

**Prisons &
Probation****Ombudsman**
Independent Investigations

Learning lessons bulletin

Fatal incident investigations | Issue 16

Second wave COVID-19 related deaths

Foreword

This learning lessons bulletin summarises our findings from the second wave of COVID-19 related deaths in prisons.¹ It covers deaths notified to us and investigations started between 8 October 2020 and 20 April 2021.

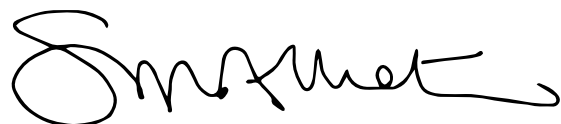
This bulletin follows on from our previous learning lessons bulletin exploring COVID-19 related deaths in the first wave.² When compared to the first wave of COVID-19 related deaths, the second wave saw a higher number of deaths and lasted longer.

We recognise the considerable pressures that COVID-19 brought for both prisoners and staff. The deaths investigated during the second wave have continued to show the care and compassion that prisoners and their families and friends have received from prison and healthcare staff. However, we have also found

cases where the correct procedures were not followed and where care was not good enough.

In this bulletin, we set out case studies that both demonstrate good practice and highlight COVID-19 related lessons to be learned. Some of the lessons are repeated from the previous bulletin.

We know that the impact of COVID-19 will continue to present a risk to safety in prisons, and that its effects will be felt across the prison estate well into the future. We hope this bulletin will provide useful learning that can play a part in supporting the ongoing response to COVID-19.



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Prisons and Probation Ombudsman

¹ There was one death of an Approved Premises resident.

² https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkhjmgw/uploads/2021/02/6.7154_PPO_LL_Bulletin_Covid_Fatal_Incidents_WEB2.pdf

Context/Policy

COVID-19

COVID-19 is an infectious disease that affects the lungs and airways. It can make anyone seriously ill, but the risk is higher for some people.³

HMPPS and policy

Prisons were initially identified as a place where COVID-19 could spread rapidly. Early predictions suggested that a high number of prisoners could die from COVID-19.⁴ HM Prison and Probation Service (HMPPS) quickly implemented disease prevention strategies, such as discrete units known as protective isolation units, shielding units and reverse cohorting units. They also began operating significantly restricted regimes within prisons, with many prisoners spending up to 23 hours a day in their cell. Family visits were suspended and transfers between prisons were limited. It was recommended that Approved Premises and immigration removal centres follow the same guidance.^{5 6}

As the pandemic has progressed, other policies and practices have been implemented, along with a testing regime for both prisoners and staff to identify those infected with COVID-19. The COVID-19 vaccination programme was rolled out across prisons using the same prioritisation as those in the community.⁷ COVID-19 continues to impact regimes.⁸

PPO definition of a COVID-19 related death

The PPO categorises a death as COVID-19 related if COVID-19 is listed on the individual's death certificate or post-mortem report as either the cause of, or contributory factor to, the death.⁹

In some cases, COVID-19 is recorded as the cause of death, or one of the causes of death. Other long-term underlying health issues and illnesses may also be recorded as having contributed to an individual's death. In other cases, COVID-19 is listed on the death certificate as a contributing factor to the death, but not the immediate cause of death.

Deaths are recorded as COVID-19 related from the outset of the investigation if there appears to be a COVID-19 element. If information provided later shows that the death does not fit our definition, the death will be re-categorised. In some cases, the cause and causes of death may change throughout our investigation.

The numbers contained in this learning lessons bulletin are correct at the time of freezing the data, but may change as investigations progress.¹⁰

The PPO does not determine the cause of death, which is usually determined by the coroner following an inquest. At the PPO, cases are separated into administrative categories that may differ from the coroner's conclusions.

3 <https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/who-is-at-high-risk-from-coronavirus/>

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf

5 <https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance/covid-19-prisons-and-other-prescribed-places-of-detention-guidance>

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/979807/S1166_EMG_transmission_in_prisons.pdf

7 <https://www.gov.uk/government/publications/covid-19-vaccination-resources-for-secure-settings/covid-19-vaccination-information-for-people-in-prison>

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011828/prisons-national-framework-august-2021.pdf

9 Whether COVID-19 is listed on the death certificate is not always consistently recorded.

10 21 October 2021.

