Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ashley Williams, a prisoner at HMP Lowdham Grange, on 17 October 2020

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 Ashley Williams died in hospital on 17 October 2020, while a prisoner at HMP Lowdham Grange. He was 56 years old. The cause of his death was multi-organ failure, as a result of COVID-19 pneumonia. He also had underlying heart disease. I offer my condolences to Mr Williams' family and friends.

4. Full details of the clinical findings are in the clinical reviewer's report. She concluded that Mr Williams' clinical care at Lowdham Grange was equivalent to that he could have expected to receive in the community. However, gaps were identified which the Head of Healthcare will wish to address.

5. While we are satisfied that Lowdham Grange implemented the national guidance on COVID-19 risk management to help prevent the spread of the infection, this was not adhered to in Mr Williams' case. We recast and repeat the clinical reviewer's recommendations directly related to Mr Williams' death.

6. We are concerned that Mr Williams was inappropriately restrained in the critical care unit in hospital, including a period when he was in a medically induced coma. This is an issue that we have raised with Lowdham Grange before and we repeat the previous recommendation. We are also concerned about the improper use of restraints as a method of controlling Mr Williams when he reacted badly to medication.

7. We commend the family liaison officer for a very high standard of support to Mr Williams' family.

Recommendations

- The Director and Head of Healthcare should ensure that staff identify prisoners who are either at high risk of contracting COVID-19, or of developing complications if they contract it, and manage such prisoners in line with national guidance.

- The Head of Healthcare should ensure that prisoners who test positive or have symptoms of COVID-19 infection are monitored in line with their care plans and national policy.

- The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

- The Director should ensure that escort staff use restraints only to manage the risk of escape, potential harm to the public or staff, or for other security reasons.

- The Director should share this report with the family liaison officer, so that she is aware of the Ombudsman's comments about her high standard of service.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Williams' clinical care at HMP Lowdham Grange.

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

10. The investigator and clinical reviewer jointly interviewed four healthcare staff on 15 and 17 December. The investigator interviewed a custodial manager on 18 December and obtained additional information from managers by email. The interviews were conducted by telephone due to the restrictions in place during the COVID-19 pandemic.

11. The PPO's family liaison officer wrote to Mr Williams' next of kin, his sister, to explain the investigation and ask if there were any matters she wanted the investigation to consider. Mr Williams' sister did not reply.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified a factual inaccuracy, which has been amended. HMPPS accepted our recommendations and an action plan is annexed to this report.

Previous deaths at HMP Lowdham Grange

13. Mr Williams was the eighth prisoner at Lowdham Grange to die, since October 2018. Of the previous deaths, two were from natural causes, two were self-inflicted and three were due to drug toxicity. There have been no other COVID-19 related deaths at Lowdham Grange. We have previously raised concerns about the use of restraints on a man in a medically induced coma.

COVID-19 (coronavirus)

14. 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.

15. 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.)

16. 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

17. Mr Ashley Williams was remanded to HMP Belmarsh on 10 August 2013, charged with murder. On 14 April 2014, he was convicted and sentenced to life imprisonment, with a minimum term of 25 years.

18. Mr Williams transferred to HMP Lowdham Grange on 28 August 2015 (with short spells at Belmarsh to receive blocks of visits from his family). A health screen noted that he had anaemia, high cholesterol, a thyroid deficiency and depression. In 2018, after reporting chest pain, Mr Williams was referred to a cardiology specialist. He was later diagnosed with heart disease but declined to have surgery.

19. From 18 February 2020, Lowdham Grange regularly issued guidance and information to staff and prisoners to raise awareness of the COVID-19 pandemic, the symptoms of the virus and the measures to prevent infection, such as social distancing and handwashing. Prisoners were risk assessed and Mr Williams was not considered to be at high risk of becoming seriously ill if he contracted COVID-19. He volunteered to be part of a small team of prisoners making scrubs, surgical gowns and other essentials and was said to be an asset to the team.

20. A notice was issued on 24 September, announcing the outbreak of COVID-19 at the prison, with 62 prisoners testing positive and a high number of staff either positive or symptomatic.

