Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Phillip Moorcroft, a prisoner at HMP Maidstone, on 8 January 2021

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Phillip Moorcroft died in hospital on 8 January 2021 of COVID-19 pneumonitis, while a prisoner at HMP Maidstone. He was 75 years old. We offer our condolences to Mr Moorcroft's family and friends.

4. Mr Moorcroft had several chronic conditions, including Type 2 diabetes, heart disease, high blood pressure and anaemia. Care plans were created, and referrals were made to secondary care providers to ensure continuity of his care.

5. On 22 December 2020, Mr Moorcroft transferred to HMP Maidstone. He had a test for COVID-19, which was negative. He had a second COVID-19 test on 28 December.

6. At 7.30am on 2 January 2021, prison officers carrying out a roll check found Mr Moorcroft lying on the floor of his cell. They helped him back onto his bed and he was seen by a prison nurse. The nurse noted that Mr Moorcroft was short of breath and experiencing chest pain, that his clinical observations were abnormal and that his COVID-19 test result (taken on the 28 December) was positive.

7. He was taken to hospital by emergency ambulance and was admitted as an inpatient. He was placed in an isolation ward and treated with oxygen therapy. His condition continued to deteriorate and he died on the evening of 8 January.

8. The clinical reviewer concluded that the healthcare Mr Moorcroft received at Maidstone was reasonable and equivalent to that which he could have expected to receive in the community. However, she has made one recommendation about record keeping and the importance of keeping contemporaneous notes.

9. We are also concerned that Mr Moorcroft was restrained with an escort chain when he was taken to hospital. Although it was removed shortly after his arrival, we consider the use of restraints was unjustified and disproportionate given the seriousness of his medical condition and his impaired mobility at the time of his final admission to hospital.

Recommendations

- The Head of Healthcare should ensure that healthcare staff record all contact with prisoners by using contemporaneous notes so that there is a full and accurate record about the prisoner's care.

- The Governor should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position; and that assessments fully take into account the

health of a prisoner and are based on the actual risk the prisoner presents at the time.

Investigation Process

10. NHS England commissioned an independent clinical reviewer to review Mr Moorcroft's clinical care at HMP Maidstone.

11. The PPO investigator has investigated non-clinical issues, including Mr Moorcroft's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

12. The PPO's family liaison officer, Ms Lizzie Laing, wrote to Mr Moorcroft's next of kin, his wife, to explain the investigation. She did not respond to our letter.

13. 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

Previous deaths at Maidstone

14. Mr Moorcroft was the second prisoner to die at Maidstone since January 2019. The previous death was a self-inflicted death. There have been no other deaths from COVID-19.

Coronavirus (COVID-19)

15. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 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 have 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 and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk, isolate those who are symptomatic, and separate newly arrived prisoners from the main prison population.

18. The Ministry of Justice and Public Health England later issued joint guidance, *Preventing and controlling outbreaks of COVID-19 in prisons and places of detention*. It provides operational recommendations for custodial and healthcare staff on preventing and managing outbreaks of COVID-19, including specific

advice on population management, social distancing, actions to take if a prisoner, or staff member develops symptoms, and the use of personal protective equipment (PPE). (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected or have tested positive for COVID-19 within 14 days.)

19. After a period of complete lockdown, the Ministry of Justice and HM Prison and Probation Service produced *COVID-19: National Framework for Prison Regimes and Services.* This outlines strategies for easing restrictions and modifying regimes, where severe constraints are disproportionate, or unsustainable. Prisons are expected to devise local policies within the parameters set in the framework.

Key Events

20. On 24 September 2013, Mr Phillip Moorcroft was sentenced to 15 years in prison for sexual offences and was taken to HMP Doncaster. It was his first time in prison. Mr Moorcroft was an Australian national and was due to be deported at the end of his sentence.

21. At an initial healthscreen, a prison nurse noted that Mr Moorcroft had been previously diagnosed with a faulty valve in his heart and that he had been receiving treatment from secondary care providers. His prescribed medications were reviewed, care plans created, and he was placed under the care of specialist clinics at the prison. Referrals were made to secondary care providers to ensure continuity of his care.

22. Over the next few years, Mr Moorcroft was also diagnosed with Type 2 diabetes, hypertension, an irregular heartbeat, anaemia and congestive cardiac failure. He was regularly reviewed by healthcare staff and sent to hospital on occasions.

2020

23. During the COVID-19 pandemic, Mr Moorcroft self-isolated for most of the time at Frankland. In August, his key worker recorded that Mr Moorcroft only left his cell to collect his medication and when staff needed to do routine security checks. Although he was able to leave his cell to take showers and make phone calls, he did not do so, and he very seldom chose to leave his cell for exercise, despite his key worker's attempts to persuade him to do so. On 2 November, his key worker noted that Mr Moorcroft had asked to be kept locked up as much as possible as he was concerned that COVID-19 infection levels were increasing in the community.

