Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Antoneli, a prisoner at HMP Long Lartin, on 15 February 2021

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*

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 Michael Antoneli died in hospital on 15 February 2021, while a prisoner at HMP Long Lartin. He was 69 years old. The cause of Mr Antoneli's death was COVID-19 pneumonitis. I offer my condolences to his family and friends.

4. Mr Antoneli had been identified as at moderate risk of complications if he contracted COVID-19 due to his underlying medical conditions but had declined to shield. It seems likely that he contracted COVID-19 at the prison.

5. Full details of the clinical reviewer's findings are in the clinical review report. She concluded that, overall, Mr Antoneli's clinical care at Long Lartin was equivalent to that he could have expected to receive in the community. However, she recommended a review of the handling of the emergency procedures, due to concern that Mr Antoneli had been moved to a treatment room, instead of calling a medical emergency code (risking delay and contamination). She also found that the method of administering oxygen did not comply with national clinical guidelines.

6. We are concerned that the medical opinion on the risk assessments for Mr Antoneli's journey and continuing hospital admission did not accurately reflect his medical circumstances; and that there was a significant delay in informing his next of kin that he was seriously ill.

Recommendations

- The Head of Healthcare should formally review the findings of the clinical reviewer and share the learning with all healthcare staff, to ensure that the correct procedures are followed in medical emergencies. The review should include:
    - reminding healthcare staff of the purpose and importance of medical emergency codes; and
    - providing training to ensure compliance with National Institute for Health and Care Excellence (NICE) guidelines on administering oxygen during COPD exacerbation.
- The Governor and Head of Healthcare should ensure that:
    - healthcare staff accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and

    - prison managers regularly review the level of restraints used on prisoners in hospital.

- 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

7. NHS England commissioned an independent clinical reviewer to review Mr Antoneli's clinical care at HMP Long Lartin.

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

9. The Ombudsman's family liaison officer wrote to Mr Antoneli's next of kin, his daughter, to explain the investigation. She did not receive a reply.

10. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted the recommendations.

Previous deaths at HMP Long Lartin

11. Mr Antoneli was the eighth prisoner at Long Lartin to die since December 2018. Three of the previous deaths were from natural causes (including two from COVID-19), two were self-inflicted and two were drug-related. There have since been two deaths (unrelated to COVID-19). We have previously raised the use of restraints and contacting prisoners' next of kin.

COVID-19 (coronavirus)

12. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

13. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. 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.)

14. 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, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) 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

15. Mr Michael Antoneli was remanded to prison on 1 October 2004 and later convicted of murder. On 25 July 2005, he was sentenced to life imprisonment, with a minimum period to serve of 20 years. Mr Antoneli transferred from HMP Belmarsh to HMP Long Lartin on 11 October and remained there.

16. Mr Antoneli's medical history included type 2 diabetes, chronic obstructive pulmonary disease (COPD), asthma, high blood pressure, obesity, neurological problems and back pain. Care plans were in place for his long-term medical conditions.

17. Mr Antoneli lived in a single cell on a normal residential wing. On 23 March 2020, at the beginning of the COVID-19 pandemic, the prison's healthcare department wrote to advise him to shield for 12 weeks. On 18 April, he told a wing officer that he did not want to shield, and this was recorded in his personal records. On 15 May, healthcare staff formally classified Mr Antoneli as at moderate risk (clinically vulnerable) of developing complications if he contracted COVID-19.

18. Mr Antoneli's back pain increased, which he attributed to spending prolonged periods in his cell during the pandemic. This led to reduced mobility. He often struggled to stand independently and used walking aids and a wheelchair to move around.

19. In December 2020, 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. As part of a mass screening of prisoners, Mr Antoneli was tested for COVID-19 on 15 December and the result was negative.

20. Healthcare staff offered Mr Antoneli a repeat test on 8 January 2021, which he declined. On 13 January, he reported feeling unwell and short of breath, despite using his inhalers and nebuliser. Mr Antoneli was immediately placed in isolation. Healthcare staff prescribed antibiotics and steroids, as well as sending a swab for testing.

21. Mr Antoneli's test returned as positive on 15 January. As he was considered to be high risk, healthcare staff conducted clinical observations twice a day and operational staff checked him frequently at night. Staff were reminded to wear the correct masks, as Mr Antoneli used a nebuliser which moved air around his cell.

