic heart disease and chronic obstructive pulmonary disease, which did not cause, but contributed to his death.

Findings

Clinical Findings

39. The clinical reviewer concluded that Mr Carney received a good standard of clinical care at Leeds, equivalent to that he could have expected to receive in the community. She found that nurses and social care providers were responsive and compassionate to Mr Carney's needs.

40. We agree with the clinical reviewer, but share her concern that a consultant's recommendation in July 2019 to refer Mr Carney to the Cancer of Unknown Primary clinic was not followed up and that this had led to a delay and missed opportunity for earlier diagnosis of his cancer. We recommend:

    The Head of Healthcare should ensure that hospital discharge recommendations and referrals are acted on and documented in prisoners' medical records.

41. A further concern was Mr Carney's cognition. Healthcare staff considered that he mostly understood the information given to him and was able to communicate his needs. However, the clinical reviewer considers that given his fluctuating capacity and increasing confusion, staff should have formally assessed Mr Carney's mental state, including his capacity to decide to stop shielding in June 2020. We recommend:

    The Head of Healthcare should ensure that there is a care plan in place for patients with impaired mental capacity and that they are formally reviewed at appropriate intervals.

42. The clinical reviewer also made two recommendations (unrelated to the cause of Mr Carney's death) about falls risk management, which the head of healthcare will need to address.

Management of Mr Carney's risk of infection from COVID-19

43. Due to Mr Carney's complex health conditions, he was at very high risk of serious illness if he contracted COVID-19.

44. In March 2020, HMPPS instructed all prisons to implement measures to contain COVID-19, including a restricted regime, social distancing, wherever possible, and shielding of the most vulnerable prisoners for 12 weeks.

45. The acting head of healthcare told the investigator that although the healthcare provider, Practice Plus Group, did not have a formal process for identifying vulnerable prisoners until May 2020, HMP Leeds had devised their own 'at risk' list and had sent a shielding letter to Mr Carney on 26 March 2020. (This was not documented in his medical record.) Healthcare staff had access to appropriate personal protective equipment (PPE).

46. Mr Carney chose to stop shielding in his cell in June, which meant that he was allowed out to areas such as the day room. However, as a resident of the Complex Care Unit he continued to benefit from a form of shielding, as prisoners

and staff within the unit were cohorted in ‘bubbles’ with medication dispensed at cell doors and restricted access to the unit.

47. When the prison became an outbreak site in October 2020, Leeds used ‘track and trace’ to identify infected staff and those at risk. The exercise identified that some staff were not complying with guidelines, such as social distancing. Therefore, further guidance and daily briefings were issued, reiterating the key requirements. Despite the measures, Mr Carney seems to have contracted COVID-19 at Leeds, as he had not left the prison since August 2020.

48. The investigation found that prison managers at Leeds followed the national guidance on managing the risks associated with COVID-19. They developed local policies covering the controls to be implemented and were responsive to identified failings. We are satisfied that Mr Carney had the opportunity to shield, in line with his vulnerable status and that he was informed of the risks of not doing so.

Sue McAllister CB
Prisons and Probation Ombudsman **November 2021**

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