Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony O'Connell, a prisoner at HMP Swaleside, on 18 September 2022

A report by the Prisons and Probation Ombudsman

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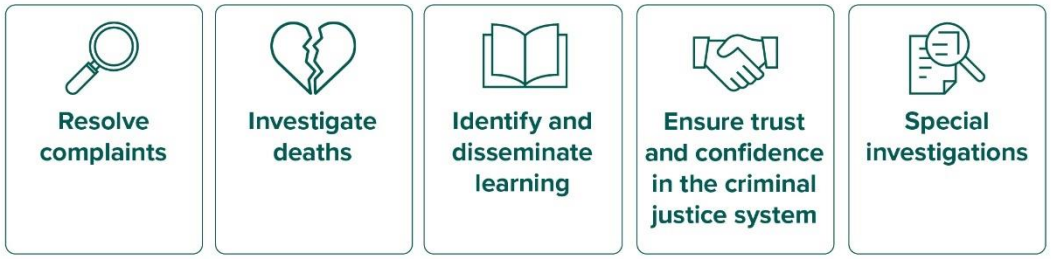
OUR VISION

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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony O'Connell was found hanged in his cell at HMP Swaleside on 18 September 2022. He was 50 years old. I offer my condolences to Mr O'Connell's family and friends.

Mr O'Connell had a long history of self-harm and suicide attempts. During his eight years at Swaleside, staff monitored him using suicide and self-harm procedures (known as ACCT) on 29 occasions.

On 14 September 2022, staff started ACCT monitoring after Mr O'Connell was found holding a bedsheet around his neck. Staff stopped ACCT monitoring at the first case review less than six hours later. He was not being monitored when he died.

I am concerned that staff stopped ACCT monitoring prematurely. I consider that staff placed too much emphasis on Mr O'Connell's own statements that he felt much better and did not need to be on an ACCT, rather than his risk factors for suicide and self-harm. I am also concerned that there was no healthcare input to the first case review and hence the decision to close the ACCT.

My investigation found no evidence that staff had carried out any post-closure monitoring after 14 September. It is possible that they may have identified that Mr O'Connell's risk had increased again had they done so.

The clinical reviewer found that Mr O'Connell's clinical care was equivalent to that which he could have expected to receive in the community. However, she was concerned that the mental health in-reach team had not tried harder to engage Mr O'Connell after repeated referrals were made to them because of his bizarre behaviour.

I am concerned that Swaleside is not providing key work sessions to prisoners due to lack of staff. I have raised before the impact that staff shortages at Swaleside are having on prisoners' care. This is an issue that needs to be addressed urgently.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **July 2023**

Contents

Summary

Events

1. In December 2013, Mr Anthony O'Connell was sentenced to 17 years in prison for manslaughter. He was moved to HMP Swaleside on 23 September 2014.

2. Between January and June 2022, staff referred Mr O'Connell to the Mental Health In-Reach Team (MHIRT) on three occasions due to his bizarre behaviour. Mr O'Connell told staff that he was hearing voices, seeing images displayed on a computer screen, and that 'nanowaves' were being put inside his head by the Prison Service. MHIRT staff assessed him following each referral but each time, Mr O'Connell said he was fine, so they discharged him.

3. On the morning of 14 September, staff started suicide and self-harm monitoring procedures (known as ACCT) after they found Mr O'Connell holding a bed sheet around his neck. Staff thought Mr O'Connell had not been taking his antidepressant medication. At the first case review later that day, Mr O'Connell said that he had felt low and had been worried his medication was not working, but this had been resolved and he felt much better. Staff stopped ACCT monitoring. There is little available information about how he presented over the next few days.

4. At 8.37pm on 18 September, while conducting a routine check, an operational support grade (OSG) saw Mr O'Connell hanging from the light fitting in his cell. The OSG radioed a code blue medical emergency, but no one responded. The OSG ran to the wing office to get help. Officers said they had not heard a code over the radio, so an officer radioed a code blue at 8.40pm.

5. Moments later staff entered Mr O'Connell's cell, cut him down and placed him on his bed. Prison staff noted that Mr O'Connell was cold and stiff, his face was drained of colour, and his tongue was black. They thought Mr O'Connell had been dead for a while so did not try to resuscitate him.

6. At 8.43pm, two nurses arrived. They started CPR and applied a defibrillator, but Mr O'Connell had no shockable rhythm. They did one round of CPR and then stopped.

