Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Andrew Clark, a prisoner at HMP Durham, on 17 May 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*

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 Andrew Clark died in hospital of COVID-19 pneumonia on 17 May 2020, while a prisoner at HMP Durham. He was 45 years old. I offer my condolences to Mr Clark's family and friends.

The clinical reviewer concluded that the care Mr Clark received at Durham was equivalent to that which he could have expected to receive in the community. She found that healthcare staff acted promptly and effectively when Mr Clark became unwell in late April.

However, I am concerned that the forehead thermometer used to take Mr Clark's temperature gave a normal reading, despite a paramedic's tympanic thermometer finding that he had a very high temperature, a key symptom of COVID-19.

I am also concerned that there was an unnecessary delay in Mr Clark's father being told of his son's death.

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

## Events

1. On 28 June 2019, Mr Andrew Clark was recalled to prison custody after failing to comply with his licence conditions and committing further offences. He had a history of drug and alcohol abuse and was prescribed methadone (an opiate substitute) in prison.

2. On 21 April 2020, Mr Clark told an officer that he had been off work with a sickness bug and had spent the day in bed.

3. On 25 April, a nurse saw Mr Clark in his cell, after officers reported that he was unwell and had vomited. Mr Clark said he had no COVID-19 symptoms. The nurse checked his temperature, which was normal. The nurse told Mr Clark to contact healthcare staff if he had any new symptoms and to isolate for 48 hours due to his vomiting symptoms.

4. On 29 April, two nurses saw Mr Clark as an officer thought he might be under the influence of an illicit substance. Mr Clark said that he had felt unwell for the past week, though he said that he did not have a cough, sore throat or chest pain. The nurse took Mr Clark's basic observations and found that his heart rate and respiratory rate were high, his oxygen saturation was very low and his temperature was normal. The nurse asked for an emergency ambulance to take Mr Clark to hospital. When paramedics arrived and took Mr Clark's temperature, they found it was high. The nurse retested Mr Clark's temperature with the forehead temperature scanner, found that it gave another normal reading and realised that there was a significant difference with the paramedics' tympanic thermometer. The paramedics then took Mr Clark to hospital.

5. Mr Clark was tested for COVID-19 and moved to the intensive treatment unit. He later tested positive. His condition continued to deteriorate and he died at 10.36pm on 17 May.

6. The post-mortem examination found that Mr Clark's death was caused by COVID-19 pneumonia.

## Findings

### Clinical care

7. The clinical reviewer found that the healthcare Mr Clark received was equivalent to that which he could have expected to receive in the community.

8. However, we are concerned that no one told healthcare staff that Mr Clark had experienced gastrointestinal symptoms from 21 April. We are also concerned that a forehead scanner used to take his temperature gave an inaccurate reading.

### Restraints, security and escorts

9. We are concerned that healthcare staff did not include crucial information about Mr Clark's medical condition in the escort risk assessment, which meant that the

authorising manager was unable to make an informed decision on whether it was justified to restrain him.

### Liaison with Mr Clark's family

10. Although most of the prison's liaison with Mr Clark's father was of a high standard, we are concerned that no one tried to contact him on the evening that his son died.

### Failure to provide prison documentation

11. The prison failed to provide us with the Control Room Log for 29 April despite repeated requests.

## Recommendations

- The Governor and Head of Healthcare should agree the circumstances in which prison staff should report prisoners with gastrointestinal symptoms to healthcare staff during the COVID-19 pandemic.
- The Governor should ensure that prison staff appropriately record and action requests from healthcare staff about isolating a prisoner on medical grounds.
- The Head of Healthcare should ensure that:
  - all clinical equipment is kept in good working order; and
  - all recent patients are rechecked if it becomes clear that a piece of clinical equipment is faulty.
- The Head of Healthcare should ensure that healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.
- The Governor should ensure that a family liaison officer breaks the news of a death to a next of kin as soon as possible, in line with Prison Rule 22 and PSI 64/2011.
- The Governor should ensure that the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody, in line with PSI 58/2010.

## The Investigation Process

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

13. He obtained copies of relevant extracts from Mr Clark's prison and medical records.

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

15. The investigator and clinical reviewer interviewed five members of staff at Durham on 14 July 2020. All the interviews were conducted by video-link due to the restrictions in place because of the COVID-19 pandemic.

16. We informed HM Coroner for County Durham and Darlington of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Clark's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Clark's father wanted to know where he caught COVID-19 and when had he become unwell.

