

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Ms Jacqueline Bradbrook, a prisoner at HMP Low Newton, on 4 April 2020

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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. My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Ms Jacqueline Bradbrook died in hospital of necrotizing pancreatitis and Covid-19 on 4 April 2020 while a prisoner at HMP Low Newton She was 46 years old. I offer my condolences to her family and friends.
4. Ms Bradbrook had received a donor kidney just before she entered custody in 2017. In December 2019, her health deteriorated, and her body appeared to reject the transplanted kidney. At the end of January 2020, her health deteriorated very quickly and on 30 January she was taken to hospital by emergency ambulance with suspected sepsis. She remained in hospital until her death two months later.
5. The clinical reviewer considered that overall, the standard of care that Ms Bradbrook received was reasonable. However, some clinical observations were missed, there were gaps in care planning and healthcare staff did not follow national guidance on monitoring Ms Bradbrook's health when it deteriorated in January 2020. Therefore, the clinical reviewer concluded that her care was not equivalent.
6. Ms Bradbrook was admitted to hospital on 30 January, nearly two months before the COVID-19 pandemic was declared. She remained in hospital until her death on 4 April. The day after her death, the result of a COVID-19 test indicated that she had the virus. It, therefore seems likely that she contracted the virus in hospital and not in prison.

## Recommendations

- The Head of Healthcare should ensure that all healthcare staff are aware of:
  - the escalation process within the National Early Warning Score (NEWS) system to ensure appropriate assessment and monitoring of a medically deteriorating prisoner; and
  - National Institute for Health and Care Excellence (NICE) guidance for sepsis to ensure accurate assessment and monitoring.

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Ms Bradbrook's clinical care at the prison, including her diagnosis and treatment.
8. The PPO investigator and the clinical reviewer were unable to visit the prison to conduct interviews as prisons are not currently facilitating visits during the COVID-19 lockdown.
9. A nurse responded in writing to the clinical reviewer's questions to clarify aspects of Ms Bradbrook's care. The clinical reviewer's report is attached as Annex 1, and the nurse's written response as Annex 2.
10. The PPO investigator investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, the security arrangements for her hospital escorts, liaison with her next of kin and whether compassionate release was considered.
11. The Ombudsman's family liaison officer contacted Ms Bradbrook's next of kin to explain the investigation. They did not have any specific issues for the investigation to consider.
12. Ms Bradbrook's family received a copy of the initial report. They did not identify any factual inaccuracies.
13. The prison also received a copy of the report and identified an incorrect name, which we have amended. An action plan for the recommendation is attached to the report as Annex 3.
14. **This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.**

### Previous deaths at HMP Low Newton

15. Ms Bradbrook was the second prisoner to die at Low Newton in the past two years. The previous death in January 2019, was from natural causes. There are no similarities between our findings in the investigation into Ms Bradbrook's death and the previous death.

### COVID-19 (coronavirus)

16. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.
17. COVID-19 can make anyone seriously ill, but the risk is higher for some people. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most

vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

18. On 13 March, PHE's National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. By this time, Ms Bradbrook had been admitted to hospital and did not return to prison.

## Key Events

19. On 31 March 2017, Ms Bradbrook was sentenced to nine years and eight months in prison. She was taken to HMP Low Newton.
20. Three weeks before entering custody, Ms Bradbrook had had a kidney transplant. Throughout her time at Low Newton, healthcare staff ensured that she received continuity of care and she attended routine follow-up appointments at hospital under the care of a renal consultant. Although Ms Bradbrook had some issues in the months after her transplant, she remained in reasonable health.
21. In December 2019, healthcare staff became concerned that Ms Bradbrook's body was rejecting the transplanted kidney. Low Newton maintained regular contact with hospital specialists, and escorted Ms Bradbrook to hospital for assessments and tests. Hospital specialists revised her medication to stabilise her condition.

### Events leading to Ms Bradbrook's admission to hospital

22. On 27 January 2020, Ms Bradbrook was sick and had diarrhoea. A nurse recorded that Ms Bradbrook's pulse was raised and her blood pressure was low. The nurse recorded a National Early Warning Score (NEWS) score of 4. (The NEWS tool determines clinical deterioration and prompts critical care intervention. A score between 0 and 4 indicates low to medium clinical risk and requires that the patient is monitored. A score of 4 requires clinical observations to be recorded at least every four to six hours.) There is no evidence in Ms Bradbrook's medical record that healthcare staff escalated concerns and she was not assessed again for 24 hours.
23. On 28 January, Ms Bradbrook's observations were recorded at four-hourly intervals, and her NEWS scores were recorded at between 2 and 3 over the day. A nurse advised Ms Bradbrook to remain hydrated. A nurse noted in Ms Bradbrook's medical record that she was unsure why she had been asked to assess her. No observations were recorded.
24. Ms Bradbrook was not reviewed again until 3.48am on 30 January when a nurse recorded that she was still sick and had diarrhoea. There is no evidence in Ms Bradbrook's medical record that observations were recorded.
25. At 9.34am, a Healthcare Assistant recorded Ms Bradbrook's observations and revised her NEWS to 2. At 2.00pm, a nurse did not revise Ms Bradbrook's NEWS but recorded that her temperature was raised, she had a high pulse and

