Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jon Gladwish, a prisoner at HMP The Verne, on 24 February 2021

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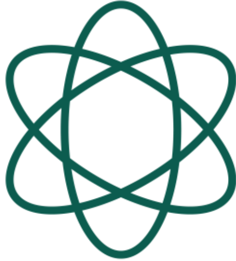
Our vision

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

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 Jon Gladwish died in hospital on 24 February 2021, from pneumonia due to COVID-19 pneumonitis, while a prisoner at HMP The Verne. He was 48 years old. I offer my condolences to Mr Gladwish's family and friends.

4. As Mr Gladwish had not left The Verne in the weeks before he was diagnosed with COVID-19, it seems likely that he contracted it in prison during an outbreak of the virus.

5. The clinical reviewer concluded that the management of Mr Gladwish's chronic conditions was satisfactory, but that there were significant flaws after he tested positive for COVID-19, and his clinical care was therefore not equivalent to that he could have expected to receive in the community.

6. Weaknesses included the lack of personalised care plans for chronic conditions; incorrect understanding of abnormal blood oxygen saturation levels; non-adherence to the expected escalation procedures when Mr Gladwish had low oxygen saturation and high NEWS2 scores; and poor recording of clinical observations.

7. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that personalised and fully documented care plans are in place for all patients with long-term medical conditions, in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The Head of Healthcare should ensure that staff understand and follow the required escalation procedures when a patient's blood oxygen saturation level or National Early Warning Score 2 (NEWS2) indicates that urgent clinical review is necessary.
- The Head of Healthcare should ensure that clinical actions and decisions are recorded in prisoners' medical records, to ensure consistency in clinical management.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Gladwish's clinical care at HMP The Verne.

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

10. The investigator and clinical reviewer jointly interviewed the Head of Healthcare, four healthcare staff and a custodial manager in April and May 2020.

11. The Ombudsman's family liaison officer wrote to Mr Gladwish's next of kin, his mother, to explain the investigation. She did not receive a reply.

12. 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.

Previous deaths at HMP The Verne

13. Mr Gladwish was the seventh prisoner at The Verne to die since February 2019, and there have been five further deaths since. Apart from the most recent death where the cause is unknown at present, all were from natural causes, including three due to COVID-19.

14. We have previously raised concerns about the lack of care plans for men with chronic conditions; the handling of low oxygen saturation levels; and the use of NEWS2. The Head of Healthcare must now take action to address these weaknesses.

COVID-19 (coronavirus)

15. 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.

16. 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.)

17. 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

18. Mr Jon Gladwish was convicted of sexual offences on 6 February 2015 and sentenced to 17 years imprisonment. After moving between several prisons, Mr Gladwish transferred to HMP The Verne on 24 June 2019. (It was his second time at the prison.)

19. Mr Gladwish's health conditions included high blood pressure, chronic obstructive pulmonary disease (COPD), asthma, angina, raised cholesterol and obesity. Healthcare staff regularly reviewed and monitored his asthma, COPD and blood pressure.

20. Mr Gladwish lived in a dormitory of eight men. Toilet and bathroom facilities were shared with other dormitories on the wing. At the beginning of the COVID-19 pandemic, all wing regime activities were stopped to minimise contact between prisoners.

21. On 21 May 2020, the healthcare department wrote to Mr Gladwish informing him that he was at moderate risk of complications from COVID-19 (also termed clinically vulnerable) and advising him to shield. He discussed the letter with a wing officer, who noted that Mr Gladwish was satisfied with the shielding arrangements already in place and felt no further measures were required.

Outbreak of COVID-19

22. On 10 January 2021, The Verne introduced new heightened measures and a change of regime to help prevent the spread of COVID-19. In spite of this, an outbreak of the virus began in February.

23. On 7 February, a wing officer told Mr Gladwish that as some other prisoners had tested positive for COVID-19, the wing had been placed in lockdown. Residents were required to isolate in their dormitories and only leave for essential reasons. Mr Gladwish was reminded to inform wing or healthcare staff if he felt any symptoms of COVID-19.

24. Later that day, Mr Gladwish reported loose bowels and a migraine. Healthcare staff took clinical observations and sent a swab to be tested. Mr Gladwish was placed in isolation and advised to report any worsening symptoms. He was checked again on 8 February, when it was noted that he had been exposed to COVID-19 but had no symptoms. The test was recorded as negative on 9 February.

25. On 16 February, Mr Gladwish felt generally unwell, with symptoms of a cough, headache, fatigue and muscle pain. A test for COVID-19 returned as positive the next day and he then received clinical checks twice a day. Between 17 and 19 February, his blood oxygen saturation level decreased from 96% to 91%.

26. Shortly after 2.00pm on 20 February, a pulse oximeter given to Mr Gladwish for self-monitoring showed an oxygen saturation level of 81%. He was advised to take deep breaths and use the inhalers prescribed for his COPD. Around half an hour later, his oxygen level had dropped to 70% and a National Early Warning Score 2 (NEWS2) was calculated as 8. (NEWS is an assessment tool to identify clinical

deterioration and a score of 7 or above suggests a high clinical risk, requiring urgent assessment by a critical care team.) A nurse gave Mr Gladwish oxygen and requested an ambulance.

27. Paramedics took Mr Gladwish to hospital at 4.45pm. He was escorted by two prison officers, using single handcuffs and an escort chain. At 11.15pm, he was transferred directly from the accident and emergency department to the intensive care unit and the restraints were removed.

