

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Robert Nevols, a prisoner at HMP Rye Hill, on 26 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



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## 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 Nevols died in hospital on 26 February 2021, while a prisoner at HMP Rye Hill. He was 69 years old. The cause of his death was aspiration pneumonia due to a stroke. I offer my condolences to Mr Nevols' family and friends.
4. The clinical reviewer concluded that Mr Nevols' clinical care at Rye Hill was equivalent to that he could have expected to receive in the community. We endorse the clinical reviewer's findings, which are set out in detail in the clinical review report, and we make recommendations on the issues directly related to Mr Nevols' death.
5. We are concerned that, as a person at high risk of complications from COVID-19, Mr Nevols was not offered the opportunity to shield when it was a national requirement; a clinical assessment tool was not used during the emergency procedures after he was found to have had a suspected stroke; the actions taken during the emergency were poorly documented; and Mr Nevols was inappropriately restrained in hospital.

## Recommendations

- The Director and Head of Healthcare should ensure that staff identify prisoners who are at high risk of complications from COVID-19 and manage such prisoners in line with national guidance.
- The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS) 2 to assess patients effectively and appropriately address any clinical deterioration.
- The Head of Healthcare should ensure that all clinical assessments are fully documented in the patient's medical record.
- The Director should ensure that managers carry out formal risk assessments when reviewing the use of restraints on seriously ill prisoners in hospital, to ensure informed and appropriate decisions.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Nevols' clinical care at HMP Rye Hill.
7. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Nevols' 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 telephoned Mr Nevols' next of kin, his son, to explain the investigation. He had no specific matters for the investigation to consider.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). They accepted our recommendations and found no factual inaccuracies. The HMPPS action plan is annexed to this report.

## Previous deaths at HMP Rye Hill

10. Mr Nevols was the 14th prisoner at Rye Hill to die since February 2019. All the deaths were from natural causes. COVID-19 caused or contributed to three of the deaths. We have previously raised concerns about identifying high risk prisoners, use of the NEWS2 assessment tool and inappropriate use of restraints.

## COVID-19 (coronavirus)

11. 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.
12. 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.)
13. 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

14. Mr Robert Nevols was remanded to HMP Leicester on 17 June 2016. He was later convicted of sexual offences and given an extended sentence of 16 years (15 years imprisonment and one year in the community). On 21 March 2017, Mr Nevols transferred to HMP Rye Hill.
15. Mr Nevols' medical history included chronic obstructive pulmonary disease (COPD), asthma, emphysema, dementia, reduced mobility and impaired vision. He also used a walking aid and required help with social care. Mr Nevols displayed challenging behaviour towards staff and his aggression was thought to be linked to his dementia. Various mental health assessments were carried out during 2020.
16. In March 2020, Mr Nevols' residential unit was placed in lockdown with a restricted regime and activities, due to the COVID-19 pandemic.
17. Entries in his medical record on 15 April and 12 August, indicated that Mr Nevols was at high risk of developing complications if he contracted COVID-19. He received weekly healthcare welfare and key worker sessions (held at his cell door). It was noted that he rarely left his cell for showers or exercise.
18. From September 2020, Mr Nevols' healthcare checks were increased from weekly to daily, as he was found to be neglecting his personal care. A prison carer assisted him and he was placed on a support plan (which provides increased support and staff contact for prisoners who are struggling).

## Transfer to hospital

19. Just after 8.00am on 23 January 2021, an officer unlocked Mr Nevols' cell and saw that he was unwell with signs of a stroke - slurred speech, loss of mobility and an inability to communicate. At 8.13am, the officer radioed a code blue emergency (which indicates a prisoner has breathing difficulties or is unresponsive). A nurse attended and found that Mr Nevols was confused, with right-sided weakness and a facial droop.
20. An ambulance was requested in response to the code blue and it arrived at the prison at 8.24am. The paramedics took Mr Nevols to hospital, escorted by two prison officers. Due to his poor condition, no restraints were used. A prison nurse contacted the hospital in the afternoon and was told that Mr Nevols had suffered a major stroke and would remain in hospital long-term.
21. Healthcare staff telephoned and visited the hospital regularly for updates. After a visit on 26 January, a prison nurse noted that Mr Nevols required help with all activities (clinical staff had to reposition him and manually open his eyes, he could not move his right arm and was fed through a tube). On 30 January, it was noted that Mr Nevols remained very unwell and had developed aspiration pneumonia, for which he was receiving intravenous antibiotics. A test for COVID-19 was negative.
22. At 4.30pm on 31 January, an entry in the bedwatch log noted that Mr Nevols had poked a cleaner with his foot. The escort officers challenged him and reported it to a prison manager, who instructed them to apply an escort chain. Mr Nevols

persistently asked for the restraints to be removed or loosened. The officers contacted the prison and a manager said it should be reviewed at midnight. There is no record of such a review.

23. The following morning, at around 8.15am, the escort officers telephoned the prison to request additional PPE. During the conversation, the head of security authorised removal of the restraints. The reason recorded was decency and due to Mr Nevols being immobile.
24. On 20 February, Mr Nevols tested positive for COVID-19 and his condition deteriorated. On 21 February, the hospital stopped active treatment and placed him on end of life care.
25. The prison completed an application for early release on compassionate grounds on 22 February and requested a medical report from the hospital. Mr Nevols died on 26 February, before the application could be fully considered.
26. A prison manager debriefed the escort officers and offered support. Notices were issued to other staff and prisoners, informing them of Mr Nevols' death and reminding them of the support available.

