

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Brown, a prisoner at HMP Lincoln, on 7 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 Jason Brown died on 7 December 2020, from COVID-19 pneumonia, at HMP Lincoln. He was 48 years old. He also had underlying heart disease and asthma. I offer my condolences to Mr Brown's family and friends.
4. It is likely that Mr Brown contracted COVID-19 during an outbreak at Lincoln, as he had not left the prison during the recognised incubation period.
5. The clinical reviewer was satisfied that Mr Brown's long-term medical conditions were well managed. However, she found that no clinical observations were taken when he reported breathing difficulties after testing positive for COVID-19 and therefore concluded that his clinical care was not equivalent to that he could have expected to receive in the community.
6. We are concerned that although Mr Brown received a letter to indicate that he was clinically vulnerable, this was not followed up by a discussion on how best to manage his risks. We also consider that operational staff should be reminded of the signs that someone has died and when it is inappropriate to attempt resuscitation.

Recommendations

- The Head of Healthcare should ensure that prisoners at high risk of complications from COVID-19 are given the opportunity to discuss their risks and this is documented in their medical records.
- The Head of Healthcare should ensure that if a COVID-19 positive patient reports new or progressive symptoms, healthcare staff take and record clinical observations.
- The Governor should ensure that operational staff are aware of the signs of rigor mortis; and fully understand the circumstances in which they should not start or continue resuscitation.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Brown's clinical care at HMP Lincoln.
8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Brown's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
9. The Ombudsman's family liaison officer wrote to Mr Brown's next of kin, his partner, to explain the investigation. She did not receive a reply.
10. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Previous deaths at HMP Lincoln

11. Mr Brown was the fifth prisoner to die at Lincoln since December 2018. Two of the previous deaths were from natural causes (unrelated to COVID-19) and two were self-inflicted. There have been four further deaths, two self-inflicted, one from the complications of COVID-19 pneumonia and one where the cause of death is presently unknown. We have previously raised the issue of inappropriate resuscitation attempts.

COVID-19 (coronavirus)

12. 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.
13. 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.)
14. 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. (two or more cases of infectious illness arising within the same 48-hour period in prisoners, detainees, residents and/or staff and among whom transmission is likely to have occurred within a 14 day period.) 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

15. Mr Jason Brown was remanded to HMP Lincoln, on 7 June 2018. He was awaiting sentencing for supplying controlled drugs and a trial for possession of a mobile phone in prison.
16. Mr Brown had several chronic medical conditions, including asthma, high blood pressure, diabetes, a heart condition and obesity. He also had a history of mental health problems, self-harm and substance misuse.
17. Due to his physical and mental health needs, Mr Brown was managed under the complex care process from January 2019 until 30 November 2020. He was allocated to a single cell for health reasons; placed on medical hold to ensure continuity of care and reviewed by a clinician every two to four weeks.
18. At a meeting with his prison officer key worker on 18 March 2020, Mr Brown was particularly keen to discuss COVID-19 and how it might affect him, given his health issues. The key worker advised him to read the notice to prisoners on the wing noticeboard. A week later, Lincoln entered lockdown and implemented a restricted regime.
19. On 8 April, healthcare staff sent a letter to Mr Brown, informing him that he was clinically vulnerable and advising him on infection control measures, such as maintaining social distancing and handwashing.
20. Mr Brown appears to have continued working as a painter, as there were references to this work in his personal records in June and July.

Outbreak of COVID-19

21. Lincoln was declared a COVID-19 outbreak site on 13 November. The prison introduced further regime restrictions and prisoners used the facilities in small cohorts. Wing staff conducted daily welfare checks of all prisoners at around 8.00am and 1.00pm, in addition to roll checks four times a day.
22. On 30 November, during an appointment with the wellbeing coordinator (a healthcare support worker), Mr Brown reported a chesty cough, congestion, sore throat, headache, hot and cold chills. The wellbeing coordinator suspected a common cold or chest infection. He planned to check Mr Brown again in 48 hours and possibly refer him to the GP.
23. At a complex case meeting the same day, an advanced clinical practitioner was concerned that Mr Brown's symptoms might be due to COVID-19 and asked for him to be tested. A nurse took clinical observations and a swab and created a COVID-19 care plan.
24. Mr Brown was moved to the protective isolation unit and healthcare staff checked him daily. He was confirmed as COVID-19 positive on 3 December. The next day, he reported breathlessness and a nurse advised him on how to position himself to manage this. On 6 December, Mr Brown was noted to be very sleepy.

