Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clive Pinder, a prisoner at HMP Risley, on 17 February 2021

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. 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.

3. Mr Clive Pinder died on 17 February 2021 of multi-organ failure caused by COVID-19 while a prisoner at HMP Risley. Mr Pinder was 53 years old. I offer my condolences to Mr Pinder's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Pinder received at HMP Risley was of a reasonable standard and equivalent to that which he could have expected to receive in the community. However, she was concerned about the lack of care planning for prisoners with COVID-19, record keeping and reception screenings, and made several recommendations.

5. We found that the emergency response on 11 February 2021, did not follow prison policy and there were delays in calling an ambulance. There were also significant gaps the family liaison officer's log and delays in providing us with key funeral documents.

Recommendations

- The Head of Healthcare should ensure care plans are implemented for prisoners who test positive for COVID-19 to ensure that appropriate individualised care is always delivered.

- The Head of Healthcare should ensure that healthcare staff explore alternative environments for delivering care to prisoners isolating with COVID-19 – including in-cell assessment – to ensure that care is received in a timely manner.

- The Head of Healthcare should:

    - ensure that all healthcare staff are aware of the need to document all clinical care in a prisoner's SystmOne record; and

    - carry out audits to ensure this is being done.

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance automatically.

- The Governor should ensure that, following a death in custody, the family liaison officer (FLO) maintains an accurate log with all significant contacts and that the prison provide relevant documents when requested in line with PSI 58/2010.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Pinder's clinical care at HMP Risley.

7. The PPO investigator has investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Pinder's location; the security arrangements for his hospital escorts; liaison with his family; and whether compassionate release was considered.

8. Our family liaison officer wrote to Mr Pinder's next of kin, his sister, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked about Mr Pinder's clinical care at Risley, his transfer to hospital and his funeral arrangements.

9. Mr Pinder's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

10. The initial report was shared with the Prison Service. HMP Risley provided further information and documents relating to funeral expenses and we have updated our report to reflect this. We have amended one recommendation. The Prison Service did not find any factual inaccuracies.

COVID-19 (Coronavirus)

11. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

12. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

13. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days. A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly received or returning prisoners from the main population through 'reverse-cohorting'. Other measures include social distancing and the use of personal protective equipment (PPE).

Previous deaths at HMP Risley

14. Mr Pinder was the tenth prisoner to die at Risley since February 2019. Of the previous deaths, six were from natural causes (including one from COVID-19) and three were self-inflicted. There has been one further COVID-19 related death since Mr Pinder's.

15. We have previously made recommendations about the emergency response and record keeping on SystmOne (the electronic medical record) at Risley. In their action plan the prison provided emergency response training to new staff and issued all staff with emergency response in custody (ERIC) cards. In their action plan for SystmOne record keeping the healthcare department committed to managerial audits of patient records to identify areas of concern.

Key Events

16. On 7 January 2014, Mr Clive Pinder was remanded to HMP Birmingham. On 2 November, he was sentenced to an Extended Determinate Sentence of four years custody and six years probation for sexual offences. The same day he was transferred to HMP Nottingham. On 26 January 2018, Mr Pinder was released to an Approved Premises (AP - a probation hostel) in Leicester.

17. In April, Mr Pinder moved to an AP in the West Midlands to be closer to his mother. However, on his first night there, he absconded. He was recalled to prison and sent to HMP Birmingham.

18. On 17 December 2020, Mr Pinder transferred to HMP Risley.

19. On arrival, in line with Public Health England (PHE) and HM Prison and Probation Service policy, Mr Pinder was placed in COVID-19 isolation for 14 days, known as 'reverse cohorting'. (Reverse cohorting aims to reduce the spread of COVID-19 by keeping newly arrived prisoners separate to the rest of the prison.) That day, Mr Pinder also had his initial and secondary health screenings.

20. On 21 December, Mr Pinder had a substance misuse screening, and a care plan was created for a methadone (heroin substitute) programme. However, this was not recorded on his SystmOne record (the electronic medical record).

21. On 14 January 2021, Mr Pinder did not attend a GP appointment to review his psychiatric and methadone medication. There is no evidence that this appointment was rebooked or rearranged.

22. In early February, an outbreak of COVID-19 was confirmed on E Wing where Mr Pinder lived. The prison and the Outbreak Control Team within PHE decided that mass COVID-19 testing of prisoners was needed.

23. On 4 February, Mr Pinder had a COVID-19 test. He was placed in isolation pending the result of the test. On 8 February, the test came back positive. He was asymptomatic (he was not showing any COVID-19 symptoms) and was in a single cell.

