

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Haygarth, a prisoner at HMP Wymott, on 29 November 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 Mark Haygarth died in hospital on 29 November 2021, while a prisoner at HMP Wymott. He was 62 years old. The cause of his death was COVID-19 pneumonia. I offer my condolences to Mr Haygarth's family and friends.
4. The clinical reviewer concluded that Mr Haygarth's clinical care was 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 satisfactory, but recognition and handling of his deteriorating condition did not meet the required standards. She made recommendations on secondary health screens, obesity care plans, escalation procedures and record keeping.
5. We are concerned that ambulances were not requested promptly in response to two medical emergency codes when Mr Haygarth had breathing difficulties; there was no clinical input to the security risk assessment for his final journey to hospital; and the prison did not comply with the national policies on contacting a prisoner's family in the event of them contracting COVID-19 or becoming seriously ill.
6. Mr Haygarth appears to have caught COVID-19 at Wymott, as he had not left the prison for several months.

Recommendations

- The Head of Healthcare should ensure that second-stage health assessments for new prisoners are completed in accordance with national clinical guidelines.
- The Head of Healthcare should ensure that an obesity care plan is created promptly when a prisoner is assessed as having a high Body Mass Index.
- The Head of Healthcare should ensure that staff follow the recommended escalation procedures when using the National Early Warning Score 2 clinical assessment tool.
- The Head of Healthcare should ensure that record keeping is in line with the Nursing and Midwifery Council Code of Conduct and the auditing process is robust.
- The Governor should ensure that staff in the communications room request an ambulance immediately when a medical emergency code is called.

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

7. NHS England commissioned an independent clinical reviewer to review Mr Haygarth's clinical care at HMP Wymott.
8. PPO investigators investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Haygarth's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
9. Three healthcare staff and a prisoner were jointly interviewed by the clinical reviewer and PPO investigators. The interviews were conducted remotely, due to the restrictions in place during the COVID-19 pandemic.
10. The Ombudsman's family liaison officer contacted Mr Haygarth's daughter and the friend he had nominated as his next of kin, to explain the investigation. Mr Haygarth's daughter had no specific matters for the investigation to consider and his friend did not reply.
11. We sent a copy of our report to Mr Haygarth's daughter. She made no comments.
12. The initial report was shared with HMPPS. They reported no factual inaccuracies but clarified that prisoners who were isolating had access to a dedicated telephone. We have reflected this and removed the related recommendation.

Previous deaths at HMP Garth

13. Mr Haygarth was the 18th prisoner at Wymott to die since November 2019. Of the previous deaths, 16 were from natural causes (five due to COVID-19) and one was drug-related. There have since been two further deaths from natural causes (one due to COVID-19) and one self-inflicted. We have previously made recommendations on creating care plans for chronic conditions; recognising deteriorating patients and escalation of care; security risk assessments and authorising the use of restraints; and notifying a prisoner's next of kin in the event of serious illness.

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. 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.)

16. 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

17. Mr Mark Haygarth was remanded to prison on 23 August 2011. He was later convicted of sexual offences and sentenced to 18 years imprisonment. After moving between several prisons, he transferred to HMP Wymott on 26 April 2018.
18. Initial and second-stage health assessments were completed on the day Mr Haygarth arrived. His physical health conditions included asthma and obesity. He had impaired hearing and mobility and had used a walking stick since 2012. Healthcare staff created an asthma care plan and prescribed inhalers. (In July 2021, an obesity care plan was added.)
19. Due to his asthma and obesity, Mr Haygarth was considered to be at the highest risk of complications from COVID-19 (formerly categorised as clinically extremely vulnerable). On 12 April 2020, he declined the offer to shield, explaining that he wanted to remain on his existing wing and would self-manage his isolation and social distancing. However, on 22 April, healthcare and operational staff discussed the risks and persuaded him to move to B wing, one of the dedicated shielding units.
20. Mr Haygarth received weekly clinical welfare checks and was noted to have adapted well to the restricted regime. He tended not to mix with other prisoners due to the risk of catching COVID-19.
21. Mr Haygarth was considered for release on temporary licence on compassionate grounds (through a special purpose licence, under the provisions for those at the highest risk of COVID-19). On 19 May, he was informed that his application would not be considered further, as he did not meet key criteria. Notably, there were continuing public protection risks and no suitable accommodation was available.

