

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Cook, a prisoner at HMP Frankland, on 24 December 2020

**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. 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 David Cook died at HMP Frankland on 24 December 2020. He was 74 years old. The cause of his death was respiratory failure due to COVID-19 pneumonitis. I offer my condolences to his family and friends.
4. Mr Cook appears to have contracted COVID-19 at Frankland, as he had not left the prison during the accepted incubation period for the infection.
5. The clinical reviewer concluded that some of Mr Cook's clinical care at Frankland was not equivalent to that which he could have expected to receive in the community. She considered that healthcare staff should have greater awareness of the range of COVID-19 symptoms. She also found that there were significant delays in sending Mr Cook to hospital when his condition worsened and providing a pressure relieving mattress and continuous pain relief as part of his palliative care.
6. Frankland went beyond the national requirements by extending the opportunity to shield to a wider group of prisoners. This was good practice, but it would be prudent to document the records of prisoners at risk of complications from COVID-19 who choose not to shield.
7. Mr Cook was restrained while receiving intravenous treatment. We are concerned that the decision to authorise the use of restraints in hospital was unsound, as the security risk assessment form was incomplete and the medical opinion did not adequately reflect Mr Cook's mobility problems and poor condition at the time. We have raised this in our last five investigations into deaths at Frankland as well as in previous investigations into deaths in 2019. The prison told us in June 2021 that they were reviewing their risk assessment processes and we will expect to see improvements in future.

## Recommendations

- The Governor and Head of Healthcare should ensure that if a prisoner at risk of serious illness from contracting COVID-19 declines to shield, it is documented in their medical and personal records.
- The Head of Healthcare should ensure that healthcare staff know the range of symptoms of COVID-19 and are able to access a comprehensive list for reference, if there is doubt.

- The Head of Healthcare should ensure that:
  - healthcare staff promptly follow the advice given by senior clinicians;
  - all interactions and decisions are fully and accurately documented in prisoners' medical records.
  
- The Head of Healthcare should ensure that there are appropriate facilities for patients with palliative care needs, including:
  - installing pressure relieving equipment at an early stage to increase comfort and minimise the risk of pressure damage; and
  - earlier consideration of use of continuous symptom relief via a syringe driver.
  
- The Governor and Head of Healthcare should ensure that:
  - all staff undertaking risk assessments for 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;
  - the security risk assessment is fully completed;
  - healthcare staff fully and accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and
  - restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.

## The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Cook's clinical care at HMP Frankland.
9. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Cook's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
10. The Ombudsman's family liaison officer wrote to Mr Cook's next of kin, his sister, to explain the investigation. She did not receive a reply.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). Following a revision to recommendation 4, they accepted our recommendations. The HMPPS action plan is annexed to this report.

### Previous deaths at HMP Frankland

12. Mr Cook was the 18th prisoner at Frankland to die, since December 2018. The previous deaths were all from natural causes (including four related to COVID-19). There has since been another death from natural causes - unrelated to COVID-19. We have previously raised the issue of poorly completed risk assessments and the unjustified use of restraints.

### COVID-19 (coronavirus)

13. 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.
14. 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.)
15. 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. (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.) 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 population. Other measures include social distancing and the use of personal protective equipment (PPE).

## Key Events

16. Mr David Cook was a life-sentenced prisoner who had been released on licence in 2009 after serving 21 years. He was recalled to prison on 28 June 2011. After a further conviction for murder, he received a whole life term on 2 May 2012. On 31 May 2017, Mr Cook transferred to HMP Frankland.
17. Mr Cook's medical conditions included clinical obesity, osteoarthritis, degenerative disc disease and vitamin D deficiency. He had reduced mobility and used walking aids to move around. During the COVID-19 pandemic, he was not considered to be at risk of serious illness if he contracted the virus, therefore he was not advised to shield.
18. Mr Cook was admitted to hospital on 21 May 2020, following a stroke. He was discharged on 24 May. On his return to Frankland, a nurse checked him for signs of COVID-19. He was isolated for 14 days and checked again for symptoms at the end of the period.
19. There were changes to the assessment criteria and shielding guidance, so Mr Cook's risk of complications from COVID-19 was reassessed. On 17 November, healthcare sent a letter informing him that he was clinically vulnerable and advising him to shield.
20. On 28 November, Mr Cook had diarrhoea, which he attributed to one of his medications. He was assessed by a nurse and placed in isolation in his cell for 48 hours. On 30 November, he said that the diarrhoea had stopped.
21. On 3 December, during a consultation for worsening back and leg pain, Mr Cook told a prison GP that he had a persistent dry cough. He was immediately placed in protective isolation and a swab to test for COVID-19 returned as positive. A clinical welfare check was conducted on 4 December and there were further checks every four hours.
22. In the early hours of 5 December, a nurse checked Mr Cook and found that his respiratory rate had increased, his blood oxygen levels had decreased and he was lethargic. At 1.55am, she telephoned the on-call Advanced Nurse Practitioner (ANP), who advised that in view of Mr Cook's COVID-19 positive status and other risk factors, he should go to hospital for further assessment, rather than waiting for his condition to become more acute. He offered to speak to the operational manager if there were any problems. (There was no further reference to this discussion in either the medical or operational records.)
23. Just after 6.00am, staff found Mr Cook on the floor. He said he had lost his balance and slipped.
24. Mid-morning, Mr Cook was admitted to the healthcare inpatient unit. He was in severe pain and struggled to get into a wheelchair. His condition worsened and at 4.00pm, the ANP repeated the advice to send him to hospital. At 4.25pm, an ambulance was requested and was expected to arrive within the hour.
25. At 5.23pm, Mr Cook was not fully alert and struggling to respond or complete simple tasks. After assessment, a nurse calculated a National Early Warning

