

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Learning lessons bulletin

Fatal incidents investigations | Issue 15

## COVID-19 PPO Fatal Incident Investigations

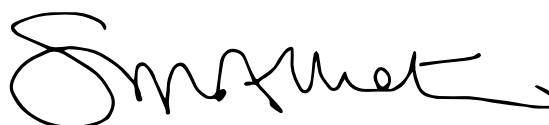
### Foreword

In March 2020, COVID-19 was declared a pandemic and brought substantial changes to how prisons, Approved Premises (APs) and immigration removal centres (IRCs) were able to function.

This report explores emerging findings based on the analysis and case studies of the COVID-19 related deaths we have investigated. It explores the first wave of COVID-19 related deaths in prisons, looking at the 26 fatal incident investigations which we started between the middle of March 2020 and the end of May 2020.<sup>1</sup>

The effects of COVID-19 are still ongoing and far reaching. We will produce further reports exploring our COVID-19 related fatal incident investigations and complaint investigations, and the lessons to be learned from them.

The cases we have investigated have shown the care and compassion prisoners and family members received from prison and healthcare staff. However, we have also found some cases where responses could be improved. I hope this bulletin, and those we produce in the future, will provide useful lessons to help to improve the ongoing response to COVID-19.



**Sue McAllister CB**

Prisons and Probation Ombudsman

<sup>1</sup> Over this timeframe, we were not notified of any COVID-19 related deaths in IRCs or Approved Premises. One death covered in this report was technically a post-release death but was investigated because, although the prisoner was released from prison while in hospital, they died in hospital without being released into the community.

# Context/Policy

## COVID-19

COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs or sneezes. The first reported positive case of COVID-19 in the UK was in late January 2020.<sup>2</sup> On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.<sup>3</sup>

COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high risk (clinically extremely vulnerable) and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant and those who have a severe lung condition with a very high risk of getting infections. Those at moderate risk include: people over 70; people with a lung condition or a medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese.<sup>4</sup> This list is not exhaustive.

## HMPPS and policy

On 23 March 2020, the government announced national lockdown restrictions in response to COVID-19. Early predictions surrounding the spread of the virus without any controls in place suggested a high number of prisoners could die.<sup>5</sup>

HM Prison and Probation Service (HMPPS) and the Home Office had to adapt their policies and working practices. As a result, measures were put in place to help reduce the spread of COVID-19. These included discrete units known as protective isolation units, shielding units and reverse cohorting units respectively.<sup>6,7,8</sup> These units were intended to limit the potential spread of the virus among the wider prison population. A number of early release schemes were introduced. According to HMPPS data, as of 30 September 2020, 316 prisoners had been released under COVID-19 temporary release schemes.<sup>9</sup>

To protect the most vulnerable in our communities, the NHS and HMPPS sent out letters to people in prisons, IRCs and APs who were deemed to be particularly high risk of becoming seriously ill if they contracted the virus and advised them to shield.

## Changes to PPO working practices

The national lockdown resulted in the closure of the PPO office in Canary Wharf and all staff began working from home full-time. As a result, we had to make some significant changes to how we worked. The closure of our office meant that, initially, we could not access our post. In mid-May 2020, we began redirecting our post to a postal scanning company. Since that date, we have been able to access our post electronically and process it as normal.

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2 <https://bfpg.co.uk/2020/04/covid-19-timeline/>

3 <https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov>

4 <https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/>

5 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/882622/covid-19-population-management-strategy-prisons.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf)

6 <https://publications.parliament.uk/pa/cm5801/cmselect/cmjust/299/29902.htm>

7 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/921491/detention-and-escorting-services-guidance-during-covid-19\\_v3.0.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921491/detention-and-escorting-services-guidance-during-covid-19_v3.0.pdf)

8 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/882622/covid-19-population-management-strategy-prisons.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf)

9 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/925232/HMPPS\\_COVID19\\_SEP20\\_Pub.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925232/HMPPS_COVID19_SEP20_Pub.pdf)

Some additional challenges to fatal incidents investigations arose due to COVID-19 restrictions. Since March 2020, we have made very few in-person visits to prisons and only in one or two cases where we felt it was essential to do so. This has demonstrated how poor the IT provision is in prisons. Our visits are normally crucial to gathering information and evidence, and interviewing staff and prisoners. Before COVID-19, documents would be collected during these visits and interviews would be conducted in person.

