

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Lawrence, a prisoner at HMP Garth, on 11 January 2022

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 George Lawrence died in hospital on 11 January 2022, while a prisoner at HMP Garth. He was 57 years old. The cause of Mr Lawrence's death was COVID-19. I offer my condolences to Mr Lawrence's family and friends.
4. The clinical reviewer found that after reporting symptoms of COVID-19, Mr Lawrence's clinical management was not in line with national and local guidance. There was a delay of ten days before a PCR test was taken; clinical observations were incomplete; and he was not monitored for signs of deterioration. The clinical reviewer concluded that Mr Lawrence's clinical care was variable. In view of these shortcomings, we consider that Mr Lawrence's clinical care was not equivalent to that which he could have expected to receive in the community.
5. We are concerned that there was a significant delay in designating Mr Lawrence to protective isolation when he reported symptoms of COVID-19. This put other prisoners and staff at risk. We are also concerned that Mr Lawrence was in restraints while sedated and receiving intravenous treatment. Prison managers should have given higher priority to authorising their removal.
6. Mr Lawrence appears to have caught the infection at Garth as he had not left the prison for several months.

Recommendations

- The Head of Healthcare should ensure that healthcare staff manage prisoners with suspected or confirmed COVID-19 in accordance with national and prison policies, including:
 - conducting prompt PCR tests for prisoners with symptoms of COVID-19;
 - completing and documenting all the necessary clinical observations; and
 - ensuring patients are appropriately monitored for signs of deterioration.
- The Governor should ensure that prisoners with symptoms of COVID-19 are immediately placed in protective isolation; are clearly identifiable and that their personal records are documented.
- The Governor should ensure that decisions to remove restraints are made quickly and communicated immediately to escorting officers.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Lawrence's clinical care at HMP Garth.
8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Lawrence's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
9. The PPO investigator and independent clinical reviewer jointly interviewed four members of the healthcare department and a prison manager. The interviews were conducted by telephone, due to the restrictions in place during the COVID-19 pandemic and summaries are attached as annexes.
10. The Ombudsman's family liaison officer wrote to Mr Lawrence's mother, his nominated next of kin to explain the investigation and ask if there were any issues she wanted the investigation to consider. A family member replied on behalf of his mother and the wider family. Although the response was received after the clinical review report had been completed, the clinical issues raised had been considered. In summary, Mr Lawrence's family asked the following:
 - For how long did Mr Lawrence have breathing difficulties before being tested for COVID-19; and what action was taken after he tested positive?
 - Was he assessed by a clinician; were his symptoms monitored; and what care was given?
 - How severe were his symptoms when he was sent to hospital?
 - Why was his family not informed that he had contracted COVID-19; and why was there no opportunity to speak to him before he was sedated?
 - Was there a COVID-19 outbreak at Garth around the time of Mr Lawrence's diagnosis and were there other COVID-19 related deaths at the prison? What protective measures were in place?
11. Mr Lawrence's family received copies of our initial report. They made no comments.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan is annexed to this report.

Previous deaths at HMP Garth

13. Mr Lawrence was the tenth prisoner at Garth to die since January 2020. Six of the previous deaths were from natural causes (one due to COVID-19), two were self-inflicted and one was drug-related. There has since been a further death, but the cause is unclear. We have previously raised concerns about the management of prisoners with symptoms of COVID-19.

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 George Lawrence was remanded to prison on 11 June 2010. He was later convicted of murder and sentenced to life imprisonment, with a minimum period to serve of 21 years. Mr Lawrence transferred from HMP Birmingham to HMP Garth on 18 May 2011.
18. Mr Lawrence had no significant medical conditions and therefore had limited contact with the healthcare department at Garth. He did not attend routine health checks and refused flu vaccinations.
19. In April and October 2021, Mr Lawrence declined the COVID-19 vaccine. On 2 and 16 December, the community matron intended to offer the vaccine again, but was unable to access the wing due to staff shortages and an outbreak of COVID-19, respectively.
20. Mr Lawrence lived on C wing. On 9 December, all the residents were placed in protective isolation for ten days, as a high number were COVID-19 positive. Mr Lawrence tested negative that day, as well as four times between 14 and 21 December. As a servery worker and cleaner, he was part of a small team that continued working.

