Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Reid, a prisoner at HMP Winchester, on 10 August 2022

A report by the Prisons and Probation Ombudsman

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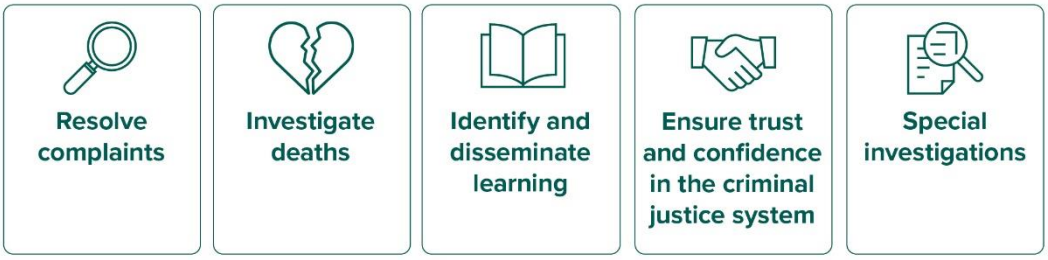
OUR VISION

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. If my office is to best assist HM Prisons 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 Reid died in hospital from COVID-19 on 10 August 2022, while a prisoner at HMP Winchester. He was 58 years old. I offer my condolences to Mr Reid's family and friends.

4. The clinical reviewer found that Mr Reid's care was equivalent to that which he could have expected to receive in the community. However, he recommended that newly arrived unvaccinated prisoners should be offered the COVID-19 vaccination; prisoners should be moved to a suitable area for emergency and resuscitation procedures; and healthcare staff should fully and accurately record medical events.

5. We identified additional concerns, including poor and inaccurate record keeping, which we have raised in several previous investigations and therefore escalate to the NHS commissioner; delays in allowing paramedics to enter and leave the prison; and an ill-judged security risk assessment.

6. As Mr Reid tested positive for COVID-19 14 days after his remand to Winchester (on the cusp of the accepted incubation period), we do not know whether he caught the infection in the community before his remand, or in prison.

Recommendations

- The Governor should review the local Emergency Call Out Protocol 2018 and ensure that there are no unnecessary delays in admitting and discharging ambulances.

- The Head of Healthcare should ensure that in a medical emergency, the patient is moved to an appropriate area where they can be fully assessed and treated.

- The NHS Commissioner for South Central should write to the Ombudsman, setting out how they intend to improve clinical record keeping at HMP Winchester.

- 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 in all cases:

    - the medical information accurately reflects the prisoner's current clinical condition and impact on their ability to escape unaided; and

- operational staff take account of this information and fully document all decisions concerning the use of restraints.

- The Governor should ensure that staff complete all relevant sections of a prisoner's personal records and wing documents; and fully document all significant interactions and decisions.

The Investigation Process

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

8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Reid's location; the security arrangements for his journey and admission to hospital; and liaison with his family.

9. The investigator obtained from the coroner the name and contact details of Mr Reid's mother and daughter, his next of kin. The Ombudsman's family liaison officer wrote to them to explain the investigation. Mr Reid's daughter asked for the investigation to consider several issues around the circumstances leading to Mr Reid's death. They are listed in full in the clinical review and include the following questions:

    - What was Mr Reid's condition when he went into prison, was he showing signs of illness and when did he first become unwell?
    - Was Mr Reid given a full examination and checked for anything other than COVID-19?
    - Given his rapid deterioration, why had medical staff not identified that Mr Reid was seriously unwell?
    - What was the ambulance response time?

10. The clinical review and this report address the issues relevant to Mr Reid's clinical management and cause of death.

11. We sent a copy of our report to Mr Reid's daughter. She identified inaccuracies in the investigation and clinical review reports, which have been amended. She also raised issues which have been dealt with in correspondence.

12. The initial report was shared with HMPPS who found no factual inaccuracies. They accepted our recommendations and their action plan is attached

Previous deaths at HMP Winchester

13. Mr Reid was the11th prisoner at Winchester to die since August 2020. Of the previous deaths, seven were from natural causes (two related to COVID-19), two were self-inflicted and one has yet to be determined. There have been two further deaths, one from natural causes and the other self-inflicted. We have previously made recommendations on clinical record keeping.

Background Information

COVID-19 (coronavirus)

14. 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.

15. 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.)

16. 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

17. Mr John Reid was remanded to HMP Winchester on 27 July 2022. He had been charged with several offences, including harassment and threatening a person with an offensive weapon.

18. Healthcare staff completed initial and second-stage health assessments on 27 and 28 July, respectively. This included clinical observations, such as checks of Mr Reid's blood pressure and temperature. No physical or mental health concerns were identified. Mr Reid was fit and well and needed no medication.

19. Mr Reid went through the prison's induction procedures. Nothing was recorded in his personal records (NOMIS) over the following two weeks and he had no contact with healthcare staff.