7. At 8.44pm, control room staff called for an ambulance. At 9.06pm, an ambulance paramedic confirmed that Mr O'Connell was dead.

Findings

8. We consider that staff stopped ACCT monitoring prematurely, less than six hours after Mr O'Connell was found with a ligature. They placed too much emphasis on Mr O'Connell's statements that he felt much better and did not want to be on an ACCT, rather than considering his risk factors and that he had recently been found with a ligature. Also, healthcare staff were not at the first case review which meant that the decision to close the ACCT was taken without healthcare input.

9. We are also concerned that some observations were missed and no post-closure monitoring was carried out.

10. We found that there was a delay in calling a medical emergency code when Mr O'Connell was found and a four-minute delay in calling an ambulance. It made no difference to the outcome in this case as Mr O'Connell was dead when found, but any delays in a future medical emergency could be critical.

11. We are concerned that nurses started CPR when it was clear that Mr O'Connell had been dead for some time.

12. The clinical reviewer found that the care Mr O'Connell received at Swaleside was equivalent to that which he could have expected to receive in the community. However, she said that given the repeated referrals to the MHIRT due to Mr O'Connell's bizarre behaviour, the MHIRT could have had a more assertive policy to try to get him to engage.

13. We are concerned that Swaleside is not providing prisoners with key worker sessions in line with national policy. Mr O'Connell had not received a key worker session since August 2021. We were told this was due to staff shortages.

14. We are concerned that non-vulnerable prisoners were being placed on B Wing, which is a vulnerable prisoner unit.

15. There were times when Mr O'Connell did not collect his medication and generally this was recorded. However, there were five occasions when no medication was dispensed to Mr O'Connell and no reason was recorded.

16. Prisoners told us that staff spoke in a derogatory way about Mr O'Connell during and after the emergency response. While we found no evidence of derogatory remarks, there was some unrelated chatter and laughter which could have been interpreted as disrespectful.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that they:
    - assess risk based on a prisoner's risk factors rather than what the prisoner tells them;
    - invite healthcare staff to the first case review;
    - carry out and record observations at the agreed frequency; and
    - carry out and record post-closure monitoring.
- The Governor should ensure that when staff draw a radio or receive one from another staff member, they check that the radio is functioning correctly and is set to the appropriate channel.
- The Governor should ensure that control room staff call for an ambulance immediately when a medical emergency code is called.

- The Head of Healthcare should ensure that staff, including agency staff, understand when not to perform cardiopulmonary resuscitation in accordance with European Resuscitation Council Guidelines.

- The Head of Healthcare should create an assertive outreach policy for patients who are repeatedly referred to the MHIRT but decline to engage, which should include a flexible assertive method utilising the multidisciplinary team with an early intervention and recovery focused approach.

- The Governor should ensure that the key worker scheme provides meaningful and ongoing support to all prisoners in line with national policy.

- The Governor should ensure that before prisoners are located on B Wing, they are appropriately assessed to ensure they are vulnerable prisoners or are suitable to be housed with vulnerable prisoners.

- The Head of Healthcare should ensure that when a prisoner does not receive their medication, healthcare staff record the reason on the prisoner's medications history sheet.

- The Governor and Head of Healthcare should ensure that staff are reminded that during a medical emergency and in the event of a prisoner's death, the conduct and language staff use should be professional and reflect the seriousness of the situation.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. Several prisoners contacted him.

18. The investigator visited Swaleside on 17 and 18 November 2022. He obtained copies of relevant extracts from Mr O'Connell's prison and medical records.

19. The investigator interviewed 10 members of staff and five prisoners. He conducted some of these interviews in person while at Swaleside on 17 and 18 November. The remaining interviews took place over telephone and video call between November 2022 and March 2023.

20. NHS England commissioned an independent clinical reviewer to review Mr O'Connell's clinical care at the prison.

21. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent her a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr O'Connell's uncle and aunt to explain the investigation and to ask if they had any matters they wanted us to consider. They were concerned that Mr O'Connell had put a ligature around his neck a few days before his death, which we have addressed in this report.

23. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

24. We sent a copy of our initial report to Mr O'Connell's uncle and aunt. They did not notify us of any factual inaccuracies.

Background Information

HMP Swaleside

25. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It holds up to 1,090 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work in the prison Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services. Forward Trust provides substance misuse treatment.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Swaleside was in October 2021. Inspectors reported that incidents of self-harm had almost doubled since the last inspection. The quality of support delivered through ACCT case management for prisoners at risk of suicide and self-harm was variable, with some inconsistent case management and care plans that lacked meaningful or completed actions. They found that only just under half of prisoners with experience of being on an ACCT said that they had felt cared for by staff.