21. Mr Williams was identified through the track and trace system as one of several prisoners who had had contact with someone who had tested positive for COVID-19 and who needed to be checked by healthcare staff and to self-isolate for 14 days. At his check on 27 September, he said that he had had a cough, body aches and fever for three days. A swab was taken, which returned as positive on 30 September. Mr Williams self-isolated in his cell and painkillers were delivered to him.

22. On 1 October, Mr Williams had breathing difficulties and was sent to hospital by emergency ambulance. He was examined as an outpatient and returned to the prison that evening.

23. On 3 October, Mr Williams again had difficulty breathing. Just after 1.00pm, wing staff called a code blue (a medical emergency in which a prisoner is unconscious or has breathing difficulties). The prison paramedic and several nurses attended and gave him oxygen until an ambulance arrived.

24. Mr Williams was initially taken to Queen's Medical Centre, Nottingham, double handcuffed (with a standard handcuff and an escort chain) and escorted by two prison officers. A few hours later, he was transferred to the critical care unit at City Hospital. (Healthcare staff kept in touch with the hospital over the following two weeks to check Mr Williams' condition.)

25. A family liaison officer was appointed on 4 October. She frequently updated Mr Williams' family and encouraged them to contact the hospital directly, so that they could receive more detailed information. She also went to the hospital to meet his son when he visited.

26. In the early hours of 6 October, Mr Williams was sedated and placed on a ventilator. The handcuffs were removed, but the escort chain remained. At 9.15am, doctors asked for the restraints to be removed. When the escort officers rang the prison for permission, they were told to wait for a manager to attend. A custodial manager arrived at around 11.00am and authorised removal of the restraints.

27. On 15 October, Mr Williams had surgery to remove blood clots from his lungs. His condition did not improve. On 17 October, the hospital withdrew all treatment and Mr Williams died that day.

28. Prison managers debriefed and offered support to the escort officers. They delayed notification of Mr Williams' death to staff and prisoners until the following day, to ensure that they could effectively monitor those in need of additional support and manage the response to his death safely. (Intelligence reports had suggested resentment among prisoners that staff had been responsible for introducing the virus to the prison.)

29. Mr Williams' funeral was held on 11 November. In line with national policy, the prison contributed to the funeral expenses.

Cause of death

30. No post-mortem examination was held, as the Coroner accepted the cause of death certified by the hospital - multi-organ failure as a result of COVID-19 associated pneumonia. Mr Williams also had underlying ischaemic heart disease which did not cause but had contributed to his death.

Findings

Clinical Findings

31. The clinical reviewer concluded that although the care Mr Williams received in relation to COVID-19 was not in line with healthcare and management guidelines, his clinical care was good, overall, and at least equivalent to that he could have expected to receive in the community. She made several recommendations and we repeat those directly linked to Mr Williams' cause of death.

Management of Mr Williams' risk of infection from COVID-19

32. Lowdham Grange issued clear guidance to staff and prisoners at an early stage of the pandemic and regularly issued updates throughout. They operated a restricted regime; implemented prevention control measures; and placed social distancing markers around the prison. When it became an outbreak site, there were frequent multidisciplinary outbreak control team meetings, attended by around 24 representatives from Public Health England (PHE), NHS and prison staff.

Assessment of Mr Williams' risk of complications from COVID-19

33. In line with national guidance for the general population, prisons were expected to identify prisoners at risk of serious illness if they contracted COVID-19 and provide the opportunity to shield. Lowdham Grange assessed prisoners at the beginning of the pandemic, but there is no record of Mr Williams' risk assessment.

34. The clinical reviewer considered that due to his heart disease, Mr Williams should have been identified as at moderate risk and clinically vulnerable. She also noted that he was at increased risk due to his ethnicity. (She cited recent evidence showed that adult black males are 2.9 times more likely to die from COVID-19.) We share the clinical reviewer's concern that Mr Williams was inappropriately assessed and recommend:

    The Director and Head of Healthcare should ensure that staff identify prisoners who are either at high risk of contracting COVID-19, or of developing complications if they contract it, and manage such prisoners in line with national guidance.

Monitoring Mr Williams after he contracted COVID-19

35. Prison staff promptly isolated Mr Williams when the track and trace process identified him as having had close contact with someone who was COVID-19 positive. For capacity reasons, he self-isolated in his cell and remained there when he became symptomatic. He was tested quickly; a care plan was created; and he was sent to hospital without delay on both occasions that he had severe breathing difficulties.

