

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond O'Connell, a prisoner at HMP Long Lartin, on 26 December 2020

A report by the Prisons and Probation Ombudsman

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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Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Raymond O’Connell died in hospital on 26 December 2020, while a prisoner at HMP Long Lartin. He was 66 years old. Mr O’Connell died of COVID-19 pneumonia. I offer my condolences to his family and friends.
4. Full details of the clinical reviewer’s findings are in the clinical review report. She concluded that Mr O’Connell’s clinical care at Long Lartin was equivalent to that he could have expected to receive in the community. However, she found that Mr O’Connell did not have care plans in place for hypertension and as an older person. She was also concerned that staff did not comply with the healthcare provider’s policy to take clinical observations when a clinically vulnerable person reports symptoms of, or tests positive for COVID-19. We make recommendations on the issues related to the cause of death.
5. Although Long Lartin took reasonable steps to protect prisoners, Mr O’Connell appears to have contracted the infection during the initial outbreak at the prison. We are concerned that restraints were used while Mr O’Connell was in the intensive care unit at hospital and that his next of kin was not informed of his illness before he died.

Recommendations

- The Head of Healthcare should ensure that care plans are in place for patients with hypertension and other chronic health conditions.
- The Head of Healthcare should ensure that healthcare staff comply with the Practice Plus Group policy on monitoring patients who are symptomatic or have tested positive for COVID-19.
- The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner’s health and are based on the actual risk he presents at the time.
- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr O'Connell's clinical care at HMP Long Lartin.
7. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr O'Connell's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
8. The Ombudsman's family liaison officer wrote to Mr O'Connell's next of kin, his daughter, to explain the investigation. She did not receive a reply.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). They accepted our recommendations and provided an updated definition of 'outbreak' which has been reflected in this report.

Previous deaths at HMP Long Lartin

10. Mr O'Connell was the seventh prisoner at Long Lartin to die since December 2018. Two of the previous deaths were from natural causes (none related to COVID-19), two were self-inflicted and two were drug-related. There have since been four deaths (of which two were due to COVID-19). We have previously raised the issue of risk assessments and the unjustified use of restraints.

COVID-19 (coronavirus)

11. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
12. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
13. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners or staff in the prison who meet the case definition for COVID-19 or have a positive test result and among whom transmission was likely to have occurred within a 14-day period.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

14. Mr Raymond O’Connell was remanded to HMP Cardiff on 6 August 2016. He was later convicted of murder and sentenced to life imprisonment, with a tariff of 17 years and 4 months. On 9 November 2017, Mr O’Connell transferred to HMP Long Lartin.
15. Mr O’Connell’s medical conditions included asthma, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD) and high cholesterol. Care plans were in place for asthma and COPD.
16. Due to his underlying health conditions, Mr O’Connell was assessed as being at moderate risk of developing complications in the event of contracting COVID-19. On 23 March 2020, he received a letter explaining the risks and offering the opportunity to shield. He agreed and shielded in his cell.
17. On 15 June, after the initial 12-week period, it was noted in his personal records (but not in his medical notes) that Mr O’Connell had refused to continue shielding. He therefore left his cell for association and exercise with other prisoners and over the following months, there were several entries referring to him mixing with staff and his peers.
18. In the middle of December, Long Lartin had an outbreak of COVID-19 and became a red site, which meant that the prison was placed in ‘lockdown’ and implemented a very basic regime.
19. On 19 December, a wing officer telephoned healthcare staff to inform them that Mr O’Connell had reported a cough and was feeling hot. He was placed in isolation in his single cell on a residential unit. A swab was taken and sent to a laboratory by taxi.
20. In line with local policy, Mr O’Connell’s meals and medication were brought to his cell and he was monitored daily by healthcare staff. On 21 December, he told a nurse that he had vomited and was short of breath. No clinical observations were taken, and he was advised to use his cell bell if his symptoms became worse. On 22 December, Mr O’Connell was confirmed to be COVID-19 positive.
21. Just after 9.30am on 23 December, a wing officer told healthcare staff that Mr O’Connell was struggling to breath. A nurse examined him and found that his oxygen saturation levels were low. A code blue medical emergency was called (which indicates that a prisoner is having breathing difficulties or is unconscious) and an ambulance was requested. Mr O’Connell was given oxygen while waiting for the ambulance.
22. Paramedics took Mr O’Connell to hospital, escorted by two prison officers. He was double handcuffed, using standard handcuffs and an escort chain. In the evening, Mr O’Connell was moved to the intensive care unit.
23. At 11.00am on 24 December, a hospital doctor spoke to the duty governor. He advised that Mr O’Connell was to be sedated and placed on ventilator, with a nurse at his side continuously and that it would be safer for the escort officers to remain outside the unit. The escort officers then removed the restraints.

