Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Reed, a prisoner at HMP Isle of Wight, on 24 January 2022

A report by the Prisons and Probation Ombudsman

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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

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 Christopher Reed died in hospital on 24 January 2022, while a prisoner at HMP Isle of Wight. He was 63 years old. The cause of Mr Reed's death was respiratory failure, due to COVID-19 pneumonia and underlying chronic obstructive pulmonary disease (COPD). I offer my condolences to Mr Reed's family and friends.

4. The clinical reviewers found that Mr Reed's care was equivalent to that which he could have expected to receive in the community. However, they recommended that prisoners who decline vaccinations and clinical investigations should be given the opportunity to discuss and reconsider their decisions and offered support. They also recommended a review of out-of-hours GP provision.

5. We are concerned that there was a lack of clarity about family contact after Mr Reed's death, resulting in a delay of several months before his funeral was arranged. This might have been avoided if contact after his death had been properly documented and staff had provided written information on the processes after a death.

6. Mr Reed appears to have caught COVID-19 at Isle of Wight, as he had twice tested negative two weeks before his positive test.

Recommendations

- The Head of Healthcare should ensure that prisoners who decline COVID-19 vaccinations are given the opportunity to reconsider their decision, and that healthcare staff discuss and record the reasons for the refusal.

- The Head of Healthcare should ensure that if a patient refuses investigation of potential medical conditions, healthcare staff fully explore and document the reasons, and consider whether they need information or support to address any concerns.

- The Head of Healthcare should review the use of the NHS 111 service to determine whether there is a need to extend the provision of prison GPs.

- The Governor should ensure that the method of communication with bereaved families is appropriate to their needs and that all contact is fully documented.

The Investigation Process

7. NHS England commissioned independent clinical reviewers to review Mr Reed's clinical care at HMP Isle of Wight.

8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners, Mr Reed's location, the security arrangements for his journey and admission to hospital, liaison with his family and whether early release was considered.

9. The Ombudsman's family liaison officer wrote to Mr Reed's next of kin, his mother, to explain the investigation and ask if there were any issues she wanted us to consider. She did not respond.

10. The investigation was suspended while waiting for the cause of Mr Reed's death.

Previous deaths at HMP Isle of Wight

11. Mr Reed was the nineteenth prisoner at Isle of Wight to die since January 2020. Of the previous deaths, fourteen were from natural causes (three due to COVID-19) and four were self-inflicted. There have since been six deaths (four from natural causes, one self-inflicted and one to be determined. There are no similarities between the findings in this investigation and those of the previous deaths.

COVID-19 (coronavirus)

12. 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.

13. 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.)

14. In September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield, on the basis that vaccination had reduced the risk. HMPPS initially continued to routinely offer shielding to clinically high-risk prisoners. This has 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.

15. In Mid-November 2021, Isle of Wight had an outbreak of COVID-19. The prison was placed in lockdown and there was mass testing of prisoners. On 2 December, following a review, the restrictions were lifted, and symptomatic testing replaced mass testing.

Key Events

16. Mr Christopher Reed was convicted of sexual and other violent offences on 25 September 2018 and remanded to HMP Lewes. It was not his first time in prison. He was later sentenced to 15 years imprisonment. On 27 December, Mr Reed was transferred to HMP Isle of Wight. He then spent a year in HMP High Down and returned to Isle of Wight (Albany site) on 14 December 2021.

17. A nurse conducted an initial health screen. She recorded that Mr Reed had no significant physical health conditions but was obese and his pulse rate and blood pressure were both raised. There was no evidence of a second-stage health assessment.

18. As a new prisoner, Mr Reed took lateral flow tests for COVID-19 on 14 and 20 December. Both were negative.

Deterioration in Mr Reed's health

19. On 4 January 2022, Mr Reed took a lateral flow test, which was positive. A PCR test was therefore taken and sent for analysis. The reason he was tested was not recorded. Mr Reed was expected to self-isolate for ten days and advised to contact healthcare if he felt unwell.

20. On 5 January, healthcare staff gave Mr Reed information about the monitoring procedures, including daily welfare and symptom checks. During a check in the afternoon, a healthcare assistant found that he had a slight cough (which Mr Reed had attributed to vaping) but no temperature.

21. Later that afternoon, a nurse reviewed Mr Reed. She noted there was no cough or shortness of breath and that his temperature and respiratory rate were normal. However, he had a raised pulse rate, and his blood oxygen saturation level was low, fluctuating between 88 - 91%. The nurse calculated an Early Warning Score 2 (NEWS2) of 4. (NEWS2 is a clinical assessment tool to determine the severity of a patient's illness and identify deterioration. A score of 4 indicates that increased monitoring or escalation of treatment should be considered.)

