

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Stephen Duggan, a prisoner at HMP Leeds, on 6 June 2021**

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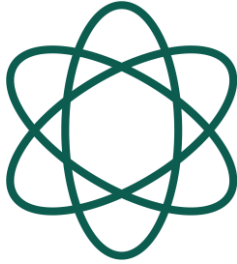
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## Our vision

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

**OGL**

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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 Stephen Duggan died in hospital from cancer on 6 June 2021, while a prisoner at HMP Leeds. He was 68 years old. I offer my condolences to Mr Duggan's family and friends.

Mr Duggan was sent to hospital on 5 June. The hospital suspected that he had a kidney and liver infection. However, the post-mortem examination found that Mr Duggan had widespread cancer. He had not been diagnosed with cancer while he was alive.

The clinical reviewer concluded that the standard of care Mr Duggan received at Leeds was in part equivalent to that which he could have expected to receive in the community.

The clinical reviewer was satisfied that staff responded appropriately when they realised that Mr Duggan was very unwell on 5 June. However, she was concerned that when Mr Duggan became unwell with sickness and diarrhoea on 2 June, healthcare staff did not arrange any follow up, so his symptoms were not monitored. It was only when Mr Duggan's wife telephoned the prison on 5 June to tell them that she was very concerned about Mr Duggan, that a healthcare assistant went to see him. Better monitoring would not have prevented Mr Duggan's death, but it would have been best practice and steps could have been taken to make him more comfortable.

We are also concerned that a healthcare assistant was asked to call Mr Duggan's wife to tell her that Mr Duggan was in hospital. This should have been done by a trained family liaison officer.

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**

**January 2022**

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# Summary

## Events

1. On 20 May 2021, Mr Stephen Duggan was remanded in custody for sexual offences. He was sent to HMP Leeds. The reception nurse noted that Mr Duggan was not taking any medication and had no health concerns.
2. On 2 June, Mr Duggan told an officer that he had been sick all morning. A nurse saw Mr Duggan and told him to isolate in his cell to avoid spreading sickness to other prisoners.
3. On 5 June, Mr Duggan's wife called the prison's safer custody hotline and said that she was worried about Mr Duggan because he had been unwell for several days. A healthcare assistant went to see Mr Duggan. She was concerned so asked a nurse to see him. After the nurse arrived, Mr Duggan deteriorated further so they called a medical emergency code.
4. Paramedics arrived shortly afterwards and said that Mr Duggan needed to go to hospital. He was admitted with a suspected kidney and liver infection.
5. On 6 June, Mr Duggan's health deteriorated quickly. He was moved to the intensive care unit but died later that day.
6. A post-mortem report concluded that Mr Duggan died of metastatic cancer.

## Findings

7. The clinical reviewer considered that the standard of care Mr Duggan received was mixed and not wholly equivalent to that which he could have expected to receive in the community.
8. While the clinical reviewer was satisfied that staff acted quickly when they realised that Mr Duggan was very unwell on 5 June, she was concerned that Mr Duggan had not been monitored since he had become unwell with sickness and diarrhoea on 2 June. It was only when Mr Duggan's wife called the prison on 5 June that nurses went to see Mr Duggan and took his observations.
9. Neither healthcare staff nor wing staff recorded that Mr Duggan was isolating due to illness. This meant that when new staff came on shift, they did not know how long Mr Duggan had been unwell.
10. We are also concerned that a healthcare assistant was asked to call Mr Duggan's wife to tell her that Mr Duggan was in hospital. It is the role of a trained family liaison officer to contact a prisoner's next of kin when a prisoner becomes seriously unwell.

## Recommendations

- The Head of Healthcare should ensure that staff follow up prisoners who report sickness and diarrhoea and monitor them if symptoms continue.

