

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr William McGurk a prisoner at HMP Woodhill on 7 April 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr William McGurk died on 4 April 2016 of asphyxia (lack of oxygen), after food became stuck in his throat, at HMP Woodhill. He was 58 years old. I offer my condolences to Mr McGurk's family and friends.

Mr McGurk had a number of long-term health conditions, including dementia. Healthcare staff managed his chronic illnesses as well as they could and reviewed him frequently. However, I am concerned that they did not create care plans documenting the management of his medical conditions, or discuss with his family the decision to implement a do not resuscitate order. In spite of these weaknesses, I am satisfied that, generally, Mr McGurk received a satisfactory standard of healthcare at Woodhill, equivalent to that he could have expected to receive in the community.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**October 2016**

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# Summary

## Events

1. Mr William McGurk had been at HMP Woodhill since February 2013. In June, he was sentenced to ten years imprisonment, for wounding with intent to do grievous bodily harm. Mr McGurk suffered from chronic back and neck pain, and had a history of alcohol misuse.
2. Shortly after Mr McGurk's arrival at Woodhill, healthcare and prison staff became increasingly concerned about his overall health and transferred him to the prison's inpatient unit. On 18 July 2014, after a noticeable deterioration in Mr McGurk's mental health, a consultant psychiatrist diagnosed alcohol-related dementia. Healthcare staff monitored Mr McGurk's chronic health conditions frequently. They provided ongoing support, prescribed medication, and attended regular multidisciplinary meetings. However, Mr McGurk did not always cooperate with his treatment due to his erratic and often disruptive behaviour.
3. At a multidisciplinary meeting on 16 October 2015, healthcare staff discussed a do not attempt resuscitation order with Mr McGurk. A prison psychiatrist judged that Mr McGurk was not receptive to the discussion and the order was issued in his best interests, under section 5 of the Mental Capacity Act 2005. The prison did not inform Mr McGurk's family that this order had been implemented.
4. Shortly before midday on 7 April 2016, two prison officers found Mr McGurk in his cell, unresponsive, with a chocolate bar in his mouth. An officer called an emergency medical code to indicate that he was unconscious. Minutes later, healthcare staff arrived and advised the officers not to start cardiopulmonary resuscitation, as a do not attempt resuscitation order was in place. At 11.58am, a prison GP recorded that Mr McGurk had died.

## Findings

5. Mr McGurk did not have a history of swallowing difficulties and there were no episodes of choking documented in medical record. The clinical reviewer found that his care was equivalent to that he could have expected to receive in the community and we are satisfied that he received appropriate care at Woodhill.
6. Despite satisfactory care, there was no documented evidence that healthcare staff had created specific care plans to manage Mr McGurk's medical conditions and the decision not to resuscitate him had not been communicated to his family. In future, healthcare staff should consider displaying do not resuscitate orders prominently in prisoners' cells, so that wing staff are aware of this.

## Recommendations

- The Head of Healthcare should ensure that prisoners with chronic conditions have detailed care plans and are managed and reviewed in line with National Institute for Health and Care Excellence (NICE) guidelines.

- The Governor and Head of Healthcare should ensure that where decisions about resuscitation are made in the best interests of a prisoner, this is effectively communicated to their nominated next of kin.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr McGurk's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr McGurk's clinical care at the prison.
10. We informed HM Coroner for Milton Keynes of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr McGurk's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any concerns, although he wanted to know more about the decision not to resuscitate Mr McGurk. He thought it odd, as he loved life.
12. Mr McGurk's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

## Background Information

### HMP Woodhill

14. HMP Woodhill has a dual role of a local prison and a high security prison and can hold 727 men. Central and North West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides physical and mental healthcare for prisoners. End of life palliative care is also provided.

### HM Inspectorate of Prisons

15. The most recent inspection of Woodhill was in September 2015. Inspectors reported that primary health services were good, although a high non-attendance rate meant prisoners waited too long for some services. The inpatient unit continued to provide good care, but the regime still needed to be more recovery focussed. Clinical records were of a high standard and included effective care planning for those with complex health needs.

