Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Pipe, a prisoner at HMP Nottingham, on 5 January 2022

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

OGL

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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 Nigel Pipe died in hospital on 5 January 2022, while in the custody of HMP Nottingham. He was 87 years old. The cause of Mr Pipe's death was COVID-19 pneumonitis. He also had heart failure and metastatic prostate cancer. I offer my condolences to Mr Pipe's family and friends.

4. Mr Pipe tested positive for COVID-19 shortly after arriving at hospital on 30 December. It is therefore reasonable to conclude that he contracted the virus at the prison.

5. The clinical reviewer considered that Mr Pipe's care at Nottingham was satisfactory and equivalent to that which he could have expected to receive in the community. However, she felt it was not good practice that his second-stage health assessment was completed on the same day as his reception health screen; and she was concerned that healthcare staff did not consistently use the National Early Warning Score 2 (NEWS2) clinical assessment tool when Mr Pipe was unwell.

6. There is no evidence that Mr Pipe's risk of complications from COVID-19 due to his cancer was formally recognised, or the option to shield discussed with him. Therefore, this aspect of his care was not managed in line with the national policy at that time.

7. We also identified several concerns about the security risk assessment for Mr Pipe's admission to hospital and the use of restraints. There were significant omissions in the medical section of the risk assessment form, as his impaired mobility and hand injury were not recorded. The use of handcuffs was inappropriate given Mr Pipe's age, impaired mobility, debility, existing hand injury and intravenous treatment; and the decision on reapplying and removing the restraints was not communicated effectively.

Recommendations

- The Head of Healthcare should ensure that second-stage health assessments for new prisoners are completed in accordance with national clinical guidelines.

- The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score (NEWS2) tool to assess unwell prisoners effectively and identify any clinical deterioration.

- The Governor and Head of Healthcare should ensure that staff manage prisoners at high risk of complications from COVID-19 in line with national guidance. Key

actions and decisions should be fully documented in prisoners' medical and personal records.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that in all cases:
  - healthcare contributions fully and accurately reflect the prisoner's mobility, current clinical condition and impact on their ability to escape unaided;
  - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk; and
  - decisions to remove restraints are made quickly and clearly communicated to escort officers.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Pipe's clinical care.

9. The PPO investigator investigated the non-clinical issues, including Mr Pipe's location; whether he was separated from other prisoners on arrival; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.

10. The Ombudsman's family liaison officer explained the investigation to Mr Pipe's daughter, who acted as the family representative. She asked for several matters to be considered and we have investigated those that fall within the Ombudsman's remit, including:

    - Clarification of the events leading to Mr Pipe being taken to hospital.
    - The reasons for wounds to his elbows and a bruised, swollen and painful wrist, which appeared to have been caused by handcuffs.
    - Whether COVID-19 testing took place?
    - The policy on handcuffing prisoners, as Mr Pipe was not handcuffed when they visited him in hospital on 30 December, but was in restraints the following day, despite his frailty and poor mobility.
    - The results of a COVID-19 PCR test taken in the prison had not been shared with Mr Pipe, but he had tested positive at the hospital.

11. We sent a copy of our report to Mr Pipe's daughter. She made several observations and pointed out a factual inaccuracy (which has been amended in this report). We responded to the other comments in correspondence.

12. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted the recommendations.

Previous deaths at HMP Nottingham

13. Mr Pipe was the fifth prisoner at HMP Nottingham to die since January 2020. Three of the previous deaths were from natural causes and one was self-inflicted. There have since been three further natural cause deaths. None of the other deaths were due to COVID-19. We have previously raised with Nottingham the need for consistent use of NEWS2 in assessing acutely unwell prisoners.

COVID-19 (coronavirus)

14. 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.

15. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. In response to the pandemic, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain outbreaks - to be implemented at local level, depending on the needs of individual prisons. (A key strategy was '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.)

16. In September 2021, the shielding programme ended in the community, but HMPPS continued to routinely offer shielding to clinically high-risk prisoners. This has recently been replaced by a system of individual risk assessments by clinical staff, to determine the measures necessary to support such prisoners. The agreed adjustments are documented in a Personal Management Plan, which is then facilitated by operational staff.

Key Events

17. Mr Nigel Pipe was convicted of sexual offences. On 14 October 2021, he was sentenced to 26 years imprisonment (with an extended licence period of two years in the community) and sent to HMP Nottingham.

