

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Unsworth, a prisoner at HMP Altcourse, on 14 February 2021

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. 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.
3. Mr William Unsworth died in hospital from COVID-19 pneumonia on 14 February 2021, while a prisoner at HMP Altcourse. He was 70 years old. I offer my condolences to Mr Unsworth's family and friends.
4. Mr Unsworth had several health conditions including chronic kidney disease, high blood pressure and obesity, and was 70 years old, all risk factors for becoming seriously ill from COVID-19.
5. On 8 February 2021, Mr Unsworth told a nurse that he had been feeling unwell for several days. His blood oxygen levels were low and he was admitted to the prison's healthcare centre for observation. The next day he tested positive for COVID-19, and following a deterioration in his condition, he was taken to hospital. He died there on 14 February.
6. The clinical reviewer concluded that although Mr Unsworth was managed with compassion by healthcare staff at Altcourse, one aspect of his care was not equivalent to that which he could have expected to receive in the community. This is because he was not identified as clinically vulnerable to COVID-19 and consequently did not receive appropriate advice about shielding.
7. The clinical reviewer also found some evidence of poor clinical record keeping. This is the fourth occasion on which we have found poor clinical record keeping at Altcourse, and the Head of Healthcare must now take robust action to improve the situation.
8. We found no non-clinical issues of concern.

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

Recommendations

- The Head of Healthcare should ensure that all prisoners with conditions identified by Public Health England as increasing their risk of serious illness if they contract COVID-19 are informed of this and their options regarding shielding, and that this is evidenced in their medical record.
- The Head of Healthcare should ensure that all staff maintain accurate and contemporaneous records in SystmOne.

The Investigation Process

9. NHS England commissioned an independent clinical reviewer, to review Mr Unsworth's clinical care at the prison. The clinical reviewer's report is attached as Annex 1.
10. The PPO's investigator, investigated non-clinical issues, including the prison response to COVID-19 and shielding prisoners, the security arrangements for Mr Unsworth's hospital escorts, liaison with his next of kin and whether compassionate release was considered.
11. The Ombudsman's family liaison officer contacted Mr Unsworth's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not reply to our letter.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy regarding the size of the prison population. This has been corrected in this final report. Their action plan is annexed to this final report.

Background Information

HMP Altcourse

13. HMP Altcourse is a local prison run by G4S and holding around 1,164 men, including around 100 young adults. As a local prison one of its primary functions is to serve the courts of Merseyside, Cheshire and North Wales. Healthcare is provided by G4S Health Services.

Previous deaths at HMP Altcourse

14. Mr Unsworth was the 14th prisoner at Altcourse to die since February 2019. Of the previous deaths, 11 were from natural causes (including four from COVID-19), one was self-inflicted, and one was drug-related. There have been no further deaths from COVID-19 at Altcourse. Following investigations into previous deaths at Altcourse, we have made recommendations about clinical record keeping.

COVID-19 (coronavirus)

15. 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.
16. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
17. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try to contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, in a prison who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly received prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

18. On 1 September 2020, Mr William Unsworth was sentenced to two years imprisonment for taking drugs into a prison and was sent to HMP Altcourse.
19. Mr Unsworth had several health issues including depression, chronic kidney disease (CKD), high blood pressure, chronic back pain, and two different blood diseases. He was also obese and was taking medication to lower high cholesterol (a fatty substance in the blood which makes heart problems and strokes more likely). A pre-sentence psychiatric assessment said he had "declining cognitive function, which caused genuine confusion and poor recall" and described him as "a disempowered and helpless individual" who meekly followed the demands of others.
20. For his first two weeks at Altcourse Mr Unsworth was housed in the prison's reverse cohorting unit (RCU, a measure designed to avoid bringing COVID-19 into the prison, by keeping new or returning prisoners separate for a period during which symptoms could be expected to show in an infected person).
21. On 4 November, Mr Unsworth said he had a persistent cough. Both he and his cellmate were tested for COVID-19 and put into isolation. On 6 November, the tests came back negative.
22. On the same day as his COVID-19 test, Mr Unsworth had an electrocardiogram (ECG) test (that checks the rhythm and electrical activity of the heart). Although this did not show anything requiring urgent attention, there was a suggestion of a slight abnormality and Mr Unsworth was referred to the hospital cardiac (heart) unit.
23. Mr Unsworth declined to attend two cardiac appointments in December, and he signed a disclaimer to say that he was not attending by choice.
24. On 3 January 2021, Mr Unsworth was scheduled to have a memory test in the prison but he declined to do this and signed a disclaimer again. He said that he did not have any worries about his memory.
25. On 30 January, Mr Unsworth was taken to hospital after taking an overdose of 30 paracetamol tablets. He said that it was accidental and he had been trying to deal with back pain. He returned to prison a few hours later.
26. On 5 February, a prison officer asked a nurse to check on Mr Unsworth after he had black outs. A nurse took his clinical observations which gave no cause for concern, but referred him to the GP who saw him the next day. The doctor asked for some tests to be done, including another ECG (which when done on 8 February showed no cause for concern in relation to his heart).
27. However, on 8 February, Mr Unsworth's clinical observations began to show some slight variations from normal. He was transferred to the prison healthcare unit so he could be kept under close observation.
28. Mr Unsworth's condition deteriorated on 9 February, and he tested positive for COVID-19. His blood oxygen levels dropped and his temperature rose. He was taken to hospital.

