Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Williams, a prisoner at HMP Birmingham, on 16 January 2022

A report by the Prisons and Probation Ombudsman

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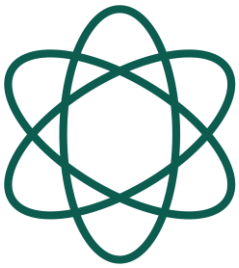
Our vision

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 John Williams died in hospital on 16 January 2022, while a prisoner at HMP Birmingham. He was 75 years old. Mr Williams died from COVID-19 pneumonia. He also had heart disease and diabetes. I offer my condolences to those who knew him.

4. Mr Williams tested positive for COVID-19 in hospital, less than 12 hours after his remand to Birmingham. Therefore, he seems to have contracted the infection in the community.

5. The clinical reviewer concluded that the clinical care Mr Williams received at Birmingham was equivalent to that which he could have expected to receive in the community. However, she found that he did not receive a COVID-19 test when he arrived at Birmingham and his vaccination status was not recorded. She also had concerns about record keeping.

6. Mr Williams was a wheelchair user. Given his advanced age, restricted mobility and poor state of health, we consider that the use of restraints was not proportionate to his risk. The inappropriate use of restraints is an issue we have raised with Birmingham before.

7. We are concerned that this is the third recent investigation in which the prison has failed to provide significant evidence documents.

Recommendation

- The Head of Healthcare should ensure that, in line with national policy, all prisoners are tested for COVID-19 during the reception procedures; and their vaccination status is recorded.

- The Head of Healthcare should carry out a record keeping audit; ensure that all healthcare staff are aware of the required standard of record keeping; and identify any learning needs.

- The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

- The Governor should ensure that documents are retained, securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Williams' clinical care at HMP Birmingham.

9. The PPO investigator investigated the non-clinical issues, including Mr Williams' location; and the security arrangements for his journey and admission to hospital.

10. Mr Williams' next of kin could not be traced.

11. 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 Birmingham

12. Mr Williams was the 10th prisoner to die at Birmingham since January 2020. Of the previous deaths, eight were from natural causes (including one with COVID-19) and one was self-inflicted. There have since been three deaths from natural causes (none were due to COVID-19), two self-inflicted deaths and one homicide. We have previously raised concerns about the inappropriate use of restraints and making documents available to PPO investigators.

COVID-19 (coronavirus)

13. 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.

14. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. In response to the pandemic, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain outbreaks - to be implemented at local level, depending on the needs of individual prisons. (A key strategy was '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.)

15. In September 2021, the shielding programme ended in the community, but HMPPS continued to routinely offer shielding to clinically high-risk prisoners. This has recently been replaced by a system of individual risk assessments by clinical staff, to determine the measures necessary to support such prisoners. The agreed adjustments are documented in a Personal Management Plan, which is then facilitated by operational staff.

Key Events

16. Mr John Williams was remanded to prison on 21 November 2015. He was later convicted of sexual offences and sentenced to 12 years imprisonment. Mr Williams was released on licence on 19 November 2021 and moved into approved premises (supervised accommodation for offenders).

17. Mr Williams agreed to comply with the approved premises rules, including taking prescribed medication and accepting medical treatment for his underlying medical conditions. On 21 November, he reported heart palpitations and was taken to hospital. Against medical advice, he discharged himself before the necessary tests took place. Staff then checked him every two hours for several days. On 22 November, his offender manager warned him that his place could be withdrawn if he failed to adhere to the conditions about his health.

18. On 3 January 2022, Mr Williams appeared unwell. Again, he persistently refused to comply with staff and NHS 111 advice about taking medication. His welfare checks were increased to half-hourly, but his condition appeared to worsen. Paramedics attended and Mr Williams said that his actions had been deliberate, to make staff "run around" after him. He remained non-compliant. On 4 January, the approved premises manager decided to withdraw his place as they could not safeguard his health and wellbeing, and his actions limited the resources available to support other residents. He was therefore recalled to prison.

19. Mr Williams arrived at HMP Birmingham early evening on 6 January. At an initial health screen, his medical conditions were recorded as ischaemic heart disease, type 2 diabetes, high blood pressure and obesity. He was also noted to be at high risk of complications from COVID-19. Due to reduced mobility, Mr Williams used walking aids and a wheelchair. He was allocated a single cell in the healthcare centre.

20. Over the next few hours, a nurse completed several assessments. At 10.11pm, she became concerned that Mr Williams seemed drowsy and confused. He also had raised ketone levels (which can be life-threatening for diabetics). The nurse calculated a National Early Warning Score 2 (NEWS2) of 0. (NEWS 2 is an assessment tool which helps to identify clinical deterioration in acutely unwell patients.) She also consulted the senior night nurse and a GP, who advised further monitoring.