18. A nurse completed initial and second-stage health screens. Mr Pipe's main physical health conditions were noted as high blood pressure, prostate cancer and metastatic bone cancer. (He was diagnosed with diabetes a few weeks later.) Mr Pipe's mobility was described as limited (and later, poor) and he used a walking aid to move around. Care plans were created to manage his chronic conditions.

19. In line with the HMPPS national COVID-19 policy at the time, Mr Pipe was initially isolated from the main population (known as reverse-cohorting). He then moved to a normal residential wing and was later allocated an adapted cell, with integral shower facilities. At meetings with his prison key worker, Mr Pipe confirmed he understood the regime and COVID-19 measures and raised no concerns.

20. On 19 October, a multidisciplinary team meeting discussed Mr Pipe's complex care needs and added him to the complex care register. He was discussed at subsequent meetings.

21. Between 19 October and 4 December, Mr Pipe tested negative for COVID-19 four times. He had already received his first two COVID-19 vaccinations in the community and was given a booster on 9 December. (A further COVID-19 test was completed on 29 December, noted as positive on 2 January.)

22. In November and December, Mr Pipe had several falls. Healthcare staff therefore created a managing the deteriorating patient/older person care plan. During falls on 14 and 17 December, he sustained wounds to his forehead and hand, which healthcare staff dressed every two days, and this continued until he went into hospital.

Admission to hospital

23. At around 6.20am on 30 December, a prison officer, who was checking prisoners, became concerned as Mr Pipe had been sitting on the toilet for a long time. He went into the cell with a colleague, and they found that Mr Pipe was incoherent and struggling to use his legs. They immediately telephoned the healthcare centre.

24. Two nurses examined Mr Pipe in his cell. He was in pain, confused and unsteady on his feet. He also had a high temperature, and his blood oxygen saturation level was low. Using the National Early Warning Score 2 (NEWS 2) assessment tool, the nurses calculated a score of 8 and, in view of this, requested an emergency ambulance to take Mr Pipe to hospital. (NEWS 2 identifies clinical deterioration. A total score of 7 or over indicates high risk and requires emergency assessment by a critical care team.)

25. Mr Pipe was escorted by two officers, who used single handcuffs. (The restraints were initially removed that afternoon.)

26. Shortly after arriving at the hospital, a test confirmed that Mr Pipe was COVID-19 positive. A scan showed a build-up of fluid around his lungs and he was thought to have heart failure. Due to his poor condition, the hospital consulted his family about resuscitation if his heart or breathing stopped. Prison healthcare staff received regular updates.

27. In the early hours of 31 December, Mr Pipe was transferred to another hospital. The restraints were reapplied before the journey but were not removed on arrival. Mr Pipe deteriorated further overnight. Members of his family visited him and the prison later authorised telephone calls with his wife, who was unable to travel. However, as he was semi-conscious, he was unable to take calls.

28. At approximately 1.15am on 1 January 2022, Mr Pipe's family asked the escort officers to remove the restraints and told them this had been agreed by a prison manager to whom they had spoken. The officers checked the risk assessment and noted there was no evidence of this, so they refused to do so.

29. At 8.00am that morning, the escort officers informed the prison that Mr Pipe's intravenous drip was to be replaced with a syringe driver and authorisation was given for the restraints to be removed. Mid-morning, the hospital withdrew treatment and began end of life care.

30. Mr Pipe's family continued to visit and stayed in hospital accommodation nearby. Mr Pipe died at 4.40pm on 5 January.

31. The family liaison officer went to the hospital to support Mr Pipe's family and provide information about the processes to be followed. Mr Pipe had a funeral plan to cover his funeral costs.

Cause of death

32. No post-mortem examination was held, as the coroner accepted the hospital's clinical certification that the cause of Mr Pipe's death was COVID-19 pneumonitis. He also had underlying congestive heart failure, as well as prostate cancer which had spread to other parts of his body. These conditions contributed to but did not cause his death.

Findings

Clinical care

33. The clinical reviewer concluded that Mr Pipe's care at Nottingham was of a good standard, equivalent to that he could have expected to receive in the community. However, she made recommendations about second-stage health assessments, the use of NEWS2 and clinical input to security risk assessments, which we reflect below.

