Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marcus Drury, a prisoner at HMP/YOI Exeter, on 23 June 2020

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 if appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Marcus Drury died of infective endocarditis at the Royal Devon and Exeter Hospital on 23 June 2020, while a prisoner at HMP/YOI Exeter. He was 46 years old. I offer my condolences to Mr Drury's family and friends.

The clinical reviewer concluded that the clinical care Mr Drury received at HMP/YOI Exeter was not equivalent to that which he could have expected to receive in the community.

On 5 June 2020, prior to Mr Drury's final admission to hospital, healthcare staff took too long to respond to Mr Drury's clear clinical deterioration. In 2022, His Majesty's Inspectorate of Prisons noted long standing issues with healthcare provision at the prison.

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 **October 2023**

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Summary

Events

1. On 1 June 2020, Mr Marcus Drury was recalled to prison for eight weeks after breaking a domestic violence restraining order. He was sent to HMP/YOI Exeter.

2. On his arrival at Exeter, Mr Drury was taken to an isolation cell because he had been displaying symptoms of COVID-19, (an infectious respiratory disease caused by the SARS-CoV-2 virus). He was required to remain in isolation until 8 June. As a result of his symptoms, a nurse did not carry out a full initial health screen. Also, healthcare staff did not complete a secondary health screen as they should have done.

3. At 5.25am on 5 June, a Healthcare Assistant (HCA) saw Mr Drury lying on the floor of his cell, moaning in pain. There were faeces on the floor. The HCA called Mr Drury's name, but he did not answer. The HCA raised his concerns with a nurse.

4. At 7.30am, a nurse checked Mr Drury, and noted that he was lying in his bed, alert and orientated. The nurse spoke with Mr Drury through the observation hatch in his cell door and considered that there were no immediate clinical concerns, so asked another nurse to review him again later that morning.

5. At 9.20am, prison staff asked for a GP to see Mr Drury because they were concerned that he was lying on the floor and had soiled himself. The GP asked a nurse to review him. At 9.34am, the nurse went to see Mr Drury and noted that he was lying on the floor, shivering. Despite repeatedly calling his name, Mr Drury did not respond. The nurse raised his concerns with another nurse and the GP.

6. Another nurse attended Mr Drury's cell wearing appropriate PPE (personal protective equipment) to allow her to examine him properly. She took a note of his observations, and they were abnormal. She considered that Mr Drury might have developed sepsis. The GP arrived shortly afterwards. She noted that Mr Drury was not responding to her questions and that he appeared extremely unwell. At 11.28 am, Mr Drury was taken to hospital by emergency ambulance.

7. In hospital, Mr Drury was diagnosed with streptococcus A (an infection caused by bacteria). He suffered a number of small seizures. Hospital staff treated him with a course of intravenous antibiotics. He was sedated and was moved to the Intensive Care Unit (ICU). Hospital staff later diagnosed him with rheumatic heart disease. On 7 June, Mr Drury was fitted with an external pacemaker (a temporary device, which delivers a current to the heart to make it beat normally.), however, his condition continued to deteriorate.

8. On 16 June, Mr Drury was diagnosed with endocarditis (a life-threatening inflammation of the inner lining of the heart's chambers and valves) and tested positive for MSRA (methicillin-resistant Staphylococcus aureus, a bacteria resistant to some types of antibiotics). Hospital staff considered that the only treatment available to him was palliative care.

9. That day, the prison started an application for compassionate release on Mr Drury's behalf. However, on 22 June, before a decision could be reached, Mr Drury's family asked for the application be withdrawn and the prison stopped the application process.

10. At 12.30am on 23 June, Mr Drury died.

Findings

11. The clinical reviewer concluded that the clinical care Mr Drury received at HMP/YOI Exeter was not equivalent to that which he could have expected to receive in the community.

12. He was concerned that on 5 June 2020, prior to Mr Drury's final admission to hospital, healthcare staff did not promptly carry out a clinical examination despite his escalating symptoms.