22. Mr Reed was referred to the prison GP, who diagnosed pneumonia arising from COVID-19 infection and Mr Reed was admitted to hospital overnight. When he returned to the prison the following day, his clinical observations were within normal range.

23. Just after 3.00pm on 7 January, Mr Reed had a welfare check. His temperature was very high and some of his other vital signs were abnormal. His NEWS2 score was 9 (which suggests a high clinical risk and the need for urgent assessment by a team with critical care skills). Staff requested an emergency ambulance, but despite the risks to his health, Mr Reed refused to go to hospital and signed a disclaimer. Healthcare staff had no concerns about his mental capacity to make the decision and created a care plan to monitor his symptoms.

24. The prison assigned Mr Reed a family liaison officer (FLO). He informed Mr Reed's mother that her son was unwell. As she was concerned that he was refusing

treatment, the FLO asked Mr Reed to call her. At around 7.30pm, after speaking to his mother, he agreed to move to the healthcare centre's inpatient unit, where he was given continuous oxygen and closely monitored.

25. Nurses continued to encourage Mr Reed to go to hospital, explaining that his condition could become life-threatening, but he persistently refused. A GP from the NHS 111 service advised that if he lost capacity due to deterioration in his condition, they should call an ambulance. Mr Reed remained alert, mobile and able to perform personal care.

26. On 8 January, healthcare and wing staff shared information on Mr Reed's situation. A security risk assessment and escort documents were prepared in case Mr Reed needed to leave the prison quickly.

27. Shortly after 4.00pm, healthcare and operational staff discussed the capacity to continue treating Mr Reed at the prison, given the limited oxygen supplies. They considered alternatives for obtaining additional oxygen tanks and how to fulfil their duty of care. Healthcare staff felt that they were not best placed to manage his deteriorating health.

28. After running out of oxygen, staff consulted the NHS 111 service. A GP said that he could not prescribe oxygen out of hours and advised them to speak to healthcare managers.

Admission to hospital

29. On 9 January, Mr Reed felt worse and agreed to go to hospital. He was escorted by two officers, using an escort chain. A nurse informed his mother that he had been admitted to hospital.

30. While waiting to be moved to a ward, Mr Reed's condition deteriorated, and he was moved to the critical care unit at 8.30pm. The restraints were removed and not reapplied.

31. A nurse updated Mr Reed's mother, gave her the contact details for the hospital and told her to expect a call from the family liaison officer. Healthcare staff obtained regular updates on Mr Reed's condition.

32. On 14 January, Mr Reed's mother left a message on the prison's safer custody line, asking where Mr Reed was. An operational manager tried to return her call, but there was no response.

33. On 15 January, Mr Reed's condition further declined, but he refused to move to the intensive care unit. A prison nurse told his mother, who asked for a message to be passed to him, encouraging him to agree. He was admitted to the unit just before midnight, sedated and placed on a ventilator.

34. At around 10.30am on 16 January, Mr Reed's mother left a message, again asking for information on Mr Reed's location. Another FLO contacted the intensive care unit. She was told that Mr Reed was very poorly, and if he did not respond to treatment within a few days, they would consider removing the ventilator. She passed on the information, and also advised Mr Reed's mother to contact hospital

staff directly. On the same day, a prison nurse also contacted Mr Reed's mother to tell her that Mr Reed remained very poorly. Members of the family liaison team noted that she was given further updates on 21 and 22 January.

35. On 23 January, a prison nurse told Mr Reed's mother that due to his worsening condition and not responding to treatment, the hospital would not attempt resuscitation if Mr Reed's heart or breathing stopped.

36. On 24 January, the hospital withdrew treatment and Mr Reed died at 11.59am. The hospital informed his mother and the family liaison officer followed this up with a call, at 2.52pm. She noted that Mr Reed's mother did not want any help from the prison or family liaison officer in the future.

37. On 25 January, Mr Reed's mother telephoned the prison, asking to speak to someone about her son's death. The Head of Safer Custody returned her call, but the details of their conversation were not documented.

38. There was no further recorded contact until six months later. On 20 July, the Head of Safer Custody wrote to Mr Reed's mother to explain that prison staff were under the impression that she had intended to arrange Mr Reed's funeral, but they had been informed that his body was still in the morgue.

39. A representative from the Salvation Army responded on behalf of Mr Reed's mother. She thought the funeral had already taken place and that the prison had arranged it. She mentioned that Mr Reed's mother was not in good health and that the prison had not responded to her requests for information while Mr Reed was in hospital. The family representative attributed the lack of information to Mr Reed's mother's struggle to accept his death.