18. 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.

19. The initial report was shared with the clinical reviewer, who pointed out some factual inaccuracies and this report has been amended accordingly.

20. Mr Clark's father received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

# Background Information

### HMP Durham

21. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. Spectrum Community Health CIC provides primary nursing, GP, clinical substance misuse, pharmacy and sexual health services. Tees, Esk and Wear Valley NHS Trust provide mental health services.

### HM Inspectorate of Prisons

22. The most recent inspection of HMP Durham was in September and October 2018. Inspectors reported all prisoners had good access to health services, regardless of their location, and that primary healthcare staffing levels were good with additional staff due to start after the inspection. They also found that medical emergencies were well managed, with appropriate equipment located across the prison, and that infection prevention audits were carried out regularly.

### 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 31 October 2019, the IMB reported that they were impressed with the care and dedication of healthcare staff and that, despite the prison's transition to becoming a reception prison and the high turnover of prisoners, some healthcare services had improved.

### Previous deaths at HMP Durham

24. Mr Clark was the 16th prisoner to die at Durham since May 2018. Four of the previous deaths were from natural causes, seven were self-inflicted and four were drug-related. We have made previous recommendations about the need for accurate information on a prisoner's medical condition when authorising the use of restraints, and about difficulties obtaining evidence from the prison.

25. There have been no other COVID-19 related deaths at Durham.

### Coronavirus (COVID-19)

26. 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.

27. 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).

28. 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).

29. 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.

30. 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.

31. 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

32. On 28 October 2017, Mr Andrew Clark was remanded in prison custody and sent to HMP Durham. On 7 March 2018, he was sentenced to 32 months imprisonment for violent offences.

33. Mr Clark was released on licence on 27 February 2019 but was recalled on 27 May. He was released on licence again on 21 June, but was again recalled on 28 June, due to failing to comply with his licence conditions and committing further offences.

34. Mr Clark had a history of substance and alcohol misuse, which was treated with methadone and regular reviews with substance misuse staff. Healthcare staff diagnosed Mr Clark with hepatitis B (a blood borne virus that infects the liver) in 2017, though a hospital infectious diseases consultant decided that he did not require active treatment.

35. On 21 April 2020, an officer saw Mr Clark for a key worker session. Mr Clark said that he had been off work with a sickness bug and had spent the day in bed. There is no record that healthcare staff were told.

36. The following day, an officer saw Mr Clark as part of the prison's safer custody welfare checks during the COVID-19 pandemic. The officer reminded Mr Clark about the need to follow social distancing. There is no record that Mr Clark referred to being unwell or suffering with any COVID-19 symptoms.

37. On 23 April, a nurse spoke to Mr Clark, on his cell telephone, for a substance misuse review. There is no record that Mr Clark referred to being unwell.

38. On 25 April, a nurse saw Mr Clark in his cell, after officers reported that he was unwell and had vomited. Mr Clark said he felt weak and nauseous but had no COVID-19 symptoms (a cough, a sore throat or a loss of taste or smell). The nurse took Mr Clark's basic observations and found that his temperature was normal at 37.0°C (a symptom of COVID-19 is a temperature of 37.8°C or above) though his heart rate and blood pressure were high. The nurse planned to review Mr Clark later that afternoon and told him to contact healthcare staff if he had any new symptoms and to isolate for 48 hours due to his vomiting symptoms. The nurse told the investigator that she 'would have told a prison officer' that Mr Clark needed to be isolated, though she could not remember who. There is no record that anyone recorded this information in the wing's observation book.

39. Later that afternoon, the nurse saw Mr Clark, who said that he felt a lot better. The nurse noted that she did not see any COVID-19 symptoms. She took Mr Clark's basic observations and found that his temperature was normal at 36.5°C though his blood pressure was high. She told Mr Clark to contact healthcare staff if he deteriorated.

40. On the mornings of 26, 27 and 28 April, nurses gave Mr Clark his methadone. None of them noted any concerns about Mr Clark.

41. At approximately 7.20am on 29 April, two nurses saw Mr Clark, as an officer thought he might be under the influence of an illicit substance. A nurse noted that Mr Clark appeared pale and short of breath. Mr Clark said that he had felt unwell for the past week and had become increasingly breathless, though he said that he did not have a cough, sore throat or chest pain. A nurse took Mr Clark's basic observations and found that his heart rate and respiratory rate were high and his oxygen saturation was very low at 44% (a normal oxygen saturation is 96 to 100%), though his temperature was normal at 36.5°C. Mr Clark was conscious and alert but required oxygen to breathe, which a nurse administered. She then asked for an emergency ambulance to take Mr Clark to hospital, which was called at 7.51am.

