

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Preston, a prisoner at HMP Stafford, on 18 November 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 Alan Preston died in hospital on 18 November 2021 of COVID-19 while a prisoner at HMP Stafford. Mr Preston was 74 years old. I offer my condolences to Mr Preston's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Preston received at HMP Stafford was satisfactory and equivalent to that he could have expected to receive in the community. She said that Mr Preston's diabetes was well monitored and that his care plans were regularly reviewed.
5. The clinical reviewer made three recommendations which were not directly related to Mr Preston's death, but that the Head of Healthcare will need to address.
6. The investigation found that Stafford generally followed national guidance on COVID-19 risk management and implemented the procedures advised to help prevent the spread of the infection, in consultation with Public Health England. Mr Preston appears to have contracted the virus in prison, as he had not attended any hospital appointments or left the prison for any other reason during the three months before his death. Mr Preston did not present with any known COVID-19 symptoms but was appropriately given a swab test prior to his hospital transfer on 15 November which was positive.
7. We found that Mr Preston was appropriately transferred to hospital without the use of restraints because of his age and mobility difficulties. However, we are concerned that a family liaison officer was not allocated as soon as Mr Preston had become seriously unwell. The hospital contacted Mr Preston's next of kin but she was not contacted by the prison until after his death.

Recommendations

- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill, in line with Prison Rule 22 and PSI 64/2011.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Preston's clinical care at HMP Stafford.
9. The PPO investigator has investigated non-clinical issues, including Mr Preston's location, the security arrangements for his hospital escort, liaison with his family, COVID-19 measures and whether compassionate release was considered.
10. The PPO family liaison officer wrote to Mr Preston's next of kin, his sister, to explain the investigation. She had a question about the COVID-19 booster vaccination and expressed concern that the prison delayed notifying her of her brother's hospital admission. These issues have been addressed in this report and the clinical review.
11. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.
12. We sent a copy of our initial report to Mr Preston's sister. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Stafford

13. There were eleven deaths in the two years before the death of Mr Preston, all of which were from natural causes. There are no similarities between our findings in the investigation into Mr Preston's death and our investigation findings for the previous deaths.

Key Events

14. On 17 November 2017, Mr Preston was sentenced to 9 years custody. He was sent to HMP Leeds and transferred to HMP Stafford on 28 November 2018.
15. During his screening at Stafford, it was noted that Mr Preston had a history of diabetes and intermittent claudication (pain in the calves and buttocks following exercise). In 2017, he was also diagnosed with angina (attacks of chest pain caused by reduced blood flow to the heart).
16. Mr Preston was identified as clinically vulnerable from COVID-19 as he had diabetes and was over 70 years old. He was subject to regular COVID-19 risk assessments by healthcare staff.
17. On 24 September 2020, healthcare asked Mr Preston if they could support him to self-isolate, as there were COVID-19 cases at HMP Stafford. He said that he did not wish to be part of the shielding regime and signed a letter to this effect.
18. Mr Preston had two COVID-19 vaccinations in Stafford on 9 February 2021 and 5 May 2021. From 16 September 2021, the NHS started delivering COVID-19 booster vaccinations. Mr Preston was not offered a booster vaccination prior to his death as he had not been identified as clinically extremely vulnerable.
19. On 15 November, a prison GP and a nurse assessed Mr Preston for reported leg pain. They called for an emergency ambulance when he developed numbness and a loss of sensation in his leg, which was also cold to the touch. The paramedics took Mr Preston to County Hospital for further investigation. A COVID-19 test taken prior to his hospital transfer showed that he was positive for COVID-19. An escort risk assessment indicated that Mr Preston was a low risk of escaping, due to his age and mobility difficulties. The duty governor authorised two officers to escort Mr Preston to hospital with no restraints.
20. On the morning of 16 November, a prison nurse called County Hospital for an update on Mr Preston's health. They told her that he had been transferred to a COVID ward at Royal Stoke Hospital and was settled. At 12.26am, an officer recorded in the bedwatch log that the consultant would consider moving Mr Preston to end of life care due to his condition if he did not keep his oxygen mask on.
21. On 17 November at 3.00am, a prison nurse contacted the hospital and was told that Mr Preston was being treated for COVID-19 pneumonia and was being given oxygen therapy. They confirmed that there were no plans to discharge him at that time. An officer was notified that she was the Family Liaison Officer (FLO) for Mr Preston at 4.15pm. The FLO finished her shift at 5.30pm and did not contact Mr Preston's next of kin as she did not know that he was very unwell. The FLO told the investigator that when a prisoner's health deteriorates and the FLO is not available, Oscar One (the duty operational prison manager) is responsible for notifying the next of kin.
22. At 10.19pm, Royal Stoke Hospital contacted the prison to tell them that Mr Preston's health was significantly deteriorating. One of the escorting officers gave Mr Preston's next of kin details to hospital staff so that they could contact them and advise that they could visit. At 12.10am, the hospital called Mr Preston's next of kin