Without visits we have had to rely on prisons being able to send us sensitive material electronically and some establishments have struggled to do this, particularly at first. There have been particular difficulties in receiving CCTV and body-worn camera footage and recordings of prisoners' telephone calls in formats we can easily access.

Almost all interviews have had to be completed either by telephone or, in a minority of cases, via video calls. This is less satisfactory than interviewing in person.

But we have also made some improvements to our new way of working. Where possible we now send letters and reports to prisoners' families and next of kin by email rather than post, which has meant quicker responses and confirmation that they have received the report. However, not all families have access to email and in those cases, we have continued to send reports by post.

Overall, we are satisfied that we have been able to develop 'workarounds' and to continue conducting our investigations and producing good quality reports. There have inevitably been delays caused either by technological difficulties or by staff shortages in prisons, among clinical reviewers and among our own

staff as a result of illness and home-schooling responsibilities. We have done all we can to minimise these delays and the consequent need for some reports to be sent out later than would normally be the case.

## **PPO definition of a COVID-19 related death**

The PPO does not determine the cause of death. This is normally determined by the coroner following an inquest.<sup>10</sup>

The PPO categorises a death as COVID-19 related if COVID-19 is listed on the prisoner's death certificate as either the main or contributory factor to the death.<sup>11</sup> In some cases, COVID-19 is recorded as the cause of death, or one of the causes of death and other long-term underlying health issues and illnesses may also contribute towards an individual's death. In other cases, COVID-19 is listed on the death certificate as a contributing factor to the death, but not causing the death.

This report focuses on COVID-19 related deaths which occurred early in the pandemic. It looks at the 26 cases we were notified of and began investigations into between 18 March 2020 and 27 May 2020.<sup>12</sup> It is important to note that, initially, testing was not widely available. A testing programme to better understand the spread of COVID-19 in prisons and the wider estate did not begin until 20 July 2020.<sup>13</sup> In some cases there was very little time between healthcare staff being made aware of a possible COVID-19 infection and the individual either dying or being taken into hospital.

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

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10 In the PPO, cases are separated into administrative categories that may differ from the coroner's conclusions.

11 Whether COVID-19 is listed on the death certificate is not completely consistently recorded.

12 There were no further COVID-19 related deaths we were notified of and started investigations into until early October 2020.

13 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/925232/HMPPS\\_COVID19\\_SEP20\\_Pub.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925232/HMPPS_COVID19_SEP20_Pub.pdf)

## PPO data

### Demographics of those who died

Between 18 March 2020 and 27 May 2020, we were notified of and began investigations into the deaths of 25 prisoners and one post-release death which were COVID-19 related.

Of the 26 deaths, the mean age was 67 years old, the youngest being 40 years old and the oldest being 90 years old.

All but two of the 26 prisoners who died were males, 22 were White British, three were Black, Asian or Minority Ethnic and one was White Irish.

The majority of the 26 deaths happened in hospital (22). Two prisoners died in their cells, one died in the prison healthcare centre and another died in a hospice.

Of the 26 deaths, 22 had COVID-19 as the main cause of death listed on the death certificate, and three noted COVID-19 as a contributory factor towards the death. In one case there was a dispute between the pathologist and the hospital doctor as to whether the main cause of death was COVID-19 induced organ failure or whether COVID-19 was just a contributory factor, which shows how complex categorising these deaths can be.

All 26 individuals had at least one underlying health condition or illness. In many cases these illnesses and health issues contributed towards their death along with COVID-19. This is consistent with England and Wales deaths data as the Office of National Statistics (ONS)<sup>14</sup> reports 90% of deaths involving COVID-19 between 1 March 2020 and 30 April 2020 were of individuals who had at least one pre-existing condition.

