Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Cobbledick, a prisoner at HMP Whatton, on 4 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*

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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 George Cobbledick died in hospital of COVID-19-associated bronchopneumonia on 4 April 2020, while a prisoner at HMP Whatton. He was 90 years old. I offer my condolences to Mr Cobbledick's family and friends.

The clinical reviewer concluded that the care Mr Cobbledick received at Whatton was equivalent to that which he could have expected to receive in the community. She found that healthcare staff appropriately supported Mr Cobbledick's existing health conditions, appropriately shielded him at the outset of the COVID-19 pandemic and quickly sent him to hospital when he showed COVID-19 symptoms.

However, I am concerned that when Mr Cobbledick was taken to hospital, there was a delay in contacting his next of kin because the details had been incorrectly recorded by his previous prison and never updated during the three years he was at Whatton.

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 **October 2020**

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Summary

Events

1. On 22 May 2017, Mr George Cobbledick was sentenced to 15 years imprisonment for sexual offences and sent to HMP Nottingham. He was moved to HMP Whatton on 9 June.

2. Mr Cobbledick had several long-term conditions including chronic obstructive pulmonary disease (COPD – serious lung disease), heart disease and asthma.

3. From 20 March, the prison decided to treat Mr Cobbledick's wing as a COVID-19 shielding unit, which meant that access was restricted, extra cleaning took place and prisoners visited the servery and exercise yard on their own.

4. On 31 March, Mr Cobbledick fell in his cell. An occupational therapist checked on Mr Cobbledick and noted that he coughed on several occasions, though he denied that he had done so.

5. On 1 April, a nurse saw Mr Cobbledick, who was very breathless, confused and struggling to speak in full sentences. His temperature, blood pressure and pulse rate were high, while his blood oxygen saturation level was low. The nurse sent Mr Cobbledick to hospital.

6. Mr Cobbledick tested positive for COVID-19. He died in hospital on 4 April. A hospital doctor recorded his cause of death as COVID-19-associated bronchopneumonia.

Findings

Clinical care

7. The clinical reviewer found that the care Mr Cobbledick received at Whatton was of a good standard and equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately supported Mr Cobbledick's existing health conditions with treatment and care plans, appropriately shielded him at the outset of the COVID-19 pandemic and quickly sent him to hospital when he showed COVID-19 symptoms.

Liaison with Mr Cobbledick's family

8. The surname of Mr Cobbledick's next of kin was incorrectly recorded and it was never checked or updated at Whatton. This led to an unnecessary delay in contacting Mr Cobbledick's next of kin when Mr Cobbledick was admitted to hospital.

Recommendation

- The Governor should ensure that a prisoner's next of kin details are kept up to date and are readily available if a prisoner becomes seriously ill.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Cobbledick's prison and medical records.

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

12. The investigator interviewed five members of staff at Whatton on 1 and 3 June 2020. The clinical reviewer joined the investigator for the two interviews on 3 June. All the interviews were conducted by telephone due to the restrictions in place because of the COVID-19 pandemic.

13. We informed HM Coroner for Nottinghamshire of the investigation. She gave us the cause of death. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers wrote to Mr Cobbledick's next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Whatton

16. HMP Whatton is a medium security prison in Nottinghamshire which holds up to 841 prisoners convicted of sex offences. Between 1 April 2017 and 31 March 2020, MITIE Care and Custody Health provided healthcare services. From 1 April 2020, Care UK has provided healthcare services.

17. The healthcare centre is open from 7.30am to 6.30pm from Monday to Friday and from 8.30am to 6.30pm on weekends and bank holidays. There is an out-of-hours service at other times. There are no inpatient beds but there is a palliative care suite in the healthcare centre for end-of-life care.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Whatton was in August 2016. Inspectors reported that the quality of health and social care was good, particularly as 49% of prisoners were aged over 50. Inspectors found that a mix of appropriately-skilled staff in well-integrated teams provided health services and interacted politely and professionally with their patients.

