Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vincent Helder, a prisoner at HMP Whitemoor, on 21 January 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 Vincent Helder died in hospital on 21 January 2021 from COVID-19 pneumonia while a prisoner at HMP Whitemoor. He was 47 years old. I offer my condolences to Mr Helder's family and friends.

4. The clinical reviewer concluded that the mental health support that Mr Helder received at Whitemoor was equivalent to that he could have expected to receive in the community.

5. The clinical reviewer was, however, concerned that there was no evidence that assessments and monitoring were in place for his high cholesterol (although she did not suggest that this contributed to his death). She was also concerned that when Mr Helder became unwell four days before his death, clinical observations were incomplete and the details of the emergency response were not accurately recorded in his medical records. She made three recommendations which we repeat below.

6. We found two non-clinical issues of concern.

7. We are not satisfied that the use of double handcuffs was proportionate when Mr Helder was taken to hospital on 18 January, given his breathing difficulties, the medical assessment on the security risk assessment, his low risk of escape, and the fact that he was accompanied by three prison officers. We are particularly concerned that Mr Helder was double cuffed for 18 hours while his health continued to deteriorate, and that double cuffing him in the ambulance and prior to his admission to hospital placed an escort officer at greater risk of infection.

8. We are not satisfied that it was necessary or appropriate for the escorting staff to have a "disagreement" with hospital staff after Mr Helder's death about access to the mortuary.

Recommendations

- The Head of Healthcare should ensure that there is adequate monitoring and support in place for identified co-morbidities (in this case hyperlipidemia). This should include at least an annual review and patient specific care plans being available in the SystmOne record.

- The Head of Healthcare should ensure (through targeted training and regular audit of practice) that all primary care staff adhere to the Royal College of Physicians National Early Warning Score guidance for frequency of monitoring of

observations and recommended clinical escalation procedures for patients who are unwell.

- The Head of Healthcare should ensure that all events relating to an emergency response are fully and accurately recorded in the SystmOne record in keeping with the NMC Code (2018).
- The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.
- The Governor should ensure escorting staff comply with infection control measures after a prisoner dies in hospital.

The Investigation Process

9. NHS England commissioned an independent clinical reviewer, to review Mr Helder's clinical care at HMP Whitemoor. Her report is attached as Annex 1.

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

11. The PPO family liaison officer wrote to Mr Helder's next of kin to explain the investigation. His family asked:

    - when did Mr Helder test positive for COVID-19;
    - how did he become infected;
    - did he have a vaccine;
    - why was he not able to have contact with his parents before he died;
    - if he had the mental capacity to agree a Do Not Resuscitate order given his mental health issues; and
    - how he came to have a bruise on his arm as noted in the post-mortem report?

12. These questions have been addressed in this report and in the clinical review, although those relating to the care Mr Helder received in hospital are outside the PPO's remit and will need to be addressed by hospital staff.

13. Mr Helder's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

HM Inspectorate of Prisons (HMIP)

15. The most recent inspection of HMP Whitemoor was in July/August 2020. This was not a full inspection but a short scrutiny visit to report on the conditions and treatment of prisoners during the COVID-19 pandemic.

16. Inspectors reported that there had been an outbreak of COVID-19 at Whitemoor in March 2020, very early in the pandemic. They found that managers had worked well with local health care providers, Public Health England (PHE) and the NHS to put in place measures that brought the outbreak under control and, at the time of the inspectors' visit, there had not been a confirmed case of COVID-19 for 12 weeks.

17. Inspectors noted that 93% of frontline operational staff surveyed said that it was quite or very difficult to socially distance from colleagues, and 70% reported difficulties in socially distancing from prisoners. Inspectors reported that although

social distancing was impossible in some areas of the prison, they saw little evidence of either staff or prisoners making any attempt to socially distance from others. They found that quarantine arrangements (referred to as 'cohorting') were in place for symptomatic prisoners, those vulnerable to the virus and prisoners in their first 14 days at the prison.

Previous deaths at HMP Whitemoor

18. Mr Helder was the fourth prisoner at Whitemoor to die since January 2019. Of the previous deaths, two were from natural causes, one was self-inflicted. There were no significant similarities with the previous deaths and there have been no other COVID-19 related deaths at the prison.

COVID-19 (coronavirus)

19. 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.

20. 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.)

21. 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

22. On 14 March 1996, Mr Vincent Helder was sentenced to life imprisonment with a five year tariff (minimum period to serve) for robbery. Mr Helder was obese and had been diagnosed with dissocial personality disorder, hyperlipidemia (high cholesterol) and a history of depression.

23. Mr Helder spent time in several prisons. In 2019, he was transferred to the Beacon Unit at HMP Garth, a specialist unit for prisoners with a personality disorder. In January 2020, Mr Helder threw boiling water over another prisoner at Garth and, as a result, he was transferred to HMP Whitemoor where he lived in the Fens Unit, one of four DSPD (Dangerous and Severe Personality Disorder) prison units in the country.