27. Inspectors noted that in their survey, more respondents than at the time of the last inspection said that they had a named officer or key worker, with around half saying that this officer was helpful or very helpful. However, the key worker scheme had almost stalled at the move to stage 2 of the COVID-19 recovery plan, as a result of more of the already stretched prison officer resource being required to manage prisoners during the increased time unlocked. With the notable exception of the specialist wings, such as the psychologically informed planned environment (PIPE) unit and the drug support wing, few case notes evidenced any meaningful contact and support from key workers.

28. HMIP carried out an Independent Review of Progress (IRP) in July 2022. Inspectors found that the shortage of officers was worse than at the previous inspection leading to very limited time out of cell. The rate of self-harm had declined considerably but there had been five self-inflicted deaths, four since the last inspection and a fifth two months after this review visit.

Independent Monitoring Board

29. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 30 April 2021, the IMB found the prison had had a difficult year coping with the COVID-19 pandemic; at one point 150 staff were off work. Although they considered that Swaleside had still managed to forge ahead and make some improvements in terms of physical repairs and collaborative working, they remarked on the lack of meaningful activity/work available for prisoners which had been necessary to keep staff and prisoners safe.

Previous deaths at HMP Swaleside

30. Mr O'Connell was the seventeenth prisoner to die at Swaleside since September 2020. Of the previous deaths, six were self-inflicted, two were drug-related and eight were from natural causes. There were five self-inflicted deaths at Swaleside during 2022, of which Mr O'Connell's was the fourth. There was a further self-inflicted death in February 2023. As a result of the number of self-inflicted deaths in the last year, Swaleside is receiving additional support from HMPPS headquarters.

31. We have previously made recommendations to Swaleside about ACCT management, about ensuring an ambulance is called immediately in response to a medical emergency code and about ensuring staff are aware of the circumstances in which resuscitation is inappropriate.

Assessment, Care in Custody and Teamwork (ACCT)

32. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

33. In December 2013, Mr Anthony O'Connell was sentenced to 17 years in prison for manslaughter. He was moved to HMP Swaleside on 23 September 2014.

34. Mr O'Connell had a history of self-harm and suicide attempts and was placed on suicide and self-harm monitoring (known as ACCT) 29 times while he was at Swaleside. This was for expressing suicidal thoughts, placing ligatures around his neck and for self-harming. His last period of ACCT monitoring prior to 2022 was in June 2021, when he said he was going to hang himself.

35. Mr O'Connell also had a history of mental health issues, and drug and alcohol misuse.

36. On 20 January 2022, Mr O'Connell's prison offender manager (POM) referred him to the Mental Health In-Reach Team (MHIRT) following reports that he was acting strangely. Mr O'Connell had told staff that he was hearing voices, seeing images displayed on a computer screen, and said that 'nanowaves' were being put inside his head by the Prison Service.

37. On 25 January, a mental health nurse assessed Mr O'Connell. She noted that Mr O'Connell did not want to talk about the issues raised by his POM and that he said that Swaleside's Offender Management Unit (OMU) and the Probation Service were "stitching me up" and wanted to sabotage his parole. Mr O'Connell said he was all right and that he did not need help from the MHIRT. The mental health nurse discharged Mr O'Connell from the MHIRT.

38. On 15 February, an officer noted that Mr O'Connell was aggressive when she responded to his cell bell, but when she returned with the toilet roll he had requested, he was smiling and pleasant. The officer noted that Mr O'Connell had displayed similar behaviour in the past when he did not take his medication. Mr O'Connell was on co-codamol (pain relief, for back pain) and mirtazapine (an antidepressant).

39. On 1 March, a psychologist met Mr O'Connell to disclose his psychological risk assessment for the Parole Board. She discussed her concerns about some of the statements he had made during the assessment, such as 'nanowaves' being implanted into him so that the Parole Board and Prison Service could monitor him. She noted that when she told Mr O'Connell that she had found no evidence to support his concerns, he called her a liar and said that she had seen the waves over him. Mr O'Connell also said that a custodial manager (CM) had told her to write the report, and that he had seen her give a "secret handshake" to staff. The psychologist challenged Mr O'Connell on this, but he again accused her of lying, and said that it would all come out in his parole hearing.

