Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Andrews, a prisoner at HMP Norwich, on 20 April 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 Paul Andrews died in hospital from acute pancreatitis on 20 April 2021, while a prisoner at HMP Norwich. He was 80 years old. COVID-19 and paraplegia also contributed to, but did not cause his death. I offer my condolences to Mr Andrews' family and friends.

4. Mr Andrews' pancreatitis was diagnosed during his final admission to hospital. The clinical reviewer concluded that he received compassionate and responsive clinical care at Norwich, equivalent to that he could have expected to receive in the community. However, she found that use of the NEWS2 tool was inconsistent during Mr Andrews' illness. Full details of her findings are in the clinical review report.

5. We are concerned that after two periods as an inpatient in hospital, the length of Mr Andrews' isolation each time he was discharged and returned to Norwich was not in line with HMPPS' national COVID-19 compartmentalisation policy.

Recommendations

- The Head of Healthcare should:
    - ensure that National Early Warning Score 2 (NEWS2) clinical assessments are completed and fully documented in the medical records when a prisoner is acutely unwell; and
    - write to the Ombudsman to set out what has been done to implement this recommendation.
- The Governor and Head of Healthcare should ensure that, in line with HMPPS and local policy, prisoners returning from hospital admissions of more than one day are placed in isolation for 14 days or until two COVID-19 tests are negative.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Andrews' clinical care at HMP Norwich.

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

8. The Ombudsman's family liaison officer wrote to Mr Andrews' next of kin, a relative, to explain the investigation. She raised no specific matters to be considered.

9. Mr Andrews' relative received a copy of our initial report. She raised an issue which has been clarified in correspondence.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan is annexed to the report.

Previous deaths at HMP Garth

11. Mr Andrews was the ninth prisoner at Norwich to die since April 2019. One of the previous deaths was self-inflicted and the other seven were from natural causes (including one due to COVID-19). There have been four further deaths: two from natural causes (none related to COVID-19) and two self-inflicted. We have previously raised concerns about the inconsistent use of NEWS2.

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. (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

15. Mr Paul Andrews was remanded to HMP Norwich on 5 September 2016. He was later convicted of sexual offences and sentenced to 24 years imprisonment, as well as an extended licence period of two years.

16. Mr Andrews' health conditions included chronic obstructive pulmonary disease (COPD), peripheral neuropathy (nerve damage affecting the hands and feet) and spinal stenosis (narrowing of the spinal canal), which affected his mobility. He lived on L wing, a 15-bed unit primarily for men with significant social care needs or receiving palliative care. He used a walking aid and a wheelchair for longer distances.

17. Mr Andrews had a COPD self-management plan and was reviewed by the long-term conditions nurse in October 2019 and July 2020. From April 2018 to November 2020, he was under the care of a colorectal consultant. In December, a prison GP re-referred him to the colorectal department for further advice.

Health concerns from January 2021

18. Mr Andrews was tested for COVID-19 on 8 January 2021, due to contact with someone who was COVID-19 positive. The result was negative, but it was noted that he should be re-tested in three days if there was continuing concern as it might have been a false negative.

19. The next day, 9 January, it was confirmed that there was an outbreak of COVID-19 on L wing. All prisoners on the wing were tested, given written information and placed in isolation for 14 days. A senior nurse spoke to them individually about their test results and the precautions necessary to safely manage their health.

20. On 10 January, Mr Andrews had a high temperature. The following day he had several symptoms indicative of COVID-19. A test on 12 January was positive.

21. The prison assigned a family liaison officer on 13 January. Due to a non-contact order by the court, there was difficulty obtaining the details for Mr Andrews' next of kin, but contact was eventually arranged through the victim liaison service.

22. On 17 January, Mr Andrews' blood oxygen saturation levels were low, he was confused and had a high temperature. An ambulance was requested and paramedics took him to hospital. Mr Andrews returned to Norwich on 29 January and was placed in isolation for 10 days. He received daily clinical checks and was noted to be weak, confused and unable to turn or adjust himself in bed. Due to his ill health, a COVID-19 vaccination planned for 9 February was postponed.

23. On 24 February, Mr Andrews was unwell with nausea, vomiting and a high temperature. A nurse assessed him, using the National Early Warning Score 2 (NEWS2 - a tool to identify acutely ill patients and monitor clinical deterioration) and calculated a score of 10. A score of 7 or over indicates that a patient requires emergency assessment by a critical care team. Mr Andrews was therefore sent to hospital, where he was diagnosed with a lower respiratory tract infection and post-

COVID-19 fibrosis (build-up of scar tissue). He was discharged on 26 February and closely monitored by prison healthcare staff.

24. On 5 March, Mr Andrews asked for a COVID-19 test. A nurse sought advice and was told that as he had previously been ill with COVID-19, he did not need one. On 8 March, it was noted that he would be out of isolation the following day.

