Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William O'Donaghue, a prisoner at HMP Ford, on 18 June 2019

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*

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 O'Donaghue died of a heart attack caused by coronary artery disease (a narrowing of the arteries to the heart) on 18 June 2019 while a prisoner at HMP Ford. He had Type 2 diabetes which contributed to but did not cause his death. He was 43 years old. I offer my condolences to his family and friends.

I am not satisfied that the care that Mr O'Donaghue received at Ford was equivalent to that which he could have expected to receive in the community. His Type 2 diabetes was poorly managed. Nurses did not bring his high blood pressure to the attention of a prison GP.

When Mr O'Donaghue had a heart attack and was taken to hospital, officers did not consider informing his wife, and I am concerned that she was not contacted until after his 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.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2020**

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Summary

Events

1. On 1 August 2016, Mr William O'Donaghue was remanded to HMP Thameside. On 3 August 2017, he was convicted of burglary and sentenced to eight years and six months in prison. On 13 February 2019, he was moved to HMP Ford.

2. At Mr O'Donaghue's initial health screen at Ford, a nurse noted that he had Type 2 diabetes and high blood pressure. His diabetes medication was re-prescribed. At his second health screen, he told the same nurse that his diabetes had resulted in him having bladder and bowel problems and thrush. The nurse noted that his blood pressure remained high.

3. On 25 February, a prison GP saw Mr O'Donaghue and noted that his weight had increased significantly since he had been in prison.

4. On 3 April, Mr O'Donaghue saw a nurse because he had a rash on his arms and legs. A prison GP noted from Mr O'Donaghue's blood test results that his blood glucose levels had increased over the previous two to three months to higher than the recommended level and asked him to make an appointment for a nurse to review the poor control of his diabetes.

5. On 17 April, a nurse saw Mr O'Donaghue. She noted that he was at cardiovascular risk, and his blood pressure remained high.

6. On 30 May, a prison GP saw Mr O'Donaghue, advised him to lose weight, and prescribed him medication to treat obesity.

7. At 9.35pm on 17 June, Mr O'Donaghue went to the centre office and told an officer that he had a pain in his lungs and shoulder and that he felt unwell. The officer telephoned the NHS helpline and they arranged for an ambulance to be sent for Mr O'Donaghue.

8. At 10.05pm, an ambulance arrived. Paramedics thought that Mr O'Donaghue was having a heart attack and took him to hospital, where he died of a heart attack a few hours later.

Findings

9. The clinical reviewer said that the care that Mr O'Donaghue received at Ford was not equivalent to that which he could have expected to receive in the community.

10. There were occasions when a prison GP should have seen Mr O'Donaghue rather than a nurse. Some of his symptoms could have been related to his diabetes. However. healthcare staff were inconsistent in requesting blood and urine tests for Mr O'Donaghue and never tested his urine for infection. Despite his diabetes, Mr O'Donaghue's cholesterol levels and liver function tests were only measured at Ford in April 2019.

11. Healthcare staff never addressed Mr O'Donaghue's high blood pressure which was extremely high at his initial health screen. They did not arrange a follow-up

appointment and did not bring his high blood pressure to the attention of a prison GP.

12. The clinical reviewer concluded that it was impossible to say that Mr O'Donaghue's death was preventable but found that the prison missed a number of opportunities to address his many health concerns. His diabetes and hypertension were poorly controlled, he was a smoker, he was overweight, he had gained weight in prison and he was at risk of having a stroke or a heart attack. Healthcare staff were reactive rather than proactive in Mr O'Donaghue's care, and many of his appointments were made without reference to previous documented findings.

13. Prison staff did not consider informing Mr O'Donaghue's wife that he had been taken to hospital with a suspected heart attack so she did not have the opportunity to see or speak to him before he died.

Recommendations

- The Head of Healthcare should review the management of long-term conditions such as diabetes and hypertension so that prisoners receive continuity of care and are reviewed in a timely manner.
- The Head of Healthcare should ensure that nursing staff bring abnormal clinical findings, such as significantly raised blood pressure, to the attention of a prison GP.
- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

The Investigation Process

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

15. The investigator obtained copies of relevant extracts from Mr O'Donaghue's prison and medical records

16. NHS England commissioned an independent clinical reviewer to review Mr O'Donaghue's clinical care at the prison.

17. We informed HM Coroner for Brighton and Hove of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer wrote to Mr O'Donaghue's wife to explain the investigation. She asked why she was not contacted after Mr O'Donaghue was taken to hospital and before he died. We have addressed this issue in this report.