24. On 22 December 2020, Mr Moorcroft transferred to HMP Maidstone as he was due to be deported to Australia when COVID-19 restrictions permitted. He stayed overnight at HMP Leicester on 21 December.

25. When Mr Moorcroft arrived at Maidstone, a prison nurse carried out an initial healthscreen and noted his pre-existing medical conditions. His care plans and prescribed medications were reviewed and updated and referrals were made to secondary care providers to ensure continuity of his care. She noted that he used a walking frame to help him to move around the wing and a wheelchair for longer distances.

26. Mr Moorcroft was tested for COVID-19 and was required to self-isolate in line with the prison's reverse cohort policy. On 25 December, healthcare staff received the result of the COVID-19 test, which was negative. On 28 December, Mr Moorcroft had another COVID-19 test.

27. On 31 December, prison officers asked a prison GP to see Mr Moorcroft because he complained of having diarrhoea. They were advised to keep Mr Moorcroft in his cell for 48 hours and increase his fluid intake.

28. At 7.30am on 2 January 2021, prison staff carrying out a roll check found Mr Moorcroft on the floor of his cell. He said that he had fallen out of bed in the

early hours of the morning but had not been able to reach the cell bell to alert staff. A prison nurse took his clinical observations and the results were abnormal. The nurse also noted that he was complaining of chest pain and shortness of breath. The COVID-19 test taken on 28 December confirmed he was COVID-19 positive.

29. Mr Moorcroft was taken to hospital by emergency ambulance accompanied by two officers and restrained with an escort chain (a length of chain with a handcuff at each end). He was admitted as an inpatient. Soon after his arrival, Mr Moorcroft was moved to an isolation ward and treated with oxygen therapy. His restraints were removed and not re-applied.

30. Prison healthcare staff telephoned hospital staff for an update on 4 January and were told that Mr Moorcroft's condition had improved. Hospital staff told prison healthcare staff that they had reduced the level of his oxygen therapy. However, the following day, Mr Moorcroft's condition began to deteriorate and he died at 6.55pm on 8 January. His death was immediately confirmed by a hospital doctor.

Cause of death

31. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Moorcroft's cause of death as COVID-19 pneumonitis. He also had Type 2 diabetes, heart failure and atrial fibrillation (an irregular heartbeat) which did not cause but contributed to his death.

Findings

Clinical Findings

32. The clinical reviewer concluded that the healthcare Mr Moorcroft received was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She was satisfied that his multiple conditions were appropriately identified and assessed, and care plans were put in place and reviewed throughout his time in custody. When Mr Moorcroft became unwell on 2 January 2021, he was appropriately sent to hospital.

33. However, the clinical reviewer identified one concern about poor recordkeeping. She was concerned that there was no mention in the clinical record of Mr Moorcroft falling out of his bed and his subsequent transfer to hospital on 2 January. Prison staff said that healthcare staff assessed him in his cell and obtained his recent COVID-19 test result. However, this was not recorded in the clinical record or other records that were made available to the clinical reviewer. She also found that there were no further entries of events beyond his positive COVID-19 test on 2 January until 4 January when contact was then made with the hospital to obtain an update on his progress. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff record all contact with prisoners by using contemporaneous notes so that there is a full and accurate record about the prisoner's care.

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

34. Given his pre-existing medical conditions, Mr Moorcroft had largely self-isolated at Frankland during the pandemic, and he was appropriately advised to self-isolate at Maidstone, which he agreed to do.

35. He had not left Maidstone in the six days before he tested positive for COVID-19 and it, therefore, appears likely that he contracted the virus at Maidstone. However, given a possible incubation period of 10 to 14 days, it is also possible that he contracted it at Frankland or during his brief stopover at Leicester or while being transported between prisons.

Restraints

36. When Mr Moorcroft was taken to hospital by emergency ambulance on 2 January, he was escorted by two prison officers who were wearing appropriate personal protective equipment (PPE), and he was restrained using an escort chain.

37. Although the restraints were removed soon after Mr Moorcroft arrived in hospital, we do not consider that their use was justified or appropriate. Mr Moorcroft was an elderly Category C prisoner who had ongoing health issues which affected his mobility and he was seriously ill with COVID-19. It is hard to see that the legal requirements justifying the level of restraint used were met prior to his final admission into hospital. Risk assessments did not appropriately consider his health when deciding on the level of restraint required. We therefore make the following recommendation:

The Governor should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Sue McAllister CB
Prisons and Probation Ombudsman **August 2021**

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