

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Adam, a prisoner at HMP Wymott, on 11 November 2021

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 John Adam died from COVID-19 pneumonia in hospital on 11 November 2021 while a prisoner at HMP Wymott. He was 71 years old. He also had chronic obstructive pulmonary disease (COPD, a lung disease), Type 2 diabetes and heart disease which contributed to but did not cause his death. We offer our condolences to his family and friends.
4. The clinical reviewer found that although the clinical care that Mr Adam received for his long-term conditions was equivalent to that which he could have expected to receive in the community, the care that he received when he contracted COVID-19 was not equivalent. We have made a number of recommendations to address this.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that healthcare staff record when prisoners are clinically vulnerable to developing serious illness from COVID-19 so that they are aware of their COVID-19 risk level when providing care.
- The Head of Healthcare should ensure that a clear pulse oximetry pathway is in place in line with NHS England's COVID-19 standard operating procedure in secure and detained settings, and that staff understand its requirements.
- The Head of Healthcare should ensure that staff use the NEWS2 assessment to identify and address clinical deterioration when responding to medical emergencies.

The Investigation Process

6. NHS England commissioned a clinical reviewer to review Mr Adam's clinical care at HMP Wymott.
7. The PPO investigator has investigated the non-clinical issues in Mr Adam's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The Ombudsman's family liaison officer wrote to Mr Adam's sister to explain our investigation. She did not respond.
9. We shared the report with the Prison Service. There were no factual inaccuracies.

HM Inspectorate of Prisons (HMIP)

10. HM Inspectorate of Prisons conducted a scrutiny visit of HMP Wymott in August 2020. They found that the senior management team showed a clear commitment to managing the COVID-19 crisis. Inspectors found that they worked closely with Public Health England and the NHS to put in place robust measures to promote infection control, including additional cleaning of the wings. However, they reported that social distancing was weak at times, and handwashing protocols were not always adhered to.

Previous deaths at HMP Wymott

11. In the two years before Mr Adam's death, 14 prisoners died from natural causes at Wymott, one of which as a result of COVID-19. There have been three deaths from natural causes at Wymott since Mr Adam's death, all of which were related to COVID-19. There are no significant similarities between our findings in this investigation and those of the other deaths.

Coronavirus (COVID-19)

12. COVID-19 is an infectious disease that affects the lungs and airways. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection.
13. In April 2020, the Government issued advice about how to manage those deemed clinically vulnerable or extremely vulnerable to becoming seriously ill if they contracted COVID-19. Shielding was a process to ensure that those deemed at greater risk of death in the event of contracting COVID-19 were protected.
14. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak which were implemented at local level, depending on the needs of individual prisons.
15. The Ministry of Justice and Public Health England later issued joint guidance, *Preventing and controlling outbreaks of COVID-19 in prisons and places of detention*. It provides operational recommendations for custodial and healthcare staff on preventing and managing outbreaks of COVID-19, including specific advice on population management, social distancing, actions to take if a prisoner, or staff member develops symptoms, and the use of personal protective equipment (PPE). (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.)
16. After a period of lockdown, the Ministry of Justice and HM Prison and Probation Service produced *COVID-19: National Framework for Prison Regimes and Services*. This outlines strategies for easing restrictions and modifying regimes, where severe constraints are disproportionate or unsustainable. Prisons are expected to devise local policies within the parameters of the framework.

