Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Hardy, a prisoner at HMP Frankland, on 25 November 2020

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 Anthony Hardy died in hospital on 25 November 2020, while a prisoner at HMP Frankland. He was 69 years old. Mr Hardy died of COVID-19 pneumonia. He also had type 2 diabetes and heart failure. I offer my condolences to his family and friends.

4. Full details of the clinical reviewer's findings are in the clinical review report. She concluded that Mr Hardy's physical care at Frankland was not always equivalent to that which he could have expected in the community. Among the clinical concerns were delays in carrying out reception and secondary health assessments; long intervals between some clinical observations, as well as inconsistent recording of observations and tests; failure to properly reflect Mr Hardy's clinical condition in the security risk assessment; and inadequate handover to the ambulance staff.

5. Mr Hardy appears to have contracted COVID-19 at Frankland, as he had not left the prison during the accepted incubation period for the infection.

6. We are concerned about the inappropriate use of restraints while Mr Hardy was receiving intravenous treatment; that he was not given the opportunity for someone to be informed that he had contracted COVID-19; and that the prison did not attempt to notify his next of kin that he was seriously ill.

Recommendations

- The Head of Healthcare should ensure that all new prisoners receive a reception health screen promptly on arrival and a secondary health assessment within seven days, in line with NICE guidance 57.

- The Head of Healthcare should ensure that clinical tests and observations are carried out at appropriate intervals and documented.

- The Head of Healthcare should ensure that all critical clinical information is provided to the ambulance service when a prisoner is taken to hospital, including medication dosages.

- The Governor and Head of Healthcare should ensure that:

    - healthcare staff accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and

    - prison managers regularly review the level of restraints used on prisoners in hospital.

- The Governor should ensure that if a prisoner is suspected of having contracted COVID-19, he is given the opportunity for someone to be notified.
- The Governor should ensure, in line with Prison Rule 22, that a prisoner's next of kin is informed promptly if he becomes seriously ill.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Hardy's clinical care at HMP Frankland.

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

9. The Ombudsman's family liaison officer wrote to Mr Hardy's next of kin to explain the investigation. Mr Hardy's next of kin had no specific questions for the investigation to consider.

10. Mr Hardy's next of kin received a copy of the initial report. He made no comments.

11. We shared the initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan has been annexed to this report.

Previous deaths at HMP Frankland

12. Mr Hardy was the 17th prisoner at Frankland to die since November 2018. The previous deaths were all from natural causes (including three related to COVID-19). There have since been two deaths (of which one was due to COVID-19). We have previously raised the issues of recording clinical observations; and risk assessments and the unjustified use of restraints.

COVID-19 (coronavirus)

13. 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.

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; 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.)

15. 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

16. Mr Anthony Hardy was convicted of murder and sentenced to life imprisonment on 25 November 2003. He was sent to HMP Wakefield, but was later transferred to Broadmoor Hospital, a high security psychiatric hospital.

17. After spending 15 years in Broadmoor, Mr Hardy transferred to HMP Frankland on 6 November 2019. No reception health screen was held and he did not receive his medication for the first few days. An entry in the medical record on 13 November, noted that a nurse was unable to complete reception screening due to operational time constraints.

18. A psychiatrist assessed Mr Hardy on 14 November. She noted memory impairment, possibly due to neurological issues or indicative of dementia, and mental health problems. (Subsequent entries in Mr Hardy's medical records by healthcare staff indicated concern about his retention of information but confirmed that he had the mental capacity to make decisions regarding his health.)

19. A reception health screen was held on 15 November. Mr Hardy's physical health conditions included poorly controlled diabetes, heart disease, chronic kidney failure and double incontinence. The next day, he had a secondary health assessment and a care plan for diabetes was created. During his time at Frankland, Mr Hardy sometimes lived in the healthcare inpatient unit due to poor health and falls.

20. In April 2020 (the exact date was not recorded), healthcare staff identified Mr Hardy as at risk of complications if he contracted COVID-19. He agreed to shield from 17 April (mostly in the inpatient unit for the initial 12-week period). On 15 July, a nurse reminded him of the rationale for shielding, the risks due to his underlying conditions and gave him the option to continue shielding. Mr Hardy chose to stop shielding and returned to a residential wing, as he preferred to collect his medication and meals. He resumed shielding on his wing on 26 August.