- The Head of Healthcare should ensure that staff record all prisoner interactions in the prisoner's healthcare record and record if they are isolating due to illness.
- The Governor should ensure that staff record when a prisoner is unwell, so that staff taking over a shift are aware who is ill and how long they have been ill for.
- The Governor and Head of Healthcare should ensure that an appropriate member of staff, preferably a designated family liaison officer, contacts a prisoner's family to notify them when a prisoner is seriously unwell.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Duggan's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Duggan's clinical care at the prison.
14. The clinical reviewer conducted joint interviews with the investigator. Due to coronavirus restrictions, the interviews were conducted by telephone.
15. We informed HM Coroner for West Yorkshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Duggan's nominated next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not ask any specific questions, but provided a statement raising several issues that we have looked into during this investigation.
17. Mr Duggan's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

## Background Information

### HMP Leeds

19. HMP Leeds is a local prison which can hold a maximum of 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group (formerly known as Care UK) provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

### HM Inspectorate of Prisons

20. The most recent inspection of HMP Leeds was in December 2019. Inspectors found that the prison had continued to face significant challenges but had improved in many areas since the previous inspection. There was good local leadership of healthcare services and clinical records were of high quality.
21. Prisoners had prompt access to a range of primary care services and clinic waiting times were acceptable. The management of long-term conditions was good.

### Independent Monitoring Board

22. 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 December 2020, the IMB reported that the pandemic had seen a greater use of in-cell phones for initial consultations with doctors and nurse practitioners. A number of key face to face contacts continued to be undertaken to meet prisoners' needs, such as wound management and the delivery of social care. This had the benefit of prisoners not having to be moved from their wing and a reduction in face-to-face contact, both of which were important in preventing the spread of COVID-19.

### Previous deaths at HMP Leeds

23. Mr Duggan was the 21st prisoner to die at Leeds since June 2019. Of the previous deaths, 13 were from natural causes, six were self-inflicted and one was drug-related.
24. In August 2021, we made a recommendation to Leeds about appointing a Family Liaison Officer (FLO) when prisoners become ill and are in hospital. The prison has not yet responded to this recommendation. We have also made a recommendation about the need for prison staff to record information when prisoners are unwell so that colleagues who take over from them are aware of it. The prison accepted this recommendation and said that a Governor's Notice would be issued to staff by April 2021.

## Key Events

25. On 20 May 2021, Mr Stephen Duggan was remanded in custody for sexual offences. He was sent to HMP Leeds.
26. When Mr Duggan arrived at Leeds, a nurse completed his initial reception screen. She noted that Mr Duggan was not on any medication and had no health concerns.
27. On 2 June, an officer went to Mr Duggan's cell to collect him for a video link call with his solicitor. Mr Duggan told her that he had been sick all morning and was not feeling very well. She asked a nurse to see Mr Duggan.
28. A nurse came to Mr Duggan's cell and told him that because he had been sick, he would need to isolate in his cell for 48 hours to avoid spreading sickness to other prisoners. Mr Duggan was unable to attend his video link call.
29. On 4 June, prison staff told a senior officer (SO) that Mr Duggan was unwell. The SO called healthcare staff to ask if they could come to Mr Duggan's cell to do a COVID test. A nurse told the SO that sickness and diarrhoea were not symptoms of COVID, and therefore, Mr Duggan did not require a COVID test. The SO did not know that Mr Duggan had already been unwell for two days.
30. On 5 June, Mr Duggan's wife called the safer custody helpline and said that she was concerned that Mr Duggan had been unwell for several days. Safer custody told her that a nurse would go to see Mr Duggan. The safer custody team contacted healthcare and a healthcare assistant (HCA) went to Mr Duggan's cell to take his observations. Mr Duggan told the HCA that he had had sickness and diarrhoea for four days and had only eaten four biscuits.
31. The HCA took Mr Duggan's observations and noted that he appeared to be pale and clammy, was short of breath when moving and had a National Early Warning Score (NEWS) score of 6. (NEWS is a tool used to assess clinical deterioration in adult patients – a score of 6 indicates medium clinical risk.)
32. The HCA was concerned, so she called a nurse to Mr Duggan's cell. While the nurse was taking Mr Duggan's observations he began to deteriorate, and she recorded a NEWS score of 10. At 3.52pm, the HCA called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).
33. At 4.35pm, an ambulance arrived. Paramedics said that Mr Duggan needed to go to hospital. Mr Duggan was escorted to hospital by two prison officers who used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer and the other to the prisoner.) Mr Duggan was admitted to hospital with a suspected kidney and liver infection.
34. The following day Mr Duggan's health quickly deteriorated. He was moved to the intensive care unit but died that afternoon.

