Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Catley, a prisoner at HMP The Verne, on 22 February 2021

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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 David Catley died in hospital of COVID-19 pneumonia on 22 February 2021, while a prisoner at HMP The Verne. He was 72 years old. I offer my condolences to those who knew him.

4. Mr Catley had several long-term health conditions, including serious lung disease, which made him vulnerable to COVID-19. Although the clinical reviewer was satisfied that Mr Catley's long-term health conditions were properly managed at The Verne, he found that the prison did not do enough to prevent Mr Catley catching COVID-19. The prison failed to identify that Mr Catley was clinically extremely vulnerable to COVID-19 and did not offer him the opportunity to shield as they should have done.

5. The clinical reviewer was also concerned that healthcare staff did not question Mr Catley's refusal to go to hospital on 13 February, despite Mr Catley showing signs of confusion. The clinical reviewer was satisfied that the delay of one day in taking Mr Catley to hospital did not affect the outcome, but staff should be aware that they may need to take decisions in the best interests of the patient if they do not have the mental capacity to make that decision themselves.

Recommendations

- The Head of Healthcare should ensure that prisoners whose health conditions make them clinically extremely vulnerable to COVID-19 are identified promptly and offered shielding in line with NHS guidelines.

- The Head of Healthcare should ensure that where a prisoner is advised to shield, healthcare staff explain the risks of not shielding to them, satisfy themselves that the prisoner understands their options and record the outcome of the discussion in the prisoner's medical record.

- The Head of Healthcare should ensure that staff are aware of the circumstances in which they may have to make a decision on treatment which is in the best interests of the patient.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Catley's clinical care at the prison.

7. The PPO investigator investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, the security arrangements for his hospital escorts, liaison with Mr Catley's next of kin and whether compassionate release was considered.

8. We informed HM Coroner for Dorset of the investigation. We have sent the Coroner a copy of this report.

9. Mr Catley did not have a nominated next of kin.

10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP The Verne

11. HMP The Verne is a medium security prison for up to 580 men convicted of sexual offences.

12. The healthcare department is staffed between 7.30am and 6.00pm. Outside those hours prison staff call either the emergency services for an ambulance, or the NHS 111 telephone line for health advice, depending on the prisoner's need. There is no inpatient facility.

Previous deaths at HMP The Verne

13. Mr Catley was the sixth prisoner to die at The Verne since February 2019. All of the previous deaths were from natural causes. Mr Catley's death was the second from COVID-19. There have been two further deaths from COVID-19 since.

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, 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.

15. COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high-risk (clinically extremely vulnerable); and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant; have a severe lung condition; or are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition; or a chronic medical condition, such as diabetes, heart, liver, lung, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

16. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

Key Events

17. In December 2017, Mr David Catley was sentenced to 12 years in prison for sexual offences. On 9 May 2019, he was moved to HMP The Verne.

18. Mr Catley had several long-term health conditions including high blood pressure, chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases) and asthma.

19. In 2019, he was also diagnosed with memory problems and from June 2020, healthcare staff noted that he often forgot to collect and take his various medications.

20. In May 2020, a prison GP assessed that Mr Catley was at moderate risk of complications from COVID-19, which put him in the 'clinically vulnerable' group. Prison staff did not offer Mr Catley the opportunity to shield as this was offered only to prisoners who were in the 'clinically extremely vulnerable' group.

21. On 2 February 2021, Mr Catley received his first dose of the Astra Zeneca COVID-19 vaccine.

22. On 5 February, a prison officer asked a nurse to see Mr Catley because he was feeling unwell. The nurse took Mr Catley's clinical observations and also took a COVID test swab. On 7 February, the COVID swab test was noted to be negative.

23. On 8 February, healthcare staff were still concerned that Mr Catley was displaying COVID symptoms so they did a lateral flow COVID test (a test that gives a result within 30 minutes). This gave a positive result. They followed this up with a PCR test (a swab that is sent to a laboratory for testing) which came back positive on 10 February.

24. Mr Catley was told of the results and given a finger pulse oximeter (a device that is placed on the finger to check the blood oxygen levels). Over the next few days his observations were taken regularly.

