Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig McConnell, a prisoner at HMP Leeds, on 22 April 2022

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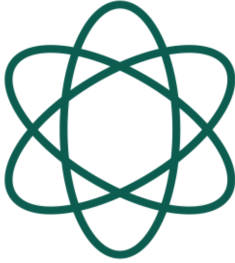
Our vision

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 Craig McConnell died in hospital from lymphoma (a type of blood cancer) on 22 April 2022, while a prisoner at HMP Leeds. He was 38 years old. I offer my condolences to Mr McConnell's family and friends.

The clinical reviewer concluded that the clinical care Mr McConnell received at Leeds was of a good standard and equivalent to that which he could have expected to receive in the community. However, Mr McConnell experienced significant weight loss while he was at Leeds which was not monitored by staff.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **December 2022**

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Summary

Events

1. On 7 March 2022, Mr Craig McConnell was remanded in prison custody, charged with burglary and fraud, and sent to HMP Leeds.

2. On 28 March, Mr McConnell became unwell and staff suspected he might have sepsis. He was taken to hospital where he was found to have COVID-19 and was treated for suspected sepsis. He had an enlarged spleen and liver, but doctors were unable to determine the underlying cause of Mr McConnell's illness. They discharged him on 5 April, with plans for further investigations as an outpatient.

3. Mr McConnell became unwell again on 17 April but initially refused to go to hospital. He agreed to go on the evening of 18 April when his condition became worse.

4. Initially, Mr McConnell's condition was relatively stable in hospital but deteriorated very quickly in the early hours of 22 April. Mr McConnell died at around 8.30am. Doctors had still not diagnosed his condition when he died.

5. A post-mortem examination found that Mr McConnell died from lymphoma (a type of blood cancer).

Findings

6. The clinical reviewer found that the care Mr McConnell received at Leeds was equivalent to that he could have expected to receive in the community. However, he found that although staff at Leeds identified that Mr McConnell was losing weight, they failed to monitor this.

Recommendations

- The Head of Healthcare should ensure that staff identify and monitor unexplained weight loss in prisoners and refer them for further investigations if the weight loss continues.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Leeds 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 McConnell's medical and prison records.

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

10. We informed HM Coroner for West Yorkshire (Eastern District) of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr McConnell's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She said that she had concerns about the healthcare that Mr McConnell received in prison. She said that he had not received adequate pain relief and that insufficient attention was given to the reasons why he lost so much weight. These issues are addressed in the clinical review.

12. Mr McConnell's mother complained that she was not able to speak to her son when he went to hospital in March and said that she was unhappy that the prison did not give her much information about him. We have addressed this issue in this report.

13. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

14. We sent a copy of our initial report to Mr McConnell's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Leeds

15. HMP Leeds is a local prison holding a maximum of 1,218 prisoners on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

16. The most recent full inspection of HMP Leeds was in November and December 2019. The inspection found that health services were generally good, and governance was robust. A range of health care services was provided by a skilled staff group, and waiting times were reasonable. Prisoners with long-term conditions and those with social and complex care needs received good support. Inspectors said that clinical records were of a high quality and the substance misuse team provided a good service.

17. HMIP carried out a short scrutiny visit to Leeds in June 2020 to assess how well the prison had responded to the COVID-19 pandemic. Inspectors reported that Leeds was calm and well-ordered, despite the severe restrictions on the regime. The prison had experienced a significant outbreak of the virus but had controlled it effectively. Prisoners reported being kept well informed.

Independent Monitoring Board

18. 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 annual report for the year ending 31 December 2020, the IMB said that there was a high number of prisoners at Leeds with significant mental health problems.

Previous deaths at HMP Leeds

19. Mr McConnell was the twenty-fifth prisoner to die at Leeds since April 2020. Of the previous deaths, 16 were from natural causes, seven were self-inflicted, and one remains unclassified. There are no similarities between our findings in the investigation into Mr McConnell's death and our investigation findings in previous deaths.

Key Events

20. On 7 March 2022, Mr Craig McConnell was remanded in prison custody, charged with burglary and fraud, and sent to HMP Leeds. (Before being remanded, he had been taken to hospital following a mixed drug overdose.)

21. Mr McConnell had a long history of substance misuse. When he arrived at Leeds, he tested positive for several different drugs. He was on methadone (a heroin substitute) in the community which was continued at Leeds. Mr McConnell also had epilepsy and a history of mental health issues. (He had been in a mental health hospital in January and February.)

22. In his first few days at Leeds, Mr McConnell asked for pain relief for back, shoulder and hip pain. He said that he had injured himself in falls in the past. A prison GP assessed him and referred him for physiotherapy. He also prescribed ibuprofen and paracetamol. Mr McConnell told an officer that he thought the doctor was reluctant to prescribe strong painkillers as they suspected he had drug-seeking behaviour.

23. On 11 March, a nurse saw Mr McConnell for a mental health assessment. She noted that he was unkempt and appeared to be emaciated. He said he was struggling to eat as he felt sick. The nurse assessed that he was still mentally very unwell and showing signs of paranoia. She referred him to a prison psychiatrist who saw him the next day but Mr McConnell wanted to discuss his back pain, not his mental health, and left early.

