Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Thompson, a prisoner at HMP Doncaster, on 10 April 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

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.

The Ombudsman's 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 Neil Thompson died in hospital on 10 April 2022, while a prisoner at HMP Doncaster. He was 73 years old. The cause of his death was bronchopneumonia, as a result of chronic emphysema. I offer my condolences to Mr Thompson's family and friends.

The clinical reviewer considered that the management of Mr Thompson's chronic health conditions was equivalent to that which he could have expected to receive in the community. However, she found that healthcare staff sometimes used the incorrect scale for assessing respiratory failure and considered that Mr Thompson's acute clinical deterioration should have been recognised sooner. These aspects of his care were not equivalent to the standard expected.

It is worrying that staff appear not to have fully considered the impact of Mr Thompson's reduced mobility, weakened condition and low security risk in their decision to use restraints. I am concerned that parts of the risk assessment process are poorly understood.

I am also concerned that the prison delayed notifying Mr Thompson's next of kin of his admission to hospital until he was close to end-of-life care. This reduced the opportunity for meaningful contact before his death.

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

Caroline Mills
Acting Deputy Prisons and Probation Ombudsman October 2022

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Summary

Events

1. On 28 May 2021, Mr Neil Thompson was sentenced to three years and nine months imprisonment for sexual offences and sent to HMP Doncaster.

2. Mr Thompson's health conditions included chronic obstructive pulmonary disease (COPD, a lung condition), heart disease, diabetes and chronic kidney disease. He also had limited mobility. Healthcare staff created care plans and managed him under the multidisciplinary complex care procedures. Mr Thompson's health deteriorated over the following months. He lost weight and had falls.

3. On 18 March 2022, Mr Thompson tested positive for COVID-19. He was placed in protective isolation and received clinical checks twice a day.

4. On 30 March, after a meeting with Mr Thompson, a prison key worker raised concerns about him with healthcare assistants in his unit. Just after midday, a healthcare assistant attended to take clinical observations, but Mr Thompson would not cooperate when she tried to check his pulse and blood oxygen level. At around 3.30pm, a nurse conducting welfare checks saw that he was very unwell. He was sent to hospital, escorted by two prison officers and initially restrained with an escort chain, which was removed after around 30 minutes.

5. Mr Thompson's family was informed that he was in hospital on 8 April. End-of-life care began the following day. Mr Thompson died from bronchopneumonia caused by chronic emphysema on 10 April. Although he tested positive for COVID-19, this was not cited as a cause of or contributory factor to his death.

Findings

6. The clinical reviewer concluded that the management of Mr Thompson's long-term medical conditions was of a good standard. However, there was a failure to recognise a significant deterioration in his health and this aspect of his care was not equivalent to that which he could have expected to receive in the community.

7. Although healthcare staff consistently used the National Early Warning Score 2 assessment tool, they sometimes failed to use the dedicated scale for patients with respiratory conditions. Use of the incorrect scale could lead to inappropriate or harmful clinical management.

8. There was a lengthy delay in responding to the dormitory's cell bell when Mr Thompson had a fall on 16 February. Cell bells should be answered promptly, particularly in a unit of clinically vulnerable men.

9. The information in the medical section of the security risk assessment for Mr Thompson's last journey to hospital was contradictory and did not fully reflect his poor condition. We are not satisfied that the use of restraints (albeit for a short period) was justified, given Mr Thompson's age, low security risk and reduced mobility, which had been further impaired by his acute illness.

10. There is no evidence that Mr Thompson's family was informed that he had contracted COVID-19. His partner was not told that he was seriously ill in hospital until end-of-life care was proposed. Given Mr Thompson's high risk of complications, we consider that Doncaster should have notified his family as soon as he was admitted to hospital.