24. On arrival at Whitemoor, a nurse reviewed Mr Helder's long-term conditions and care plans were created. Mr Helder had a second reception screen eight days later which also noted his medical history. However, neither nurse noted his hyperlipidemia.

25. A team of psychiatrists and psychologists maintained contact with Mr Helder. Healthcare staff had daily contact with him as he attended the medication hatch to receive his prescribed medication, but he had no other significant contact with healthcare staff until January 2021.

Events in January 2021

26. On Friday 15 January 2021, Mr Helder told a therapist that he felt he had a cold. On Saturday 16 January, this was treated as possible COVID-19 and he was placed in isolation in his cell. He did not leave his cell to socialise with other prisoners during this time and his meals were taken to his door. However, along with other prisoners, he was required to go to the medication hatch daily to obtain his controlled medication from a nurse. (Controlled medications are drugs that are tightly controlled by the Government because they may be abused or cause addiction. They must be handled, stored and administered in controlled way according to a protocol and prisoners are not allowed to keep them in their own possession.) Prison staff said that a yellow card was placed on his cell door to inform staff that there was a possibility of COVID-19.

27. On the evening of 18 January, Mr Helder attended the medication hatch and told a nurse he had felt unwell for the last four days but had not told anyone as he thought he had the flu. A nurse checked his observations and noted that he had a fast pulse, a very high temperature and low blood pressure. She told Mr Helder to return to his cell and isolate for 10 days as she suspected he had COVID-19, and that a COVID-19 test would be taken the next day (as the transport for samples to be taken for testing was due the next morning).

28. Later that evening the same nurse checked Mr Helder. She noted that he was sweaty and dizzy, had not eaten in four days, had not passed urine in the past 12 hours, felt nauseous and had some difficulty breathing. His blood pressure was low, temperature was high, pulse was fast and his oxygen saturation levels were low. She gave him 15 litres of oxygen (via a mask) to increase his saturations and then arranged for an ambulance to take him to hospital. At about 8.40pm,

Mr Helder was escorted to Peterborough City Hospital in double handcuffs by three prison officers wearing PPE.

29. The following day (19 January), Mr Helder tested positive for COVID-19 in hospital. He remained in double cuffs until 1.40pm, when they were replaced by a single cuff with an escort chain. The bedwatch escort was reduced to two officers shortly after 4.00pm.

30. At around 11.00pm on 19 January, hospital staff decided to put Mr Helder on a CPAP machine to help him breathe more easily. A hospital doctor spoke to him and asked if he wanted any further intervention if the CPAP machine did not work. Mr Helder said he did not want further intervention in those circumstances. The doctor explained to Mr Helder that he might die and asked if he wanted anyone informed. Mr Helder said he accepted this and that he did not want anyone informed at this stage. A prison manager authorised the removal of the escort chain at this point and the bedwatch officers moved outside Mr Helder's room to avoid the risk of infection. Before leaving, one of the officers asked Mr Helder again if he wanted anyone informed, but Mr Helder declined again.

31. On the morning of 20 January, a doctor asked Mr Helder if he wanted to be put on a ventilator as his condition was continuing to deteriorate. Mr Helder refused. Although he changed his mind in the afternoon, hospital doctors decided not to put him on a ventilator and he remained on the CPAP machine. At about 4.00pm, a bedwatch officer recorded that hospital staff were making a 'face time' call to Mr Helder's parents. At about 9.00pm, Mr Helder asked to be taken off the CPAP machine even though he knew it was keeping him alive. At about 11.00pm, a hospital doctor saw Mr Helder and assessed that he had the mental capacity to make this decision. The CPAP machine was removed and Mr Helder was given morphine to make him more comfortable. Hospital staff informed his parents. Mr Helder died at 4.49am on 21 January.

Events after Mr Helder's death

32. At the time of Mr Helder's death, the bedwatch officers were Officer A and Officer B. Officer B said in a written statement that a nurse informed them that Mr Helder had died and that he then witnessed a hospital doctor officially confirming Mr Helder's death at about 5.00am. Shortly afterwards, hospital porters came to take Mr Helder's body to the mortuary and the two officers accompanied them. Officer B said that there was then a disagreement with the hospital staff about them entering the mortuary. He said that they told them that Mr Helder's body was the responsibility of HMP Whitemoor until he had been officially transferred to the mortuary, and mortuary staff eventually allowed Officer A to enter the mortuary

Contact with Mr Helder's family

33. A prison family liaison officer contacted Mr Helder's next of kin, his parents, on the afternoon of 19 January to inform them that he was seriously ill in hospital with COVID-19. The family liaison officer maintained contact with Mr Helder's family to give them updates and offer support as his condition deteriorated. When Mr Helder died, she informed his parents shortly afterwards. In line with Prison Service policy, the prison contributed to Mr Helder's funeral.

