Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gamal Bahid, a prisoner at HMP Oakwood, on 27 May 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

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.

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.

Mr Gamal Bahid died of COVID-19 pneumonitis (inflammation of the lung tissue) on 27 May 2020 at HMP Oakwood. He was also obese and this contributed to but did not cause his death. He was 50 years old. I offer my condolences to Mr Bahid's family and friends.

I am satisfied that the healthcare that Mr Bahid received at Oakwood was equivalent to that which he could have expected to receive in the community. His health problems were appropriately treated. He was identified as clinically vulnerable and was advised to shield to minimise his risk of contracting COVID-19, but he opted not to do so.

There were deficiencies in the emergency response. I am concerned that the prison's emergency response protocol does not reflect that a code blue should be called immediately, that an officer said he would not enter a locked cell alone in any circumstances, and that both officers attending the emergency scene did not know that Mr Bahid had COVID-19 symptoms so did not take precautions. The timings displayed by key clocks in the prison were not the same which led to inconsistent timings when recording events.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **November 2020**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 6

Findings 10

Summary

1. Mr Gamal Bahid was serving a seven year sentence for drug offences and had been at HMP Oakwood since 2017.

2. On 1 May 2020, Mr Bahid was told that he was considered to be clinically vulnerable because he was extremely obese and he was advised to shield for 12 weeks to minimise his risk of contracting COVID-19. On 11 May, Mr Bahid signed a disclaimer to say that he did not wish to shield. He was a wing cleaner and was in contact with staff and other prisoners daily.

3. On the evening of 26 May, Mr Bahid told a nurse that he had lost his sense of taste, was feeling hot then cold and was lethargic, although he did not have a cough. He said he had been unwell for three days but had not told staff. The nurse gave Mr Bahid paracetamol, and told him and custodial staff that he would be moved to the prison's dedicated isolation wing the following day.

4. In the early hours of 27 May, Mr Bahid rang his cell bell and told an officer he had breathing difficulties. He was able to sit and speak normally. The officer asked the duty manager what to do, and the duty manager eventually asked healthcare staff to attend.

5. The officer could see Mr Bahid lying on the floor of his cell with a pillow under his head. The officer and his colleague eventually went into Mr Bahid's cell when he repeatedly failed to respond to them. The officers were not aware that Mr Bahid had COVID-19 symptoms so they did not wear personal protective equipment (PPE). Mr Bahid was lying on the floor, with a cushion under his head as if he was sleeping. One officer called a medical emergency code blue on the wrong radio channel so no one heard it. He quickly realised his mistake and called another.

6. The nurses who arrived were aware of Mr Bahid's symptoms but were unable to find the PPE which was stored in an unseen part of the new emergency bags. Officers had already started resuscitation attempts and the nurses took over despite the risks to themselves. Paramedics arrived at 3.46am but declared Mr Bahid's death at 4.26am.

Findings

Clinical care

7. Mr Bahid had some healthcare needs and the clinical reviewer is satisfied that the healthcare provided to him was equivalent to that which he could have expected to receive in the community.

8. However, she has made recommendations about aspects of the emergency response which the Head of Healthcare will need to address.

Emergency response

9. We are concerned that officers who attended the scene did not know that Mr Bahid was suspected of having COVID-19 symptoms and so did not wear PPE. We are also concerned that nurses could not find the PPE equipment because they were not familiar with the new emergency bags.

10. Although we are satisfied with the reason officers gave for not going into Mr Bahid's cell immediately, we are concerned that one officer said that he would not consider going into a locked cell alone in any circumstances. The preservation of life must take precedence over usual unlock procedures if it is safe to do so.

11. We are also concerned that Oakwood's emergency response protocol is not in line with the national instructions and does not set out that a code blue should be radioed immediately.

12. There were discrepancies between the time shown on clocks in key areas, which led to inconsistent timings being logged.

Recommendations

- The Director should ensure that Oakwood's emergency medical code policy reflects the provisions of PSI 03/2013 and staff understand its requirements, particularly that an emergency code should be radioed immediately in the event of an emergency.
- The Director should:
    - ensure that all staff are aware of the provisions in PSI 24/2011 on entering cells alone where there is risk to life if it is safe to do so; and
    - share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Director should ensure that all staff are aware which prisoners are shielding or have COVID-19 symptoms so that they can take necessary precautions.
- The Director should ensure that prison clocks are accurate, particularly those in key locations.

The Investigation Process

13. The PPO investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Bahid's prison and medical records. The investigator has investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, liaison with his family and whether compassionate release was considered.

