Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Eileen McDonagh, a prisoner at HMP Styal, on 2 July 2022

A report by the Prisons and Probation Ombudsman

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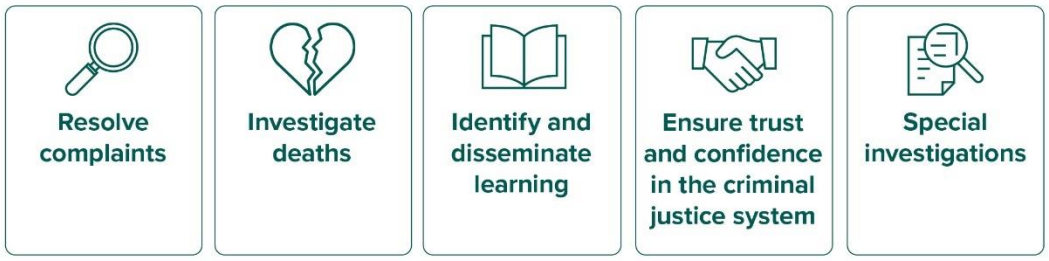
OUR VISION

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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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Ms Eileen McDonagh died on 2 July 2022 having been found hanged in her cell at HMP Styal. She was 25 years old. I offer my condolences to Ms McDonagh's family and friends.

While Ms McDonagh presented as a challenging woman to manage and her behaviour could be impulsive and difficult, there were no indications that she was at increased risk of suicide in the days and hours before her death.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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Summary

Events

1. On 28 March 2022, Ms Eileen McDonagh arrived in HMP Styal charged with assault occasioning actual bodily harm. She had been at Styal on several previous occasions.

2. Ms McDonagh had been previously diagnosed with attention deficit hyperactivity disorder (ADHD). She had not been taking any medication for this condition in the community.

3. Between April and June, Ms McDonagh was involved in several fights or altercations with other prisoners, and she broke other prison rules: this had also been a pattern for her during previous sentences.

4. On the morning of 14 June, Ms McDonagh had a fight with another prisoner. In the afternoon, she tried to climb over the landing railings and after being taken back to her cell, she deliberately cut her hand and threatened to pour boiling water over herself. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT).

5. The ACCT was closed at a review on 15 June. Staff noted that Ms McDonagh had ADHD for which she was not taking any medication but did not record whether anything further could or should be done to support her.

6. In the late morning of 2 July, Ms McDonagh had a fight with another prisoner and staff locked her in her cell. At 2.10pm, while other prisoners were on the exercise yard, they shouted to staff that they could see Ms McDonagh hanging in her cell. An officer on the yard reached through the window to cut the ligature and he then radioed a medical emergency code. Other staff went into the cell and started cardio-pulmonary resuscitation (CPR).

7. Paramedics arrived at 2.23pm and took charge of Ms McDonagh's care. At 2.31pm, the paramedics confirmed that Ms McDonagh had died.

Findings

8. Although Ms McDonagh had some known risk factors for suicide and self-harm, we found that there were no indications that her risk to self had significantly increased between the ending of ACCT procedures on 15 June and her death on 2 July.

9. The clinical reviewer concluded that the care Ms McDonagh received at HMP Styal was not equivalent to what she could have expected to receive in the community. Ms McDonagh had a diagnosis of ADHD, but she was not seen by a long-term conditions nurse and there were no entries in her record about when she should have been reviewed. Also, her mental health needs were not explored after an ACCT was opened on 14 June.

The Investigation Process

10. HMPPS notified us of Ms McDonagh's death on 3 July 2022.

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

12. The investigator visited Styal on 4 July. She obtained copies of relevant extracts from Ms McDonagh's prison and medical records.

13. The investigator interviewed 12 members of staff at Styal between December 2022 and April 2023. All of the interviews were conducted by video-link. The investigation was then transferred to one of her colleagues.

14. NHS England commissioned a clinical reviewer to review Ms McDonagh's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with clinical staff and with some of the prison staff.

15. We informed HM Coroner for Cheshire of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

16. The Ombudsman's family liaison officer contacted Ms McDonagh's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Ms McDonagh's mother said that her daughter had severe mental health problems and she asked:

    - why was her daughter not placed on constant watch after she had been treated for self-harm injuries on 14 June?