Recommendations

- The Head of Healthcare should ensure that healthcare staff are fully competent in applying the National Early Warning Score 2 (NEWS2) and use the appropriate scale for assessing patients with respiratory conditions. This should be reviewed to check compliance.
- The Head of Healthcare should ensure that healthcare staff are trained to recognise signs of clinical deterioration in patients who are unwell.
- The Director should ensure that staff respond to cell bells within five minutes, unless there are exceptional circumstances.
- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:
    - healthcare staff contributing to escort risk assessments accurately reflect the prisoner's mobility, current clinical condition and impact on their ability to escape unaided; and
    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.
- The Director should ensure that if a prisoner is suspected of contracting, or tests positive for COVID-19, he is given the opportunity for someone to be notified.
- The Director should ensure, in line with national policy, that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

The Investigation Process

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

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

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

14. We informed HM Coroner for South Yorkshire East District of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Thompson's partner to explain the investigation and to ask if she had any matters to be considered. Mr Thompson's partner had concerns about Mr Thompson's physical condition, diet and weight loss. She believed this had caused weakness and falls. She was also concerned that the prison had delayed informing her that Mr Thompson was in hospital until he was close to death.

16. Mr Thompson's partner received a copy of the initial report. She expressed concerns about the findings.

17. We shared the initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan has been annexed to this report.

Background Information

HMP Doncaster

18. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 remanded or convicted male prisoners. Practice Plus Group provides clinical services. The prison directly employs qualified paramedics as part of the healthcare team, and they respond to emergency calls in the prison.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Doncaster was in February and March 2022. Inspectors reported that the prison was very well run, with proactive and supportive staff. There was a strong healthcare leadership team, robust clinical governance and a regular, comprehensive clinical audit schedule. Healthcare policies were up to date and there were plans to discuss themes from deaths in custody at regular staff training events from March 2022.

20. Inspectors noted that there were detailed records of patients' care and treatment and they observed compassionate, empathetic interactions. A range of primary care clinics were in place and a long-term conditions nurse had been appointed. Healthcare and operational staff had positive relationships with each other and external services.

21. Inspectors found an improvement in responding to cell bells, which had been a concern at the previous inspection. Around 75% had been answered within five minutes, which was higher than at similar prisons.

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. There is no recent IMB report for HMP Doncaster.

Previous deaths at HMP Doncaster

23. Mr Neil Thompson was the seventeenth prisoner at Doncaster to die since April 2020. Of the previous deaths, nine were from natural causes (three due to COVID-19), four were self-inflicted and three were drug-related. There have since been three further deaths, two from natural causes and one self-inflicted. We have previously raised concerns around the need for correct use of the NEWS2 clinical assessment tool; responding to cell bells promptly; and informing next of kin when a prisoner is seriously ill.

COVID-19 (coronavirus)

24. 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.

25. 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.)

26. In September 2021, the shielding programme ended in the community, but HMPPS continued to offer shielding to clinically high-risk prisoners routinely. 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

27. Mr Neil Thompson was convicted of sexual offences. On 28 May 2021, he was sentenced to three years and nine months in prison and sent to HMP Doncaster.

28. During the COVID-19 pandemic, newly arrived prisoners were isolated from the main population for up to 14 days. As it was sometimes difficult to gain access to those isolating, Mr Thompson's initial and secondary health screens were completed on the same day. (This practice has since ended.)

29. Mr Thompson had several longstanding physical and mental health conditions, including COPD, Type 2 diabetes, heart disease, chronic kidney disease, high cholesterol and bipolar disorder. Due to impaired mobility, he used a wheelchair or walking frame for longer distances.

30. Healthcare staff created care plans for Mr Thompson's long-term conditions and reviewed him regularly. They also referred him to heart, kidney and respiratory consultants and placed him on the complex care register, to be discussed at weekly Multi-Professional Complex Care Caseload (MPCCC) meetings. (Care plans for social care, falls and COVID-19 were later added.)

31. On 7 June, Mr Thompson was identified as at high risk of developing complications from COVID-19, due to his COPD. He had received his first and second COVID-19 vaccinations in the community (and was given a booster in prison in December 2021).

32. As an older prisoner with complex health needs, Mr Thompson moved to the social care unit after completing the reception isolation period. Several protective measures were in place to reduce the risk to the clinically vulnerable prisoners, including restricted access to the unit, a modified regime and limited time out of cells when there was a significant increase in COVID-19 infections.