29. Mr Unsworth died in hospital on 14 February.
30. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. An inquest was held on 26 February, and the Coroner recorded the cause of death as COVID-19 pneumonia, and listed chronic kidney disease as an underlying condition that contributed to but did not cause his death.

Findings

Clinical Findings

31. The clinical reviewer considered that in most instances, the standard of care Mr Unsworth received at Altcourse was equivalent to that which he could have expected to receive in the community.
32. However, she found that staff had not assessed Mr Unsworth's risk of serious illness from COVID-19 or given him advice about shielding. This aspect of his care was not equivalent. She also had concerns about the clinical record keeping.

Management of Mr Unsworth's risk of catching COVID-19

33. Mr Unsworth had left the prison only once between his arrival in September 2020 and his illness in February 2021. This was when he went to hospital on 30 January. It is, therefore, possible that he could have caught COVID-19 either in prison or on his trip to hospital following his overdose.
34. Wherever he contracted the virus, we have concerns about the adequacy of the steps taken by the prison to protect him from COVID-19.
35. When Mr Unsworth entered prison, he was located in the RCU and when he reported a persistent cough in November 2020, he was isolated. Both are examples of good practice.
36. However, Altcourse has no records to evidence that Mr Unsworth's risk of complications from COVID-19 had been assessed or that any shielding advice had been given to him, despite his obesity, CKD, high blood pressure and age (which all put him at higher risk). Altcourse had had the experience of three prisoners dying after contracting COVID-19 in April 2020 during the first phase of the pandemic, and another prisoner had died from COVID-19 in October. So, it is a concern that they did not display a greater awareness in Mr Unsworth's case.
37. Mr Unsworth had quite a lot of contact with healthcare staff because of his various medical conditions. So, although he was not risk assessed in relation to COVID-19 on his arrival at the prison, there was plenty of opportunity to redress this later. The lack of assessment meant that Mr Unsworth was not advised to shield as would have been expected with someone with his risk factors.
38. Although the Head of Healthcare told us that there was information about COVID-19 in the prison and on the prison radio, we do not consider that this was sufficient. We consider that prisoners at high risk should have been individually advised about their risk and that healthcare staff should have spoken to them to ensure they understood their risk.
39. The Head of Healthcare suggested that the fact that this was not recorded in Mr Unsworth's case did not necessarily mean it had not happened. However, we note that Mr Unsworth's medical records contain disclaimers in relation to other medical matters, so we would have expected to see something about shielding if he had declined to follow healthcare advice on this.

40. The clinical reviewer was satisfied that Mr Unsworth had the mental capacity to make decisions. However, it is a concern that we found no evidence that he had received the information necessary for him to properly risk assess his situation in relation to COVID-19 and whether he should shield or not.
41. In assessing the Mr Unsworth's care, particularly in relation to COVID-19, the clinical reviewer found insufficient recording or detail in some instances in his clinical records. We are concerned that this is now the fourth time that we have identified poor clinical record keeping in an investigation into a death at Altcourse. This is not acceptable and the Head of Healthcare must now take robust action to improve the situation.
42. We recommend:

The Head of Healthcare should ensure that all prisoners with conditions identified by Public Health England as increasing their risk of serious illness if they contract COVID-19 are informed of this and their options regarding shielding, and that this is evidenced in their medical record.

The Head of Healthcare should ensure that all staff maintain accurate and contemporaneous records in SystemOne.

**Sue McAllister CB
Prisons and Probation Ombudsman**

July 2021

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