low blood pressure. The nurse escalated his concerns to a second nurse who asked the prison doctor to examine Ms Bradbrook. At the end of her shift, the second nurse noted that the doctor had not assessed Ms Bradbrook, so she went to F Wing to examine her.

26. At 5.00pm, the nurse assessed Ms Bradbrook. She noted that Ms Bradbrook was in bed, appeared lethargic, pale and dehydrated. Ms Bradbrook told her that she was unable to swallow her tablets. The nurse did not record observations as her equipment was in the healthcare unit but described Ms Bradbrook's pulse as slow and shallow. She telephoned for an emergency ambulance and stayed with Ms Bradbrook until the ambulance arrived at around 5.20pm. Two prison officers escorted Ms Bradbrook to a hospital of North Durham, restrained by an escort chain which was removed the next day when she was moved to another hospital.
27. The prison arranged for Ms Bradbrook to be released under a special purpose temporary licence (ROTL) while she was being treated in hospital.
28. On 18 February, Ms Bradbrook was diagnosed with sepsis and e-coli (bacteria that can cause infection) in her abdomen and she deteriorated significantly. She had emergency surgery to examine the abdominal organs the next day and she was diagnosed with peritonitis (an infection in the lining of the abdomen), heart failure, renal failure and septic shock. Her condition remained critical and she was fully ventilated.
29. Despite ongoing treatment in hospital, Ms Bradbrook remained bedbound and was increasingly frail. On 20 March, Ms Bradbrook's condition deteriorated further. The hospital told Low Newton that Ms Bradbrook's organs were failing and completed an instruction not to resuscitate her if she stopped breathing.
30. On 3 April, Ms Bradbrook was suspected to have sepsis and COVID -19, and was tested for the virus. Ms Bradbrook died the next day. After her death, test results confirmed that Ms Bradbrook had COVID-19.
31. A hospital doctor established that Ms Bradbrook had died from necrotizing pancreatitis and COVID-19. No post-mortem examination was carried out. (Acute pancreatitis is a condition where the pancreas becomes inflamed over a short period of time, a complication of which is necrotizing pancreatitis where the pancreas loses its blood supply, the tissue dies and causes infection.)

# Findings

## Clinical care

32. The clinical reviewer considered that overall, the clinical care that Ms Bradbrook received at Low Newton was of a reasonable standard. Communication between prison healthcare staff and hospital renal specialists was regular and effective. However, the clinical reviewer found that some clinical observations were missed, there were gaps in care planning and when Ms Bradbrook's health deteriorated in January 2020, missed opportunities for timely escalation of clinical concerns. Therefore, the care Ms Bradbrook received was not equivalent to that which she could have expected to receive in the wider community.
33. When Ms Bradbrook became unwell on 27 January, she had an elevated NEWS score which warranted further monitoring and assessment, but this did not happen. Ms Bradbrook's pulse was raised and her systolic blood pressure was low. NICE guidance (NG51) indicates that this put her at high risk of sepsis, and she should have been transferred to hospital for assessment. Ms Bradbrook was not re-assessed in prison for a further 24 hours. There were many occasions over the next two days when her observations were not recorded.
34. On 30 January, a nurse quickly responded to the request to assess Ms Bradbrook when her condition worsened, and she asked for GP advice. The nurse was diligent and checked if a prison doctor had assessed Ms Bradbrook. When she discovered Ms Bradbrook had not been assessed, she appropriately requested an emergency ambulance. We commend the nurse for her response.
35. However, we have identified numerous missed opportunities, which should have resulted in earlier intervention by healthcare staff, and therefore make the following recommendation:

**The Head of Healthcare should ensure that all healthcare staff are aware of:**

- **the escalation process in the NEWS system to ensure appropriate assessment and monitoring of a medically deteriorating prisoner; and**
  - **NICE guidance for sepsis to ensure accurate assessment and monitoring.**
36. The clinical reviewer has made recommendations not directly related to Ms Bradbrook's death, which we have not included in our report, but should be actioned by the Head of Healthcare.

## COVID-19

37. Ms Bradbrook was transferred to hospital on 30 January before the first known case of COVID-19 in the UK. She tested positive for COVID-19 in hospital in April 2020, and it is likely therefore that she contracted the virus in hospital.

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

**September 2020**

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