

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Dennis, a prisoner at HMP Bullingdon, on 9 February 2021

A report by the Prisons and Probation Ombudsman



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



© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Nigel Dennis died in hospital on 9 February 2021 of hypoxic cardiac arrest and COVID-19 pneumonitis while a prisoner at HMP Bullingdon. He was 58 years old. I offer my condolences to Mr Dennis's family and friends.
4. The clinical reviewer concluded that Mr Dennis's clinical care at Bullingdon was equivalent to that which he could have expected to receive in the community. However, he found that there were shortcomings in identifying and informing Mr Dennis of his risk of complications from COVID-19. He made several recommendations some of which are repeated below.
5. We are concerned that prison staff used an escort chain when Mr Dennis was taken to hospital on 13 January despite his breathing difficulties, that he was a category D prisoner accompanied by two prison officers and that handcuffing him placed an escort officer at greater risk of infection.
6. One of Mr Dennis's toenails was found in his cell after his death and was sent to his family along with his possessions. This caused his family distress.

Recommendations

- The Head of Healthcare should ensure that all prisoners with conditions identified by Public Health England as at moderate or increasing their risk of serious illness if they contract COVID-19 are informed of this and this is recorded in their medical record.
- The Governor and Head of Healthcare should ensure that:
 - all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints; and
 - healthcare staff always complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.
- The Governor should share this report with the manager who authorised the restraints and discuss the Ombudsman's findings with them.

- The Governor should:
 - write to Mr Dennis's family and apologise for the distressed caused; and
 - ensure that the possessions being returned to a prisoner's family following a death in custody are appropriate and in line with PSI 64/2011.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Dennis's clinical care at HMP Bullingdon.
8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Dennis's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
9. The Ombudsman's family liaison officer wrote to Mr Dennis's next of kin, his daughter, to explain the investigation. She raised a number of questions about Mr Dennis's management and care at Bullingdon. We have addressed her questions in this report and the clinical review.
10. Mr Dennis's family received a copy of the initial report. The solicitor representing them wrote to us pointing out an omission. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
11. The initial report was shared with the Prison Service as part of the consultation process. The Prison Service objected to the wording of the first recommendation. This recommendation has been amended.
12. The Prison Service also objected to the recommendation about risk assessments for employment for prisoners with complex medical needs. We have amended our report to acknowledge and take account of that further information.

Previous deaths at HMP Bullingdon

13. Mr Dennis was the tenth prisoner to die at Bullingdon since February 2019. Of the previous deaths, five were from natural causes, two were self-inflicted, one was drug-related, and one was unascertained. Since Mr Dennis's death, there has been one COVID-19 related death (in September 2021).

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, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
15. 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.)

16. 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).
17. On 17 September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield. This was on the basis that vaccination had reduced the risk to them.

Parole Board

18. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Indeterminate Public Protection Sentences (IPP)

19. Sentences of Imprisonment for Public Protection (IPPs) were created by the Criminal Justice Act 2003 and started to be used in April 2005. Indeterminate public protection sentences were intended to protect the public against offenders whose crimes were not serious enough to merit a life sentence but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.
20. IPP sentences were abolished in 2012, but IPP prisoners sentenced before that continue to serve their sentences and will only be released when the Parole Board is satisfied that they no longer pose a risk to the public. People released on an IPP sentence remain subject to recall indefinitely if they breach their licence conditions. Those recalled must again convince the Parole Board that they are safe to be released.

Key Events

21. In 2008, Mr Nigel Dennis received an indeterminate sentence for public protection for robbery and possession of a bladed article. The Parole Board granted his release on licence in 2018. He was recalled to prison in October 2018, after he tested positive for Class A drugs. He was then released again in July 2019 but recalled in July 2020, after he allegedly committed a further offence and displayed poor behaviour. On 9 July 2020, Mr Dennis was sent to HMP Bullingdon. He was categorised as a category D prisoner (the lowest security category).
22. On arrival at Bullingdon, Mr Dennis had a reception medical screen which noted his medical history. Mr Dennis had schizophrenia and type 2 diabetes. Healthcare staff contacted his community mental health in-reach team and community GP to obtain information about his medications. They continued his prescription for anti-psychotic, anti-depressant, diabetic and cholesterol lowering medications. He also received pain relief and physiotherapy for back pain which had been ongoing for 25 years. Healthcare staff noted that Mr Dennis had good control of his diabetes. They advised him to lose weight as he was clinically obese and gave him smoking cessation advice.
23. In March, Bullingdon went into lockdown due to the COVID-19 pandemic and they implemented a special regime. The Head of Healthcare said that prisoners were given information about protection measures (handwashing and advice on reporting symptoms). She said that every effort was made to mitigate risk, for example by not mixing the wings, wearing face masks and coverings and increased hand hygiene. Newly arrived prisoners were allocated to Reverse Cohorting Units for up to 14 days. Mr Dennis isolated in the Reverse Cohorting Unit until 23 July.
24. On 10 July, Mr Dennis was identified as being in the at low risk category for risk of complications from COVID-19. The Head of Healthcare said that Mr Dennis was not on a shielding list as he did not fall into the extremely clinically vulnerable category. He worked in the prison laundry (at his request).

