

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Mercer, a prisoner at HMP Wymott, on 8 November 2021

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

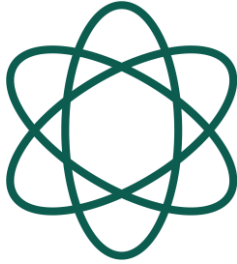
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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 Paul Mercer died on 8 November 2021 of COVID-19 pneumonitis while a prisoner at HMP Wymott. He was 72 years old. I offer my condolences to Mr Mercer's family and friends.
4. The clinical reviewer concluded that the healthcare Mr Mercer received at HMP Wymott was of a variable standard and partially equivalent to that which he could have expected to receive in the community. She made several recommendations about aspects of Mr Mercer's care in relation to his mental health, risk of falls and staff training. We repeat those recommendations that relate directly to Mr Mercer's death below.
5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure where appropriate that those prisoners who test positive for COVID-19 are provided with a pulse oximeter.
- The Head of Healthcare should ensure that staff are fully trained to demonstrate their competence in recognising a deteriorating prisoner.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Mercer's clinical care at HMP Wymott.
7. The PPO investigator has investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, Mr Mercer's location, the security arrangements for his hospital escorts and liaison with his family.
8. The PPO's family liaison officer wrote to Mr Mercer's next of kin, his brother, to explain the investigation. He did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at Wymott

10. Mr Mercer was the 14th prisoner to die at Wymott since November 2019. Of the previous deaths, twelve were from natural causes and one was drug related. None of the deaths were related to COVID-19.

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. On 14 June 1977, Mr Paul Mercer was remanded to HMP Risley, charged with the rape and murder of a child.
15. On 21 October, Mr Mercer was sentenced to life imprisonment. Due to the severity of his offence, no minimum tariff was set. He returned to Risley.
16. On 11 January 2017, Mr Mercer transferred to HMP Wymott.
17. Mr Mercer had a number of pre-existing medical conditions, including peripheral vascular disease (narrowing of the arteries), COPD (a collection of respiratory conditions) asthma, deep vein thrombosis and poor mental health. In 2019, he was diagnosed with vascular dementia. As his dementia deteriorated over time, he experienced falls and a decline in his mobility and cognitive function. Healthcare staff referred Mr Mercer to the prison's long-term condition clinics to manage his care. Care plans were created, and he had regular blood tests and reviews over the months that followed. Mr Mercer also received social care support to assist him with daily tasks and was referred to the prison's mental health in reach team (MHIRT) for support.
18. In March 2020, restrictions began to be imposed in response to the COVID-19 pandemic. On 23 March, a national lockdown was imposed. Prison regimes were severely curtailed and face-to-face services were reduced or stopped.
19. Mr Mercer was identified as being in the high-risk category for risk of complications from COVID-19. The healthcare team sent Mr Mercer a shielding letter advising him to shield, which he agreed to do. He was located on the shielding wing throughout the pandemic.

2021

20. On 1 February 2021, Mr Mercer received his first dose of the COVID-19 vaccination. Healthcare staff recorded in his medical records that he was a high priority for 'severe respiratory syndrome COVID 2 vaccination', but they did not document that he was in the extremely clinically vulnerable category. Mr Mercer received his second dose of the vaccine on 15 April.
21. In July, Mr Mercer had a COVID-19 test and the result was negative. It was not recorded why he had taken a test at this time.
22. On 19 September, a nurse saw Mr Mercer after he complained of having no feeling or movement in his left arm. He was taken to hospital by emergency ambulance and was admitted as an inpatient. He had a series of tests and the results showed nothing of note. He was discharged from hospital and went back to Wymott the following morning. On his return to Wymott, staff asked Mr Mercer to self-isolate, which he agreed to do.
23. On 22 September, Mr Mercer attended hospital for more tests. On his return to the prison, he was required to self-isolate for seven days. However, a healthcare assistant recorded that she saw Mr Mercer walking down the wing the next day

when he was supposed to be isolating. There is no evidence to indicate that she challenged him or asked him why he was not isolating. On 24 September, healthcare staff recorded that Mr Mercer was isolating following his hospital appointment on 22 September, and that his meals were being delivered to his cell. On 25 September, Mr Mercer told his support worker that he was annoyed about having to self-isolate. The support worker explained the reasons why, and Mr Mercer said that he understood, but was feeling lonely and was missing interaction with other people.

