

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David McConnell a prisoner at HMP Exeter on 11 January 2018

**A report by the Prisons and Probation Ombudsman**

PO Box 70769  
London, SE1P 4XY

Email: [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100  
F | 020 7633 4141

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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 David McConnell died on 11 January 2018 of a brain tumour while a prisoner at HMP Exeter. He was 74 years old. I offer my condolences to Mr McConnell's family and friends.

Mr McConnell was cared for at Dartmoor and arrived at Exeter only hours before his death. This investigation focuses on the care Mr McConnell received at Dartmoor.

I am satisfied that Mr McConnell received a good standard of care at Dartmoor, equivalent to that which he could have expected to receive in the community.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**July 2018**

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# Summary

## Events

1. On 15 January 2016, Mr McConnell was sentenced to five years and 6 months imprisonment for sexual offences. He arrived at HMP Dartmoor on 2 February. He took medication for high blood pressure and hip pain.
2. On 2 August 2017, Mr McConnell became confused and unwell and was immediately taken to hospital. An MRI scan showed he had a bleed on his brain. On 8 August, he returned to Dartmoor knowing it was likely that he had a brain tumour. This diagnosis was confirmed on 24 August and the next day Mr McConnell had surgery to remove the tumour. He spent a period of recovery in the palliative care suite at HMP Exeter and was returned to Dartmoor on 11 September.
3. From October 2017, Mr McConnell met monthly with a Macmillan nurse and she liaised with the hospital when his condition deteriorated in December. On 28 December, Mr McConnell was admitted to hospital because Dartmoor could not meet his healthcare needs. He was discharged on 4 January 2018 but readmitted the next day. A bed became available for him at Exeter and he transferred there on 11 January but died shortly after arrival.
4. Mr McConnell's partner was kept informed about his illness, and arrangements were put in place so that she could visit him in hospital. Following Mr McConnell's death, a prison chaplain telephoned his partner to tell her that Mr McConnell had died.

## Findings

5. Mr McConnell's illness was diagnosed promptly. We agree with the clinical reviewer that Mr McConnell received a good standard of clinical care at Dartmoor, equivalent to that which he could have expected to receive in the community. We commend Dartmoor and Exeter for their communication with the hospital and each other to manage his illness and respect his wishes.
6. Although the news of Mr McConnell's death was broken over the phone, this was at the request of his partner and we make no recommendations.

## The Investigation Process

7. Other than a brief period spent in Exeter's palliative care suite following brain surgery, Mr McConnell was cared for at Dartmoor and only arrived at Exeter very shortly before his death. This investigation focuses on the care Mr McConnell received at Dartmoor.
8. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr McConnell's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr McConnell's clinical care at the prison.
11. We informed HM Coroner for Exeter and Devon of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
12. The investigator wrote to Mr McConnell's partner to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
13. The investigation has assessed the main issues involved in Mr McConnell's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
14. Mr McConnell's family received a copy of the initial report. They did not make any comments.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HM Prison Dartmoor

16. HMP Dartmoor holds up to 640 adult male prisoners. It has six residential wings known as 'tors'. Healthcare services are provided by Care UK and mental healthcare is provided by Devon Partnership Trust.

## HM Inspectorate of Prisons

17. The last inspection at HMP Dartmoor was conducted in August 2017. Inspectors reported that while the availability of primary care assessments to prisoners was reasonable, this had been affected by staff shortages. They noted that nurses' clinics were often interrupted or cancelled with nurses having to cover alternative tasks.
18. Inspectors also noted that the standard of monitoring of some patients with long-term conditions had deteriorated in comparison to the standard found at their previous inspection. They had identified cases where diagnostic tests had not been ordered. However, as in their previous inspection, inspectors noted that there was particularly good support for older prisoners and those with disabilities.

## Independent Monitoring Board

19. 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 September 2017, the IMB reported that healthcare staff shortages were an issue and were impacting on the prison's ability to deliver healthcare services. They found that an increasingly elderly prison population with complex needs was difficult to manage, and that the number of escorts required for hospital visits greatly outnumbered the number of officers detailed to work in healthcare.

## Previous deaths at HMP Dartmoor

20. Mr McConnell was the seventh prisoner to die from natural causes at Dartmoor since January 2016. There were no similarities with those earlier deaths.

## Findings

### Diagnosis of Mr McConnell's terminal illness and informing him of his condition

21. Mr McConnell was sentenced to five years and 6 months imprisonment for sexual offences on 15 January 2016. On 2 February 2016, he arrived at HMP Dartmoor. Mr McConnell took medication for high blood pressure and pain relief for hip pain.
22. On 2 August 2017, Staff Nurse A attended the workshop where Mr McConnell worked because staff and prisoners were concerned about him. She found him to be vague, muddled and unable to give his year of birth. The nurse discussed his presentation with a doctor who decided he should go to hospital for further assessment.
23. At hospital, Mr McConnell had an MRI scan which showed a bleed on his brain. On 8 August, he was discharged back to Dartmoor, having been made aware that he very likely had a brain tumour. On 24 August, a neurosurgeon confirmed this diagnosis to Mr McConnell who was told he would have an operation the next day. We are satisfied that there was no delay in diagnosing Mr McConnell's brain tumour and that he was fully aware of his condition.