24. Mr O'Connell died at 7.16am on 26 December. The Deputy Governor informed his daughter later that morning.
25. A prison manager debriefed the escort officers and offered support. Notices were issued to staff and prisoners informing them of Mr O'Connell's death and reminding them of the support mechanisms. Staff reviewed prisoners considered to be at risk of self-harm.
26. A manager telephoned to check on Mr O'Connell's daughter on 27 January and a family liaison officer was assigned the next day. The family liaison officer kept in touch with Mr O'Connell's daughter as support and to assist with various arrangements.
27. In line with national policy, the prison paid for Mr O'Connell's funeral, which was held on 22 January 2021.

Cause of death

28. No post-mortem examination was held as the Coroner accepted the hospital's clinical certification that Mr O'Connell had died of COVID-19 pneumonia. He also had asthma and hypertension which did not cause but contributed to his death.

Findings

Clinical Findings

29. The clinical reviewer concluded that Mr O'Connell's care at Long Lartin was of a good standard and equivalent to that he could have expected to receive in the community. However, she felt that Mr O'Connell would have benefitted from hypertension and older persons' care plans. She was also concerned about clinical monitoring once Mr O'Connell became symptomatic and this is discussed further below.
30. The clinical reviewer made three recommendations, which the Head of Healthcare will wish to consider. We repeat those linked to Mr Ryman's cause of death. We recommend:

The Head of Healthcare should ensure that care plans are in place for patients with hypertension and other chronic health conditions.

Management of Mr O'Connell's risk and monitoring his COVID-19 infection

31. HM Inspectorate of Prisons carried out a scrutiny visit of Long Lartin in February 2021. Inspectors found that following the outbreak of COVID-19 in December 2020, partnership working between the prison, healthcare provider and Public Health England had been effective, with good communication about the restrictions in place to help prevent the spread of the infection.
32. Mr O'Connell was immediately advised of his risks at the beginning of the pandemic and shielded for 12 weeks. He chose not to shield after this, but from the start of Long Lartin's COVID-19 outbreak he was, in effect, shielded by the imposition of a restricted regime across the prison and being placed in a cohort for basic activities outside his cell, such as exercise and showers.
33. In spite of these precautions, it seems that Mr O'Connell contracted the virus during the initial outbreak, as he had not left Long Lartin for any reason in the weeks leading to his positive diagnosis.
34. The clinical reviewer highlights the expectation in the Practice Plus Group (healthcare provider) COVID-19 monitoring policy, that clinical observations should be taken if a patient is short of breath and has underlying health conditions which increase his risk of complications from COVID-19; and if a patient is confirmed as COVID-19 positive. No clinical observations were taken on 21 and 22 December, when Mr O'Connell fell in these categories.
35. The clinical reviewer acknowledges that the outbreak might have impacted on the delivery of healthcare services and that we cannot say whether the outcome for Mr O'Connell would have been any different if the assessments had been completed. However, we agree with her view that compliance with the policy is important. We recommend:

The Head of Healthcare should ensure that healthcare staff comply with the Practice Plus Group policy on monitoring patients who are symptomatic or have tested positive for COVID-19.

Security risk assessments and the use of restraints

36. 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.
37. 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 he has 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. These requirements are reflected in Prison Service Instruction (PSI) 33/2015 on external prisoner movements, as well as on the prison's risk assessment form.
38. The security risk assessment concluded that Mr O'Connell was low risk on all specific factors of concern, such as risk of escape and risk to the public and no behavioural problems were identified. The medical section of the form was completed and indicated no objections to the use of restraints. Mr O'Connell was double handcuffed, with an escort chain in place of the second cuff in line with the COVID-19 external escort policy.
39. Admission to an intensive care unit is an indication that a person is acutely ill with a life-threatening condition and high dependency needs. We are concerned that it was considered appropriate to continue using restraints after being told that Mr O'Connell's condition had deteriorated and after he was admitted to the unit. We recommend:

The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

Contacting Mr O'Connell's next of kin

40. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic.
41. The prison escort officers updated prison managers regularly about Mr O'Connell's deteriorating condition. On 25 December, they told the prison that he was likely to die within 24 to 48 hours.
42. The prison's local policy precludes visits and telephone calls within the first 72 hours of admission to hospital. Although the security risk assessment was reviewed daily, it seems that managers rigidly adhered to this policy despite Mr O'Connell's poor state of health.

43. We consider that Long Lartin should have notified Mr O'Connell's daughter as soon as he was admitted to hospital and as a priority when he moved to the intensive care unit. The failure to do so denied her the opportunity of contact before he died. We recommend:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

**Sue McAllister CB
Prisons and Probation Ombudsman**

December 2021

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