Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher McDonagh, a prisoner at HMP Erlestoke, on 25 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 Christopher McDonagh died in hospital of COVID-19 pneumonitis on 25 February 2021, while a prisoner at HMP Erlestoke. He was 56 years old. I offer my condolences to Mr McDonagh's family and friends.

4. The clinical reviewer concluded that the clinical care Mr McDonagh received at HMP Erlestoke was of a reasonable standard and equivalent to that he could have expected to receive in the community. However, she found that there had been a delay in offering Mr McDonagh, who was clinically vulnerable to COVID-19, the opportunity to shield and that staff at Erlestoke had not always followed COVID-19 policies to protect prisoners from the virus.

5. We found that the delay of around a week in telling Mr McDonagh's next of kin that he was in hospital was not justified.

6. We also found that the decision to send Mr McDonagh to hospital 'double cuffed' was not justified given his poor health. We are also concerned that, although we were told that the cuffing level was reduced, there is no record of this.

7. There were long delays in Erlestoke providing information to us, which delayed our investigation. It took nearly four months for some routine information to be sent to us. There are still documents that we requested that have not been provided.

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

Recommendations

- The Governor and Head of Healthcare should ensure that:
    - all COVID-19 policy requirements for prisoner isolation, shielding and/or 'reverse cohorting' are consistently enforced;
    - isolation, shielding and/or 'reverse cohorting' requirements are clearly documented in the patient's clinical and prison records; and
    - staff and prisoners are aware of those requirements.
- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill, in line with Prison Rule 22 and PSI 64/2011.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should revise the prison's escort risk assessment form to ensure that it requires:
    - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
    - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.
- The Governor should ensure that any changes to the level of restraints are recorded accurately and promptly.
- The Governor should ensure that information requested by the PPO is provided promptly, in line with PSI 58/2010.

The Investigation Process

9. NHS England commissioned an independent clinical reviewer to review Mr McDonagh's clinical care at HMP Erlestoke and at prior prisons, notably HMP Ranby.

10. The PPO investigator has investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, the security arrangements for Mr McDonagh's hospital escorts, liaison with his family and whether compassionate release was considered.

11. The PPO family liaison officer wrote to Mr McDonagh's next of kin to explain the investigation and ask if she had any issues she wanted the investigation to cover. She did not respond to our letter.

12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

COVID-19 (Coronavirus)

13. 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.

14. 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.)

15. 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 received or returning prisoners from the main population through 'reverse-cohorting'. Other measures include social distancing and the use of personal protective equipment (PPE).

Previous deaths at HMP Erlestoke

16. Mr McDonagh was the fourth prisoner at Erlestoke to die since February 2019. Of the previous deaths, two were from natural causes and one was self-inflicted. Mr McDonagh's death is the only one from COVID-19. There are no similarities between our findings in the investigation into Mr McDonagh's death and our investigation findings for the previous deaths.

Key Events

17. In January 2000, Mr Christopher McDonagh (then known as Christopher Holgate) was sentenced to life imprisonment for murder. He was released on licence 14 years later.

18. On 13 July 2019, Mr McDonagh was recalled to prison because of reports that he was coercively controlling his then partner. On 22 January 2020, Mr McDonagh was sentenced to 12 months imprisonment. (His recall to prison remained in place and was subject to Parole Board review.)

19. In June 2020, while Mr McDonagh was at HMP Ranby, healthcare staff suspected he was suffering from chronic obstructive pulmonary disease (COPD). A COPD care plan was created by the healthcare team on 17 June. As this made him vulnerable if he contracted COVID-19, staff offered him the opportunity to shield, which he accepted. He shielded for the rest of his time at Ranby.

20. Healthcare staff at Ranby referred Mr McDonagh to the respiratory team at Doncaster & Bassetlaw Hospital for his suspected COPD. Mr McDonagh remained under the care of the respiratory team until his transfer to HMP Erlestoke. Mr McDonagh needed to have spirometry tests as part of a COPD diagnosis, but these were not available as the service was halted by the COVID-19 pandemic.