### Mr McConnell's clinical care

24. On 25 August, Mr McConnell had surgery to remove his brain tumour. Following surgery, he was told that it was an aggressive tumour. He was given a prognosis of 12-18 months to live if he had additional treatment of chemo- and radiotherapy.
25. On 1 September, Mr McConnell returned to Dartmoor but transferred to Exeter the next day for a period of recovery in the prison's palliative care suite. The prison doctor clarified with the hospital the requirements for managing Mr McConnell's recovery. She was informed that observations every four hours were required. Mr McConnell returned to Dartmoor on 11 September.
26. On 21 September, Mr McConnell had a follow up appointment at hospital where he was told his likely prognosis was 6-12 months with three weeks of radiotherapy. His radiotherapy started on 23 October and he had three sessions per week.
27. On 4 October, a Macmillan nurse met Mr McConnell and discussed how he was managing. She planned to meet him monthly, and met him again on 8 November to discuss his condition. Mr McConnell was aware his condition would deteriorate and understood that his level of care would be increased.
28. A discussion about Mr McConnell's end of life wishes had first taken place on 4 September 2017, when he discussed his diagnosis with a prison doctor. He said that he wanted to be resuscitated if the need arose. Mr McConnell maintained this view and discussed it with his partner on 22 December. On 11 January, as his condition deteriorated, hospital staff put in place a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order which meant that in the event of cardiac or respiratory arrest, no attempt at resuscitation would be made.

29. On 13 December, the Macmillan nurse met with Mr McConnell. She was concerned that Mr McConnell's health was deteriorating. She noted that he had worsening levels of confusion and was finding it hard to find words. She sought advice from the neuro-oncology team, which advised increasing his medication.
30. On 28 December, Head of Healthcare contacted the oncology team at Derriford Hospital because of concerns about Mr McConnell's health. He had laboured breathing and was confused and disorientated. The team requested that he be brought to hospital, and an ambulance was arranged.
31. On 4 January 2018, Mr McConnell was discharged from hospital to Dartmoor. He was short of breath, wobbly and confused on arrival and struggled to sit up in bed to take medication. Staff were concerned about how he would manage overnight without healthcare support. The Head of Healthcare arranged for 15-minute checks to be made at his cell overnight.
32. On 5 January, Mr McConnell was readmitted to hospital because his palliative care needs could not be met at Dartmoor and there was no transport available to take him to Exeter.
33. On 11 January, Mr McConnell was discharged from hospital to Exeter, where he arrived around 5pm. The prison doctor reviewed him at 6.30pm and found him agitated and distressed. His eyes were closed and she was unable to get a verbal response. She prescribed medication to reduce his agitation and asked for his next of kin details. The doctor called Mr McConnell's partner to let her know that he was very unwell and might not survive the night.
34. Nurse B responded to an emergency call to attend Mr McConnell's cell at 9.31pm. She found he had stopped breathing and had no pulse. The prison doctor pronounced Mr McConnell dead at 9.46pm.
35. The clinical reviewer concluded that the care that Mr McConnell received was equivalent to that which he could have expected to receive in the community and made no recommendations. He commended Dartmoor for considering Mr McConnell's wishes and for communicating well with hospital specialists. He also found the communication between Dartmoor and Exeter to be effective, especially a joint meeting to review Mr McConnell's care after he died. We agree with the findings of the clinical reviewer.

### **Mr McConnell's location**

36. Inpatient healthcare services are not available at Dartmoor so Mr McConnell was located on a wing during his illness. He was given a wrist alarm and was supported by a prisoner 'buddy'. After his brain surgery he was transferred to the palliative care suite at Exeter to allow 24-hour care.
37. When he recovered, Mr McConnell transferred back to Dartmoor in accordance with his preference. He said he had friends there and it was closer for his partner to visit. On 13 December, Mr McConnell discussed a possible transfer to a hospice with Macmillan nurse. This offer was made several times but the Macmillan nurse said he preferred to remain at Dartmoor.

38. On 5 January 2018, Mr McConnell was taken to hospital because Dartmoor could not meet his palliative care needs, which had increased, and Exeter did not have a space available for him. On 11 January, when a bed became available, he was transferred from hospital to Exeter where he died. We are satisfied that Mr McConnell's wishes were taken into account and he was located appropriately.

### **Restraints, security and escorts**

39. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
40. From August 2017 onwards, Mr McConnell did not have any restraints applied when taken to hospital. We agree with the prison's decision not to restrain Mr McConnell throughout this period.

### **Liaison with Mr McConnell's family**

41. On 22 December 2017, prison chaplain was appointed as Family Liaison Officer. He chaired a meeting in the prison involving Mr McConnell, his family and a prison manager to discuss Mr McConnell's health. The chaplain kept in regular contact with Mr McConnell's family, let them know when he was taken to hospital and arranged permission for them to visit him.
42. On 11 January, Mr McConnell's partner told the chaplain that she was worried about the planned transfer from hospital to HMP Exeter as she felt that he was not well enough to travel. The chaplain was contacted at home by Exeter that evening to ask for Mr McConnell's next of kin details because he was very unwell. The prison doctor contacted Mr McConnell's partner to let her know that he was very unwell and might not survive the night. Mr McConnell's partner asked to be telephoned if he died and the chaplain at Exeter called her to tell her that he had died later that night. The chaplain contacted her again shortly afterwards to check that she was well. He visited her at home with a prison manager on 15 January.
43. While policy recommends informing next of kin of a person's death in person rather than by phone, in this instance Mr McConnell's partner specifically requested communication by telephone and we make no recommendation in this respect.
44. The funeral took place on 13 February and the chaplain led the service. The prison contributed to funeral costs in line with national policy.

### **Compassionate release**

45. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. On 9 January 2018, Mr McConnell was told that an application for

compassionate release was not approved by the Secretary of State for Justice because he had not been given a prognosis of three months or less to live.

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