

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Alldridge, a prisoner at HMP The Verne, on 20 February 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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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Arthur Alldridge died in hospital from pneumonia on 20 February 2021, while a prisoner at HMP The Verne. He was 88 years old. I offer my condolences to Mr Alldridge's family and friends.

The clinical reviewer was satisfied that the standard of care Mr Alldridge received at The Verne was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer noted that on two occasions in February when staff found that Mr Alldridge had low blood oxygen levels and called an ambulance, they did not give him any oxygen while they waited for paramedics to arrive. While it would not have changed the outcome for Mr Alldridge, it would have made him more comfortable.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

August 2021

Contents

Summary	1
The Investigation Process.....	2
Background Information.....	3
Key Events.....	4
Findings	6

Summary

Events

1. On 18 July 2019, Mr Arthur Alldridge was sentenced to 15 years in prison for sexual offences. On 22 August, he was moved to HMP The Verne.
2. Mr Alldridge had several long-term health conditions including bronchiectasis (a lung condition that can make the lungs more vulnerable to infection) and asthma. He was prescribed appropriate medication for his conditions.
3. On 4 February 2021, Mr Alldridge was admitted to hospital and treated for COVID-19 pneumonia. His condition improved and on 9 February, he was discharged and returned to prison.
4. The following day, a nurse saw Mr Alldridge and noted that his blood oxygen levels were low. She called an ambulance and Mr Alldridge was taken back to hospital.
5. Over the next ten days, Mr Alldridge's health deteriorated and he died on 20 February.
6. The post-mortem report concluded that Mr Alldridge died from pneumonia (lung infection) caused by bronchitis and chronic obstructive pulmonary disease (serious lung disease).

Findings

7. The clinical reviewer considered that the standard of care Mr Alldridge received was equivalent to that he could have expected to receive in the community.
8. However, the clinical reviewer noted that on both 4 and 10 February, staff did not give Mr Alldridge any oxygen while they were waiting for the ambulance to arrive. The clinical reviewer said that this would not have changed the outcome for Mr Alldridge but would have made him more comfortable.

Recommendations

- The Head of Healthcare should ensure that prisoners with low blood oxygen levels are given oxygen therapy where appropriate.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP The Verne informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Alldridge's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Alldridge's clinical care at the prison.
12. We informed HM Coroner for Dorset of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Alldridge's nominated next of kin, his niece, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP The Verne

15. HMP The Verne is a medium security prison for 580 men convicted of sexual offences.
16. The healthcare department is staffed between 7.30am and 6.00pm. Outside those hours prison staff call either the emergency services for an ambulance, or the NHS 111 telephone line for health advice, depending on the prisoner's need. There is no inpatient facility.

HM Inspectorate of Prisons

17. The most recent inspection of HMP The Verne was in February 2020. Inspectors reported that many aspects of the health service were stretched and under-resourced to meet the needs of an ageing population with increasing and complex health issues.
18. The inspectors also noted that recruitment was a considerable challenge, despite efforts to attract staff. Care planning was recorded in some individual patient records but this was not consistent. The risk associated with this was further exacerbated by the use of temporary staff.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 July 2020, the IMB reported that, with the exception of the oldest and frailest prisoners, the health and wellbeing needs of the majority were adequately met. The Board welcomed the proposal of a 'community hospital' within The Verne to reduce hospital visits but said that consideration should also be given to establishing an appropriately staffed 'care' unit for prisoners with social care needs.
20. The Board noted that the prison had been COVID-free during the reporting year.

Previous deaths at HMP The Verne

21. Mr Alldridge was the fifth prisoner to die at The Verne since February 2019. All the previous deaths were from natural causes (including one from COVID-19). There have been three further COVID-related deaths since Mr Alldridge's.

Key Events

22. On 18 July 2019, Mr Arthur Alldridge was sentenced to 15 years in prison for sexual offences. On 22 August, he was moved to HMP The Verne.
23. Mr Alldridge had several long-term health conditions including bronchiectasis (where the airways of the lungs become abnormally widened, leading to a build-up of excess mucus that can make the lungs more vulnerable to infection), asthma and high blood pressure. He was prescribed appropriate medication for these conditions.
24. On 13 January 2021, a nurse saw Mr Alldridge because he had a cough. She took his clinical observations and noted they were normal. On 30 January, the nurse saw Mr Alldridge again because his cough had got worse. She recorded that his observations were normal apart from a raised pulse. She took a swab to test for COVID-19, but it came back negative.
25. On 2 February, Mr Alldridge received his first dose of the AstraZeneca COVID-19 vaccination.
26. On 4 February at 4.15pm, prison staff asked for a member of healthcare staff to see Mr Alldridge because he appeared to be confused. A nurse saw Mr Alldridge in his cell. She noted that his temperature was high and his blood oxygen levels were low. She suspected that he may have sepsis and called an ambulance.
27. Mr Alldridge was taken to hospital, where he was admitted. Shortly after being admitted, he tested positive for COVID-19.
28. On 5 February, hospital staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with Mr Alldridge, who agreed that if he stopped breathing he did not want to be resuscitated.
29. On 9 February, hospital staff said that Mr Alldridge was stable and discharged him back to prison.
30. The following day, a nurse saw Mr Alldridge. She took Mr Alldridge's observations and noted that his blood oxygen levels were low. She called an ambulance and Mr Alldridge was taken back to hospital, where he was again admitted.
31. Over the next week, Mr Alldridge's health continued to deteriorate and he died on 20 February.

Contact with Mr Alldridge's next of kin

32. On 5 February, when Mr Alldridge was taken to hospital, the prison appointed the prison chaplain, as the family liaison officer (FLO). Mr Alldridge's niece was listed as his next of kin. The family liaison officer contacted her to tell her that Mr Alldridge was unwell in hospital. Over the next two weeks Mr Phillips maintained contact with Mr Alldridge's niece, and when Mr Alldridge died, he notified her immediately.
33. The prison paid for Mr Alldridge's funeral in line with national guidelines. The funeral took place on 7 April.

Support for prisoners and staff

34. The prison told the investigator that the escorting officers on the bed watch when Mr Alldridge died were offered support from the care team.
35. The prison posted notices informing other prisoners of Mr Alldridge's death and offering support.

Post-mortem report

36. The post-mortem report concluded that Mr Alldridge died from bilateral lobar pneumonia (lung infection) caused by acute exacerbation of chronic bronchitis and chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases). Acute endocarditis (infection of the inner lining of the heart) was listed as a contributing factor.

Findings

Clinical Care

37. The clinical reviewer considered that the standard of care Mr Alldridge received at The Verne was equivalent to that which he could have expected to receive in the community. Mr Alldridge received appropriate medication and his long-term health conditions were well managed.
38. The clinical reviewer was concerned that on both 4 and 10 February, while waiting for an ambulance to arrive, staff did not give Mr Alldridge any oxygen. Although this would not have changed the outcome for Mr Alldridge, it would have made him more comfortable while waiting for paramedics.
39. We appreciate that during the pandemic, healthcare staff at The Verne were under a huge amount of strain. On 4 February, there were 118 prisoners that had tested positive for COVID-19, many of whom required regular observations. We recognise that this had an impact on the services nursing staff could offer. Nevertheless we recommend:

The Head of Healthcare should ensure that prisoners with low blood oxygen levels are given oxygen therapy where appropriate.

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