21. Both nurses reviewed Mr Williams at 12.40am on 7 January. They found that his blood oxygen saturation level was low and reducing, so they gave him oxygen. He was still confused, short of breath and had a cough, so they suspected he might have COVID-19. His overall NEWS2 score had increased to 5, which requires an urgent assessment by a clinician qualified in the care of acutely ill patients. The nurses arranged for Mr Williams to be taken to Birmingham City Hospital, by emergency ambulance. He left the prison at 2.30am and was escorted by two prison officers, using restraints.

22. At around 4.40am, a prison nurse spoke to the escort officers, who told her that Mr Williams had tested positive for COVID-19. At 10.25am, the officers contacted the

prison to ask for the restraints to be temporarily reduced to an escort chain only, to facilitate treatment.

23. At 9.00am on 9 January, the escort officers saw that Mr Williams' handcuffed arm was blistered, the other arm was swollen and he could not move his body. At their request, the duty governor allowed removal of the restraints.

24. On 11 January, the hospital informed healthcare staff that Mr Williams' condition had worsened and it had been agreed that resuscitation would not be attempted if his heart or breathing stopped.

25. Prison staff tried to obtain details of Mr Williams' next of kin through several sources, including his solicitor, community GP and probation officer. They found that his family had moved abroad, with no forwarding address.

26. On 13 January, the Governor approved a special purpose licence for temporary release, due to Mr Williams' failing health. This allowed the escort to be reduced to one officer.

27. Mr Williams died on 16 January. The prison arranged and paid for his funeral.

Cause of death

28. No post-mortem examination was held as HM Coroner accepted the hospital's clinical certification that the cause of Mr Williams' death was COVID-19 pneumonia. He also had ischaemic heart disease and type 2 diabetes, which did not cause, but contributed to his death.

Findings

29. We are satisfied that Mr Williams' recall to prison was justified, as he failed to comply with the approved premises rules, a condition of his residency. He only spent around ten hours at Birmingham before his admission to hospital. Therefore, the investigation focussed on the reception procedures, monitoring of his symptoms of illness and communication between the hospital and the healthcare team.

Clinical Findings

30. The clinical reviewer concluded that Mr Williams received a good standard of clinical care at Birmingham, equivalent to that which he could have expected to receive in the community. However, she made two recommendations which are reflected below.

Reception COVID-19 tests

31. The national guidance on managing COVID-19 is set out in Preventing and controlling outbreaks of COVID-19 in prisons and places of detention. It states that all new prisoners should be tested for COVID-19 on reception and separated from existing residents for up to ten days.

32. When Mr Williams arrived at Birmingham, healthcare staff identified that he was at high risk of complications from COVID-19. Due to health and mobility problems, he was immediately accommodated in the prison's inpatient unit and therefore had no contact with the main prison population.

33. The clinical reviewer noted that healthcare staff did not confirm Mr Williams' vaccination status, or carry out the required COVID-19 test. We recommend:

    The Head of Healthcare should ensure that, in line with national policy, all prisoners are tested for COVID-19 during the reception procedures; and their vaccination status is recorded.

34. As Mr Williams was unwell when he arrived at Birmingham and tested positive for COVID-19 in hospital less than 12 hours later, it seems that he contracted the virus in the community.

Clinical record keeping

35. A nurse closely monitored Mr Williams. She used formal assessment methods and sought advice from senior staff, as necessary. Although record keeping was generally good, the clinical reviewer noted that the names of clinicians consulted were not always recorded. We recommend:

    The Head of Healthcare should carry out a record keeping audit; ensure that all healthcare staff are aware of the required standard of record keeping; and identify any learning needs.

Security risk assessments and the use of restraints

36. 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.

37. 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. This guidance is reinforced in Prison Service Instruction 33/2015 External Escorts, which states that handcuffs will not normally be necessary if a prisoner's mobility is severely limited, for example due to advanced age or disability, unless the prison has grounds to believe that an escape might be made with external assistance.

38. Despite several requests, the prison was unable to provide either the security risk assessment or person escort record for Mr Williams' journey and admission to hospital. Therefore, we do not know the level of restraints used. From the information in the escort log, we deduce that it was at least single handcuffs and possibly double handcuffs (comprising single handcuffs and an escort chain). The restraints were briefly reduced to an escort chain only, for treatment and finally removed over 48 hours after Mr Williams had arrived at hospital.

39. We are not satisfied that the use of restraints was justified, given Mr Williams was a category C, older prisoner and a wheelchair user, with no family contacts to plan or assist an escape. If double handcuffs were used, this needlessly placed the escort officers at greater risk of infection from being physically closer to someone confirmed to be COVID-19 positive.

    The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

Provision of supporting evidence

40. Prison Service Instruction 58/2010, The Prisons and Probation Ombudsman (PPO) states that the PPO must have unfettered access to documents for investigations. Despite several requests, the prison was unable to provide the security risk assessment and person escort record for Mr Williams' journey and admission to hospital. There were also delays in providing some of the other documents. We are concerned that this is the third recent investigation in which there have been delays or failures to provide key documents. We recommend:

The Governor should ensure that documents are retained, securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

Inquest

41. At the inquest, heard on 14 July 2022, the Coroner concluded that Mr Williams died from natural causes.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2023**

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