    - why was her daughter not placed in a shared cell for support?

17. We have addressed these questions in this report.

18. The initial report was shared with Ms McDonagh's mother and with HM Prison and Probation Service (HMPPS). HMPPS pointed out several factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Styal

19. HMP Styal holds up to 486 women. There is a variety of residential units, with 16 separate houses each holding about 20 women. There is also a mother and baby unit.

20. Spectrum Community Health runs healthcare services at the prison. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. The prison has 24-hour nursing cover.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Styal was in September and October 2021. Inspectors noted that incidents of violence at Styal had increased significantly since the previous inspection in 2018, although most of the incidents were not serious and reflected a build-up of frustration. Inspectors found that violent incidents were investigated well, and management of perpetrators and victims was good. Inspectors found that the quality of ACCT records was not good enough and care plans were particularly poor and did not fully reflect the women's concerns or triggers. Inspectors found that an experienced clinical manager led health services well. However, inspectors noted that despite strenuous efforts to recruit registered nurses, the service remained reliant on agency staff and the nursing team was occasionally stretched.

Independent Monitoring Board

22. 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 April 2022, the IMB reported that incidents of self-harm had reduced significantly since the previous reporting year, although Styal remained concerned about an increase in self-harm among prisoners with learning difficulties. The IMB noted that prisoner-on-prisoner assaults at Styal were the highest in the female estate. The IMB reported that relationships between staff and prisoners generally remained positive with many staff showing skill and compassion in dealing with prisoners in crisis.

Previous deaths at HMP Styal

23. Ms McDonagh was the fourth prisoner to die at Styal since May 2019. Of the previous deaths, one was self-inflicted and two were from natural causes. We also investigated a stillbirth.

24. In our investigation into the self-inflicted death of a prisoner at Styal in December 2020, we found that staff failed to take account of all the known risk factors when considering whether to start ACCT procedures and we made a recommendation. The prison responded to the recommendation and said that the Safety department at Styal had re-launched their Safety Strategy which placed emphasis on the national guidelines used to support those at risk of self-harm or suicide. The prison

planned to run weekly coaching drop-in sessions for ACCT Case Coordinators to enhance their skills and provide ACCT briefings in morning operational meetings.

Assessment, Care in Custody and Teamwork

25. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care plan to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. On 28 March 2022, Ms Eileen McDonagh was remanded to HMP Styal charged with assault occasioning actual bodily harm. Ms McDonagh had been at Styal on several previous occasions and had last been released one month before.

27. A nurse saw Ms McDonagh for a reception health screen. Ms McDonagh said that she smoked crack cocaine daily, and had a history of self-harm, but had no current thoughts of suicide or self-harm. The nurse noted that Ms McDonagh had a history of poor mental health and had been diagnosed with attention deficit hyperactivity disorder (ADHD). She also noted that Ms McDonagh was chatty, laughing, engaged well and maintained eye contact. Ms McDonagh was not able to pass urine for a drug test.

28. Ms McDonagh's prison security record shows that she had an extensive history of fighting with other prisoners, threatening staff and climbing onto or over the landing railings. Ms McDonagh was assessed as unsuitable to share a cell.

29. On 29 March, Ms McDonagh provided a urine sample that was positive for cocaine and cannabis. A nurse noted that Ms McDonagh had been given appointments for a learning disability blood test and review at the learning disability long-term conditions clinic (part of an approach recognising that people with learning disabilities often have poorer health than the general population and, therefore, to identify possible health problems that the patient might not have reported). The appointments did not go ahead as planned prior to Ms McDonagh's death.

30. That day, a nurse visited Ms McDonagh to complete a mental health assessment, but she said that she had no concerns and did not want to be seen. The investigator was told that the assessment would have included an assessment of her neurodiversity needs and whether she needed help from the learning disability nurse (neurodiversity refers to how different people behave and react differently from one another). In keeping with standard practice, Ms McDonagh was offered an assessment the following day which she again declined; as a result, she did not receive any input from the learning disability nurse. Any internal staff or external agencies can refer a prisoner for a mental health assessment at any time, but no such referrals were made.

31. On 30 March, Ms McDonagh saw a substance misuse worker and had several appointments with the substance misuse team in the following months.