24. On 23 October, the prison began mass testing for COVID-19. Mr Mercer's test result was negative, but there were a number of prisoners who had tested positive. They self-isolated in their cells.
25. Blood test results received on 28 October were abnormal and further tests were arranged. Mr Mercer died before this could take place.
26. On 29 October, Mr Mercer displayed COVID-19 symptoms. A nurse saw him and took his observations. His oxygen saturation level was low and his blood pressure was raised. Mr Mercer took a COVID-19 test and while waiting for the results he self-isolated in his cell. Healthcare staff implemented a COVID-19 care plan. The test results showed that Mr Mercer was COVID-19 positive. He continued to self-isolate in his cell, and healthcare staff completed daily welfare checks, but they did not provide Mr Mercer with a pulse oximeter to help monitor his condition.
27. At 3.36am on 31 October, prison officers completing the night checks found Mr Mercer on the floor of his cell. Mr Mercer told the prison officers that he had rolled out of bed but had no injuries. Healthcare staff completed his physical and neurological observations, which were normal.
28. At 12.26pm, a nurse saw Mr Mercer and completed his observations. His NEWS2 score was recorded as zero (National Early Warning System used to identify and monitor acutely ill patients, patients who score zero should be routinely monitored again within twelve hours and continue to be routinely monitored). The nurse reviewed him again at 3.30pm. She took his observations and noted that his oxygen saturation level was extremely low, and that his temperature was high.
29. At 6.00pm, the nurse saw Mr Mercer again. She noted that although his temperature had dropped slightly, it remained high. She considered that he needed to go to hospital and control room staff telephoned for an ambulance. The ambulance arrived at 6.51pm. Paramedics attempted to stabilise Mr Mercer's oxygen saturation level, but they were unsuccessful. At 7.35pm, he was taken to Royal Preston Hospital by emergency ambulance and was admitted as an inpatient.
30. Mr Mercer's condition continued to deteriorate, and on 8 November, hospital staff signed a Do Not Attempt Resuscitation (DNACPR) order on his behalf. This meant that in the event his heart or breathing stopped, he would not be resuscitated.
31. At 8.25pm, it was confirmed that Mr Mercer had died in hospital.

Cause of death

32. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Mercer's cause of death as COVID-19 pneumonitis. He also had COPD, asthma and vascular dementia, which did not cause but contributed to his death.

Clinical Findings

Management of Mr Mercer' risk of infection from COVID-19 and risk to others

33. On 22 September 2021, Mr Mercer was required to self-isolate following a hospital outpatient appointment.
34. Mr Mercer was given a test for COVID-19 on 23 October 2021. The result of the test was negative. He was tested again on 29 October due to displaying the symptoms of COVID-19 and the result was positive. It is likely that Mr Mercer caught COVID-19 at Wymott as he had not left the prison in the previous four weeks before he tested positive.
35. The clinical reviewer concluded that the healthcare Mr Mercer received at Wymott was of a variable standard, and partially equivalent to that which he could have expected to receive in the community.
36. She was concerned that after testing positive for COVID-19, a pulse oximeter was not available for Mr Mercer to monitor his condition as it should have been. We recommend:

The Head of Healthcare should ensure where appropriate that those prisoners who test positive for COVID-19 are provided with a pulse oximeter.

37. The clinical reviewer was also concerned that at 12.26pm on 31 October, when a nurse reviewed Mr Mercer and completed his observations, she recorded his NEWS2 score as zero. When she carried out a follow up review at 3.30pm, she recorded that his oxygen saturation level was extremely low and that his temperature was high. However, it was not until 6.00pm following a further review, that the nurse considered that he needed to go to hospital for review.
38. The clinical reviewer was concerned that the nurse noted that Mr Mercer's condition had worsened at 3.30pm, yet it was not until two and a half hours later that she requested an emergency ambulance. We recommend:

The Head of Healthcare should ensure that staff are fully trained to demonstrate their competence in recognising a deteriorating prisoner.

Kimberley Bingham

Acting Prisons and Probation Ombudsman

December 2022

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Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
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