24. On 24 March, Mr McConnell again complained of pain in his back and shoulder and was prescribed ibuprofen gel. He was also prescribed mirtazapine to help him sleep.

25. On 26 March, the psychiatrist saw Mr McConnell again but he was still focused on his physical health (including some lumps on his chest, which he said he had not mentioned before). Mr McConnell thought his health problems were due to too much antipsychotic medication and not enough methadone. (He thought he was having withdrawal symptoms because his methadone dose was too low.) The psychiatrist asked healthcare and substance misuse staff to follow up Mr McConnell's issues and scheduled to review him again in a week's time.

26. However, on 28 March, Mr McConnell became unwell. He was breathless, had a raised heart rate and a low blood oxygen level. A nurse considered that there was a possibility that Mr McConnell had sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues) and called an ambulance.

27. Mr McConnell was treated for sepsis in hospital and also tested positive for COVID-19. Further tests were carried out which were inconclusive but showed that Mr McConnell had an enlarged liver and spleen, which were possibly caused by haemophagocytic lymphohistiocytosis (a rare immune disorder where the body reacts inappropriately to infection, causing inflammation). Mr McConnell was discharged from hospital on 5 April, with the intention that further tests, including

biopsies (a procedure to remove a tissue sample from the body so that it can be tested in a laboratory), would be carried out as an outpatient.

28. Mr McConnell had a hospital appointment for follow-up investigations on 21 April. However, he became unwell again on 17 April. Mr McConnell did not want to return to hospital and healthcare staff monitored him throughout the day and his condition improved a little. The following day, he was still unwell but insisted that he did not want to go to hospital. That evening, when he felt worse, he agreed to go. Two officers escorted him and he was restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

29. Hospital doctors suspected that Mr McConnell had leukaemia (cancer of the white blood cells). His condition was stable initially but deteriorated very quickly in the early hours of 22 April. At 7.55am, a nurse told the bedwatch officers that Mr McConnell was expected to die within an hour. A bedwatch officer contacted a prison manager, who authorised the removal of the escort chain. Mr McConnell died at around 8.30am. Doctors had not diagnosed his illness when he died.

Contact with Mr McConnell's family

30. After Mr McConnell was moved to a hospital high dependency unit on 19 April, Leeds appointed a family liaison officer (FLO) and he contacted Mr McConnell's mother on 20 April to update her. Another FLO was subsequently appointed by Leeds and they kept in regular contact with Mr McConnell's mother. The prison contributed to the expenses of the funeral in line with national policy.

Support for prisoners and staff

31. After Mr McConnell's death, there was good support from the prison for the bedwatch officers. One of them was affected by Mr McConnell's death and was followed up with support from the Care Team. Officers visited Mr McConnell's cellmate, who knew him well, to inform him of his death. They offered support, and the chaplaincy arranged to visit his cellmate and to take him to the chapel to spend some time there and pay his respects to Mr McConnell.

32. The prison also posted notices informing other prisoners of Mr McConnell's death, and offering support.

Post-mortem report

33. A post-mortem examination found that Mr McConnell had died from diffuse large B cell lymphoma (a fast-growing cancer that affects white blood cells).

Findings

Lack of weight monitoring

34. When Mr McConnell arrived at Leeds on 7 March, staff recorded his weight as 75kg (towards the upper end of the healthy weight range for his height). However, on 11 March, a nurse recorded that Mr McConnell "appears to be emaciated" and that he was struggling to eat because he felt sick. (This casts doubt on whether the 75 kg recorded for Mr McConnell's weight when he arrived at Leeds was accurate.) The mental health nurse who saw Mr McConnell on 26 March, said that he appeared underweight, but he told her he was eating.

35. When Mr McConnell returned to prison from hospital at the beginning of April, a hospital consultant wrote in the discharge letter that Mr McConnell had said that he had lost 31kg in the last 12 months. While this appears to be an overestimate, his clinical records show that he weighed 78kg in February 2021 and only 60kg when he died.

36. The clinical reviewer noted that Mr McConnell's weight had been known to fluctuate since May 2020 but on 15 January 2022, a GP recorded that Mr McConnell's weight loss needed to be investigated. This was never followed up. Best practice would have been to monitor his weight weekly and refer for clinical investigations if unexplained weight loss remained ongoing. We note the despite staff at Leeds noting that Mr McConnell appeared very underweight, no one started weight monitoring. We recommend:

    The Head of Healthcare should ensure that staff identify and monitor unexplained weight loss in prisoners and refer them for further investigations if the weight loss continues.

Family contact

37. Mr McConnell's mother complained to us that she was not able to speak to her son when he went to hospital in March 2022. She said that she was also unhappy that the prison did not give her much information about him. However, we found that the prison acted within the security guidelines on hospital admissions and that Mr McConnell was able to speak to his mother by telephone on 4 April. We therefore do not make a recommendation about this issue.

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