32. On 14 April, Ms McDonagh was placed on report following a fight with another prisoner. A disciplinary hearing was arranged for the following day.

33. At the disciplinary hearing on the morning of 15 April, Ms McDonagh was found guilty of fighting, and she received a suspended punishment of seven days cellular confinement. That afternoon, Ms McDonagh climbed onto the landing railings because she had not received her canteen order (canteen is the prison shop where prisoners can buy various items such as confectionary). After around ten minutes, Ms McDonagh climbed down, and staff placed her on report and moved her to the segregation unit (where prisoners are kept apart from other prisoners) pending a disciplinary hearing.

34. At a disciplinary hearing the following day, Ms McDonagh was found guilty of deliberately endangering her safety and her suspended punishment of seven days cellular confinement was activated. Ms McDonagh had been assessed by a mental health nurse as fit to be segregated when she first arrived, but her records indicated that a healthcare practitioner only visited her twice in the following days. (Segregation can increase the risk of suicide or self-harm because it isolates the prisoner and reduces their access to the normal regime and can have a negative impact on their mental health. As a result, a nurse must complete a safety algorithm to indicate if there are any medical reasons why an individual should not be segregated, a duty Governor will then countersign it. Prisoners in segregation should be visited every day by a healthcare practitioner.)

35. Ms McDonagh returned to a standard unit on 21 April.

36. On 26 April, Ms McDonagh hit another prisoner with a hair dryer. As a result, staff suspended her from association (social time) for seven days.

37. On 29 April, an officer mistakenly unlocked Ms McDonagh's cell so that she could attend association. When staff asked her to return to her cell, she climbed onto the landing railings. Staff managed to talk her down and she was taken back to her cell. A Supervising Officer (SO) was one of the staff who spoke to Ms McDonagh. She told the investigator that Ms McDonagh would often climb onto the railings as she knew this would give her some time in the segregation unit.

38. On 21 May, Ms McDonagh had a fight with another prisoner (a different prisoner).

39. On 2 June, Ms McDonagh went to the medication hatch to collect paracetamol that had been prescribed for a headache. When staff asked her for her identification card, she became aggressive as she did not have her card with her. Officers intervened and took her back to her cell.

40. On the morning of 14 June, Ms McDonagh was again involved in an altercation with another prisoner (a different prisoner to the previous three). An officer helped separate the two women. He told the investigator that he had had a good relationship with Ms McDonagh but said, "she could go from zero to 100 miles an hour in a millisecond" and often had confrontations with other prisoners. He said that the incident that morning had been a confrontation rather than a fight and after they were separated, the two women were locked in their cells.

41. Shortly afterwards, the officer escorted a nurse to Ms McDonagh's cell to check for any injuries. When he unlocked her door, Ms McDonagh left her cell, started walking down the landing and then attempted to climb onto the railings. He and a colleague escorted Ms McDonagh back to her cell.

42. Around 15 minutes later, Ms McDonagh pressed her cell bell and when the officer responded, she showed him that she had cut her hand. She also threatened to pour boiling water on herself. He called a nurse, who noted a moderate cut to Ms McDonagh's left hand, which she cleaned and dressed in gauze. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT). Staff moved Ms McDonagh to a cell on a different landing to separate her and the other prisoner.

43. An offender supervisor saw Ms McDonagh on the morning of 15 June for an ACCT assessment interview. Ms McDonagh said that since the age of eight she had used self-harm to relieve frustration and had harmed herself the previous day following her fight with the other prisoner. She said that she had no present thoughts of suicide or self-harm and that she would speak to staff if she needed support.

44. An SO chaired an ACCT review with Ms McDonagh shortly afterwards. An officer and a mental health nurse also attended the review. The SO noted that Ms McDonagh engaged well, and she reiterated that she had no thoughts of suicide or self-harm. He noted that Ms McDonagh was positive, presented well and explained that she had a good relationship with her mother, which was a protective factor for her.

45. The SO noted that Ms McDonagh discussed ADHD medication with the nurse, but the nurse's record contains no reference to this. Instead, he noted that Ms McDonagh presented in a bright mood and was in a stable mental state. Ms McDonagh said that she harmed herself in reaction to her fight with the other prisoner, had cut herself to help her cope and had not intended to end her life. The SO noted that all parties were content for the ACCT to be closed. Ms McDonagh's ACCT had no care plan actions.