Deterioration in Mr Lawrence's health

21. On 11 December, Mr Lawrence reported breathing difficulties and a headache which had started a few days before. A nurse gave him paracetamol and a pulse oximeter, with instructions on monitoring his blood oxygen saturation levels. She explained the signs of deterioration and advised him to tell healthcare staff if his symptoms worsened.
22. On 21 December, Mr Lawrence was unwell and a nurse reviewed him. He initially refused to be swabbed, stating that he had taken four lateral flow tests in the past week, but he relented when told it would be a Polymerase Chain Reaction (PCR) test to be sent to a laboratory. He said that he had not eaten for around ten days, as he could not smell or taste the food. The nurse did not have the equipment to complete full observations so his blood pressure, temperature and respiratory rate were not checked. However, he was not short of breath and the pulse oximeter showed his oxygen level was within acceptable limits. Mr Lawrence asked the nurse to leave so he could go back to bed.
23. Just before 11.00am on 23 December, staff found that Mr Lawrence was struggling to breathe, talk and walk and had been unable to reach his emergency cell bell. A code blue medical emergency was called (which indicates that a prisoner has breathing difficulties, or is unresponsive) and staff in the control room telephoned the ambulance service.
24. A nurse examined Mr Lawrence and found that he was warm to the touch, short of breath, as well as slightly confused and disorientated. On checking his medical records, staff found that the result of the PCR test had returned as positive at 2.00am that morning. The nurse gave Mr Lawrence oxygen, completed clinical observations and calculated a National Early Warning Score 2 (NEWS2) of 12. (NEWS 2 is an assessment tool which identifies clinical deterioration. A total score

of 7 or over suggests high risk and requires emergency assessment by a critical care team.)

25. Paramedics took Mr Lawrence to hospital, arriving at 12.30pm. He was escorted by two prison officers, using an escort chain rather than handcuffs, in line with the policy on restraints for COVID-19 positive prisoners. It was removed at 4.40pm.
26. The prison's family liaison officer telephoned Mr Lawrence's mother at 2.30pm. While they were speaking, she was informed that Mr Lawrence had been sedated and was to be moved to the critical care unit. She told Mr Lawrence's mother immediately and arranged for her to maintain direct contact with hospital staff. She also gave updates to the family at significant points.
27. Healthcare staff obtained regular, detailed updates from the hospital. On 24 December, CT scans showed that Mr Lawrence had COVID-19 pneumonitis.
28. Mr Lawrence did not recover and died at 5.10pm on 11 January 2022. The family liaison officer immediately telephoned his family to offer condolences and kept in touch to provide support and information on the procedures to be followed.
29. A custodial manager debriefed staff. Notices were issued to other staff and prisoners informing them of Mr Lawrence's death and reminding them of the support available.
30. Mr Lawrence's funeral was held on 18 February 2022. In line with national policy, the prison contributed to the expenses.

Cause of death

29. No post-mortem examination was held as HM Coroner accepted clinical certification from a hospital doctor that Mr Lawrence's death was due to COVID-19 infection.

Findings

Clinical Findings

30. The clinical reviewer considered that Mr Lawrence's care at Garth was variable. Although there were good examples of risk management, healthcare staff did not comply with the procedures for monitoring him when he developed symptoms of COVID-19. In view of this, we conclude that Mr Lawrence's clinical care was not equivalent to that which he could have expected to receive in the community.
31. Full details of the clinical reviewer's findings are in the clinical review report. The weaknesses identified are summarised below and we reflect the recommendations.

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

32. Mr Lawrence had no significant underlying health conditions to suggest that he was at particular risk from COVID-19, although ethnicity can be a risk factor in terms of potential impact and outcomes.
33. Protective measures at Garth included placing the men in cohorts for basic activities outside their cells, such as showers and exercise. A limited number were unlocked together and social distancing was in place. If a prisoner in a cohort tested positive, the others were placed in smaller groups. Only essential work was carried out, by the same team of men and there was no mixing of cohorts in work areas. The prison gave information to residents in different ways, including notices, verbally through wing representatives and on the prison's TV channel. Mass testing also took place.
34. We are satisfied that Garth implemented appropriate infection control measures. Despite their efforts, it seems that Mr Lawrence contracted the virus at the prison, as he had not left for any reason in the weeks before his diagnosis.

Monitoring Mr Lawrence after he contracted COVID-19

35. National guidance, *Preventing and controlling outbreaks of COVID-19 in prisons and places of detention*, states that prisoners with COVID-19 symptoms should self-isolate and take a PCR test.
36. Garth's healthcare department also has a detailed staff guide, *COVID: patient-held oxygen saturation monitoring and clinical escalation procedure*. Patients are expected to monitor their blood oxygen saturation level with a pulse oximeter and alert staff if it falls below 94%. The guidance sets out the required clinical observations and escalation procedures relevant to the severity of the symptoms.
37. Wing staff are expected to conduct three welfare checks per day for all prisoners, regardless of their clinical status and there was provision for healthcare staff to request extra checks for specific prisoners, if necessary.
38. The investigation found shortcomings in Mr Lawrence's clinical management and cohorting arrangements. After he first reported symptoms of COVID-19 on 11 December, the nurse who reviewed him did not take a full set of observations, or calculate a NEWS2 score, but gave him a pulse oximeter, as a precaution. At that

time, symptomatic patients were expected to have a PCR test. The nurse said she did not arrange this, as a lateral flow test taken on 9 December had been negative.

