Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Mears, a prisoner at HMP Channings Wood, on 17 August 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

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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 David Mears died in hospital on 17 August 2021, while a prisoner at HMP Channings Wood. He was 65 years old. The cause of Mr Mears' death was COVID-19 and diabetic foot. He also had underlying diabetes, asthma and heart disease. I offer my condolences to Mr Mears' family and friends.

4. Given the variable incubation period of COVID-19, we cannot say whether Mr Mears caught the virus in prison or as an inpatient in hospital.

5. The clinical reviewer concluded that Mr Mears' clinical care was not equivalent to that he could have expected to receive in the community. Notably, there were no formal care plans to manage his long-term health conditions and inadequate follow-up when his blood sugar levels were raised. There was also a lack of clarity as to the responsibility for mental capacity assessments and they were not timely, nor recorded in sufficient detail. Full details of the findings are in the clinical reviewer's report.

6. We did not receive all the hospital escort documents. However, from the information on those available, we consider that the use of restraints was not justified, given Mr Mears was a wheelchair user who had been assessed as a low risk of escape. It is of particular concern that they were used in spite of the debilitation caused by intravenous treatment and surgery to amputate two toes.

7. There was a delay in notifying Mr Mears' wife that he was seriously ill in hospital and that he had contracted COVID-19.

Recommendations

- The Head of Healthcare should ensure that:
    - formal care plans are in place to manage patients with chronic health conditions; and
    - healthcare staff record the details and outcome of assessments in patients' medical records; and follow the protocols for escalating concerns or deterioration.
- The Head of Healthcare should ensure that a formal mental capacity assessment is promptly completed and fully documented when there are concerns that a prisoner has declined medical advice or treatment.

- The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and mobility and are based on the actual risk he presents at the time.
- The Governor should ensure that, in line with national policy, prisoners' next of kin are notified promptly when a prisoner becomes seriously ill and that there is a full record of contact and action taken.
- The Governor should ensure that if a prisoner is suspected of, or confirmed as having contracted COVID-19, he is given the opportunity for someone to be notified.
- The Governor should ensure that documents are 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

8. NHS England commissioned an independent clinical reviewer to review Mr Mears' clinical care at HMP Channings Wood.

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

10. The clinical reviewer and investigator jointly interviewed three members of healthcare staff on 16 and 17 November. The interviews were conducted by telephone, due to the COVID-19 restrictions in place at that time.

11. The Ombudsman's family liaison officer wrote to Mr Mears' next of kin, his wife, to explain the investigation. She did not receive a reply.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

Previous deaths at HMP Channings Wood

13. Mr Mears was the sixth prisoner at Channings Wood to die since August 2019. Three of the previous deaths were from natural causes (two due to COVID-19), one was self-inflicted, and one was drug-related. There has since been a further death from natural causes, unrelated to COVID-19. We have previously made a recommendation about the inappropriate use of restraints.

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. 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.)

16. 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-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

17. Mr David Mears was remanded to prison on 22 April 2016, charged with a sexual offence. He was later convicted and sentenced to life imprisonment, with a minimum period to serve of 8 years. On 11 April 2019, Mr Mears transferred to HMP Channings Wood.

18. At an initial health screen, Mr Mears' health conditions were recorded as type 2 diabetes, heart disease, asthma, anxiety and depression. No secondary health screen took place, and no care plans were created. On 19 April, a prison GP referred him to the mental health team.

19. Due to reduced mobility, Mr Mears used a walking frame and a wheelchair for longer distances. A prison buddy helped him with cleaning and collecting meals.

20. Mr Mears' diabetes was poorly controlled. He did not always take his insulin and other medication, so he was not permitted to keep it in his cell. He was expected to collect it daily, but repeatedly failed to do so as queueing with the other prisoners made him anxious. Staff then arranged for him to go to the medication hatch after the other men had left.

21. On 2 May, a detailed mental health assessment concluded that Mr Mears had anxiety and was coping poorly with his sentence. Although not actively suicidal, he hoped that by missing his diabetes medication he would die. Due to his thoughts and passive self-harm, Mr Mears was often managed under the prison's suicide and self-harm prevention measures, known as Assessment, Care in Custody and Teamwork (ACCT).

22. As a result of Mr Mears' complex mental health problems, he was managed under the multidisciplinary Care Programme Approach. Concerns were raised several times about his mental capacity to make decisions about his health and clinicians' views about this varied over time.

2020

23. At Mr Mears' annual diabetes foot check on 16 March 2020, the podiatrist found signs of poor circulation and a loss of sensation. He concluded that Mr Mears was at moderate risk of diabetic neuropathy (nerve damage).

24. On 6 April, shortly after confirmation of the COVID-19 pandemic, Mr Mears was handed a letter informing him that he was at high risk of complications if he contracted the virus and advising him to shield. On 8 April, healthcare staff had a discussion with him about his risks, but he decided not to shield.

