

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Joseph Carty, a prisoner at HMP Humber, on 20 March 2021**

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

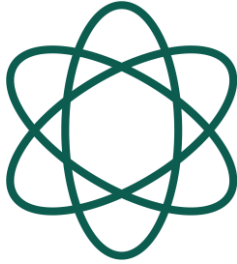
Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100



## 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 Joseph Carty died in hospital of COVID-19 pneumonia on 20 March 2021, while a prisoner at HMP Humber. He was 51 years old. I offer my condolences to Mr Carty's family and friends.
4. Mr Carty became unwell with COVID-19 symptoms on 3 March 2021 and was taken to hospital. He died there on 20 March.
5. The clinical reviewer concluded that the healthcare Mr Carty received at Humber was not of a good standard and was not equivalent to that which he could have expected in the community. She found that Mr Carty, who was morbidly obese, had not been identified as clinically vulnerable to COVID-19 as he should have been. She also had concerns about the healthcare screening and the care Mr Carty received for his diabetes. She made five recommendations.
6. We identified no non-clinical concerns.

## Recommendations

- The Head of Healthcare should ensure that all prisoners with an elevated BMI are identified and recorded in medical records as clinically vulnerable and at increased risk of developing serious complications from COVID-19, in line with Public Health England (PHE) Guidance: *Excess weight and COVID-19: insights from new evidence* (July 2020).
- The Head of Healthcare should ensure that the NICE Guidance 57: *The physical health of people in prison* (November 2016) templates for use during reception screening in medical records are completed fully and accurately.
- The Head of Healthcare should ensure that second reception screening is undertaken in line with NICE Guidance 57.
- The Head of Healthcare should ensure that prisoners presenting with a long-term condition (LTC) are referred to the appropriate LTC clinic for monitoring and support.
- The Head of Healthcare should ensure that all care plans for transferring prisoners are updated to reflect the new establishment and any change in circumstances.

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Carty's clinical care at Humber.
8. The PPO investigator investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, the security arrangements for Mr Carty's hospital escort, and liaison with his next of kin.
9. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. The Coroner provided the cause of death. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr Carty's next of kin, his stepmother and father, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Carty's stepmother and father wanted to know how COVID-19 had got into the prison and how Mr Carty became infected when he was locked up 23 hours a day. Unfortunately, it is impossible to say how COVID-19 got into the prison or how Mr Carty became infected.
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 Carty's stepmother and father. They did not notify us of any factual inaccuracies.

## Background Information

### HMP Humber

13. HMP Humber is a medium security prison in Yorkshire that can hold approximately 1,000 men. City Health Care Partnership provides healthcare services between the hours of 7.00am and 8.30pm.

### HM Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) carried out a Scrutiny Visit at HMP Humber in October/November 2020. They reported that the prison held slightly fewer prisoners than before the pandemic, which helped to control the spread of the virus as fewer prisoners were sharing cells. They considered that the senior management team had reacted quickly to minimise the spread of the virus following the announcement of the restrictions in prisons at the end of March 2020. There had been an outbreak among staff in May 2020, but this had been handled well. Many prisoners inspectors spoke to were positive about the steps taken during the previous seven months to keep them safe, and at the time of HMIP's visit, few staff had tested positive and no prisoners were currently positive.
15. However, inspectors reported that, despite a clear desire and regular reminders to maintain social distancing, this was very difficult to achieve in some parts of the prison where corridors and landings were very narrow. Arrangements to keep new prisoners separate from others on the two reverse cohort units were proportionate and sensible, but the use of a shared exercise yard with prisoners from other wings presented an avoidable risk of the virus being transmitted.

### Previous deaths at HMP Humber

16. Mr Carty was the fifth prisoner at Humber to die since March 2019. Of the previous deaths, one was drug-related, two were self-inflicted and two were from natural causes. There were no significant similarities between the findings in our investigation into Mr Carty's death and our findings from the investigations into the previous deaths at Humber.
17. Mr Carty's death was the second of four COVID-19 related deaths in March 2021. There have been no further deaths from COVID-19.

### COVID-19 (coronavirus)

18. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.
19. 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.)

20. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try to 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, in a prison 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 received prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

## Key Events

21. On 18 September 2008, Mr Joseph Carty was given an Imprisonment for Public Protection (IPP) sentence, with a minimum term of five years, for grievous bodily harm. On 24 November 2020, he was sent to HMP Humber.
22. Mr Carty had type two diabetes. He also had a Body Mass Index (BMI) of 42.13, so was considered morbidly obese. However, healthcare staff did not identify him as someone who was at risk of serious complications if he were to catch COVID-19 ('clinically vulnerable') so they did not offer him the opportunity to shield.
23. In mid-February 2021, Humber had a significant outbreak of COVID-19 infections which escalated quickly. In response, and in accordance with national guidelines, the prison wings were put into lockdown and prisoners were isolated in their cells.
24. On 25 February, during a mass testing programme at Humber, Mr Carty was swabbed for COVID-19. However, his sample had 'insufficient patient identifiers' on it, and so it was not tested.
25. On the morning of 3 March, prison staff found that Mr Carty was short of breath and unable to speak in full sentences. Prison staff called a medical emergency code blue (used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance).
26. A nurse responded to the code blue and attended to Mr Carty. She found that his pulse rate ranged from 126-158 beats per minute (a normal pulse rate is 60-100 beats per minute), and his respiratory rate was high at 28 breaths per minute (a normal respiratory rate is between 12-16 breaths per minute). Mr Carty had an oxygen saturation level of 41%, which rose to only 61-81% when the nurse gave him oxygen.
27. The nurse assessed Mr Carty using the National Early Warning Score (NEWS2 – a tool to assess clinical deterioration in adult patients). Mr Carty had a NEWS2 score of 14, which meant that he needed an emergency response.
28. An ambulance took Mr Carty to hospital, where he was admitted and treated for COVID-19. He was placed in the Intensive Care Unit (ICU), sedated and placed on a ventilator. However, he did not recover and died on 20 March.