Events from January 2021

25. On 13 January 2021, Mr Dennis became unwell while working in the laundry. He returned to his cell. Wing staff called healthcare to visit him in his cell and asked a nurse to assess him. The nurse noted that Mr Dennis looked very sweaty and short of breath. His blood oxygen saturation level was 86% (the normal range in a healthy person is 95-100%) so she gave him oxygen. She used the National Early Warning Score (NEWS) 2 tool, which calculated an initial score of 8, which increased to 9. (NEWS2 identifies clinical deterioration. A total score of 7 or over suggests high risk and requires emergency assessment by a critical care team.) The nurse requested an urgent ambulance as she suspected Mr Dennis had COVID-19. She did not have time to complete a COVID-19 test as the ambulance had already arrived.
26. Records show that an ambulance was called at 2.35pm. The ambulance service advised there would be a delay as an ambulance had been diverted. Paramedics arrived at 3.50pm. They took Mr Dennis to John Radcliffe Hospital, Oxford. Mr Dennis was escorted by two prison officers wearing PPE and was restrained using

an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

27. When Mr Dennis arrived at the hospital he was assessed and admitted to a ward. The bedwatch log says that there were two officers beside his bed and one of the officers was handcuffed to him. The restraints were removed in the early hours of 14 January and were never reapplied. Hospital tests confirmed that Mr Dennis was COVID-19 positive. The bedwatch log noted that on 16 January the prison escort officers requested PPE from the prison managers.
28. Healthcare staff obtained regular updates from the hospital and escort officers. Mr Dennis was noted to be in a stable condition and received ventilation and high oxygen treatment.
29. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The Governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff. The Governor granted Mr Dennis ROTL on 16 January.
30. On 17 January, Mr Dennis moved to the Cardiothoracic Intensive Care Unit (ICU) in the hospital as his condition had deteriorated. The escort officers remained outside the ICU. He was sedated and placed on a ventilator. By 7 February it was noted that Mr Dennis was not making progress and had developed septicaemia.
31. Mr Dennis died in hospital on 9 February 2021.

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 Dennis's cause of death as hypoxic cardiac arrest (following endotracheal tube change) and COVID-19 pneumonitis. Mr Dennis also had schizophrenia and type 2 diabetes, which did not cause but contributed to his death.

Contact with Mr Dennis's family

33. Bullingdon appointed a family liaison officer (FLO) and a deputy FLO. The deputy FLO telephoned Mr Dennis's next of kin on 14 January to tell her that he was in hospital. The FLO rang her the next day and provided frequent updates on Mr Dennis's condition.
34. Under normal circumstances the next of kin should, wherever possible, be informed of a death in person by a FLO. However, due to the COVID-19 restrictions the FLO informed Mr Dennis's next of kin of his death by telephone. He offered his condolences and ongoing support.
35. In line with Prison Service instructions, the prison contributed towards the costs of Mr Dennis's funeral.

Events after Mr Dennis's death

36. Two officers cleared Mr Dennis's belongings from his cell. They made a list of the items they had removed which included "1 removed toenail". Mr Dennis's belongings were placed in two bags and sealed. The prison arranged for Mr Dennis's belongings to be returned to his next of kin.

Findings

Clinical Findings

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

37. The clinical reviewer concluded that Mr Dennis's care at Bullingdon was good and equivalent to that which he could have expected to receive in the community.
38. The clinical reviewer noted that, in line with HMPPS guidelines, Mr Dennis was required to isolate for 14 days when he first arrived at Bullingdon and was checked daily during this period.
39. At the beginning of the pandemic, prisons were expected to identify prisoners at risk of serious illness if they contracted COVID-19 and provide them with the opportunity to shield. The clinical reviewer found that healthcare staff incorrectly identified Mr Dennis as being at low risk of complications if he contracted COVID-19.
40. The clinical reviewer considered that with his history of diabetes, schizophrenia, obesity and race, Mr Dennis should have been considered at moderate risk, in line with the government guidance and the assessment criteria. However, the clinical reviewer said that Mr Dennis's race and obesity would not have been sufficient reasons to increase his risk status to high (clinically extremely vulnerable). He also said that, as Mr Dennis was not in a high risk group, he would not have been advised to shield in the community.
41. We agree with the clinical reviewer that it would be prudent for the Head of Healthcare to review the process to ensure that there is no systemic problem with the arrangements for identifying and informing prisoners of their risk of complications due to COVID-19 infection. We recommend:

The Head of Healthcare should ensure that all prisoners with conditions identified by Public Health England as increasing their risk of serious illness if they contract COVID-19 are informed of this and this is recorded in their medical record.

