

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Kathleen Salmond, a prisoner at HMP Foston Hall, on 11 January 2021

A report by the Prisons and Probation Ombudsman

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

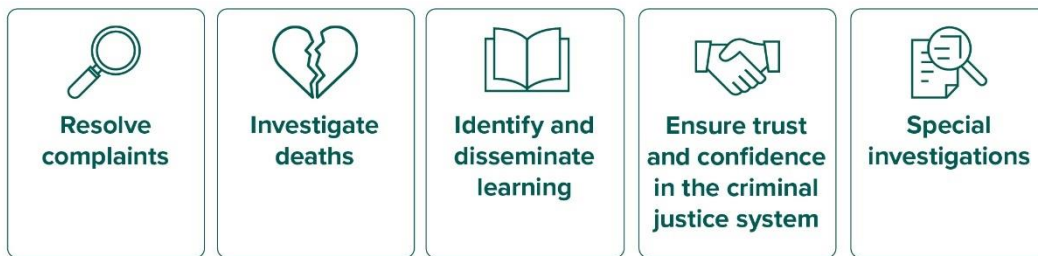
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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.
1. My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
2. Ms Kathleen Salmond died of COVID-19 infection on 11 January 2021, at HMP Foston Hall. She was 42 years old. I offer my condolences to Ms Salmond's family and friends.
3. The clinical reviewer concluded that the clinical care Ms Salmond received at Foston Hall was equivalent to that which she could have expected to receive in the community. However, she made two recommendations which we have included in this report.
4. The clinical reviewer was concerned that there was a delay in diagnosing that Ms Salmond had COVID-19 as the swab that was taken from her on 8 January, after she became unwell, was not sent to the laboratory. Another swab had to be taken two days later and Ms Salmond was not confirmed as COVID positive until 11 January.
5. We also found that information on COVID testing was not shared with operational staff, which led to frustration and confusion.

Recommendations

- The Head of Healthcare should ensure that there is a process in place for sending COVID tests to the laboratory without delay.
- The Head of Healthcare should ensure that COVID guidelines are shared with operational staff where appropriate to avoid misunderstandings.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Ms Salmond's clinical care at the prison.
7. The clinical reviewer conducted joint interviews with the investigator. Due to coronavirus restrictions, the interviews were conducted by telephone. The transcripts are attached to this report.
8. The PPO's investigator investigated non-clinical issues, including the prison response to COVID-19 and shielding prisoners, the security arrangements for Ms Salmond's hospital escorts, liaison with her next of kin and whether compassionate release was considered.
9. We informed HM Coroner for Derbyshire of the investigation. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Ms Salmond's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He said that he thought his sister was ill-treated. The family liaison officer told him that this would be looked into during the investigation.
11. Ms Salmond's family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies in the clinical review and this has been amended accordingly.

Background Information

HMP Foston Hall

13. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 344 prisoners, including young adult women under the age of 21, unconvicted and unsentenced women, and sentenced women (including some serving life sentences).
14. Practice Plus Group (formerly known as Care UK) provides primary and mental healthcare services. There are daily GP sessions from Monday to Friday, with out of hours provision for other times. Three primary nurses and a healthcare assistant are on duty during the day, reducing to one nurse and healthcare assistant at night.

Previous deaths at HMP Foston Hall

15. Ms Salmond was the fourth prisoner at Foston Hall to die since January 2019. Of the previous deaths, two were self-inflicted and one was from natural causes. There have been no other deaths from COVID-19 at Foston Hall.

COVID-19 (coronavirus)

16. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.
17. 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.)
18. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try to 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, in a prison 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-received prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

19. On 13 December 2019, Ms Kathleen Salmond was sentenced to life imprisonment for murder. Ms Salmond had complex medical and nursing needs so was sent to a nursing home while HMP Foston Hall prepared facilities to be able to care for her. She was moved to Foston Hall on 6 February 2020.
20. Ms Salmond was paralysed from the chest down following a spinal stroke in 2013. She was bed and wheelchair bound needing two carers four times a day. She had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place.
21. Healthcare staff put extensive care plans in place to support Ms Salmond's complex health needs. Ms Salmond was cared for in a single adapted cell with its own shower on the healthcare wing at Foston Hall.
22. On 1 January 2021, Ms Salmond was having problems with her catheter, so was sent to hospital, where she was admitted. On 4 January, she was discharged from hospital and sent back to Foston Hall.
23. On 6 January, when Ms Salmond was given her night medication, she said that she felt unwell. A nurse took her observations which were within normal range. The nurse told her that she should call for help if she felt worse.
24. On 8 January, Ms Salmond told a nurse that she still did not feel well. The nurse took her observations and noted that they were all still within normal ranges. Even though Ms Salmond's observations were within normal limits, healthcare staff took a swab to exclude COVID-19. Later that day, staff noted that Ms Salmond had a temperature and gave her ibuprofen painkillers.
25. The following day, a nurse saw Ms Salmond and noted that she had a National Early Warning System (NEWS) score of 8. (NEWS is a tool used to assess clinical deterioration in adult patients – a score of 8 indicates high clinical risk.) She also noted that her chest was wheezing and rattling. The nurse said that Ms Salmond needed to be assessed by paramedics. Paramedics arrived and said that she needed to go to hospital. Ms Salmond said that she did not want to go to hospital and signed a disclaimer to that effect.
26. Throughout the rest of the day Ms Salmond was checked regularly and her observations were taken every two hours. A nurse had an in-depth discussion with Ms Salmond and asked her why she did not want to go to hospital. Ms Salmond said that she had had enough of hospital admissions and no longer wanted treatment.
27. On 10 January, a nurse reviewed Ms Salmond and noted that she was still refusing to go out to hospital for further assessment. A mental health nurse assessed Ms Salmond and said that she had full capacity to make decisions about her care and treatment.
28. Later that day, staff discovered that the COVID swab that had been taken on 8 January had not been sent for testing, so another swab was taken and sent immediately by taxi to the laboratory.