In the 26 deaths, the most common underlying health condition listed in our reports was ischaemic heart disease with 11 occurrences. This is also consistent with the ONS<sup>15</sup> data on pre-existing health conditions where ischaemic heart diseases are the second most common health condition after Dementia and Alzheimer's disease in deaths involving COVID-19 between 1 March 2020 and 30 April 2020.<sup>16</sup>

### Where those who died may have caught COVID-19

In the cases we investigated, it was not always possible to establish with certainty where the deceased caught the virus. This information, where available, will be useful to reduce future infections and we will include it when we can.

In eight out of the 26 cases it was likely they caught the virus in prison. In six cases it was likely they caught the virus either as an inpatient in hospital or attending hospital appointments.

In seven cases there was no reference in our reports as to where the deceased caught the virus. In a further four cases we were unable to say where they caught the virus.

In one case it is possible that a new cell mate who had been in the community and previously shared another cell with three other prisoners who had been in the community may have passed on the virus when moved into the deceased prisoner's cell.

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14 <https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/deathsfromcovid19bothwithandwithoutunderlyinghealthconditions>

15 <https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/deathsfromcovid19bothwithandwithoutunderlyinghealthconditions>

16 Please see the 'about the data' section.

## Case studies

The case studies below have been specifically chosen as they highlight areas for improvement or show positive practice. The case studies are not representative of all the COVID-19 related deaths we have investigated and were not chosen at random.

### Case study 1

Ms A, who was 55, was serving a life sentence for murder.

Ms A was clinically vulnerable to becoming seriously ill if she contracted COVID-19 due to her chronic health conditions, including lung disease and asthma. Senior prison managers advised her to shield but she refused to do so and continued working as a cleaner until the day before she was admitted to hospital.

On the morning of 5 April, Ms A had a high temperature. She was given paracetamol and her temperature dropped but remained high. Ms A's temperature was in the normal range the next day and she tested negative for COVID-19. She continued to work as a cleaner.

On 8 April, Ms A's health deteriorated, her oxygen level was extremely low and she was sent to hospital, where she was diagnosed with pneumonia and tested positive for COVID-19. She received oxygen therapy but she was moved to intensive care on 14 April, and died three days later from respiratory failure caused by COVID-19 pneumonia. The death certificate stated that her chronic health conditions did not cause but contributed to her death.

We are satisfied that prison staff advised Ms A about the risks of not shielding and that she was encouraged to do so. She had the mental capacity to understand the risks she took by opting not to shield.

However, we are concerned that Ms A had a known COVID-19 symptom (a high temperature) but continued her cleaning job which increased the risk of spreading the virus to other prisoners and staff. We therefore recommended the Governor and Head of Healthcare should ensure that prisoners or members of staff who develop symptoms associated with COVID-19 follow Public Health England's (PHE) guidance and self-isolate.

### Case study 2

Mr B was 75 years old and serving a sentence of Imprisonment for Public Protection for sexual offences.

Mr B had several chronic medical conditions, including high blood pressure, chronic heart disease and a past stroke. This made him clinically vulnerable to becoming seriously ill if he contracted COVID-19, so he shielded in his cell.

On 18 March, Mr B felt unwell with symptoms of slurred speech, difficulties balancing, a headache and neck pain. Healthcare staff examined him and asked about COVID-19 symptoms. He replied that he had coughed a few times the previous night, but he did not cough during the assessment. Mr B was sent to hospital and a scan in the stroke unit confirmed he had not had a further stroke and he returned to prison.

On 6 April, Mr B had a high temperature and headache. Healthcare staff suspected that he might have contracted COVID-19 and took a swab test. The result was positive, and Mr B continued to self-isolate. Nurses monitored him closely and a GP reviewed him daily.

Mr B's oxygen levels dropped on 10 April. A prison GP sent him to hospital, with a view to administering oxygen therapy. Mr B returned to the prison the same day and was closely monitored. An officer remained outside his room each night and healthcare staff sought advice from the out-of-hours service when Mr B's oxygen level fell on 11 and 12 April.

On 14 April, Mr B's oxygen levels worsened. After consulting a COVID-19 clinical specialist, the prison GP sent him to hospital immediately. He was escorted by two officers in appropriate personal protective equipment (PPE), who remained outside his room. In hospital, Mr B often refused to wear his oxygen mask due to claustrophobia and the risks were explained to him.

