Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Coonan, a prisoner at HMP Frankland, on 13 November 2020

A report by the Prisons and Probation Ombudsman

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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 Peter Coonan, formerly known as Mr Peter Sutcliffe, died in hospital of COVID-19 pneumonia on 13 November 2020, while a prisoner at HMP Frankland. He was 74 years old. I offer my condolences to Mr Coonan's family and friends.

The clinical reviewer concluded that the care Mr Coonan received at Frankland was equivalent to that which he could have expected to receive in the community. He found that healthcare staff acted responsively and appropriately when Mr Coonan became unwell in late October and early November.

However, I am concerned that, on one occasion, a local hospital discharged Mr Coonan back to Frankland, yet it took nearly eight hours to obtain a secure vehicle and he arrived at the prison at 1.45am.

I am also concerned that managers in the Category A Team made decisions about the use of restraints based on limited input from healthcare staff about Mr Coonan's current condition and mobility. In addition, it took too long for escorting officers to remove the restraints after a manager had granted permission to do so.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2021**

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Summary

Events

1. On 22 May 1981, Mr Peter Coonan, formerly known as Mr Peter Sutcliffe, was sentenced to life imprisonment for 20 counts of murder and attempted murder. Mr Coonan spent much of his sentence in a high-security psychiatric hospital before moving to HMP Frankland on 24 August 2016.

2. Mr Coonan had several long-term physical health conditions, including Type 2 diabetes and heart conditions. His heart conditions remained relatively stable until October 2020.

3. On 28 October, a prison GP sent Mr Coonan to hospital after an electrocardiogram (ECG – a test to check the heart's rhythm and electrical activity) showed that Mr Coonan was in full heart block (where electrical activity that stimulates the heart is not passing to the heart properly). Mr Coonan was fitted with a pacemaker while he was in hospital. They also tested him for COVID-19 on 28 October and 2 November, and he tested negative on both occasions.

4. On 4 November, hospital doctors discharged Mr Coonan back to Frankland. That day, prison healthcare staff tested Mr Coonan for COVID-19, and he tested positive.

5. On 8 and 9 November, Mr Coonan spent two short periods in hospital as prison healthcare staff were concerned about his low oxygen saturation rate and that he had diarrhoea and vomiting. On both occasions the hospital discharged Mr Coonan back to Frankland as his oxygen saturation level had improved.

6. On 10 November, a prison GP spoke to a hospital consultant about Mr Coonan's most recent hospital admission. The consultant said that there was limited treatment that the hospital could provide but they agreed that Mr Coonan's kidney function had deteriorated due to his diarrhoea and vomiting so he should be sent back to hospital.

7. Mr Coonan's condition continued to deteriorate and he died in hospital at 1.45am on 13 November.

8. The post-mortem examination found that Mr Coonan's death was caused by COVID-19 pneumonia.

Findings

Clinical care

9. The clinical reviewer found that the healthcare Mr Coonan received was equivalent to that which he could have expected to receive in the community.

10. However, we are concerned that, at 6.00pm on 3 November, the local hospital discharged Mr Coonan back to Frankland, yet it took nearly eight hours to obtain a secure vehicle to transport him back to the prison. He finally arrived at 1.45am on 4 November.

Restraints, security and escorts

11. We are concerned that healthcare staff did not include crucial information about Mr Coonan's medical condition in the escort risk assessment, which meant that the authorising managers in the Category A Team were unable to make informed decisions on whether it was justified to restrain him.

12. We are also concerned that when hospital doctors were giving Mr Coonan end of life care, the decision to remove Mr Coonan's restraints took too long and that escorting officers did not remove the restraints promptly after an authorising manager gave verbal permission to do so.

Contact with Mr Coonan's next of kin

13. Although most of the prison's liaison with Mr Coonan's next of kin was of a good standard, we are disappointed that he could not talk directly with his next of kin when he was dying and that prison staff had to act as messengers for their personal messages.

Recommendations

- The Head of Healthcare should liaise with the local hospital trusts to ensure that they are fully aware of the constraints and limitations of treatment that can be delivered in the healthcare unit at HMP Frankland.
- The Head of Healthcare should ensure that healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.
- The Governor should ensure that decisions to remove restraints are made quickly and communicated immediately to escorting officers.
- The Governor should ensure that staff formally consider whether a seriously or terminally ill prisoner in hospital should be allowed to have direct contact with their next of kin or family member via mobile phone, laptop or similar means.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Coonan's prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Coonan's clinical care at the prison.