Support for prisoners and staff

34. A prison manager debriefed the escort officers and other staff involved in Mr Helder's care and offered support. Notices were issued to other staff and prisoners, informing them of Mr Helder's death and reminding them of the avenues of support.

Post-mortem report

35. The post-mortem found that Mr Helder's cause of death was COVID-19 pneumonia.

Findings

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

36. At the time that Mr Helder became unwell, a restricted regime was in place on residential units at Whitemoor to limit the spread of the virus, and we note that when HMIP visited the prison in July/August 2020, they found that appropriate quarantine ('cohorting) arrangements had been put in place. However, inspectors reported that social distancing was impossible in parts of the prison (because of the physical layout) and that the majority of frontline operational staff said that it was difficult to socially distance from colleagues or prisoners. They also reported that they saw little evidence of either staff or prisoners making any attempt to socially distance from others.

37. In spite of the measures to control the risk of infection and protect prisoners, it is likely that Mr Helder contracted COVID-19 within Whitemoor, as he had not left the prison for some months previously. Prison managers said that at that time there was one officer who tested positive for COVID-19. However, staff and prisoners who had been in contact with Mr Helder were tested and all the tests were negative.

Security risk assessments and the use of restraints

38. 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.

39. 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.

40. This is reinforced in Prison Service Instruction (PSI) 33/2015, *External Escorts.* This says that the normal practice is for Category B prisoners to be double cuffed when they are escorted outside the prison, but that handcuffs will not normally be necessary if a prisoner's mobility is severely limited, e.g. due to advanced age or disability, unless the prison has grounds to believe that an escape might be made with external assistance.

41. The medical section of the risk assessment for Mr Helder's last journey to hospital was ticked to indicate that his medical condition restricted his ability to escape unaided, but there were no medical objections to the use of restraints. It did not alert staff that Mr Helder was suspected of having the COVID-19 virus.

42. The security assessment noted that Mr Helder was a high risk to the public as he was a life sentenced prisoner. He was assessed as medium risk for risk to hospital staff and risk of escape and likelihood of outside assistance (although it

was noted that he was “not believed to have access to any resources outside of prison”). He was also considered to pose a risk to females and a low risk of hostage taking. It was noted that Mr Helder had been compliant, polite and appropriate with hospital staff on a previous appointment.

43. A prison manager decided that, for the journey and treatment/consultation, Mr Helder should be accompanied by three escorting officers and double handcuffed (meaning his hands were cuffed together in front of him and one hand was cuffed to an officer). This could be changed to an escort chain if requested by medical staff.

44. Apart from when he went to the toilet and had some medical procedures, Mr Helder remained double cuffed from the time he was taken to hospital at about 8.40pm on 18 January until 1.40pm on 19 January (a total of 18 hours), although when he was admitted to hospital he was no longer handcuffed directly to an officer and was handcuffed by an escort chain instead.

45. Restraints were then changed to a single handcuff and escort chain and were removed altogether at about 11.00pm on 19 January when medical staff told the escort officers that they should not stay in the same room as Mr Helder when he was connected to the CPAP machine and should only enter the room for short periods wearing PPE. After this, the escort officers sat outside the room in sight of Mr Helder.

46. We recognise that many factors have to be taken into account in determining the level of restraints. Mr Helder was a Category B prisoner with a history of serious violence. He was also relatively young and had had no mobility problems before he became ill with suspected COVID-19. However, we question whether the use of double cuffs was proportionate when Mr Helder was admitted to hospital, given that he was sufficiently ill to require an emergency ambulance and was struggling to breathe, and the medical opinion on the risk assessment. We question whether he had the ability to escape, particularly as he was accompanied by three prison officers for the first 17 hours of his admission, and we certainly cannot see the justification for double cuffing him for so long when his condition was deteriorating. We are also concerned that double cuffing en route to the hospital and prior to his admission, needlessly placed one of the escort officers at greater risk of contracting COVID-19. We recommend:

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

Events after Mr Helder died

47. Public Health England published guidance for the care of the deceased with confirmed COVID-19. This says that “although the risk of infectious transmission is lower than in living patients, action should be taken to mitigate that risk”. It goes on to say that all non-essential contact with the deceased should be avoided to minimise risk of exposure.

48. After Mr Helder died, the escort officers said that Mr Helder's body was the responsibility of Whitemoor until he had been transferred to the mortuary, and they had a "disagreement" with hospital staff over entering the mortuary.

49. The escort staff had witnessed a doctor confirming Mr Helder's death and we consider that it was completely unnecessary for them to enter the mortuary. We consider that their disagreement with hospital staff showed a lack of respect for Mr Helder and contravened hospital infection control measures.

50. We recommend:

The Governor should ensure escorting staff comply with infection control measures after a prisoner dies in hospital.

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

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