

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Leonard Weller, a prisoner at HMP Elmley, on 22 November 2021**

**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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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.

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

Mr Leonard Weller died from heart disease on 22 November 2021 at HMP Elmley. He was 83 years old. I offer my condolences to Mr Weller's family and friends.

The clinical reviewer concluded that the clinical care Mr Weller received at Elmley was equivalent to that which he could have expected to receive in the community.

Staff requested an ambulance promptly when Mr Weller was found unresponsive. However, I am concerned that they were unable to provide basic information requested by the call handler. It did not delay the despatch of the ambulance in this case, but it could in future cases.

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

**Sue McAllister CB**

**Prisons and Probation Ombudsman**

**July 2022**

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# Summary

## Events

1. On 14 October 2020, Mr Leonard Weller was remanded in prison custody, charged with arson, and sent to HMP Elmley. He was subsequently convicted and sentenced to three years and 11 months imprisonment
2. Mr Weller arrived at Elmley with several long-term health conditions, including a history of heart problems and chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases).
3. At around 8.45am on 22 November 2021, staff unlocked Mr Weller's cell so that Mr Weller could collect his morning medications. Mr Weller was sitting in his chair and unresponsive. An officer called a medical emergency code and started cardiopulmonary resuscitation (CPR), which was continued by paramedics when they arrived shortly before 9.00am. However, attempts to revive Mr Weller were unsuccessful and he was pronounced dead at 9.23am.
4. A post-mortem examination found that Mr Weller died from heart disease.

## Findings

5. The clinical reviewer found that the care Mr Weller received at Elmley was equivalent to that which he could have expected to receive in the community. However, she found that there was a lack of a multi-professional approach to managing Mr Weller's long-term conditions.
6. Although staff in the prison's communications room called for an ambulance immediately when the medical emergency code was called, they were unable to answer standard questions asked by the call handler. It took staff nearly six minutes to confirm whether Mr Weller was breathing or not. This did not affect the outcome for Mr Weller as an ambulance was despatched regardless, but it could cause delays in future cases.

## Recommendations

- The Head of Healthcare should ensure that the systems and processes for managing prisoners with multiple long-term conditions are effective and consistently applied.
- The Governor and Head of Healthcare should ensure that staff are aware of the standard questions asked by ambulance call handlers and that when staff use a medical emergency code, they provide relevant information about the prisoner's condition to the communications room without delay.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of the relevant extracts from Mr Weller's medical and prison records.
9. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Weller's clinical care at Elmley.
10. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
11. The Ombudsman's family liaison officer contacted Mr Weller's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

## Background Information

### HMP Elmley

13. HMP Elmley holds around 1,100 prisoners, remanded or sentenced, in six houseblocks, with a mixture of single and double cells. During this period, Integrated Care 24 Ltd provided 24-hour primary healthcare services, with input from Minster Medical Group, and Oxleas NHS Foundation Trust provided mental health services. Oxleas NHS Foundation Trust took over the provision of the healthcare services in April 2022.

### HM Inspectorate of Prisons

14. The most recent full inspection of HMP Elmley was in April 2019. Inspectors reported that health provision was reasonably good. There was a range of primary care services, although the wait for nurse triage appointments was considered to be too long. The inpatient unit was well-run. A GP was available every day. Inspectors also found that non-attendance for healthcare appointments had reduced since the previous inspection.
15. The inspectorate also carried out a short scrutiny visit at Elmley in April 2020, during the COVID-19 pandemic. Inspectors reported that there had been a good leadership and management response to a fast-changing situation and management oversight of healthcare was effective. Most routine health provision, such as external hospital appointments had stopped temporarily due to the risks of COVID-19, but there had been an increased focus on oversight and supporting those most at risk.

### Independent Monitoring Board

16. 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 31 October 2021, the IMB said that health provision had been patchy due to staffing difficulties. They said that although the system was largely effective at identifying health issues, it was critically under pressure. They said that the inpatient unit continued to be a calm and well maintained area.

### Previous deaths at HMP Elmley

17. Mr Weller was the 14th prisoner to die at Elmley since November 2019. Nine of the previous deaths were from natural causes, two were self-inflicted, and two were drug related. There are no similarities between our findings from our investigation into Mr Weller's death and our investigation findings from the previous deaths.

