Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Price, a prisoner at HMP The Verne, on 31 March 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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Price died in hospital on 31 March 2021 of COVID-19 pneumonitis while a prisoner at HMP The Verne. Mr Price was 40 years old. I offer my condolences to Mr Price's family and friends.

The clinical reviewer concluded that the clinical care Mr Price received at HMP The Verne was not equivalent to that which he could have expected to receive in the community.

The clinical reviewer was concerned that in the days after his positive COVID-19 test, Mr Price was not clinically assessed for four days and that NEWS-2 calculations were not consistently used, which inhibited any assessment of Mr Price's clinical deterioration. He was also concerned that the way in which oxygen saturation levels were used to determine hospital admission was out of line with national NHS guidance. We have reflected the clinical reviewer's recommendations about these issues in this report.

I am also concerned that the emergency response on 4 March did not follow prison policy and there were delays in calling an ambulance.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

Contents

Summary

Events

1. On 28 May 2014, Mr Paul Price was convicted at Worcester Crown Court of sexual offences and remanded to HMP Hewell. On 13 October, he was sentenced to an Extended Determinate Sentence (EDS) of 17 years.

2. On 1 August 2018, Mr Price transferred to HMP The Verne.

3. On 25 February 2021, Mr Price tested positive for COVID-19 and he isolated in his room. His unit was also deemed as COVID-19 positive and a significantly reduced 'outbreak' regime was introduced. Mr Price was given a machine to monitor his oxygen saturation levels and was asked to report any concerns to staff.

4. On 4 March, a Healthcare Assistant (HCA) saw Mr Price in his cell. Mr Price told her that he had a sore throat and breathlessness. His oxygen saturation was 90% and his pulse was raised.

5. That afternoon, a nurse saw Mr Price. Mr Price said he had shortness of breath. His oxygen saturation was 84%. The nurse administered oxygen to Mr Price and then assessed him. He calculated Mr Price's NEWS-2, which was 9, indicating he needed an emergency medical response. The nurse immediately asked prison staff to call an ambulance.

6. The ambulance arrived at the prison at 3.15pm. Paramedics assessed Mr Price and then took him to Dorset County Hospital. That evening, the prison contacted Mr Price's next of kin, his mother, to tell her that Mr Price was in hospital.

7. By 12 March, Mr Price's health had deteriorated in hospital and he was placed on a ventilator and sedated. On 27 March, Mr Price suffered a significant deterioration in his health, and doctors said he was unlikely to survive.

8. On 31 March, at 1.35pm Mr Price died at Dorset County Hospital with family members at his side.

Findings

9. The clinical reviewer concluded that the clinical care that Mr Price received at The Verne was not equivalent to that which he could have expected to receive in the community. He made recommendations about the care Mr Price received after he had tested positive for COVID-19, specifically on the monitoring and assessment of patients with COVID-18 and the use of NEWS-2 scores to assess for signs of a deterioration in health. He made a recommendation about the local oxygen saturation threshold used in determining when hospital admission was needed.

10. We found that on 4 March, there was a delay in calling an ambulance. While this did not contribute to his death, it was not in line with prison policy.

Recommendations

- The Head of Healthcare should ensure that the guidance given to staff about the levels of oxygen saturation that indicate significant and serious illness and the action that should be taken as a result, takes account of NHS national guidance.

- The Head of Healthcare should ensure that the policies and protocols around monitoring and assessment of patients with COVID-19 require comprehensive observations to be made, recorded, acted on and escalated appropriately.

- The Head of Healthcare should ensure that healthcare staff understand when to calculate and record NEWS-2 scores.

- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance automatically, and control room staff should call 999 immediately.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP The Verne informing them of the investigation and asking anyone with relevant information to contact them. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Price's prison and medical records.

13. NHS England commissioned an independent clinical reviewer to review Mr Price's clinical care at the prison.

14. The investigator and clinical reviewer interviewed two members of staff on 27 and 28 May. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic. Unfortunately, the audio quality of one of the interviews was so poor that it was not useable. This interview was replaced with a statement.

15. We informed HM Coroner for Dorset of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The PPO family liaison officer wrote to Mr Price's next of kin, his mother, to explain the investigation. She did not respond to our letter.

17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP The Verne

18. The Verne is a medium security prison on the Isle of Portland, with the capacity to hold 580 men convicted of sexual offences. It is managed by HM Prison Service.

19. Physical healthcare services are provided by Practice Plus Group. 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.

HM Inspectorate of Prisons

20. The most recent inspection of HMP The Verne was in February 2020. Inspectors reported that the prison was performing well in terms of safety and decency and reasonably well in rehabilitation and release planning.

21. The inspectors reported some concerns about healthcare provision. They found that many aspects of the health service were stretched and under-resourced to meet the needs of an ageing population with increasing and complex health issues.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2020, the IMB urged HM Prison Service to set up a community hospital facility at the prison.

Previous deaths at HMP The Verne

23. Mr Price was the eighth prisoner to die at The Verne since March 2019. All of the previous deaths were from natural causes (including four COVID-19 related deaths in February 2021).