Independent Monitoring Board

19. 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 31 May 2019, the IMB considered that there had been a discernible improvement in healthcare provision, despite the number of older prisoners, and an improvement in staffing levels. They also considered that while prisoners received a standard of care equivalent to that they would expect to receive in the community, the standard of accommodation in healthcare remained a concern.

Previous deaths at HMP Whatton

20. Mr Cobbledick was the 12th prisoner to die at Whatton since April 2018. All the previous deaths were from natural causes. There are no similarities between this investigation and previous deaths at Whatton.

21. There have been no other COVID-19 related deaths at Whatton.

Coronavirus (COVID-19)

22. 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.

23. 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).

24. 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).

25. 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.

26. 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.

27. 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 general population. These units could also accommodate any one returning from hospital.

Key Events

28. On 22 May 2017, Mr George Cobbledick was convicted and sentenced to 15 years imprisonment for sexual offences. He was sent to HMP Nottingham but moved to HMP Whatton in June 2017.

29. Mr Cobbledick had chronic obstructive pulmonary disease (COPD – a group of serious lung conditions that can cause breathing difficulties), atrial fibrillation (an irregular heart beat), ischaemic heart disease, asthma and chronic kidney failure. His conditions were treated with prescribed medication. He had poor mobility and needed to use walking aids. Care plans were created for his COPD, asthma and atrial fibrillation.

30. When he arrived at Nottingham, Mr Cobbledick named his next of kin and gave his address but no telephone number. The surname was recorded incorrectly when the details were added to Mr Cobbledick's electronic prison record.

31. In August 2019, a nurse saw Mr Cobbledick as he was suffering with shortness of breath and stomach pain. She sent him to hospital as an emergency. Hospital doctors treated Mr Cobbledick with nebulisers and oral antibiotics for an exacerbation of his COPD and discharged him back to the prison after two days.

Events of March 2020

32. On 15 March 2020, a nurse saw Mr Cobbledick as he was suffering with pain in his chest and stomach. She took Mr Cobbledick's basic observations. All were normal, including his temperature at 37.1°C (a symptom of COVID-19 is a temperature of 37.8°C or above), except his blood pressure which was high. She wanted Mr Cobbledick to go to hospital but he refused.

33. On 19 March, a nurse visited Mr Cobbledick in his cell. Mr Cobbledick said that he did not have a fever or a cough but he would let his carer know if these developed. She checked his chest and gave him a COPD rescue pack, which contained extra medication to be used if he experienced a worsening of his condition.

34. From 20 March, the prison decided to treat Mr Cobbledick's wing as a COVID-19 shielding unit, as it held many prisoners with complex medical needs. This decision meant that access to the wing was restricted, additional cleaning took place and prisoners visited the servery and exercise yard on their own.

35. On 26 March, a nurse checked on Mr Cobbledick, who said that he was feeling well. She took Mr Cobbledick's basic observations, which were normal, including his temperature at 36.5°C.

36. On 31 March, Mr Cobbledick fell in his cell and officers asked for assistance from healthcare staff. A nurse took Mr Cobbledick's basic observations, which were normal. The same day, an occupational therapist saw Mr Cobbledick for an occupational therapy assessment and noted that he coughed on several occasions, though he denied doing so. She also noted that Mr Cobbledick looked frailer and less well than when she had seen him before.

37. At 8.45am on 1 April, a nurse saw Mr Cobbledick, who was very breathless, confused and struggling to speak in full sentences. She took his basic observations and found that his temperature was high (37.6°C), as was his blood pressure and pulse rate, and his blood oxygen saturation level was low at 86% (normal range is 95-100%). She decided to send Mr Cobbledick to hospital.

38. At approximately 9.15am, paramedics took Mr Cobbledick to a hospital. Two prison officers escorted Mr Cobbledick to hospital but did not restrain him. When he arrived, hospital doctors admitted him to the resuscitation unit and tested him for COVID-19, as a chest X-ray showed evidence of the virus. Later that evening, Mr Cobbledick tested positive for COVID-19.

