Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Aubrey, a prisoner at HMP Swaleside, on 24 February 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 John Aubrey died at HMP Swaleside on 24 February 2021. He was 75 years old. The cause of Mr Aubrey's death was COVID-19 pneumonitis. He also had underlying diabetes and heart and lung conditions. I offer my condolences to Mr Aubrey's family and friends.

4. The clinical reviewer concluded that, overall, Mr Aubrey's clinical care at Swaleside was equivalent to that he could have expected to receive in the community. However, he made a recommendation about the failure to refer Mr Aubrey to a specialist to continue his treatment for skin cancer, which the Head of Healthcare should consider.

5. We consider that key workers, as well as other operational staff conducting wellbeing checks, should be mindful of recording the key points of discussions with prisoners who have dementia or reduced cognitive function. This might act as a prompt to help such prisoners to remember important information.

Recommendations

- The Governor should ensure that staff make appropriate entries in the records of prisoners with dementia, or other forms of cognitive impairment, to help ensure that they are consistently reminded of important information and that any continuing needs are addressed.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Aubrey's clinical care at HMP Swaleside.

7. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Aubrey's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.

8. The Ombudsman's family liaison officer wrote to Mr Aubrey's next of kin, his son, to explain the investigation. She did not receive a reply.

9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They accepted our recommendation.

Previous deaths at HMP Swaleside

10. Mr Aubrey was the 11th prisoner at Swaleside to die since February 2019. Of the previous deaths, two were drug related, one was due to a fire and seven were from natural causes. There have since been four further deaths, two self-inflicted and two from natural causes, unrelated to COVID-19. We have previously made recommendations about key worker meetings.

COVID-19 (coronavirus)

11. 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.

12. 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.)

13. 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

14. Mr John Aubrey was convicted of sexual offences. On 18 July 2019, he was sentenced to 16 years, 6 months in prison and sent to HMP Dovegate. Mr Aubrey moved to HMP Swaleside on 4 December.

15. Reception and secondary health assessments were held on 5 and 9 December, respectively. Mr Aubrey's health conditions included high blood pressure, ischaemic heart disease, type 2 diabetes mellitus, chronic obstructive pulmonary disease, angina, osteoarthritis, and spinal problems.

16. Mr Aubrey had also been diagnosed with Alzheimer's disease, but was discharged from the memory clinic in 2018. The clinic refused a further referral in December 2019 and advised that the prison GP should conduct annual reviews and re-refer him if there were any changes.

17. Mr Aubrey lived in a single cell on a residential wing. On 3 April 2020, a nurse conducted a welfare check to discuss the COVID-19 pandemic. The nurse informed him that he was clinically extremely vulnerable to complications from COVID-19 and advised him to shield for 12 weeks. She gave him an advice sheet and noted that Mr Aubrey understood the situation.

18. During 2020, Mr Aubrey received weekly welfare checks and his long-term conditions were reviewed. He was also monitored by specialists (often remotely due to the pandemic).

19. On 2 February 2021, Mr Aubrey received the AstraZeneca COVID-19 vaccine.

20. Mr Aubrey collected his insulin daily, so the nurses knew him well. When he went to the medication hatch on 21 February, he appeared confused, disorientated and unsteady on his feet. A wing officer said that he had been confused for a few days. The officer and a nurse helped him back to his cell. The emergency nurse was asked to assess Mr Aubrey and found that all his vital signs were within normal range, except for his blood glucose level. He could not remember whether he had taken his insulin and other medication that day and there were concerns about his capacity to take his medication.

21. Healthcare staff kept Mr Aubrey under observation. Just after 5.00pm, they admitted him to the inpatient unit for closer monitoring and to find the underlying reason for his confusion.

22. At around 7.30pm, Mr Aubrey called for help and a nurse found him sitting on the cell floor. He was described as very shaky and mentally confused. He had a high temperature and low blood oxygen saturation levels. An ambulance was requested, and paramedics took Mr Aubrey to hospital.

23. To avoid delaying the journey, the operational manager recorded the details of the security risk assessment on the Person Escort Record. Mr Aubrey was escorted by two prison officers and due to his advanced age, condition and poor mobility, no restraints were used.

24. On 23 February, a prison nurse obtained an update from the hospital. A doctor told her that Mr Aubrey had tested positive for COVID-19 on admission and had

been diagnosed with COVID-19 pneumonia. He was receiving oxygen, but his lungs were filled with fluid and his kidneys were not working. Mr Aubrey had agreed not to be resuscitated if his heart or breathing stopped and a doctor had signed the relevant order. The nurse notified the safer custody team and the prison's family liaison officer.