33. Mr Thompson lost a significant amount of weight during his first six months in prison. This was partly attributed to a reduced appetite due to worsening COPD and falls in September and November. Healthcare staff assessed him with a nutritional screening tool, provided a soft diet and protein supplements and monitored his intake using food and fluid charts.

34. Mr Thompson's prison key worker, a Prison Custody Officer (PCO), knew about his health needs and that his medical problems restricted his appetite. Entries in Mr Thompson's NOMIS personal records noted that he was frail and poorly but was eating small amounts. If he found certain meals unsuitable, alternatives were offered and a healthcare assistant sometimes made soup and toast, which he had appreciated. Mr Thompson later said that he preferred to have food from the servery. Mr Thompson's key worker pointed out that this meant an element of 'pot luck' with choices but Mr Thompson was content.

Deterioration in Mr Thompson's health

35. On 16 February 2022, Mr Thompson fell while getting out of bed and another prisoner in the dormitory pressed the cell bell to alert staff. Healthcare staff

examined him and monitored his pain. It was noted that he became weaker. Mr Thompson refused to attend an X-ray that had been arranged to determine whether there had been any unseen injuries from the fall.

36. During mass testing on 18 March, Mr Thompson tested positive for COVID-19. Healthcare staff created a COVID-19 care plan and took clinical observations twice a day during his 10-day protective isolation period.

37. Late in the evening of 20 March, a nurse found that Mr Thompson had breathing difficulties and a low blood oxygen saturation level. He was unable to sustain a normal level despite receiving additional oxygen. The nurse calculated a National Early Warning Score 2 (NEWS2) of 4, which indicated that Mr Thompson required urgent review for acute illness. (NEWS2 is a clinical assessment tool to identify critical illness and deterioration.)

38. Mr Thompson was sent to hospital, where an X-ray showed that his breathing problems were due to worsening COPD and COVID-19. He was discharged in the early hours of 21 March, with a prescription for antibiotics and steroids.

39. On 26 March, a prisoner in the dormitory told a healthcare assistant that Mr Thompson's behaviour at times suggested that he might be confused. Healthcare staff saw no signs of this during clinical checks but took a urine sample to be tested.

40. Sometime between 8.00am and 8.45am on 30 March, Mr Thompson's key worker held a key worker session with him in which they mostly spoke about his health. Other prisoners had told the key worker that Mr Thompson made a lot of noise at night, due to his respiratory problems. Mr Thompson said he felt unwell and thought he was going to die soon. Mr Thompson's key worker discussed his comments with the healthcare assistants and the consensus was that there were no immediate concerns, but he seemed to be giving up. The healthcare assistants and prison carer had encouraged him to eat but had found uneaten food and snacks when cleaning. Mr Thompson's key worker noted that healthcare and unit staff were aware of and monitoring Mr Thompson's problems.

41. At lunchtime, a healthcare assistant tried to obtain a further urine sample and take clinical observations. Mr Thompson refused to cooperate. He pulled his hand away, so she was unable to check his pulse and blood oxygen saturation level. She intended to try again in the afternoon.

42. At around 3.30pm, a nurse saw Mr Thompson during welfare checks. She was shocked at his appearance, describing him as unwell, weak and unkempt, with acute confusion and unable to stand. Other prisoners and a healthcare assistant told her that he had been hallucinating for several days. The nurse recorded her concerns that staff appeared not to have noticed or reported that Mr Thompson was clearly very unwell.

43. The nurse and a prison GP assessed Mr Thompson. He was confused, hallucinating and appeared to be dehydrated. They sent him to hospital by emergency ambulance. Mr Thompson was escorted by two prison officers and handcuffed with an escort chain. They left the prison at 5.30pm, arrived at the hospital at 5.40pm and the restraints were removed 20 minutes later.