17. The investigator interviewed eight members of staff at HMP Frankland on 2, 11 and 16 February 2020. The clinical reviewer joined the investigator for some of the interviews on 2 and 11 February. All the interviews were conducted by video-link due to the restrictions in place because of the COVID-19 pandemic.

18. We informed HM Coroner for County Durham and Darlington of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Coonan's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

20. We shared a copy of our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

21. We shared a copy of our initial report with an NHS Foundation Trust. The NHS Foundation Trust pointed out some factual inaccuracies and this report has been amended accordingly.

22. After we issued our initial report, Mr Coonan's next of kin contacted us and we sent a copy of our report to them. They identified no factual inaccuracies.

Background Information

HMP Frankland

23. HMP Frankland is a high security prison. It holds up to 852 men. There is 24-hour inpatient care. Spectrum CIC Healthcare provide primary care, GP, substance misuse and pharmacy services. Tees, Esk and Wear Valleys Mental Health NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Frankland was in January 2020. Inspectors reported that in a survey of prisoners, 38% described GP services as good and 41% described the overall quality of healthcare as good. They found that skilled nurses cared for prisoners with complex long-term health conditions, that healthcare staff provided an impressive range of primary and secondary health clinics and that the inpatient unit remained a positive environment.

Independent Monitoring Board

25. 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 November 2019, the IMB reported that 2019 had been a testing year for the healthcare department, though the healthcare provider was due to transfer from G4S to Spectrum in April 2020. They found that recruitment of healthcare staff was challenging and that prison facilities had not kept pace with the number of prisoners with medical and social care needs.

Previous deaths at HMP Frankland

26. Mr Coonan was the 15th prison to die at Frankland since November 2018. All the deaths were from natural causes. Mr Coonan was the second prisoner to die from COVID-19. There have been three deaths from COVID-19 since Mr Coonan's death.

27. We have made previous recommendations that healthcare staff should record a prisoner's current health and mobility on the escort risk assessments.

Coronavirus (COVID-19)

28. 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 case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

29. 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; have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart,

liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

30. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as ‘social distancing’ and ‘lockdown’ (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

31. On 13 March, PHE’s National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.

32. On 24 March, HMPPS issued an instruction, in line with Government advice, to all prisons to introduce social distancing and to implement a restricted regime and supported enforcement of social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were identified and put into protective isolation.

33. On 31 March, HMPPS, in consultation with PHE, issued an order to significantly reduce transfers between prisons. Other measures, known as ‘compartmentalisation’ were also announced. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included:

    - Protective Isolation Units (PIUs): to accommodate known or probable COVID-19 cases, ideally in single-cell accommodation.
    - Shielding Units (SUs): to protect the most vulnerable identified through collaboration with NHS England, with enhanced levels of bio-security including dedicated staff.
    - Reverse Cohorting Units (RCUs): to accommodate new receptions or transfers in for a period of 14 days to detect any emergent infectious cases before entering general population. These units could also accommodate any one returning from hospital.

Category A Team

34. A Category A prisoner is a prisoner whose escape would be highly dangerous to the public, the police or the security of the State, and for whom the aim must be to make escape impossible. When a Category A prisoner is taken to hospital, the senior healthcare professional must obtain written authority from the duty manager and the Category A Team within the Long-Term and High Security Estate (LTHSE) Group, though this can be a verbal authority in emergencies.

35. The Category A Team operates from 9.00am to 5.00pm on Monday to Friday. Outside of these hours, any decisions are taken by operational managers who sit outside the Category A Team, though they are all part of the LTHSE Group.

Key Events

36. On 22 May 1981, Mr Peter Coonan, formerly known as Mr Peter Sutcliffe, was sentenced to life imprisonment for 13 counts of murder and seven counts of attempted murder. Mr Coonan spent much of his sentence at a high-security psychiatric hospital until, on 24 August 2016, he was moved to HMP Frankland. Mr Coonan was a Category A prisoner throughout his time in custody.

37. When he arrived at Frankland, Mr Coonan had several long-term physical health conditions, including Type 2 diabetes, diabetic ocular oedema (a complication from type 2 diabetes that causes swelling in the eye and impaired vision), first degree atrioventricular heart block and left bundle branch block (a condition where the electrical conductivity to the heart is blocked or interrupted) and angina (a condition where reduced blood flows to the heart). Mr Coonan also suffered with paranoid schizophrenia (a severe, psychotic mental illness that may cause hallucinations, delusions, and thought disorders). Mr Coonan's conditions were treated with various prescribed medications and he had regular reviews and referrals to secondary care providers. In March 2017, Mr Coonan refused an angiography (a type of X-ray used to check blood vessels), as he preferred to be treated with medication.