25. The next day, a prison key worker spoke to Mr Mears and other prisoners about the regime restrictions during the pandemic and requirements such as social distancing to limit contact with others. During outbreak periods when the prison was in lockdown, Mr Mears' prison buddy accompanied him to healthcare every morning to collect his medication.

26. Throughout the pandemic, healthcare and safer custody staff reminded Mr Mears of the option to shield, as well as the risks and possible consequences if he failed to follow medical advice. He persistently declined and signed disclaimers.

27. On 29 April, Mr Mears received a letter and application form to be considered for release on temporary licence (ROTL). On 14 May, he was informed that due to a change in policy, he was no longer eligible, but he could apply for compassionate release under a special purpose licence. On 11 June, Mr Mears was informed that his application could not be progressed due to his risk of harm.

28. Over the following months, primary care and mental health staff continued to monitor and review Mr Mears to help improve his physical and mental health, as well as his compliance with taking his medication. However, he missed several medical appointments.

2021

29. Despite initial reluctance, Mr Mears received his first and second COVID-19 vaccines on 30 March and 20 June 2021, respectively.

30. Mr Mears was admitted to hospital on 16 July, due to high blood pressure. He discharged himself the next day. No abnormalities were found, and healthcare staff checked him on his return.

31. On 30 July, Mr Mears said he had felt unwell for three days. On examination, a nurse found that he had a temperature, and his left leg was red/purple, painful and hot. She removed a drawing pin stuck in the sole of his left foot, just below his second toe. Mr Mears had been unaware of it, due to the loss of sensation in his feet. (Prisoners do not have drawing pins in their cells, but they are used on noticeboards in communal areas.) He received antibiotics and was checked several times a day, but the infection did not improve.

32. After examining Mr Mears on 4 August, the prison GP suspected sepsis and osteomyelitis and advised that he needed to be admitted to hospital. Mr Mears was reluctant to go, although the GP told him he could lose his toe, or foot and it was potentially life threatening. He was eventually persuaded by wing staff who knew him well. Mr Mears was escorted by two prison officers and handcuffed with an escort chain (which was removed on 8 August).

33. Healthcare staff obtained frequent updates on Mr Mears' condition and reported significant changes and deterioration to operational managers. On 5 August, it was noted that he was receiving intravenous treatment for a diabetic foot infection. He then had two operations to remove toes and was due to have a third on 13 August.

34. On 9 August, Mr Mears asked for his wife to be told that he was in hospital.

35. Mr Mears tested positive for COVID-19 on 10 August. His condition deteriorated and he became too unstable for surgery.

36. On 13 August, an entry in the escort log noted that the family liaison officer had spoken to Mr Mears' wife and passed on the telephone number of the ward.

37. On 16 August, the hospital said that the priority was treating Mr Mears' COVID-19 infection, which was more serious than his foot infection and the prognosis was poor.

38. At around 1.00pm on 17 August, hospital staff asked for the details of Mr Mears' next of kin and the escort staff passed this request to the prison. A further request was noted at 3.58pm, as he was not expected to last the night. At 4.01pm, the escort nurses informed the escort staff that Mr Mears had died.

39. The prison assigned another family liaison officer, who promptly notified Mr Mears' wife of his death and kept in close contact to explain the procedures and help with the arrangements.

40. Notices were issued to staff and prisoners, informing them of Mr Mears' death and reminding them of the support available.

41. In line with national policy, the prison contributed to the costs of Mr Mears' funeral, which was held on 9 September.

Cause of death

42. No post-mortem examination was held, as HM Coroner accepted the cause of death certified by the hospital as COVID-19 and diabetic foot. Mr Mears also had underlying type 2 diabetes, asthma and ischaemic heart disease, which had contributed to, but did not cause, his death.

Findings

Clinical Findings

43. The clinical reviewer found that healthcare staff at Channings Wood were compassionate, diligent and attentive in their management of Mr Mears. However, he also identified several shortcomings and concluded that his clinical care at the prison was not equivalent to that he could have expected to receive in the community. Full details of his findings are in the clinical review report. We summarise below the issues linked to the conditions which caused or contributed to Mr Mears' death.

Management of Mr Mears' risk of infection from COVID-19

44. In line with national HMPPS policy, Channings Wood implemented protective measures to manage the risks associated with COVID-19, such as a restricted regime, social distancing and shielding prisoners at high risk of complications from the virus. Prisoners could continue shielding when it was no longer a mandatory requirement for the prison to facilitate this.

45. Mr Mears persistently declined to accept medical advice to shield. He tested positive for COVID-19 six days after admission to hospital. The incubation period of the virus is thought to be between two and fourteen days, so we cannot say for certain whether he contracted the infection at Channings Wood, or in hospital.