Events of 10 August

20. At around 10.00am on 10 August, Mr Reid tested positive for COVID-19 (we do not know what prompted the test). At midday, a wing officer noticed that he seemed unwell.

21. Two nurses examined Mr Reid in his cell and found he was grey, with a mottled appearance on his hands and feet, cold and drowsy. Although he was alert, the nurses were unable to take his blood pressure, pulse rate, or blood oxygen saturation readings. The nurses called a code blue medical emergency and an ambulance was requested at 12.08pm. They gave Mr Reid oxygen and glucose while waiting.

22. Paramedics arrived at the prison at 12.37pm and reached the cell at 12.45pm. Prison officers helped them to move Mr Reid from the top bunk of the bed to the landing. The paramedics had similar problems to the nurses when they tried to take clinical observations.

23. At around 1.10pm, Mr Reid went into cardiac arrest and stopped breathing. The paramedics began cardiopulmonary resuscitation (CPR) and requested another ambulance crew, which arrived a few minutes later. Mr Reid's pulse returned intermittently, but he had a further cardiac arrest.

24. CPR continued while Mr Reid was taken from the landing to the ambulance and throughout the journey to hospital. He was escorted, without restraints, by two prison officers.

25. Mr Reid arrived at the hospital at 1.30pm. His death was confirmed at 2.09pm.

26. The prison assigned a family liaison officer shortly after the ambulance left the prison. While he and his deputy were discussing Mr Reid's condition and reviewing his records, they were told that he had died. No next of kin contact details had been recorded. The family liaison officer checked with the police liaison officer and Mr Reid's community GP surgery and staff searched his cell for possible contacts. Mr Reid had made no telephone calls in prison and a telephone number listed in his records was out of service.

27. A prison manager debriefed staff and offered support. Mr Reid's cell mate received a welfare check. The prison issued notices to other staff and prisoners, informing them of Mr Reid's death and reminding them of the avenues of support.

Post-mortem report

28. The post-mortem report concluded that Mr Reid died from COVID-19 infection. Coronary artery atheroma (a build-up of fatty deposits on the walls of the arteries around the heart) was listed as a contributory factor.

Findings

Clinical Findings

29. The clinical reviewer considered that Mr Reid's clinical care at Winchester was of a reasonable standard and equivalent to that which he could have expected to receive in the community. However, he identified deficiencies in Mr Reid's care, which we reflect in this report.

Management of Mr Reid's risk of infection from COVID-19

30. To reduce the risk of infection, the HMPPS COVID-19 policy at the time of Mr Reid's death required new prisoners to be isolated away from the main population for up to 14 days (known as reverse cohorting). Winchester held such prisoners on two dedicated landings, C3 and C4 on the induction wing, and there were detailed local operating procedures for the management of those landings. Although not explicitly recorded, Mr Reid appears to have isolated, as he was given a cell on C3. (We were unable to verify either this, or the cohort status of Mr Reid's cell mate, as the prison did not provide the relevant wing document.)

31. When Mr Reid arrived at Winchester, his health assessments identified no existing health conditions or concerns. However, there is no evidence that his COVID-19 vaccination status was checked, or that he was offered the opportunity to receive the vaccine.

32. As Mr Reid died 14 days after his remand to prison, it is unlikely that he would have benefitted from the vaccine, as protection from the first dose begins around three or four weeks after it is received. Since Mr Reid's death, the Head of Healthcare has reviewed the prison's vaccination clinics. She has included this issue on the risk register and implemented monitoring arrangements. In view of these steps, we make no further comment.

33. The reason that Mr Reid was tested for COVID-19 was not documented in either his medical or personal records, but the investigator was told that it was because he had reported symptoms of COVID-19. The only reference to his positive test was a brief entry by a clinical administrator, written shortly after his death. (We address record keeping later in the report.)

34. As the incubation period for COVID-19 is thought to be between 2 and 14 days, we cannot say whether Mr Reid caught the infection in the community, or in prison.

Emergency response

35. Prison Service Instruction (PSI) 3/2013, *Medical Emergency Response Codes,* sets out the actions staff should take in a medical emergency. This includes a mandatory requirement that prisons must, "…prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison (with or without the patient) …"

36. Winchester and South Central Ambulance Service have a jointly agreed *Emergency Call Out Protocol 2018,* developed in conjunction with the local healthcare

commissioner and local ambulance trust. The protocol is supposed to be reviewed annually, or automatically if the agreed procedures are not fulfilled.

37. The paramedics recorded that there was a long delay in getting to Mr Reid's cell, and leaving the prison, as they had to be escorted through several locked gates. Records show that after arriving at the prison, it took at least eight minutes for the paramedics to reach the cell.

38. Healthcare staff initially treated Mr Reid on the top bunk of the cell bed. He was moved at the request of the paramedics. The clinical reviewer noted that the clinical assessment by healthcare staff might have been more effective if Mr Reid had been moved to a more suitable space.