38. Mr Coonan's heart conditions remained relatively stable, with regular healthcare reviews and no requirement for significant healthcare intervention, until October 2020.

39. On 27 October, Mr Coonan told a nurse that he felt unwell and very dizzy. She noted that Mr Coonan was very disorientated, so she took his basic observations. She found that he had a slow heart rate, a low blood sugar level and high blood pressure. She gave Mr Coonan some food and drink and checked him later that day.

40. On 28 October, a prison GP saw Mr Coonan, due to his slow heart rate, and referred him for an urgent electrocardiogram (ECG – a test to check the heart's rhythm and electrical activity). She reviewed the ECG result, which showed that Mr Coonan was in full heart block (where electrical activity that stimulates the heart is not passing to the heart properly) and sent him to hospital for a pacemaker to be fitted urgently.

41. Paramedics initially took Mr Coonan to hospital before transferring him to a second hospital. While he was in hospital, hospital staff tested Mr Coonan for COVID-19 on 28 October and 2 November, and he tested negative on both occasions. On 2 November, hospital surgeons fitted Mr Coonan with a pacemaker and, at 6.00pm on 3 November, hospital doctors discharged Mr Coonan back to Frankland. Due to difficulties obtaining a secure vehicle to transport Mr Coonan back to Frankland, he did not arrive at the prison until 1.45am on 4 November.

42. That day, healthcare staff tested Mr Coonan for COVID-19, as he had returned to the prison from hospital, and he began isolating on the healthcare wing. On 5 November, a prison GP noted that Mr Coonan had tested positive for COVID-19.

43. On 6 November, a nurse noted that Mr Coonan was coughing continuously and was unable to get out of bed. She asked a prison GP to consider prescribing Mr Coonan antibiotics and steroids, and a prison GP prescribed him amoxicillin (an antibiotic).

44. Later that day, Mr Coonan began vomiting. A nurse checked on him, found that his blood sugar level was low and gave him food and drink. Mr Coonan's blood sugar level improved, though she asked healthcare staff to monitor him.

45. On 8 November, a nurse checked on Mr Coonan and found that he had had diarrhoea and vomiting. She cleaned Mr Coonan, gave him a diarrhoea pad and offered him his medication, though he was unable to take it.

46. Later that day, a nurse checked on Mr Coonan and found that his oxygen saturation rate was very low at 82% (a normal rate is 95% and above). She discussed Mr Coonan's condition with Spectrum's Associate Medical Director, who decided that he needed to go to hospital for further assessment and support.

47. Before leaving the prison, Mr Coonan told a healthcare support worker that he wanted his next of kin to know that he had COVID-19 and she passed his request to prison staff.

48. At approximately 3.45pm on 9 November, hospital doctors discharged Mr Coonan back to Frankland as his oxygen saturation rate had stayed at 90% without oxygen. Shortly after arriving at Frankland, a nurse checked on Mr Coonan and found that his oxygen saturation level was 87%. In line with hospital advice, she gave Mr Coonan one litre of oxygen.

49. At 8.35pm, a nurse noted that Mr Coonan's oxygen saturation rate was 82-84% without oxygen and that he wanted to return to hospital as he had chest pain and his cough was bothering him. She discussed Mr Coonan's condition with Spectrum's Associate Medical Director, who decided that that he needed to go to hospital for further treatment given his comorbidities and his recent cardiac history.

50. Paramedics then took Mr Coonan to hospital. A supervising officer and two officers accompanied Mr Coonan and restrained him with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

51. At 5.10am on 10 November, hospital doctors discharged Mr Coonan back to Frankland, as his oxygen saturation rate had maintained on two litres of oxygen. Hospital doctors said that he needed to be monitored every four hours.

52. At 9.45am, a prison GP saw Mr Coonan, who said that he had vomited again though he felt "okay". The GP asked whether Mr Coonan wanted to return to hospital if he deteriorated and he answered that there was "no point as all the too-ing and fro-ing isn't helping him or doctors". He prescribed Mr Coonan anticipatory medication to help with any symptoms of distress that he may suffer.

53. At 3.00pm, a prison GP spoke to a hospital consultant about Mr Coonan's most recent hospital admission. The consultant said that Mr Coonan's condition did not only require palliative care, though the care the hospital would provide would

be limited to use of a constant pressure airway pressure machine (CPAP – a device for delivering oxygen to the lungs under pressure) and dexamethasone (a steroid that helps treat COVID-19). The consultant said that if Mr Coonan's oxygen saturation rate dropped below 90%, then hospital readmission should be considered.

