Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John O'Rourke, a prisoner at HMP Wayland, on 19 January 2022

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 John O'Rourke died of ischaemic heart disease (narrowed heart arteries) on 19 January 2022 at HMP Wayland. He was 77 years old. I offer my condolences to Mr O'Rourke's family and friends.

The clinical reviewer concluded that the clinical care that Mr O'Rourke received was equivalent to that which he could have expected to receive in the community and was generally of a good standard. His death was unexpected and could not have been prevented.

However, I am concerned that Mr O'Rourke's death was not identified for a number of hours despite three members of staff attending his cell. This was due to staff misunderstanding their responsibilities for checking that a prisoner is alive and well, which we have highlighted in a previous investigation. Although we found no evidence to suggest that this affected the outcome for Mr O'Rourke, it represents a pattern that might impact on outcomes in future. It is positive that Wayland have developed a new local policy to address the learning. If implemented correctly, this will improve these processes going forward.

I am also concerned that systems for sharing information and offering support to staff involved in emergency responses and deaths in custody were unclear at Wayland. We were unable to clarify these arrangements during the course of our investigation, but the prison have since rectified this. It is important that prisons provide the appropriate information to the PPO in a timely fashion, to ensure that we can effectively investigate the deaths of individuals in their care and identify learning.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

Contents

Summary

Events

1. On 1 December 2011, Mr John O'Rourke was sentenced to 14 years in prison for murder. On 3 July 2015, he was transferred to HMP Wayland. At his reception healthcare screen, healthcare noted that his blood pressure was high.

2. On 19 January 2022, three different officers attended Mr O'Rourke's cell on three separate occasions to deliver food, complete the roll check and unlock prisoners for afternoon activities. All three officers observed that Mr O'Rourke was asleep.

3. At 2.35pm, a prisoner went into Mr O'Rourke's cell to give him a newspaper. He told another prisoner that Mr O'Rourke was still asleep. At 2.41pm, that prisoner went into Mr O'Rourke's cell and thought that he looked dead. He shouted for help.

4. An officer ran to Mr O'Rourke's cell and found him lying in bed, pale and with a fixed stare. He called a medical emergency code blue and started cardiopulmonary resuscitation (CPR). After around two minutes, the officer stopped CPR because he recognised signs of rigor mortis. A prison GP pronounced Mr O'Rourke's death at 3.00pm.

Findings

5. The clinical reviewer found that the clinical care that Mr O'Rourke received at Wayland was equivalent to that which he could have expected to receive in the community.

6. Staff did not sufficiently check on Mr O'Rourke's welfare on the day he died. The staff on duty were unaware of when a welfare check should take place and who was responsible for the check. The three staff who attended Mr O'Rourke's cell wrongly assumed that he was asleep, and that other staff had checked on his welfare.

7. In response to the early learning from Mr O'Rourke's death and the death of another prisoner, a multidisciplinary team meeting was held to review roll check and welfare check practices. Wayland subsequently released a notice to staff which clearly defined what was required when completing a roll check and a welfare check, and when these checks should take place. We are satisfied that, if implemented correctly, the policy addresses our concerns.

8. During our investigation, Wayland did not supply us with information on the hot debrief (a meeting that management are required to provide to staff involved emergency responses). This impacted on our ability to investigate this matter. When we issued our draft report, Wayland responded to confirm that a hot debrief had taken place.

9. We also identified that not all of the staff involved in the response were invited to the debrief.

Recommendations

- The Governor should ensure that, in line with PSI 64/2011, all those involved in the incident are invited to attend a hot debrief.

- The Governor should ensure that, in line with PSI 58/2010, prison staff provide the PPO with prison documentation and information requested as part of a PPO investigation.

The Investigation Process

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

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

12. The investigator interviewed four members of staff by telephone on 25 May 2022.

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

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

15. The Ombudsman's family liaison officer contacted Mr O'Rourke's daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked us to report on the discovery of Mr O'Rourke's body and whether he had visited the healthcare unit in the weeks before his death. These questions are addressed in this report.