Score 2 (NEWS2) of 10 and the ambulance request was upgraded. (NEWS2 is an assessment tool to identify clinical deterioration. A total score of 7 or over suggests high risk and requires emergency assessment by a critical care team.) Mr Cook went to hospital at 6.51pm. He was escorted by two prison officers, using an escort chain.

26. Healthcare staff obtained regular updates. On 6 December, they were told that Mr Cook was receiving antibiotics and antiviral medication (both intravenously), as well as high flow oxygen through a face mask. Overnight on 7/8 December, this was changed to a CPAP machine and later to high flow oxygen through a nasal cannula (which is used for acute respiratory failure). His prognosis was poor and the hospital planned to withdraw treatment if his oxygen levels did not stabilise. The restraints were removed that day. Mr Cook said he did not want to be resuscitated if his heart or breathing stopped.
27. A prison family liaison officer was assigned on 8 December. The contact details for Mr Cook's sister, his next of kin, were incomplete, so the family liaison officer asked the police to visit her home. His sister telephoned the prison the same day and they told her about Mr Cook's condition.
28. On 21 December, Mr Cook was medically fit for discharge and the hospital planned to transfer him to a rehabilitation hospital to help his mobility. However, he would not cooperate with the planned physiotherapy, so he was discharged to the prison.
29. Healthcare staff obtained the required breathing equipment and Mr Cook returned to the prison at around 8.00pm on 22 December. He was closely monitored, in consultation with the on-call GP. NEWS2 calculations fluctuated between 7 and 10, but Mr Cook persistently refused to go back to hospital and reiterated that he did not want to be resuscitated.
30. On 23 December, an urgent multidisciplinary team meeting was held to discuss Mr Cook's needs. The North East Region Macmillan Palliative Care Lead attended. Mr Cook was moved to the palliative care cell the same day. Staff created care plans; sought advice from a respiratory consultant; and obtained advance approval for an open-door policy. A nurse sat with Mr Cook throughout his final hours and he died at 2.45pm on 24 December.
31. A prison manager debriefed and offered support to the operational and healthcare staff. Notices were issued to staff and prisoners informing them of Mr Cook's death and reminding them of the avenues of support. Prisoners considered to be vulnerable were reviewed.
32. The family liaison officer complied with Mr Cook and his sister's wish not to inform his family of his death, but later offered his sister Mr Cook's property. The prison arranged and paid for his funeral, which was held on 18 January 2021.

### **Cause of death**

33. No post-mortem examination was held as HM Coroner accepted the prison GP's clinical certification that Mr Cook had died from respiratory failure due to COVID-19 pneumonitis.

# Findings

## Clinical Findings

34. The clinical reviewer concluded that some of Mr Cook's clinical care at Frankland was not equivalent to that he could have expected to receive in the community. She found weaknesses in his clinical management after he contracted COVID-19, which are set out in detail in the clinical review report. We summarise the issues below and make similar recommendations.

### *Management of Mr Cook's risk and monitoring his COVID-19 infection*

35. At the beginning of the pandemic, Government guidelines listed those aged 70 years or older as being clinically vulnerable and therefore at increased risk of complications from COVID-19. This does not appear to have been recognised in Mr Cook's medical record. Mr Cook was advised that he was clinically vulnerable in November 2020.
36. One of the prison's COVID-19 team said that all prisoners were offered the opportunity to shield. In addition, healthcare staff had identified and written to the men who were clinically vulnerable to offer shielding. Those who chose to shield were isolated from all other prisoners and accessed regime activities separately. They were allocated a specific officer to deal with their requests, who isolated from other members of staff. Prisoners were frequently reminded of their options and the availability of shielding, generally in line with any changes in the community. The prison continued to offer shielding to prisoners when it was no longer a national requirement and had ceased in the community.
37. There is no record that Mr Cook shielded at any time, nor any evidence of a response to the advice to shield in either his medical or prison records. The prison said this suggests that he declined.
38. It is commendable that the prison went beyond national requirements, by offering shielding to a wider range of prisoners. However, for those who are identified as being at risk, we consider that a refusal to shield should be documented so that it is clear that they have not been overlooked. We recommend:

**The Governor and Head of Healthcare should ensure that if a prisoner at risk of serious illness from contracting COVID-19 declines to shield, it is documented in their medical and personal records.**

39. After a hospital admission in May 2020, Mr Cook was managed in line with the national reverse cohorting policy.
40. When Mr Cook reported a persistent cough, he was quickly isolated and tested. However, the clinical reviewer considers that if healthcare staff had recognised diarrhoea as a possible symptom, his COVID-19 infection might have been diagnosed sooner. We agree that it is important for healthcare staff to be aware of the range of COVID-19 symptoms, including those that are less common. We recommend:

**The Head of Healthcare should ensure that healthcare staff know the range of symptoms of COVID-19 and are able to access a comprehensive list for reference, if there is doubt.**

41. Due to a worsening of symptoms on the night of 4/5 December, the out-of-hours ANP advised a nurse to send Mr Cook to hospital to pre-empt any further deterioration. We do not know why this advice was not actioned, as the nurse made no further entries about it. Nothing was recorded in either personal or operational records to suggest that the nurse had contacted the operational manager, or that there had been any operational difficulty in facilitating such a request. Mr Cook was not sent to hospital until over 16 hours later, when the ANP was consulted again. We recommend:

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

- **healthcare staff promptly follow the advice given by senior clinicians; and**
  - **all interactions and decisions are fully and accurately documented in prisoners' medical records.**
42. As Mr Cook had not left Frankland during the accepted incubation period for COVID-19, it is likely that he contracted the virus at the prison. He received close attention on his discharge from hospital and staff complied with his wish to remain at Frankland.

#### *Palliative care*

43. The clinical reviewer was concerned about two aspects of Mr Cook's palliative care. After he was discharged from hospital, he had a foam rather than a pressure relieving mattress. As he already had pressure sores, this placed him at risk of further pressure damage.
44. In addition, although relevant pain relief had been prescribed, Mr Cook received single doses. The clinical reviewer considered that continuous pain relief should have been provided through skin patches, or a syringe driver. We recommend:

**The Head of Healthcare should ensure that there are appropriate facilities for patients with palliative care needs, including:**

- **installing pressure relieving equipment at an early stage to increase comfort and minimise the risk of pressure damage; and**
- **earlier consideration of use of continuous symptom relief via a syringe driver.**

#### **Security risk assessments and the use of restraints**

45. 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.

46. 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 he has 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. These requirements are reflected in Prison Service Instruction (PSI) 33/2015 on external prisoner movements, as well as on the prison's risk assessment form.
47. The NEWS2 score completed just before Mr Cook went to hospital indicated he was in a poor condition and needed to be assessed by a critical care team. In spite of this, the medical section of the security risk assessment was ticked to indicate that Mr Cook's condition did not restrict his ability to escape unaided and no objections to the use of restraints. The nurse who completed this part of the form did not mention Mr Cook's mobility problems, use of walking aids and a wheelchair, or that he was receiving continuous oxygen at that time. However, she did record on the Person Escort Record "has impaired mobility - struggling with sticks".
48. Other sections of the risk assessment and the Person Escort Record noted Mr Cook's reduced mobility due to his previous stroke, and his inability to access the category A prison van. His individual risk factors were annotated as low to medium, yet none of them were actually ticked to indicate the level of risk. Mr Cook had failed to return to an open prison in 2006, handing himself in after a week, but there had been no problems during outpatient hospital appointments and inpatient stays. No telephone numbers were listed in his records (meaning little risk of outside help). An escort chain was in place throughout the first three days of Mr Cook's hospital admission.
49. We are concerned that the medical input to the risk assessment did not fully reflect the severity of Mr Cook's condition, or his mobility problems and we question whether it was appropriate to use restraints while he was seriously ill and receiving intravenous medication.
50. Similar issues have been raised in recent investigations at Frankland. In response, the Governor and Head of Healthcare planned to review the process for healthcare contributions to escort risk assessments and begin daily management checks for prisoners in hospital. These were agreed after Mr Cook's death. We recommend:

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

- **all staff undertaking risk assessments for 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;**
- **the security risk assessment is fully completed;**

- **healthcare staff fully and accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and**
- **restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.**

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**November 2021**

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