22. In the early hours of 19 January, Mr Antoneli pressed his cell bell and told an officer that he was having difficulty breathing. A nurse assessed him and found that his blood oxygen saturation level was low. The nurse gave him oxygen and it returned to normal. Over the next two days his oxygen levels fluctuated, and officers checked him hourly during the night.

23. At around 8.40am on 21 January, a nurse was called to examine Mr Antoneli in his cell, as he was again short of breath. The nurse took him to the wing treatment room, gave him oxygen and requested an ambulance. Paramedics arrived within 15 minutes and took Mr Antoneli to hospital at around 10.30am.

24. Mr Antoneli was escorted by four prison staff - a supervising officer and three prison officers (later reduced to three) and he was double handcuffed with standard handcuffs. After assessment by hospital staff, Mr Antoneli was started on oxygen and intravenous antibiotics. At 2.20pm, the restraints were reduced to an escort chain, which remained in place while on a ward, but increased to double cuffs when he moved around to other areas, such as the X-ray department.

25. Healthcare staff obtained daily updates. Mr Antoneli was initially stable with a slight improvement after a few days. However, on 8 February, hospital staff said his condition was poor and asked for the details of his next of kin. He did not meet the criteria for the intensive care unit as he was unlikely to recover. As Mr Antoneli had three cannulas, it was difficult to apply double cuffs when he needed to go for tests, so permission was given to reduce this to an escort chain.

26. On 9 February, the Category A team at the Prison Service approved removal of Mr Antoneli's restraints on the basis that he was critically ill and multiple organ failure was likely.

27. Mr Antoneli was a foreign national and his family lived abroad. On 10 February, the prison's family liaison officer informed his daughter, his next of kin, that he was in hospital. He remained in daily contact, advising the family on travel plans to the UK and the quarantine arrangements.

28. At the request of the security department, a prison nurse visited Mr Antoneli on 11 February, to assess the use of handcuffs (presumably to advise on whether they could be reinstated as they had already been removed). The same day, a doctor said that if his condition did not improve within 48 hours, they would consider withdrawing treatment.

29. Mr Antoneli's family visited him on 13 and 14 February and were with him when he died at 1.45am on 15 February. The family liaison officer spoke to his daughter later that morning and gave her relevant information. He also helped to arrange the repatriation of Mr Antoneli's body.

30. Mr Antoneli's funeral was held on 21 February 2021. The prison offered to contribute to the funeral expenses.

Cause of death

31. No post-mortem examination was held as the Coroner accepted the hospital's clinical certification that Mr Antoneli's cause of death was COVID-19 pneumonitis.

Findings

Clinical Findings

32. The clinical reviewer concluded that, overall, Mr Antoneli's care at Long Lartin was equivalent to that he could have expected to receive in the community, and that the management of his long-term conditions was particularly good. However, she was concerned about the handling of the emergency response when Mr Antoneli's condition deteriorated. Full details of her findings are in the clinical review report and we summarise those about the emergency procedures below.

33. The clinical reviewer also made a recommendation about record keeping, which the Head of Healthcare will need to address.

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

34. 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, the 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.

35. Mr Antoneli was advised of his risks at the beginning of the pandemic but chose not to shield. However, like other prisoners, after the outbreak of COVID-19 at Long Lartin, he benefitted from some protection by the imposition of a restricted regime across the prison. This included placing the men in cohorts for basic activities outside their cells, such as exercise, showers and collecting medication.

36. The prison said that after Mr Antoneli tested positive for COVID-19 in January 2021, he was placed in a cohort of positive prisoners to allow reasonable access to the regime and the unit was cleaned between each cohort's use of the facilities. Healthcare staff conducted regular clinical checks and operational staff monitored him closely. The prisoners from his original cohort were also tested.

37. Mr Antoneli complained that it had taken two hours for wing staff to answer his cell call bell on 19 February. The call bell records show that the bell was answered within one minute.

38. Mr Antoneli appears to have contracted COVID-19 at Long Lartin, as he had not left the prison for any reason in the weeks before he tested positive. However, we are satisfied that the prison implemented appropriate protective measures and that he had been given the opportunity to shield due to his vulnerability.

