Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Denis Hayes, a prisoner at HMP Leeds, on 24 July 2023.

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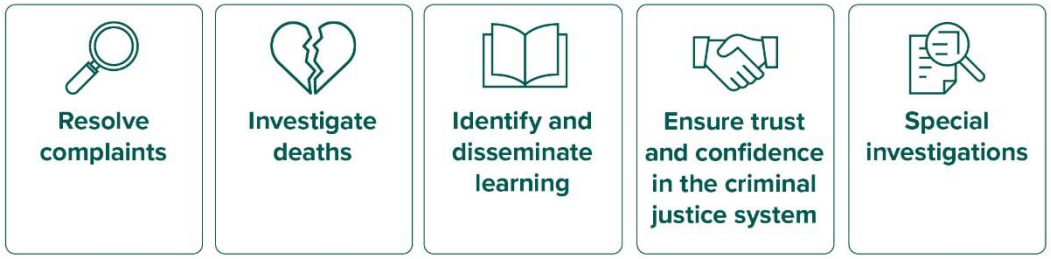
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Denis Hayes died of aspiration pneumonia (a lung infection) caused by vocal cord paresis (paralysis of the vocal cord muscles) on 24 July 2023, in hospital, while a prisoner at HMP Leeds. He was 54 years old. We offer our condolences to his family and friends.

4. The PPO family liaison officer wrote to Mr Hayes' mother to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Hayes' clinical care at HMP Leeds.

6. The clinical reviewer concluded that the clinical care Mr Hayes received at HMP Leeds was equivalent to that which he could have expected to receive in the community. She found that the healthcare team worked hard to ensure that Mr Hayes' care needs in relation to his spinal injury were met and they appropriately responded to the deterioration in his health.

7. However, the clinical reviewer made two recommendations not related to Mr Hayes' death which the Head of Healthcare will wish to consider.

8. The PPO investigator investigated the non-clinical issues relating to Mr Hayes' care. We did not find any non-clinical issues of concern. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. Mr Hayes' Mother received a copy of the initial report. She did not make any comments.

11. The inquest into Mr Hayes' death was held on 4 August 2023 and a verdict of natural causes was recorded. The coroner concluded that Mr Hayes' death was due to aspiration pneumonia (a lung infection) caused by vocal cord paresis (paralysis of the vocal cord muscles).

Adrian Usher **February 2024**
Prisons and Probation Ombudsman

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