24. On 9 February, Mr Pinder did not attend a healthcare clinic appointment for blood tests and an echocardiogram (ECG – a test used to check the heart's rhythm and electrical activity) because he was isolating following his positive COVID-19 test. There is no evidence that staff either attended his cell to carry out the tests or rebooked the appointment.

25. The same day, Mr Pinder's sister said she received a call from him. She said he told her that he had tested positive for COVID-19, that he could not stand and kept banging his head. She said that she urged him to call a nurse.

26. On 11 February, at around 9.00am, an officer carried out welfare checks on E Wing and saw Mr Pinder in his cell, shaking severely. As he did not have full PPE on, another prison officer opened the cell. They found Mr Pinder panting and groaning. He was unable to speak.

27. An officer went immediately to the medication suite on the wing, where healthcare staff were dispensing medication, and asked them to see Mr Pinder. After a brief delay, healthcare staff stopped issuing medication and went to assess Mr Pinder. Two nurses saw Mr Pinder and noted he was having difficulty breathing. One nurse immediately requested an ambulance at 9.11am. At 9.15am the prison's Control Room called an emergency ambulance.

28. The nurse then assessed Mr Pinder using the National Early Warning Score (NEWS-2). This is a tool to help clinicians respond to clinical deterioration in adult patients. She calculated his NEWS-2 score as 17, which indicated he needed an emergency clinical response. (The scoring was incorrect but the correct score of 10 would have indicated the same required response.) Both nurses continued to monitor Mr Pinder's vital signs until paramedics arrived and took over his care.

29. At 9.54am, an ambulance arrived at Risley. Paramedics treated Mr Pinder and advised that he was so unwell that he might need to be defibrillated en route to the hospital. Mr Pinder was taken to Warrington Hospital. He was escorted by two prison officers and was not restrained. They arrived at the hospital at 10.53am.

30. At around 2.00pm, a prison manager rang Mr Pinder's sister, his next of kin, to tell her that Mr Pinder was in hospital.

31. On 12 February, the prison appointed a family liaison officer (FLO). Later in the day the hospital told the prison that Mr Pinder had been placed on a ventilator and was in an induced coma. On 13 February, the prison helped facilitate Mr Pinder's brother visiting him in hospital.

32. On the evening of 17 February, at around 6.35pm, Mr Pinder died at Warrington Hospital. The hospital contacted Mr Pinder's next of kin.

Cause of death

33. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Pinder's cause of death as multi-organ failure caused by COVID-19.

Clinical Findings

Management of Mr Pinder's risk of infection from COVID-19 and risk to others

34. The clinical reviewer concluded that the care that Mr Pinder received at Risley was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

35. The clinical reviewer did, however, have concerns about Mr Pinder's care and care planning for prisoners with COVID-19, record keeping and reception screenings.

Shielding status

36. She found that Risley followed 'reverse cohorting' guidance when Mr Pinder arrived on 17 December. Mr Pinder was not advised to shield during the COVID-19 pandemic as he did not meet the criteria set out by Public Health England (PHE) and was not assessed as clinically extremely vulnerable if he contracted COVID-19. There is no evidence to suggest that Mr Pinder had asked to shield while at Risley.

37. The prison told us that throughout Mr Pinder's time at Risley, they had enough PPE supplies, and that healthcare staff wore appropriate PPE when caring for Mr Pinder. We were told in interview that prison staff on E Wing had enough PPE as well.

COVID-19 isolation

38. It is likely that Mr Pinder caught COVID-19 at Risley. The prison wing which he lived on had a COVID-19 outbreak in early February 2021. We were told in interview that around one third of prisoners on Mr Pinder's wing were isolating at that time because they had tested positive for COVID-19, were displaying symptoms of COVID-19 or were shielding.

39. Mr Pinder and other prisoners were tested on 4 February and his positive test result came back on 8 February.

40. Mr Pinder isolated, in line with Prison Service and PHE guidance, between his COVID-19 test on 4 February and his hospitalisation on 11 February. The clinical reviewer was concerned that once Mr Pinder had tested positive for COVID-19, no care plan was created to deliver appropriate, individualised care.

41. The clinical reviewer found that there was no evidence that Mr Pinder told healthcare staff directly or via prison staff of any worsening of his health during that period. However, she noted there were no SystmOne records for this period.

42. In interview, the Head of Healthcare said that during the period between his COVID-19 test and his hospitalisation, Mr Pinder was seen daily by healthcare staff for medication. He said that Mr Pinder did not raise any concerns about his health when he attended the dispensary. Again, the clinical reviewer noted there were no SystmOne records for this period.