21. On 4 January 2021, Mr McDonagh was transferred to HMP Erlestoke. He was placed in isolation and subject to 'reverse-cohorting' in line with COVID-19 guidelines. (Reverse cohorting aims to reduce the spread of COVID-19 by keeping newly arrived prisoners separate to the rest of the prison.) The nurse who carried out the reception screen wrote "shielding" and later "to shield" in his initial review, but with no further context or tasking.

22. On 16 January, Mr McDonagh told a nurse that he had been feeling unwell for three days. She completed a NEWS-2 assessment. (NEWS-2 is a tool to measure clinical deterioration in adult patients.) Mr McDonagh had a score of zero, indicating no deterioration but that routine monitoring should continue. She advised him to tell prison staff if he did not feel better in 48 hours.

23. On the evening of 18 January, Mr McDonagh told a nurse that he had flu-like symptoms and chest pain when breathing. She completed a NEWS-2 assessment. Mr McDonagh had a score of 1. She told wing staff to observe Mr McDonagh overnight and call 999 if there were any concerns. She asked for a GP review of Mr McDonagh.

24. On 19 January, a prison GP saw Mr McDonagh. Mr McDonagh said he had had flu-like symptoms for three days. The GP noted that this could be poorly controlled COPD. She prescribed antibiotics and steroids for a chest infection. Healthcare staff also tested Mr McDonagh for COVID-19.

25. On 22 January, Mr McDonagh attended the healthcare unit for a blood test. Mr McDonagh should have been in isolation following his COVID-19 test three days earlier. A nurse rang wing staff to tell them Mr McDonagh should be isolating. Mr McDonagh was placed in isolation on his return from the healthcare unit. On

25 January, his COVID-19 test came back negative, and Mr McDonagh came out of isolation. There is no evidence he was offered shielding.

26. On 5 February, Mr McDonagh saw a nurse. She noted he was breathless and unwell. He had a NEWS-2 score of 6 and she referred him to a prison GP. The GP thought his symptoms might be COVID-19. On 7 February, Mr McDonagh had a COVID-19 test. There is no evidence to show that Mr McDonagh was isolated following this test.

27. On 9 February, the prison GP reviewed Mr McDonagh again. She noted he had a shielding letter from Ranby. She tasked nurses to issue Mr McDonagh with a shielding letter and explain it to him. There is nothing in his medical record to show that this letter was issued or that a nurse met with Mr McDonagh prior to his hospitalisation. There is no evidence that Mr McDonagh shielded.

28. On 11 February, Mr McDonagh's COVID-19 test result came back positive. Later that afternoon, at around 1.35pm, a prison officer found Mr McDonagh apparently unconscious in his cell. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and a nurse attended. She completed a NEWS-2 assessment. Mr McDonagh scored 8, indicating he needed emergency treatment.

29. The prison control room called 999 at 1.39pm. South West Ambulance Service (SWAS) dispatched an ambulance at 2.13pm, which arrived at 2.51pm. Paramedics treated Mr McDonagh at the scene and then took him to Salisbury District Hospital. He was escorted by two prison officers and was 'double cuffed' with an escort chain (his wrists were handcuffed together and then he was attached to a prison officer with an escort chain).

30. In hospital, Mr McDonagh was treated for COVID-19 pneumonia and acute kidney injury (where the kidneys stop working properly). On 13 February, Mr McDonagh was discharged from hospital and returned to the prison, where he was placed in 'reverse-cohort' isolation in line with policy.

31. On the afternoon of 15 February, a prison paramedic was asked to review Mr McDonagh. Mr McDonagh had apparently been seen by another nurse earlier in the day (although there is no record of this). The paramedic found Mr McDonagh had difficulty breathing. He carried out a NEWS-2 assessment. Mr McDonagh scored 9 indicating he needed emergency treatment.

32. The prison made a 999 call at 2.52pm. An ambulance arrived at the prison at 3.18pm. Paramedics treated Mr McDonagh at the scene and then took him to Salisbury District Hospital. Again, he was escorted by two prison officers in 'double cuffs'.

33. On 18 February, prison officers at the hospital with Mr McDonagh told the prison that Mr McDonagh was receiving Continuous Positive Airway Pressure (CPAP) ventilation.