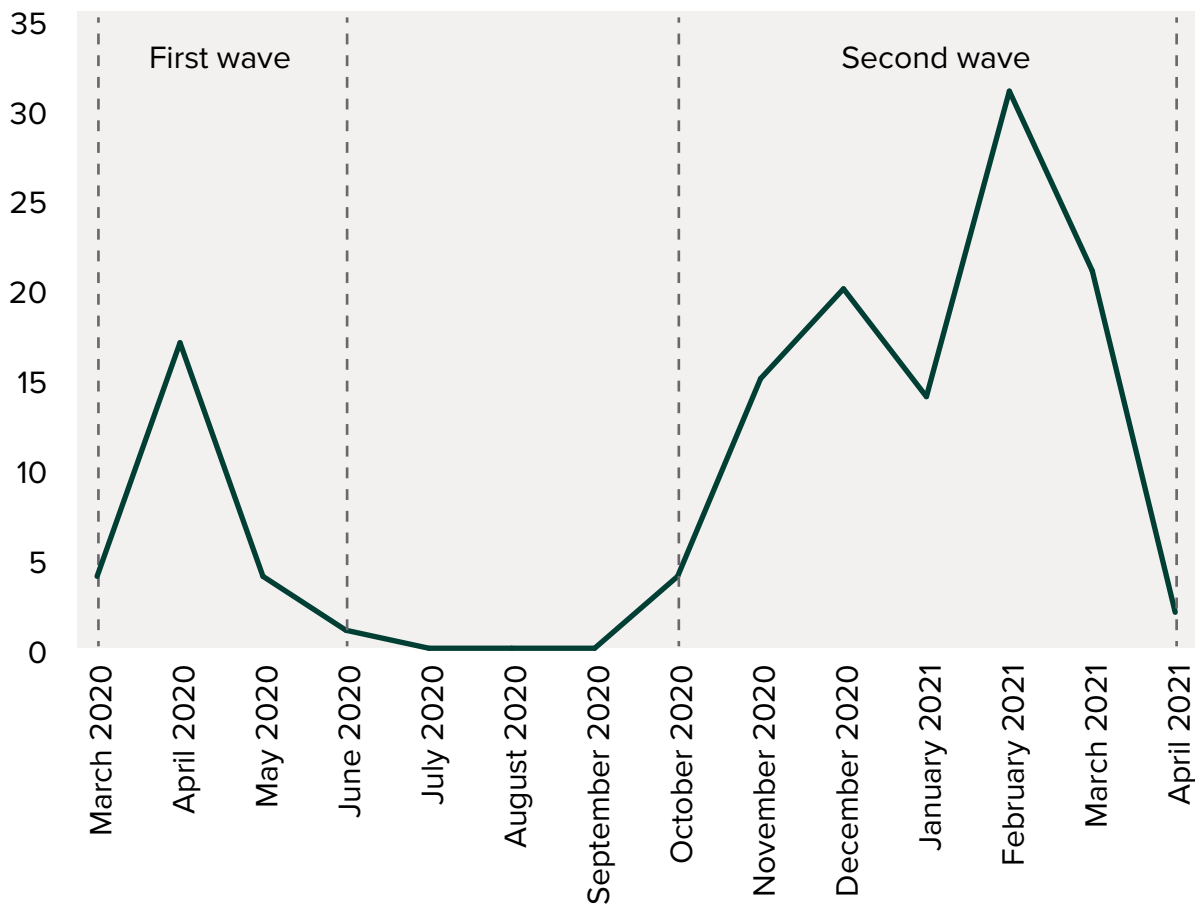
The PPO and HMPPS have different defining criteria for classifying COVID-19 related deaths. For this reason, the totals in this bulletin will differ slightly from those published by HMPPS.

Second wave of COVID-19 related deaths

The first wave of COVID-19 related deaths was between 18 March 2020 and 27 May 2020 and consisted of 26 deaths.^{11 12}

The second wave of COVID-19 related deaths was longer and included more deaths than the first wave. Between 8 October 2020 and 20 April 2021, we were notified of, and started investigating, 107 COVID-19 related deaths.¹³

COVID-19 related deaths between March 2020 and April 2021¹⁴



11 One case referred to in this cohort of data was notified to us in June 2020, but the date of death was April 2020.

12 https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhjkmgw/uploads/2021/02/6.7154_PPO_LL_Bulletin_Covid_Fatal_Incidents_WEB2.pdf

13 There were no further COVID-19 related deaths that we were notified of and started investigations into until early August 2021.

