Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Leadbitter, a prisoner at HMP Hull, on 31 January 2024

A report by the Prisons and Probation Ombudsman

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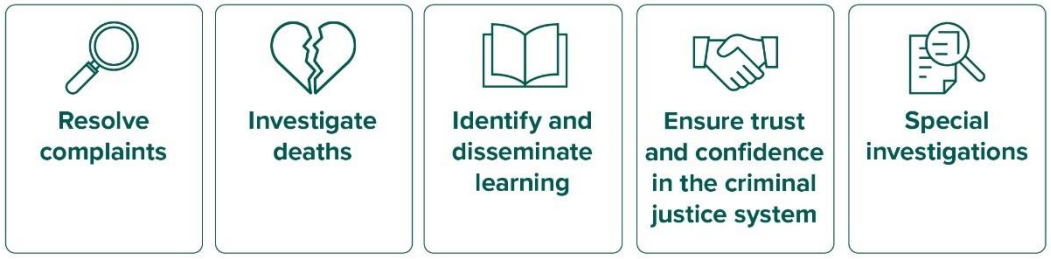
OUR VISION

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

Summary

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 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.

3. Mr John Leadbitter died from acute obstructive pneumonitis (an inflammation of the lung tissue) caused by lung cancer on 31 January 2024, while a prisoner at HMP Hull. He was 62 years old. We offer our condolences to Mr Leadbitter's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Leadbitter received at HMP Hull was partially equivalent to that which he could have expected to receive in the community. She made seven recommendations that the Head of Healthcare will want to address, five of which were not directly related to Mr Leadbitter's death.

5. Mr Leadbitter had poor health, limited mobility and there was no indication he posed a risk. Despite medical objections to using restraints, prison staff did not take into account Mr Leadbitter's current condition and restrained him when he was taken to hospital. We saw no evidence that Hull's decisions to restrain him were justified and in line with the Graham judgment and national policy. Hull told us that they could not explain why some of Mr Leadbitter's escort paperwork was left incomplete. This meant that we could not establish the extent to which he was restrained during hospital escorts or why.

Recommendations

- **The Head of Healthcare should ensure that staff are appropriately trained and clinically competent to deliver end-of-life care as per NICE [NG31] and the 'Dying Well in Custody Charter'.**

- **The Head of Healthcare at HMP Hull should ensure that the appropriate equipment, including a syringe pump, is available within the prison to support the delivery of safe and effective end-of-life care.**

- **The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that:**

    - **healthcare staff complete the healthcare section of the escort risk assessment fully and accurately;**

- **managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner poses at the time;**
- **all escort risk documentation is stored securely and can be retrieved, as necessary; and**
- **ensure that a robust quality assurance process is implemented to check that these measures are in place and effective.**

The Investigation Process

6. HMPPS notified us of Mr Leadbitter's death on 1 February 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Leadbitter's clinical care at HMP Hull.

8. The PPO investigator investigated the non-clinical issues relating to Mr Leadbitter's care.

9. As part of the investigation process, the clinical reviewer and investigator interviewed healthcare staff and the Head of Healthcare.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). Spectrum pointed out some factual inaccuracies and the clinical review has been amended accordingly.

Previous deaths at HMP Hull

11. Mr Leadbitter was the tenth prisoner to die at HMP Hull since April 2022. Of the previous deaths, eight were from natural causes and one was self-inflicted. There are no similarities between the findings in our investigation into Mr Leadbitter's death and the findings from our investigations into the previous deaths.

Key Events

12. On 31 August 2023, Mr John Leadbitter was remanded to HMP Hull, charged with arson and possessing a knife in a public place.

13. On 24 October, nurses were called to Mr Leadbitter's cell where they found him vomiting 'coffee grounds' (when vomit contains coagulated blood and is a sign of internal bleeding). He said he felt a 'sharp burning pain' on the left side of his chest. He said that he had swallowed three batteries and two razors four days earlier in an attempt to kill himself. A code blue was called and he was taken to hospital. A risk assessment was not completed properly but Mr Leadbitter was restrained with an escort chain (a length of chain with a handcuff at each end, one attached to the prisoner and the other to an officer).

14. Hull told the investigator that they did not know why the restraints paperwork was not completed but it was out-of-hours and there were limited resources in the prison. They said that the risk assessment should have been completed subsequently and should have noted that Mr Leadbitter posed a very low risk. This did not happen.

15. On 25 October, Mr Leadbitter had a chest X-ray which showed a lesion on his lung.

16. On 30 October, Mr Leadbitter told prison staff that he had lung cancer. On 5 November, during a suicide and self-harm prevention review, he said that he had a number of health conditions, including cancer, spine, knee and hip issues and was in a lot of pain. Staff agreed that Mr Leadbitter would be assessed for a wheelchair.

17. On 7 and 10 November, Mr Leadbitter attended hospital appointments, restrained with double cuffs (when a set of handcuffs is applied to a prisoner, with an additional cuff on one arm that is attached to a cuff on a prison officer). On 7 November, there were no medical objections to the use of restraints but on 10 November, he was restrained despite medical objections.

18. On 21 November, Mr Leadbitter had a medical appointment at the lung clinic to assess his lung capacity. He was restrained using double cuffs. The Head of Offender Management Services told the investigator that double cuffs were justified because Mr Leadbitter was unsentenced and uncategorised, and he was conscious, mobile, and there was no immediate risk to his life.