46. That day, Ms McDonagh had a disciplinary hearing to consider the circumstances surrounding her fight on 14 June. A prison manager chaired the hearing. Ms McDonagh was found guilty, and a note made that she had been found guilty of a similar offence in April. Staff moved Ms McDonagh to the segregation unit for seven days cellular confinement.

47. On 20 June, a prison manager recognised that a defensible decision log had not been completed for Ms McDonagh: defensible decision logs are completed for prisoners who are moved to the segregation unit and who are presently being supported by ACCT procedures or had had an ACCT closed in the recent past. The manager noted that Ms McDonagh was a person with a pattern of violent behaviour who often behaved in a way to try to secure a move to the segregation unit for a period of "time out." In a section of the form on options for alternative locations, the manager noted that Ms McDonagh was unsuitable for the Valentina unit as that was a unit for vulnerable prisoners. The manager concluded that as Ms McDonagh was due to return to a standard unit the following day, there appeared little need to move her that day.

48. On 21 June, Ms McDonagh left the segregation unit and was moved to second floor cell on X wing. The following day, Ms McDonagh moved to a ground floor cell on X wing.

Events of 2 July

49. In the late morning of 2 July, Ms McDonagh was unlocked for lunch, and she then began fighting with another prisoner: again, a different prisoner to all the previous ones. An officer and a colleague separated them and locked them in their cells. He delivered Ms McDonagh's lunch to her cell.

50. The officer told the investigator that he knew Ms McDonagh quite well. He said that she was always involved in conflicts with other prisoners but was generally okay

with staff. He said that when he gave Ms McDonagh her lunch tray, she was her usual self and was talking normally.

51. A nurse checked Ms McDonagh at around 12.00pm and noted that she had slight bruising on her face and slight bruising on one of her fingers. Ms McDonagh reported no other injuries.

52. At just after 2.00pm, prisoners were unlocked for exercise, but Ms McDonagh and the other prisoner were kept locked in their cells. An officer said that he let the women onto the exercise yard and just as he was about to relock the yard gate, he heard women screaming that Ms McDonagh was hanging (her cell window looked out onto the exercise yard). He ran to Ms McDonagh's cell window and radioed for staff assistance. While standing on the yard, he reached through Ms McDonagh's window, cut the ligature and lowered her to the floor. He then radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). The code blue call was made at 2.12pm and control room staff called an emergency ambulance.

53. Two officers responded to the officer's call for assistance, and they went into the cell. One officer cut the remaining piece of ligature from Ms McDonagh's neck, and the officers moved her to the centre of the room and started CPR.

54. A nurse told the investigator that she was treating a prisoner on the second landing of X wing when she heard the code blue and responded immediately. She said that while waiting for a colleague to collect the emergency bag, she held Ms McDonagh's head up to keep her airway clear. She noted that Ms McDonagh was cold to the touch, and she had no signs of life. Ms McDonagh was checked with a defibrillator which instructed that no shock could be given, and that CPR should continue.

55. Ambulance paramedics arrived at 2.23pm and took charge of Ms McDonagh's care. At 2.31pm, the paramedics declared that further efforts to resuscitate Ms McDonagh should cease and confirmed that Ms McDonagh had died.

Contact with Ms McDonagh's family

56. A prison manager and a family liaison officer went to the family home accompanied by one of the prison chaplains. They arrived at 8.15pm and broke the news to Ms McDonagh's mother and two of her siblings.

57. The prison contributed to cost of Ms McDonagh's funeral in line with national instructions.

Support for prisoners and staff

58. A prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

59. The prison posted notices informing other prisoners of Ms McDonagh'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 Ms McDonagh's death.

Post-mortem report

60. The post-mortem report gave Ms McDonagh's cause of death as hanging. A toxicology report found a low concentration of gamma-hydroxybutyrate (GHB), but the concentration was consistent with natural body processes and was not deemed by the pathologist to be indicative of use of the drug prior to death.