14 Data based on date of notification, not date of death.

In March 2021, SAGE published a report on COVID-19 in prisons. This found that the “number and size of [COVID-19] outbreaks, hospitalisation and mortality rates have increased markedly in wave 2 compared to wave 1, as also observed in the community”. SAGE commented that this may have reflected the increased transmissibility of the B.1.1.7 strain, more commonly known as the Alpha variant. It may also have been linked to higher community incidence, and potentially a degree of fatigue with control measures in prison.

SAGE found that “Prisons are highly prone to large-scale outbreaks, leading to higher rates of infection and hospitalisation and much higher levels of COVID-19 mortality than seen in the general population after adjusting for age. Both the higher incidence of infection and the poorer underlying health of prisoners are likely to contribute to this increase in mortality.”¹⁵

PPO data

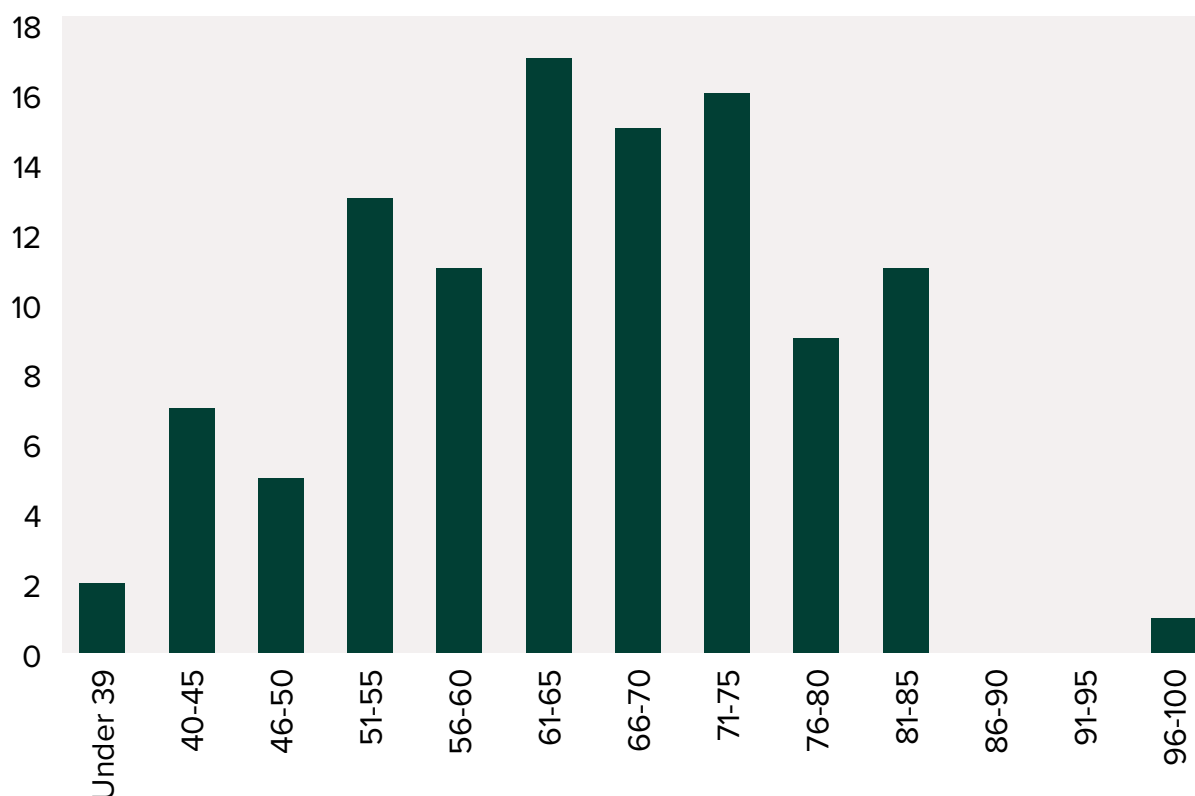
Demographics of those who died

We were notified of, and began investigations into, 107 COVID-19 related deaths between 8 October 2020 and 20 April 2021. We have set out the basic demographics of those who died, but the relatively small numbers mean that we are unable to draw conclusions.