## **Contact with Mr Duggan's next of kin**

35. On 6 June, when Mr Duggan's health deteriorated, the prison appointed an officer as the family liaison officer (FLO). Mr Duggan's wife was listed as his next of kin. The FLO contacted her to tell her that Mr Duggan was unwell in hospital. Shortly after the call, Mr Duggan died. The FLO met Mr Duggan's wife at the hospital to offer her support.
36. The prison paid for Mr Duggan's funeral in line with national guidelines.

## **Support for prisoners and staff**

37. The prison told the investigator that the escorting officers on the bed watch when Mr Duggan died were offered support from the care team.
38. The prison posted notices informing other prisoners of Mr Duggan's death and offering support.

## **Post-mortem report**

39. The post-mortem report concluded that Mr Duggan died from extensive metastatic cancer of the upper gastrointestinal tract, lung or pancreatic origin.

# Findings

## Clinical Care

40. The clinical reviewer considered that the standard of care that Mr Duggan received was mixed, and not wholly equivalent to the care that he could have expected to receive in the community.
41. Mr Duggan did not disclose any health problems when he arrived at Leeds.
42. The clinical reviewer was satisfied that staff acted quickly and appropriately when they realised that Mr Duggan was very unwell on 5 June. However, the clinical reviewer was concerned that when Mr Duggan first became unwell with sickness and diarrhoea on 2 June, healthcare staff made no plans to monitor his symptoms. This meant that he was not formally reviewed or seen again by healthcare staff between 2 and 5 June.
43. The clinical reviewer also noted that healthcare staff did not record their interactions with Mr Duggan on 2 June in his healthcare records. Nor was it recorded that he was isolating because of illness.
44. If Mr Duggan had been monitored after 2 June, it would not have prevented his death from advanced and widespread cancer. But it would have been good practice and might have meant that healthcare staff could have made him more comfortable.
45. We make the following recommendations:
  - The Head of Healthcare should ensure that staff follow up prisoners who report sickness and diarrhoea and monitor them if symptoms continue.**
  - The Head of Healthcare should ensure that staff record all prisoner interactions in the prisoner's healthcare record and record if they are isolating due to illness.**
46. We are also concerned that prison staff had not noted in the wing observation book or handed over to incoming members of staff, that Mr Duggan had sickness and diarrhoea and had been isolating since 2 June. This meant that when the SO called healthcare staff on 4 June, she was unaware that Mr Duggan had already been unwell for several days.
47. We make the following recommendation:
  - The Governor should ensure that staff record when a prisoner is unwell, so that staff taking over a shift are aware who is ill and how long they have been ill for.**
48. We made a very similar recommendation following a previous death at Leeds and were told that a Governor's Notice would be issued by April 2021 to remind staff to do this. It is, therefore, disappointing to find the same problem arising in June 2021. It is for the prison to decide how to implement the recommendation, but we note that simply issuing a Governor's Notice does not appear to be an effective means of ensuring that the recommendation is implemented.

## Liaison with Mr Duggan's family

49. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health an appropriate member of prison staff should engage with their next of kin to provide information and support. If a prisoner's health deteriorates a family liaison officer should be appointed immediately and next of kin should be contacted.
50. On 6 June at 9.10am, a SO asked a HCA to contact Mr Duggan's wife to tell her that he had been taken to hospital and was stable.
51. At 11.30am on the same day, bedwatch staff notified the prison that Mr Duggan's health had deteriorated, and he had been taken to intensive care. A prison manager immediately appointed an officer as family liaison officer, and he made contact straightaway with Mr Duggan's wife. She told him that she had already been contacted and was aware that Mr Duggan was in hospital.
52. We are concerned that Mr Duggan's wife was initially contacted by a member of healthcare staff who was not trained as a family liaison officer. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that an appropriate member of staff, preferably a designated family liaison officer, contacts a prisoner's family to notify them when a prisoner is seriously unwell.**

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