

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Garry Neilson, a prisoner at HMP Altcourse, on 5 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. 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 Garry Neilson died in a hospice on 5 April 2020, of cancer of the digestive system, while a prisoner at HMP Altcourse. He had also been diagnosed with COVID-19, which did not cause, but contributed to his death. He was 57 years old. I offer my condolences to Mr Neilson's family and friends.
4. Mr Neilson had been diagnosed with terminal cancer before he was recalled to prison in February 2020. On 26 March, he was admitted to a hospice for end of life care. While at the hospice, he developed symptoms of COVID-19 and later tested positive.
5. We cannot say when or where Mr Neilson contracted the virus. The investigation found that Altcourse immediately followed national guidance on COVID-19 risk management and implemented the procedures advised at the time to help prevent the spread of the infection.
6. The clinical reviewer concluded that the clinical care Mr Neilson received at Altcourse was equivalent to that he could have expected to receive in the community. She made no recommendations.
7. We found no non-clinical issues of concern and make no recommendations.

## The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Neilson's clinical care at HMP Altcourse, including his diagnosis and treatment. She interviewed the Head of Healthcare and discussed her findings with the PPO investigator. Her report is attached as Annex 1.
9. The PPO investigator reviewed Mr Neilson's personal records, as well as HMPPS and local policy documents. She investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Neilson's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
10. As there were three COVID-19 related deaths of healthcare inpatient residents at Altcourse within a short period, the PPO investigator also held a separate interview with the Head of Healthcare to discuss the non-clinical management of the unit and changes to its regime since the start of the pandemic.
11. The PPO family liaison officer wrote to Mr Neilson's next of kin, his mother, to explain the investigation. Mr Neilson's mother did not have any specific questions for us to consider.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

### Previous deaths at HMP Altcourse

13. Mr Neilson was the 11th prisoner to die at Altcourse since April 2018. Of the previous deaths, six were from natural causes, three were self-inflicted and the cause of one death was unknown. There are no similarities between our findings in the investigation into Mr Neilson's death and those of the previous deaths. There have since been three further deaths from natural causes, two due to COVID-19.

### 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 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.
15. COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high-risk (clinically extremely vulnerable); and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant; have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).
16. 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).

17. 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. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.
18. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation. From 31 March, HMPPS put in place further measures to contain COVID-19. By then, Mr Neilson was in a hospice and he did not return to the prison.
19. We note that in his report on short scrutiny visits to local prisons, issued in April 2020, HM Chief Inspector of Prisons identified positive practice at Altcourse, including the development of bespoke patient logs which had improved oversight of COVID-19 monitoring.

## Key Events

20. Mr Garry Neilson was diagnosed with gastrointestinal stromal tumour (GIST) in 2015 and this had spread to his liver. (GIST is a rare cancer that develops in the digestive system, usually the stomach or small intestine.) In December 2019, Mr Neilson was given a life expectancy of two months, while at HMP Liverpool. He was released, on licence, on 28 January 2020.
21. Mr Neilson breached his licence conditions and was recalled to prison to serve the remainder of a 15-month sentence for breach of a Sexual Harm Prevention Order. He was arrested and taken to HMP Altcourse on 14 February 2020.
22. During reception health screens, healthcare staff noted that Mr Neilson was terminally ill and a prison GP re-prescribed his medication. He was immediately admitted to the inpatient unit within the healthcare centre.
23. A palliative care nurse was assigned to Mr Neilson and she created several care plans. She also discussed Mr Neilson's diet and his wishes about family contact. On 17 February, a prison GP updated an existing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form, as Mr Neilson restated that he did not want to be resuscitated if his heart, or breathing stopped.
24. In line with the Government policy on COVID-19, Mr Neilson was shielded in the inpatient unit from 23 March. On 25 March, it was agreed to keep his cell door open overnight, so that healthcare staff could easily monitor him.
25. On 26 March, Mr Neilson's condition deteriorated. He was taken, without restraints to a hospice (located in a hospital) to receive end of life care. The prison kept in touch with hospice staff. Mr Neilson was estranged from his family and did not want them to be told he was in hospital.
26. At the hospice, Mr Neilson developed a persistent cough. On 29 March, hospice staff suspected that this might be a symptom of COVID-19 and swabs were taken. The escort officers were immediately issued with full PPE and they later moved out of Mr Neilson's room and observed him from a distance.
27. On 2 April, the test results were positive for COVID-19. The same day, Altcourse authorised Mr Neilson's release on temporary licence (ROTL) and reduced security to one escort officer, to provide decency during Mr Neilson's final days.
28. Mr Neilson died at 2.35pm on 5 April. The police informed his family, as the prison had no contact details. The prison's family liaison officer telephoned the following day and provided information and support. In line with national policy, the prison contributed to the funeral expenses.

### Post-mortem report

29. The Coroner's inquest, held on 15 April, concluded that Mr Neilson died of metastatic gastrointestinal stromal tumour, with COVID-19 as an underlying condition which did not cause, but contributed to his death.

# Findings

## Clinical findings

30. The clinical reviewer concluded that Mr Neilson's clinical care was of a good standard and equivalent to that which he could have expected to receive in the community. Healthcare staff were responsive to his needs and quickly arranged for him to be transferred to a hospice for end of life care.

## *Management of Mr Neilson's risk of contracting COVID-19*

31. Mr Neilson had lived in the healthcare inpatient unit between his recall to prison on 14 February 2020 and his admission to the hospice on 26 March. Given he was at high risk of contracting the infection, he was shielded from 23 March. He was the first of three prisoners from the inpatient unit to die with COVID-19, within a three-week period.
32. We cannot say when or where Mr Neilson acquired the virus. The Head of Healthcare said that some staff had symptoms around the time of the three deaths, but it had been difficult to determine whether the infection had been passed from staff to prisoner, or vice versa. Those who had died might have had contact with other prisoners but, through their own choice and due to the nature of their medical conditions, most of the men had spent a lot of time in their cells. No prisoners other than patients and the prison orderlies were allowed in the inpatient unit.
33. The investigation found that healthcare staff had access to appropriate personal protective equipment (PPE) and the prison had followed the national guidance on managing the risks associated with COVID-19. To help prevent infection to others after Mr Neilson's death, swabs for testing were received on 6 April. As an outbreak site, Altcourse had weekly telephone conferences with HMPPS, PHE and NHS England from 10 April.

**Sue McAllister CB**  
Prisons and Probation Ombudsman

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