

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Warburton, a prisoner at HMP Berwyn, on 25 March 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 Peter Warburton died in hospital on 25 March 2021, while a prisoner at HMP Berwyn. He was 64 years old. The cause of his death was COVID-19 pneumonia. He also had underlying lung disease and high blood pressure. I offer my condolences to Mr Warburton's family and friends.
4. As Mr Warburton had not left the prison during the months before he developed symptoms of COVID-19, he seems to have contracted the virus at the prison.
5. The clinical reviewer concluded that the clinical care Mr Warburton received at Berwyn was equivalent to that he could have expected to receive in the community. However, he considered that clinical observations should have been taken when Mr Warburton first reported his symptoms, to help identify any deterioration in his condition.
6. We are concerned that staff seem not to have used a medical emergency code when Mr Warburton reported chest pains and breathing difficulties; and that there was no medical input to the security risk assessment authorising the use of restraints.
7. There were some anomalies in record keeping which could not be resolved due to the lapse of time. However, the prison should consider addressing this issue more broadly.

Recommendations

- The Head of Healthcare should ensure that healthcare staff complete and record clinical observations when prisoners report symptoms of COVID-19, to help identify any deterioration.
- The Governor and Head of Healthcare should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies, including that staff promptly use a recognised emergency code to communicate the nature of the emergency.
- The Governor 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 complete the medical information section of the escort risk assessment, accurately reflecting how the prisoner's current health and medical condition affects their risk of escape; and

- authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.
- The Governor should ensure that documents are 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 Governor should remind staff of the need for accurate record keeping and consider whether the auditing process is sufficiently robust.

The Investigation Process

8. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Warburton's clinical care at HMP Berwyn.
9. The PPO investigator, investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Warburton's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
10. The PPO family liaison officer wrote to Mr Warburton's next of kin, his brother, to explain the investigation. He had no specific matters for the investigation to consider.
11. Mr Warburton's brother received a copy of our initial report. He made no comments.
12. 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.

Previous deaths at HMP Berwyn

13. Mr Warburton was the seventh prisoner to die at Berwyn since March 2019. Of the previous deaths, four were from natural causes (two as a result of COVID-19), one was self-inflicted and one was due to the effect of psychoactive substances. There have been two further deaths from natural causes, unrelated to COVID-19. We have previously raised the issue of medical input to security risk assessments.

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).

Key Events

17. Mr Peter Warburton had been convicted of sexual offences in 2005 and was released from prison on 6 October 2017. After breaching his licence conditions and committing further sexual offences, he was recalled to prison and taken to HMP Berwyn on 7 July 2020.
18. At an initial health screen, it was noted that Mr Warburton had several physical health conditions, including high blood pressure, asthma, chronic obstructive pulmonary disease (COPD) and chronic back pain. He also reported a history of depression and anxiety, as well as substance misuse.
19. Mr Warburton was isolated from the main prison population for 14 days (known as reverse cohorting), in line with the national Prison Service COVID-19 policy. He then moved to a shared cell on a residential unit.
20. Over the following months, healthcare staff actively monitored Mr Warburton's health and reviewed his medication.

COVID-19 infection

21. On 18 February 2021, Mr Warburton's cell mate reported symptoms of COVID-19. Both men were moved to single cells in the protective isolation unit. Mr Warburton was placed on the list to be tested. However, on 19 February, it was noted in the medical records that this was unnecessary unless he became symptomatic. Wing staff conducted and documented daily welfare checks.
22. On 22 February, Mr Warburton developed a cough and a swab was taken to be tested.
23. At around 5.25am, on 25 February, Mr Warburton pressed his cell bell and told a wing officer that he had chest pains and was short of breath. The officer telephoned the healthcare centre.
24. A healthcare support worker checked Mr Warburton's medical record and saw that his COVID-19 test result had returned as positive. To minimise the risk of infection, a nurse triaged him using the in-cell telephone. During their conversation, the nurse could hear that he had breathing difficulties. The nurse and the healthcare support worker then went to Mr Warburton's cell to assess him and found that his blood oxygen saturation levels were low. They requested an emergency ambulance and gave him oxygen while waiting for the paramedics.
25. Mr Warburton was taken to hospital, escorted by two prison officers using an escort chain. At lunchtime, he was admitted to a ward and the restraints were removed at 1.30pm.
26. The prison assigned a family liaison officer who tried, unsuccessfully, to contact Mr Warburton's brother the same day. She therefore left a message, as well as her contact details.
27. On 26 February, Mr Warburton was moved to the intensive care unit. The family liaison officer called again and spoke to Mr Warburton's sister-in-law. She kept in touch and supported his family over the following weeks.

