

**Prisons &
Probation**

Ombudsman
Independent Investigations

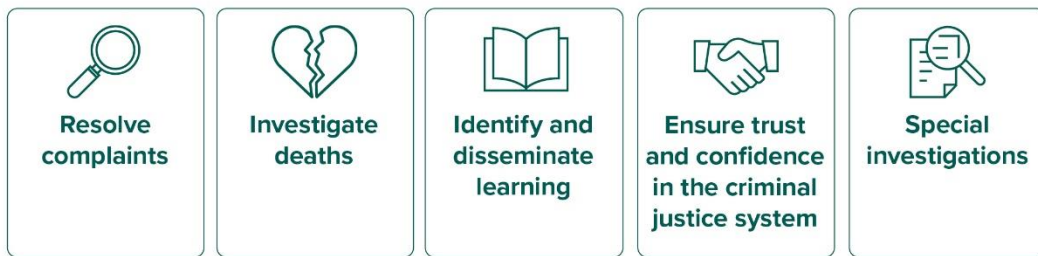
Independent investigation into the death of Mr Lawrence Watson, a prisoner at HMP Brixton, on 20 January 2021

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Lawrence Watson died of COVID-19 on 20 January 2021 while a prisoner at HMP Brixton. He was 81 years old. He also had chronic kidney disease and heart disease which contributed to but did not cause his death. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Watson received at Brixton was equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer has made three recommendations which do not directly relate to Mr Watson's death, but which the Head of Healthcare will need to address.
6. We did not identify any non-clinical issues of concern.

The Investigation Process

7. NHS England commissioned a clinical reviewer to review Mr Watson's clinical care at HMP Brixton.
8. The PPO investigator has investigated the non-clinical issues in Mr Watson's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The Ombudsman's family liaison officer wrote to Mr Watson's next of kin to explain our investigation. They had no specific questions.
10. We shared the initial report with the Prison Service. There were two factual inaccuracies in the initial report and three factual inaccuracies in the clinical review, which have been amended accordingly.
11. We shared the initial report with Mr Watson's next of kin. They did not respond.

Previous deaths at HMP Brixton

12. There were two deaths from natural causes and one self-inflicted death at HMP Brixton in the two years before Mr Watson's death. One prisoner has died as a result of COVID-19 at Brixton since Mr Watson's death.

Coronavirus (COVID-19)

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. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant, have severe lung or kidney disease or have 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 years, people under 70 years who have an underlying health condition, such as diabetes, chronic respiratory, heart, liver or kidney disease, those with a weakened immune system or who are very overweight. (These lists are not exhaustive.)
15. 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 prison population.
16. The Ministry of Justice and Public Health England (PHE) later issued joint guidance, *Preventing and controlling outbreaks of COVID-19 in prisons and places of detention*. It provides operational recommendations for custodial and healthcare

staff on preventing and managing outbreaks of COVID-19, including specific advice on population management, social distancing, actions to take if a prisoner, or staff member develops symptoms, and the use of personal protective equipment (PPE). (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.)

17. After a period of complete lockdown, the Ministry of Justice and HM Prison and Probation Service produced *COVID-19: National Framework for Prison Regimes and Services*. This outlines strategies for easing restrictions and modifying regimes, where severe constraints are disproportionate, or unsustainable. Prisons are expected to devise local policies within the parameters set in the framework.