42. At 7.59am, paramedics reached Mr Clark. They took Mr Clark's basic observations and found that his temperature was high at 38.6°C. A nurse told the investigator that the paramedics had taken Mr Clark's temperature using a tympanic thermometer inserted in his ear while she took it using a forehead scanner, and that the discrepancy in results made her realise that the forehead scanner had produced an inaccurate result.

43. At 9.18am, paramedics took Mr Clark to hospital. Two prison officers accompanied Mr Clark and restrained him with a single set of handcuffs. At 11.20am, the acting Head of Safer Prisons authorised the escorting officers to remove the restraints, which were not reapplied.

44. After arriving at hospital, hospital doctors tested Mr Clark for COVID-19 and moved him to the COVID-19 ward, though by 3.20pm, he had been moved to the intensive treatment unit with suspected pneumonia.

45. The following day, a nurse spoke to one of the escorting officers, who said that Mr Clark had tested negative for COVID-19, though he was being re-tested.

46. On 1 May, a nurse spoke to a hospital ward sister, who said that Mr Clark had tested positive for COVID-19 and he was receiving oxygen from a CPAP machine. The following day, hospital doctors placed Mr Clark on a ventilator and said that he was critically ill.

47. Mr Clark's condition continued to deteriorate and he died at 10.36pm on 17 May.

### Contact with Mr Clark's family

48. On 29 April, the prison appointed a reverend as the prison's family liaison officer (FLO). That afternoon, the FLO telephoned Mr Clark's father and told him that Mr Clark had been admitted to the hospital's COVID-19 ward. The FLO continued to support Mr Clark's father by telephone.

49. At 8.20am on 18 May, the FLO telephoned Mr Clark's father, though he did not answer the call. At 12.10pm, he telephoned Mr Clark's father and offered his condolences and support.

50. The FLO continued to support Mr Clark's father before and after his funeral, which was held on 17 June. The prison contributed towards the costs of the funeral in line with national instructions.

## Support for prisoners and staff

51. The escorting officer who was at the hospital when Mr Clark died was debriefed and offered the support of the prison's care team.

52. The prison posted notices informing other prisoners of Mr Clark'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 Clark's death.

## Post-mortem report

53. The post-mortem examination found that Mr Clark's death was caused by COVID-19 pneumonia.

# Findings

## Clinical care

### *Management of Mr Clark's risk of infection from COVID-19*

54. As Mr Clark had not left Durham before he became unwell, we must assume that he contracted COVID-19 in prison. Although there were suspected cases of COVID-19 in the prison when Mr Clark became unwell, there were none on his wing. However, as a kitchen worker, Mr Clark would have come into contact with prisoners from other wings.

55. Mr Clark became ill during the early weeks of the COVID-19 pandemic. The Head of Transformation/Healthcare told us that the prison was following the current Public Health England and Prison Service guidance on cleaning, waste, Personal Protection Equipment (PPE) and social distancing, and were shielding prisoners who were at high risk and isolating prisoners who showed COVID-19 symptoms. At that time the symptoms were though to be a high temperature, a new persistent cough and a sore throat (although the list was later extended).

56. Mr Clark was not considered to be at high risk. (After Mr Clark's death, the hospital specialist who was treating Mr Clark for his chronic Hepatitis B infection confirmed that Mr Clark's Hepatitis B positive status and his history of drug misuse were not conditions that required 'shielding' measures and that that there was no COVID-19 guidance which applied specifically to Mr Clark.)

### *Mr Clark's COVID-19 symptoms*

57. Mr Clark began vomiting around 21 April, though healthcare staff only became aware of it from 25 April. At that time, vomiting was not recognised as a potential COVID-19 symptom. The clinical reviewer considered that it was highly likely that Mr Clark was showing the early symptoms of COVID-19, but this was unknown at the time. She considered that Mr Clark received appropriate attention for the potential risk of COVID-19 based on what was known about the disease.

58. The clinical reviewer was also satisfied that healthcare staff responded promptly and appropriately when Mr Clark became acutely unwell on 29 April.

59. Overall, she found that the healthcare Mr Clark received was of a good standard and equivalent to that which he could have expected to receive in the community.