43. The clinical reviewer was also concerned that a planned clinical appointment on 9 February, which was to take blood tests and an echocardiogram (ECG), did not take place because Mr Pinder was isolating. In interview, the Head of Healthcare could not explain why healthcare staff did not attend Mr Pinder's cell to complete the tests. We make the following recommendations:

The Head of Healthcare should ensure care plans are implemented for prisoners who test positive for COVID-19 to ensure that appropriate individualised care is always delivered.

The Head of Healthcare should ensure that healthcare staff explore alternative environments for delivering care to prisoners isolating with COVID-19 - including in-cell assessment - to ensure that they receive care in a timely manner.

Clinical record keeping

44. The clinical reviewer found that information relating to Mr Pinder's physical care was not fully recorded on his SystmOne record. This includes the purpose of his 9 February appointment and the general lack of SystmOne records for the period of 4-11 February when Mr Pinder was isolating with COVID-19 but being seen daily by healthcare staff. Much of the information for this period was later provided by the Head of Healthcare in interview. We make the following recommendation:

The Head of Healthcare should:

- **ensure that all healthcare staff are aware of the need to document all clinical care in a prisoner's SystmOne record; and**
- **carry out audits to ensure this is being done.**

45. The clinical reviewer has made several recommendations about record keeping in relation to Mr Pinder's substance misuse, care plans and health screens which we do not repeat in this report but which the Head of Healthcare will need to address.

Non-clinical Findings

Emergency Response

46. PSI 03/2013, Medical Emergency Response Codes, requires prisons to have a medical emergency response code protocol which should trigger healthcare staff to attend immediately (if they are on duty) and control room staff to call an ambulance immediately. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.

47. It makes it clear that there should be no delay in calling an ambulance (for example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called). The PSI also says, "It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required".

48. On 11 February, Mr Pinder was found by prison staff at around 9.00am panting, groaning, sweating and unable to speak, but it was only at 9.15am that the prison called 999 for an ambulance. This is a delay of around 15 minutes. An officer said in interview that he did not call a code blue because there were healthcare staff on E Wing. However, the purpose of calling an emergency code is not only to summon healthcare staff but also to alert the prison's Control Room to call an ambulance immediately.

49. The clinical reviewer considers that these delays did not contribute to Mr Pinder's death. However, in other cases, a delay of even a few minutes might make a critical difference in a medical emergency. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance automatically.

Funeral Costs

50. Prison Service Instruction (PSI) 64/2011 - Management of prisoners at risk of harm to self, to others and from others – sets out the requirements on prisons to provide financial support to the costs of a prisoner's funeral. Chapter 17 covers the funeral arrangements and states:

    "*Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000.* The only exceptions are where the family has a pre-paid funeral plan or is entitled to claim a grant from other government departments e.g., Department of Work and Pensions.

    "As a guide, reasonable funeral costs may include:

    - funeral director's fees
    - hearse
    - simple coffin

- cremation/burial fees, this does not include the cost of the burial plot
- Minister's fees (although the Governor may consider offering the services of their own Chaplain to conduct the service)

"All funeral expenses must be paid directly to the funeral directors upon receipt of an original invoice".

51. Mr Pinder's next of kin told us that she had wanted to have her brother buried, but that the prison told her that they would only pay for the cost of Mr Pinder's cremation. She did not tell us what type of funeral was held.

52. We contacted the prison and asked for their records of the advice and information they gave Mr Pinder's next of kin. The prison told us that they did not advise Mr Pinder's next of kin that they would only pay for him to be cremated. They said they had told her the amount of money the prison could contribute and what the contribution could or could not be used for – in line with the policy.

53. The prison did not provide us with information about the advice they gave the next of kin, or the expenses information from the funeral directors. However, following the release of our initial report, the prison provided further information and documents relating to Mr Pinder's funeral and the financial contribution the prison made. The evidence provided indicated that Mr Pinder was buried, as his family wished. It is unfortunate that this information was not sent to us in a timely manner.

54. The prison tried to get an updated log from the FLO. She had moved to work in another prison and no updated log was provided to us. We note that Mr Pinder's family felt that they were steered towards a cremation. This may well not have been the FLO's intention. We are concerned that the log does not cover these key contacts with Mr Pinder's family and the discussions the FLO had with them. We make the following recommendation:

The Governor should ensure that, following a death in custody, the family liaison officer (FLO) maintains an accurate log with all significant contacts and that the prison provide relevant documents when requested in line with PSI 58/2010.

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

Inquest

The inquest, held on 17 July 2024, concluded that Mr Pinder died from natural causes.

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