Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Teague, a prisoner at HMP Humber, on 22 January 2022

A report by the Prisons and Probation Ombudsman

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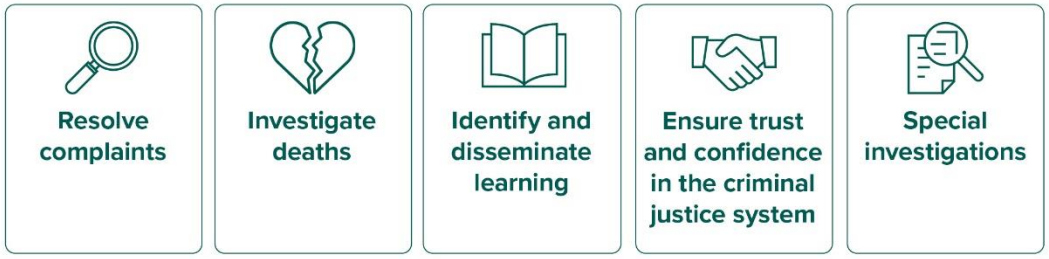
OUR VISION

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Edward Teague died in hospital on 22 January 2022, while a prisoner at HMP Humber. He was 39 years old. Mr Teague died from multi-organ failure as a result of bacterial pneumonia and COVID-19 pneumonitis. He also had hepatitis C and asthma. I offer my condolences to Mr Teague's family and friends.

4. The clinical reviewer concluded that Mr Teague received a good standard of clinical care at Humber, equivalent to that which he could have expected to receive in the community. She noted there had been a delay in completing his secondary health assessment but considered this had not adversely impacted on his care. She made no recommendations.

5. Mr Teague had not disclosed a diagnosis of asthma, so staff were unaware that he was possibly at higher risk of complications from COVID-19. He had repeatedly declined to be vaccinated. We are satisfied that he was managed in line with the national guidance on COVID-19 risk management. However, given that he had not left Humber for several months, it seems that he caught the infection at the prison.

6. We were unable to fully consider and comment on the risk assessment and use of restraints for Mr Teague's journey and admission to hospital, as the prison did not provide the relevant documents.

Recommendation

- The Governor should ensure that documents are retained, securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

The Investigation Process

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

8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Teague's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered. She also spoke to a prisoner who had responded to the PPO notice of investigation.

9. The PPO family liaison officer wrote to Mr Teague's next of kin, his mother, to explain the investigation and ask if there was anything she wanted the investigation to consider. Mr Teague's mother said her son had mentioned several concerns about his care, including:

    - Mr Teague had a chest infection for several weeks before he tested positive for COVID-19 but had not been prescribed antibiotics when he asked for them.
    - He had been unable to use an asthma inhaler, as he had to wait for three to eight days for a replacement when he finished one.
    - He had not been prescribed steroids when his asthma worsened.
    - Mr Teague had to use an oxygen cylinder and pulse oximeter in his cell. Was he shown how to use them, did nurses check his oxygen level and was chronic obstructive pulmonary disease (COPD) taken into account when administering this?
    - He had been taken to hospital on 8 January, discharged the same day but returned on 9 January.

10. Mr Teague's mother received a copy of the initial report. She made no comments.

11. We shared the initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They accepted our recommendation and provided an action plan.

Previous deaths at HMP Humber

12. Mr Teague was the seventh prisoner to die at Humber since January 2020. Of the previous deaths, five were from natural causes (three with COVID-19) and one was self-inflicted. There has since been a further death, which appears to have been drug-related. There are no significant similarities between the findings in our investigation into Mr Teague's death and those of previous deaths at Humber.

COVID-19 (coronavirus)

13. 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.

14. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. In response to the pandemic, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain outbreaks - to be implemented at local level, depending on the needs of individual prisons. (A key strategy was 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population.)

15. In September 2021, the shielding programme ended in the community, but HMPPS continued to routinely offer shielding to clinically high-risk prisoners. This has recently been replaced by a system of individual risk assessments by clinical staff, to determine the measures necessary to support such prisoners. The agreed adjustments are documented in a *Personal Management Plan*, which is then facilitated by operational staff.

Key Events

16. Mr Edward Teague was remanded to prison on 31 January 2007. On 16 May 2007, he was convicted of robbery and sentenced to Imprisonment for Public Protection, with a minimum period to serve of two years.

17. Mr Teague transferred from HMP Manchester to HMP Humber on 7 September 2021. At his initial health screen, it was recorded that he had a history of hepatitis C, epilepsy, substance misuse and mental health conditions. He had persistently declined treatment for hepatitis C and healthcare staff at Humber later re-referred him to a specialist. He had also refused COVID-19 vaccinations at Manchester in February, March and May 2021 and further refused the vaccine on reception to Humber.

18. Mr Teague did not tell the reception nurse that he had been diagnosed with asthma. His medical records indicated that an inhaler had not been prescribed since 2013, his last review for this condition was in 2014 and he was not on the national register for asthma. Mr Teague was subject to reverse cohorting until 18 September, in line with the national policy to separate all new arrivals from existing residents for up to 14 days.

19. The secondary health screen was conducted on 28 September. Over the following months, Mr Teague's contact with the healthcare department was largely for medication and substance misuse support.