Monitoring Mr Mears' long-term medical conditions

46. Mr Mears' health conditions were identified when he arrived at Channings Wood in 2019. However, the diabetes and hypertension care plans that had been created at his previous prison were not continued and there were no care plans to manage his cardiovascular and respiratory disease. There were care plans for medical compliance and blood sugar monitoring, but the latter was not used.

47. The clinical reviewer found that despite Mr Mears' challenging stance, healthcare staff worked hard to encourage him to cooperate with medical advice and take his medication. They checked his feet and frequently monitored his blood sugar levels. However, when the levels were high, they were rarely followed up with a urine analysis, or escalation to senior clinicians for advice on whether he needed targeted treatment, or admission to hospital.

48. We agree with the clinical reviewer that formal care plans should have been in place for Mr Mears' diabetes and other long-term conditions and would have helped to ensure better clinical management. We recommend:

The Head of Healthcare should ensure that:

- **formal care plans are in place to manage patients with chronic health conditions; and**

- **healthcare staff record the details and outcome of assessments in patients' medical records; and follow the protocols for escalating concerns or deterioration.**

Mental capacity

49. Due to Mr Mears' attitude about managing his health and taking his medication, healthcare staff often questioned his mental capacity. Assessments were carried out by the prison GP, nurses, the mental health team and a psychologist. Opinions about his mental capacity varied.

50. The clinical reviewer had several concerns about the handling of mental capacity assessments. There were delays in acting on concerns that Mr Mears' blood sugar levels might have affected his capacity, as well as conflicting opinions on who should complete the assessments; and, although judgements were made, no formal assessments were recorded in his medical record. We recommend:

    The head of Healthcare should ensure that a formal mental capacity assessment is promptly completed and fully documented when there are concerns that a prisoner has declined medical advice or treatment.

Secondary health assessment

51. National Institute for Health and Care Excellence (NICE) Guideline 57, *Physical Health of People in Prison*, states that every prisoner should have a second-stage health assessment within seven days of the initial health screen. There was no evidence of a secondary assessment.

52. The clinical reviewer considered that the circumstances did not merit a recommendation. As this omission did not adversely affect Mr Mears' clinical care and given the lapse of time since his reception, we make no further comment. However, the Head of Healthcare will need to be mindful of this issue.

Security risk assessments and the use of restraints

53. 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.

54. 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. This is reinforced in Prison Service Instruction (PSI) 33/2015 External Escorts, which states that handcuffs will not normally be necessary if a prisoner's mobility is severely limited, e.g. due to advanced age or

disability, unless the prison has grounds to believe that an escape might be made with external assistance.

55. Mr Mears was a category C prisoner, on the enhanced level of the prison's incentives scheme, who was assessed as a low risk of escape (on a scale of low, normal or high). Reduced mobility and wheelchair use were reflected in the healthcare section of the risk assessment. In spite of this, the authorising prison manager annotated the form, "appropriate – wheelchair" in reference to use of an escort chain. The escort chain was removed on 8 August, with a note that the decision should be reviewed in 24 hours. It does not appear to have been used again, but we were unable to verify this as Channings Wood could not provide the relevant escort logs.

56. We consider that the use of restraints was inappropriate, given Mr Mears' reduced mobility, intravenous treatment, serious foot infection and surgery. We recommend:

The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and mobility and are based on the actual risk he presents at the time.

Notifying Mr Mears' family of his illness

57. HMPPS guidance on contacting a prisoner's next of kin during the pandemic states that if a prisoner is symptomatic, or has contracted COVID-19, they should be given the opportunity for someone to be informed and, with consent, the prison should arrange to do this. Additionally, prisons are expected to comply with the existing policy (set out in Prison Rule 22 and PSI 64/2011) that a prisoner's next of kin should be informed immediately if they become seriously ill, or if there is unpredicted or rapid deterioration in their physical health.

58. There was a delay in contacting Mr Mears' wife. A brief handover entry (in the chronology section of the original risk assessment) referred to Mr Mears asking for his wife to be notified and the escort log suggested that this was done on 13 August. No other contact or actions taken were recorded in the available escort logs and the family liaison log submitted to the investigation began on the day Mr Mears died. We recommend:

The Governor should ensure that, in line with national policy, prisoner's next of kin are notified promptly when a prisoner becomes seriously ill and that there is a full record of contact and action taken.

The Governor should ensure that if a prisoner is suspected of, or confirmed as having contracted COVID-19, he is given the opportunity for someone to be notified.

59. The omissions identified are no reflection on the family liaison officer appointed on the day of Mr Mears' death, who contacted Mr Mears' wife quickly, provided very good support in the following weeks and maintained a comprehensive record of events.

Provision of documents

60. Despite several requests, the prison was unable to provide the escort logs covering the period from 4 to 11 August. We recommend:

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2024**

Inquest

The inquest, held on 5 June 2025, concluded that Mr Mears died from natural causes.

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