19. By December, Mr Leadbitter was using a wheelchair.

20. On 24 December, Mr Leadbitter was found on the landing at approximately 10.00am, struggling to breathe. A code blue was called and the Head of Healthcare and healthcare staff attended. Mr Leadbitter complained of chest and neck pain, and numbness to his arm. He was taken to hospital. The prison and healthcare sections of the risk assessment were unsigned. Hull told the investigator that the Prison Escort Record (PER) was missing so we could not establish if Mr Leadbitter was restrained.

21. On 25 December, Mr Leadbitter was told that his lung tumour was spreading aggressively. The hospital consultants gave him a prognosis of one month.

22. On 1 January 2024, Mr Leadbitter returned to Hull.

23. 3 January 2024, Mr Leadbitter started to receive palliative care. He was moved to the palliative care suite, and was only able to move from his bed to his chair.

24. On 23 January, Mr Leadbitter was due to be taken to hospital as a palliative bed was made available. However, the bed was no longer available at the time of transport so Mr Leadbitter remained in prison.

25. At 7.42pm on 31 January, a nurse found Mr Leadbitter had died. An out-of-hours doctor verified his death at 9.37pm.

Post-mortem report

26. A hospital doctor gave Mr Leadbitter's cause of death as acute obstructive pneumonitis (an inflammation of lung tissue), caused by lung cancer. He also had ischaemic heart disease which contributed to but did not cause his death. The Coroner accepted this cause of death and no post-mortem examination was carried out.

Inquest

27. At an inquest held on 6 June 2025**,** the Coroner concluded that Mr Leadbitter died of natural causes.

Findings

Clinical findings

28. The clinical reviewer concluded that the clinical care Mr Leadbitter received at HMP Hull was partially equivalent to that which he could have received in the community. She found that Mr Leadbitter was supported up to and following his diagnosis of lung cancer.

    However, she noted that the healthcare department was not appropriately equipped to care for prisoners receiving palliative care. She noted that staff lacked the clinical competence to care for palliative patients. She also noted that the healthcare department did not have a syringe pump to deliver pain relief medication. She found they were not commissioned to provide this, despite having a member of staff trained to use syringe pumps. She made a number of recommendations, which the Head of Healthcare will want to address, including the following two which were related to Mr Leadbitter's death:

    The Head of Healthcare at HMP Hull should ensure that staff are appropriately trained and clinically competent to deliver end of life care as per NICE [NG31] and the 'Dying Well in Custody Charter'.

    The Head of Healthcare at HMP Hull should ensure that the appropriate equipment, including a syringe pump, is available within the prison to support the delivery of safe and effective end-of-life care.

Non-clinical findings

Restraints, security and escorts

29. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

30. A judgment in the High Court in 2007, known as the Graham judgment, made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The Prevention of Escape: External Escorts policy framework states that restraints should not routinely be used where mobility is severely limited such as in the case of advanced age and ill health.

31. On multiple occasions, Mr Leadbitter was taken to hospital restrained with an escort chain or a double cuff. Mr Leadbitter was 62 years old, he had terminal cancer, he used a wheelchair and had a Prisoner Emergency Evacuation Plan (PEEP) in place. He was an unsentenced prisoner but had no disciplinary hearings in prison

and there was no intelligence to suggest he posed a security risk in terms of escape or risk to staff or the public. Despite this, Hull restrained Mr Leadbitter.

32. On occasion, prison staff overruled medical objections to the use of restraints and they did not explain why in the restraints paperwork. Restraints arrangements were inconsistent and not in line with the policy framework which states that staff should assess unsentenced prisoners on a case-by-case basis when deciding whether to use restraints.

33. The Head of Offender Management Services told the investigator that Mr Leadbitter was mobile, a risk as an unsentenced and uncategorised prisoner, and the medical objections did not provide a clear explanation. We recognise that healthcare staff provided very little information in their justification in several of the risk assessments, and this did not empower prison staff to make an informed decision on the level of restraints that should be used. However, given Mr Leadbitter's low risk of escape and harm and the deterioration in his health, he should not have been restrained.

34. The Head of Healthcare told us that Mr Leadbitter did not say he felt dizzy or in pain and he did not have mobility concerns (despite an entry in the medical records to say that Mr Leadbitter asked for a wheelchair due to mobility issues from 5 November).

35. The Head of Healthcare told us that healthcare staff should use the medical records to complete the paperwork and that the staff member who completed the paperwork was a member of agency staff and might therefore not have had training on completing escort paperwork and the Graham judgment.

36. Hull told us that they could not explain why some of Mr Leadbitter's escort paperwork was incomplete. This prevented us from establishing if Mr Leadbitter was restrained every time he attended hospital. The policy framework allows for paperwork to be completed retrospectively, up to 18 hours after leaving the prison. However, this was not done in Mr Leadbitter's case. The unsigned paperwork meant that the investigator could not establish why Mr Leadbitter was restrained. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that:

- **healthcare staff complete the healthcare section of the escort risk assessment fully and accurately;**
- **managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner poses at the time;**
- **all escort risk documentation is stored securely and can be retrieved, as necessary; and**
- **ensure that a robust quality assurance process is implemented to check that these measures are in place and effective.**

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

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