Reception and second-stage health assessments

34. National Institute for Health and Care Excellence (NICE) Guideline 57 covers the management of the physical health of people in prison. It states that in order to provide continuity of care, every prisoner should receive a health assessment (to identify immediate health needs) before they are allocated to their cell, as well as a second-stage health assessment within seven days of their arrival.

35. Mr Pipe's initial and secondary health assessments were completed on the same day. The clinical reviewer noted that while this might have been expedient for staff, it is not good practice. We agree, as the reception process does not allow sufficient time for health issues to be explored in depth. We recommend:

    The Head of Healthcare should ensure that second-stage health assessments for new prisoners are completed in accordance with national clinical guidelines.

Clinical monitoring and use of the National Early Warning Score 2

36. The clinical reviewer found that healthcare staff conducted clinical observations when Mr Pipe was unwell and after falls. However, on at least two occasions in December 2021, they omitted to calculate NEWS2 scores, a key process to identify acutely unwell and deteriorating patients. We recommend:

    The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score (NEWS2) tool to assess unwell prisoners effectively and identify any clinical deterioration.

Management of Mr Pipe's risk of infection from COVID-19

37. During the COVID-19 pandemic, prisons were required to identify prisoners who were clinically extremely vulnerable to complications from COVID-19, inform them of the risks and offer the opportunity to shield. Staff were expected to support them to make an informed decision by discussing the benefits of shielding and the possible consequences of not doing so. It was also a requirement to record the decision in prisoners' medical and NOMIS personal records. Shielding continued to be offered after it had stopped in the community, due to the high-risk nature of the prison environment.

38. Nottingham had a dedicated shielding unit, as well as a protective isolation unit. During COVID-19 outbreaks, mass testing took place and wings would be locked down until the results were received. Prisoners who tested positive for COVID-19 were unlocked separately for regime activities, such as exercise and showers. Around the time of Mr Pipe's death, due to the outbreak, the prison had limited contact with others by restricting movement and activities.

39. As Mr Pipe had cancer, he fell within a COVID-19 NHS at-risk category. While he would have benefitted from some protection due to the restricted regime and protective measures, there is no evidence in either his clinical or personal records that he was advised that he could opt to shield. We therefore conclude that his risk was not appropriately managed.

40. The government's shielding guidance and terminology has since changed, and the shielding programme is no longer mandatory. Nevertheless, it is important that healthcare and prison staff comply with current and future policies on managing those at risk and ensure that records are appropriately documented. We recommend:

The Governor and Head of Healthcare should ensure that staff manage prisoners at high risk of complications from COVID-19 in line with national guidance. Key actions and decisions should be fully documented in prisoners' medical and personal records.

41. It seems that Mr Pipe contracted COVID-19 at Nottingham, as he had not left the prison during the recognised incubation period.

Restraints, security and escorts

42. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

43. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

44. Mr Pipe was a category C prisoner, who had been assessed as low risk on all the specific areas of concerns, including risk of escape. He had reduced mobility and received intravenous medication in hospital. The 'medical information' page of the risk assessment was ticked to indicate that there was no medical objection to the use of restraints, but the subsection for information on mobility and other relevant clinical information was blank.

45. Mr Pipe's reduced mobility and the injury to his hand were significant omissions and the absence of this information casts doubt on whether healthcare staff fully

understand their responsibilities in completing such assessments. The use of standard handcuffs might well have exacerbated the wound to Mr Pipe's left hand and an escort chain could have alleviated any further injury or discomfort if restraints were deemed essential.

46. There also appears to have been miscommunication about the removal and reapplication of the restraints. A prison manager had instructed that restraints should not be used until Mr Pipe was well enough to be moved and they should be reapplied for the transfer between the hospitals. While not entirely clear from the documents, it seems that the intention was for the restraints to be reapplied temporarily for the journey to hospital, but they were not actually removed after he arrived.

47. We are not satisfied that the use of restraints was justified, or that the level of restraint was proportionate to Mr Pipe's risk. In addition, it was unacceptable that he was restrained while receiving intravenous treatment. We are not critical of the escort officers' refusal to remove the restraints, as they had not received authorisation to do so, but we consider that managers should have communicated the decision sooner. We recommend:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that in all cases:

- **healthcare contributions fully and accurately reflect the prisoner's mobility, current clinical condition and impact on their ability to escape unaided;**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk; and**
- **decisions to remove restraints are made quickly and clearly communicated to escort officers.**

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Prisons and Probation Ombudsman **June 2022**

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