Mr B died on 17 April. The hospital certified the cause of death as COVID-19. He also had cerebrovascular disease which did not cause but contributed to his death.

While it is likely that Mr B caught COVID-19 in prison, we are satisfied that staff followed the national guidance on risk management and took the appropriate steps to help prevent the spread of the infection. When Mr B presented with symptoms, he was tested immediately and carefully monitored. We commended the prison's family liaison officer for her assiduous and attentive communication with Mr B's family. We made two recommendations about clinical observations and record keeping, but neither of these issues had adversely affected the outcome for Mr B.

### Case study 3

Mr C was 60 years old and serving a life sentence for murder. Mr C was clinically extremely vulnerable to becoming seriously ill if he contracted COVID-19, as he had been diagnosed with leukaemia and the medication used in his treatment put him at increased risk. After discussing the risks with his hospital consultant, he decided to continue his treatment for leukaemia, attending the prison's medication hatch daily. Due to his concern about the pandemic, Mr C gave up his job in the laundry and self-isolated, before there was a requirement to shield high-risk prisoners. He did not leave his cell, other than to collect his daily medication.

On 25 March, the prison designated a shielding unit for clinically vulnerable prisoners (both high and moderate risk). A dedicated team of four prisoner mentors delivered meals to each cell and cleaned communal areas, as well as the cells of those unable to do so. The men were allowed to exercise outside for twenty minutes a day, but Mr C chose not to. Staff made daily welfare checks, using the in-cell phones.

The prison put in place several other measures to reduce the spread of COVID-19. This included delivering medication to prisoners with symptoms of COVID-19, in the prisoner isolation unit. This facility was not extended to the shielding unit.

On 1 May, Mr C was unwell. A nurse examined him and noted that he seemed lethargic, with a high temperature and a cough. As these were symptoms of COVID-19, Mr C was sent to hospital and admitted there as an inpatient. He was escorted by two officers in PPE and no restraints were used.

On 3 May, Mr C tested positive for COVID-19. On 10 May, he was admitted to the critical care unit and placed on a ventilator. On 26 May, Mr C's life support was withdrawn and he died that day.

The cause of Mr C's death will be determined at inquest but has been provisionally certified as COVID-19. He also had underlying chronic lymphocytic leukaemia which contributed to his death.

A study<sup>17</sup> has shown that people with blood cancers are more likely to die from COVID-19 than those with other cancers. The only real protection to reduce their risk of COVID-19 is effective isolation. We were very concerned that Mr C had to leave his cell to get his medication and it is highly likely that this is how he contracted COVID-19. We therefore recommended that medication for prisoners at the highest risk (clinically extremely vulnerable) is dispensed safely at their cell door.

When the clinical reviewer visited the prison on 4 August 2020, they observed many instances where prison officers worked closely together (within one metre) and interacted socially, without social distancing or PPE such as face masks.

Despite the weaknesses identified, we found that Mr C received excellent clinical care, equivalent to that he could have expected to receive in the community and was treated with care and dignity by staff and a custodial manager in particular.

## Case study 4

Mr D, who was 50 years old, was serving a seven-year sentence for drug offences.

Mr D was considered clinically vulnerable to becoming seriously ill if he contracted COVID-19 as he was obese and was advised to shield. He was told the risks of not shielding but on 11 May 2020, he signed a disclaimer to confirm that he did not wish to shield. He continued his role as a wing cleaner and was in contact with staff and other prisoners daily.

On 26 May, Mr D told healthcare staff that he had felt unwell with possible COVID-19 symptoms (a fever and loss of taste) for three days. He was in a single cell and was due to move to the prison's COVID-19 isolation unit the next day. He was not tested for COVID-19 at any point. Mr D was told to isolate in his cell and the healthcare team's COVID-19 spreadsheet was updated. The Head of Healthcare was informed and the nurse handed over verbally to night duty nurses. Prison staff were unaware that Mr D had suspected COVID-19 symptoms.

On 27 May, his condition worsened. He rang his cell bell at 3.04am, with breathing difficulties. Communication issues between prison staff and healthcare staff led to an 18-minute delay. These difficulties included that an officer failed to use a radio but instead used a cordless phone, which lost signal. The officer who escorted the nurses did not know where Mr D was located but one of the nurses knew and that he had been unwell earlier that day.