21. At around 9.00am on 17 November, Mr Hardy collapsed on his way back from the medication hatch to his cell and said that he felt unwell and dizzy. A nurse checked him and found that his clinical observations were within normal range and he did not have the common symptoms of COVID-19, such as a cough or high temperature. However, a swab was taken for testing and he was admitted to the healthcare unit, where he was placed in isolation.

22. On 18 November, the result of the swab test was confirmed as positive for COVID-19. Over the next few days, healthcare staff took clinical observations and regularly calculated Mr Hardy's National Early Warning Score (NEWS) 2 - an assessment tool to identify critical illness and deterioration. When his condition worsened on 22 November, he was given oxygen to help improve his blood oxygen saturation levels.

23. On 23 November, Mr Hardy's saturation levels became even lower and his NEWS2 score was 9. (A score of 7 or over indicates the need for emergency assessment by a critical care team, usually leading to higher dependency care.) He was therefore sent to hospital as an emergency. A custodial manager and two prison officers escorted him, using single handcuffs and an escort chain, which were to be

applied at all times. (The next day, the restraints were reduced to an escort chain only.)

24. A prison nurse obtained an update at lunchtime on 24 November and was told that Mr Hardy was on high flow oxygen and was soon to be placed on intravenous antibiotics and antiviral medication.

25. The same day, the prison appointed a family liaison officer. He obtained information from the escort officers and the duty governor about Mr Hardy's condition, noting that Mr Hardy had continued to deteriorate, with pneumonia and a suspected internal bleed that might require a blood transfusion.

26. At 11.30pm, the ward nurse advised the escort staff that Mr Hardy was likely to die within the next two days if his oxygen levels did not improve. At midnight, the escort staff passed this information to the prison. Mr Hardy was noted to be conscious in the early hours and at 4.00am (25 November), a nurse gave Mr Hardy medication to help him settle.

27. At around 4.20am, the escort officers called a nurse as Mr Hardy was not breathing or moving. Two nurses said that he had died but they had to wait for verification by a doctor. At 4.30am, the nurses laid Mr Hardy flat on the bed and the escort officers removed the restraints. His death was certified at 5.27am.

28. The custodial manager in the escort team debriefed the escort officers and offered support.

29. The family liaison officer could not get through on the telephone numbers listed for the woman named in Mr Hardy's records as his next of kin. He therefore arranged for the police to visit her home to break the news of his death. She was extremely distressed, so the police telephoned the prison to double check the details. It transpired that she was not Mr Hardy's next of kin, but the partner of another prisoner with same surname.

30. On 27 November, one of Mr Hardy's sons telephoned the prison, as he had read about his father's death in a newspaper. Another of Mr Hardy's sons called the same day. After establishing their identity a few days later, the family liaison officer shared relevant information. The prison arranged and paid for Mr Hardy's funeral.

Cause of death

31. No post-mortem examination was held as HM Coroner accepted the hospital's clinical certification that Mr Hardy had died of COVID-19 pneumonia. He also had type 2 diabetes and heart failure which did not cause but contributed to his death.

Findings

Clinical Findings

30. The clinical reviewer identified several deficiencies in Mr Hardy's physical healthcare at Frankland and concluded that it was not always equivalent to that he could have expected to receive in the community. Detailed findings are in the clinical review report. We summarise and make similar recommendations on issues related to Mr Hardy's cause of death.

Reception and secondary health assessments

31. 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 before they are allocated to their cell and a second-stage health assessment within seven days of their arrival. Mr Hardy's initial and secondary health assessments were not completed until the ninth and tenth day, respectively, and he missed a few days of medication. We recommend:

    The Head of Healthcare should ensure that all new prisoners receive a reception health screen promptly on arrival and a secondary health assessment within seven days, in line with NICE guidance 57.

Management of Mr Hardy's risk and monitoring his COVID-19 infection

32. Mr Hardy had a history of poorly controlled diabetes and his blood sugar levels should have been monitored twice a day. The clinical reviewer found that the results were not always recorded.