### Independent Monitoring Board

16. 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 May 2015, the IMB reported that healthcare and mental health services continued to improve but recruitment remained a major issue. Healthcare appointments were monitored monthly and waiting times for clinics have been significantly reduced, although a high prisoner non-attendance rate remained an issue.

### Previous deaths at HMP Woodhill

17. Mr McGurk was the first man to die of natural causes at HMP Woodhill since January 2015. There have been two subsequent deaths. There were no significant similarities with the circumstances of this death.

## Key Events

18. On 4 February 2013, Mr William McGurk was remanded to HMP Woodhill, charged with wounding with intent to do grievous bodily harm. (He was subsequently convicted and, on 12 June 2013, sentenced to ten years imprisonment.)
19. At an initial health screen, a prison GP noted that Mr McGurk had a history of chronic back and neck pain and alcohol misuse. He prescribed painkillers and medication for alcohol withdrawal, and referred Mr McGurk to the prison's detoxification team, but he declined treatment.
20. During induction sessions on 5 February, an officer noted that Mr McGurk often forgot what he was saying. The officer asked healthcare staff about referring him to the mental health team, but they did not consider it necessary, as there had been no concerns about his mental health during his health screen.
21. Over the next two months, Mr McGurk frequently refused to take his medication and staff became increasingly concerned about his erratic behaviour and poor personal hygiene. On 2 April, he moved to the prison's inpatient healthcare unit (where he remained until his death). Mr McGurk's behaviour continued to deteriorate despite ongoing support from healthcare and the prison's mental health team. He frequently displayed disruptive behaviour and was often verbally and physically abusive.
22. On 11 March 2014, a prison GP examined Mr McGurk and, suspecting a form of dementia, requested a routine blood test. The blood test results were normal. On 18 July, a consultant psychiatrist for the elderly assessed Mr McGurk at hospital and diagnosed alcohol-related dementia. Healthcare staff attended frequent multidisciplinary meetings to assess Mr McGurk's ongoing risk and monitored his mood, behaviour and confusion daily. They provided medication and helped Mr McGurk with his personal care when he let them.
23. On 5 January 2015, a consultant psychiatrist reviewed Mr McGurk. He noted that Mr McGurk had trouble walking, due to the degeneration of his brain, and he appeared confused, with memory problems. On 22 January, the psychiatrist attended a multidisciplinary meeting and noted that a future hospital placement should be explored, due to Mr McGurk's physical frailty and ongoing cognitive difficulties. At another multidisciplinary meeting on 13 April, the psychiatrist noted that Woodhill should consult HMP Littlehey about the possibility of assistance from their dementia service. However, there is no evidence that these actions were followed up.
24. At a multidisciplinary meeting on 16 October, healthcare staff agreed that in light of Mr McGurk's significant and deteriorating physical and mental health problems, it would not be in his best interests to resuscitate him should he fall critically ill. They thought resuscitation was likely to be futile due to his frailty, and would lead to discomfort and a lack of dignity in death. The consultant psychiatrist tried to obtain Mr McGurk's view on a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which means that in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made. He was not satisfied that Mr McGurk had the mental capacity to make an informed decision. Therefore, he

implemented a DNACPR, under section 5 of the Mental Capacity Act 2005. Copies of the form were placed on his electronic medical record, the wing office and in the duty governor's file. It was noted that the prison would contact his family about the DNACPR, but there is no record of any attempts to do this.

25. Over the next six months, Mr McGurk continued to display unsettled behaviour and aggression towards staff. His mood varied greatly and he continued to experience chronic pain. Healthcare staff frequently reviewed his medication to control his pain, monitored his behaviour daily, and attended regular review meetings.

#### **7 April 2016**

26. At 8.57am, a nurse gave Mr McGurk his medication and noted that he appeared to be in good spirits. Two officers gave Mr McGurk his lunchtime meal at 11.20am.
27. At 11.55am, while conducting a routine check of prisoners, an officer noticed that Mr McGurk was lying on his bed in an unusual position. After failing to get a response, he entered Mr McGurk's cell with another officer, and found him unconscious with a chocolate bar in his mouth. At 11.56am, he called an emergency code blue (which indicates that a prisoner is unconscious or not breathing) and prepared to start cardiopulmonary resuscitation (CPR), while his colleague called for healthcare assistance. Within minutes, a prison GP arrived and told the officer not to start CPR because a DNACPR was in place. At 11.58am, the GP completed a short examination and confirmed that Mr McGurk had died.

#### **Contact with Mr McGurk's family**

28. Later that afternoon the prison appointed an officer and a prison Imam as the prison's family liaison officers. They went to see Mr McGurk's parents to break the news of his death. When they arrived, at 3.35pm, his parents were not at home. At 7.00pm, they returned to the prison and tried to find another address.
29. At 12.30pm on 8 April, the officer spoke to Mr McGurk's brother, who told him that his parents were due home later that afternoon. At 5.10pm, the Imam, along with another prison family liaison officer, went to see Mr McGurk's parents and informed them that Mr McGurk had died. They offered their condolences and support. The family liaison officer remained in contact with Mr McGurk's family.
30. The prison contributed to the costs of Mr McGurk's funeral, which was held on 19 May 2016, in line with national policy.

#### **Support for prisoners and staff**

31. A senior 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.
32. The prison posted notices informing staff and prisoners of Mr McGurk's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by McGurk's death.

## Post-mortem report

33. A post-mortem examination found that Mr McGurk had died of asphyxia by choking on a food bolus (a mass of food found in the mouth after chewing). Dementia was also a contributory factor.

# Findings

## Clinical care

34. Mr McGurk had several complex chronic health conditions and frequently displayed erratic and unpredictable behaviour, which became increasingly difficult to manage as his dementia progressed. The clinical reviewer considered that healthcare staff appropriately referred Mr McGurk to a psychiatrist for the elderly. The mental health team reviewed him frequently and doctors prescribed appropriate medication. A multidisciplinary team assessed Mr McGurk's future management and his frailties were addressed accordingly. There was no history of swallowing difficulties or choking documented in his medical record.
35. Although there was no evidence that the prison explored a secure hospital placement, or consulted Littlehey's dementia service, as planned, the clinical reviewer considered that Mr McGurk's condition was manageable within the inpatient unit. We are satisfied that healthcare staff managed Mr McGurk's challenging behaviour proportionately by working in conjunction with prison staff and he was appropriately located. However, we are concerned that they did not create specific care plans to manage his conditions. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners with chronic conditions have detailed care plans and are managed and reviewed in line with National Institute for Health and Care Excellence (NICE) guidelines.**

36. In spite of the shortcomings identified, we agree with the clinical reviewer that, overall, Mr McGurk's care and treatment in prison was equivalent to that he could have expected to receive in the community.

## Resuscitation

37. A multidisciplinary meeting decided that it would be best not to attempt to resuscitate Mr McGurk if his heart or breathing stopped, as it might be ineffective and cause discomfort. A consultant psychiatrist assessed Mr McGurk and concluded that he did not have the capacity to give an informed view to help reach a decision, so he put in place a DNACPR order, under the provisions of the Mental Capacity Act 2005. Staff noted that Mr McGurk's family should be consulted about the decision not to resuscitate him, but this did not happen. We make the following recommendation:

**The Governor and the Head of Healthcare should ensure that where decisions about resuscitation are made in the best interests of a prisoner, this is effectively communicated to their nominated next of kin.**

## Emergency response

38. We are satisfied that both officers responded quickly when they noticed that Mr McGurk was unresponsive and that they used an appropriate emergency medical code. This allowed healthcare staff to respond promptly. A doctor conducted a suitable examination to confirm that Mr McGurk had died.

39. While the DNACPR order had not been communicated to Mr McGurk's family before his death, we are satisfied that healthcare staff made the correct decision not to attempt resuscitation. In the future, healthcare staff might wish to consider displaying a copy of the order in a prominent position in the prisoner's cell, so that prison staff are immediately aware of it.

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