2021

22. Mr Haygarth received COVID-19 vaccinations in February and April 2021. (He died before the booster injections were rolled out in prisons.)
23. Wymott had an outbreak of COVID-19 from October 2021 and mass testing took place. On 14 November, Mr Haygarth was one of 22 men on B wing who were confirmed as positive the same day. A COVID-19 care plan was created, he was placed in protective isolation and given a pulse oximeter to measure his blood oxygen level. He was also listed for daily welfare checks and clinical observations.
24. On 15 November, Mr Haygarth had problems breathing. A nurse found that his temperature was raised, but his clinical observations were otherwise normal. She calculated a National Early Warning Score 2 (NEWS2) of 2. (NEWS2 is a clinical assessment tool to identify acutely unwell and deteriorating patients.) Mr Haygarth felt better the next day.
25. At midday on 17 November, Mr Haygarth's NEWS2 score was 5 (which indicates medium risk of clinical deterioration and the need for urgent review by an acute care specialist.) He was checked again just after 5.00pm and his NEWS2 score remained at 5. A nurse gave him paracetamol for his temperature, advised him to

tell staff if he felt worse and arranged for the night staff to review him again in the evening. Further checks took place at 8.54pm and 10.20pm, with NEWS2 scores of 3 and 2, respectively. (The score of 3 was related to his raised temperature and should have prompted a review of the monitoring arrangements.)

26. At 5.22am on 18 November, Mr Haygarth fell on the landing on his way to the toilet. A wing officer radioed a code blue medical emergency (which indicates that a prisoner has difficulty breathing or is unresponsive). A nurse examined Mr Haygarth and his clinical observations were normal. He was advised to take paracetamol and the ambulance requested was stood down.
27. At 8.29am (recorded in error as 9.29am), a wing officer called another code blue as they were concerned about Mr Haygarth's breathing and saw that his pulse oximeter indicated a low oxygen level. A nurse found that Mr Haygarth was in pain, struggling to breath and confused. His blood oxygen level was low and his NEWS2 score was 5.
28. The control room called an ambulance at 8.31am and paramedics took Mr Haygarth to hospital. He was escorted by two prison officers, who used an escort chain for the journey. He arrived at the hospital at 10.33am and was taken to the COVID-19 area. The prison authorised removal of the escort chain at 10.40am.
29. On 25 November, Mr Haygarth moved to the critical care unit. He attempted to remove equipment, refused medication and threatened to harm himself unless he was allowed to return to the prison. Prison staff supported him, using the Assessment, Care in Custody and Teamwork (ACCT) care planning process. A prison chaplain also spoke to him, and he settled for a short time.
30. On 26 November, the hospital asked for Mr Haygarth's next of kin to be informed that he was likely to die, as he was refusing treatment. The prison then assigned a family liaison officer. That evening, Mr Haygarth was sedated and placed on a ventilator.
31. At 12.05pm on 29 November, the hospital withdrew Mr Haygarth's treatment, and he died at 12.34pm.
32. There was no telephone number for Mr Haygarth's nominated next of kin and the address listed was found to be holiday accommodation. The family liaison officer eventually obtained the contact details for Mr Haygarth's daughter. On 2 December, he informed her that her father had died and provided further information over the following weeks.
33. The prison arranged and paid for Mr Haygarth's funeral, which was held on 24 December.

Cause of death

34. No post-mortem examination was held as the Coroner accepted a hospital doctor's certification that the cause of Mr Haygarth's death was COVID-19 pneumonia. He also had underlying asthma and obesity, which contributed to but did not cause his death.

Findings

Clinical Findings

35. The clinical reviewer concluded that Mr Haygarth's clinical care was only partly equivalent to that he could have expected to receive in the community. She considered that the management of his long-term clinical care was generally satisfactory, but the recognition and handling of his deterioration between 15 and 18 November 2021 did not meet the expected standards. Full details of the clinical reviewer's findings are in the clinical review report. We reflect the issues linked to the cause of Mr Haygarth's death.

Reception and second-stage health assessments

36. National Institute for Health and Care Excellence (NICE) Guideline 57 covers the management of the physical health of people in prison. It states that for continuity of care, every prisoner should receive a health assessment (to identify immediate health needs) before they are allocated to their cell, as well as a second-stage health assessment within seven days of their arrival.
37. Mr Haygarth's initial and secondary health assessments were completed on the same day. The clinical reviewer noted that this was not good practice, as there is insufficient time during the reception process for health issues to be explored in depth. We recommend:

The Head of Healthcare should ensure that second-stage health assessments for new prisoners are completed in accordance with national clinical guidelines.

Obesity care plan

38. The clinical reviewer found that healthcare staff identified that Mr Haygarth was obese during his reception health screen in 2018, but an obesity care plan was not put in place until April 2021. We recommend:

The Head of Healthcare should ensure that an obesity care plan is created promptly when a prisoner is assessed as having a high Body Mass Index.