who were nearly 4 hours' drive away, but said they intended to visit. A do not attempt cardiopulmonary resuscitation (DNACPR) form was completed by the consultant as there was no other treatment available for Mr Preston.

23. Mr Preston's condition continued to deteriorate, and he died at 5.00am on 18 November from COVID pneumonia. At 5.15am, hospital nursing staff telephoned Mr Preston's next of kin and informed them of his death.
24. The FLO started work at 7.00am and was notified immediately of Mr Preston's death by a custodial manager. She called Mr Preston's family at 7.15am to pass on her condolences and offer support.

Post-mortem report

25. The pathologist concluded that Mr Preston had died of COVID pneumonia. He also had lower limb ischaemia (a severe blockage in the artery) from peripheral vascular disease (a blood circulation disorder that can cause blood vessels to block), which did not cause but contributed to his death.

Clinical Findings

26. The clinical reviewer concluded that the care that Mr Preston received was satisfactory, and equivalent to that he could have expected to receive in the community. The clinical reviewer said that Mr Preston's diabetes was appropriately managed and reviewed regularly. She was concerned that healthcare staff did not contribute to Mr Preston's escort risk assessment but we are content that Mr Preston was not restrained. The clinical reviewer's full findings and additional recommendations are set out in her report.

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

27. Mr Preston was identified as a prisoner at high risk of serious illness if he contracted COVID-19. The clinical reviewer is satisfied that COVID-19 risk assessments were undertaken appropriately and regularly with Mr Preston. He was appropriately advised to self-isolate again in September 2020 when there was a known outbreak of cases at Stafford. However, Mr Preston said that he no longer wanted to be part of the shielding regime.
28. On 15 November, Mr Preston tested positive for COVID-19 prior to transfer to hospital with leg pain. He did not report or present with any known COVID-19 symptoms. At the time, the main symptoms of COVID-19 were identified as a high temperature; a new continuous cough; and a loss or change to the person's sense of smell or taste.
29. We are satisfied that Stafford followed the national guidance on managing the risks associated with COVID-19 and implemented the policies and measures expected following any outbreaks. Infection control measures were in place and healthcare staff had access to appropriate personal protective equipment (PPE).
30. We make no recommendations about these measures.

Non-Clinical Findings

Liaison with Mr Preston's family

31. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the processes that should be followed when a prisoner suffers a rapid deterioration in their physical health and when they die. This includes that prisons must have procedures to promptly engage with the prisoner's next of kin.
32. HMPPS guidance, Acting as Family Liaison Officer by telephone – communicating with a prisoner's next of kin, published in March 2020, sets out the processes for family liaison during the COVID-19 pandemic. It says that prisoners' families should continue to be told if a prisoner becomes seriously ill, but that, due to social distancing rules, this should be done by telephone.
33. A day after Mr Preston was taken to hospital on 16 November, he was given oxygen therapy. On the same day, the hospital doctor also told bedwatch staff that he could be moved to end of life care if he continued to remove his oxygen mask. Despite the rapid deterioration in his condition, the prison did not appoint a family liaison officer until 4.15pm on 17 November and the prison had no contact with Mr Preston's next of kin until 2 hours after he died. While Mr Preston's sister had received some information from the hospital before this, we are concerned that no one from the prison contacted her before Mr Preston's death. We make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill, in line with Prison Rule 22 and PSI 64/2011.

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