25. At around lunchtime the same day, the family liaison officer informed Mr Aubrey's next of kin, his son, that he was in hospital. He told him about Mr Aubrey's medical conditions and that he had tested positive for COVID-19. He gave his own and the hospital's contact details so that Mr Aubrey's son could contact them directly for information.

26. On 24 February, the family liaison officer told Mr Aubrey's son that his father's condition had deteriorated and that he had been placed on palliative care. Mr Aubrey died at 10.00pm and the family liaison officer notified him shortly afterwards.

27. A custodial manager debriefed the escort staff and offered support. Wing staff checked prisoners considered to be at risk of self-harm. A notice was later issued to staff and prisoners, informing them of Mr Aubrey's death and reminding them of the support available.

28. The prison arranged and paid for Mr Aubrey's funeral, which was held on 6 April.

Post-mortem examination

29. No post-mortem examination was held as HM Coroner accepted a hospital consultant's clinical certification that Mr Aubrey had died from COVID-19 pneumonitis. He also had underlying hypertension, chronic obstructive pulmonary disease, ischaemic heart disease, Alzheimer's dementia, and type 1 diabetes mellitus which had contributed to but did not cause his death.

Findings

Clinical Findings

30. The clinical reviewer concluded that Mr Aubrey's clinical care at Swaleside was of a reasonable standard, equivalent to that he could have expected to receive in the community. However, he found that Swaleside omitted to make a referral to continue Mr Aubrey's treatment for skin cancer and has made a recommendation which the Head of Healthcare will need to consider. Full details of the clinical reviewer's findings are in the clinical review report.

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

31. Shortly after confirmation of the COVID-19 pandemic, Swaleside went into 'lockdown' and implemented a restricted regime. Prisoners were placed in cohorts of up to 15 men and were unlocked for 30 minutes a day for regime activities. The size of the cohorts gradually increased and, at the time of publication of this report, comprised up to 60 men, with 90 minutes a day outside of their cell. Operational staff were expected to conduct daily wellbeing checks of all the vulnerable men.

32. Mr Aubrey was informed that he was at high risk of complications if he became infected and he accepted the advice to shield. There was no delay in administering his COVID-19 vaccination.

33. The Acting Head of Healthcare told the investigator that there was a log of prisoners vulnerable to COVID-19, who were managed in separate cohorts. The clinical nurse manager, or another senior nurse, conducted weekly healthcare welfare checks and medication was delivered to cells. Some vulnerable prisoners preferred to collect their medication, as it enabled them to spend a little more time out of their cell, but they did so in their respective cohorts. Most of Mr Aubrey's medication was supplied in dossette boxes, which he held in his cell. However, he went to the medication hatch daily to get an insulin pen as they were concerned that he might forget to take this.

34. When Mr Aubrey became unwell, he was closely monitored and sent to hospital promptly as his symptoms worsened. The diagnosis of COVID-19 was made in hospital.

35. We are satisfied that Mr Aubrey's risk of infection was managed appropriately. However, in spite of this, it seems that he contracted COVID-19 at Swaleside, as he had not left the prison for any reason during the accepted incubation period for the virus.

Key worker meetings

36. All prisoners in closed prisons must have a key worker to engage with them, identify their needs and provide one to one support through their sentence. Key workers should document meetings in prisoners' electronic case notes and management checks should be made.

37. The prison said that key work meetings continued throughout the pandemic but were delivered as wellbeing checks and reduced to 15 minutes per prisoner per week. There was also a system of weekly welfare checks for prisoners over 70.

38. There was only one key work entry (June 2020) in Mr Aubrey's personal record during the pandemic, although it appears that other sessions or conversations took place.

39. We accept that prisons face very challenging problems during the pandemic, not least in managing changing circumstances and maintaining adequate staffing levels. We are therefore sympathetic to the difficulties in routinely documenting every key work session. However, given Mr Aubrey's additional vulnerability due to dementia, we consider there should have been more frequent entries in his records so that any staff who dealt with him were aware of what had been previously discussed and his continuing needs. In the absence of such records, we cannot be certain that he fully understood and/or remembered the various policy or procedural changes, as well as what was expected of him to ensure compliance with infection control measures. We recommend:

The Governor should ensure that staff make appropriate entries in the records of prisoners with dementia, or other forms of cognitive impairment, to help ensure that they are consistently reminded of important information and that any continuing needs are addressed.

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

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