44. Healthcare staff obtained regular updates about Mr Thompson's condition and treatment. On 31 March, they were informed that he was being treated for COVID-19 and acute kidney injury (sudden kidney failure, usually as a complication of another serious illness).

45. On 6 April, the prison assigned a family liaison officer. She was informed that Mr Thompson had agreed not to be resuscitated if his heart or breathing stopped, but was initially advised not to contact his family until they received more information from the hospital. Mr Thompson was thought to be refusing food and drink, but the family liaison officer later found out that he was 'nil by mouth' and on intravenous fluids, as there was a problem with his throat.

46. Mr Thompson's condition worsened on 8 April and the hospital began end-of-life care the following day.

Contact with Mr Thompson's family

47. Mid-afternoon on 8 April, the family liaison officer notified Mr Thompson's partner that he was in hospital receiving treatment for secondary COVID-19, but his condition had deteriorated. She called again the following day to say that he had been placed on end-of-life care. She arranged for his family to visit and met them at the hospital. After they left, she continued to provide updates.

48. Mr Thompson died on 10 April. The family liaison officer contacted Mr Thompson's partner within minutes of his death and offered support over the following weeks. In line with national policy, the prison contributed to the costs of Mr Thompson's funeral, which was held on 12 May.

Support for prisoners and staff

49. After Mr Thompson's death, the Head of Safety debriefed the escort staff and offered support. He also referred them to the care team.

50. Staff and peer support representatives told prisoners in Mr Thompson's dormitory personally about his death. The prison posted notices informing staff and other prisoners and offering support.

Post-mortem report

51. A post-mortem examination found that the cause of Mr Thompson's death was bronchopneumonia, caused by chronic emphysema.

52. Underlying diabetes, polycystic kidney disease, ischaemic heart disease and urinary tract infection contributed to but did not cause his death.

Findings

Clinical care

53. The clinical reviewer concluded that Mr Thompson's clinical care was variable and only partly equivalent to that which he could have expected to receive in the community. She considered that the management of his long-term conditions was appropriate and well-coordinated under the complex case arrangements. However, there was a need for improvement in recognising and managing clinical deterioration and this element of Mr Thompson's care did not meet expectations.

Clinical assessment of patients with respiratory conditions

54. The clinical reviewer found that while healthcare staff had consistently used NEWS2 to assess Mr Thompson, they did not always use the dedicated scale for patients with respiratory conditions such as COPD. Although this did not adversely affect Mr Thompson, use of the incorrect scale could lead to either inappropriate escalation of care or excessive dispensing of oxygen which, in turn, can cause respiratory failure.

55. The Head of Healthcare has since arranged training for staff. However, we agree with the clinical reviewer that the use of NEWS2 should be reviewed to ensure it has been appropriately embedded. We recommend:

    The Head of Healthcare should ensure that healthcare staff are fully competent in applying the National Early Warning Score 2 (NEWS2) and use the appropriate scale for assessing patients with respiratory conditions. This should be reviewed to check compliance.

Recognition of Mr Thompson's deteriorating health

56. The clinical reviewer acknowledged that clinical deterioration can be rapid, but felt that healthcare and operational staff who saw Mr Thompson earlier in the day, before the nurse, should have noticed the obvious decline in his health.

57. Mr Thompson had regularly discussed his health with his key worker. It was clear from entries in his personal records that his key worker knew about his medical conditions and how they impacted on him. The key worker made a detailed entry of his early morning conversation with Mr Thompson on 30 March, including information obtained from prison carers and other prisoners in the dormitory. We note that he actively discussed his concerns with healthcare assistants that day (and previously) and he believed that Mr Thompson was being monitored by both healthcare and unit staff. We are satisfied that the key worker took appropriate steps, given his concern.

58. We agree it is the responsibility of both clinical and operational staff to be alert to possible deterioration when a prisoner is unwell. However, it is conceivable that there had been no significant interaction with Mr Thompson between the healthcare assistant's failed attempt to take his observations and the nurse checking him, as this largely covered the lunchtime period, at a time when there were challenges due to the COVID-19 outbreak. We do not know whether escalating his care earlier in

the day would have affected the eventual outcome, but it is possible that he would have been sent to hospital for treatment sooner. We recommend:

The Head of Healthcare should ensure that healthcare staff are trained to recognise signs of clinical deterioration in patients who are unwell.