25. Mr Andrews continued to feel unwell, with constant nausea, a poor appetite and vomiting. On 11 March, a prison GP urgently referred him to a gastroenterology specialist under the NHS pathway for suspected cancer. Authorisation was given for Mr Andrews' cell door to remain open at all times to enable close clinical monitoring. He remained poorly and was again admitted to hospital between 13 and 19 March. On his return to the prison, he was placed in isolation and the open-door policy was reinstated.

Final admission to hospital

26. Due to severe pain, Mr Andrews was readmitted to hospital on 23 March. He was escorted by two prison officers and no restraints were used due to his poor health and reduced mobility. Healthcare staff initially had difficulty contacting the hospital ward for updates, but escort officers reported that a CT scan had revealed an inflamed pancreas.

27. On 25 March, Mr Andrews tested positive for COVID-19. (A test on 15 March, during his previous hospital admission had been negative.)

28. Mr Andrews' condition worsened. On 14 April, he was reviewed by the hospital's palliative care team and placed on end of life care. Healthcare and hospital staff then discussed the arrangements to discharge him back to the prison, including the medical aids and anticipatory medication needed. However, Mr Andrews' health continued to deteriorate and he became too ill to be discharged.

29. Mr Andrews died on 20 April. A prison manager informed the victim liaison service.

30. The duty governor debriefed the escort officers and offered support. Notices were issued, informing prisoners and other staff of Mr Andrews' death and reminding them of the available support.

31. A relative of Mr Andrews later contacted the family liaison officer, who provided information and support, as well as consulting about the funeral arrangements. In line with national policy, the prison arranged and paid for Mr Andrews' funeral, which was held on 17 May. As the sole attendee, the family liaison officer ensured that it was dignified and in keeping with the wishes of Mr Andrews' next of kin. He was compassionate and supportive throughout his contact with her.

Cause of death

32. No post-mortem examination was conducted as the coroner accepted confirmation by a hospital doctor that the cause of Mr Andrews' death was acute on chronic pancreatitis. ("Acute on chronic" is an acute worsening of a chronic condition.) Mr Andrews also had COVID-19 and paraplegia secondary to thoracic lumbar

myelopathy (injury to the spinal cord), which did not cause but contributed to his death.

Findings

Clinical Findings

33. Mr Andrews had been unwell for several months and was diagnosed with chronic pancreatitis during his final stay in hospital. He twice tested positive for COVID-19, in January and March 2021.

34. The clinical reviewer concluded that Mr Andrews' care at Norwich was satisfactory and equivalent to that he could have expected to receive in the community. She found that staff were compassionate and responsive, while closely monitoring his health. However, she made a recommendation about the use of NEWS2 assessments. Full details of the clinical reviewer's findings are in the clinical review report.

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

35. As part of Norwich's local cohorting policy, L wing was designated a shielding unit due to the vulnerability of its residents. Mr Andrews was at very high risk of complications from COVID-19. Therefore, due to his location on L wing, he was shielded throughout the pandemic. After the outbreak of COVID-19 on the wing, there were additional adjustments to the regime and facilities.

36. It seems likely that Mr Andrews first contracted COVID-19 during the outbreak on L wing, as he had not left the prison for several weeks. It is unclear whether the positive test in March was due to his existing infection, or a new infection. If the latter, it could have been caught either in the prison, or during a previous hospital stay.

Monitoring Mr Andrews' illness

37. The clinical reviewer found that use of the NEWS2 clinical assessment tool was inconsistent. Notably, NEWS2 assessments were not completed on 13 and 16 January, after Mr Andrews became unwell and tested positive for COVID-19. Neither was it used on 23 March after a significant deterioration in his health.

38. In response to a previous PPO recommendation in 2020, the Head of Healthcare at Norwich undertook to address the deficiencies in the use of NEWS2 and monitor use through clinical governance. We remain concerned that this has yet to be properly embedded in clinical practice as this is the third recent investigation in which weaknesses in the use of the tool have been identified. We recommend:

The Head of Healthcare should:

- **ensure that National Early Warning Score 2 (NEWS2) clinical assessments are completed and fully documented in the medical records when a prisoner is acutely unwell; and**
- **write to the Ombudsman to set out what has been done to implement this recommendation.**

Non-clinical findings

Isolation after inpatient admissions to hospital

39. HMPPS and Norwich's local cohorting policy requires newly arrived prisoners (including those returning from a hospital visit of more than one day) to be isolated for 14 days or until they have two negative COVID-19 tests. This is known as reverse cohorting. (There is also provision for protective isolation for symptomatic prisoners for a minimum of 10 days.)

40. Entries in Mr Andrews' medical records indicate that after hospital admissions in January and February 2021, he was in isolation for 10 and 11 days, respectively. The shorter isolation periods appear to have been fixed at the outset, rather than shortened as a result of testing. We are therefore concerned that staff might be unclear about the relevant isolation period for prisoners returning from hospital. We recommend:

The Governor and Head of Healthcare should ensure that, in line with HMPPS and local policy, prisoners returning from hospital admissions of more than one day are placed in isolation for 14 days or until two COVID-19 tests are negative.

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Prisons and Probation Ombudsman **March 2022**

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