19. We shared the initial report with the Prison Service. There was one factual inaccuracy, this report has been amended accordingly and their action plan has been appended to this report.

20. Mr O'Donaghue's wife received a copy of the initial report. She did not make any comments.

Background Information

HMP Ford

21. HMP Ford is an open prison which houses up to 544 men. Sussex Partnership NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 8.00am to 6.00pm. An Integrated Drug Treatment Service dispenses medication to prisoners at the weekend. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Ford was in June 2016. Inspectors reported that the prison was a safe, decent and respectful place where relationships between staff and prisoners were generally positive. They noted that most residential units were grubby and poorly maintained. Prisoners were very positive about access to and the overall quality of health services.

Independent Monitoring Board

23. 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 October 2018, the IMB reported that prisoners were treated fairly by staff and management. They found that the accommodation remained in a very poor state.

Previous deaths at HMP Ford

24. There have been no deaths at HMP Ford since 2014.

Key Events

25. On 1 August 2016, Mr William O'Donaghue was remanded to HMP Thameside. He was later transferred to HMP Durham. On 3 August 2017, he was convicted of burglary and sentenced to eight years and six months in prison. In September 2017, he moved back to Thameside and on 13 February 2019, he was moved to HMP Ford.

26. On 13 February, a nurse completed Mr O'Donaghue's initial health screen. She noted that he had Type 2 diabetes and that his blood pressure was high (149/112). He was re-prescribed diabetes medication (metformin and gliclazide).

27. On 19 February, a nurse completed Mr O'Donaghue's second health screen. He told her that his diabetes had caused him bladder and bowel problems and thrush (an infection of the penis). She noted that his blood pressure remained high (132/97). She gave him batteries for his glucometer (a tool to test blood glucose levels).

28. On 25 February, a prison GP saw Mr O'Donaghue and noted that his weight had increased significantly since he had been in prison. The GP gave Mr O'Donaghue advice on how to lose weight.

29. On 3 April, Mr O'Donaghue saw a nurse because he had a rash on his arms and legs. He said that he was unable to control his diabetes because his glucometer was not working. The nurse asked a GP to review Mr O'Donaghue, she asked for blood tests and for him to be referred to a dermatologist. That day, a GP reviewed Mr O'Donaghue's blood test results, noted that his blood glucose level was high and asked him to make an appointment to see a nurse.

30. On 17 April, a nurse saw Mr O'Donaghue to discuss his diabetes. She noted that his cardiovascular risk and blood pressure (140/92) remained high. The National Institute for Health and Care Excellence (NICE) guidelines for the management of diabetes recommends that if cardiovascular risk is high, a statin (cholesterol-lowering medication) should be offered to lower the risk. Mr O'Donaghue was not offered a statin. He told the nurse that he had not been taking his gliclazide and did not know much about diabetes. The nurse gave him a new glucometer.

31. Mr O'Donaghue had more blood tests in April and on 17 May, a GP noted that his blood glucose level had risen and asked for a nurse to see Mr O'Donaghue to review the results.

32. On 28 May, a nurse saw Mr O'Donaghue. She noted that his blood glucose level was slightly raised and that his weight had increased. She arranged to increase his dose of gliclazide and made an appointment for him to see a doctor to discuss weight loss medication. On 30 May, a prison GP saw Mr O'Donaghue and advised him to lose weight. The GP prescribed orlistat, a medication to treat obesity.

Events of 17 June

33. On 17 June, a prisoner said that Mr O'Donaghue told him that he felt like he had flu and 'had done a round with Mike Tyson'.

34. At 9.35pm, Mr O'Donaghue went to the office and told an operational support grade (OSG) that he had a pain in his lungs and shoulder and that he had been feeling unwell all day. The OSG telephoned the NHS helpline. Mr O'Donaghue spoke to the operator who agreed to send an ambulance for him.

35. At 10.05pm, an ambulance arrived and paramedics saw Mr O'Donaghue. At 10.35pm, a paramedic told the OSG that Mr O'Donaghue was having a heart attack and that they were taking him to hospital.

36. Before Mr O'Donaghue went to hospital, the Head of the Offender Management Unit authorised that he could go to hospital unaccompanied under a Special Purpose Licence (a licence granted, often at short notice and in exceptional circumstances, to allow low risk prisoners to attend medical appointments without an escort).