24. There are similarities between our findings in this investigation and our investigation findings for several of the previous deaths where we found that long-term conditions did not have a care plan. We recommended that the Head of Healthcare should ensure that care plans for long-term conditions are appropriately stored in the correct section of SystmOne. In August 2021, the prison accepted our recommendation and said that a plan is in place to develop care plans for all patients with complex health conditions but due to the volume, this work would be undertaken over several months. We have not repeated this recommendation, but we will be looking to see evidence that it has been implemented in any future investigations.

25. We also found in this case that there was a delay in calling an ambulance. We have previously recommended that the Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. The prison again

accepted our recommendation and said that the Secondary Emergency Notification Dispatch protocol was already embedded with staff in the control room who call an ambulance as soon as a code blue or red has been raised and then start ambulance triage questions. They also said that aide memoir laminated cards were being produced to issue to all staff by April 2021 and a revised Governor's notice to staff was published in February 2021, and that medical emergencies were also being covered in Suicide and Self Harm training.

COVID-19 (Coronavirus)

26. 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.

27. 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.)

28. 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 received or returning prisoners from the main population through 'reverse-cohorting'. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

29. On 28 May 2014, Mr Paul Price was convicted at Worcester Crown Court of sexual offences and remanded to HMP Hewell. On 13 October, he was sentenced to an Extended Determinate Sentence (EDS) of 17 years.

30. On 1 August 2018, Mr Price transferred to HMP The Verne.

31. 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.

32. On 20 October, Mr Price was diagnosed with diabetes. He was prescribed medication, but a care plan was not created. In line with NHS guidelines and HMPPS national policy, The Verne offered shielding to prisoners identified as extremely clinically vulnerable. Mr Price's diagnosis placed him in the clinically vulnerable category, one below the extremely clinically vulnerable. Mr Price was therefore not offered shielding, and he did not shield.

33. On 21 February 2021, Mr Price had his first COVID-19 vaccination.

34. In late February, The Verne experienced a significant COVID-19 outbreak. On 24 February, the prison was identified by HM Prison Service and Public Health England (PHE) as a COVID-19 outbreak site, and mass COVID-19 testing began. While most residential units had some COVID-19 cases, 14 prisoners on Mr Price's unit tested positive for COVID-19 in February.

35. On 25 February, Mr Price tested positive for COVID-19 and he isolated in his room. His unit was also deemed as COVID-19 positive and a significantly reduced 'outbreak' regime was introduced. Mr Price was given a machine to monitor his oxygen saturation levels and was asked to report any concerns to staff. Healthcare staff assessed Mr Price that day and the following day. The results of the assessments were not of concern.

36. Healthcare staff calculated a National Early Warning Score (NEWS-2 - a tool to measure clinical deterioration) for Mr Price on 25 February, but after that, Mr Price was not reviewed by healthcare staff for four days. On 2 March, a nurse saw Mr Price and assessed him. Mr Price told her that he felt well, and she recorded that his oxygen saturation levels were 98%. She did not record his NEWS-2 score.

37. On 3 March, the nurse saw Mr Price again. She noted that Mr Price's oxygen levels were 91% and described this as "borderline". His pulse was also raised. She did not record his blood pressure or NEWS-2 score.

Events of 4 March

38. On 4 March, a healthcare assistant (HCA) saw Mr Price in his cell. Mr Price told her that he had a sore throat and breathlessness. His oxygen saturation was 90% and his pulse was raised. No NEWS-2 score was calculated. She referred Mr Price for review by a nurse.

39. That afternoon, a nurse saw Mr Price. He found Mr Price in his cell walking around and vaping. Mr Price said he had shortness of breath. His oxygen saturation was

84%. The nurse administered oxygen to Mr Price and then assessed him. He calculated Mr Price's NEWS-2, which was 9, indicating he needed an emergency medical response. He immediately asked prison staff to call an ambulance.

40. At 2.50pm, a prison officer rang the control room requesting an ambulance. At 2.54pm the prison control room made a 999 call and South West Ambulance Service dispatched an emergency ambulance.

41. The ambulance arrived at the prison at 3.15pm. Paramedics assessed Mr Price and then took him to Dorset County Hospital. Mr Price was escorted by two prison officers and was restrained using an escort chain. That evening, the prison contacted Mr Price's next of kin, his mother, to tell her that Mr Price was in hospital. On 5 March, the prison appointed a family liaison officer (FLO), who updated Mr Price's mother on his condition.

42. By 12 March, Mr Price's health had deteriorated in hospital, and he was placed on a ventilator and sedated. On 27 March, Mr Price suffered a significant deterioration in his health, and doctors said he was unlikely to survive.

43. On 31 March, at 1.35pm Mr Price died at Dorset County Hospital with family members at his side.

Contact with Mr Price's family

44. Following Mr Price's death, the FLO provided information and advice to Mr Price's family. In line with Prison Service policy, the prison contributed to the cost of the Mr Price's funeral.

Support for prisoners and staff

45. After Mr Price's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The prison posted notices informing other prisoners of Mr Price's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Price's death.