## Key Events

18. On 14 October 2020, Mr Leonard Weller was remanded in prison custody, charged with arson, and sent to HMP Elmley. He was convicted in May and in November, was sentenced to three years and 11 months imprisonment.
19. Mr Weller had several serious health problems. These included atrial fibrillation (a heart condition which causes it to beat irregularly), heart failure (the heart's inability to pump blood around the body properly), chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), hypertension (high blood pressure), benign prostate hyperplasia (non-cancerous growth of the prostate gland), which was associated with recurrent urinary tract infections. While at Elmley he had multiple trips to different hospital departments for investigations of his conditions. He also had poor mobility, and his severe hearing problems made communication more difficult during the COVID-19 pandemic because of mask wearing.
20. During initial health assessments on 15 October 2020, Mr Weller had an elevated rate of breathing. He told a nurse that he was aware that this was linked to his heart problems. On 2 January 2021, staff called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) after Mr Weller experienced breathlessness. An ambulance was called but stood down after healthcare staff assessed Mr Weller. However, the prison took him to hospital later as a precaution because a prison GP had concerns about possible heart problems. The hospital identified atrial fibrillation as the cause and returned him to the prison on the same day with medications to treat the condition.
21. Mr Weller had another episode of breathlessness on 13 January, which prompted a code blue. However, he did not require any emergency treatment and a prison GP saw him the next day and adjusted his medication and arranged for him to have X-rays taken at hospital on 18 January. These showed he had an enlarged heart and some recent scarring to the lungs.
22. On 17 February, Mr Weller was breathless again, but also had a high temperature and low blood oxygen levels. A prison GP was concerned this could be sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues) but, after being taken to hospital, Mr Weller's condition improved, and he returned to prison on the same day.
23. Over the following months, there were no further incidents relating to breathlessness. On several occasions Mr Weller had either telephone appointments with hospital consultants or went to hospital for these or for investigations into his existing conditions. This included further X-rays and scans. Adjustments were made to his prescriptions, although Mr Weller was not always willing to take all his prescribed medication. Mr Weller's decision to stop taking two of the medications for his heart conditions was against medical advice, but he gave his reasons and healthcare staff assessed that he had the mental capacity to make those decisions.
24. Mr Weller was fairly stable for most of the year and there were no more code blue incidents between February and November.

## **Events of 22 November**

25. At around 8.45am on 22 November, prison staff unlocked Mr Weller's cell so that he could collect his morning medications. He was found sitting in his chair and unresponsive. An officer called a code blue and started cardiopulmonary resuscitation (CPR), and then other officers took turns to carry this out. This was continued by paramedics when they arrived around 9.00am. However, attempts to revive Mr Weller were unsuccessful and he was pronounced dead at 9.23am.

## **Contact with Mr Weller's family**

26. On the morning that Mr Weller died, Elmley appointed a family liaison officer (FLO). Mr Weller made no telephone calls in prison and had not listed any telephone contact for a next of kin. The FLO contacted the next of kin via Mr Weller's solicitors. Another person subsequently took over as the FLO and continued the communication with the next of kin, including arrangements for Mr Weller's funeral and the return of his property to them.
27. In line with national policy, the prison contributed to the costs of Mr Weller's funeral which took place on 4 January 2022.

## **Support for prisoners and staff**

28. After Mr Weller's death, a Supervising Officer carried out a hot debrief in the board room for the staff who had been involved in the incident. Later in the morning he went along with an officer to inform the residents of the wing about Mr Weller's death.
29. The prison posted notices to staff and prisoners informing them of Mr Weller's death, and offering support.

## **Post-mortem report**

30. A post-mortem examination found that Mr Weller died from ischaemic heart disease (due to a restriction in the blood supply to the heart due to blockages in the arteries and an enlargement of the heart). COPD was given as an underlying issue which contributed to but did not cause the death.

# Findings

## Clinical care

31. The clinical reviewer noted that Mr Weller was elderly with several complex medical conditions, and that he did not always cooperate with the treatment prescribed to him. She said that it would have been challenging to provide clinical care for him in any circumstances. She found that the care Mr Weller received at Elmley was equivalent to that which he could have expected to receive in the community. However, she found that there was a lack of a multi-professional approach to managing Mr Weller's long-term conditions. We recommend:

**The Head of Healthcare should ensure that the systems and processes for managing prisoners with multiple long-term conditions are effective and consistently applied.**

## Emergency response

32. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, says that when a medical emergency code is called, staff in the control/communications room should call an ambulance immediately. It says, '...the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process'.
33. Although staff in the communications room called for an ambulance immediately when the code blue was called for Mr Weller, they were unable to answer the standard questions asked by the call handler about Mr Weller's condition, including whether he was breathing. Staff in the communications room transferred the call to the wing office but no one was there. The communications officer had to put a call out over the radio before someone was able to give the call handler the information they needed. It was nearly six minutes into the telephone call before staff told the call handler that Mr Weller was not breathing. Although this did not affect the outcome as an ambulance had already been dispatched by the call handler, it is unacceptable that it took six minutes to pass on basic information. Not only do such delays waste the call handler's time, but it also means they cannot assess the urgency of the emergency and prioritise accordingly. We recommend:

**The Governor and Head of Healthcare should ensure that staff are aware of the standard questions asked by ambulance call handlers and that when staff use a medical emergency code, they provide relevant information about the prisoner's condition to the communications room without delay.**

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