28. The following morning, the prison informed Mr Gladwish's mother that her son had been taken to hospital as a precautionary measure. On 22 February, the prison assigned a family liaison officer, who contacted her with further details.

29. Mr Gladwish's condition worsened and he was sedated and placed on a ventilator on 23 February. The family liaison officer informed Mr Gladwish's mother and gave her the hospital's contact details to obtain additional updates.

30. The prison began the procedures for compassionate release on temporary licence, to be granted through a special purpose licence. However, Mr Gladwish died just after 3.00pm on 24 February, before a decision was made.

31. The family liaison officer notified Mr Gladwish's mother promptly and kept in touch to provide information and assist with arrangements.

32. The duty governor and an operational manager debriefed the escort officers and offered support. Notices were issued to other staff and prisoners, informing them of Mr Gladwish's death and reminding them of the support available.

33. The Verne met the full costs of Mr Gladwish's funeral, which was held on 15 April.

Cause of death

34. No post-mortem examination was held as HM Coroner accepted clinical certification that Mr Gladwish had died from pneumonia caused by COVID-19 pneumonitis. He also had underlying COPD which did not cause, but had contributed to his death.

Findings

Clinical Findings

35. The clinical reviewer's findings are set out in detail in the clinical review report. He considered that Mr Gladwish received appropriate care at The Verne for his long-term medical conditions and there were examples of good clinical practice. However, while recognising the extreme pressures facing healthcare staff during the pandemic, the clinical reviewer felt there were weaknesses in some areas of Mr Gladwish's clinical management after he contracted COVID-19.

36. The clinical reviewer concluded that, in view of the deficiencies highlighted, Mr Gladwish's clinical care was not of the required standard, or equivalent to that he could have expected to receive in the community. We summarise the issues below and reflect his recommendations.

Reviewing and monitoring Mr Gladwish's long-term medical conditions

37. The clinical reviewer noted that although Mr Gladwish's asthma, COPD and blood pressure were regularly reviewed and followed National Institute for Health and Care Excellence (NICE) guidance, formal care plans would have provided a more coordinated approach. We recommend:

The Head of Healthcare should ensure that personalised and fully documented care plans are in place for all patients with long-term medical conditions, in line with National Institute for Health and Care Excellence (NICE) guidelines.

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

38. The Verne told us that at the beginning of the pandemic a lot of pre-emptive work was completed collaboratively between the operational and healthcare departments. Managers required everyone on Mr Gladwish's wing to shield (including prisoners who were not clinically required to do so). The men were placed in cohorts, took exercise in a different location to other prisoners and were supervised by the same cohort of staff, as far as possible. Waste management and kitchen workers were also located in one place. All wing activities stopped and wing staff took on the role of keyworkers.

39. After the outbreak of COVID-19, around 230 prisoners tested positive. Staff treated each dormitory as a household and reinforced hand hygiene, wearing masks and restricting movement to other areas. Due to the physical layout of the dormitories, cohorting was challenging and there was a limit on how well it could be managed, particularly as toilet and bathroom facilities had to be shared.

40. The provision for isolating COVID-19 positive men varied, depending on circumstances at the time. Initial plans to use the segregation unit were changed as eight cells were insufficient and some men were reluctant to move to the unit as it was unpleasant. They were happier to disclose symptoms and self-isolate once the

prison set up Evershot, temporary accommodation similar to portacabins, with single occupancy cells and integral sanitation.

41. We are satisfied that Mr Gladwish was given the option to shield but we recognise that the physical constraints of the dormitory environment and facilities made it difficult to separate groups of prisoners effectively.

42. As Mr Gladwish had not left The Verne for any reason, it is reasonable to conclude that he contracted COVID-19 during the outbreak at the prison.

Monitoring Mr Gladwish's COVID-19 infection

43. The clinical reviewer noted that The Verne's policy of monitoring COVID-19 positive men twice daily was good practice. However, he was concerned about the quality of monitoring after Mr Gladwish became infected.

44. Mr Gladwish's oxygen saturation level fell below 92% from 19 February. (The risk of death increases significantly when the level falls below 93%).

45. The clinical reviewer found that some healthcare staff had misunderstood the threshold for acting on low oxygen saturation levels (an issue he had noted in another recent investigation at The Verne.) At interview, the Head of Healthcare initially said nurses had been advised that oxygen saturation of 91% was acceptable, and possibly lower for those with COPD. However, in subsequent correspondence, she accepted that 92% was abnormal and would need inpatient hospital treatment.

46. The clinical reviewer also noted failures to follow the correct escalation procedures in response to high NEWS2 scores.

47. We recommend:

The Head of Healthcare should ensure that staff understand and follow the required escalation procedures when a patient's blood oxygen saturation level or National Early Warning Score 2 (NEWS2) indicates that urgent clinical review is necessary.

Clinical record keeping

48. Although daily multidisciplinary team meetings were held to manage COVID-19 positive patients, the outcome of discussions about individual patients were written on a whiteboard, not in their medical records. This meant that the information was not accessible to staff reviewing them.

49. Due to healthcare staffing pressures and the high number of men to be monitored, the results of clinical observations were often entered in the medical records by other staff. The entries did not name the clinician who took the observations and errors were found in some of the entries. The Head of Healthcare said that they had never had to use transcribers before the pandemic and this had been a learning point.

50. We recommend:

The Head of Healthcare should ensure that clinical actions and decisions are recorded in prisoners' medical records, to ensure consistency in clinical management.

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

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