Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Leach, a prisoner at HMP Forest Bank, on 4 January 2023

A report by the Prisons and Probation Ombudsman

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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

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.

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

Mr Dean Leach died of peritonitis (inflammation of the inner abdominal wall) caused by a perforated duodenal ulcer on 4 January 2023 at HMP Forest Bank. He was 37 years old. I offer my condolences to Mr Leach's family and friends.

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

We found that the non-clinical care provided to Mr Leach was of a good standard. We make no recommendations.

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

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

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Summary

Events

1. On 29 December 2022, Mr Dean Leach was charged with assault and remanded to HMP Forest Bank. No pre-existing physical medical conditions were listed in his medical records and his observations were all within normal ranges.

2. On 31 December officers asked for healthcare assistance when Mr Leach reported that he was vomiting and not eating. He became aggressive during the assessment and threatened to stop eating. Nursing staff advised Mr Leach to stay hydrated and created a food refusal care plan to manage the risks, which involved regular GP appointments. The plan was closed the next day when healthcare and officers established Mr Leach had been eating small amounts. Healthcare staff advised officers to seek assistance if they had any concerns.

3. On 3 January 2023, officers called for assistance when they saw Mr Leach rolling around the floor of his cell in pain and holding his stomach. He said he had been given medication for his symptoms in the community but had not taken it recently. Nursing staff found that Mr Leach's pulse and heart rates were high, so they took him to see the GP. Mr Leach told the GP he had a history of stomach ulcers for which he had taken medication in the past. The GP completed a thorough assessment for serious illness and found that Mr Leach's observations were all within normal ranges, although he had lost 3kg of weight since his arrival at Forest Bank. A care plan was created to manage the symptoms and Mr Leach's medication was re-prescribed.

4. Later in the afternoon Mr Leach was checked by nursing staff. He said he had ongoing abdominal pain, but it was less severe. Nursing staff completed a test to identify the risk of deterioration, the result indicated a low risk. No concerns were raised by Mr Leach for the remainder of the evening.

5. At 4.15am the following day, a nurse contacted Mr Leach's wing to request staff check on him. An Operational Support Grade (OSG) went to his cell before the morning roll check and found him semi-naked on his cell floor. When the OSG called his name Mr Leach was unresponsive, so he called an emergency code requesting assistance from staff and triggering a call for an ambulance. Healthcare staff and other officers responded quickly and found rigor mortis was present so made the decision not to commence resuscitation. Paramedics pronounced Mr Leach's death at 5.32am.

Findings

6. The clinical reviewer concluded that the clinical care Mr Leach received at HMP Forest Bank was at least equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

7. We found no non-clinical issues of concern.

The Investigation Process

8. We were notified of Mr Leach's death on 4 January 2023.

9. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Leach's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Leach's clinical care at the prison. The clinical reviewer and investigator jointly conducted six interviews with healthcare staff in February and March 2023. The investigator interviewed a prison manager.

12. We informed HM Coroner for Greater Manchester West of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Leach's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Leach's father responded and requested a copy of our report. He shared that Mr Leach had seen a nurse and a doctor and had a history of stomach problems which he was on medication for. He said that for his son to complain, it must have been really bad, and told us that he was supposed to be watched closely by prison staff because of mental health issues. We have addressed these concerns in our report.

14. We shared the initial report with HM Prison and Probation Service and NHS England, who identified one factual inaccuracy, which we have amended.

15. We also share the initial report with Mr Leach's family. They did not provide any feedback.

Background Information

HMP Forest Bank

16. HMP Forest Bank is a local prison in Salford, serving courts in north-west England. It holds 1,460 remanded and sentenced men. The prison is operated by Sodexo Justice Services. At the time of Mr Leach's death, primary care and substance misuse services at Forest Bank were provided by Sodexo and mental health services were provided by Greater Manchester Mental Health (GMMH) Foundation Trust. On 1 April 2023, it was announced that Spectrum Community Health CIC had been awarded a contract to provide primary care and substance misuse services at the prison.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) most recently inspected Forest Bank in January 2023, to complete an independent review of progress (IRP). In their previous inspection in February 2022, HMIP identified deterioration in two of their healthy prison tests: purposeful activity and rehabilitation, and release planning. Shortly before the February inspection, HM Prison and Probation Service (HMPPS) had issued Sodexo with a formal rectification notice because of concerns about the safety of prisoners and the conditions in which they were held. Sodexo responded promptly, recruiting a new director, and decisive action had seen improvements in living conditions with a renewed focus on improving safety.

18. In January's IRP, HMIP assessed progress against 12 recommendations about issues including safety, early days in custody and health, wellbeing, and social care. There had been good or reasonable progress in five of the recommendations that they examined, although there remained insufficient or no meaningful progress against three. These were staff-prisoner relationships, health, wellbeing and social care, and education, skills, and work.

Independent Monitoring Board

19. 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 October 2022, the IMB noted that significant improvements in the prison regime had taken place in the last four to five months. They reported a reduction in incidents of both self-harm and violence and noted that purposeful activity and out of cell time had increased.

Previous deaths at HMP Forest Bank

20. Mr Leach was the thirteenth prisoner to die at Forest Bank since January 2020. Of the previous deaths, seven were from natural causes, two were self-inflicted and three were drug related. There are no similarities between our findings in the investigation into Mr Leach's death and our investigation findings for the previous deaths.

21. Since Mr Leach's death, one further prisoner has died at Forest Bank, however the cause of death has not yet been ascertained.

Key Events

22. On 29 December 2022, Mr Dean Leach was remanded in custody at HMP Forest Bank after being charged with assault by beating. It was not his first time in prison.

