Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of James Trewick, a prisoner at HMP Northumberland, on 17 December 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 Prison 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 James Trewick died in hospital on 17 December, while a prisoner at HMP Northumberland. He was 67 years old. The cause of Mr Trewick's death was a lung infection caused by COVID-19. I offer my condolences to his family and friends.

4. The clinical reviewer found that Mr Trewick's care was partly equivalent to that which he could have expected to receive in the community. She made recommendations on referrals and care plans for long-term conditions, and managing hospital appointments, which we reflect in this report.

5. There are no recommendations on non-clinical issues.

6. Mr Trewick appears to have caught COVID-19 at Northumberland.

Recommendation

- The Head of Healthcare should ensure that there is an auditable process to manage long-term medical conditions in line with the National Institute for Health and Care Excellence (NICE) guidelines, including:
    - timely and appropriate referrals after reception health screens;
    - implementation of personalised care plans, with regular monitoring and reviews; and
    - identifying and managing outstanding hospital appointments.

The Investigation Process

7. We were notified of Mr Trewick's death on 17 December 2022. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review his clinical care at HMP Northumberland.

8. The PPO investigator investigated the non-clinical issues.

9. The Ombudsman's family liaison officer wrote to Mr Trewick's next of kin, his wife, to explain the investigation and ask if there were any issues she wanted us to consider. She did not respond.

10. The initial report was shared with HMPPS, and they found no factual inaccuracies.

Previous deaths at HMP Northumberland

11. Mr Trewick was the seventeenth prisoner at Northumberland to die since December 2019. Of the previous deaths, nine were from natural causes (one due to COVID-19), six were self-inflicted and one was drug-related. There have since been five deaths, four from natural causes and one self-inflicted.

12. We have previously made recommendations about the management of long-term medical conditions. In response, the prison said that two days per week protected time had been allocated for long-term conditions and a specialist nurse had been employed. In addition, they had planned regular auditing of the referral pathway and interventions.

Background Information

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 until 2022. This has since 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.

16. COVID-19 policies on testing and managing symptoms have changed to align with those for people in the community. Further guidance on managing COVID-19 in prisons was issued and updated in September 2023.

Key Events

17. Mr James Trewick was convicted of sexual offences. On 6 January 2022, he was sentenced to thirteen and half years' imprisonment, with an extended supervision period of two years. Mr Trewick was sent to HMP Durham and transferred to HMP Northumberland on 11 February.

18. Before Mr Trewick went into prison, he had been diagnosed with several chronic conditions, including ischaemic heart disease, angina, hypertension, osteoarthritis, chronic back pain, migraines, depression and anxiety. Mr Trewick had reduced mobility and used a walking aid.

19. When Mr Trewick arrived at Northumberland, there was insufficient time to complete his initial reception health screen. However, a transfer safety risk assessment indicated that he had no immediate physical, mental health, or substance misuse needs. The initial health screen was rearranged three times, for 14, 15 and 16 February, but he did not attend, and no reasons were recorded for his non-attendance. The health screen was then combined with Mr Trewick's second-stage health assessment on 17 February. It was noted that he had received his COVID-19 vaccinations and boosters.

20. In line with HMPPS' COVID-19 policy at that time, Mr Trewick was subject to reverse cohorting for 14 days after his arrival, to avoid contact with existing prisoners.

21. Over the following months, Mr Trewick's contact with healthcare staff was mainly to resolve medication issues.

22. On 14 June, Mr Trewick's community GP informed the prison that as Mr Trewick had failed to attend cardiology hospital appointments, his consultant had discharged him. Healthcare staff contacted the hospital. Mr Trewick was reinstated, and an appointment was arranged for 29 June.

Mr Trewick's illness and admission to hospital

23. On 1 December, a wing officer notified the healthcare department that Mr Trewick had been poorly for a few days and his appearance had changed significantly. A healthcare assistant checked Mr Trewick and agreed there had been a noticeable change since she last saw him. His face was drawn, his speech was slurred, and he had a low temperature. The healthcare assistant was unable to check his blood oxygen saturation level as his hands were very cold and his fingers were blue.

24. A GP at the prison reviewed Mr Trewick at around 5.00pm and found that although he was alert and oriented, he looked unwell. He struggled to speak and walk and had a lesion on his head from a fall. The GP sent him to hospital for assessment. Mr Trewick was escorted by two prison officers and no restraints were used, due to his reduced mobility. Mr Trewick tested positive for COVID-19 when he arrived at the hospital.

25. At around midnight on 2 December, the hospital contacted Mr Trewick's wife, and she was allowed to visit Mr Trewick in the early hours, with other family members. The prison assigned a family liaison officer later that morning.