Findings

Assessment of risk

61. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff must follow where a prisoner is at risk of suicide and self-harm. It lists a range of factors that might increase a prisoner's risk of suicide and self-harm. Ms McDonagh had several risk factors including a history of deliberate self-harm, impulsivity, and propensity to violence. In addition, Ms McDonagh had a diagnosis of ADHD but was not in receipt of medication or receiving any other treatment or support.

62. Staff started ACCT procedures for Ms McDonagh on 14 June after she cut herself and threatened to pour boiling water over herself following a fight with another prisoner. Ms McDonagh had been involved in several incidents of inappropriate behaviour in her brief time in Styal, and this was consistent with her behaviour during previous sentences: it is clear that Ms McDonagh would react inappropriately and without thought when frustrated. The SO who chaired the ACCT review on 15 June, noted that Ms McDonagh and a nurse discussed ADHD medication, but there is no such discussion referenced in the nurse's notes, and we note that Ms McDonagh was not in receipt of any medication for ADHD and nor would there appear to have been any formal assessment of this condition during her time at Styal.

63. The ACCT was closed on 15 June and there were no further indications that Ms McDonagh was at heightened risk in the two weeks between the closure of the ACCT and her death. We do not consider that there was ever any clear indication that Ms McDonagh was at risk of suicide or that the ACCT needed to be reopened.

Use of segregation

64. Prison Service Order 1700, Segregation, sets out the process that should be followed when a prisoner is segregated. The PSO says that:

> *"Those prisoners who are the most 'difficult' are often the most vulnerable … Staff are undoubtedly faced with difficult decisions as to where to hold some prisoners and frequently care for prisoners in segregation units when all other options have been exhausted. However, there have been cases where prisoners have been held in segregation units and the justifications for doing so have not been convincing. There have been cases where alternative options to segregation have not been adequately explored."*

65. As already noted, it is clear that Ms McDonagh had long-established behavioural problems and was frequently in conflict with other prisoners. It also seems clear that she would sometimes deliberately act in a way to manufacture a period of time in segregation. It is unclear, however, whether staff made sufficient efforts to consider and explore alternative options on where she could be housed while maintaining good order and discipline. As Ms McDonagh did not die in segregation, we do not make a recommendation, but the Governor might wish to consider how best to

manage prisoners who are frequently in conflict with other prisoners and with the prison regime.

Clinical care

66. The clinical reviewer concluded that Ms McDonagh's physical and mental health care at Styal was not of a reasonable standard and was not equivalent to what she could have expected to receive in the community. The clinical reviewer noted that Ms McDonagh had a diagnosis of ADHD, but she was not seen by a long-term conditions nurse and there were no entries in her record about when she should have been reviewed. The clinical reviewer considered that if Ms McDonagh had been seen, it is possible that she might have been prescribed medication which might have helped with her impulsive behaviour that was evident throughout her time at Styal. We note that Ms McDonagh declined a mental health assessment (also a gateway to assessment by the learning disability nurse) on 29 and 30 March on her initial arrival into Styal, as she was entitled to do so, but there is no evidence that staff referred her to the mental health team thereafter.

67. The clinical reviewer considered that there should have been further exploration of Ms McDonagh's mental health needs after the ACCT was opened on 14 June. The clinical reviewer noted that there was limited recording by healthcare staff while Ms McDonagh was in the segregation unit. The clinical reviewer also noted that Ms McDonagh reported a significant crack cocaine habit when she arrived at Styal but was only monitored through the night of 28 and 29 March. The clinical reviewer has recommended that the Head of Healthcare should implement substance misuse monitoring for prisoners who arrive with crack cocaine misuse problems.

68. The clinical reviewer has made a number of other recommendations which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Governor to note

69. The Governor will be aware that no defensible decision log was completed for Ms McDonagh when she was moved to the segregation unit on 15 June, just hours after her ACCT had been closed. We understand that the duty governor that day was unaware that an ACCT had just been closed but another duty governor identified the omission on 20 June. We understand that a process has been put in place to prevent such a recurrence and the Governor will wish to ensure that the new process is robust.

70. The Governor will also be aware from an internal early learning review that an ACCT post closure review was not completed for Ms McDonagh as should have been the case.

Inquest

71. An inquest into Ms McDonagh's death concluded on 21 August 2024 that her medical cause of death was hanging as a result of misadventure.

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