54. At 4.08pm, the Head of Healthcare told Mr Coonan about the prison GP's discussion with a hospital consultant and the potential treatment available to him. Mr Coonan agreed to return to hospital, provided he went to a particular hospital.

55. At 4.49pm, a prison GP noted that Mr Coonan continued to have diarrhoea and vomiting, which had affected his kidney function. The GP discussed Mr Coonan's condition with a hospital consultant, who agreed that he should be readmitted.

56. At approximately 7.30pm, paramedics took Mr Coonan to hospital. Following a key party meeting involving the Head of Security, the Head of Operations and healthcare staff, the prison wanted to send Mr Coonan to hospital without restraints. However, the on-call manager for the LTHSE Group rejected this and decided that he should be restrained with an escort chain. A supervising officer and two officers accompanied Mr Coonan and restrained him with an escort chain.

57. At 10.38pm, Spectrum's Associate Medical Director spoke to a hospital consultant about Mr Coonan, who said that he had been admitted for treatment with CPAP and dexamethasone. The hospital consultant hoped that the treatment would be successful and that Mr Coonan could return to Frankland within 48 hours.

58. At 9.25am on 11 November, a Supervising Officer (SO) wrote in the Bed Watch Log that he had spoken to a hospital sister about Mr Coonan's treatment and the positioning of the escorting officers. He wrote, "She was asking about where staff could be positioned as the oxygen to be given would spread the COVID and was concerned that staff would be at risk. I informed her that any re-arranging of prison staff deployment, I would have to contact the duty governor for advice. Sister will now look at other courses of treatment and contact establishment h/care". There is no record that anyone discussed this with the duty governor or with the healthcare department.

59. At 10.30am on 12 November, a hospital consultant told a prison manager that Mr Coonan was expected to die over the next day or two. Ten minutes later, the prison manager spoke with a senior prison manager and asked for permission to remove the restraints for decency. At 1.12pm, the Category A clerk at Frankland telephoned an operational manager with the Category A Team in the LTHSE Group, explained that Mr Coonan had deteriorated and asked permission for officers to remove the restraints. He immediately granted permission on behalf of the Deputy Director of Custody for the LTHSE Group. At 2.52pm, the escorting officers removed the restraints, which were not reapplied.

60. Mr Coonan's condition continued to deteriorate and he stopped breathing at 1.09am on 13 November. At 1.45am, a hospital doctor declared that he had died.

Contact with Mr Coonan’s next of kin

61. On 8 November, the prison appointed a prison manager as the family liaison officer (FLO) and an officer as the deputy FLO. That day, another prison manager telephoned Mr Coonan’s next of kin and told them that he had contracted COVID-19, though no further details were disclosed as his condition was not considered to be as critical as first thought.

62. On 12 November, the FLO telephoned Mr Coonan’s next of kin and told them Mr Coonan was seriously ill in hospital. She took a personal message from Mr Coonan’s next of kin and arranged for it to be relayed to him by a prison manager.

63. At 2.06am on 13 November, the FLO telephoned Mr Coonan’s next of kin to break the news of his death and to offer condolences and support.

64. The FLO and the deputy FLO continued to support Mr Coonan’s next of kin before and after his funeral, which was held on 27 November. The prison contributed towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

65. The escorting officers who were at the hospital when Mr Coonan died were debriefed and offered the support of the prison’s care team.

66. The prison posted notices informing other prisoners of Mr Coonan’s death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Coonan’s death.

Post-mortem report

67. The post-mortem examination found that Mr Coonan’s death was caused by COVID-19 pneumonia. The pathologist listed diabetes and ischaemic heart disease as contributory factors.

Findings

Management of Mr Coonan's risk of contracting COVID-19

68. Mr Coonan was sent to hospital on 28 October and remained in hospital until 4 November. He tested negative for COVID-19 on 28 October and 2 November. However, when he was tested on 4 November, on the day of his return to HMP Frankland, he tested positive for COVID-19. It therefore appears that Mr Coonan contracted COVID-19 in hospital.

69. In April 2020, prison healthcare staff noted that Mr Coonan's health conditions put him at greater risk of severe illness if he contracted COVID-19 and offered him the opportunity to 'shield' on a different wing. He declined and said he preferred to remain on the same wing. We consider that prison staff managed Mr Coonan's risk from COVID-19 appropriately. As noted above, it appears that he did not contract the virus at Frankland.

Clinical care

70. The clinical reviewer concluded that the care Mr Coonan received was generally of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer considered that healthcare staff managed Mr Coonan's long-term conditions and COVID-19 responsively, appropriately and compassionately.