39. On 2 April, the hospital told the prison that Mr Cobbledick had deteriorated and that he was close to death. Mr Cobbledick's condition continued to deteriorate and, at 6.45am on 4 April, a hospital doctor recorded that he had died.

Contact with Mr Cobbledick's family

40. On 1 April, a senior manager contacted Nottinghamshire Police to find a telephone number for Mr Cobbledick's next of kin so she could tell him that he was seriously ill in hospital. The police could not initially locate the details for him as the name recorded in Mr Cobbledick's records was incorrect. However, on 3 April, the police suggested an alternative name, the correct one, and found a telephone number for Mr Cobbledick's next of kin.

41. At approximately 10.00am on 3 April, the senior manager telephoned Mr Cobbledick's next of kin but he did not answer the call. Four hours later, she telephoned him again and told him that he was very ill in hospital. Mr Cobbledick's next of kin asked her to telephone him if he died.

42. After Mr Cobbledick's death, the prison appointed a custodial manager as the family liaison officer (FLO) and a prison manager, as the deputy FLO. At 10.50am on 4 April, the deputy FLO telephoned Mr Cobbledick's next of kin to break the news of his death and to offer his condolences and support.

43. The FLO continued to support Mr Cobbledick's next of kin until his funeral, which was held on 28 April. The prison paid for the costs of the funeral in line with national instructions.

Support for prisoners

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

Cause of death

45. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor recorded Mr Cobbledick's cause of death as COVID-19-associated bronchopneumonia caused by emphysema (damage to the air sacs in the lungs). Peripheral

vascular disease and ischaemic heart disease were listed as underlying conditions which contributed to but did not cause Mr Cobbledick’s death.

Findings

Clinical care

46. Mr Cobbledick had several long-term health conditions. The clinical reviewer considered that healthcare staff at Whatton appropriately maintained and monitored plans for Mr Cobbledick's treatment and care in line with NICE guidance.

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

47. As Mr Cobbledick had not left the prison in the months before he developed COVID-19 symptoms, we assume he contracted the virus in prison. Healthcare staff told us that three prisoners on Mr Cobbledick's wing displayed possible symptoms on 23 March and that some staff (both prison and healthcare staff) were having to self-isolate as they also had possible symptoms. No COVID-19 tests were being conducted on prisoners or staff at the time, so we cannot say if they had the virus or not.

48. The clinical reviewer was satisfied that at the start of the COVID-19 pandemic, healthcare staff put Mr Cobbledick into a protected group, gave him rescue medication and shielded him in line with Public Health England advice. When Mr Cobbledick began to experience COVID-19 symptoms, healthcare staff quickly responded and sent him to hospital within an hour.

49. The clinical reviewer concluded that the care Mr Cobbledick received was of a good standard and equivalent to that which he could have expected to receive in the community. 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.

50. We note that a nurse wanted to send Mr Cobbledick to hospital more than two weeks before he died but that he refused to go. It is not possible to say whether the outcome might have been different if he had agreed to go.

Liaison with Mr Cobbledick's family

51. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, says that prisons must record a prisoner's next of kin during their reception into or early days in a prison and that these details must be kept up-to-date.

52. While Mr Cobbledick arrived in prison, the surname of his next of kin was incorrectly recorded on his prison record. During his time at Whatton, almost three years, there is no record that staff checked the details for Mr Cobbledick's next of kin. Although the police were eventually able to provide contact details before Mr Cobbledick died, we are concerned that failing to accurately record details for a prisoner's next of kin or keep them up-to-date could mean that the next of kin cannot be contacted in time in future cases. We make the following recommendation:

    The Governor should ensure that a prisoner's next of kin details are kept up to date and are readily available if a prisoner becomes seriously ill.

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