13. COVID-19 protocols were not objective and were based on Mr Drury's own observations of his condition rather than being based on clinical observations. There was no evidence of a NEWS2 score (National Early Warning Score is a tool to assess unwell patients) being used to assess Mr Drury's condition.

14. The clinical reviewer found that Mr Drury's initial health screen was delayed and that there was no evidence that healthcare staff completed a secondary health screen, which is not in line with national guidelines. He made a number of recommendations in his review which we do not repeat below.

Recommendation

- The Head of Healthcare should ensure staff use the best available evidence when assessing prisoners' physical health.

The Investigation Process

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

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

17. NHS England commissioned an independent clinical reviewer, to review Mr Drury's clinical care at HMP/YOI Exeter.

18. Both the investigator and clinical reviewer interviewed one member of staff on 8 August 2022, and three members of staff on 10 August 2022.

19. We informed HM Coroner for Exeter & Greater Devon of the investigation. The investigation was suspended from 3 August 2020 until 1 October 2022, while we waited for the outcome of a police investigation into concerns of staff negligence. The police took no action against any member of staff at Exeter.

20. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. We have sent the Coroner a copy of this report.

21. The PPO family liaison officer wrote to Mr Drury's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Drury's sister did not have any issues she wanted to raise but asked for a copy of our report. We have sent her a copy.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies. The action plan has been annexed to this report.

Background Information

HMP/YOI Exeter

23. HMP/YOI Exeter holds up to 431 adult men and young offenders, and serves the courts of Devon, Cornwall and Somerset.

24. At the time of Mr Drury's death, GP and primary care health services were delivered by Practice Plus Group (PPG), formerly known as Care UK. Devon Partnership NHS Trust provide mental health services and substance misuse services are provided by PPG and EDP Drug and Alcohol Services.

25. In December 2022, provision of GP and primary health services changed to Oxleas NHS Foundation Trust.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Exeter was in November 2022. Inspectors noted the health care contract was due to transfer from Practice Plus Group to Oxleas NHS Foundation Trust on 1 December 2022 and that the prison was focusing on the transfer of those services to a new provider.

27. The inspectors noted long-standing issues with health care delivery had been worsened by the imminent transition of health care services to the new provider. Senior clinical leaders were not present on site, and staff did not always feel supported by senior managers.

28. Inspectors considered chronic staff shortages in all areas of healthcare had compromised the delivery of care and support to prisoners and services had to be prioritised each day to cover essential and urgent care.

Independent Monitoring Board

29. 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 December 2021, the IMB reported that the prison's response to COVID-19 had been generally well managed. However, they noted that several prison processes and programmes had suffered. They noted the high proportion of newly appointed officers, the difficulty of retraining staff and staff doing extra hours to cover shifts resulting in some staff fatigue.

30. The IMB concluded that staffing problems in healthcare had coincided with the need to manage the pandemic. Some healthcare appointments had been restricted to urgent care and medications only, although GP appointments continued via the telephone.

Previous deaths at HMP/YOI Exeter

31. Mr Drury was the twentieth prisoner to die at HMP/YOI Exeter since July 2017. Of the previous deaths, ten were from natural causes, eight were self-inflicted and one

was drug related. There have been nine deaths since Mr Drury's death, two were from natural causes and seven were self-inflicted. There are no particular similarities between the findings in this investigation and those in previous investigations.

COVID-19 (Coronavirus)

32. 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.

33. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection.

34. 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 was 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who were symptomatic; and separate newly received or returning prisoners from the main population through 'reverse-cohorting'. Other measures included social distancing and the use of personal protective equipment (PPE).

Key Events

35. In March 2020, restrictions began to be imposed in response to the COVID-19 pandemic. On 23 March, a national lockdown was imposed. Prison regimes were severely curtailed and face-to-face services were reduced or stopped.

