Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Tierney, a prisoner at HMP Altcourse, on 7 April 2020

A report by the Prisons and Probation Ombudsman

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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*

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 Sean Tierney died in hospital on 7 April 2020, while a prisoner at HMP Altcourse. He was 74 years old. The cause of his death was COVID-19 and urinary sepsis (a severe urinary infection). He also had underlying diabetes. I offer my condolences to Mr Tierney's family and friends.

4. Mr Tierney had longstanding urinary problems, including previous episodes of sepsis. Due to deteriorating health, he was admitted to the prison's inpatient unit on 4 January 2020, where he remained until he was sent to hospital on 2 April. A chest X-ray taken shortly after Mr Tierney's arrival indicated symptoms of COVID-19 and he tested positive for the disease on 4 April.

5. While we cannot say for certain when or where Mr Tierney contracted the virus, it seems likely that it was at the prison, rather than in hospital.

6. 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.

7. The clinical reviewer concluded that the clinical care Mr Tierney received at Altcourse was of a good standard and equivalent to that he could have expected to receive in the community. She made no recommendations.

8. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

9. NHS England commissioned an independent clinical reviewer to review Mr Tierney's clinical care at HMP Altcourse. She interviewed the Head of Healthcare and discussed her findings with the PPO investigator.

10. The PPO investigator reviewed Mr Tierney's personal records, as well as HM Prison and Probation service (HMPPS) and local policy documents. She investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Tierney's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.

11. As there had been three COVID-19 related deaths of healthcare inpatient residents within a short period (between 5 and 25 April), 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.

12. The PPO family liaison officer wrote to Mr Tierney's next of kin, a friend, to explain the investigation. Mr Tierney's friend did not have any specific questions for us to consider.

13. Mr Tierney's friend received a copy of our initial report. She made comments which have been dealt with in correspondence.

14. The initial report was shared with HMPPS. They found a factual inaccuracy and this has been amended.

Previous deaths at HMP Altcourse

15. Mr Tierney was the 12th prisoner to die at Altcourse since April 2018. Of the previous deaths, seven were from natural causes (including one prisoner who died with COVID-19), three were self-inflicted and the cause of one death was unknown. There are no similarities between our findings in the investigation into Mr Tierney's death and those of the previous deaths. There have since been two further deaths from natural causes, including one due to COVID-19.

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. 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).

18. 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).

19. 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.

20. 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. Mr Tierney went into hospital on 2 April.

21. 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

22. On 22 August 2012, Mr Sean Tierney was remanded to HMP Altcourse. On 28 January 2013, he was convicted of attempted murder and sentenced to life imprisonment, with a minimum period to serve of 15 years.

23. Before Mr Tierney went to prison, he had been diagnosed with type 2 diabetes and mental health problems. Over the following years at Altcourse, he developed numerous chronic health conditions, including peripheral vascular disease, anaemia, high blood pressure, neurological and orthopaedic problems. Mr Tierney's mobility declined and he used walking aids and a wheelchair. He was sometimes hostile to staff, refusing medication and health assessments.

24. In July and August 2019, Mr Tierney had persistent and severe urinary problems and a prison GP referred him to a urology specialist on 19 September. Between 14 and 18 December, he was an inpatient in hospital, where he was diagnosed with urinary sepsis, a life-threatening complication of a urinary tract infection.

25. Mr Tierney's health deteriorated and he was admitted to the prison's inpatient unit on 4 January 2020. Some of his urinary symptoms continued, but he cooperated with health reviews and accepted help with personal and social care. On 6 February, he attended an outpatient urology appointment at Aintree University Hospital, but subsequent appointments were postponed due to the COVID-19 pandemic and the need to limit people attending hospital.

26. On the morning of 2 April, Mr Tierney said he felt weak, breathless and generally unwell. A prison GP reviewed him and asked healthcare staff to complete clinical observations every 30 minutes. At lunchtime, healthcare staff noticed that Mr Tierney was visibly sweating, but his observations were within normal range.

27. At around 10.50pm the same day, Mr Tierney pressed his cell call bell. A nurse and a healthcare assistant went to see him. They noted that Mr Tierney had rigors (a rise in temperature, with severe shivering) and difficulty breathing. They gave him oxygen and requested an ambulance.

28. Paramedics took Mr Tierney to hospital. There were two prison escorts, but no restraints were used. In the early hours, a prison nurse spoke to a hospital doctor, who said that a chest CT scan suggested symptoms of COVID-19. Later that morning, the hospital said that Mr Tierney was receiving end of life care.

29. Healthcare staff kept in touch with the hospital, who confirmed on 4 April that Mr Tierney had tested positive for COVID-19. Mr Tierney died in hospital at 11.47pm on 7 April.

Post-mortem report

30. The Coroner's inquest, held on 24 April concluded that Mr Tierney died of COVID-19 and urinary sepsis, with diabetes type 2 as an underlying factor, which did not cause, but contributed to his death.

Findings

Clinical Findings

31. The clinical reviewer concluded that Mr Tierney's clinical care was of a good standard and equivalent to that he could have expected to receive in the community.

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

32. Mr Tierney was one of three prisoners from the inpatient unit at Altcourse to die with COVID-19, within a three-week period. He had lived in the prison's inpatient unit since January 2020 and, as a prisoner at high risk of contracting the infection, he was shielded from 23 March. When he became unwell with symptoms of COVID-19, on 2 April, healthcare staff monitored him closely throughout the day and sent him to hospital promptly when his condition worsened that night.

33. Given that Mr Tierney had not been outside Altcourse between 6 February and 2 April, we consider that he almost certainly contracted the virus in prison, but we do not know how or when. 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.

34. The investigation found that the prison had followed the national guidance on managing the risks associated with COVID-19 and promptly put in place the policies and measures expected. Healthcare staff had access to appropriate personal protective equipment (PPE). To help prevent infection to others after Mr Tierney'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 **October 2020**

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