

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Cave, a prisoner at HMP Hewell, on 22 January 2021

A report by the Prisons and Probation Ombudsman



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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 Paul Cave died from a bleed on the brain on 22 January 2021 while a prisoner at HMP Hewell. He also had COVID-19 pneumonitis and chronic obstructive pulmonary disease (COPD) which contributed to but did not cause his death. He was 49 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that, overall, the clinical care that Mr Cave received at Hewell was equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer found that healthcare staff acted promptly and appropriately in managing Mr Cave's suspected COVID-19.
6. The clinical reviewer has made four recommendations which are not directly related to Mr Cave's death, but which the Head of Healthcare will need to address.
7. We found that even though Mr Cave contracted COVID-19 at Hewell, staff followed the national guidance on managing the risks associated with COVID-19.
8. We have made no recommendations.
9. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

The Investigation Process

10. NHS England commissioned a clinical reviewer to review Mr Cave's clinical care at the prison.
11. The PPO investigator has investigated the non-clinical issues in Mr Cave's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
12. The Ombudsman's family liaison officer wrote to Mr Cave's mother to explain our investigation. Mr Cave's mother asked where he could have caught COVID-19. We have addressed this in our report and the clinical review. Mr Cave's mother asked questions about Mr Cave's care and treatment in hospital. While these concerns are not covered by the scope of the PPO investigation, we have addressed this in separate correspondence.
13. We shared the initial report with the prison service. There were no factual inaccuracies.
14. We shared the initial report with Mr Cave's mother. She did not respond.

Previous deaths at Hewell

15. There were five deaths from natural causes and three self-inflicted deaths at HMP Hewell in the two years before Mr Cave's death. There have been two self-inflicted deaths at Hewell since Mr Cave's death. There are no significant similarities to the findings in our investigation of these deaths.

Coronavirus (COVID-19)

16. 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.
17. 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 years; people under 70 years with an underlying health condition such as diabetes, chronic respiratory, heart, liver or kidney disease, those with a weakened immune system or who are very overweight. (These lists are not exhaustive.)
18. 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

19. On 11 October 2019, Mr Paul Cave was remanded to HMP Hewell.
20. At his initial health screen, Mr Cave told a nurse that he used heroin and had a history of alcohol abuse. Mr Cave said that he had recently had deep vein thrombosis (DVT) in his right groin. (DVT is a serious condition where a blood clot forms in a vein.) Mr Cave tested positive for cocaine, cannabis, methadone and benzodiazepine. The nurse referred him to a prison GP, the substance misuse service and to the alcohol brief intervention service.
21. On 11 October, a prison GP reviewed Mr Cave and represcribed methadone. A nurse carried out a substance misuse assessment. Mr Cave told her that he would not engage with the service and just wanted methadone.
22. On 18 August 2020, Mr Cave was sentenced to two years and nine months in prison for drug trafficking.
23. On 24 September, Mr Cave went to hospital for an ultrasound scan because he had ongoing pain and swelling in his right leg. The scan showed that he had a DVT, for which a prison GP prescribed him apixaban (a blood thinning medication).
24. On 20 November, the Deputy Governor issued a community notice to all prisoners, explaining that there was an increase in COVID-19 cases in the community and that there would be a second national lockdown period. In the community notice, he said that prison staff were putting in place additional measures to prevent the spread of the virus. He said that prison staff had to wear surgical face masks in most areas of the prison, that all prisoners returning from hospital and courts would be tested for COVID-19 and that prison staff would be restricted to gathering in specific numbers in their offices.
25. At midday on 8 December, a nurse saw Mr Cave after prison staff said that he had COVID-19 symptoms. He started a COVID-19 isolation log and arranged for Mr Cave to have a COVID-19 test.
26. At 5.23pm, a Healthcare Assistant (HCA) saw Mr Cave because he had difficulty breathing. She radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing) and a prison paramedic went to Mr Cave's cell. She noted that Mr Cave had had a cough for two days and had lost his sense of taste and smell, and had a high temperature, low blood oxygen saturation and a high pulse rate. She noted that his National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 10 which indicated that he was at very high clinical risk. (The NEWS guidelines say

that a score above 7 requires an emergency response.) She gave Mr Cave oxygen and sent him to hospital, where he tested positive for COVID-19.

27. On 8 December, Hewell declared that it was a COVID-19 outbreak site, with three prisoners infected and a further fifteen isolating with symptoms of COVID-19.
28. On 22 January 2021, Mr Cave died in hospital. A post-mortem examination found that he died of a spontaneous intercranial haemorrhage (a bleed on the brain). He also had COVID-19 pneumonitis and chronic obstructive pulmonary disease (COPD, a lung disease) which contributed to but did not cause his death.
29. On 15 February, Hewell declared that it was no longer an outbreak site.

Findings

Clinical findings

30. The clinical reviewer concluded that overall, the clinical care that Mr Cave received at Hewell was equivalent to that which he could have expected to receive in the community. Healthcare staff acted promptly and appropriately in managing Mr Cave's suspected COVID-19 and, when they saw him on 8 December, they were wearing full PPE in line with local and national guidelines.
31. The clinical reviewer has made four recommendations which are not directly related to Mr Cave's death but which the Head of Healthcare will need to address.

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

32. HM Inspectorate of Prisons carried out a short scrutiny visit of HMP Hewell in August 2020 and found that the prison had taken prompt action to manage the risks posed by COVID-19 and had been effective in safeguarding prisoners and staff. They found that national instructions had been followed and cohorting arrangements had been agreed following consultation with health partners. They noted that a senior manager had been appointed as the COVID-19 lead and had delivered an effective communication strategy to prisoners and staff, mostly through notices and the use of the information channel on the television network.
33. 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 September 2020, the IMB reported that the Acting Governor and staff had responded speedily and energetically to the lockdown. They noted that new systems and ways of working were rapidly devised and introduced. The IMB said that prisoners were kept fully informed of developments and accepted being locked up for 23 and a half hours a day, which in normal circumstances would have been considered inhumane treatment.
34. The clinical reviewer found no evidence in the medical records to suggest that Mr Cave had COVID-19 before he became unwell on 8 December.
35. As Mr Cave had not left the prison in the months before he developed COVID-19 symptoms, we assume that he contracted the virus in prison. The COVID-19

lead said that Hewell had a Protective Isolation Unit (PIU) for prisoners who were shielding and a Reverse Cohorting Unit (RCU) for prisoners arriving from courts and hospitals.

36. The COVID-19 lead said that prisoners were divided into bubbles (a family of up to 26 prisoners) who came out of their cells at the same time for exercise, to make telephone calls and carry out other domestic chores. There was an enhanced cleaning regime in place. Prisoners were asked to maintain social distancing and signs were displayed to remind prisoners and staff to maintain social distancing.
37. The COVID-19 lead said that when Hewell had COVID-19 cases, the then COVID-19 lead had regular telephone conferences with Public Health England (PHE) and the NHS. She said that she held COVID-19 recovery meetings at a local level.
38. When there was a move to a national lockdown, the Deputy Governor updated prisoners in a Community Notice about measures to prevent the spread of the virus.
39. We are satisfied that Hewell followed the national guidance on managing the risks associated with COVID-19. We make no recommendations.

Sue McAllister CB
Prisons and Probation Ombudsman

October 2021

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