Post-mortem report

47. The pathologist concluded that Mr Price died of COVID-19 pneumonitis. He also had micronodular liver cirrhosis which did not cause but contributed to his death.

Findings

Clinical Findings

48. The clinical reviewer concluded that the clinical care that Mr Price received at The Verne was not equivalent to that which he could have expected to receive in the community.

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

49. The clinical reviewer found that Mr Price contracted coronavirus in prison. There was an outbreak of COVID-19 at The Verne in February 2021. The prison told us that in February and March 2021, over 200 prisoners tested positive for COVID-19. They said that running isolation regimes at The Verne was made more complex by the physical design of the units which have shared toileting and washing facilities, rather than in-cell facilities. This meant that while COVID-19 positive prisoners and other prisoners did not use the facilities at the same time, they had to share them. This made complete isolation more difficult.

50. The prison and healthcare followed national guidance on COVID-19 shielding and had a local COVID-19 outbreak management policy which was implemented in February 2021. Healthcare staff said that they had PPE policies and supplies in place from the beginning of the pandemic, although we were told that at one-point in February and March 2021 they ran out of face masks.

51. The clinical reviewer found that there were three issues with Mr Price's care once he was diagnosed with COVID-19: the use of oxygen saturation levels to determine hospital admission was out of line with national NHS guidance; Mr Price was not clinically assessed for four days after his positive COVID-19 test; and NEWS-2 calculations were not consistently used, which inhibited any assessment of his clinical deterioration.

Oxygen saturation levels and hospital admission

52. We were told in interview that healthcare staff at The Verne followed local guidance that a patient with COVID-19 would not be considered as needing hospital admission until their oxygen saturation levels fell below 90%. We were told that this advice had been provided by clinical staff from Dorset County Hospital (DCH). We have not seen written guidance from DCH to this effect.

53. National NHS guidance says that hospital admission should be considered when a patient's oxygen saturation falls below 92% and guidance should be obtained from a local respiratory physician. This concurs with guidance followed by the NHS 111 COVID-19 Assessment Service.

54. The clinical reviewer had previously conducted a clinical review following a COVID-19 death at The Verne in February 2021. In that investigation he was sent an email from clinical staff saying that guidance at that time said that hospital admission should be considered when oxygen saturation was 92%.

55. In Mr Price's case, he had two clinical assessments when his oxygen saturation fell below 92% - on 3 March and on the morning of 4 March. On both occasions no NEWS-2 score was calculated, and Mr Price was not immediately reviewed or admitted to hospital. This delayed Mr Price's admission to hospital by around 24 hours. We recommend:

The Head of Healthcare should ensure that the guidance given to staff about the levels of oxygen saturation that indicate significant and serious illness, and the action that should be taken as a result, takes account of NHS national guidance.

Clinical Reviews

56. The clinical reviewer was concerned that, after Mr Price tested positive for COVID-19, there is no record that clinical staff saw him for four days between 26 February and 2 March. We were told at interview that the frequency of healthcare visits was determined by a prisoner's COVID-19 age and the duration of their infection. Mr Price had a COVID-19 age of 76 and tested positive on 25 February. We were also told that this gap in observations was "unusual". It is unclear why no observations were completed for 26 February to 2 March. We recommend:

The Head of Healthcare should ensure that the policies and protocols around monitoring and assessment of patients with COVID-19 require comprehensive observations to be made, recorded, acted on and escalated appropriately.

NEWS-2 calculations

57. The clinical reviewer was concerned that healthcare staff did not calculate a NEWS-2 score for Mr Price when they assessed him in the days after he tested positive for COVID-19. This meant that staff did not know if his health was deteriorating and therefore what actions to take. We recommend:

The Head of Healthcare should ensure that healthcare staff understand when to calculate and record NEWS-2 scores.

Non-Clinical Findings

Emergency Response

58. PSI 03/2013, *Medical Emergency Response Codes*, requires prisons to have a medical emergency response code protocol which should trigger healthcare staff to attend immediately (if they are on duty) and control room staff to call an ambulance immediately. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. It makes it clear that there should be no delay in calling an ambulance (for example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called). The PSI also says, "It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required".

59. When a nurse assessed Mr Price in his cell on the afternoon of 4 March, he determined that Mr Price needed urgent hospital admission. He asked prison staff to ask the prison control room to call an ambulance.

60. There is no evidence that healthcare or prison staff raised this as 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) in line with policy. The use of the code blue helps control room staff to identify the urgency of the situation.

61. The control room records show that a prison officer called the control room and asked for an ambulance at 2.50pm. The control room records sent to us were redacted (for reasons we do not understand), and we were unable to see when the outgoing 999 call was logged. However, the ambulance service call log timed the call they received at 2.54pm. There was therefore a delay of up to four minutes in calling an ambulance.

62. In this case, the clinical reviewer considered that the delay did not contribute to Mr Price's death. However, in other cases, a delay of even a few minutes might make a critical difference in a medical emergency. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance automatically, and control room staff should call 999 immediately.

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