28. Mr Warburton's condition worsened. On 11 March, he was sedated and placed on a ventilator.
29. On 25 March, the hospital withdrew Mr Warburton's treatment and he died at 4.25pm. The family liaison officer and a member of the staff care team arrived at the hospital shortly afterwards.
30. A prison manager debriefed the escort staff and family liaison officer and reminded them of the support services available.
31. The prison arranged and paid for Mr Warburton's funeral, which was held on 19 April.

Cause of death

32. No post-mortem examination was held. Pending the inquest, the coroner provisionally recorded the cause of Mr Warburton's death as COVID-19 pneumonia. He also had underlying COPD and hypertension, which did not cause but contributed to his death.

Findings

Clinical Findings

33. The clinical reviewer concluded that the standard of clinical care at Berwyn met or exceeded that which Mr Warburton could have expected to receive in the community. He noted that some clinical services, such as respiratory blowing tests were suspended during the COVID-19 pandemic, as they were considered too hazardous. However, this did not affect the outcome for Mr Warburton.
34. The clinical reviewer identified a concern about the omission of clinical observations when Mr Warburton reported symptoms of COVID-19, which we reflect below. Full details of his findings are in the clinical review report.

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

35. Berwyn had a dedicated shielding wing. In line with national policy, prisoners at the highest risk of serious illness from COVID-19 were given the opportunity to shield. The prison did not routinely offer shielding to those at moderate risk, but it was provided for prisoners who requested it.
36. The clinical reviewer noted that although Mr Warburton was at higher risk of complications from COVID-19, he was not in the highest risk group as his asthma was not severe. He also stated that there had been no objective diagnosis of COPD.
37. Due to Mr Warburton's age and asthma, he was in a priority group to receive the COVID-19 vaccination. However, the vaccine was not rolled out nationally until 15 February and he was admitted to hospital before the prison received supplies.
38. We are satisfied that Mr Warburton's risk was managed appropriately.

Monitoring Mr Warburton after he reported symptoms of COVID-19

39. Mr Warburton was promptly isolated after possible exposure to COVID-19 and he received daily welfare checks. However, after he developed symptoms of the virus, key clinical observations, such as his respiratory rate and blood oxygen saturation level, were not completed. Such checks enable healthcare staff to identify clinical deterioration and are particularly important for monitoring those at increased risk. We recommend:

The Head of Healthcare should ensure that healthcare staff complete and record clinical observations when prisoners report symptoms of COVID-19, to help identify any deterioration.

40. Mr Warburton appears to have contracted COVID-19 at Berwyn, as he had not left the prison since he was recalled in July 2020.

Emergency response

41. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. This includes a requirement to use a code system to ensure that an ambulance is called immediately in a life-threatening medical emergency and to enable staff to bring the relevant equipment. The guidance is clear that chest pains, or breathing difficulties are medical emergencies which require an immediate response and it is not necessary to wait for healthcare staff to attend before requesting an ambulance.
42. There was no reference to use of an emergency code by either the operational or clinical staff. The investigator was unable to verify how the emergency was communicated and the status of the ambulance request, as the relevant documents were not provided.
43. The operational and healthcare staff were supportive and well-intentioned when they responded to Mr Warburton's deterioration and request for help. However, they do not appear to have followed the expected medical emergency procedures, which were designed to ensure a timely response and minimise delays. While this did not affect the outcome for Mr Warburton, it could be critical in future emergencies. We recommend:

The Governor and Head of Healthcare should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff promptly use a recognised emergency code to communicate the nature of the emergency.

Security risk assessments and the use of restraints

44. 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.
45. 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 they have 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 and on the prison's risk assessment form.
46. While we are not necessarily critical of the decision to use restraints, we are concerned that there was no clinical input to the initial risk assessment to indicate how Mr Warburton's condition impacted on his risk. A medical opinion should be routinely included for all hospital visits and admissions. Otherwise, decisions on the use and level of restraints are tenuous. We recommend:

The Governor 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 complete the medical information section of the escort risk assessment, accurately reflecting how the prisoner's current health and medical condition affects their risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

Documents and record keeping

47. Despite several requests, the prison was unable to provide the control room log and several other standard investigation documents. We recommend:

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

48. On 28 February, an officer noted in the NOMIS personal record the details of a key work session said to have been held with Mr Warburton the same day (three days after he was admitted to hospital). Also, on 3 March, one of the safer custody team noted in the record that as Mr Warburton was COVID-19 positive, he was unable to see him that day. The authors referred to Mr Warburton by name in the body of both entries, so it is unlikely that they had selected the wrong record.

49. There was no detriment to Mr Warburton and the lapse of time means it would be difficult to determine the reasons for these specific irregularities. However, these errors cast serious doubt on the standard and reliability of record keeping. We recommend:

The Governor should remind staff of the need for accurate record keeping and consider whether the auditing process is sufficiently robust.

Kimberley Bingham

Acting Prisons and Probation Ombudsman

September 2022

Inquest

The inquest, held on 1 November 2023, concluded that Mr Warburton died from natural causes.

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