### **Contact with Mr Nevols' family**

27. Mr Nevols and his son, his next of kin, had been estranged for over 20 years and the contact details in his personal records were incomplete. On 24 January, a prison manager obtained two telephone numbers from the police, in order to inform his son that he had been admitted to hospital. The mobile phone number was not recognised, several attempts on the landline were unanswered and there was no facility to leave a message. Mr Nevols' condition was not considered to be life-threatening at that point.
28. On 25 February, when it became apparent that Mr Nevols was likely to die, the prison asked the police to trace and visit his son. The next day, his son telephoned the prison's family liaison officer and they discussed his preferences in the event of his father's death. Mr Nevols died around two hours after their conversation and the family liaison officer informed his son immediately. The prison arranged and paid in full for Mr Nevols' funeral, which was held on 30 March.

### **Cause of death**

29. No post-mortem examination was held as the coroner accepted the cause of death certified by the hospital as aspiration pneumonia, as a result of a stroke. Mr Nevols also had chronic obstructive pulmonary disease (COPD), asthma and COVID-19, which did not cause but contributed to his death.

# Findings

## Clinical Findings

30. The clinical reviewer concluded that, overall, Mr Nevols' care at Rye Hill was equivalent to that he could have expected to receive in the community. She was satisfied that his physical healthcare and long-term medical conditions were managed in line with National Institute for Health and Care Excellence (NICE) guidelines.
31. The clinical reviewer identified weaknesses that the Head of Healthcare will need to address. These include the absence of a care plan to manage Mr Nevols' back pain and mobility; delays in mental health referrals; unclear dementia assessments; management of the emergency response; and poor record keeping. We endorse the clinical reviewer's recommendations and make similar ones on the issues directly linked to Mr Nevols' cause of death.

## Management of Mr Nevols' risk of infection from COVID-19

32. At the beginning of the pandemic, prisons were expected to identify prisoners at risk of serious illness if they contracted COVID-19 and provide the opportunity to shield. Due to Mr Nevols' underlying respiratory conditions, a code was automatically generated to his medical records to denote that he fell within this category.
33. It was repeatedly documented in Mr Nevols' personal records that he understood the implications of COVID-19; was content with the regime restrictions while the prison was in lockdown; and did not like to socialise or leave his cell for showers or exercise. While he would have benefitted from protection as a result of the limited regime and his own choice to mostly stay in his cell, there is no evidence that he was given the option to shield, in line with national guidance at that time. (The guidance has since changed.) We have raised this issue with Rye Hill before and repeat our previous recommendation:

**The Director and Head of Healthcare should ensure that staff identify prisoners who are at high risk of complications from COVID-19 and manage such prisoners in line with national guidance.**

34. Mr Nevols almost certainly contracted COVID-19 in hospital, as he tested positive 28 days after his admission, well outside the accepted incubation period.

## Emergency response

35. The clinical reviewer had concerns about the management of the emergency incident and how it was documented.
36. In spite of Mr Nevols' poor condition and signs of a suspected stroke, there is no evidence that the nurse who attended the emergency used the National Early Warning Score (NEWS) 2 assessment tool (to identify critical illness and deterioration).

37. Mr Nevols' blood oxygen saturation level was 89% (normal range is 95% to 100%). Although the nurse later subsequently told the Head of Healthcare that he gave Mr Nevols 15 litres of oxygen, there is no record of this and it was not mentioned in the handover to the paramedics. The nurse also failed to record the key clinical information, such as the actions taken during the emergency, timings, other clinicians involved and the interventions by the paramedics. We recommend:

**The Head of Healthcare should ensure that healthcare staff use the National Early Warning Score (NEWS) 2 to assess patients effectively and appropriately address any clinical deterioration.**

**The Head of Healthcare should ensure that all clinical assessments are fully documented in the patient's medical record.**

## **Restraints, security and escorts**

38. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, considering factors such as the prisoner's health and mobility. This should be kept under review as circumstances change.
39. As a result of his stroke, Mr Nevols was partially paralysed, his speech was affected and he received intravenous medication. Entries in the bedwatch log noted instances of him trying to pull off his oxygen mask, occasional verbal aggression to the escort officers and failed attempts to get out of bed (presumably due to his paralysis). A restraints risk assessment authorised at 2.00pm on 31 January, indicated that restraints would be considered due to rude and aggressive behaviour. Two and a half hours later, a manager authorised use of an escort chain, after an incident where Mr Nevols touched a staff member with his foot.
40. It was wholly unacceptable if Mr Nevols intentionally touched the staff member with his foot, but we note that the possibility of using restraints had been suggested before this incident and no other problems with physical contact were recorded. We question the necessity for restraints, given Mr Nevols' immobility, particularly as this would not have stopped use of his foot, or verbal aggression. The use of restraints in the circumstances described could be interpreted as punitive, rather than preventative or protective. A further formal risk assessment might have considered alternatives to managing concerns about behaviour.
41. We have previously raised concerns about the inappropriate use of restraints with the Director and the Prison Group Director. We recommend:

**The Director should ensure that managers carry out formal risk assessments when reviewing the use of restraints on seriously ill prisoners in hospital, to ensure informed and appropriate decisions.**

**Sue McAllister CB  
Prisons and Probation Ombudsman**

**November 2021**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100