40. The psychologist noted that when she told Mr O'Connell that she had recommended he have a psychiatric assessment, he slammed his hand down on the table, picked up the draft report and walked out of the office. She tried to get the draft report back, but Mr O'Connell refused to return it and would not speak to her. She alerted wing staff and submitted an intelligence report.

41. On 11 March, the POM again referred Mr O'Connell to the MHIRT.

42. On 16 March, a nurse met Mr O'Connell to complete a mental health assessment. The nurse noted that Mr O'Connell's mood appeared normal and calm, and identified no concerns or risks. She noted that Mr O'Connell said he had no thoughts of harming himself or others. Mr O'Connell said there was nothing wrong with his mental health and declined to engage. She discharged him from the MHIRT.

43. On 18 March, an information officer for the MHIRT received a self-referral from Mr O'Connell. Mr O'Connell had requested an assessment and report on his mental health for his upcoming parole hearing. He said there was nothing wrong with his mental health and he wanted this documented. He also said that he was hoping the Parole Board would approve a move to open conditions (Category D) or possibly release. She concluded that the referral was inappropriate and closed it.

44. On 26 June, officers again referred Mr O'Connell to the MHIRT. The referral said that Mr O'Connell appeared to be 'having a wobble'. The referral was triaged on 27 June, and it was highlighted that Mr O'Connell had been referred many times in the past due to reports of bizarre thoughts and behaviour.

45. On 27 June, an officer noted that Mr O'Connell said he was not all right and had been awake all night. He said that a CM had been standing outside his window all night. He said later that he had not taken his medication and apologised.

46. On 1 July, a mental health nurse assessed Mr O'Connell. He noted that when he arrived at the cell, the lights were off and Mr O'Connell was lying on his bed with a blanket over his head. The nurse offered to speak to Mr O'Connell in a private room but Mr O'Connell said he did not need any help from the MHIRT. The nurse discussed Mr O'Connell at a MHIRT meeting later that day and staff agreed to close the referral.

47. On 25 July, an officer noted that Mr O'Connell was very angry while collecting his medication and that she asked him if he was okay. Mr O'Connell responded, "Do I look ok? You can tell [a CM] she has the kids she can fucking come and get me out of here". Mr O'Connell then started to smash his chair on his cell floor and after his door was closed, he smashed his sink off the wall.

48. On 25 August, staff noted that Mr O'Connell had met the criteria for further assessment for admission to a Psychologically Informed Planned Environment (PIPE – for high-risk offenders who are likely to have a personality disorder where staff are trained to work in a psychologically informed way) and would be added to the waiting list.

Events of 14 September 2022

49. Shortly before 6.20am on 14 September, Mr O'Connell rang his emergency cell bell. When an Operational Support Grade (OSG) responded, he saw Mr O'Connell had tied a bedsheet around his neck. He radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Officer A responded, and Mr O'Connell said to him repeatedly, 'You know what's happening.' Staff managed to talk Mr O'Connell into removing the bedsheet. They suspected that Mr O'Connell had not been taking his medication. Officer A started suicide and self-harm monitoring (known as ACCT) and set observations at one an hour.

50. An officer told us that she spoke to a member of healthcare staff before she held the ACCT assessment interview with Mr O'Connell later that morning. The member of healthcare staff told her that Mr O'Connell was prescribed medication, which he took. (This was not correct as Mr O'Connell frequently did not collect his medication.)

51. At the ACCT assessment interview, Mr O'Connell said that he had felt low the previous night and had thought that his antidepressant medication was not working. He said things had been building up and he 'just blew' in the early hours and tied a ligature. He said that he felt much better now as he had been out on association and had been chatting to his peers. He said he no longer had any thoughts of harming himself and did not want to be on an ACCT.

52. A supervising officer (SO) held a case review at around 12.00pm. Two officers from the safer custody unit attended, along with Mr O'Connell. Mr O'Connell said that he had tied the ligature because he was worried about his medication, but this had been resolved (we found no evidence that Mr O'Connell had spoken to healthcare about his medication, or that any issues had been resolved). He said that he had overreacted and did not want or need to be on an ACCT. The review panel closed the ACCT and scheduled the post-closure review for 21 September.

53. The medication administration records show that Mr O'Connell 'missed' collecting his medication (co-codamol and mirtazapine) from the prison pharmacy hatch that afternoon.

Events of 15 to 17 September 2022

54. On 15 September, Mr O'Connell collected his medication from the prison pharmacy hatch. On 16 and 17 September, Mr O'Connell did not collect his medication.