29. On 11 January, Ms Salmond's COVID test result showed she was COVID positive. Her health continued to deteriorate. As Ms Salmond was still refusing to go to hospital, she was prescribed antibiotics and observations were taken every two hours. Later that evening she deteriorated further, so was given one to one care. At 8.40pm, a nursing Sister noted that Ms Salmond was unresponsive, and her pulse was weak and breathing slow. As Ms Salmond had a DNACPR in place, no intervention was given. At 10.09pm, Ms Salmond died.

Post-mortem report

30. The post-mortem examination concluded that Ms Salmond died from COVID-19 infection.

Findings

Clinical Findings

31. The clinical reviewer considered that the standard of care Ms Salmond received at Foston Hall was equivalent to that which she could have expected to receive in the community. Ms Salmond received appropriate medication and her long-term health conditions were properly managed with care plans.

Management of Ms Salmond's risk of catching COVID-19

32. On 13 March 2020, the NHS Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and support the enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation.
33. On 31 March, HMPPS, in consultation with Public Health England (PHE), issued an order to significantly reduce transfers between prisons. Other measures, designed to be implemented at local level, depending on the needs of each individual establishment, were also implemented. These measures were known as 'compartmentalisation' and included:
 - Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.
 - Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of bio-security, including dedicated staff.
 - Reverse Cohorting Units (RCUs): to accommodate any new prisoners arriving at the prison for a period of 14 days to detect any emergent infectious cases before entering the general population. These units could also accommodate anyone returning from hospital.
34. Ms Salmond was assessed as clinically vulnerable because of her multiple health conditions. In March 2020, she was advised to shield. This did not affect her care package as clinical staff and carers cared for Ms Salmond in her cell and wore full personal protective equipment. Ms Salmond had a single cell with its own shower room, both adapted for prisoners with disabilities, so during the pandemic she was able to remain in her cell while still being able to shield.
35. On 1 January 2021, Ms Salmond was admitted to hospital for a suspected urine infection. She tested negative for COVID-19 on admission. She was discharged from hospital on 4 January, and within 72 hours of returning to the prison, Ms Salmond became unwell and subsequently tested positive for COVID-19. While we cannot say for sure, it appears likely that she caught COVID-19 in hospital.

36. The investigation found that the prison had followed the national guidance on managing the risks associated with COVID-19 and promptly put in place the policies and measures expected.

COVID-19 testing at Foston Hall

37. The investigation found that when a swab was taken from Ms Salmond on 8 January, it was not sent off to the laboratory to be tested for COVID, so another test had to be taken on 10 January. The Head of Healthcare told us that this was because there was only one member of staff responsible for processing COVID tests and that member of staff was not on duty on 8 January.

38. This meant that there was an unacceptable delay in diagnosing that Ms Salmond was COVID positive, although this would not have affected the outcome for Ms Salmond. The Head of Healthcare has told us that there is now a process in place to ensure that this does not happen again. We recommend:

The Head of Healthcare should ensure that there is a process in place for sending COVID tests to the laboratory without delay.

39. A custodial manager contacted the PPO investigator to say that she was concerned that several members of staff had asked for Ms Salmond to have a COVID test for several days before the swab was taken.

40. We raised this with the Head of Healthcare at interview. She said that prisoners were tested in line with Public Health England guidelines at the time which stated that tests should only be taken if someone was showing symptoms. As Ms Salmond's observations were within normal limits and she had no symptoms, there was no reason for earlier testing.

41. These guidelines were not shared with prison staff, which led to frustrations and misunderstanding. We recommend:

The Head of Healthcare should ensure that COVID guidelines are shared with operational staff where appropriate to avoid misunderstandings.

**Sue McAllister CB
Prisons and Probation Ombudsman**

October 2021

Inquest

The inquest, held on 10 October 2023, concluded that Ms Salmond died from natural causes.

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