33. Due to his underlying health conditions, Mr Hardy was at risk of complications if he contracted COVID-19. He was advised of this and opted to shield from 17 April 2020 (with the exception of six weeks in July/August). When he became unwell, Mr Hardy was immediately admitted to the prison's inpatient unit and isolated. Staff wore full PPE during their contact with him.

34. In addition to the irregular recording of blood sugar levels, the clinical reviewer was concerned that there had been long and inconsistent intervals between clinical observations while Mr Hardy was unwell. No observations were taken between 11.10pm on 22 November (the day his condition worsened) and 9.43am the next morning. She considered that although staff had conducted visual observations during the night, Mr Hardy should have had the opportunity of clinical observations, given the risk of acute deterioration. We recommend:

    The Head of Healthcare should ensure that clinical tests and observations are carried out at appropriate intervals and documented.

Handover of relevant information to the ambulance service

35. The clinical reviewer found weaknesses in the handover to the ambulance crew who took Mr Hardy to hospital. There was a suggestion that the paramedics were

not told that he was COVID-19 positive, but there is conflicting information on this in the ambulance service records. However, it is clear that Mr Hardy's insulin and warfarin dosages and blood clotting information were not given to the paramedics. We recommend:

The Head of Healthcare should ensure that all critical clinical information is provided to the ambulance service when a prisoner is taken to hospital, including medication dosages.

36. Mr Hardy had not left Frankland during the accepted incubation period for COVID-19, therefore we assume that he contracted the virus at the prison.

Security risk assessments and the use of restraints

37. 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.

38. 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 he has 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. These requirements are reflected in Prison Service Instruction (PSI) 33/2015 on external prisoner movements, as well as on the prison's risk assessment form.

39. There was a detailed security risk assessment. A senior nurse indicated in the medical section that Mr Hardy's condition did not restrict his ability to escape, there were no objections to the use of restraints and they would not need to be removed for treatment. Security staff assessed Mr Hardy as a low risk of escape, with no likelihood of outside assistance, but a high risk to the public, hospital and prison staff, on the basis of his index offence, as well as over familiarity and intimidating behaviour to female staff. (His security record notes an incident of attempting to strike a female officer on 9 March 2020. All other entries related to him as a potential victim of bullying.)

40. Escort staff had informed the prison of Mr Hardy's continuing deterioration and the probability that he would die. We agree with the clinical reviewer that the medical input to the risk assessment did not fully reflect Mr Hardy's risk and poor condition. We are also concerned that, despite the prison being aware of his deterioration, Mr Hardy remained in restraints while gravely ill and receiving intravenous medication and that they were not removed until after his death.

41. We previously raised the issue of the inappropriate use of restraints with Frankland in October 2020. In response to that recommendation, the Governor and Head of Healthcare undertook to review the processes for healthcare contributions to escort risk assessments and to introduce daily management checks on prisoners in hospital by June 2021. We made a similar recommendation in March 2021 and we repeat this once again:

The Governor and Head of Healthcare should ensure that:

- **healthcare staff accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and**
- **prison managers regularly review the level of restraints used on prisoners in hospital.**

Contacting Mr Hardy's next of kin

42. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill.

43. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic. The guidance also states that if a prisoner is suspected of contracting COVID-19 (a formal diagnosis is not required), they should be asked if they want to inform anyone and the prison should facilitate this. The prison told us that the local policy is that the wing manager contacts the family and/or next of kin of any resident who is COVID-19 positive.

44. Mr Hardy became ill eight days before his death. There is no evidence that prison staff gave him the opportunity to have someone notified at this stage, neither did they attempt to notify his next of kin that he was seriously ill in hospital.

45. It appears that the next of kin details were incorrectly entered in the records due to human error, rather than a systemic failing. However, this kind of error is unacceptable. In addition, if the prison had adhered to the policy to inform Mr Hardy's next of kin of his illness at the outset, the error would have come to light earlier, caused less distress to the family wrongly notified and allowed tracing of Mr Hardy's family to begin sooner. We recommend:

The Governor should ensure that if a prisoner is suspected of having contracted COVID-19, he is given the opportunity for someone to be notified.

The Governor should ensure, in line with Prison Rule 22, that a prisoner's next of kin is informed promptly if he becomes seriously ill.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **September 2022**

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