Emergency response

39. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes* sets out the actions staff should take in a medical emergency, including mandatory instructions on efficiently communicating the nature of a medical emergency, to ensure staff take the relevant equipment to the incident and that there are no delays in calling an ambulance.

40. The clinical reviewer identified several concerns about the emergency procedures when Mr Antoneli's condition deteriorated on 21 February. She questioned the accuracy of the recorded timings of events; and the propriety of moving Mr Antoneli to the treatment room rather than calling a code blue emergency, given that this would have delayed treatment and potentially caused contamination. She also found that the administration of oxygen to Mr Antoneli was not in line with National Institute for Health and Care Excellence (NICE) guidance on treating severe COPD symptoms as the nurse did not use an appropriate delivery device to give oxygen.

41. The Deputy Head of Healthcare considered that the nurse's actions were justified, for speed, as well as to allow better ventilation and space to treat Mr Antoneli. However, we agree with the clinical reviewer that the management of the emergency procedures would benefit from review and reflection to determine possible training needs. We recommend:

The Head of Healthcare should formally review the findings of the clinical reviewer and share the learning with all healthcare staff, to ensure that the correct procedures are followed in medical emergencies. The review should include:

- **reminding healthcare staff of the purpose and importance of medical emergency codes; and**
- **providing training to ensure compliance with National Institute for Health and Care Excellence (NICE) guidelines on administering oxygen during COPD exacerbation.**

Security risk assessments and the use of restraints

42. 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.

43. 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.

44. Mr Antoneli was a Category A prisoner. A detailed security risk assessment concluded that he was a high risk to the public; medium risk in terms of likelihood of outside assistance to escape; and low risk on all the other factors, including risk of escape. He was an enhanced prisoner under the incentives policy and there had been no problems during previous hospital visits. There were few security intelligence reports about him in recent years, none were linked to escape or mobile phone usage. In line with national policy, the security

arrangements and changes to restraints while he was in hospital were made in consultation with the Prison Service Category A team.

45. The medical section of the form noted that Mr Antoneli used a wheelchair, yet it was ticked to indicate that his medical condition did not restrict his ability to escape unaided; there were no objections to the use of restraints; and they would not have to be removed for treatment.

46. The section completed by the senior manager noted, "seriously ill not mobile at present". The officer who conducted the physical security checks noted in the Person Escort Record that it was difficult to verify his identity as he was in "extremely poor health". The Category A Team advised an escort strength of four staff, as the prison had yet to translate two recent telephone conversations that were not in English.

47. A member of the prison's security team told the investigator that Mr Antoneli was double handcuffed, with an escort chain in place of the second cuff, in line with the COVID-19 external escort policy, but the evidence in the escort documents suggests otherwise.

48. Given the risk assessment cited a clear security concern which had to be balanced against other factors, we would not wish to second-guess the judgement on the initial level of security. However, we are not satisfied that the medical opinion properly reflected Mr Antoneli's circumstances, or that there were sufficient reviews of his clinical condition, to assess whether his risk had reduced (for example, due to intravenous treatment). Without such details, the Category A Team did not have full, accurate and up to date information to determine whether the use of restraints was proportionate to the risk. We recommend:

The Governor and Head of Healthcare should ensure that:

- **healthcare staff accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and**
- **prison managers regularly review the level of restraints used on prisoners in hospital.**

Contacting Mr Antoneli's next of kin

49. 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.

50. Although the prison's local policy precludes visits and telephone calls within the first 72 hours of admission to hospital, this should not have prevented staff from informing his family (who live abroad) that he was unwell. Twenty days had elapsed before Mr Antoneli's daughter was told. By then, it was clear that Mr Antoneli was unlikely to live. Given the complexity of travel arrangements during the pandemic and the requirement at that time for visitors from abroad to self-isolate, the failure to inform her sooner significantly reduced the opportunity for

Mr Antoneli's family to spend time with him in his final days and the quality of the contact.

51. This is the third recent COVID-19 death in which Long Lartin has not adhered to the national policy on contacting the next of kin of seriously ill prisoners. We therefore repeat the following recommendation:

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.

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Prisons and Probation Ombudsman **April 2022**

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