34. On 22 February, prison officers at the hospital with Mr McDonagh told the prison that hospital staff had advised that Mr McDonagh was being treated palliatively and he was not expected to be able to survive without the CPAP machine. Later that day, prison healthcare staff spoke with a hospital doctor who confirmed this.

35. The same day, the prison appointed a family liaison officer (FLO). She rang Mr McDonagh's next of kin to tell her that he was in hospital and seriously unwell. On 24 February, the FLO rang Mr McDonagh's next of kin and helped arrange for her to visit Mr McDonagh in hospital.

36. On 25 February, at around 10.00am, Mr McDonagh died in Salisbury District Hospital with his next of kin at his bedside.

Cause of death

37. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr McDonagh's cause of death as COVID-19 pneumonitis. The doctor also listed COPD as a contributory factor.

Clinical Findings

38. The clinical reviewer concluded that the care Mr McDonagh received at Erlestoke was equivalent to that which he could have expected to receive in the community.

39. However, she found some areas of concern as set out below.

Management of Mr McDonagh's risk of infection from COVID-19 and risk to others

40. The clinical reviewer found that it was most likely that Mr McDonagh contracted COVID-19 at Erlestoke in the days prior to his test on 7 February. The healthcare team told us that when Mr McDonagh arrived at HMP Erlestoke, around 27% of prisoners had tested positive for COVID-19. It is unfortunate that Mr McDonagh, who had been assessed as clinically vulnerable to COVID-19 while at Ranby due to his suspected COPD, transferred into Erlestoke at the start of a significant COVID-19 outbreak at the prison.

41. Both the clinical reviewer and the investigator asked for HMP Erlestoke's local COVID-19 management policy. Despite multiple requests, neither the clinical reviewer nor the investigator received a copy. Given this, we cannot know what the local policy for COVID-19 shielding and other key management policies were. The clinical reviewer was told by a senior manager that "guidance issued centrally formed the basis for our local working". It appears therefore that Erlestoke did not have a local COVID-19 policy.

Shielding Status

42. Mr McDonagh had been shielding at Ranby. This was known by some staff at Erlestoke in advance of the transfer. On 4 January, at his initial health screening at Erlestoke, a nurse made the notes "shielding" and later "to shield" in his initial review, but with no further context or tasking.

43. The clinical reviewer spoke with the Head of Healthcare at Erlestoke who said:

> "Initially Mr McDonagh had not been advised to shield. All patients are reviewed by prison GPs to identify those who should be offered shielding. The guidance changed and following a further GP review, it was decided on 09.02.2021 that he should be invited to shield."

Despite the efforts of the clinical reviewer, we have not been able to find out what this guidance was and when it changed.

44. It appears that Mr McDonagh did not shield prior to a review with a prison GP on 9 February. By this time, it was likely he had already contracted COVID-19. The GP tasked nurses to issue Mr McDonagh with a shielding letter and explain it to him. There is no evidence that this letter was issued or that a nurse met with Mr McDonagh prior to his hospitalisation. There is no evidence that Mr McDonagh shielded. A note on the medical records indicates that a nurse printed his shielding letter on 21 February, by which time he had been in hospital for a week.

45. The clinical reviewer found that Mr McDonagh was clinically vulnerable in relation to COVID-19, due to his history of chronic long-term respiratory disease, although he did not have a definitive diagnosis of COPD at that time. The NHS

Shielded Patient guidance would have recommended he shield. She found that he was assessed as not requiring shielding until 9 February when he saw the GP. However, Mr McDonagh's respiratory condition pre-existed this date, meaning his clinical vulnerability was not new.

COVID-19 isolation

46. There were two instances at Erlestoke when Mr McDonagh was unwell and displaying symptoms that required a COVID-19 test, where COVID-19 isolation was not enforced in line with prison policy or where there is no evidence it was.

47. On 19 January, Mr McDonagh had a COVID-19 test. He should have been placed in isolation pending the result of the test. However, on 22 January he was allowed to attend the healthcare unit for a blood test. When the healthcare rang the prison wing staff, they did not appear to know about his test. Although his test came back negative on 25 January, this was a breach of policy. Had he been positive, there would have been a risk of him spreading COVID-19 to prisoners and staff at Erlestoke.