Two prison officers went into Mr D's cell without any PPE as they did not know that Mr D was suspected of having COVID-19.

17 Lennard Lee and others, 'COVID-19 prevalence and mortality in patients with cancer and the effect of primary tumour subtype and patient demographics: a prospective cohort study', *Lancet Oncology*, published online 24 August 2020, [https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(20\)30442-3/fulltext](https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(20)30442-3/fulltext)

Two nurses then went into his cell without PPE as they had been given new medical bags and could not find the PPE in the bags.

Mr D was pronounced dead at 4.26am. The death certificate stated that he died from COVID-19 pneumonitis. Obesity contributed to but did not cause his death.

We are satisfied that prison staff advised Mr D of the risks of not shielding, that he understood the risks and that he had the mental capacity to decide not to shield. We are concerned that prison staff were unaware that Mr D was suspected of having COVID-19 and that staff were not aware of prisoners who were shielding or had COVID-19 symptoms. This put a number of staff who entered his cell without PPE at risk. We are also concerned that the nurses on duty could not find the PPE in the new medical bags but the prison has since resolved this issue and staff now carry PPE pouches.

## Case study 5

Mr E, who was 58, was remanded in custody, charged with sexual and violent offences.

Mr E had many health conditions including a type of dementia, hypertension (high blood pressure) and type 2 diabetes, which made him clinically vulnerable to becoming seriously ill if he contracted COVID-19.

Due to his vulnerability, the prison asked Mr E and his cellmate to start shielding and they started shielding on 19 March 2020. However, on 26 March, Mr E's cellmate left the prison. The next day, Mr E was given a new cellmate, who had only spent 10 days in the induction unit and had shared cells with three other prisoners while there. When the new cellmate moved into Mr E's cell, there was no HMPPS policy preventing this.

The policy on this was published four days later. However, we considered that it was poor judgment and put Mr E at an unnecessary risk of contracting COVID-19, particularly as the new cellmate had been in the community 10 days earlier and had shared with three other prisoners.

On 4 April, Mr E saw a nurse as he felt lethargic and had had aching muscles and a dry cough for a few days. As a COVID-19 symptom was present, the nurse created a COVID-19 care plan for Mr E, instructing staff that he must isolate for seven days and review his health daily, but no test was carried out at this point. The following day, Mr E had a high temperature and his oxygen level was low. A nurse asked paramedics, who were responding to another call, to check Mr E but they decided he did not need to go to hospital.

Mr E's health continued to weaken, and, on 7 April, a nurse sent him to hospital as his oxygen level was very low. Officers restrained Mr E, including when doctors moved him to the resuscitation unit. We were concerned about the use of restraints, as officers restrained Mr E for close to 12 hours despite a clear deterioration in his condition and a hospital doctor saying that the officers faced the risk of being exposed to the virus. While there may have been a miscommunication between prison staff when deciding whether to remove the restraints, we questioned whether they were necessary in the case of Mr E at all.

While in hospital, Mr E tested positive for COVID-19. Mr E's condition continued to deteriorate, and he died on 9 April from COVID-19 pneumonia. The death certificate stated that his diabetes and hypertension contributed to but did not cause his death.



## Case study 6

Mr F, who was 72 years old, was sentenced to life imprisonment for murder.

He had chronic health conditions including ischaemic heart disease, angina, possible dementia (he was never formally diagnosed), emphysema and Chronic Obstructive Pulmonary Disease. These underlying conditions made him clinically vulnerable and at higher risk of becoming seriously ill if he contracted COVID-19. The NHS published guidance which advised clinically vulnerable people to shield. In response the prison healthcare department wrote to all prisoners considered to be clinically vulnerable to advise them to shield. Mr F did not respond to the letter and there was no system in place to follow up a non-response. No one checked that Mr F understood the contents of the letter and the risks that were associated with not shielding. Given his medical record of possible dementia, we considered this to be a worrying omission and recommended that the Head of Healthcare should ensure all prisoners understand the reasons for shielding and have the capacity to make an informed choice about whether to do so.