37. At 1.50am on 18 June, Mr O'Donaghue died in hospital of a heart attack.

Contact with Mr O'Donaghue's family

38. The night orderly officer said that the paramedics told him that Mr O'Donaghue was having a possible heart attack. He said that he did not call Mr O'Donaghue's wife because he was not aware that he needed to call the next of kin of a prisoner taken to hospital.

39. On 18 June, the Deputy Governor appointed the Head of Security as the family liaison officer (FLO) and the Community Engagement Manager as the deputy FLO. At 9.30am, the FLO telephoned Mr O'Donaghue's wife and told her that they wanted to visit her. She agreed to meet the FLO at her daughter's school.

40. The FLO and deputy FLO met Mr O'Donaghue's wife at the school. She was with her young daughter but insisted that they spoke to her with her child present. They broke the news of Mr O'Donaghue's death to her and offered their condolences. She was very upset and ran out of the school with her daughter.

41. At 11.00am, Mr O'Donaghue's elder daughter telephoned the prison. The FLO spoke to her. She became very upset and put the phone down. At 2.05pm, the FLO telephoned Mr O'Donaghue's brother who was with Mr O'Donaghue's wife. He offered his condolences and explained what had happened.

42. The FLO and deputy FLO remained in contact with Mr O'Donaghue's wife.

43. Mr O'Donaghue's funeral took place on 5 July, and Ford contributed to its cost in line with national instructions.

Support for prisoners and staff

44. After Mr O'Donaghue's death, the Deputy Governor debriefed the staff who were on duty when Mr O'Donaghue reported feeling ill to give them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

45. The prison posted notices informing other prisoners of Mr O'Donaghue'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 Mr O'Donaghue's death.

Post-mortem report

46. A post-mortem examination concluded that Mr O'Donaghue died of a myocardial infarction (a heart attack) caused by coronary artery disease (a narrowing of the arteries to the heart). He also had Type 2 diabetes which contributed to but did not cause his death.

Findings

Clinical care

47. The clinical reviewer concluded that the care that Mr O'Donaghue received at Ford was not equivalent to that which he could have expected to receive in the community.

48. He said that Mr O'Donaghue was a smoker, with poorly controlled diabetes and hypertension. He was overweight and had put on a significant amount of weight in prison. He was at risk of having a stroke or a heart attack and little effort appears to have been made to prevent this.

49. Although the clinical reviewer said that it was impossible to say whether Mr O'Donaghue's death was preventable, he noted that healthcare staff missed a number of opportunities to address his healthcare concerns. There were occasions when a prison GP should have seen Mr O'Donaghue rather than a nurse (such as when he had a rash, when his blood pressure or blood glucose level was significantly raised).

50. The clinical reviewer also noted that Mr O'Donaghue's urinary symptoms and thrush might have been caused by poorly controlled diabetes but healthcare staff never tested his urine for infection and did not consistently request blood and urine tests. Mr O'Donaghue's cholesterol levels and liver function tests relevant to diabetes were only measured at Ford in April 2019. His high blood pressure was never dealt with. At his initial health screen, it was recorded as severe according to NICE guidelines and he should have had immediate treatment. The reading was not brought to the attention of a prison GP and no follow-up was arranged.

51. The clinical reviewer found that Mr O'Donaghue's care was reactive and fragmented and that many of his appointments were made without reference to previous documented findings. We make the following recommendations:

    The Head of Healthcare should review the management of long-term conditions such as diabetes and hypertension so that prisoners receive continuity of care and are reviewed in a timely manner.

    The Head of Healthcare should ensure that nursing staff bring abnormal clinical findings, such as significantly raised blood pressure, to the attention of a prison GP.

52. The clinical reviewer made a number of recommendations which are not directly related to Mr O'Donaghue's death but which the Head of Healthcare will need to address.

Contact with Mr O'Donaghue's family

53. Prison Service Instruction (PSI) 64/2011 on safer custody requires prison staff to tell a prisoner's next of kin if he is seriously or terminally ill. When Mr O'Donaghue went to hospital on 17 June, paramedics told prison staff that they believed he was having a heart attack. We consider that a heart attack constitutes a serious illness. Although we recognise that Mr O'Donaghue's wife

would probably not have been able to reach the hospital to see Mr O'Donaghue before he died, prison staff should have told her what had happened. We make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

54. When the family liaison officers telephoned Mr O'Donaghue's wife, she asked them to meet her at a school. It was unfortunate that her young daughter was with her when they told her that Mr O'Donaghue had died. However, as she had insisted that the child remain in the room with her, we are satisfied that their actions were reasonable in the circumstances.

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