Key Events

17. In November 2019, Mr John Adam was sentenced to 15 years in prison for sex offences. On 19 February 2020, he was transferred to HMP Garth.
18. Mr Adam had chronic COPD, Type 2 diabetes, high blood pressure and heart disease. He had had a heart attack in 2016. Healthcare staff identified that Mr Adam was clinically extremely vulnerable to becoming seriously ill from COVID-19 and was advised to shield. On 5 January 2021, Mr Adam signed a disclaimer to say that he had declined the advice and had decided not to shield.
19. On 3 February 2021, Mr Adam received his first dose of the COVID-19 vaccine. This was followed by a second dose on 15 April 2021.
20. On 21 May, Mr Adam was transferred to HMP Wymott.
21. On 18 October 2021, Wymott started COVID-19 booster vaccinations for prisoners. (Mr Adam was eligible to receive the booster vaccine but he had not received one before he died due to the high number of eligible prisoners.)
22. On 25 October, Wymott was declared a COVID-19 outbreak site.
23. On 31 October, a nurse saw Mr Adam because he felt unwell, had a headache and COVID-19 symptoms. Mr Adam's observations were all normal. The nurse gave Mr Adam a pulse oximeter (a device to measure blood oxygen levels).
24. On 1 November, a Healthcare Assistant (HCA) tested Mr Adam for COVID-19. There is no evidence to establish whether healthcare staff reviewed him or that he was isolated while he waited for the result.
25. On 2 November, a prison governor posted a notice to staff, explaining the mass testing arrangements and that he would restrict the prison regime to minimise the spread of COVID-19.
26. At about 3.15pm on 3 November, two prison officers responded when a prisoner pressed the emergency call button on Mr Adam's wing. Prisoners told them that Mr Adam had collapsed. They saw Mr Adam sitting on a chair in his cell. He told them that he had collapsed while trying to get to the toilet. He was confused and struggling to breathe. One officer radioed a medical emergency code blue promptly (which indicates that a prisoner is unconscious or has breathing difficulties and triggers the control room to call an ambulance immediately) and at 3.19pm, control room staff telephoned the ambulance service.
27. A nurse went to Mr Adam's cell. She found that Mr Adam had low blood pressure, low blood oxygen saturation and low body temperature. She gave him oxygen. At 3.50pm, control room staff updated the ambulance service on Mr Adam's condition. At 5.20pm, an ambulance arrived at Wymott and at 6.36pm, paramedics took Mr Adam to hospital.
28. On 4 November, hospital staff told healthcare staff that Mr Adam had tested positive for COVID-19. The following day, Mr Adam was transferred to the acute respiratory ward. On 11 November, Mr Adam died in hospital.

Cause of death

29. A hospital doctor concluded that Mr Adam died from COVID-19 pneumonia. He also had COPD, Type 2 diabetes and heart disease which contributed to but did not cause his death. There was no post-mortem examination.

Findings

Clinical findings

30. The clinical reviewer found that the clinical care that Mr Adam received at Wymott for his long-term conditions was equivalent to that which he could have expected to receive in the community. However, she found that the clinical care he received when he contracted COVID-19 was not equivalent.

Mr Adam's clinical care in relation to COVID-19

31. Mr Adam was clinically extremely vulnerable to becoming seriously ill from COVID-19. Although we recognise that he signed a disclaimer at Garth to state that he chose not to shield and that he lived on a wing designated for prisoners who were clinically vulnerable at Wymott, the clinical reviewer found no evidence that healthcare staff discussed his clinical vulnerability, shielding or arrangements to protect those at risk of severe illness from COVID-19.
32. The clinical reviewer found no evidence that healthcare staff recorded in Mr Adam's medical records that he was extremely clinically vulnerable so staff would therefore not have known his status or risk level. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff record when prisoners are clinically vulnerable to developing serious illness from COVID-19 so that they are aware of their COVID-19 risk level when providing care.

33. The clinical reviewer said that after Mr Adam told healthcare staff that he had COVID-19 symptoms, there is no evidence that he was asked to isolate while waiting for his test result in line with national guidance.
34. From February 2021, NHS England's COVID-19 standard operating procedure (SOP) in secure and detained settings recommended that healthcare providers put in place a COVID oximetry pathway to support earlier detection of low blood oxygen saturation. This involves providing a prisoner with a pulse oximeter to measure their blood oxygen saturation when they are diagnosed with COVID-19 under certain conditions. The prisoner should be told how to record their readings and how to escalate concerns and alert healthcare staff if their blood oxygen saturation reading is 92% or less. The SOP also states that healthcare staff should arrange check-in visits to confirm that a prisoner is using the oximeter and diary correctly and that the readings are 95% and above.
35. The clinical reviewer found that although Mr Adam was appropriately given a pulse oximeter and told how to use it, there is no evidence that healthcare staff reviewed him or his readings. We make the following recommendation:

The Head of Healthcare should ensure that a clear pulse oximetry pathway is in place in line with NHS England's COVID-19 standard operating procedure in secure and detained settings and that staff understand its requirements.

Emergency response

36. When officers found that Mr Adam was struggling to breathe, they promptly radioed a medical emergency code blue and control staff telephoned the ambulance service. The clinical reviewer noted that the nurse who assessed Mr Adam did not complete the National Early Warning Score assessment (NEWS2, a tool to detect clinical deterioration). Although this did not affect the outcome for Mr Adam, the clinical reviewer noted that NEWS2 should supplement clinical judgement in assessing and addressing any deterioration in a prisoner's state of health. We make the following recommendation:

The Head of Healthcare should ensure that staff use the NEWS2 assessment to identify and address clinical deterioration when responding to medical emergencies.

37. The clinical reviewer has made three further recommendations which are not directly related to Mr Adam's death but which the Head of Healthcare will need to address.

**Sue McAllister CB
Prisons and Probation Ombudsman**

June 2022

Annexes

1. Clinical review

Additional document

2. Prison action plan

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