26. Mr Trewick was admitted to the critical care unit and treated with intravenous antibiotics and oxygen therapy. Although he initially responded well to the treatment, he later deteriorated and found it difficult to tolerate the CPAP machine, which helped him to breathe.

27. On 17 December, the hospital began end of life care as Mr Trewick did not want to continue using the CPAP machine. Members of his family were with him when he died that afternoon.

28. A prison manager debriefed both the escort officers when they returned to the prison. Notices were posted informing other staff and prisoners of Mr Trewick's death and offering support. Staff also checked prisoners who might have been affected by Mr Trewick's death.

29. The family liaison officer contacted Mr Trewick's wife on 19 December, to offer condolences and discuss the funeral arrangements.

30. Mr Trewick's funeral was held on 11 January 2023. In line with national policy, the prison contributed to the costs.

Cause of death

31. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The cause of death was viral pneumonitis arising from COVID-19. Mr Trewick also had underlying ischaemic heart disease, which did not cause but contributed to his death.

Findings

Clinical Findings

32. The clinical reviewer considered that, due to deficiencies in managing Mr Trewick's long-term medical conditions, his clinical care at Northumberland was only partly equivalent to that which he could have expected to receive in the community.

33. Full details of the clinical reviewer's findings are in the clinical review report. We summarise and reflect in this report the issues that caused or contributed to Mr Trewick's death.

Management of Mr Trewick's long-term health conditions

34. National Institute for Health and Care Excellence (NICE) Guideline 57, *Physical health of people in prison*, states that a prisoner's health needs should be assessed at first and second-stage health assessments. It sets out expectations that chronic conditions will be identified, referred to the appropriate clinic or GP, monitored; and outstanding medical appointments will be managed and rearranged, if necessary.

35. The clinical reviewer highlighted the following specific concerns about the handling of Mr Trewick's chronic health conditions:

- when Mr Trewick's blood pressure was found to be raised at his reception health screen, healthcare staff did not refer him to the GP for review;
- no action was taken to refer him to the prison's long-term conditions clinic to manage his heart disease and hypertension;
- no care plans were in place to monitor him; and
- an outstanding cardiology appointment was not actioned.

36. The Head of Healthcare said that the omissions were due to staff shortages at that time, but a long-term conditions nurse had since been appointed and the referral process was under review.

37. We raised similar concerns in a previous investigation around a year before Mr Trewick's death. At that time, we were told that the long-term specialist nurse was in place and other measures were underway to ensure compliance with the NICE guidance. This does not appear to have been sustained. We recommend:

The Head of Healthcare should ensure that there is an auditable process to manage long-term medical conditions in line with the National Institute for Health and Care Excellence (NICE) guidelines, including:

- **timely and appropriate referrals after reception health screens;**
- **implementation of personalised care plans, with regular monitoring and reviews; and**
- **identifying and managing outstanding hospital appointments.**

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

38. Mr Trewick had been fully vaccinated in the community, to help protect him from COVID-19 and he was appropriately isolated for the first fourteen days after his arrival at Northumberland. He was tested for the virus when he went into prison and on the fifth day after his arrival.

39. We are satisfied that Mr Trewick was managed in line with the COVID-19 policy at that time. National COVID-19 restrictions were removed in October 2022.

40. Mr Trewick tested positive for COVID-19 when he was admitted to hospital on 1 December. Except for an appointment the previous day, he had not left the prison for some time, so it is likely that he contracted the virus at Northumberland.

Director to note

Contacting Mr Trewick's next of kin

41. Prison Service Instruction (PSI) 64/2011, about safer custody, says that prisons must arrange for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill; and must nominate a family liaison officer after a death in custody to provide information and support. The PSI explicitly states that the family liaison role should start as soon as the family is informed of the prisoner's death.

42. Mr Trewick's wife was with him when he died, but there was then a delay of two days before the prison made contact. A prison manager explained that the family liaison officer was not on duty until 19 December and the delay was to allow the family time, respectfully, to process Mr Trewick's death.

43. We note that the prison adopted best practice by appointing a family liaison officer soon after Mr Trewick's admission to hospital and we acknowledge the sentiments around handling. However, as families can be anxious and bewildered immediately after a death, it is essential that the prison promptly acknowledges their bereavement, offers the family condolences and support, and provides information on the processes to be followed.

44. We consider that if the family liaison officer is temporarily unavailable, another suitable member of staff should be nominated to make early contact – even if it is only brief. At the very least, as a courtesy, as well as to find out whether the family has any immediate information needs.

Inquest

45. At an inquest held on 9 July 2024, the Coroner concluded that Mr Trewick died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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