55. The medication administration records show that Mr O'Connell was not consistently compliant with his medication in September and had not collected it on six occasions up to 18 September.

Events of 18 September 2022

56. On 18 September, shortly before 4.00pm, Mr O'Connell collected his medication.

57. An officer noted that Mr O'Connell was walking around the wing landing asking other prisoners for vapes and 'empties' (vape capsules that may have some liquid left in them). At around 4.00pm, the officer said she saw a prisoner give Mr O'Connell a vape capsule. The prisoner told the investigator he did not give Mr O'Connell a capsule but thought another prisoner had.

58. The officer noted that she checked on Mr O'Connell at 5.00pm, and asked him if he had taken his medication, as he had a history of selling his medication for vapes. She said Mr O'Connell did not engage with her. This was the last time that Mr O'Connell was seen alive.

59. At 8.37pm, while conducting a routine check, an OSG saw Mr O'Connell hanging in his cell. He called out for staff support and radioed a code blue several times, but got no response. He then ran to the wing office to get help.

60. Officer A told the investigator that when the OSG arrived at the office, he said that he had been calling a code blue over the radio, but Officer A and other staff had not heard these calls.

61. At 8.40pm, Officer B radioed a code blue and along with an Acting SO (ASO) and two officers, went to Mr O'Connell's cell. Officer B opened the cell door flap and saw Mr O'Connell facing the window suspended off the floor by a ligature attached to the light fitting.

62. Staff cut Mr O'Connell down and placed him on his bed. Staff noted that Mr O'Connell was cold and rigid to touch, his face was drained of colour, and his tongue appeared black. An officer said he thought Mr O'Connell had been dead for a while.

63. The ASO told the investigator that because Mr O'Connell was "stone cold", and he thought rigor mortis had set in, staff did not start cardiopulmonary resuscitation (CPR).

64. At 8.43pm, two nurses arrived and entered Mr O'Connell's cell. The nurses started CPR and attempted to use a defibrillator, but Mr O'Connell's heart had no shockable rhythm. A nurse noted that Mr O'Connell was cold to the touch, had a purple and dry tongue, mottling around the abdominal area, was not breathing, had no pulse, his temperature registered as low, and when his blood pressure was taken it gave no reading. However, the other nurse said he did not consider that Mr O'Connell had rigor mortis.

65. The ASO told the investigator that he thought the nurses did one round of CPR that took 30 seconds to a minute, and then stopped.

66. At 8.44pm, control room staff called for an ambulance.

67. An ambulance paramedic arrived at 9.04pm and pronounced Mr O'Connell dead at 9.06pm.

Contact with Mr O'Connell's family

68. On 18 September, the prison appointed a CM as the family liaison officer. He made concerted attempts to contact Mr O'Connell's next of kin in person but was unsuccessful. After further investigation, contacting police, solicitors, and family members, the family liaison officer made contact with Mr O'Connell's family on 7 October.

69. The prison contributed to the costs of Mr O'Connell's funeral in line with national policy.

Support for prisoners and staff

70. After Mr O'Connell's death, prison staff involved in the emergency response were debriefed to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

71. The healthcare staff involved were agency workers. They supported each other and received additional support from their employer.

72. All B Wing prisoners on an ACCT at the time of Mr O'Connell's death, were checked and offered support by staff.

73. Via the in-cell computer system, the prison sent notices to all prisoners informing them of Mr O'Connell's death and offering support.

Post-mortem report

74. The post-mortem report concluded that the cause of Mr O'Connell's death was hanging. The toxicology report showed no illicit substances in Mr O'Connell's system at the time of his death.

Findings

Management of Mr O'Connell's risk of suicide and self-harm

75. Prison Service Instruction (PSI) 64/2011, Managing prisoners at risk of harm from self, from others and to others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

76. Mr O'Connell had a long history of suicidal thoughts, attempts and self-harm. He had been behaving strangely in the months before his death and was prescribed medication to treat depression.

77. Staff started ACCT monitoring for Mr O'Connell at around 6.45am on 14 September, after he tied a bedsheet around his neck. We are concerned that staff stopped ACCT monitoring prematurely, less than six hours later, at the first case review. Staff told us that Mr O'Connell was upbeat and positive at the review. However, we consider that it was too soon to be satisfied that Mr O'Connell's risk of suicide and self-harm had reduced significantly. We are also concerned that they placed too much emphasis on Mr O'Connell's statements that he felt much better and did not want to be on an ACCT, rather than considering his risk factors and that he had so recently been found with a ligature around his neck.