Key Events

18. On 18 April 2018, Mr Lawrence Watson was sentenced to six years in prison for sex offences. On 30 January 2020, he was transferred to HMP Brixton.
19. Mr Watson had ischaemic heart disease and had had a stent fitted (a procedure to widen blocked or narrow coronary arteries) after a heart attack in 2005. He also had chronic kidney disease.
20. On 8 April 2020, a prison GP noted that Mr Watson was in the category for those at high risk of developing complications from COVID-19. On 27 April, healthcare staff wrote to Mr Watson to advise him to shield. Mr Watson refused to do so. On 18 May, healthcare staff again wrote to Mr Watson urging him to shield. On 17 June, a nurse saw Mr Watson and explained to him the importance of shielding. Mr Watson refused to do so and signed a disclaimer to that effect.
21. On 18 November, healthcare staff sent Mr Watson another letter advising him to shield. Mr Watson continued to refuse to do so.
22. On 14 December and 23 December, Mr Watson tested negative for COVID-19.
23. On 7 January 2021, healthcare staff tested Mr Watson for COVID-19 again.
24. At 9.43am on 11 January, a nurse saw Mr Watson after he had been found lying on the floor of his cell. When he arrived, Mr Watson was sitting on his bed, confused and disorientated. He noted that Mr Watson's National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 4, which indicated a low clinical risk.
25. A nurse later reviewed Mr Watson and noted that his respiratory rate had increased, he had low blood oxygen saturation and a raised pulse rate. She noted that Mr Watson's NEWS score was now 5. She did not consider that Mr Watson was so immediately unwell that he needed to go to hospital and planned to review him again later that day.
26. At 3.00pm, the nurse went back to see Mr Watson and found that his blood oxygen saturation levels had worsened. She gave him oxygen. She noted that Mr Watson had a NEWS score of 12 which indicated a high clinical risk and required an emergency response. She arranged for an ambulance to take him to hospital as a medical emergency.
27. On 15 January, the test result (for 7 January) showed that Mr Watson had COVID-19. (A regional manager for Practice Plus Group which provides healthcare services at Brixton, said that all swabs were being processed at Public Health England laboratories and there were delays throughout London at that time due to the volume of cases.)
28. Mr Watson remained in hospital, where he died on 20 January.

Cause of death

29. There was no post-mortem examination. The Coroner accepted the cause of death provided by a histopathology registrar, who said that Mr Watson died of COVID-19. He also had chronic kidney disease and ischaemic heart disease which contributed to but did not cause his death.

Inquest

30. The inquest into Mr Watson's death was held on 13 October 2023 and a verdict of natural causes was recorded.

Findings

Clinical Findings

31. The clinical reviewer found that the care that Mr Watson received at Brixton was equivalent to that which he could have expected to receive in the community.

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

32. The clinical reviewer found that appropriate advice was repeatedly given to Mr Watson about COVID-19 shielding and that there was no evidence that Mr Watson lacked the capacity to decide not to shield.
33. The Head of Healthcare said that the shielding letters sent to Mr Watson and other high-risk prisoners at Brixton were the same as the NHS England shielding letters sent to people in the community. She said that the prisoners who were advised to shield mirrored those advised to shield in the community.
34. The Head of Healthcare said that from December 2020 until 8 March 2021, Brixton had outbreak status. She said that during this period, healthcare staff tested every prisoner on day 0, day 7 and day 28 for COVID-19 throughout the outbreak dates. On 11 January, when Mr Watson became ill, 22 prisoners at Brixton were shielding, 73 prisoners had tested positive for COVID-19 and were self-isolating, and four prisoners were in hospital with COVID-19.
35. At the time of Mr Watson's death, Brixton had COVID-19 restrictions in place, including limiting time out of cell to 30 minutes a day and giving prisoners their meals at their cell doors. Prisoners were given letters from PHE explaining the importance of wearing masks and social distancing and were kept up to date with community notices explaining the COVID-19 regime.
36. We have to assume that Mr Watson contracted COVID-19 in Brixton as he had not left the prison in the fourteen days before his positive test (the accepted incubation period). When Mr Watson contracted the virus, staff were managing a large outbreak of COVID-19. The investigator did not identify any specific concerns about Brixton's management of the situation.
37. The clinical reviewer was satisfied that when Mr Watson became unwell, he was reviewed and examined in line with national advice to try to avoid hospital admission. When his condition did not improve, he was promptly sent to hospital.

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October 2021

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