Of the 107 COVID-19 related deaths we investigated in the second wave:

- 106 were prisoners and 1 was a resident at a probation Approved Premises
- 104 were men and 3 were women
- the youngest was 36 years old and the oldest was 98 years old

COVID-19 related deaths between 8 October 2020 and 20 April 2021 by age



¹⁵ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/979807/S1166_EMG_transmission_in_prisons.pdf

COVID-19 related deaths between 8 October 2020 and 20 April 2021 by ethnicity

Ethnicity	Number
Asian or Asian British	5
Black or Black British	5
Mixed	1
White	95
Other ethnic group	1
Total	107

Where those who died may have caught COVID-19

In all the case studies described below, we found it was likely that the prisoner caught COVID-19 in prison because they had not left the prison in the 14 days before becoming ill or testing positive (the likely incubation period for COVID-19 is 14 days). In other COVID-19 related deaths during the second wave, it was clear that the deceased had caught COVID-19 in hospital as they had been an inpatient for other reasons before testing positive. In some cases, it was impossible for us to say where the deceased had caught COVID-19 because they had been moving between locations prior to becoming ill (for example, moving between prisons, or attending court hearings or hospital outpatient appointments).

During the pandemic, we have carried out very few prison visits as part of our fatal incident investigations. We have not had the opportunity to see for ourselves how prisoners and staff were able to observe measures, such as social distancing, aimed at preventing the spread of the virus. However, Her Majesty's Inspectorate of Prisons (HMI Prisons) undertook 35 short scrutiny visits during spring and summer 2020.¹⁶

HMI Prisons found that the restrictions put in place had helped to prevent the spread of the virus but at some prisons, overcrowding and the prison design made social distancing difficult. HMI Prisons also found that some staff did not observe social distancing when it was possible.

Case studies

At the time of writing,¹⁷ of the 107 COVID-19 related deaths notified to us and into which we began investigations between 8 October 2020 and 20 April 2021, 21 final reports have been published on our website. A further 20 final reports have been issued but not yet published and 37 are at initial report stage.¹⁸

The case studies below have been chosen to reflect some of the COVID-19 related themes we identified, areas for improvement or positive practice from the 78 cases where an initial or final report had been issued at the time of writing. We found other non-COVID-19 related issues in these cases, similar to concerns over other natural-cause deaths, but we have not focused on them in this bulletin.

Good practice

In the first two case studies, we were satisfied that the prison followed national guidance in place at the time and that the prisoners concerned received good care.

¹⁶ <https://www.justiceinspectorates.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2020/08/SSV-aggregate-report-web-2020.pdf>

¹⁷ 21 October 2021.

¹⁸ <https://www.ppo.gov.uk/document/fii-report/>

Case study 1

Mr A, who was 68, had several long-term medical conditions including chronic obstructive pulmonary disease (COPD), high blood pressure and diabetes. As a result, Mr A was identified as being at high risk of becoming seriously ill if he contracted COVID-19.

Mr A's prison record showed that he was advised to shield three times, but refused to do so each time. We were satisfied that he had the mental capacity to make the decision and he was aware of the risks. We found that the mental health team supported him well.

In October 2020, another prisoner pressed their emergency cell bell after hearing a thud and groaning noises from Mr A's cell. An officer found that Mr A was having difficulty breathing. The officer called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties, alerting healthcare staff and telling the control room to call an ambulance). A prison nurse responded to the code blue and gave Mr A oxygen. The ambulance arrived and took Mr A to hospital.

When Mr A arrived at the hospital, he was taken to intensive care and all restraints were removed. Two days later, he was released on temporary licence (ROTL). His health deteriorated and he died several weeks later. The cause of death was COVID-19 pneumonia, with COPD and diabetes listed as contributory factors.

The clinical reviewer was satisfied that Mr A's care was equivalent to what he would have received in the community, and that his long-term conditions were properly managed. Our investigation found that the prison had responded to national guidance on COVID-19. Despite this, we concluded that he must have contracted COVID-19 in prison.

Case study 2

Mr B, who was 73, had several long-term health conditions including kidney disease, vascular disease and diabetes. As a result, Mr B was located on the wing for older prisoners, which acted as a shielding unit from the beginning of the pandemic.

In mid-November 2020, a prison officer asked a nurse to see Mr B because he was feeling unwell. The nurse thought he had a chest infection and asked the doctor to prescribe antibiotics. The nurse also tested him for COVID-19.