40. After further correspondence with the Salvation Army representative, the prison arranged and paid for Mr Reed's funeral. This took place on 30 August and prison staff later delivered the ashes to his mother.

Post-mortem report

41. The post-mortem report concluded that Mr Reed died of respiratory failure caused by COVID-19 pneumonia and chronic obstructive pulmonary disease.

Findings

Clinical Findings

42. The clinical reviewers were satisfied that Mr Reed's care at Isle of Wight was equivalent to that which he could have expected to receive in the community. Notably, his management and care in the inpatient unit was of a high standard, exceeding the level he could have expected in the community. However, they found areas of weakness, which we reflect below.

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

43. When Mr Reed returned to Isle of Wight in December 2021, he was promptly identified as at moderate risk of complications from COVID-19, and it was noted that he had previously declined the vaccine. The clinical reviewers were concerned that staff at Isle of Wight had not discussed the reasons for his decision with him or given him a further opportunity to receive the vaccine. This was pertinent as there had been an outbreak of COVID-19 just before his return. Mr Reed appears to have contracted COVID-19 at Isle of Wight, as two lateral flow tests in December 2021 were negative.

44. Mr Reed had also refused investigations to identify possible health conditions linked to past habits, such as smoking and substance misuse. As some of those conditions can increase a person's risk from COVID-19, the clinical reviewers considered that healthcare staff should have further explored his concerns, as well as the support available. We recommend:

    The Head of Healthcare should ensure that prisoners who decline COVID-19 vaccinations are given the opportunity to reconsider their decision, and that healthcare staff discuss and record the reasons for the refusal.

    The Head of Healthcare should ensure that if a patient refuses investigation of potential medical conditions, healthcare staff fully explore and document the reasons and consider whether they need information or support to address any concerns.

Monitoring Mr Reed after he contracted COVID-19

45. The healthcare department has a local protocol for monitoring patients who test positive for COVID-19. Those at moderate risk of complications are reviewed daily, observations taken and NEWS2 scores calculated.

46. The investigation found that Mr Reed was appropriately managed after he tested positive and healthcare staff were responsive to signs of deterioration. They respected his initial wish not to go to hospital and monitored him closely in the inpatient unit. Any concerns were escalated to the prison GP, and they also sought advice from the NHS 111 service. However, when the prison ran out of oxygen, the on-call GP was unable to prescribe replacement tanks.

47. The clinical reviewers considered that it might be beneficial to review the use of the NHS 111 service to assess whether out-of-hours GP provision is adequate. We recommend:

The Head of Healthcare should review the use of the NHS 111 service to determine whether there is a need to extend the provision of prison GPs.

Contact with Mr Reed's next of kin

48. Prison Service Instruction 64/2011, *Safer Custody,* states 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. Following the death of a prisoner, a family liaison officer must be appointed, and a log of contacts, actions and discussions should be kept. The guidance also states that the wishes of the prisoner's family should be respected if they do not want contact with the prison and gives advice on ending contact at an appropriate time.

49. Isle of Wight adopted best practice by quickly assigning a family liaison officer to share information with Mr Reed's mother. Healthcare staff also contacted Mr Reed's mother at key points where there were changes or concerns. We cannot account for her view that she was not given information as the family liaison log and healthcare staff contact were well-documented while he was an inpatient. However, as some of her requests for information were shortly after such contact, it is conceivable that she did not understand what was said, particularly given her poor health.

50. The quality of contact after Mr Reed's death is less clear. The prison contacted her within three hours and a brief entry noted, "Contact made with NOK. Has declined any help from prison or FLO in the future." The next day, Mr Reed's mother telephoned to ask for information, but the details of the conversation were not documented. We acknowledge that the prison intended to respect the wishes for no contact. However, given she was elderly and likely to have been shocked and distressed at such an early stage, it would have been prudent to send written information after the telephone call, detailing the processes and avenues of support, as well as confirming their understanding of her wish for no contact.

51. Six months passed before it came to light that there had been a misunderstanding about arranging Mr Reed's funeral and he had yet to be buried. His mother was understandably distressed by this disclosure. Without a proper record, we cannot determine how this mistake happened. The prison should review their communication process for bereaved families to prevent a similar error in the future. We recommend:

The Governor should ensure that the method of communication with bereaved families is appropriate to their needs and that all contact is fully documented.

Kimberley Bingham
Acting Prisons and Probation Ombudsman March 2025

Inquest

At the inquest, held on 13 August 2025, the Coroner concluded that Mr Reed died from natural causes.

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