

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Connolly, a prisoner at HMP Dartmoor, on 16 April 2021

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Martin Connolly died in hospital as a result of cerebrovascular disease (stroke) on 16 April 2021, while a prisoner at HMP Dartmoor. Mr Connolly was 81 years old. I offer my condolences to Mr Connolly's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Connolly received at Dartmoor (and at HMP Exeter) was equivalent to that he could have expected to receive in the community. She made seven recommendations but, as four were not related to Mr Connolly's death, we have included only three in our report.
5. We found no non-clinical issues of concern.

Recommendations

- The Heads of Healthcare at Dartmoor and Exeter should ensure that prisoners' medical records provide a clear and accurate account of all care including discharge planning that has taken place between hospital and prison staff, in order to fully meet the NMC Code of Conduct and Health Care Professional Council (HCPC) standards of conduct, performance and ethics.
- The Head of Healthcare at Exeter should review the management of head injuries in patients prescribed anticoagulation medication in line with NICE Guidelines on Head Injury: Assessment and Early Management recommendations.
- The Heads of Healthcare at Dartmoor and Exeter should consider using the NICE multi morbidity quality standards and care plan framework.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Connolly's clinical care at Dartmoor.
7. The PPO investigator has investigated non-clinical issues, including Mr Connolly's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Connolly's next of kin, his granddaughter, to explain the investigation. She did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Dartmoor

10. Mr Connolly was the eighth prisoner at Dartmoor to die since April 2019. Of the previous deaths, five were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation into Mr Connolly's death and our investigation findings for the previous deaths.

Previous deaths at HMP Exeter

11. Twelve prisoners at Exeter died between April 2019 and the date of Mr Connolly's death. Of these deaths, seven were from natural causes, four were self-inflicted and one was drug related. There are no similarities between our findings in the investigation into Mr Connolly's death and our investigation findings for the previous deaths.

Key Events

12. In January 2017, Mr Martin Connolly was sentenced to 19 years in prison for sexual offences. He was moved to HMP Dartmoor on 8 June 2018.
13. Mr Connolly had several health conditions when he was sent to prison, including ischemic heart disease (caused by narrowed arteries) and hypertension (high blood pressure). At Dartmoor, Mr Connolly was diagnosed with chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases), mixed Alzheimer’s and dementia and osteoarthritis. Healthcare staff saw him frequently to monitor his conditions.
14. From July 2019, Mr Connolly experienced dizziness. Prison healthcare staff reviewed him and concluded that his dizziness was due to his changing blood pressure, age related vestibular disturbance in his ear (disruption to the body’s balance system), coupled with complications of his severe ischemic heart disease and his medications.
15. On 17 December 2020, Mr Connolly complained of a sharp central chest pain. A nurse took his observations and carried out an electrocardiogram (ECG - a test that checks the heart's rhythm). Healthcare staff decided that because of his cardiac history and the absence of a GP on site that day, Mr Connolly should go to hospital for review. Hospital specialists diagnosed stable angina (chest pain caused by reduced blood flow to the heart).
16. On 21 January 2021, prison healthcare staff sent Mr Connolly to hospital by emergency ambulance, after they found him slumped in a chair, responsive, but very confused. Hospital specialists diagnosed a stroke.
17. On 2 February, Mr Connolly said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
18. On 26 February, hospital staff said that discharge was planned within the next ten days.
19. On 5 March, at a meeting between Dartmoor senior healthcare staff, the Governor and hospital staff, it was agreed that returning to Dartmoor would not be suitable for Mr Connolly, due to his complex needs. On 15 March, he was due to transfer to a care home. However, this was later cancelled.
20. Healthcare staff at Dartmoor contacted HMP Exeter (which has a social care wing and facilities for terminally ill prisoners) to discuss discharge planning for Mr Connolly. However, none of this is recorded in his medical record.

Transfer to HMP Exeter

21. On 22 March, the hospital confirmed they were intending to discharge Mr Connolly to Exeter. When Mr Connolly arrived at Exeter on 31 March, it became evident that he would need a considerable amount of care. The prison GP noted it was in Mr Connolly’s best interests to accept him as the hospital advised there was no longer a bed available for him. Mr Connolly was admitted to the social care unit, and a

comprehensive care plan was created. Despite receiving care at Exeter, Mr Connolly remained in the custody of Dartmoor.

22. That evening, Mr Connolly fell from his bed and hit his head. The prison GP said it was not appropriate to send Mr Connolly to hospital, as there were no apparent injuries, and it would cause him further disruption. (Mr Connolly was on an anticoagulant (medication to help prevent blood clots) and NICE (National Institute for Health and Care Excellence) guidelines state that adults on anticoagulants should have a head CT scan within eight hours of a head injury.)
23. In line with Mr Connolly's care plan, healthcare staff completed a referral to Devon County Council who commission the Social Care for Devon Prisons. The referral was made to them so that they were aware that he was at Exeter and to ask for an assessment of his needs and appropriate package of care to be agreed. He had a poor swallow reflex and was coughing after his medications.
24. On 1 April, a multi-professional complex case conference (MPCCC) was held to discuss Mr Connolly's care plan. It concluded that a care home would be the most suitable option for him.
25. On 2 April, a nurse reviewed Mr Connolly. The nurse recorded that he had an increased respiratory and heart rate, reduced oxygen saturation, a clear wheeze, and reduced air entry with a potential diagnosis of aspiration pneumonia (inflammation of the lungs caused by breathing in food, liquids or vomit). The nurse gave Mr Connolly a nebuliser to help him breathe and called an ambulance. Mr Connolly was escorted by two guards and was not restrained. Hospital specialists diagnosed aspiration pneumonia and exacerbation of COPD.
26. On 11 April, hospital staff told prison healthcare staff that the results of a CT scan showed that Mr Connolly's condition was terminal. He died in hospital on 16 April.

Post-mortem report

27. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Connolly's cause of death as aspiration pneumonia caused by cerebrovascular disease. The doctor also noted that Mr Connolly had ischaemic heart disease which did not cause but contributed to his death.

Louise Richards
Assistant Ombudsman

May 2022

Inquest

The inquest, held on 30 November 2023, concluded that Mr Connolly died from natural causes.

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