2022

20. Humber had an outbreak of COVID-19 in January 2022 and conducted mass testing of prisoners. On 4 January 2022, a lateral flow test taken by Mr Teague was positive. A nurse then took a swab for a PCR test. She showed him how to use a pulse oximeter to check his blood oxygen saturation level and gave him advice on the warning signs of deterioration. Mr Teague told her that he had a sore throat and cough but no long-term health conditions. He was placed in protective isolation in his cell, pending the result of the test (which later returned as positive).

21. Late evening, Mr Teague rang his cell bell. He told a wing officer that he was coughing up small amounts of blood and had tested positive for COVID-19 earlier in the day. The officer informed the operational manager, who requested an ambulance, but it was stood down as Mr Teague's symptoms improved. The officer also agreed to check Mr Teague through the night and told him to press his bell again immediately if he felt worse.

22. Mr Teague received daily welfare checks (apart from 6 January). This included full clinical observations scored with the National Early Warning Score 2 (NEWS2 – a system to assess the severity of acute illness, identify deterioration and determine the appropriate escalation procedures). On 7 January, Mr Teague was prescribed antibiotics and steroids for a suspected chest infection.

23. At his health check on 8 January, a nurse found that Mr Teague's blood oxygen level was low, he was short of breath and his NEWS2 score had increased to 6.

This score indicated he should be urgently assessed by a specialist in acute care. The nurse requested an ambulance and gave him oxygen.

24. Mr Teague was admitted to hospital as an inpatient. He was escorted by two prison officers, using restraints. Healthcare staff obtained daily updates on his condition.

25. On 9 January, prison staff informed Mr Teague's mother that he was unwell and in hospital.

26. In the early hours of 10 January, Mr Teague moved to the intensive care unit and was placed on a ventilator the following day. The prison assigned a family liaison officer who gave daily updates to his family.

27. On 13 January, the Governor approved Mr Teague's release on temporary licence, through a special purpose licence. The escort was reduced to one officer.

28. On 15 January, the Governor and the family liaison officer met Mr Teague's family at the hospital after a visit.

29. Mr Teague died at 11.03am on 22 January. A family member was already on her way to the hospital and arrived shortly afterwards. The family liaison officer telephoned Mr Teague's sister. The hospital had already informed the family.

30. One of the prison's care team went to the hospital to support the escort officer. A prison manager later held a formal debrief. Other prison staff and prisoners were informed of Mr Teague's death and reminded of the avenues of support.

31. In line with national policy, the prison contributed to the costs of Mr Teague's funeral, which was held on 24 February.

Post-mortem report

32. The post-mortem report concluded that the cause of Mr Teague's death was COVID-19 pneumonitis. He also had underlying hepatitis C and obesity, which did not cause, but contributed to his death.

Findings

Clinical Findings

33. The clinical reviewer concluded that Mr Teague received a good standard of clinical care, equivalent to that which he could have expected to receive in the community. She noted that Mr Teague's secondary health screen had not been completed within the prescribed timescales but considered that this had no bearing on his death. She made no recommendations.

Management of Mr Teague's risk of infection and monitoring his illness

34. During the pandemic, prisons were expected to identify those at risk of complications from COVID-19 and offer them the opportunity to shield. Mr Teague had not disclosed that he had asthma and reported no symptoms while at Humber. Therefore, healthcare staff believed he had no underlying medical conditions that placed him at higher risk.

35. Information to prisoners about protective measures was reinforced by healthcare staff, who encouraged Mr Teague to have the COVID-19 vaccine. He declined and was considered to have the mental capacity to make decisions about his health.

36. As Mr Teague had not left the prison in the weeks before he contracted COVID-19, it is reasonable to conclude that he caught the virus at Humber.

37. We are satisfied that when Mr Teague became unwell, healthcare staff monitored him closely and sent him to hospital immediately when his condition deteriorated.

Security risk assessment and the use of restraints

38. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking account of factors such as the prisoner's health and mobility.

39. We do not know the level of restraints during Mr Teague's journey and admission to hospital, as the prison did not provide the supporting evidence such as the security risk assessment, person escort record and escort logs from 8 – 13 January. (We address this further below.) An entry in Mr Teague's NOMIS personal record suggests that, in line with the national policy on COVID-19, an escort chain was used, but it is unclear if this was in conjunction with handcuffs.

40. In principle, we are not critical of the decision to use restraints initially, as Mr Teague was relatively young, alert and mobile. However, we were unable to consider conclusively whether his risk was assessed appropriately; whether the level of restraints was proportionate throughout his stay in hospital; and whether their removal was timely when his health deteriorated.

Provision of supporting evidence

41. Prison Service Instruction 58/2010, The Prisons and Probation Ombudsman (PPO) states that the PPO must have unfettered access to documents for investigations. There was a delay of around ten weeks before we received the investigation documents, and they were incomplete. Despite several requests, the prison was unable to provide key security documents.

42. The Head of Security apologised and gave assurances that appropriate systems are in place to collate evidence and prevent this happening again. While we acknowledge the considerable operational difficulties faced by staff during the COVID-19 pandemic and outbreaks at the prison, it is essential that due priority is given to assisting fatal incident investigations to learn lessons that will help prevent future deaths. We recommend:

    The Governor should ensure that documents are retained, securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **February 2023**

Inquest

The inquest, held on 16 July 2024, concluded that Mr Teague died from natural causes.

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