Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dewi Hughes, a prisoner at HMP Gartree, on 16 January 2022

A report by the Prisons and Probation Ombudsman

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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 Dewi Hughes died in hospital of bronchopneumonia caused by COVID-19 pneumonitis, severe liver disease and liver cancer on 16 January 2022 while a prisoner at HMP Gartree. He was 58 years old. I offer my condolences to his family and friends.

4. The clinical reviewer concluded that the care Mr Hughes received at HMP Gartree was of a satisfactory standard and equivalent to that which he could have expected to receive in the community. She was, however, concerned that after Mr Hughes returned from hospital on 6 January 2022, staff failed to take his clinical observations. We repeat her recommendation about this below. The clinical reviewer also made a number of recommendations about annual care plan reviews and updating care plans which we do not repeat in this report but which the Head of Healthcare will need to address.

5. We did not find any non-clinical issues of concern.

Recommendation

- The Head of Healthcare should ensure that clinical observations are completed for all prisoners returning from a hospital in-patient admission in order to recognise a “failed discharge’ if applicable.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Hughes' clinical care at HMP Gartree.

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

8. The Ombudsman's family liaison officer wrote to Mr Hughes' next of kin, his uncle, to explain the investigation and to ask if there were any issues he wanted us to consider. 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.

Previous deaths at HMP Gartree

10. Mr Hughes was the twelfth prisoner to die at Gartree since January 2020. Of the previous deaths, eight were from natural causes (three were due to COVID-19) and three were self-inflicted.

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.

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. 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).

14. On 17 September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield as vaccination had reduced the risk to them.

Key Events

15. On 7 August 2003, Mr Dewi Hughes was sentenced to life imprisonment for manslaughter. On 26 June 2019, he was transferred to HMP Gartree.

16. Mr Hughes had several pre-existing medical conditions, including liver disease, high blood pressure (hypertension) and asthma. At his initial and secondary health screens, healthcare staff recorded his medical conditions and continued to have regular contact with him to monitor his conditions and to arrange hospital referrals.

17. In September, healthcare staff created a hypertension care plan and scheduled his reviews. He had two reviews over the months that followed. However, no reviews were scheduled for him in 2020.

18. In December (2019), Mr Hughes was diagnosed with liver cancer, and in February 2020, he began palliative treatment.

19. On 23 March, a national lockdown was imposed due to the COVID-19 pandemic. Prison regimes were severely curtailed and face-to-face services were reduced or stopped.

2021

20. On 10 February and 12 April 2021, Mr Hughes had his COVID-19 vaccinations, and in May and July, healthcare staff completed his hypertension care plan reviews. They did not review his asthma care plan.

21. Mr Hughes was due to be released from prison on 14 December. However, there was mass COVID-19 testing at the prison and Mr Hughes tested positive. As a result, his release was postponed. Healthcare staff created a COVID-19 care plan that day and they reviewed him daily. Mr Hughes isolated in his cell until 25 December. He told healthcare staff that he preferred to remain in his cell as he still felt like he had COVID-19.

22. On 26 December, healthcare staff saw Mr Hughes because he felt unwell and was breathless. A nurse noted that he was coughing and appeared confused. She checked his observations and noted that his respiratory rate and oxygen saturations were outside of the normal range and his NEWS2 score (a tool to facilitate the early detection of deterioration) was five (which meant that he was at medium risk of clinical deterioration/sepsis). Healthcare staff arranged for his emergency transfer to hospital. Two officers escorted him, and he was not restrained.

23. Mr Hughes' release was rescheduled for 29 December (after his COVID-19 isolation period). However, he had been admitted to hospital as an inpatient at that time. Hospital staff treated him for a chest infection and COVID-19.

2022

24. On 6 January 2022, Mr Hughes returned to Gartree. Prison staff ensured that he was in reverse isolation (meaning staff wore gloves and masks when entering his cell) in his cell. Healthcare staff noted that he was "a little breathless", however, they did not take his clinical observations as they should have done.

25. On 7 January, a nurse visited Mr Hughes in his cell and checked his clinical observations. They were abnormal and his NEWS2 score was 11. She arranged for an emergency ambulance to return him to hospital. Two prison officers escorted him to hospital, and he was not restrained.

26. In hospital, Mr Hughes' condition deteriorated. On 16 January, it was confirmed that Mr Hughes had died.

27. The prison assigned a family liaison officer who contacted Mr Hughes' uncle to inform him that his nephew had died. One of the prison's care team offered support to the escort officer. A prison manager held a formal debrief. Other prison staff and prisoners were informed of Mr Hughes' death and reminded of the support available.

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 Mr Hughes' cause of death as bronchopneumonia (lung inflammation) caused by coronavirus (COVID-19) pneumonitis and hepatic encephalopathy (severe liver disease), terminal hepatocellular carcinoma and hepatic cirrhosis. Hypertension (high blood pressure) was also listed as a contributory factor.

Findings

Clinical Findings

29. The clinical reviewer concluded that overall, the healthcare that Mr Hughes received at Gartree was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

30. She was satisfied that appropriate monitoring of Mr Hughes' cancer treatment was undertaken during his time at Gartree. She also found that his hypertension care was satisfactory, but noted that he did not have any care plan reviews in 2020 and his asthma care plan was not reviewed in 2021.

31. The clinical reviewer found that when Mr Hughes returned to Gartree on 6 January 2022, healthcare staff did not check his clinical observations as they should have done. From the record of his presentation the next morning, healthcare staff correctly and quickly arranged for him to return to hospital. The clinical reviewer considered that any prisoner returning from hospital as an inpatient should have their clinical observations checked. This would have highlighted any issues of a failed discharge (when a patient requires re-admission back to hospital within 48 hours of being discharged because insufficient measures were not in place). We recommend:

    The Head of Healthcare should ensure that clinical observations are completed for all returning prisoners from a hospital in-patient admission in order to recognise a "failed discharge' if applicable.

32. The clinical reviewer made some recommendations about annual care plan reviews, which were not directly related to Mr Hughes' cause of death, but which the Head of Healthcare will need to address.

Management of Mr Hughes' risk of infection from COVID-19

33. The clinical reviewer was satisfied that healthcare staff managed Mr Hughes' risk satisfactorily and that they followed Public Health England guidance appropriately. She noted that due to Mr Hughes' cancer diagnosis, he would have been considered clinically vulnerable.

Monitoring Mr Hughes after he contracted COVID-19

34. Mr Hughes appears to have caught the COVID-19 infection at Gartree as he had not left the prison for several months.

35. We are satisfied that when Mr Hughes became unwell, healthcare staff monitored him closely and sent him to hospital as soon as his condition deteriorated.

Kimberley Bingham
Acting Prisons and Probation Ombudsman March 2023

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