Two days later, Mr B collapsed on his cell floor. The nurse took his observations, which were within the normal range. Later that day, his health deteriorated and he had a high temperature with a NEWS score of 5.¹⁹ This meant he needed urgent clinical assessment. An ambulance was called and Mr B was taken to hospital.

The following day, the hospital confirmed that Mr B had COVID-19 but as he did not have any symptoms, he was sent back to the prison. The day after he returned, a nurse took Mr B's observations and recorded a NEWS score of 11, which requires an emergency response. He was taken back to hospital and was released on temporary licence (ROTL), meaning he was able to remain in hospital without a prison escort.

Mr B agreed that if he stopped breathing, he did not want to be resuscitated and agreed to a DNACPR (do not attempt cardiopulmonary resuscitation) order being put in place. His health continued to deteriorate, treatment was withdrawn and he died in hospital.

¹⁹ National Early Warning Score (NEWS) is a tool used to assess clinical deterioration in adult patients.

The cause of his death was COVID-19 pneumonia and a urinary tract infection. Peripheral vascular disease, kidney disease and hypertension were listed as contributory factors.

The clinical reviewer concluded that when Mr B began to experience COVID-19 symptoms, healthcare staff responded quickly. Although it appears that Mr B had contracted the virus in prison, we were satisfied that the prison had followed national guidance on managing the risks of COVID-19 and promptly put in place the recommended policies and measures.

Correctly identifying those at risk from COVID-19

The following case study shows the importance of correctly identifying any health conditions that may lead to a higher risk of complications if a prisoner contracts COVID-19.

Case study 3

Mr C, who was 77, had several health conditions including COPD, chronic kidney disease, ischaemic heart disease and several other heart related conditions. These put him at high risk of becoming seriously ill if he contracted COVID-19.

When Mr C arrived at the prison, he had an initial health screen in reception. However, Mr C did not attend his secondary health screening appointment, and this was not followed up. We were concerned that Mr C's previous COPD diagnosis was not correctly recorded in his medical records, which meant he was not identified as being at risk and was not advised to shield at the outbreak of the COVID-19 pandemic. We were also concerned that Mr C's other long-term medical conditions were not identified in a timely way and no care management plans were in place.

In mid-December 2020, wing staff asked healthcare staff to assess Mr C as he felt unwell. Clinical observations were taken and the NEWS tool was used. An ambulance was requested and Mr C was given oxygen. He was admitted to hospital and tested positive for COVID-19 three days later.

Mr C died from COVID-19 pneumonia 13 days after being admitted to hospital. COPD, ischaemic heart disease and chronic kidney disease also contributed to his death. It appears that Mr C contracted the virus in prison, as he had not left within the usual incubation period.

Recording prisoners' mental capacity to make decisions about shielding and consistent use of NEWS

The following case study demonstrates the need to record prisoners' mental capacity to make decisions about shielding from COVID-19. It also shows the importance of consistently using and recording the NEWS tool.

Case study 4

Mr D, who was 83, had several long-term medical conditions including angina, atrial fibrillation (for which he was fitted with a pacemaker), COPD and high blood pressure. Coupled with his age, these conditions meant he was at high risk of becoming seriously ill if he contracted COVID-19.

From the end of March 2020, prison and healthcare staff repeatedly advised him to shield but he refused to do so. Healthcare staff considered that he had the mental capacity to make this decision, but we were concerned that there was no documentation to show any formal assessment.

In mid-January 2021, Mr D was given a new cellmate. In line with national prison policy, his new cellmate had been in the reverse cohorting unit for 14 days after arriving at the prison, and had twice tested negative for COVID-19. However, the cellmate started showing symptoms of COVID-19 the day after he moved into Mr D's cell. Mr D and his cellmate were put into isolation. Both subsequently tested positive for COVID-19.

At the end of January 2021, Mr D went to hospital twice – initially following a fall, and then because of breathing difficulties. During this time, we were concerned that the NEWS tool was not consistently used, and clinical observations were not recorded by the prison healthcare staff to ensure timely escalation of unwell patients.

Following Mr D's deterioration on 30 January 2021, an ambulance took him to hospital.