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

39. In line with national policy, Wymott identified prisoners who were at high risk of complications from COVID-19 and gave them the opportunity to shield. Although shielding ended in the community in April 2021, it was continued in prisons due to the high-risk nature of the prison environment.
40. Wymott offered shielding until November 2021. Staff advised Mr Haygarth that it was in his best interests to move to a shielding unit, and, after initial reluctance, he agreed. It was an open wing, with no in-cell toilets or showers. Prisoners in protective isolation had a sign on their door and were instructed to remain in their cells unless they needed to use the toilet, which they were able to access twenty-

four hours a day. They were also given advice on wearing PPE and avoiding contact with others when they left their cells.

41. We are satisfied that the prison identified Mr Haygarth's risk and implemented protective measures. However, we recognise that the environment on an open wing, as well as the lack of integral sanitation, made it difficult to separate groups of prisoners effectively.
42. As Mr Haygarth had not left Wymott in the months before testing positive for COVID-19, we conclude that he contracted the infection during the outbreak at the prison.

Monitoring Mr Haygarth after he contracted COVID-19

43. The clinical reviewer noted that although Mr Haygarth received regular clinical observations when he contracted COVID-19, healthcare staff did not follow the appropriate NEWS2 escalation procedures. There was no evidence of an urgent referral for specialist care, or review of monitoring intervals, when clinical assessments indicated NEWS2 scores of 5 and 3, on 17 November. We recommend:

The Head of Healthcare should ensure that staff follow the recommended escalation procedures when using the National Early Warning Score 2 clinical assessment tool.

Clinical record keeping

44. The clinical reviewer found that some of the retrospective entries in Mr Haygarth's medical records had been recorded several hours after the contact with the patient. This had led to inaccuracies and insufficient detail about the actions taken. At interview, healthcare staff said that there was no access to medical records on the wings, so notes were taken and transcribed sometime later.
45. The lack of access to IT facilities and clinical records on wings is not uncommon in prisons, but the onus is on staff to ensure that note taking is good enough to ensure clinical entries are prompt and accurate. We recommend:

The Head of Healthcare should ensure that record keeping is in line with the Nursing and Midwifery Council Code of Conduct and the auditing process is robust.

Emergency response

46. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes* set out the actions staff should take in a medical emergency. It states that if an emergency code is called over the radio network, an ambulance must be called immediately. In response to failings identified by the PPO and HM Coroner in a previous investigation, Wymott's local emergency response protocol was reissued on 13 July 2021, to reinforce this requirement.

47. Entries in the communications room log indicate that code blue emergencies were called for Mr Haygarth at 5.22am and 8.29am on 18 November. There were delays of four and two minutes, respectively, in requesting an ambulance. While this did not affect the outcome for Mr Haygarth, it could be critical in future emergencies. We recommend:

The Governor should ensure that staff in the communications room request an ambulance immediately when a medical emergency code is called.

Security risk assessments and the use of restraints

48. 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.
49. 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 suffering from 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.
50. Mr Haygarth was a Category C prisoner, on the enhanced level of the prison's incentives scheme. The security risk assessment for his journey and admission to hospital concluded that he was a high risk to the public and low risk on all the other factors of concern, including risk of escape and the likelihood of outside assistance. The medical section of the form was blank, so there was no clinical input to indicate how Mr Haygarth's condition and reduced mobility impacted on his risk.
51. A clinical opinion should be routinely included on such risk assessments, to ensure that decisions on the use of restraints are justified and proportionate. 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.**

Contacting Mr Haygarth's next of kin

52. 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. The prison said that a dedicated mobile phone, linked to the prisoner PIN phone system, was available on every wing for use by prisoners who were isolating. Mr Haygarth did not use it as he had no contacts on his account.

53. Additionally, prisons are expected to comply with the existing policy (set out in Prison Rule 22 and PSI 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. Mr Haygarth's security risk assessment was annotated that his next of kin should not be notified unless this was requested by the hospital. No reason was recorded.
54. In view of Mr Haygarth's condition and clinical risk, we consider that prison staff should have tried to contact his next of kin when he was first admitted to hospital. They should also have acted with greater urgency at other points, such as when he moved to the critical care unit; when hospital staff asked for his family to be informed; and when he was placed on a ventilator. Had the prison complied with the national policies and attempted contact sooner, they would have realised before Mr Haygarth's death that the contact details were incomplete. We recommend:

The Governor 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.

Inquest

55. The inquest, held on 9 June 2023, concluded that Mr Haygarth died from natural causes.

Kimberley Bingham

Acting Prisons and Probation Ombudsman November 2023

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