Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Callaghan, a prisoner at HMP Norwich, on 21 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 Brian Callaghan died on 21 February 2021 at HMP Norwich. He was 85 years old. He died from COVID-19 pneumonia. He also had underlying chronic heart disease, dementia and diabetes. We offer our condolences to Mr Callaghan's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Callaghan received at Norwich was equivalent to that which he could have expected to receive in the community.

5. The clinical reviewer said that Mr Callaghan's long-term conditions were managed appropriately. However, the clinical reviewer was concerned that healthcare staff did not use the National Early Warning Score (NEWS2 – a tool to detect and monitor acute illness) consistently when Mr Callaghan contracted COVID-19.

6. The clinical reviewer made one recommendation related to Mr Callaghan's death, which we have included below. She made one further recommendation which was not directly related to Mr Callaghan's death, but that the Head of Healthcare will need to address.

7. The investigation found that Norwich generally followed national guidance on COVID-19 risk management and implemented the procedures advised to help prevent the spread of the infection, in consultation with Public Health England. Mr Callaghan appears to have contracted the virus in prison, as he had not attended any hospital appointments or left the prison for any other reason during the six months before his death. When his condition deteriorated, staff conducted COVID-19 tests in a timely manner.

8. We did not identify any non-clinical issues of concern.

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.

Recommendations

- **The Head of Healthcare should ensure that staff use the National Early Warning Score 2 (NEWS2) assessment tool and follow the recommended clinical escalation procedures.**

The Investigation Process

10. NHS England commissioned a clinical reviewer to review Mr Callaghan's clinical care at Norwich. The clinical review is attached to this report at Annex 1.

11. The PPO investigator has investigated the non-clinical issues in Mr Callaghan's care, including aspects of the prison's response to COVID-19 and shielding prisoners, his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

12. 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.

Previous deaths at HMP Norwich

13. There were seven deaths from natural causes (one of which was related to COVID-19) and one self-inflicted death at Norwich in the two years before Mr Callaghan's death. There has since been one further suspected COVID-19 death.

14. We have previously made one recommendation about the consistent use of the NEWS2 tool to detect acute illness or deterioration at Norwich. In May 2020, the Head of Healthcare agreed to ensure that all clinical staff consistently used and were aware of the triggers for escalating care. The clinical reviewer noted that a project for improving the deteriorating patient's pathway is currently being developed following lessons learnt from the COVID-19 pandemic.

COVID-19 (coronavirus)

15. 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.

16. 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.)

17. 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 received prisoners

from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

18. On 30 July 2014, Mr Brian Callaghan was convicted of sexual offences and was sentenced to 24 years in prison. He was sent to HMP Bure and transferred to HMP Norwich on 10 April 2020.

19. On arrival at Norwich, it was noted that Mr Callaghan had several pre-existing health concerns. These included vascular dementia (a type of dementia caused by reduced blood flow to the brain), Alzheimer's Disease, high blood pressure, diabetes and chronic obstructive pulmonary disease (COPD – a lung condition that makes it difficult to breathe).

20. Mr Callaghan was transferred to Norwich during the COVID-19 pandemic and was required to isolate for 14 days on arrival in line with national guidance. Mr Callaghan was located on the older persons' inpatient unit to ensure that his health and social care needs were met during this time, and remained on the unit throughout his time at Norwich. The clinical reviewer found that Mr Callaghan was appropriately located, particularly as it was also a shielding unit.

21. On 8 January 2021, Mr Callaghan took a COVID-19 test following contact with someone who had tested positive, but his test was negative. On 12 January, A nurse noticed that Mr Callaghan was more sleepy than usual and he reported some COVID-19 symptoms. Later that day, he tested positive for COVID-19.

22. Mr Callaghan was isolated in his cell after this result and checked regularly by healthcare staff throughout the day. However, the clinical reviewer said that healthcare staff should have taken and recorded his observations and NEWS2 scores twice a day, in line with national guidelines.

23. On 20 January, Mr Callaghan was taken to Norfolk and Norwich University Hospital after a suspected stroke. He was treated in hospital for a week for symptoms of COVID-19. The consultant referred him for end of life care and it was concluded that it was not in Mr Callaghan's best interests to remain in hospital. Mr Callaghan returned to the prison's healthcare unit on 27 January, where healthcare staff started palliative care.

24. Due to Mr Callaghan's vascular dementia, he was deemed not to have capacity to make decisions about his care. Healthcare staff at Norwich and hospital staff liaised with Mr Callaghan's family and involved them in decisions about his care.

25. On 21 February at 10.18pm, Mr Callaghan died of COVID-19 pneumonia. A Healthcare Assistant was with him when he died.

Post-mortem report

26. The Coroner accepted clinical certification that Mr Callaghan died of COVID-19 pneumonia. There were no post-mortem tests following his death. The coroner also noted that Mr Callaghan had chronic heart disease, dementia and diabetes which did not cause but contributed to his death

Clinical Findings

27. The clinical reviewer concluded that the care that Mr Callaghan received was equivalent to that he could have expected to receive in the community. The clinical reviewer recommended the consistent use of the NEWS2 tool for monitoring patients. She said that healthcare staff should have taken and recorded Mr Callaghan's observations and NEWS2 scores twice a day after he tested positive for COVID-19.

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

28. In April 2020, when he first got to HMP Norwich, Mr Callaghan was identified as a prisoner at high risk of serious illness if he contracted COVID-19 and he was shielded on a dedicated wing where he remained until he died. There was a restricted regime with minimal contact between prisoners. Prison managers issued regular updates to staff and residents on Government advice and local policies. Healthcare staff supported Mr Callaghan with ongoing care and social needs and understanding the regime. His diagnosis of dementia was a potential barrier to full understanding of expected processes.

29. When Mr Callaghan was known to have had contact with a positive COVID case, he was tested immediately. Four days later, Mr Callaghan reported that he felt unwell and the clinical reviewer was satisfied that staff took the appropriate precautions to isolate him. He remained in the protective isolation unit with regular monitoring and eventually tested positive for COVID-19.

30. We are satisfied that Norwich followed the national guidance on managing the risks associated with COVID-19 and promptly implemented the policies and measures expected. Infection control measures were in place and healthcare staff had access to appropriate personal protective equipment (PPE). As face to face visits with prisoners had been stopped, managers were aware that the infection could only get into the prison through staff, so it was made mandatory for all staff to wear face masks, before the national guidance on this was introduced.

31. We make no recommendations about these measures.

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

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