60. There is no record that healthcare staff knew that Mr Clark had had a sickness bug from 21 April. However, as this was not a recognised COVID-19 symptom at the time, there was no reason for prison staff to have informed healthcare staff.

61. We do, however, have two concerns. First, although a nurse said that she 'would have' told a prison officer that Mr Clark should be isolated until his sickness bug cleared up on 25 April, this is not recorded in the wing observation book. We have been unable to confirm whether Mr Clark continued working in the kitchen after this. (This would not have put Mr Clark at risk but may have put other prisoners at risk.)

62. We are also concerned that the forehead scanner used to take Mr Clark's temperature on 29 April was faulty and gave an inaccurate reading. While we cannot be sure, it is possible that the same forehead scanner was used to check Mr Clark's temperature on 25 April. If so, there may have been another faulty reading which may have prevented him from being treated for suspected COVID-19 earlier.

63. The Head of Transformation/Healthcare told the investigator that immediate steps were taken to replace the forehead scanners with tympanic thermometers. However, there is no record that patients' temperatures were rechecked once the fault was discovered. Given that a high temperature is one of the key symptoms of COVID-19, we are concerned that this was not done.

64. We make the following recommendations:

**The Governor and Head of Healthcare should agree the circumstances in which prison staff should report prisoners with gastrointestinal symptoms to healthcare staff during the COVID-19 pandemic.**

**The Governor should ensure that prison staff appropriately record and action requests from healthcare staff about isolating a prisoner on medical grounds.**

**The Head of Healthcare should ensure that:**

- **all clinical equipment is kept in good working order; and**
- **all recent patients are rechecked if it becomes clear that a piece of clinical equipment is faulty.**

### Restraints, security and escorts

65. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

66. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

67. When a nurse decided to send Mr Clark to hospital on 29 April, he was acutely unwell with a very low oxygen saturation of 44% (normal oxygen saturation is between 96 and 100%) that did not improve when given oxygen. Despite Mr Clark's poor condition, the medical information section of the escort risk assessment made no reference to his very low oxygen saturation and a member of healthcare staff answered "no" to the question "*Any other Medical conditions likely to influence the escort? e.g. physical ability to escape, disability, need for medication, etc.*"

68. While Mr Clark was only restrained for a little over two hours, we are concerned that crucial information about his condition was not included in the escort risk assessment and that the authorising manager was unable to make an informed decision on whether it was justified to restrain him with a single set of handcuffs. We make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.**

### Liaison with Mr Clark's family

69. Prison Rule 22 says that when a prisoner dies, the governor should "at once inform the prisoner's spouse or next of kin". This is reflected in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which requires prisons to contact the next of kin of prisoners who die. This PSI states that time is of the essence when breaking the news of a prisoner's death to prevent the next of kin from finding out from another source.

70. HMPPS guidance, *Acting as Family Liaison Officer by telephone – communicating with a prisoner's next of kin*, published in March 2020, sets out the processes for family liaison during the COVID-19 pandemic. It says that news about a prisoner must be given by telephone.

71. For the most part, the family liaison that the FLO provided to Mr Clark's father was of a high standard, including notifying him as soon as Mr Clark was taken to hospital and continuing to support him after the funeral. However, we are concerned that the FLO did not attempt to break the news of Mr Clark's death until 8.20am on 18 May, nearly ten hours after he had died. As all family liaison during the COVID-19 pandemic needs to be made by telephone, we consider that he should have telephoned Mr Clark's father on the evening of 17 May. We make the following recommendation:

**The Governor should ensure that a family liaison officer breaks the news of a death to a next of kin as soon as possible, in line with Prison Rule 22 and PSI 64/2011.**

### Failure to provide prison documentation

72. On 29 April, when Mr Clark was sent to hospital, there is a gap of approximately 30 minutes between officers asking healthcare to check on him and the prison calling for an emergency ambulance. During the interview with a nurse she could not remember whether a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) had been called, though a nurse thought that a code had been called. Both nurses agreed that if a code blue is called then the prison would automatically call for an ambulance.

73. We tried to investigate this matter further and asked the prison for a copy of the Control Room Log for 29 April. Despite repeated requests, the prison has been unable to provide this document. Therefore, we cannot say whether an emergency code was called at around 7.20am (in which case an ambulance

should have been called immediately), or whether it was appropriate for the prison to call for an emergency ambulance at 7.51am. We make the following recommendation:

**The Governor should ensure that the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody, in line with PSI 58/2010.**

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