

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Douglas, a prisoner at HMP Liverpool, on 7 March 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 Robert Douglas died from COVID-19 in hospital on 7 March 2021 while a prisoner at HMP Liverpool. He also had aspiration pneumonia (a lung infection which occurred after he inhaled vomit into the lungs) which did not cause but contributed to his death. He was 84 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the standard of clinical care that Mr Douglas received at Liverpool was very good and equivalent to that which he could have expected to receive in the community.
5. She concluded that healthcare staff did all they could to lessen Mr Douglas' risk of contracting COVID-19 and that they responded appropriately when his health deteriorated in February and March 2021.
6. The clinical reviewer found good practice in the monitoring, management and mitigation of the risk of COVID-19 at Liverpool in line with national guidance.

The Investigation Process

7. NHS England commissioned a clinical reviewer to review Mr Douglas' clinical care at the prison. The clinical review is annexed to this report.
8. The PPO investigator has investigated the non-clinical issues in Mr Douglas' care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The Ombudsman's family liaison officer wrote to Mr Douglas' daughter to explain our investigation. She did not respond.
10. An inquest into Mr Douglas' death took place on 19 March 2021.
11. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Previous deaths at HMP Liverpool

12. Eight prisoners died from natural causes, two of which were as a result of COVID-19 at HMP Liverpool in the two years before Mr Douglas' death. Three prisoners have died at Liverpool since Mr Douglas' death, two as a result of natural causes. There are no significant similarities between our findings in this investigation and those of the other deaths.

COVID-19 (coronavirus)

13. 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.
14. 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 years, people under 70 years with an underlying health condition such as diabetes, chronic respiratory, heart, liver or kidney disease, those with a weakened immune system or who are very overweight. (These lists are not exhaustive.)
15. On 17 September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield. This was on the basis that vaccination had reduced the risk to them.
16. In response to the pandemic, 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

17. In March 2018, Mr Robert Douglas was sentenced to 21 years in prison for sex offences and was sent to HMP Liverpool.
18. At his initial health screen, a nurse referred Mr Douglas to the clinic for long-term conditions. The nurse noted that Mr Douglas was mobile and able to meet his physical and social care needs.
19. In March 2020, healthcare staff considered that Mr Douglas was clinically extremely vulnerable to developing complications from COVID-19. On 25 March, healthcare staff wrote to Mr Douglas to advise him to shield. He declined to do so and signed a disclaimer to that effect. Healthcare staff frequently reviewed his decision not to shield.
20. On 23 December, Public Health England (PHE) declared that Liverpool was a COVID-19 outbreak site.
21. On 9 February 2021, Mr Douglas had his first dose of a COVID-19 vaccine.
22. On 1 March, Mr Douglas had a high temperature and was tested for COVID-19. Healthcare staff arranged for him to be isolated and closely monitored in the inpatient unit.
23. On 2 March, Mr Douglas had a cough and loose stools. He had blood tests which indicated a chest infection for which he was prescribed antibiotics.
24. On 3 March, Mr Douglas' COVID-19 test result for 1 March confirmed that he had COVID-19. At 2.43pm, a nurse assessed that his blood oxygen saturation level was low. He called for an ambulance but stood it down when Mr Douglas' condition stabilised. Healthcare staff continued to monitor him closely.
25. At 11.18pm, a nurse saw Mr Douglas and found that his blood saturation level remained low and that he had a high pulse rate, temperature, blood pressure and respiratory rate. She noted that Mr Douglas' National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 7 which indicated a high clinical risk, and she arranged for an ambulance.
26. At 12.40am on 4 March, ambulance paramedics transferred Mr Douglas to hospital, where hospital staff also diagnosed pneumonia in the lower part of his right lung. At 6.33am, Mr Douglas went back to Liverpool. At 9.03pm, Mr Douglas had difficulty breathing and was vomiting. A nurse saw that his blood oxygen saturation level was low and gave him oxygen. He noted that Mr Douglas' NEWS score was 10 and sent him back to hospital by ambulance.
27. On 7 March, Mr Douglas died in hospital. There was no post-mortem examination. A hospital doctor, established that Mr Douglas had died of COVID-19. He also had aspiration pneumonia (secondary to vomiting) which contributed to but did not cause his death. Mr Douglas' cause of death was confirmed at an inquest on 19 March.
28. On 8 April, PHE declared that Liverpool was no longer an outbreak site.

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