36. Mr Williams' care plan included daily healthcare welfare checks. Although nurses saw him briefly on 28 and 29 September to dispense painkillers, he did not have the required welfare check between 27 September, when he first reported symptoms and 1 October, when he had difficulty breathing and needed

to go to hospital. He was not checked on his return from hospital late that night, nor on 2 October. He was next examined on 3 October, due to being very unwell.

37. We are concerned that as a high risk and symptomatic patient, Mr Williams did not receive the specified clinical welfare checks. In mitigation, the Head of Healthcare said that healthcare staff became overwhelmed with the number of COVID-19 positive prisoners and were unable to review them all every day. While we are sympathetic to the unique challenges faced by both healthcare and operational staff during the pandemic, we cannot overlook that they missed all Mr Williams' routine checks over several days and he was only seen when his condition was so severe that he needed secondary care. We recommend:

The Head of Healthcare should ensure that prisoners who test positive or have symptoms of COVID-19 infection are monitored in line with their care plans and national policy.

38. Mr Williams almost certainly caught COVID-19 at Lowdham Grange during the initial outbreak, as he had not left the prison in the preceding weeks. The clinical reviewer noted that the failings in his care did not contribute to his death.

Security risk assessments and the use of restraints

39. 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.

40. 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.

41. Mr Williams was admitted to the critical care unit a few hours after being admitted to hospital. Admission to such a unit indicates that a person is acutely ill with a life-threatening condition and high dependency needs. He was initially on a non-invasive ventilator with a mask. Mr Williams was noted as being "double cuffed COVID arrangements" meaning that he had standard handcuffs, as well as being cuffed to an escort officer by an escort chain, to maintain social distancing. The handcuffs were removed temporarily on 4 October, at the request of doctors, but were later replaced by the escort staff, purportedly for safety, due to a "funny turn" after a reaction to sleeping tablets. The handcuffs were removed when he was placed in a coma, but the escort chain remained. Doctors asked for the restraints to be fully removed, but the prison told the escorts to wait for a manager to attend.

42. Mr Williams was an enhanced prisoner, with no adjudications during his sentence. He had previously been escorted to hospital eight times, without incident. Given his previous conduct, life-threatening condition and location in the critical care

unit, we consider that he presented no risk of escape and that restraints were unnecessary. It is highly questionable that they were used as a means of subduing him when he reacted adversely to medication and certainly unacceptable that he was restrained while in a coma. We note that if a non-prisoner patient's behaviour was affected by their clinical condition or by an adverse reaction to medication, hospital staff would deal with it without the use of handcuffs and we consider that prisoners should be treated in the same way.

43. The prison could not explain the reason for the decision in Mr Williams' case. However, once the investigator drew attention to the actions, the security manager reviewed the documents. He then raised with staff performing duty senior manager roles the need to document any justification for not removing restraints when a prisoner is in a coma.

44. In 2019, we raised similar concerns about the inappropriate use of restraints on a prisoner in an induced coma. In response, the Director issued a notice to custodial operational managers and duty directors about our recommendation, reminding them of their obligations to correctly assess prisoners. The security department also amended and reissued their operational practice guide on escorting prisoners with serious illness or injury, including specific advice on the lessons learned from two PPO thematic reports. In spite of this constructive response by the Director, it seems that some staff are still not following the guidance. We therefore repeat our recommendation and add another about the use of restraints for anything other than security reasons:

The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

The Director should ensure that escort staff use restraints only to manage the risk of escape, potential harm to the public or staff, or for other security reasons.

Good practice - family liaison

45. We consider that the prison's family liaison officer provided an exceptional standard of support to Mr Williams' family. She was in contact with several family members, making a number of calls each day, often outside standard working hours. She also liaised with hospital, healthcare, chaplaincy and escort staff, as well as the Coroner's officer, to get accurate information and resolve issues that arose, with detailed record keeping. In spite of the risks associated with the pandemic, she also visited the hospital to meet Mr Williams' son. We commend her sympathetic and compassionate support and recommend:

The Director should share this report with the family liaison officer, so that she is aware of the Ombudsman's comments about her high standard of service.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2022**

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