36. On 19 May, Mr Marcus Drury was charged with domestic violence offences against his partner. He was sentenced to eight weeks imprisonment and sent to HMP/YOI Exeter. On 29 May, he was released from prison and was required to comply with his licence conditions. However, on 1 June, Mr Drury was recalled to prison for eight weeks after breaking a domestic violence restraining order. He was returned to Exeter.

37. Mr Drury had a number of pre-existing medical conditions, including anxiety, depression, asthma, knee osteoarthritis, hepatitis C and haematemesis. He received appropriate medications for his conditions.

38. On his arrival at Exeter, Mr Drury was taken to an isolation cell because he had been displaying symptoms of COVID-19, (an infectious respiratory disease caused by the SARS-CoV-2 virus). He was required to remain in isolation until 8 June.

39. Nurse A was tasked with completing Mr Drury's initial health screen. She was unable to complete a full health screen because of Mr Drury's move to the isolation cell. However, she noted that Mr Drury had arrived in prison having been previously prescribed 35ml of methadone (a synthetic opioid used in the treatment of drug addiction). He told the nurse that he had not collected his medication for the past few days. He also said that he had been using heroin and cocaine regularly. Mr Drury complained of knee and back pain and the nurse gave him some pain relief medication. The nurse referred Mr Drury to the prison's Substance Misuse Team for treatment and support. Healthcare staff reviewed him regularly while he was in isolation.

40. The following day, healthcare staff did not complete a full health screen as they should have done, instead they sent Mr Drury a secondary health screening questionnaire to complete and a COVID-19 information leaflet to read.

41. That day, Nurse B saw Mr Drury through the hatch of his cell door. She used a self-reporting, three-question template to assess his condition. She asked him if he had a temperature, whether his cough had worsened and how he felt generally. She did not take his clinical observations to assess his condition (if the prisoner felt that their temperature was normal that is what was recorded rather than his actual temperature). The nurse asked Mr Drury to come to the cell door to collect his daily methadone prescription. He told her that he was unable to move from his bed because of the pain in his back. He eventually made his way to the end of the bed and collected the methadone. Mr Drury asked the nurse for an ice pack to relieve the pain in his back which she gave to him later.

42. Later that day, Nurse C, from the prison's Substance Misuse Team saw Mr Drury. She had to review him through the hatch in his cell door and was unable to complete a full assessment. Mr Drury told her that he was experiencing pain in his back and asked for pain relief medication. She told him that she would pass on his

request to healthcare staff. He told her that before he arrived in prison, he had not collected his prescribed dose of methadone since 29 May. She agreed to carry on his previously prescribed methadone dosage and to carry out a full review once he had completed his period of isolation.

43. On 3 June, Nurse D saw Mr Drury. She used the same self-reporting, three-question template to assess his condition. She noted that he said he did not have a temperature and that his condition had not worsened. She did not take any clinical observations to assess his condition.

44. At 9.29am on 4 June, Nurse B saw Mr Drury again through the hatch of his cell door. Again, she used the same self-reporting, three-question template. She did not take any clinical observations to assess his condition. Mr Drury told her that while he did not have a temperature, he was still unable to get out of his bed due to the pain in his back and that he had vomited. As Mr Drury was unable to collect his medication, she passed it to him through the cell hatch. She planned to revisit him again later that day, but told him to use his emergency cell bell should he need assistance in the meantime.

45. At 9.38am, a Healthcare Assistant (HCA) saw Mr Drury. She noted that he was still lying on his back in his bed. She also noted there was bile-like liquid on the floor next to his bed. She asked him twice to come to the cell door on so she could speak with him, but he refused to speak with her. She went to see him again at 11.08am. She noted that he appeared asleep, so she woke him up and asked if he had any concerns. Mr Drury said that he was unable to get out of bed due to the pain in his back, had been experiencing chest pains and had vomited a number of times. The HCA immediately raised her concerns with Nurse B and Nurse C.