Mr D's health continued to deteriorate and he died in hospital six days later. A post-mortem found that Mr D died from cardiac failure. COVID-19 and COPD were listed as contributory factors. It is likely that Mr D caught COVID-19 in prison.

Isolation of prisoners with suspected COVID-19

The following case study shows the importance of isolating prisoners with COVID-19 symptoms and communicating positive COVID-19 test results, in order to avoid spreading the virus to other prisoners and staff.

Case study 5

Mr E, who was 43, had several long-term health conditions including epilepsy, type 2 diabetes, high blood pressure, obesity, bilateral leg lymphedema/gravitational eczema, leg ulcers and osteoarthritis. These conditions put him at high risk of becoming seriously ill if he contracted COVID-19.

In October 2020, there was an outbreak of COVID-19 at Mr E's prison. At the end of October 2020, Mr E told a nurse that he felt unwell and wanted a GP appointment. There is no record of any clinical observations being made. Five days later, Mr E was seen by a nurse after he said again that he felt unwell and had collapsed. Later that day, he tested positive for COVID-19. He was admitted to hospital six days later, where he died of COVID-19 pneumonia. He was also obese, which contributed to his death.

We were concerned that Mr E was not placed in protective isolation as soon as healthcare staff became aware that he was feeling unwell, considering the prison was experiencing an outbreak of COVID-19 at the time. There was also no record of Mr E's positive COVID-19 test results being shared with prison staff. This meant that he may have infected other prisoners and staff over a five-day period.

It appears that Mr E contracted COVID-19 in prison, as he had not left within the usual incubation period.

Monitoring prisoners who test positive for COVID-19

The following two case studies show the importance of monitoring prisoners with COVID-19, so that any deterioration is picked up quickly.

Case study 6

Mr F, who was 55, had several health conditions including asthma, rheumatoid arthritis, stiff man syndrome (a neurological disorder causing progressive rigidity), peripheral vascular disease and type 2 diabetes. These put him at high risk of becoming seriously ill if he contracted COVID-19. He had refused help to control some of these conditions.

In October 2020, there was an outbreak of COVID-19 at Mr F's prison. At the beginning of November 2020, Mr F tested positive for COVID-19 and was isolated in his cell. A week later, a nurse examined Mr F as he said that he was short of breath. She noted that he was struggling to breathe and in distress. She examined him, gave him oxygen and referred him to the prison GP. The prison GP examined Mr F, noting that this was his eighth or ninth day with COVID-19 symptoms, diagnosed a lower respiratory tract infection/developing pneumonia and sent Mr F to hospital.

Mr F's condition continued to deteriorate, and he died in hospital from acute COVID-19 related bronchopneumonia 10 days after his positive test.

We were concerned that there was no record of Mr F being monitored by healthcare staff in the week after his positive COVID-19 result. If he had been monitored, his deterioration might have been identified sooner and he might have been sent to hospital earlier. We recommended that all prisoners diagnosed with COVID-19 have a clinical management plan in place to treat the

illness and are regularly monitored by healthcare for any signs of deterioration.

It appears that Mr F contracted COVID-19 in prison, as he had not left in the weeks before testing positive.

Case study 7

Mr G, who was 76, had been assessed as at moderate risk of becoming seriously ill if he contracted COVID-19. This was mainly due to his age but also due to high blood pressure and high cholesterol. As he was not assessed as being at high risk, he was not advised to shield.

Following an outbreak of COVID-19 at Mr G's prison, he tested positive for COVID-19 in mid-December 2020 and was placed in protective isolation. There was an anomaly between the prison and healthcare records about the date he tested positive for COVID-19, and we were concerned that Mr G's positive COVID-19 result was not recorded in his medical records.

On 22 December 2020, an officer opened Mr G's door to give him his lunch and found him lying on the bed unresponsive. A nurse attended, but cardiopulmonary resuscitation was not attempted as there were signs of rigor mortis and it was clear that Mr G was dead.

A post-mortem examination concluded that on the balance of probabilities, Mr G's death was due to COVID-19.

We were concerned that, as Mr G was not showing symptoms, he was not checked by healthcare staff during the week after he tested positive. (This was in line with healthcare policy at the time. The policy has since changed and the prisoner's age, ethnicity, gender and health conditions are now considered in order to calculate risk

and determine whether welfare checks are needed.) Wing staff were supposed to carry out welfare checks of prisoners at around 8.00 to 8.30am, but there is no evidence that Mr G was checked, and we recommended that prison staff check the welfare of every prisoner each morning.