71. However, the clinical reviewer was initially concerned that hospital doctors discharged Mr Coonan back to Frankland in the early hours of the morning on 4 November and 10 November. Information from the NHS Foundation Trust showed that Mr Coonan had been discharged at 6.00pm on 3 November, but that his return to the prison had been significantly delayed due to obtaining a secure vehicle. Additionally, the second discharge on 10 November was from the NHS Foundation Trust's A&E department and in line with their discharge policy. As a result, Mr Coonan's discharge was equivalent to what would have happened to any other person using the NHS Foundation Trust's A&E department.

72. While the concern about the hospital's involvement in Mr Coonan's discharge had been removed, the clinical review was concerned that during interviews with the Head of Healthcare at Frankland and Spectrum's Associate Medical Director, they said they thought that the local hospital had a misconception about the prison's healthcare unit and saw it, wrongly, as akin to a hospital unit. The Head of Healthcare said that this issue had also arisen during the treatment of other patients. In order to avoid this misconception in the future, we make the following recommendation:

    The Head of Healthcare should liaise with the local hospital trusts to ensure that they are fully aware of the constraints and limitations of treatment that can be delivered in the healthcare unit at HMP Frankland.

73. We also draw the attention of the Governor and the Head of Healthcare to further recommendations made by the clinical reviewer, which we do not repeat here.

74. We are also concerned that it took nearly eight hours to obtain a secure vehicle to transport Mr Coonan back to Frankland after the hospital discharged him on 3 November. While we appreciate that this delay occurred after 6.00pm and during the COVID-19 pandemic, we expected Mr Coonan to be returned to the prison far quicker. Due to these contributory factors, we do not make a recommendation in this area but draw the attention of the Governor to the delay.

Restraints, security and escorts

75. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

76. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

77. Between 28 October and 12 November, prison and healthcare staff completed six separate escort risk assessments to cover Mr Coonan's four hospital admissions and two changes to his condition. Of the five escort risk assessments that the prison has provided to us (we have not been provided with a copy of the assessment completed on 8 November), healthcare staff recorded information about Mr Coonan's impaired mobility in the assessments completed on 28 and 29 October and on 9 November, but did not do so for those completed on 10 or 12 November.

78. We appreciate that Mr Coonan was a high-profile prisoner and that his degree of mobility may have been known to the managers responsible for completing the escort risk assessments at Frankland. However, the Category A Team would not have had this knowledge. We are concerned that the Category A Team were unable to make informed decisions on the use of restraints because they were not provided with full information about Mr Coonan's mobility. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape.

79. By 10.40am on 12 November, senior prison managers knew that Mr Coonan had a short time to live and they began the process to seek permission to remove the restraints. Although there were only limited changes in the content of the escort risk assessment, completed on 12 November, compared to previous risk assessments, the prison did not contact a senior prison manager for permission until 1.12pm. After he immediately authorised the restraints to be removed, we

note that escorting officers did not remove them until 2.52pm, a delay of over an hour and a half.

80. We are concerned that the decision to remove the restraints when Mr Coonan was dying took over four hours and that escorting officers did not remove them promptly after the senior prison manager had granted verbal permission to do so at 1.12pm. We make the following recommendation:

The Governor should ensure that decisions to remove restraints are made quickly and communicated immediately to escorting officers.

Contact with Mr Coonan's next of kin

81. We are satisfied that prison staff appropriately contacted Mr Coonan's next of kin after he had contracted COVID-19 and when hospital doctors said that he had approached the end of his life. However, we are disappointed that the FLO and the Deputy Governor had to deliver personal messages between Mr Coonan and his next of kin rather than allowing him to speak directly to them on a mobile phone or laptop.

82. During the interviews with the FLO and the acting Deputy Governor, they disagreed on whether there had been any consideration of allowing Mr Coonan to talk directly with his next of kin. The FLO said she had asked him for permission whereas the Deputy Governor could not recall this conversation. We note that information about this consideration is not mentioned in the family liaison officer log or in the duty governor's log book.

83. While we accept that Mr Coonan's ability to speak directly with his next of kin may have been affected by his condition, his location in the hospital and the need to limit the spread of COVID-19, we believe that the possibility should have been formally considered. This is particularly necessary during the COVID-19 pandemic when hospitals, including the one Mr Coonan went to, are preventing people from visiting patients. We make the following recommendation:

The Governor should ensure that staff formally consider whether a seriously or terminally ill prisoner in hospital should be allowed to have direct contact with their next of kin or family member via a mobile phone, laptop or similar.

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