46. Nurse E went to Mr Drury's cell to carry out an ECG (electrocardiogram). Mr Drury refused and signed a disclaimer form to that effect. Dr A, a GP at Exeter, prescribed him with prochlorperazine (used to reduce the feeling of sickness).

Events of 5 – 23 June 2020

47. At 5.25am on 5 June, a second HCA checked Mr Drury. He noted that Mr Drury was lying on the floor and was moaning in pain. He also noted that there were faeces on the floor. He called his name, but Mr Drury did not answer. The HCA raised his concerns with the healthcare nurse on duty overnight.

48. At 7.30am, on her return from carrying out duties in the prison's reception area, the healthcare nurse on duty overnight saw Mr Drury. She noted that he was lying on the floor but was alert and orientated. She noted that there was evidence of dried faeces on the floor. She considered that Mr Drury was behaving bizarrely. However, she considered that there were no immediate clinical concerns, and asked Nurse C to review him again later that morning.

49. However, at 9.20am, prison staff asked for a GP to see Mr Drury because they were concerned that he was lying on the floor and had soiled himself. The prison GP asked Nurse E to go and see Mr Drury.

50. At 9.34am, Nurse E went to see him. Mr Drury was lying on the floor of his cell and was shivering. Despite repeatedly calling his name, Mr Drury did not answer. The

nurse recorded that Mr Drury was being uncooperative and raised his concerns with Nurse C and the GP.

51. At 11.20am, Nurse c attended the cell wearing appropriate PPE (personal protective equipment) and moved Mr Drury to his chair. She took a note of his observations. His pulse was low and his temperature was high. She considered that he might have developed sepsis (a life-threatening reaction to an infection). The prison GP arrived shortly afterwards. She noted that Mr Drury was not responding to her questions and that he appeared extremely unwell. She agreed that he might have developed sepsis. Staff in the prison control room telephoned for an emergency ambulance at 11.24am. Paramedics arrived at 11.28 am, and Mr Drury was taken to hospital by emergency ambulance. He was not restrained.

52. In hospital, Mr Drury was diagnosed with streptococcus A and suffered a number of small seizures. Hospital staff administered a course of intravenous antibiotics. They sedated him, moved him to the ICU and placed him on a ventilator to help him to breathe. However, his condition continued to deteriorate. Hospital staff subsequently diagnosed him with rheumatic heart disease.

53. On 7 June, Mr Drury was fitted with an external pacemaker. Later that day, hospital staff told the prison officers accompanying Mr Drury that he was losing brain function. They planned to stop his sedation in order to assess the extent of his brain function. On 10 June, hospital staff told prison staff that Mr Drury's prognosis was poor and that he was not expected to survive.

54. On 16 June, Nurse F telephoned hospital staff for an update on his condition. They told her that Mr Drury had developed endocarditis and that he had also tested positive for MSRA. They decided that Mr Drury was no longer suitable for active treatment and that the only treatment option open to him was palliative care.

55. Later that day, the prison made an application for compassionate release on Mr Drury's behalf. However, on 22 June, before a decision could be reached, Mr Drury's family asked for the application be withdrawn. They said that they preferred for him to remain in hospital, accompanied by prison officers. The prison withdrew the application.

56. Mr Drury's condition continued to deteriorate and at 12.30am on 23 June, Mr Drury died.

Contact with Mr Drury's family

57. On 6 June, the prison appointed Senior Officer (SO) to act as Family Liaison Officer. She telephoned his next of kin, his sister, that day to inform her of the seriousness of Mr Drury's condition. She remained in daily contact with Mr Drury's family, keeping them updated on his condition and offering support and information.

58. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

59. After Mr Drury's death, a prison manager debriefed the staff who were involved giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

60. The prison posted notices informing other prisoners of Mr Drury'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 his death.