39. The clinical reviewer was also concerned that the sequence of events during the emergency response was unclear, as staff actions were not recorded in sufficient detail. The quality of healthcare record keeping is a matter that we have raised at Winchester several times. We recommend:

The Governor should review the local *Emergency Call Out Protocol 2018* and ensure that there are no unnecessary delays in admitting and discharging ambulances.

The Head of Healthcare should ensure that in a medical emergency, the patient is moved to an appropriate area where they can be fully assessed and treated.

The NHS Commissioner for South Central should write to the Ombudsman, setting out how they intend to improve clinical record keeping at HMP Winchester.

Security risk assessments

40. 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.

41. A judgment in the High Court in 2007 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. The judgment indicated 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.

42. These requirements are reflected in the Prison Service policy on the use of restraints, which encourages sensitive handling to ensure that the needs of security are balanced against the clinical needs of a seriously ill prisoner. It also makes clear that the handcuffing of a prisoner receiving lifesaving treatment must be justified by documented security considerations which are specific to the prisoner.

43. Mr Reid had been resuscitated after a cardiac arrest and lost consciousness several times during the resuscitation attempts. Paramedics continuously performed CPR from the cell to the ambulance (and during the journey). Despite this clinical background, the medical section of the security risk assessment was ticked to indicate that Mr Reid's medical condition did not impact on the escort and there were no objections to the use of restraints. The only written comment was that Mr Reid was COVID-19 positive.

44. The security risk assessment concluded that Mr Reid was a low risk of escape and the likelihood of outside assistance was also low. The authorising manager (head of operations) instructed that Mr Reid should be restrained with double handcuffs, which could be reduced to an escort chain for treatment. This decision was rescinded, but the change was not documented. The prison informed the investigator that a custodial manager had verbally told the escort officers not to use restraints.

45. Although restraints were not actually used, we are concerned that they were authorised while paramedics were still actively resuscitating Mr Reid after a cardiac arrest. The judgements in the risk assessment suggest that some prison and healthcare staff were either unfamiliar with, or ignored the guidance on use of restraints. A further concern is that the retraction of the decision on restraints was not documented.

46. Since Mr Reid's death, representatives from the PPO and HMPPS' senior casework team have delivered a joint awareness session on this issue to senior managers at the prison. The Head of Safety has also briefed staff on learning from escorts and the Group Safety Team complete regular checks of risk assessments and feed back to the team. We hope this has helped to improve the quality of security risk assessments. We recommend:

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 in all cases:

- **the medical information accurately reflects the prisoner's current clinical condition and impact on their ability to escape unaided; and**
- **operational staff take account of this information and fully document all decisions concerning the use of restraints.**

Record keeping

47. The investigation found several examples of poor and inaccurate record keeping.

48. Very little was recorded about Mr Reid. His personal prison record (NOMIS) was blank, except for the details of a restraining order and a few personal details (his name, date of birth, age, ethnicity and level on the incentives scheme). No interactions with staff were recorded, neither were there any alerts about risks, or reverse cohorting dates. The date of Mr Reid's remand to Winchester and his remand status were added to NOMIS after his death.

49. One of the induction forms, dated 27 July and signed by an officer, suggested that Mr Reid had declined to give emergency contact details. Mr Reid had not signed the section for prisoners to confirm this.

50. The national COVID-19 policy, at that time, required prisons to record periods of reverse cohorting, shielding and protective isolation in prisoners' personal records. In addition, Winchester's local policy stated that prisoners on the reverse cohorting unit should be identified and added to the C wing COVID-19 new reception spreadsheet. Prison staff were expected to include the prisoner's reception date and when they would relocate to a standard wing. The prison did not provide the spreadsheet.

51. The Notice to Staff about Mr Reid's death, issued on 11 August, stated that his family had been informed of his death and were being supported. This was not the case. We recommend:

The Governor should ensure that staff complete all relevant sections of a prisoner's personal records and wing documents; and fully document all significant interactions and decisions.

Contacting Mr Reid's next of kin

52. The family liaison officer unsuccessfully tried to identify Mr Reid's next of kin through several sources.

53. In September 2022, the investigator asked the coroner's officer to share the details of Mr Reid's next of kin with the PPO and the prison, if they had been traced. This was provided to the PPO in October. However, towards the end of the investigation, it came to light that the prison had not been informed.

54. A prison manager explained that the family liaison officer was new to the role and had not been fully trained, as there were no training courses during the COVID-19 pandemic. She did not contact the coroner, as she thought there was no family involvement. The prison has since contacted Mr Reid's family to offer a contribution to funeral expenses. In view of the mitigating circumstances, we make no further comment.

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

Inquest

The inquest, held on 11 March 2024, concluded that Mr Reid died from natural causes.

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