23. At the initial health screening, a nurse completed basic observations and recorded that Mr Leach's weight, blood pressure and other readings were within normal ranges. Mr Leach had no known physical medical conditions according to his medical record, but he had not been in regular contact with a GP in the community.

24. On 31 December, a nurse recorded on Mr Leach's medical record that she had been asked to urgently examine him due to concerns raised by officers. Mr Leach had been vomiting and refusing food for three days and could not sit up in bed. When the nurse arrived at Mr Leach's cell, he immediately sat up in his bed. She told us that his immediate presentation contradicted the telephone call she had received. Mr Leach told her that he had not been eating anything and had been vomiting. She told Mr Leach to take regular sips of water, to stay hydrated. Mr Leach asked for medication, but she said it was not necessary at that point. Mr Leach became verbally abusive, started swearing and made threats that he would stop eating. In response, the nurse commenced a food refusal care plan, which involved keeping a food diary, daily visits by a nurse and regular GP appointments.

25. On 1 January 2023, after discussion with officers on Mr Leach's wing, the nurse established that he had been eating biscuits and drinking tea with other prisoners. She considered that Mr Leach was just angry in the moment when he threatened to refuse food, so chose not to continue with the food refusal care plan. The nurse advised officers to contact the healthcare emergency responder or use the healthcare triage system if they had any concerns.

26. On the morning of 3 January, prison officers asked healthcare staff to urgently examine Mr Leach. Officers had found Mr Leach grunting and rolling around in his cell, holding his stomach. Mr Leach told a nurse that he was supposed to be on omeprazole (a medication taken for gastritis, inflammation of the lining of the stomach) but that he had not taken it for some time because he had been "on the run" while resisting police arrest in the community. Mr Leach explained that the pain was worse if he ate, so he had not eaten for a few days. The nurse assessed Mr Leach and found that he was breathing quickly and had a fast pulse.

27. At around midday, officers escorted Mr Leach to the healthcare centre for an appointment with a GP. Mr Leach reported that he was suffering from indigestion, burping, and vomiting. He explained that he had a history of stomach ulcers for which he had been prescribed omeprazole in the past, however he had not taken it recently. The GP noted that Mr Leach had lost 3kg in weight since his arrival. He completed a thorough examination of Mr Leach and checked for signs of serious illness. He did not find any issues of concern, other than Mr Leach's trouble opening his bowels. The GP noted that Mr Leach's breathing, blood pressure and temperature were within the normal ranges. He diagnosed Mr Leach with gastritis and created a care plan to monitor his treatment, which included a prescription for omeprazole. The GP explained the red flag symptoms Mr Leach should look out for and refer to staff, using his emergency cell bell where necessary.

28. At 3.05pm, a nurse noted in Mr Leach's medical record that he had returned to the wing and should be reviewed by a night nurse later in the evening.

29. At 6.05pm, a nurse attended Mr Leach's cell to check on him and noted that he was fully alert and orientated, lying on his bed. Mr Leach reported ongoing abdominal pain but said it was less severe. He said he had not vomited again. The nurse recorded that Mr Leach had eaten a bowl of cereal and a warm drink. She administered his medication and completed a set of checks on the severity of illness and risk of deterioration, which indicated a low risk.

30. Shortly before 10.00pm, an operational support grade (OSG) completed a routine check of prisoners on Mr Leach's wing. He had a brief conversation with Mr Leach and did not raise any concerns.

4 January

31. At around 4.45am, a duty nurse called the OSG to ask if he could check on Mr Leach during his early morning routine check. Mr Leach had been sick the previous day and the early morning roll check was due in 15 minutes.

32. At interview, the OSG told us that following the nurse's telephone call, he decided to check on Mr Leach straightaway. At 4.58am, the OSG attended Mr Leach's cell and opened the cell observation panel. He turned on the cell light and saw that Mr Leach was semi-naked on the cell floor. The OSG banged on the door and called Mr Leach's name, but he was unresponsive.

33. The OSG radioed a medical emergency 'code blue', and officers and healthcare staff, including the duty nurse, responded quickly. The code blue triggered a call for an ambulance. At interview, the nurse told us that Mr Leach's body was rigid, cold to the touch and had no pulse. He noted that rigor mortis was present. As there were no signs of life, cardiopulmonary resuscitation (CPR) was not started.

34. At 5.26am, paramedics arrived at the cell. At 5.32am, they confirmed that Mr Leach had died.

Contact with Mr Leach's family

35. At around 9.00am on 4 January, prison family liaison officers travelled to Mr Leach's next of kin's home address and broke the news of Mr Leach's death.

36. Forest Bank contributed to the costs of Mr Leach's funeral, in line with Prison Service instructions.

Support for prisoners and staff

37. After Mr Leach's death, the duty governor debriefed the staff involved in the emergency response, to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

38. The prison posted notices informing other prisoners of Mr Leach's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Leach's death.

Post-mortem report

39. The post-mortem report concluded that Mr Leach died of peritonitis, secondary to a perforated duodenal ulcer and Chronic Obstructive Pulmonary Disease.

40. Peritonitis secondary to a perforated duodenal ulcer means a burst stomach ulcer which has caused an infection in the fluid that surrounds the organs in the space below the ribs and above the legs.

41. Chronic Obstructive Pulmonary Disease is the name for a group of lung conditions that cause breathing difficulties.

Findings

42. The clinical reviewer concluded that the clinical care Mr Leach received at Forest Bank was equivalent to that which he could have expected to receive in the community. He highlights areas of good practice and makes no recommendations.

43. We found that the non-clinical care provided to Mr Leach was of also of a good standard. Staff addressed Mr Leach's needs and responded swiftly and with compassion when they found him unresponsive. The outcome was unexpected and shocking for everyone involved.

Inquest

44. The inquest into Mr Leach's death concluded on 23 May 2025, returning a verdict of natural causes.

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