Cause of death

61. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor gave Mr Drury's cause of death as infective endocarditis (an infection caused by bacteria that enter the bloodstream and settle in the heart lining, a heart valve or a blood vessel) caused by cerebral (brain), renal (kidney), splenic (spleen) and hepatic (liver) abscesses.

Findings

Clinical care

62. The clinical reviewer concluded that the clinical care Mr Drury received at HMP/YOI Exeter was not equivalent to that which he could have expected to receive in the community.

Mr Drury's care on 5 June

63. At 5.25am on 5 June, the second HCA checked Mr Drury. Mr Drury was lying on the floor and was moaning in pain. There was also faeces on the floor and Mr Drury did not respond to his name being called. The HCA raised his concerns with Nurse E, the healthcare nurse on duty overnight. Mr Drury was checked again at 7.30am, 9.20am when prison officers expressed concern about his condition and again at 9.34am. During this time, Mr Drury's presentation did not change. It appears that healthcare staff formed the view that Mr Drury was being uncooperative. The clinical reviewer was concerned that healthcare staff chose to accept that Mr Drury was uncooperative without attempting to gather objective evidence about his wellbeing first. There is no evidence that they took his clinical observations to establish his current state of health or used the NEWS2 tool (to measure clinical deterioration in a patient). The clinical reviewer considered that at around 9.34am, it was likely that Mr Drury had lost capacity due to sepsis and that healthcare staff did not respond appropriately when they were asked to review Mr Drury.

64. We considered whether the actions of any of the healthcare staff involved in Mr Drury's care on 5 June fell sufficiently short of reasonable expectations that they should be referred to the independent regulator, the Nursing and Midwifery Council. The clinical reviewer did not consider that a referral was justified. The legal team for Practice Plus Group, also responded that they had not considered a referral was appropriate in the circumstances. Some of the staff involved on 5 June are still employed at Exeter. The Head of Healthcare will want to consider how to share the learning from this investigation with relevant staff.

Clinical observations and NEWS2

65. On 1 June, Mr Drury entered prison with COVID-19 symptoms. He was appropriately placed in an isolation cell and was required to isolate until 8 June. On 2, 3 and 4 June, healthcare staff saw Mr Drury to check on his condition. They used a three-question template to assess his condition. They did not take any clinical observations.

66. NEWS2 is a nationally recognised tool to facilitate the early detection of deterioration in health. The clinical reviewer was concerned that the COVID-19 protocols were not objective and were based on Mr Drury's own observations of his condition rather than being based on clinical observations. He was also concerned there was no evidence of a NEWS2 score being used to assess Mr Drury's condition when he began to deteriorate on 5 June. We recommend:

    The Head of Healthcare should ensure staff use the best available evidence, including NEWS2 scores, when assessing prisoners' physical health.

Head of Healthcare to note:

67. The clinical reviewer found evidence of poor record keeping in Mr Drury's medical records. Healthcare staff also failed to sufficiently challenge and encourage Mr Drury when he refused to comply with his treatment.

68. The National Institute for Clinical Guidance (NICE) NG57 (assessing diagnosing and managing physical health problems of people in prison) recommends that a healthcare professional should carry out a second stage health assessment for every person received into prison. It is also recommended that the second stage health screen should be carried out within seven days of the prisoner's initial health screen.

69. Nurse A was tasked with completing Mr Drury's initial health screen when he arrived at Exeter on 1 June 2020. However, she was unable to complete a face to face, full health screen because of Mr Drury's move to an isolation cell. The following day, healthcare staff did not complete a full initial health screen as they should have done, instead they sent Mr Drury a secondary health screening questionnaire to complete as well as a COVID-19 information leaflet. The clinical reviewer considered that a full initial health screen and a secondary health screen should have been completed, in line with NICE guidance NG57.

70. We bring these issues to the Head of Healthcare's attention.

Inquest

71. The inquest, heard on 11 March 2024, concluded that Mr Drury died from infective endocarditis, the cause of which could not be determined.

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