Mr Dennis's employment

42. Mr Dennis's family asked why he was working in the laundry if he should have been 'shielding'.
43. As Mr Dennis was not in the high risk group, he would not have been advised to shield. The clinical reviewer said that people in the moderate risk category were not automatically advised to stop working, but employers were encouraged to make risk assessments on an individual basis and, where possible, make suitable adaptations to their work or working environment to reduce risk.
44. The Head of Healthcare told us that all prisoners were given information about COVID-19, including advice on how to protect themselves, for example, handwashing. (As Mr Dennis had been recorded as being at low risk, he would not have been informed about the increased risk he had due to his medical conditions

and ethnicity. However, the advice on reducing risk would have been the same for both the moderate and low risk groups.)

45. The staff who gave Mr Dennis work in the prison laundry told the investigator that they were not aware of any special arrangements during the pandemic and that they had followed the standard policies on allocation for work. However, they said that all prisoners at work were required to wear fluid resistant surgical masks (a grade of facemask that is commonly used in most clinical settings).

Response when Mr Dennis became unwell

46. When Mr Dennis became unwell, Bullingdon was in lockdown and operating a restricted regime (there was an outbreak of 77 positive cases of COVID-19 among prisoners). Prisoners who tested positive were required to isolate in line with HMPPS guidelines.
47. When prison staff discovered that Mr Dennis was feeling unwell with possible COVID-19 symptoms in January 2021, they took immediate steps to check and isolate him. Healthcare staff took his clinical observations and arranged for his urgent transfer to hospital.
48. We are satisfied that the prison implemented appropriate measures to help control the risk of infection and protect prisoners. Mr Dennis was managed in line with national requirements and staff were quick to respond to the rapid and significant deterioration in his health on 13 January.
49. The incubation period for COVID-19 is thought to be up to 14 days and Mr Dennis had not left the prison within that period. We, therefore, assume that he contracted the virus at Bullingdon, notwithstanding the measures that had been put in place.

Restraints, security and escorts

50. We are concerned that when Mr Dennis was taken to hospital on 13 January, he was restrained by an escort chain and that he remained restrained until 14 January.
51. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
52. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. These requirements are reflected in Prison Service Instruction (PSI) 33/2015 on external prisoner movements.
53. Mr Dennis was category D prisoner on the enhanced level of the incentives scheme, who was recognised as cooperative with staff, with no intelligence information, no recent adjudications and no problems during previous hospital visits.

Mr Dennis was assessed as medium risk to the public, hospital staff, hostage taking, escape potential and likelihood of outside assistance.

54. The medical section of the risk assessment was ticked to say that there were no medical reasons to prevent normal handcuffing of Mr Dennis; no reason why he should not remain handcuffed during his hospital admission; and that the removal of the restraints for treatment or consultation was not required. No information was recorded about his medical condition at the time or to alert staff to the possibility of contact with a suspected COVID-19 patient.
55. We recognise that many factors have to be taken into account in determining the level of restraints. However, we are concerned that the medical opinion did not adequately reflect Mr Dennis's poor condition at the time and how this impacted on his risk. We also find it difficult to understand how Mr Dennis was assessed as a medium risk in all the risk categories, given his security categorisation, age and poor mobility. We question whether the use of the escort chain was proportionate when Mr Dennis was admitted to hospital, given that he was sufficiently ill to require an emergency ambulance and was struggling to breathe. We question whether he had the ability to escape, particularly as he was accompanied by two prison officers and his condition was deteriorating. Consequently, we consider that the authorising manager's decision to use restraints was flawed.
56. We are concerned that handcuffing Mr Dennis en route to the hospital, prior to and after his admission, needlessly placed the escort officers at greater risk of contracting COVID-19. We recommend:

The Governor and Head of Healthcare should ensure that:

- **all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints; and**
- **healthcare staff always complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.**

The Governor should share this report with the manager who authorised the restraints and discuss the Ombudsman's findings with them.

