

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Leonard Duggan, a prisoner at HMP Doncaster, on 21 December 2020

**A report by the Prisons and Probation Ombudsman**

## 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*



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## 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 Leonard Duggan died in hospital on 21 December 2020, while a prisoner at HMP Doncaster. He was 80 years old. The cause of his death was COVID-19 pneumonitis. He also had ischaemic heart disease. I offer my condolences to Mr Duggan's family and friends.
4. The clinical reviewer concluded that due to delays in care planning for long-term conditions; weaknesses in managing the risk of malnutrition; and the absence of advance care planning, Mr Duggan's clinical care at Doncaster was only partly equivalent to that he could have expected to receive in the community. Full details of her findings are in the clinical review report. We share the clinical reviewer's concerns and make similar recommendations on the issues related to the cause of death.
5. Mr Duggan appears to have contracted the virus at Doncaster, as he had not left the prison within the usual incubation period for COVID-19. We are satisfied that the prison implemented the relevant infection control measures and that Mr Duggan was appropriately shielded. However, we make a recommendation about the delay in notifying his wife that he had been admitted to hospital.

## Recommendations

- The Head of Healthcare should ensure that there is an auditable process to follow up non-attendance of appointments.
- The Head of Healthcare should ensure that care plans for long-term conditions are put in place without delay.
- The Head of Healthcare should ensure that advance care planning takes place for prisoners with chronic and life-limiting conditions.
- The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Duggan's clinical care at HMP Doncaster.
7. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Duggan's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
8. The Ombudsman's family liaison officer wrote to Mr Duggan's next of kin, his wife, to explain the investigation and ask if she wanted any specific matters to be considered. There was no reply.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

### Previous deaths at HMP Doncaster

10. Mr Duggan was the 20th prisoner at Doncaster to die, since December 2018. Nine of the previous deaths were self-inflicted, eight were from natural causes and two were drug-related. There have been five further deaths. Three were from natural causes (including two from COVID-19), one was self-inflicted and the other is awaiting classification. There are no similarities between our findings in this investigation and those of previous deaths at Doncaster.

### COVID-19 (coronavirus)

11. 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.
12. 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.)
13. 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-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

## Key Events

14. Mr Leonard Duggan was convicted of sexual offences. On 5 January 2018, he was sentenced to nine years imprisonment and sent to HMP Doncaster.
15. A reception health screen identified that Mr Duggan had a history of ischaemic heart disease, chronic kidney disease, asthma, angina, alcohol dependency, partial removal of his bowel and mental health problems. Mr Duggan was therefore given a place in the social care unit, for prisoners over 60 with mobility or social care needs. He received social care daily and used a wheelchair for long distances.
16. Mr Duggan was later subject to weekly reviews by both an assigned nurse and the Multi Professional Complex Case Conference (MPCCC). He was an inpatient in hospital several times.
17. On 25 March 2020, Mr Duggan received a letter explaining that he had been identified as at high risk of complications if he contracted COVID-19 (clinically extremely vulnerable) and giving advice on shielding and other preventative measures. He was moved from a dormitory to a single cell within the same unit and began shielding. A detailed care plan was later created and reviewed monthly; meals and medication were delivered to his cell; and he continued to receive social care daily. Formal weekly reviews continued.
18. On 1 October, Mr Duggan decided to stop shielding and began to mix with other men in communal areas, such as the dining room. (National advice for the vulnerable to shield paused between August and November.)
19. On 13 December, Mr Duggan's social carer was concerned about his health and asked a nurse to examine him. He said he felt dizzy and unwell. The nurse found no signs of breathlessness, loss of smell or taste, or cough. Clinical observations were taken and repeated in the early hours of the next morning and he was kept under review. Mr Duggan's medical and personal records noted that he had refused all medication and food. It was recorded that he had full cognition and the capacity to make decisions.
20. A test for COVID-19 was confirmed as positive on 15 December. A management plan was put in place, requiring monitoring of Mr Duggan's symptoms, daily clinical observations and assessments using the National Early Warning Score (NEWS) 2. Over the next two days, Mr Duggan appeared confused and persistently refused to go to hospital.
21. Early evening on 17 December, it was decided that Mr Duggan no longer had the capacity to refuse secondary care and a nurse sent him to hospital, where he was admitted to the acute medical unit. He was escorted by two prison officers and no restraints were used.
22. Healthcare staff contacted the hospital for updates. On 19 December, Mr Duggan's treatment for extensive pneumonia was withdrawn and he was placed on the end of life care pathway. It was noted that he had 24 hours to live. An entry in the medical record just before midnight indicated that Mr Duggan's family had been notified.

23. On 20 December, the prison assigned a family liaison officer. At midday, she introduced herself to Mr Duggan's wife and niece. They were unable to visit the hospital and asked the family liaison officer for Mr Duggan's niece to be informed when Mr Duggan died and she would tell his wife.
24. Mr Duggan died at 12.12am on 21 December and the duty director notified his family shortly afterwards.
25. Notices were issued to staff and prisoners, informing them of Mr Duggan's death and offering support.
26. Mr Duggan's funeral was held on 22 January 2021. In line with national policy, the prison contributed to the funeral expenses.

#### **Post-mortem examination**

27. A post-mortem examination indicated that Mr Duggan had died from COVID-19 pneumonitis. He also had ischaemic heart disease due to underlying artery atheroma and calcific aortic stenosis.

# Findings

## Clinical Findings

28. The clinical reviewer concluded that Mr Duggan's care at Doncaster, was only partly equivalent to that he could have expected to receive in the community. She made recommendations about following up appointments to ensure timely management of long-term conditions; screening of patients at risk of malnutrition; and the need for better advance care planning, particularly in Mr Duggan's circumstances where his views on secondary care were variable.
29. We endorse the clinical reviewer's recommendations and make similar recommendations on the issues relevant to Mr Duggan's death. We recommend:

**The Head of Healthcare should ensure that there is an auditable process to follow up non-attendance of appointments.**

**The Head of Healthcare should ensure that care plans for long-term conditions are put in place without delay.**

**The Head of Healthcare should ensure that advance care planning takes place for prisoners with chronic and life-limiting conditions.**

## *Management of Mr Duggan's risk of infection from COVID-19*

30. Mr Duggan was promptly identified as clinically extremely vulnerable and appropriately shielded. A comprehensive care plan was in place, which was regularly reviewed by staff. Due to the vulnerability of the residents on the social care unit, the regime was changed to ensure added protection for the men and a restricted access policy was imposed. Therefore, Mr Duggan benefitted from a form of shielding at times when it was not a formal requirement.
31. Prison managers developed local policies, which were issued to staff and prisoners and updated as circumstances and national guidance changed. Infection control measures were in place and a COVID-19 hub stocked PPE, soap and hand sanitiser. All staff were issued with two face masks each day when they arrived at the prison.
32. We are satisfied that Doncaster took appropriate steps to minimise the spread of the virus and the risk of infection, in line with government advice and national Prison Service policy. Mr Duggan was isolated and tested as soon as he became unwell.

## Contacting Mr Duggan's family

33. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic.
34. Mr Duggan's wife was notified two days after Mr Duggan went into hospital, after end of life care had started and he had been given a very short time to live. We

consider that she should have been told sooner that he had been admitted to hospital.

**The Director should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.**

**Sue McAllister CB  
Prisons and Probation Ombudsman**

**July 2021**

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