It is likely that Mr G contracted COVID-19 in prison, as he had not left the prison during the pandemic.

Keeping friends and family informed

The case of Mr H highlights the need to inform the nominated next of kin promptly if a prisoner is suspected of having COVID-19 (subject to the prisoner's wishes) and if they become seriously ill.

Case study 8

Mr H, who was 75, had several health conditions including high blood pressure, type 2 diabetes, chronic kidney disease and ischaemic heart disease. He had suffered a heart attack in 1999 and was clinically overweight. These conditions meant he was at high risk of becoming seriously ill if he contracted COVID-19.

At the end of February 2021, despite consistently shielding since June 2020, Mr H and his cellmate displayed COVID-19 symptoms. They were both tested for COVID-19 and isolated. Two days later, Mr H's test came back positive for COVID-19.

The next day, a nurse found Mr H on his bed covered in his own faeces, vomit and urine. He was semi-conscious, disoriented and his blood oxygen levels were 85% (a normal level is 95-100%). The nurse gave Mr H oxygen and he was taken to hospital, but his condition deteriorated. Three days after his admission to hospital, Mr H was put on an end-of-life pathway and he died later that evening. The doctor gave the cause of his death as COVID-19

pneumonia, with type 2 diabetes, hypertension, stroke and chronic kidney disease as contributory factors.

We were concerned that Mr H's family were not informed promptly that he was ill. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner becomes seriously ill. In March 2020, this obligation was reinforced in national prison service guidance on family liaison and communicating with prisoners' families during the pandemic. The guidance also states that if a prisoner is suspected of having COVID-19 (a formal diagnosis is not required), they should be given the opportunity to inform someone.

We were concerned that when Mr H tested positive for COVID-19, there was no evidence of asking him if he wanted next of kin to be informed. The prison did not appoint a family liaison officer (FLO) until two days after Mr H had been taken to hospital, and the FLO did not make contact with Mr H's next of kin until the day after that (the day of his death). Although the FLO noted that someone from the prison's Safer Custody department had spoken to the family the day before, we found no evidence of this. The family should have been contacted when Mr H was first taken to hospital.

Mr H had not left the prison for over four weeks before he tested positive for COVID-19, and it appears that he caught COVID-19 in prison.

Appropriate use of restraints

The case of Mr E, which we discussed earlier, also illustrates the need to make risk assessments based on prisoners' current state of health and the risk of staff exposure to COVID-19.

Case study 5 continued

When Mr E (the subject of case study 5) was taken to hospital in early November 2020, the healthcare section of the risk assessment form said that there were "no medical objections to the use of restraints" and did not alert the escorting prison staff to the COVID-19 risks. The healthcare section also said that Mr E's "medical condition did not restrict his ability to escape" and that the restraints should not be removed for consultation or treatment. It made no mention of his long-term medical conditions, reduced mobility or the fact that he was extremely unwell and would have had difficulty breathing without oxygen support.

A second risk assessment completed on the same day raised no objections to the use of restraints, although it did note that Mr E had long-term health conditions, received a large amount of medication and used a walking stick. It noted that there was an active COVID-19 alert on his record.

Prison staff assessed Mr E as a medium risk to the public and hospital staff. He was considered to be high risk for hostage taking, and a low risk for escape potential and outside assistance. A manager authorised a single handcuff (for the journey to hospital) and an escort chain (for hospital admission).

The following morning, the escort chain was temporarily removed in hospital for treatment. 35 minutes later, the duty manager instructed the officers to reapply the restraints on the grounds that Mr E's behaviour had changed (he had tried to remove his oxygen hood). The restraints remained in place for another 30 minutes until hospital staff asked for them to be removed. Mr E died 20 minutes later.

We were not satisfied that there was appropriate and considered healthcare input into Mr E's risk assessment. We recognised that Mr E had a history of hostage taking, as his offence was unlawful imprisonment, but we were concerned that prison managers did not consider Mr E's life-threatening health condition, even when he was moved to the hospital's high dependency unit. COVID-19 patients can find oxygen treatment very uncomfortable and claustrophobic, and it is not uncommon for them to try to remove the equipment. We were concerned that prison staff interpreted this as poor behaviour that merited reapplying restraints.