78. Also, there was no input from healthcare staff to the review, even though PSI 64/2011 says that healthcare staff should always be invited to attend, or provide a written contribution to, the first case review. Staff told the investigator that it was challenging to get healthcare staff to attend ACCT reviews due to staffing levels and availability. The ACCT assessor told the investigator that she did contact healthcare by telephone before the ACCT assessment interview and they told her that Mr O'Connell had in-possession medication, which he took. However, the medication administration records show Mr O'Connell was not consistently compliant with his medication in September and had not collected it on six occasions in the 18 days prior to his death. It is possible that if healthcare staff had been asked to attend the first case review, they would have looked more closely at Mr O'Connell's medication compliance.

79. When staff started ACCT monitoring, staff were required to check Mr O'Connell once an hour. Mr O'Connell's ACCT document shows that staff carried out checks at 7.00am and 8.00am. However, no observations were recorded for the following three hours up to 12.00pm, when the ACCT was closed.

80. PSI 64/2011 says that after closure of an ACCT, a Post-Closure Monitoring Form must be completed for a minimum of seven days. Staff failed to do this for Mr O'Connell. The purpose of the post-closure phase of ACCT is to allow additional opportunities for staff to engage with and monitor someone who has been considered at an increased risk of suicide or self-harm. Mr O'Connell's medications history sheet shows that he did not receive his medication (co-codamol and mirtazapine) on 16 and 17 September because he did not attend the medications hatch. This could have been explored with Mr O'Connell had the post-closure monitoring taken place. This is just one example of a missed opportunity to identify and address potential issues that were concerning Mr O'Connell.

81. We recommend:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that they:

- **assess risk based on a prisoner's risk factors rather than what the prisoner tells them;**
- **invite healthcare staff to the first case review;**
- **carry out and record observations at the agreed frequency; and**
- **carry out and record post-closure monitoring.**

Emergency response

Delay in calling a medical emergency code

82. PSI 03/2013, Medical Emergency Response Codes, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately.

83. There was around a three-minute delay between the OSG finding Mr O'Connell hanging and a code blue medical emergency being called over the radio. The OSG said he radioed a code blue message several times when he found Mr O'Connell, but this did not seem to go through on the radio.

84. The OSG told the investigator that a female staff member had borrowed his radio that morning. She changed the radio channel on his radio to have a private conversation with another staff member. When the OSG got the radio back, he did not notice that it was set to the wrong channel. The OSG said that this was the reason no one responded when he radioed a code blue.

85. When no one responded to his code blue calls, the OSG did the right thing by going to search for help. However, the female member of staff who borrowed his radio should have set it back to the correct channel when giving it back, and the OSG should have checked his radio was working correctly. This would have prevented a delay in calling the code blue. We recommend:

The Governor should ensure that when staff draw a radio or receive one from another staff member, they check that the radio is functioning correctly and is set to the appropriate channel.

Delay in ambulance being called

86. The control room log shows that the code blue was called at 8.40pm. However, the ambulance was not called until 8.44pm, a delay of four minutes. The investigator

made several attempts to interview the officer in the control room but he was not at work for the duration of the investigation. We recommend:

The Governor should ensure that control room staff call for an ambulance immediately when a medical emergency code is called.

Inappropriate resuscitation

87. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. The guidelines state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile."

88. When staff found Mr O'Connell, he was stiff, cold to touch, had a purple and dry tongue, and mottling of skin around his abdomen and feet. Officers thought he had been dead for some time.

89. However, when nurses arrived, they started CPR. A nurse told the investigator and the clinical reviewer that there was a culture at Swaleside to start and continue CPR until the ambulance service arrived, who would then make the decision to continue or stop. This is not in line with the European Resuscitation Council Guidelines.

90. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The nurses should not have attempted CPR on Mr O'Connell. We recommend:

The Head of Healthcare should ensure that staff, including agency staff, understand when not to perform cardiopulmonary resuscitation in accordance with European Resuscitation Council Guidelines.

Clinical care

91. The clinical reviewer was satisfied that the physical and mental health care Mr O'Connell received at Swaleside was equivalent to that which he could have expected to receive in the community. However, she raised some concerns.

Approach to dealing with patients who are difficult to engage

92. On several occasions, Mr O'Connell was referred to the MHIRT for a mental health assessment but then when the MHIRT went to assess him, he said he was fine and refused to engage. This meant he was discharged from the MHIRT.