## Post-mortem report

29. The post-mortem report concluded that Mr Carty died from COVID-19 pneumonia.

# Findings

## Clinical Findings

30. The clinical reviewer considered that care Mr Carty received at Humber was not of a good standard and was not equivalent to that which he could have expected to receive in the community. She identified several areas of concern which we cover below.

### Management of Mr Carty's risk of infection from COVID-19

31. Mr Carty was morbidly obese. The clinical reviewer noted that in line with Public Health England (PHE) guidance, *Excess weight and Covid-19: insights from new evidence* (July 2020), Mr Carty should have been identified as clinically vulnerable and at increased risk of developing serious complications from COVID-19 when he arrived at Humber. She said that this should have been included in his medical records. We recommend:

**The Head of Healthcare should ensure that all prisoners with an elevated BMI are identified and recorded in medical records as clinically vulnerable and at increased risk of developing serious complications from COVID-19, in line with Public Health England (PHE) Guidance, *Excess weight and COVID-19: insights from new evidence* (July 2020).**

### The impact of Humber's COVID-19 outbreak on Mr Carty

32. The Head of Healthcare told the investigator that in early February 2021, a prisoner working on the servery (serving meals to other prisoners) tested positive for COVID-19. (We cannot say how he contracted the virus.) Due to his job role, this prisoner had been in contact with prisoners and staff from other wings. Once this prisoner had tested positive, other prisoners on his wing came forward with COVID-19 symptoms. Their wing was locked down and its residents tested. Unfortunately, because of the prisoner's contact with staff and prisoners on other wings, COVID-19 had spread to other areas of the prison and a large number of prisoners tested positive. The Head of Healthcare said that due to the number of infected prisoners, the healthcare team were unable to cope and provide their normal quality of service.
33. Due to infections escalating so quickly, Humber was classified as a COVID-19 outbreak site. In response and in accordance with national guidelines, the prison wings were in lockdown and prisoners were isolated in their cells, and mass testing for COVID-19 began.
34. As Mr Carty had not left the prison in the weeks before he developed COVID-19 symptoms, we are satisfied that he caught the virus in the prison.

### Testing of Mr Carty for COVID-19

35. In response to the outbreak, an external contractor conducted a mass testing programme on 25 February, and Mr Carty was swabbed for COVID-19. However,

his swab was not tested, as there were 'insufficient patient identifiers' on the sample. This error was identified and addressed in the healthcare provider's own 72-hour post review, which resulted in a review of the COVID-19 screening programmes at Humber. The clinical reviewer did, therefore, make a recommendation.

### **Management of Mr Carty's overall clinical care**

36. We appreciate that when Humber became an outbreak site, significant strain was placed on staff and resources. However, we are concerned about the frequency of errors in healthcare processes.
37. The clinical reviewer found that when Mr Carty arrived at Humber in November 2020, his first transfer reception screening did not follow the NICE Guidance 57 template. Clinical observations were incomplete, and Mr Carty was not referred to GP services or the Long-Term Conditions (LTC) clinic despite being morbidly obese and having an elevated pulse on arrival. The clinical reviewer also said that the second reception screening was not undertaken in seven days or the 15-day period, allowed as part of the COVID-19 isolation flowchart. We recommend:

**The Head of Healthcare should ensure that the NICE Guidance 57: *The physical health of people in prison* (November 2016) templates for use during reception screening in medical records are completed fully and accurately.**

**The Head of Healthcare should ensure that second reception screening is undertaken in line with NICE Guidance 57.**

38. The clinical reviewer was also not satisfied with the assessment and monitoring in place for Mr Carty's existing medical condition of type 2 diabetes. Healthcare staff did not make any referrals made for his diabetes at his reception screening. She also said that Mr Carty's care plans should have been updated to reflect a change in establishment. This would have identified the review date for his diabetes, which was not undertaken. We recommend:

**The Head of Healthcare should ensure that prisoners presenting with a long-term condition are referred to the appropriate LTC clinic for monitoring and support.**

**The Head of Healthcare should ensure that all care plans for transferring prisoners are updated to reflect the new establishment and any change in circumstances.**

**Elizabeth Moody  
Deputy Prisons and Probation Ombudsman**

**January 2022**

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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