Emergency response

25. During a welfare and roll check at 5.00am on 7 December, Mr Brown was found lying on the floor of his cell, unresponsive. A prison officer radioed a code blue emergency and the control room requested an ambulance. Operational staff were the first to arrive at the cell and a custodial manager instructed a first aid trained officer to start cardiopulmonary resuscitation (CPR). Staff took turns to carry out compressions.
26. Two or three minutes later, a nurse and a healthcare support worker arrived with the emergency bag and defibrillator. The nurse saw clear signs that Mr Brown was dead, including mottled skin and rigor mortis, and told the staff to stop CPR. Paramedics arrived at 5.10am and confirmed Mr Brown's death at 5.15am.
27. A prison manager debriefed the staff involved in the emergency and offered support.
28. The prison's family liaison officer, duty governor and a member of the chaplaincy, visited Mr Brown's partner together to break the news of his death and offer support. The family liaison officer kept in touch with Mr Brown's partner to help with questions and arrangements.
29. Mr Brown's funeral was held on 18 January and the prison met the full costs.

Post-mortem report

30. The post-mortem report concluded that the cause of Mr Brown's death was COVID-19 pneumonia. Morbid obesity, asthma, COPD and cardiomegaly (a heart condition) also contributed to, but did not cause, his death.

Clinical Findings

31. The clinical reviewer found that Mr Brown's long-term medical conditions were managed in line with national guidelines. However, she considered that his clinical care after he caught COVID-19 was not equivalent to that he could have expected to receive in the community, as there were weaknesses in clinical monitoring. Full details of her findings are in the clinical review report. We reflect those relating to Mr Brown's cause of death.

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

32. During the pandemic, HMPPS national policy required prisons to identify and offer shielding to prisoners considered to be clinically extremely vulnerable to serious illness from COVID-19. On 21 April, Lincoln designated a shielding unit and separate regime for prisoners in this category and operational staff spoke to them about risks.
33. The cohorting guidance in place when Mr Brown contracted COVID-19 (issued in November 2020) emphasised that vulnerability was subject to clinical judgement in each case; there was discretion for prisons to offer shielding to the clinically vulnerable; and shielding should be provided for prisoners who requested it, regardless of their health status. (Government policy on shielding and the categorisations have since changed.)
34. Lincoln's COVID-19 lead told the investigator that clinically vulnerable prisoners received NHS guidance letters on minimising risk and were supposed to discuss it with a clinician, but it was the responsibility of the healthcare department to arrange this. Prisoners within this category were not routinely offered shielding but, in line with the national policy, if a prisoner requested this, the prison facilitated it in their existing cell.
35. As Mr Brown had previously sought advice from his key worker, it is likely that he would have been receptive to a discussion with a clinician about managing his risks. However, there is no evidence that he was given this opportunity. Although the limited regime and living in a single cell would have offered him some protection, we consider he might have benefitted from personalised advice. We recommend:

The Head of Healthcare should ensure that prisoners at high risk of complications from COVID-19 are given the opportunity to discuss their risks and this is documented in their medical records.

36. As Mr Brown had not left Lincoln since attending a hospital scan on 2 November, it seems likely that he caught the infection in prison.

Monitoring Mr Brown after he contracted COVID-19

37. Mr Brown's daily welfare checks were consistently documented in his records. On 4 December, a nurse gave advice about relieving increased breathlessness, but took no clinical observations. As respiratory problems are a key symptom of COVID-19, we share the clinical reviewer's concern that this was a missed opportunity to monitor signs of deterioration. We recommend:

The Head of Healthcare should ensure that if a COVID-19 positive patient reports new or progressive symptoms, healthcare staff take and record clinical observations.

Resuscitation

38. Operational staff attempted to resuscitate Mr Brown when he was found unresponsive. However, when the healthcare staff arrived, they immediately identified signs of rigor mortis, including the colour of Mr Brown's skin and that his left arm was stiff and pointing towards the ceiling.
39. Resuscitation Council UK guidelines state that CPR should not be given when it will be futile. We appreciate that staff believed they were acting in Mr Brown's best interests and trying to give him the chance of recovery. However, performing CPR in these circumstances would have been distressing for them and undignified for the deceased. Operational staff at Lincoln might therefore benefit from refresher guidance on how to recognise signs of death and when it is inappropriate to attempt resuscitation. We recommend:

The Governor should ensure that operational staff are aware of the signs of rigor mortis; and fully understand the circumstances in which they should not start or continue resuscitation.

**Sue McAllister CB
Prisons and Probation Ombudsman**

February 2022

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