Given his long-term health conditions and limited mobility when he went to hospital, and deteriorating health after his admission, we consider it unlikely that Mr E would have been able to escape or pose a risk to the public while being escorted by two officers. The restraints should have been removed earlier. The clinical reviewer also expressed concern that the escort staff were exposed to a higher risk of contracting COVID-19 as a result of being closely handcuffed to Mr E.

Lessons to be learned

Based on our findings, HMPPS and prison healthcare providers should ensure that:

- all prisoners at high risk of becoming seriously ill if they contract COVID-19 are identified and are given appropriate advice about shielding
- prisoners at high risk of becoming seriously ill if they contract COVID-19 are formally assessed to check they have the mental capacity to understand the risks of not shielding, and this is recorded
- prison and healthcare staff are made aware of prisoners who are shielding and/or self-isolating due to COVID-19
- positive COVID-19 tests are recorded in individuals' medical records
- all prisoners with suspected or confirmed COVID-19 are regularly monitored by healthcare staff through clinical observations (including NEWS), and these are recorded
- all prisoners with suspected or confirmed COVID-19 have an appropriate clinical management plan that reflects their individual needs
- prisoners suspected of having COVID-19 are given the opportunity for a relative or friend to be notified
- the risk of staff exposure is considered when prisoners with suspected or confirmed COVID-19 are restrained

We also found other non-COVID-19 related lessons to be learned in the second wave of COVID-19 related deaths. These were typical of concerns that we often see in natural-cause deaths, so we have not focused on them in this bulletin.

What the data does not tell us

As we only investigate deaths within our remit and do not investigate other cases where prisoners have contracted COVID-19, there is much that our data and investigations cannot tell us.

We have no evidence on the care of those who had COVID-19 and have since recovered. We also have no information on prisoners who are still suffering from the effects of long COVID-19 and have additional healthcare needs.

About the data

Please see the 'PPO definition of a COVID-19 related death' section for more details about how the PPO defines a COVID-19 related death.

Fatal incident data was frozen on 21 October 2021 and is based on the date that the PPO were notified of the death.

The case studies are not representative of all the COVID-19 related deaths we have investigated and were not chosen at random.

The ethnicity data is grouped into Asian, Black, Mixed, White and Other, and includes ethnic minorities from these groups.

Glossary

Protective isolation units: Units used for the temporary isolation of prisoners who are displaying symptoms of COVID-19.²⁰

Reverse cohorting units: Are required to test all newly arrived prisoners. Polymerase chain reaction tests are to be completed on day 0 and day 5, and a lateral flow device test is completed at the point of movement to a residential wing. This can impact and decrease the 14-day cohort period and provides additional reassurance in limiting infection spread. In many prisons, the reverse cohort period is kept to between 7 and 10 days, depending on testing engagement. This is in line with community isolation and cohorting requirements.²⁰

Shielding units: A form of social distancing for those who are more vulnerable to COVID-19.²⁰

DNACPR/DNAR: Stands for 'do not attempt (cardiopulmonary) resuscitation' if the patient's heart or breathing stops.²¹

NEWS: National Early Warning Score is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients and monitor deterioration.²²

Code blue: A medical emergency code indicating that a prisoner has chest pain, breathing difficulties or is unconscious. This should automatically trigger the prison to call an ambulance immediately and healthcare staff to attend with the correct equipment.²³

ROTL: Release on temporary licence is when prisoners are released from prison temporarily for short periods of time.²⁴

FLO: Family liaison officers are a named point of contact for the family.²⁵

COPD: Chronic obstructive pulmonary disease is the name for a group of lung conditions that cause breathing difficulties.²⁶

NICE guidelines: National Institute for Health and Care Excellence guidelines are evidence-based recommendations for health and care in England.²⁷



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20 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/979807/S1166_EMG_transmission_in_prisons.pdf

21 <https://www.nhs.uk/conditions/do-not-attempt-cardiopulmonary-resuscitation-dnacpr-decisions/>

22 <https://www.nice.org.uk/advice/mib205/chapter/The-technology>

23 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1015954/psi-03-2013-medical-emergency-response-codes.pdf

24 <https://www.gov.uk/government/publications/release-on-temporary-licence>

25 <https://www.gov.uk/government/publications/managing-prisoner-safety-in-custody-psi-642011>

26 <https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/>

27 <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines>