Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerald O'Rourke, a prisoner at HMP Risley, on 23 August 2022

A report by the Prisons and Probation Ombudsman

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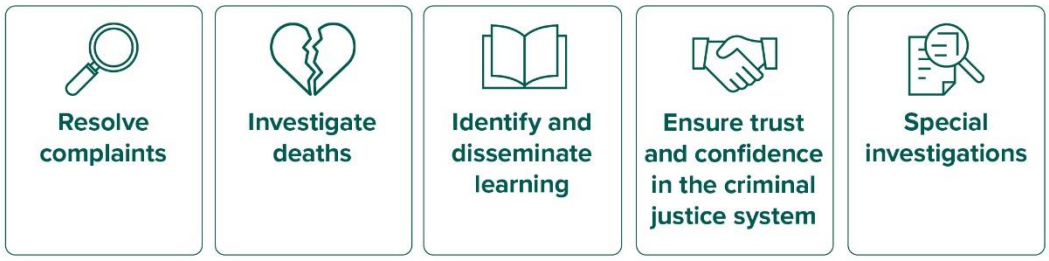
OUR VISION

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

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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Gerald O'Rourke died of multiorgan failure in hospital on 23 August 2022, while a prisoner at HMP Risley. He was 58 years old. I offer my condolences to Mr O'Rourke's family and friends.

The clinical reviewer concluded that the clinical care Mr O'Rourke received at Risley was equivalent to that which he could have receive in the community. She makes recommendations on improved clinical practice which the Head of Healthcare should address.

We found a delay in the prison's nomination of a family liaison officer when Mr O'Rourke's condition deteriorated.

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 **September 2023**

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Summary

Events

1. Mr Gerald O'Rourke was serving an Imprisonment for Public Protection (IPP) sentence with a seven-year minimum tariff for robbery and assault with intent to rob. On 3 July 2019, he was transferred to HMP Risley.

2. Mr O'Rourke had complex health needs and several existing long-term conditions, including Hepatitis C (a slow, progressive disease of the liver caused by the hepatitis C virus), Chronic Obstructive Pulmonary Disease (COPD - chronic inflammatory lung disease) and a history of heart attacks. These were managed by the prison healthcare teams, based on individualised care plans.

3. On 20 May 2022, Mr O'Rourke told staff that he was experiencing pain in his abdomen. Staff organised a transfer to the local hospital who made an urgent referral for a liver ultrasound. Mr O'Rourke returned to Risley later the same day. Mr O'Rourke's abdominal pain continued, and the prison healthcare team provided pain relief.

4. On 6 June, Mr O'Rourke was transferred to hospital, where his ultrasound was completed. He returned to Risley the same day and the prison healthcare team prescribed pain relief while they followed up the ultrasound report, which they requested on four occasions but did not receive.

5. On 19 August, prison officers noticed that Mr O'Rourke had some dark fluid on his bed and asked the healthcare team to attend his cell. When a nurse tried to enter the cell, Mr O'Rourke said he did not want any assistance. The nurse asked officers to continue to monitor Mr O'Rourke and request healthcare assistance if they had any further concerns.

6. Later that day, officers made another call to healthcare and a nurse completed an assessment of Mr O'Rourke in his cell. He was experiencing rectal bleeding, had soiled himself and was confused. Healthcare staff completed Mr O'Rourke's observations which showed he required hospital care. He was taken to hospital where he underwent surgery. A stomach ulcer was found.

7. Mr O'Rourke continued to be cared for in hospital, but his health continued to deteriorate, and he died on 23 August.

Findings

8. The clinical reviewer concluded that Mr O'Rourke's clinical care at Risley was equivalent to that which he could have expected to receive in the community. The clinical reviewer has made several recommendations on ensuring clinical processes are compliant with national guidelines, which the Head of Healthcare will need to address.

9. We found that the prison did not initiate family contact when Mr O'Rourke's health deteriorated and did not appoint a family liaison officer until the day before he died.

Recommendations

- The Governor should appoint a family liaison officer as soon as a prisoner becomes seriously ill, to enable timely contact with the next of kin or other family members in accordance with PSU 64/2011.

The Investigation Process

10. We were notified of Mr O'Rourke's death on 23 August 2022.

11. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact her. We did not receive a response.

12. NHS England commissioned a clinical reviewer to review Mr O'Rourke's clinical care at the prison.

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

14. The Ombudsman's family liaison officer notified Mr O'Rourke's next of kin of the investigation and asked if they had any questions. The next of kin did not wish to be contacted.

Background Information

HMP Risley

15. HMP Risley is a medium security prison which holds over 1,000 convicted men. Manchester Mental Health NHS Foundation Trust provides healthcare services in the prison. Greater Manchester West Mental Health Foundation Trust provide mental health services. Change, Grow, Live (CGL) provide substance misuse services. There is 24-hour healthcare cover.

HM Inspectorate of Prisons

16. At the time of Mr O'Rourke's death, the most recent full inspection of HMP Risley was in June 2016. HMIP carried out a short scrutiny visit in November 2020, on the conditions and treatment of prisoners during the COVID-19 pandemic. This found that regime restrictions at the time were causing prisoners to make an unacceptable choice between healthcare, dental and substance misuse appointments and exercise, showering and exercise. Inspectors also found that unless prisoners had a job, they were out of their cell for only one hour a day, and for their meal collection.

Independent Monitoring Board

17. 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 annual report for the year to March 2021, the IMB reported that initial health screenings for new arrivals were undertaken promptly with immediate healthcare needs being identified.

Previous deaths at HMP Risley

18. Mr O'Rourke was the 13th prisoner to die at Risley in three years. Eight of the previous deaths were from natural causes and three were self-inflicted.

19. There are no significant similarities between our findings in this investigation and that of the previous deaths.

Key Events

20. On 29 January 2010, Mr Gerald O'Rourke was given a seven-year Imprisonment for Public Protection (IPP) sentence for robbery and assaults with intent to rob. On 3 July 2019, he was transferred to HMP Risley from HMP Thorn Cross.

21. Mr O'Rourke's initial health screens identified several long-term medical conditions including Hepatitis C, COPD and high blood pressure. He had experienced a stroke and four heart attacks. Mr O'Rourke's health needs were managed by prison healthcare teams in accordance with individual care plans.

22. On 20 May 2022, Mr O'Rourke told staff that he was experiencing pain in his abdomen. He was taken to the local hospital, who made an urgent referral for a liver ultrasound. Mr O'Rourke returned to hospital the same day.

23. Over the next few weeks Mr O'Rourke's abdominal pain continued and the prison GP prescribed pain relief. On 20 July 2022, the prison GP requested that blood tests were taken and sent an urgent request to administration team to chase the hospital for Mr O'Rourke's ultrasound results. These were requested four times but never received.

24. On the morning of 19 August, prison officers were completing a roll check on Mr O'Rourke's wing and observed a patch of dark coloured fluid on his bed. They alerted healthcare who sent a nurse to assess Mr O'Rourke, but he said he did not want help. The nurse asked officers to monitor Mr O'Rourke and to contact healthcare if they had any concerns or if he changed his mind.

25. Later that morning, another nurse attended Mr O'Rourke's cell to complete an assessment, following reports that he was experiencing rectal bleeding. Mr O'Rourke appeared confused, had soiled himself and was showing signs of jaundice (when your skin or the whites of your eyes turn yellow). The nurse took Mr O'Rourke's observations and assessed that he required emergency care. Mr O'Rourke was transferred to Warrington Hospital by ambulance.

26. At 6.56pm, the hospital contacted the prison healthcare team and advised that Mr O'Rourke had undergone surgery which had found a stomach ulcer. He was being monitored in the High Dependency Unit. Healthcare staff shared information on Mr O'Rourke medical history with the hospital, to inform care planning.

27. On 20 August at around 7.30pm, the hospital contacted the prison healthcare team and confirmed that Mr O'Rourke had been moved into the Intensive Care Unit (ICU) and put into an induced coma because his blood pressure was too high.

28. On 21 August at 7.32pm, the prison healthcare team contacted the hospital to request an update on Mr Rourke's condition. They confirmed that Mr O'Rourke was in liver failure. He also had a chest infection and sepsis, for which he was receiving treatment.

29. On 22 August, the hospital told the prison healthcare team that Mr O'Rourke's health had deteriorated, and he was not expected to survive.

30. On 23 August at 4.45am, Mr O'Rourke passed away.

Contact with Mr O'Rourke's family

31. On 22 August 2022, a prison officer was allocated the role of family liaison officer. She was asked to contact Mr O'Rourke's next of kin because he was seriously ill. She had issues locating information on Mr O'Rourke's next of kin on the prison database. The following day, she located information for Mr O'Rourke's brother-in-law and notified him of Mr O'Rourke's condition. Mr O'Rourke's brother-in-law did not know who his next of kin might be and the family liaison officer was unable to identify anyone.

32. After further investigation, Risley were able to make contact with the daughter of Mr O'Rourke's next of kin, who advised them in writing that they did not wish to act as the next of kin. Mr O'Rourke's niece advised the prison to try and find Mr O'Rourke's son but did not provide any further information on how to do so.

33. Risley and the local police force tried to locate Mr O'Rourke's son, to notify him of his father's death, however they were unsuccessful.

34. Risley offered to contribute to the cost of Mr O'Rourke's funeral, in line with national policy.

Support for prisoners and staff

35. The prison posted notices informing other prisoners of Mr O'Rourke's death and offering support.

36. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr O'Rourke's death.

Post-mortem report

37. A post-mortem examination concluded that Mr O'Rourke died of multiorgan failure caused by Hepatitis C, heart disease and bowel disease. A stomach ulcer and COPD were listed as contributory factors.

Findings

Clinical care

38. The clinical reviewer concluded that the clinical care Mr O'Rourke received was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community during the global Covid-19 pandemic. The clinical reviewer highlights areas of good practice at Risley but also found aspects of care that did not reflect national healthcare guidelines. She makes several recommendations for the Head of Healthcare to address.

Liaison with Mr O'Rourke's next of kin

39. Prison Rule 22 states that when a prisoner becomes seriously ill, the Governor should quickly inform their next of kin. This is reflected in Prison Service Instruction (PSI) 64/2011, which requires that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill. The instruction also states that when a prisoner has no recorded next-of-kin, reasonable steps must be taken to trace any family.

40. Risley did not initiate family contact when Mr O'Rourke became seriously unwell on 19 August. A family liaison officer was not appointed until 22 August, when the hospital advised that Mr O'Rourke would not survive. Mr O'Rourke had not identified a next of kin when he arrived at Risley, which made it difficult for the family liaison officer to locate a contact. We recognise the efforts made by Risley to identify a suitable contact in the hours leading up to his death. Unfortunately, no one was identified. Timely appointment of a family liaison officer increases the chances of locating and notifying family members when prisoners become seriously ill. Therefore, we make the following recommendation:

    The Governor should appoint a family liaison officer as soon as a prisoner becomes seriously ill, to enable timely contact with the next of kin or other family members in accordance with PSU 64/2011.

Inquest

41. The inquest into Mr O'Rourke's death concluded on 16 May 2024, returning a verdict of natural causes.

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