25. On 13 February, a nurse saw Mr Catley and was concerned that his oxygen levels had dropped. Healthcare staff called an ambulance but Mr Catley refused to go to hospital for treatment because he said that he felt fine.

26. The following day, the nurse saw Mr Catley again. He was struggling to breathe and his oxygen levels had fallen further. The nurse called an ambulance and Mr Catley was taken to hospital. Mr Catley told the nurse that he did not remember refusing to go to hospital the previous day.

27. Mr Catley died in hospital on 22 February.

Cause of death

28. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave the cause of Mr Catley's death as COVID-19 pneumonia caused by COPD.

Findings

Clinical Findings

29. The clinical reviewer was satisfied that Mr Catley's long term health conditions were properly managed and that this aspect of his care was equivalent to that he could have expected to receive in the community. However, he was not satisfied that prison staff did everything they could to prevent Mr Catley catching COVID-19 and found that the care in this respect was not equivalent.

Management of Mr Catley's risk of catching COVID-19

30. Mr Catley had not left the prison in the weeks before he became ill and it appears, therefore, that he caught COVID-19 in prison. We have therefore looked at what steps the prison took to protect him from COVID-19.

31. In line with national guidance for the general population, prisons were expected to identify prisoners at risk of serious illness if they contracted COVID-19 and provide them with the opportunity to shield.

32. We were told that a prison GP assessed Mr Catley in May 2020 and assessed that he was at moderate risk of complications from COVID-19, which put him in the 'clinically vulnerable' group. He was not sent a shielding letter as only prisoners at high risk (the 'clinically extremely vulnerable' group) were sent a letter. The Head of Healthcare told us, "However, he [Mr Catley] was on D Wing and as a whole the wing was advised they were shielding and given instruction on what to do by the prison I believe." She added that it would have been challenging to speak to every prisoner about their individual risk level and that they would have been aware of the risks from the media coverage on television.

33. The clinical reviewer considered that at the start of the pandemic, Mr Catley should have been identified as being at high risk of complications from COVID-19 due to his severe COPD, and therefore in the 'clinically extremely vulnerable' group. He should have been offered shielding.

34. We are very concerned that, healthcare staff failed to identify that Mr Catley was 'clinically extremely vulnerable' to COVID-19 and did not offer him shielding as they should have done. The Head of Healthcare said that the wing Mr Catley was on was in effect shielding, as prisoners on the wing were told to come out only when they needed to (such as for meals, phone calls, showers and recess) and only those who were working on D Wing were allowed to enter.

35. However, while D Wing prisoners may have been kept separate from the rest of the prison, it appears that Mr Catley was still mixing with other prisoners on D Wing. Moreover, as we said in our report on the COVID-related death of another prisoner at The Verne two weeks before Mr Catley's, we do not consider it was acceptable to expect prisoners to understand and manage their risk on the basis of media coverage on television. This was especially the case with elderly prisoners like Mr Catley who had some memory problems. His vulnerability to COVID-19 should have been properly assessed, and then staff should have spoken to him about his risks and how he could best manage those by shielding.

36. We recommend:

The Head of Healthcare should ensure that prisoners whose health conditions make them clinically extremely vulnerable to COVID-19 are identified promptly and offered shielding in line with NHS guidelines.

The Head of Healthcare should ensure that where staff assess that a prisoner is advised to shield, healthcare staff explain the risks of not shielding to them, satisfy themselves that the prisoner understands their options and record the outcome of the discussion in the prisoner's medical record.

Mr Catley's refusal to go to hospital on 13 February

37. Mr Catley refused to go to hospital on 13 February and was not taken until the next day.

38. The clinical reviewer was satisfied that the delay in Mr Catley being admitted to hospital was unlikely to have affected the outcome. However, he was concerned that when a nurse saw Mr Catley on 13 February, he noted there was 'evidence of new onset confusion'. The clinical reviewer considered that given this, alongside existing concerns about Mr Catley's cognitive function, staff should have considered whether a 'best interests' decision (where a patient lacks mental capacity to give consent to treatment and healthcare staff make a decision in their best interests) was appropriate. We recommend:

The Head of Healthcare should ensure that staff are aware of the circumstances in which they may have to make a decision on treatment which is in the best interests of the patient.

Sue McAllister CB **April 2022**
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