Family liaison and returning Mr Dennis's property

57. Mr Dennis's next of kin received his property which included his toenail. She said she found this disgusting and very distressing. The next of kin asked the investigator why Mr Dennis was told to keep it and asked if he had been given any medical assistance. She also asked, as it was very visible in the property bag, why the toenail was sent to her with all his possessions.
58. The investigator contacted the prison to ask why this had happened. We do not know why Mr Dennis had kept the toenail in his cell. The prison's FLO said that all of Mr Dennis's property was packed together. Staff had seen the container with the toenail and decided it should be included as "some families want all things that

remind them of the deceased [and] this allows the next of kin to make a decision of what they want to keep or throw away”.

59. We consider that the decision to send the toenail showed a lack of respect for Mr Dennis and his family and that the prison should have checked with the family before sending it. The FLO apologised and said that in future the prison will ensure that relatives are asked about more intimate items before they are sent on. We recommend:

The Governor should:

- **write to Mr Dennis’s family and apologise for the distressed caused; and**
- **ensure that, the possessions being returned to a prisoner’s family following a death in custody are appropriate and in line with PSI 64/2011**

Comments received after the initial report

60. The Prison Service and their Healthcare partner objected to two recommendations in the initial report.
61. Healthcare managers did not agree with our finding and recommendation in relation to Mr Dennis’s level of risk of serious illness if he contracted COVID-19 and possible options. The Head of Healthcare at Bullingdon stated that:
- “At the time of Mr D’s death, there was no requirement for those at risk of harm from COVID-19 to shield. In HMP Bullingdon, all men were informed of their options and all men were advised, in a variety of ways, of the risks of contracting COVID-19 and steps that could be taken to protect themselves such as handwashing and reporting symptoms. If the concern is that there was no information about Mr D’s risk status on his medical record, or no information detailing that he had been spoken to about his risk, then the recommendation would benefit from being reworded to reflect that and the specific reference to shielding removed. It’s also worth noting that the categorisation of a person’s risk level was not made by the healthcare team but automatically on SystmOne, something that has been identified and raised.”
62. The issue was escalated through senior managers at Health and Justice South East who agreed with the Head of Healthcare. We concluded that the recommendation was relevant but that we would remove the reference to shielding. This has now been amended.
63. In the initial report, the second recommendation said that:
- The Governor and Head of Healthcare should ensure that prisoners who are classified as at moderate risk of infection from COVID-19 have a risk assessment of their suitability for particular types of work.
64. The Head of Healthcare objected to the recommendation and the matter was escalated through the Prison Service and NHS England and NHS Improvement.

The National Quality and Patient Safety manager – Health and Justice NHS England and NHS Improvement said that:

“At the time of Mr D’s death, employers were encouraged to make risk assessments on an individual basis and ‘where possible’ make suitable adaptations to their work or working environment to reduce risk. The choice to continue working would have been Mr D’s. HMP Bullingdon had made it a requirement that all men at work had to wear fluid resistant surgical masks to reduce risk (the type used in clinical settings) so it appears they had indeed made an adjustment, albeit minor, to reduce risk and the Head of Health and Justice, South East and I agree this recommendation should be removed.”

65. The Prison Service said it was their view that staff acted appropriately. We are disappointed that healthcare managers did not agree that a prisoner’s health can impact on decisions about employment. The prison staff who make those final decisions had said they were unaware of any special arrangements during the pandemic. We accept that during the pandemic the Prison Service has had to grapple with risks and procedures they were not previously forced to consider. It is clear that Mr Dennis had complex health needs. Just as the Prison Service already has risk assessments for in-possession medication and the use of restraints, we are disappointed that they refused to accept arrangements to assist with the allocation process for work for those prisoners in this vulnerable group.
66. We found the prison’s approach to the investigation, in particular the provision of supporting documentation and explanation of the identified deficits to the investigator, disappointing.
67. Mr Dennis’s family solicitor also had comments. They queried whether Mr Dennis should have been on a shielding list and if he had been correctly categorised as clinically vulnerable. In separate correspondence we have said that nationally, the only prisoners advised to shield were those in the extremely clinically vulnerable group. We have therefore amended paragraph 24.

Inquest conclusion

68. The inquest into Mr Dennis’s death took place on 20 April 2023, and the Senior Coroner’s narrative conclusion said that Mr Dennis died from hypoxic cardiac arrest (following endotracheal tube change), caused by COVID pneumonitis. He also had schizophrenia and type 2 diabetes mellitus.
69. The Senior Coroner’s narrative said that in hospital there was a problem with a connector on his breathing tube, resulting in it dislodging and tape was used to secure it in place. On 9 February, during an attempt to change the endotracheal tube, Mr Dennis suffered severe hypoxia and cardiac arrest resulting in his death.

Sue McAllister CB
Prisons and Probation Ombudsman

July 2022

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

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

T | 020 7633 4100