48. On 5 February, Mr McDonagh saw a prison GP, who thought his symptoms might be COVID-19. He had a COVID-19 test on 7 February. However, there is no evidence that he isolated in line with national prison policy. His COVID-19 test came back positive on 11 February. If he did not isolate during this period, he was at risk of spreading COVID-19 to prisoners and staff at Erlestoke.

49. We make the following recommendations.

The Governor and Head of Healthcare should ensure that:

- **all COVID-19 policy requirements for prisoner isolation, shielding and/or 'reverse cohorting' are consistently enforced;**
- **isolation, shielding and/or 'reverse cohorting' requirements are clearly documented in the patient's clinical and prison records, and;**
- **staff and prisoners are aware of those requirements.**

Non-Clinical Findings

Liaison with Mr McDonagh's next of kin

50. Prison Rule 22 says that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction (PSI) 64/2011, about safer custody, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health, an appropriate member of prison staff should engage with their next of kin to provide information and support.

51. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic. This also said that if a prisoner is diagnosed with COVID-19, they should be asked if they want to inform anyone.

52. Mr McDonagh tested positive for COVID-19 on 11 February and was sent to hospital for the second time on 15 February, but the prison did not tell his family until 22 February, after the hospital had told the prison that they were treating him palliatively. We consider that the family should have been told earlier.

53. While we acknowledge that the prison's family liaison officer arranged for Mr McDonagh's next of kin to visit the hospital and be with him when he died, the delay in informing her reduced the time available to visit him. We recommend:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill, in line with Prison Rule 22 and PSI 64/2011.

Restraints, security and escorts

54. 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 a prisoner's health and mobility.

55. 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.

56. PSI 33/2015, *External Escorts*, says that normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort and that "all other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate".

57. Mr McDonagh was a Category C prisoner. On both 11 and 15 February 2021, when Mr McDonagh was taken by ambulance to hospital, he left the prison 'double cuffed'. The Prison Escort Record (PER) risk assessments are nearly identical. The risk assessment concludes, "Prisoner's wrists to be D cuffed together and attached to officer by escort chain," and was signed by the authorising prison manager.

58. The medical section of the PER risk assessment reflects only Mr McDonagh's long-term conditions (COPD) and that there were no medical objections to the use of restraints. There was no information about his current condition, his mobility or how his health impacted on his ability to escape. On both occasions, Mr McDonagh was taken to hospital when there were still nursing staff on site, meaning clinical staff would have been able to provide this information.

59. Information from the medical records for 11 and 15 February shows that on both occasions Mr McDonagh's NEWS-2 score showed he required urgent medical care. On 11 February, he had been found unconscious by prison staff and was assessed as "grey" in skin colour, with chest pains and shortness of breath. On 15 February, he was assessed as struggling to breathe.

60. We raised the cuffing arrangement with the prison and were told that it was a COVID-19 safety measure rather than a security measure. We were told this was to maintain social distancing between prisoner and officers. However, this is not recorded on the PER risk assessments in any way.

61. We struggle to see that the cuffing arrangement provided any additional COVID-19 safety to an escort chain only. We consider that the use of double cuffs was not in line with Prison Service policy as there was no individual risk assessment to justify their use. We consider that the lack of information on his current medical condition meant that there was no consideration to his risk of escape and undermined the quality and defensibility of the risk assessment.

62. From reviewing the available documentation, we were unable to work out when the double cuff was removed and when cuffing was stopped completely. The prison was not able to tell us when this happened. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Governor should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's <u>current</u> state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

The Governor should ensure that any changes to the level of restraints are recorded accurately and promptly.

Delay in providing documents

63. PSI 58/2010, *The Prisons and Probation Ombudsman*, says that Governors must ensure that when the PPO is carrying out investigations or enquiries, staff comply with requests for information and assistance.

64. The PPO investigator initially requested the documents he required for his investigation on 1 March. Despite repeated requests, he was not sent any documents until mid-April and even then, some were missing. He did not receive all the initially requested documents until 14 June.

65. With the exception of the documents sent on 14 June, which were delayed due to staff sickness, we were never given any explanation for the months of delay.

66. We recommend:

The Governor should ensure that information requested by the PPO is provided promptly, in line with PSI 58/2010.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2021**

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