On 23 April 2020, officers noted that Mr F looked unwell and had not eaten that day. They asked the nurse to check him, but he refused to let her into his cell. Later that day, officers asked the nurse to see him again, but said it was not an emergency. She went into his cell and found he had not eaten, but all his medical observations were normal and he had no symptoms of COVID-19.

The next day, a different nurse gave Mr F his medication and found him lying in bed. He had been incontinent and could not walk. The doctor prescribed Mr F antibiotics for a suspected urinary tract infection. Later that day, Mr F had a low blood oxygen level, which was improved by giving Mr F oxygen. During the afternoon, other prisoners told officers that Mr F was slumped in his chair and looked unwell. Officers said they were aware, and healthcare staff were monitoring him. At 6.30pm, healthcare staff checked Mr F and found that his oxygen levels were low again and he looked very unwell. They called an ambulance and Mr F was taken to hospital.

Mr F's condition did not improve, and he died on 25 April. The death certificate stated that his cause of death was COVID-19 pneumonia. Chronic Obstructive Pulmonary Disease and ischemic heart disease contributed to, but did not cause, his death.

We were concerned about the prison's management of the risk of Mr F contracting COVID-19.

## Lessons to be learnt

Based on what we found, HMPPS should:

- ensure all staff adhere to infection control measures, including hand-washing and social distancing, unless there is a medical or security emergency
- give appropriate advice about shielding to all prisoners who are clinically vulnerable or clinically extremely vulnerable
- ensure prisoners have the mental capacity to understand the risks of choosing not to shield and, if they do not have the mental capacity taking appropriate steps to safeguard them
- protect prisoners who are shielding, so they do not have to leave the cell to collect medication or any other services which would put them at an unnecessary risk of contracting the virus
- ensure that prisoners who are shielding do not have to share cells with newly arrived prisoners who have not completed their self-isolation to ensure they are COVID-19 free
- ensure there is an effective communication system to notify staff of prisoners who are shielding and/or self-isolating due to COVID-19
- ensure that prisoners who are displaying possible COVID-19 symptoms are isolated to protect other prisoners and staff
- ensure that staff use the correct PPE, in line with HMPPS policies and PHE guidelines
- ensure risk assessments on the security arrangements (including restraints) required when prisoners are escorted to hospital take into account the effect of the prisoner's current state of health and mobility on their risk of escape
- where prisoners are restrained when escorted to hospital, ensure that the risk to staff of exposure to COVID-19 is taken into account and that staff wear suitable PPE

### What the data does not tell us

Because we only investigate deaths within our remit, and do not investigate other cases where people in prison 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 have had COVID-19 and since recovered. We also have no information about prisoners who are still suffering from the effects of long COVID-19 and have additional healthcare needs.

## About the data

The PPO does not determine the cause of death. This is determined by a coroner following an inquest. Cases are separated into administrative categories by the PPO, but these categories may differ from a coroner's conclusions. Classifications may change during the course of an investigation. However, they are not altered following the conclusion of the inquest. The PPO and HMPPS have different defining criteria for classifying cases. For this reason, the totals in each category may differ from what is published by HMPPS.

A natural cause death is defined as any death of a person as a result of a naturally occurring disease process that is organic and not triggered by something non-natural.

Underlying health issues are collected from death certificates, medical notes and notes from inquests. In some cases, they are not totally consistently recorded.

Fatal incident data was frozen in December 2020.

The average age is calculated from actual age at time of death and rounded to no decimal places.

In some cases, the cause of death may change throughout and after our investigations have been complete due to an inquest taking place.

One case referred to in this report was notified to us in June 2020 but the date of death was April 2020.

The findings in this bulletin focus on the prison response to illness and healthcare. It does not go into depth on the standard of clinical care and surrounding healthcare issues.

## Glossary

**Personal Protective Equipment (PPE) consists of:** an FFP2 or FFP3 face mask, nitrile gloves, eye protection, a clinical gown or apron, and alcohol hand gel.

**Protective isolation units:** Unit/area used for the temporary isolation of prisoners who are displaying symptoms of COVID-19.

**Reverse cohorting units:** Units where newly arrived prisoners are quarantined for 14 days.

**Shielding units:** A form of social distancing for those who have a heightened vulnerability to COVID-19.



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