15. NHS England commissioned an independent clinical reviewer to review Mr Bahid's clinical care at the prison.

16. The investigator interviewed ten members of staff. The clinical reviewer led on the clinical interviews. All the interviews were conducted by telephone because of the restrictions in place during the COVID-19 pandemic.

17. We informed HM Coroner for the South Staffordshire District of the investigation. He confirmed the cause of death. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Bahid's mother to explain the investigation and to ask if she had any matters she wanted us to consider. The issues Mr Bahid's family raised were either not within the remit of this investigation or have been addressed in separate correspondence to the family.

19. Mr Bahid's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the PPO report. They identified one factual inaccuracy within the clinical review which has been amended.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Oakwood

21. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs. From 4 May 2020, NHS England commissioned Care UK to change the hours of healthcare services from 7.00am to 8.00pm to 24-hour care.

HM Inspectorate of Prisons

22. The last inspection of HMP Oakwood was in February and March 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although healthcare staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2019, the IMB reported that healthcare vacancies had reduced significantly and that a new scheme had reduced the number of missed appointments. They also found that the healthcare department provided excellent end-of-life care.

Previous deaths at HMP Oakwood

24. Mr Bahid was the 12th prisoner to die at HMP Oakwood since May 2018. Of these deaths, ten were from natural causes (one of which was COVID-19 related) and one was drug-related. There are no similarities between our findings in this investigation and those in our investigation findings for the previous deaths.

COVID-19 (coronavirus)

25. 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.

26. 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 years old, 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).

27. 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).

28. 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.

29. 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.

30. On 31 March HMPPS, in consultation with PHE, issued an order to significantly reduce transfers between prisons. Other measures, known as 'compartmentalisation', were also announced. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included:

- Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.
- Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of bio-security including dedicated staff.
- Reverse Cohorting Units (RCUs): to accommodate new receptions or transfers in for a period of 14 days to detect any emergent infectious cases before entering the general population. These units could also accommodate anyone returning from hospital.

Key Events

31. In March 2017, Mr Gamal Bahid was remanded to HMP Dovegate for drug-related offences and sentenced to seven years in prison. On 27 March 2017, Mr Bahid was moved to HMP Oakwood.

32. Mr Bahid had a long-standing ankle injury, was obese and was on a methadone maintenance programme. He received appropriate treatment for his conditions.

33. On 1 May 2020, Mr Bahid was given a document explaining that he was in a clinically vulnerable group (because of his obesity) and advising him to shield for 12 weeks to minimise his risk of contracting COVID-19.

34. On 7 May, a nurse noted that Mr Bahid weighed 19 stones 8 pounds and was extremely obese. He said that he had been trying to lose weight but had struggled since lockdown.

35. On 8 May, a nurse noted that Mr Bahid was at a moderate risk of developing complications from COVID-19 because of his weight. She advised him to lose weight before weight loss medication could be considered.

36. On 11 May, Mr Bahid signed a shielding disclaimer to confirm that he did not want to shield and that he understood the risks.

37. On 19 May, a nurse noted that Mr Bahid had lost some weight (5 pounds) but he remained extremely obese.

38. At 7.09pm on 26 May, Nurse A noted that she and a healthcare assistant had seen Mr Bahid in his cell after wing staff had said at around 6.00pm that he had possible COVID-19 symptoms. Mr Bahid was in a single cell. He said that he had felt unwell for the past three days. He complained that he had fever and had lost his sense of taste. He was lethargic but denied having a cough. He said he had not previously reported any of his symptoms to prison staff.

39. Nurse B took Mr Bahid's observations. His pulse was fairly rapid due to a high temperature, but his National Early Warning Score (NEWS) was 3 (which indicated low clinical risk). Nurse B gave Mr Bahid paracetamol and advised him to keep cool and to drink plenty of fluids. She also reminded him of COVID-19 symptoms and that he should alert wing staff if he became more concerned. He was to be moved to the COVID-19 isolation unit the next day.

40. Nurse A said she told an unidentified female wing officer that Mr Bahid needed to be isolated in his cell. Nurse B also informed the wing manager, completed the healthcare team's COVID-19 spreadsheet, emailed the Head of Healthcare and gave a verbal handover to night duty nurses.

Events of 27 May 2020

41. At approximately 3.04am, Mr Bahid rang his cell bell. Officer A arrived at Mr Bahid's cell two minutes later and found him sitting on the edge of his bed. Mr Bahid told Officer A that he had breathing difficulties, although he was talking normally. Officer A told Mr Bahid that he was going to call the duty manager for advice.

42. Between 3.06pm and 3.14pm, CCTV footage shows Officer A walking back and forth from Mr Bahid's cell, occasionally looking in while talking on a cordless phone. Officer A said he was speaking to the duty manager, an SO, who was in the Orderly Office (in the admissions building). The SO told Officer A to go back to Mr Bahid's cell and see how he was. In his statement, the SO said that he wanted further information such as whether Mr Bahid had asthma and how long he had felt unwell so that he could update healthcare staff.

43. Officer A went back to Mr Bahid's cell while on the cordless phone which, according to the SO but not Officer A, lost signal. He looked through the observation panel and saw Mr Bahid lying on his back on the floor of his cell with a pillow under his head. Officer A said that he could see chest movements. (It is not possible to say exactly when Officer A saw this but it is likely that it was at around 3.14am which is when he was last at the cell door alone.)

44. Officer A called the SO back to update him. The SO said he was on his way and asked Officer B, who was also in the Orderly Office, to radio the control room immediately to arrange for healthcare staff to attend.

45. Nurse B told the investigator that she heard her radio 'bleep' but no message followed. Nurse C phoned staff in the control room. Officer C was on duty in the control room and Nurse C asked him if healthcare staff were needed, the nature of the incident and what they should bring, but he did not know. Officer C told Nurse C that custodial staff would collect them.

46. The nurses collected an emergency bag and waited to be collected. Officer B arrived at the healthcare unit to escort the nurses, and when Nurse B asked him what was going on, he said that he was not sure. Nurse C asked where they were going, and Officer B seemed confused about where Mr Bahid lived. Nurse B said that the only person she had been aware of who was unwell was Mr Bahid on Beech Wing (because Nurse A had told her at the handover).

47. Officer A was not willing to enter Mr Bahid's cell alone and contacted staff in the control room to ask them to contact Officer D. Officer D arrived at approximately 3.16pm The officers could not get a verbal response from Mr Bahid from outside the cell. Officer D told the investigator that the observation panel was not entirely clear – a mixture of scratching and clouding on the perspex pane made it difficult to tell if Mr Bahid was breathing. He also said that Mr Bahid's positioning on the floor, with a pillow underneath his head, was not characteristic of someone who had just collapsed. However, Officer D told Officer A to tell the SO that he was going into the cell unless the SO objected. The SO said that was okay if they were comfortable doing so.

48. Officer D told the investigator that he was aware there was PPE in the wing office but he did not want to cause any further delay by fetching it. Neither he nor Officer A was aware that Mr Bahid had suspected COVID-19 symptoms. They entered Mr Bahid's cell at 3.19am.

49. Officer D checked Mr Bahid for signs of life. He could not detect a pulse and started cardiopulmonary resuscitation (CPR). Officer D asked Officer A to call a medical emergency code blue once they were in the cell. Officer A initially called

the code blue on the wrong channel so staff in the communications room did not hear it, but he quickly followed it up with a code blue on the correct channel.

50. The control room log states that Officer C heard the code blue at 3.16am but did not call an ambulance until 3.20am. The control room entry, requesting an ambulance, has been changed from 3.25am to 3.20am. At 3.22am, the SO and Officer E arrived at Mr Bahid's cell.

51. At 3.24am, the nurses arrived at Mr Bahid's cell but could not find any PPE in the emergency bag. (Nurse C explained that the equipment was in a discrete front pocket of new emergency bags – they had not been given information about the new bags or where the PPE was kept within them). They entered Mr Bahid's cell without it and officers were also not wearing any PPE. Officer D was already delivering chest compressions. Nurse B found the oxygen cylinder in the bag but said it was empty.

52. Nurse C and one of the officers went to get another oxygen cylinder from the healthcare unit. However, the SO obtained one from the Beech hub, which was closer, and returned at 3.32am. (Just afterwards, another member of staff brought the defibrillator from the office.) Nurse B, Officer A and Officer D had continued to deliver chest compressions. CCTV footage shows two cylinders of oxygen arriving, one directly after the other at 3.32am.

53. The control room log says that paramedics arrived at the prison at 3.32am (changed from 3.38am) and that they reached the wing at 3.39am. CCTV shows that paramedics arrived at Mr Bahid's cell at 3.46am. They continued with life support but could not resuscitate Mr Bahid. His death was confirmed at 4.26am.

Contact with Mr Bahid's family

54. On 27 May, the prison appointed a prison manager as the family liaison officer (FLO). She phoned Mr Bahid's mother that morning to inform her of Mr Bahid's death in line with government advice and national measures. Mr Bahid's mother did not answer so the FLO broke the news to his sister instead. Oakwood contributed to the costs of Mr Bahid's funeral in line with national instructions.

Support for prisoners and staff

55. After Mr Bahid's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

56. Custodial staff were advised to take a COVID-19 test and self-isolate for two weeks.

57. Despite their exposure to a person suspected of having COVID-19 without PPE, the Head of Healthcare checked the position with Public Health England and told the nurses that they were expected to work the next day. This advice concurs with that published on the Royal College of Nursing's website. In general, healthcare staff who were symptomatic were expected to organise their own COVID-19 tests and self-isolate.

58. The prison posted notices informing other prisoners of Mr Bahid's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Bahid's death.

Cause of death

59. The post-mortem report concluded that Mr Bahid died from COVID-19 pneumonitis. It found that Mr Bahid was obese, and this contributed to but did not cause his death.

Findings

Clinical care

60. The clinical reviewer considered that the standard of care that Mr Bahid received at Oakwood, including for obesity and his COVID-19 infection, was equivalent to that which he could have expected to receive in the community.

61. The investigation found that HMP Oakwood had responded quickly and effectively in following HMPPS's national guidance on compartmentalisation issued on 31 March.

62. Mr Bahid was identified as clinically vulnerable because of his age and obesity and was appropriately advised to shield. Although he was a wing cleaner exposed to staff and prisoners daily, Mr Bahid chose not to shield. We are satisfied that the risks were explained to him and that he had the mental capacity to make this choice.

63. Mr Bahid had felt ill for approximately three days before he told staff about his symptoms. We understand that although prisoners had been given information about COVID-19 symptoms and the dangers of the disease, some wanted to avoid shielding or isolating. We do not consider that staff could reasonably have done any more to prevent this.

Emergency response

Oakwood's protocol and communicating the emergency

64. PSI 03/2013 requires prisons to have a medical emergency response code protocol so that an ambulance is called as soon as an emergency code is radioed. It requires staff to 'clearly and concisely convey the nature of the medical emergency simultaneously to all interested parties and contact the communication or control room' if they find that a prisoner has breathing difficulties or a range of other symptoms which require an emergency response.

65. However, Oakwood's local protocol states that if there is a medical emergency, staff should provide first aid, then summon other staff by shouting, radio or telephone and then call a code blue. These steps do not reflect the PSI. Calling a code blue straight away alerts healthcare staff to attend immediately and should also trigger the control room to call an ambulance immediately, and prevents any delay caused by shouting or telephoning them first.

66. Mr Bahid initially reported breathing difficulties to Officer A at 3.04am but it took at least ten minutes until healthcare staff were summoned and a further eight minutes before they were at the scene. This was an unnecessary 18- minute delay caused by poor communication between staff.

67. Officer A was using a cordless phone (which according to the SO lost signal) to ask the SO what to do. Officer A told the investigator he had a radio with him but found it awkward to have a fluid conversation by radio. We consider that a stop-start conversation is more effective than one where the signal is lost halfway through, particularly when the conversation is about an individual's health and safety.

68. When the SO decided to alert nurses, they were initially just 'bleeped'. Nurse B said that when her colleague phoned to ask the control room what was required for whom and where, Officer C in the control room had little idea. Officer C told the investigator he could not remember this conversation. Nurse B said she also asked Officer B (who escorted the nurses to the scene) for more information, but he too appeared to know very little.

69. Officer A went on to radio the first code blue on the wrong radio channel so no one heard it, and we do not know exactly when it was called. However, he told the investigator he realised quickly what he had done and called the second code blue soon afterwards, so this aspect of delay is unlikely to have had much impact.

70. Although we understand that Oakwood switched to 24-hour healthcare cover partly to alleviate pressures on the local ambulance service during the COVID-19 pandemic, we consider that a code blue should have been called as soon as Officer A discovered that Mr Bahid had breathing difficulties. The PSI is clear that local procedures must ensure that staff understand that they should not delay calling for emergency assistance. We recognise that Officer A initially assessed that Mr Bahid was still able to talk normally despite having breathing difficulties. However, the PSI states that local procedures must make it clear that if staff have any doubt about the nature of the incident, they must call an ambulance as it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not needed. We make the following recommendation:

The Director should ensure that Oakwood's medical emergency code policy reflects the provisions of PSI 03/2013 and staff understand its requirements, particularly that an emergency code should be radioed immediately in the event of an emergency.

Prison clocks and record keeping

71. Officer C in the control room recorded the code blue as being broadcast at 3.16am. He did not hear the first code blue because it was broadcast across the wrong radio channel. This timing of 3.16am does not tally with the CCTV clock (which shows the officers going into the cell at 3.19am which is when Officer A says he called a code blue). A prison manager checked the clocks in the control room at the investigator's request and confirmed there were four clocks which were not all set to the same time. The CCTV clock was almost three minutes fast.

72. Officer C's log stated that he did not call an ambulance until 3.20am, which was four minutes after he recorded that the code blue was called. He said at interview that the ambulance request was made immediately after the code blue was called – 3.20am was the time he remembered to record that it had been done. He also amended the timings in the log because he said that he subsequently realised he had glanced at his watch instead of the CCTV screen for timings. With clocks not set to the same time, it is not surprising that there are logging discrepancies.

73. The emergency services did not respond to our request for their records so we cannot verify this, but we have no reason to disbelieve Officer C's version of

events. It is more likely that recording events after they have taken place and consulting clocks set to different times account for any perceived delays. We recommend that:

The Director should ensure that prison clocks are accurate, particularly those in key locations.

Entering cells

74. Prison Service Instruction (PSI) 24/2011 on the management and security of nights, says that under normal circumstances, prisoners' cells can only be opened on the authority of the Night Orderly Officer and with at least two staff present. However, it goes on to say that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer and an individual member of staff can enter the cell on their own. It says that any lone member of staff's decision to enter a cell should be informed by a 'dynamic risk assessment' – informed by attempts to gain a response, what they can see through the observation panel and any other knowledge of the prisoner. Oakwood's local policy mirrors these provisions.

75. Officer A told the investigator that before he went into Mr Bahid's cell, he was very unsure if he needed assistance. He said it was not unusual for prisoners to sleep on the floor and the fact that Mr Bahid had a pillow underneath his head made him think that this is what he had decided to do. However, he went on to say he would not go into a cell alone in any circumstances.

76. Officer D arrived at 3.16am and he and Officer A were outside Mr Bahid's cell for another three minutes before they went in. Officer D shared Officer A's opinion that it did not look like Mr Bahid had collapsed and also said that visibility through the observation panel was not very good. He ultimately decided to open the cell and go in as long as the SO did not object – which he did not.

77. We understand that it was not obvious to staff that Mr Bahid needed assistance, but we are concerned that Officer A said he would not go into a cell alone in any circumstances. In some cases immediate intervention may be crucial. We make the following recommendation:

The Director should:

- **ensure that all staff are aware of the provisions in PSI 24/2011 on entering cells alone where there is risk to life if it is safe to do so; and**
- **share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.**

Communication between staff

78. When they entered Mr Bahid's cell, Officer A and Officer D did not know that Mr Bahid was suspected of having COVID-19 and did not therefore use the PPE which was available in the wing office. Officer A told the investigator that the wing office usually has a list of prisoners who were shielding, but that the list was

not displayed that night. Mr Bahid was not shielding but was displaying symptoms of COVID-19 so it is even more unfortunate that this information had not been shared with officers. As Nurse A told us that she told all appropriate parties about Mr Bahid, we make the following recommendation:

The Director should ensure that all staff are aware which prisoners are shielding or have COVID-19 symptoms so that they can take necessary precautions.

Equipment

79. Nurses did not arrive at the scene until 3.22am (according to the CCTV clock), 18 minutes after Mr Bahid, a person with COVID-19 symptoms, reported breathing difficulties. Nurse B and Nurse C told the investigator that they could not find the PPE in the emergency bag as new bags were in use and they had not been told that the PPE was in a special compartment. While this was not acceptable, we understand that nurses now always carry PPE pouches. We have not therefore made a recommendation.

80. Nurse B and Nurse C told the investigator that the oxygen cylinder in the emergency bag was empty. However, the Head of Healthcare said that she had investigated the matter and there was a small amount of oxygen left. We cannot verify the accuracy of either account but we note that the Head of Healthcare has since revised the emergency bag checking procedures.

Compassionate release

81. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months. In addition, a scheme was introduced in response to the COVID-19 pandemic to enable risk-assessed prisoners within two months of their release date to be temporarily released from custody. Among other factors, prisoners had to have served at least half of their time in prison, be close to release and have suitable accommodation to be eligible for consideration for temporary early release. (This scheme has now been paused.)

82. The Resettlement Unit Manager said that there were issues with Mr Bahid's post-release accommodation as he had said on 18 May that he could not return to his pre-custody accommodation. We are satisfied that Mr Bahid did not meet the criteria for early release.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141