93. The clinical reviewer considered that there should have been more creative plans to try and re-engage Mr O'Connell to better understand the reports of his bizarre behaviour and beliefs. This could have included an objective collation of his history and current presentation from those that knew him, to understand the severity and level of his symptoms consistent with untreated psychosis. We recommend:

The Head of Healthcare should create an assertive outreach policy for patients who are repeatedly referred to the MHIRT but decline to engage,

which should include a flexible assertive method utilising the multidisciplinary team with an early intervention and recovery focused approach.

Keyworker support

94. The Prison Service's Manage the Custodial Sentence Policy Framework 2018 states that all prisoners within the male closed estate must be allocated to a prison officer who will have a key worker role. It also says that Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for the delivery of key work, which should include time with each prisoner.

95. Since August 2021, Mr O'Connell received no key worker sessions.

96. A prison manager told the investigator that when COVID-19 restrictions and emergency regimes were put in place at Swaleside, key worker sessions were stopped. He said that due to current staffing levels, key worker sessions for the majority of prisoners were not possible.

97. The prison manager said that due to external funding and higher staffing levels, prisoners from the PIPE unit and F Wing (linked to the PIPE unit) were receiving key worker sessions. He said that more recently prisoners who were segregated or were recently segregated have also received key work sessions, as were those who were self-isolating. He said that there are also some prisoners who had been identified as priority prisoners for key work, such as those who had self-harmed over the last year but were not currently being supported in any other way.

98. The prison manager said that although not all prisoners received key worker sessions, they still have meaningful conversations with staff and are able to raise concerns.

99. We recognise that Swaleside faces challenges on multiple fronts, such as their low staffing levels and complex prison population. However, we are concerned that Swaleside is not providing key work in line with national policy, and prisoners such as Mr O'Connell, who would have benefited from key worker support, are slipping through the cracks. We recommend:

The Governor should ensure that the keyworker scheme provides meaningful and ongoing support to all prisoners in line with national policy.

Non- vulnerable prisoners on the vulnerable prisoner unit

100. Mr O'Connell was located on B Wing, Swaleside's vulnerable prisoner (VP) wing. We were told that prisoners were located on B Wing because they were considered at risk of suicide and self-harm, and/or of being bullied.

101. A prisoner told the investigator that B Wing had previously been a good wing to live on, but in recent years the officers that were staffing the wing were less helpful and pleasant to prisoners. He said that they were bringing prisoners on the wing who were not meant to be there, and these prisoners were aggressive and would bully other prisoners.

102. A CM told the investigator that for security reasons or because of lack of space, prison managers would routinely put non-VPs on B Wing. She said she had challenged this but had been overruled.

103. The CM said that the impact of placing a non-VP on the wing was that the VPs felt unsafe. She said the number of ACCT documents being opened would increase and VPs that were not normally on an ACCT would require one, and some VPs would respond by self-isolating. The CM also said that VPs who wanted to protect themselves from the non-VPs, would do what the non-VPs told them to, which would include bullying and harming other prisoners.

104. We are concerned that prison management are locating non-VPs on B Wing. From prisoner and staff accounts it has a detrimental effect on the safety and wellbeing of the prisoners on the wing. It also increases the workload for staff, creating more complex and challenging issues to deal with, which likely has further knock-on negative effects. We recommend:

The Governor should ensure that before prisoners are located on B Wing, they are appropriately assessed to ensure they are vulnerable prisoners or are suitable to be housed with vulnerable prisoners.

Allegations from prisoners

Denied medication

105. The investigator received a letter from several prisoners on B Wing which said that staff routinely stopped Mr O'Connell from collecting his medication. They said that officers would tell healthcare staff that Mr O'Connell did not want his medication when he did want it, and that sometimes healthcare staff said they did not have any medication to give Mr O'Connell.

106. A prisoner told the investigator that Mr O'Connell would receive his medication, which would come in little envelopes, and sometimes there were 10 to 15 envelopes on the floor of Mr O'Connell's cell. He said that Mr O'Connell's cell door was always opened for him to collect his medication, but sometimes Mr O'Connell would not go and collect his medication.

107. Mr O'Connell's 'medications history sheet' records that between 11 June and 18 September 2022, there were 39 occasions when Mr O'Connell was not dispensed his antidepressant medication, and 52 occasions when he did not collect his pain relief medication. For most of these occasions, healthcare staff recorded the reason, such as 'patient refused' or 'did not attend [the medications hatch]'. There were five occasions when no medication was dispensed, and no reason was given.