59. The clinical reviewer also made a recommendation about oral health, which the Head of Healthcare will need to address.

Response to cell bells on 16 February

60. Prisoners in Mr Thompson's dormitory raised concerns that there was a significant delay in attending to Mr Thompson when he fell on 16 February and alleged that an officer had refused to open the door until healthcare staff arrived. While it has not been possible to resolve the conflicting accounts of events, it is not disputed that a prisoner in the dormitory pressed the cell bell to alert staff.

61. HM Chief Inspector of Prisons considers, as a general principle, that cell bells should be answered within five minutes. Bells in Mr Thompson's dormitory were activated at 6.57am and 7.03am. Both were reset at 7.10am, lapses of 13 and 7 minutes, respectively. Due to the type of accommodation, it was not possible to clarify who had pressed the bell and whether both calls related to Mr Thompson. However, these delays were excessive, particularly in a unit of clinically vulnerable men. We recommend:

The Director should ensure that staff respond to cell bells within five minutes, unless there are exceptional circumstances.

Security risk assessments and the use of restraints

62. 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.

63. 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.

64. Mr Thompson was a 73-year-old Category C prisoner with reduced mobility, who had been assessed as weak and unable to stand just before he went to hospital. The medical section of the security risk assessment noted that he used a wheelchair, yet it was ticked to indicate that his medical condition did not restrict his ability to escape unaided. It also stated there were no objections to the use of restraints; and they would not need to be removed for treatment. We are not

satisfied that the medical judgement properly reflected Mr Thompson's circumstances.

65. The security risk assessment concluded that Mr Thompson was a medium risk to the public; and low risk on all the other factors of concern, including risk of escape and likelihood of outside assistance to escape. There was no reference to any adverse behaviour or problems during previous hospital visits.

66. The conclusions of both the clinical and operational staff cast doubt on whether they fully understand their responsibilities in completing such assessments. We recognise that the restraints were removed after a relatively short period. However, we question whether they were necessary at all, given Mr Thompson's age, reduced mobility, poor and deteriorating state of health, low security risk and the lack of any identified security concerns. We recommend:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff contributing to escort risk assessments accurately reflect the prisoner's mobility, current clinical condition and impact on their ability to escape unaided**; **and**

- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

Notifying Mr Thompson's family of his illness

67. HMPPS guidance on contacting a prisoner's next of kin during the pandemic states that if a prisoner is symptomatic or has contracted COVID-19, they should be given the opportunity for someone to be informed and, with consent, the prison should make arrangements to do this. Additionally, prisons are expected to comply with the existing policy (set out in Prison Rule 22 and Prison Service Instruction 64/2011) that a prisoner's next of kin should be informed immediately if they become seriously ill, or if there is unpredicted or rapid deterioration in their physical health. Doncaster did not comply with these policies.

68. Mr Thompson's partner was informed of his illness nine days after his admission to hospital, when he had a short time to live. When she asked why she had not been told sooner, the prison replied that she had been informed at the earliest opportunity as their policy is to notify families if an illness is life-threatening and the prisoner is to be placed on end-of-life care.

69. We consider there was undue delay in contacting Mr Thompson's partner, which significantly reduced the opportunity for quality contact before he died. We recommend:

The Director should ensure that if a prisoner is suspected of contracting or tests positive for COVID-19, he is given the opportunity for someone to be notified.

The Director should ensure, in line with national policy, that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

70. The failure to inform Mr Thompson's family promptly of his illness and admission to hospital is no reflection on the family liaison officer, who had been instructed by a manager to delay contact. She was accessible, supportive and kept detailed records of her interaction with Mr Thompson's partner and other agencies.

Inquest

71. The inquest, held on 27 March 2023, concluded that Mr Thompson's death was from natural causes.

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