39. It is unclear whether Mr Lawrence was placed in protective isolation at this point (as he should have been). The weight of evidence and the lack of a relevant alert in his NOMIS personal records suggests that he was not. The list of those in protective isolation was held centrally on a white board on each wing. As an essential worker, Mr Lawrence would have been out of his cell if not self-isolating. (A prison manager thought it likely that he was isolated 24-48 hours before the result of the PCR test, which was recorded on 23 December.) The lack of clarity about his isolation status casts doubt on the effectiveness of the cohorting arrangements.
40. Over the nine days from 11 December, there was no clinical monitoring and no concerns were raised. When Mr Lawrence's health deteriorated on 21 December, the clinical observations were again incomplete, no NEWS2 score was calculated and, again, no clinical monitoring was arranged.
41. At interview, the Head of Healthcare said that since Mr Lawrence's death, staff have been given additional guidance on recognising deterioration in patients and the importance of recording the NEWS2 score. Refresher sessions are planned and individual observation kits will be re-issued to staff.
42. We are satisfied that Garth has formal processes for managing and monitoring prisoners with symptoms of COVID-19 and note the action taken to address the shortcomings identified. However, we share the clinical reviewer's concern that healthcare staff failed to comply with these important procedures. Mr Lawrence did not receive appropriate care and the failure to isolate him promptly put others at risk. Clinical monitoring of COVID-19 patients is an issue we have raised with the prison before and it is important to ensure that improvements are embedded and sustained. We recommend:

The Head of Healthcare should ensure that healthcare staff manage prisoners with suspected or confirmed COVID-19 in accordance with national and prison policies, including:

- **conducting prompt PCR tests for prisoners with symptoms of COVID-19;**
- **completing and documenting all the necessary clinical observations; and**
- **ensuring patients are appropriately monitored for signs of deterioration.**

The Governor should ensure that prisoners with symptoms of COVID-19 are immediately placed in protective isolation; are clearly identifiable and that their personal records are documented.

Emergency response

43. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, explains the actions staff should take in a medical emergency. It is a mandatory

requirement that if an emergency code is called, control room staff request an ambulance immediately.

44. Prison and ambulance service records indicate that an ambulance was requested at 11.00am, six minutes after the code blue was called. A prison manager said they recently found that control room staff only recorded the time of connection with the call handler, rather than when they first dialled and there were sometimes delays of several minutes before calls were answered. To address this and other weaknesses identified in previous investigations, Garth recently updated their local protocol and staff notices. These reflect the national policy and include new, detailed guidance posted on the wall of the control room.
45. As Garth has substantively addressed our previous recommendation, made shortly before Mr Lawrence's death, as well as weaknesses they have identified since, we make no further comment on this issue.

Security risk assessments and the use of restraints

46. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, explains the actions staff should take in a medical emergency. It is a mandatory requirement that if an emergency code is called, control room staff request an ambulance immediately.
47. Prison and ambulance service records indicate that an ambulance was requested at 11.00am, six minutes after the code blue was called. A prison manager said they recently found that control room staff only recorded the time of connection with the call handler, rather than when they first dialled and there were sometimes delays of several minutes before calls were answered. To address this and other weaknesses identified in previous investigations, Garth recently updated their local protocol and staff notices. These reflect the national policy and include new, detailed guidance posted on the wall of the control room.
48. As Garth has substantively addressed our previous recommendation, made shortly before Mr Lawrence's death, as well as weaknesses they have identified since, we make no further comment on this issue.

Contacting Mr Lawrence's next of kin

49. National guidance on family liaison and communicating with prisoners' families during the pandemic states that if a prisoner is either diagnosed with, or suspected of contracting, COVID-19, they should be given the opportunity for someone to be informed.
50. Mr Lawrence's family asked why they were not informed that Mr Lawrence had tested positive for COVID-19 and why there had been no opportunity to speak to him before he was sedated.
51. At Garth, prisoners isolate in their own cells (rather than a dedicated unit) and are therefore able to keep in touch with friends and family using in-cell telephones, if they are well enough to do so. Mr Lawrence had tested negative several times and the result of his positive PCR test was received in the early hours of the morning that he was taken to hospital.

52. The family liaison officer informed Mr Lawrence's mother that he was in hospital within two hours of his arrival, before he had been admitted to a ward. The intention to sedate him came to light during their telephone conversation and she was informed immediately.
53. We appreciate that it was distressing for Mr Lawrence's family to have been deprived of contact with Mr Lawrence before he was sedated. However, we are satisfied that the escort staff notified the prison promptly of the hospital's plans and that the information was passed on with no avoidable delay.

Kimberley Bingham

Acting Prisons and Probation Ombudsman

August 2022

Inquest

The inquest, held from 18 to 19 December 2023, concluded that Mr Lawrence died from natural causes.

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