108. We are satisfied that there were times when Mr O'Connell chose not to collect his medication. From the available evidence we cannot say that staff intentionally prevented Mr O'Connell from receiving his medication.

109. We are concerned that there were five occasions when no medication was dispensed to Mr O'Connell, and no reason was recorded. We recommend:

The Head of Healthcare should ensure that when a prisoner does not receive their medication, healthcare staff record the reason on the prisoner's medications history sheet.

Officer A's conduct on 14 September 2022

110. The letter from the prisoners on B Wing says that several days before Mr O'Connell's death, he had expressed suicidal thoughts to Officer A, who responded by saying, 'Any more talk like that and I will have you transferred to C Wing in the morning and you won't like that, remember what happened last time.' (Mr O'Connell had previously been seriously assaulted on C Wing.) This interaction appears to have been on 14 September, after a code blue was called due to Mr O'Connell putting a bedsheet around his neck.

111. At interview, some prisoners gave the same account. Prisoners also told the investigator that Officer A was 'rough' and 'nasty' when talking to Mr O'Connell.

112. Officer A told the investigator that he had a good rapport with Mr O'Connell. He said that on 14 September, when he attended Mr O'Connell's cell, he could not recall anyone (including himself) mentioning a wing move.

113. A CM told the investigator that when she was managing B Wing, she was Officer A's line manager. She said Officer A 'liked a little bit of banter', could be firm and fair and some prisoners liked him, some did not. The CM said that because of work pressures, at times, Officer A may not have been patient with certain people.

114. The prisoner told the investigator that he never saw any prison staff mistreat Mr O'Connell, and if he had, he would have raised it.

115. While we cannot say for sure what Officer A said to Mr O'Connell on 14 September, we note that he immediately started ACCT monitoring for him.

Derogatory comments after Mr O'Connell's death

116. The letter states that there were some cruel and derogatory remarks made about Mr O'Connell by healthcare and prison staff after Mr O'Connell had died.

117. A prisoner told the investigator that one of the staff that attended the emergency response said Mr O'Connell 'took the easy way out.' Another prisoner said that staff swore, out of shock of the situation, but he did not hear them say anything they should not have. Healthcare and prison staff told the investigator that they did not hear any staff say anything inappropriate about Mr O'Connell.

118. CCTV footage covers the whole of the emergency response. Body Worn Video Camera (BWVC) footage does not as it covers only from when the ambulance service arrives, and later when the police arrive, and Mr O'Connell's body is taken away. BWVC footage has audio, unlike CCTV.

119. From BWVC footage staff can be seen chatting, for extended periods of time, when waiting for the ambulance or for the police to finish investigating the cell. At no time is anyone heard saying anything derogatory about Mr O'Connell. However, staff do appear to talk quite in a matter-of-fact manner about the situation and Mr O'Connell,

they also talk about unrelated issues and at times had a laugh and a joke, all be it quietly.

120. Mr O'Connell was well liked by other prisoners and had personal relationships with those occupying the cells around him. To hear staff appear to be unaffected by Mr O'Connell's death, chat normally and laugh and joke, would have been further distressing for these prisoners and would have, reasonably, given them the impression that staff did not care.

121. We understand that finding a prisoner hanging is a stressful and traumatic situation for the staff involved and that in the heat of the moment, they may use inappropriate language or use humour inappropriately. However, staff must consider the impact this has on the prisoners around them and behave respectfully at all times. We recommend:

The Governor and Head of Healthcare should ensure that staff are reminded that during a medical emergency and in the event of a prisoner's death, the conduct and language staff use should be professional and reflect the seriousness of the situation.

Officer B

122. The letter stated that a male staff member was upset about what had happened to Mr O'Connell, and a female member of staff said to them, 'it's only one of them, they don't count as real people, so don't worry about it, they die'.

123. CCTV footage shows the OSG walking away from Mr O'Connell's cell with Officer B. The OSG told the investigator he felt traumatised. It was the first experience of a self-inflicted death in custody. He said he was shaking. The OSG told the investigator that Officer B told him not to worry, 'it's your first experience, I have been here for a while, and seen a few'. The OSG said Officer B did not say that the prisoners did not matter.

124. No Body Worn Video Camera footage captures Officer B and the OSG's conversation. While we cannot say for sure what Officer B said, we think it is possible that prisoners either misheard or misinterpreted what she said to the OSG.

Inquest

125. At the inquest, held from 20 to 28 May 2024, the jury concluded that Mr O'Connell died by suicide.

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