16. Mr O'Rourke's family received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

17. The initial report was shared with HM Prison and Probation Service (HMPPS), who identified some factual inaccuracies that have been amended accordingly.

Background Information

HMP Wayland

18. HMP Wayland is a medium security prison in Norfolk. The prison holds just under 1,000 convicted adult male prisoners. Practice Plus provides healthcare services. Wayland has experienced a long-term staffing issue and relies on staff doing overtime and detached duty officers (officers from other prisons) to run effectively.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Wayland was in June 2017. Inspectors found that staff took a courteous and constructive approach to prisoners, with most prisoners being reasonably positive about staff engagement with them. Inspectors found that reasonable progress had been made in addressing previous PPO recommendations such as prison staff checking on prisoners' welfare during morning unlock.

Independent Monitoring Board

20. 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 2021, the IMB reported that as the prison came out of the COVID-19 pandemic, they were concerned that there were low staffing numbers and that a high proportion of prison officers had almost no experience of the challenging management of prisoners outside of a tightly controlled, pandemic restricted environment.

Previous deaths at HMP Wayland

21. Mr O'Rourke was the fourth prisoner to die at HMP Wayland since June 2020. The three previous deaths were from natural causes. Our investigation into one of these deaths also found that roll checks were conducted but a prisoner was later identified as dead, and with rigor mortis present.

22. Since Mr O'Rourke's death, there has been one further death, which was self-inflicted. It is too early to say if there are any similarities between our findings in this report and the learning from this death.

Key Events

Background

23. On 1 December 2011, Mr John O'Rourke was sentenced to 14 years in prison for murder. On 3 July 2015, he was transferred to HMP Wayland.

24. At his initial reception screen, healthcare staff noted that Mr O'Rourke had hypertension (high blood pressure) and gout (swelling and joint pain). At his second reception screen, healthcare staff recorded that Mr O'Rourke's blood pressure reading was high. He regularly took medication to treat high blood pressure and sleep medication. Mr O'Rourke was assessed as fit to keep and administer his medication, as opposed to healthcare staff dispensing this daily.

25. On 18 August 2020, a hypertension care plan was created in line with National Institute for Health and Care Excellence (NICE) guidelines. Healthcare staff were to review the care plan annually.

26. At the second care plan review meeting on 15 June 2021, healthcare staff noted that Mr O'Rourke's blood pressure readings were within the acceptable range and that he had increased his exercise to mitigate the risks of hypertension.

27. Healthcare staff last saw Mr O'Rourke on 4 December 2021 for a blood pressure check. His blood pressure was recorded as normal.

Events of 19 January 2022

28. On 19 January 2022, E wing (the wing where Mr O'Rourke lived) was subject to a regime management plan. This meant that due to staff shortages, prisoners were locked in their cells until after lunchtime.

29. At 6.05am, prison staff completed a roll check (when prison staff check that a prisoner is in their cell) and found no issues on E wing.

30. At 11.12am, an officer and two prisoners delivered lunch to Mr O'Rourke's cell. The officer noticed that the cell curtains were drawn, and Mr O'Rourke was still in bed, which struck him as unusual behaviour for Mr O'Rourke. He looked again at Mr O'Rourke, thought that he saw Mr O'Rourke's blankets move and then left the cell.

31. At 11.36am, an officer carried out the post-lunch roll check. She looked through the cell door observation panel and saw Mr O'Rourke in bed. She too observed that this was unusual behaviour for Mr O'Rourke. She looked back through the observation panel, assumed Mr O'Rourke was asleep and moved to the next cell.

32. At 2.22pm, an officer unlocked Mr O'Rourke's cell for afternoon activities and saw that he was in bed. He thought that it was unusual behaviour for Mr O'Rourke but said that sometimes, he would stay in bed if he felt unwell. He said that he planned to go back and check on Mr O'Rourke but was unable to do so due to demands on the wing.

33. At 2.35pm, a prisoner entered Mr O'Rourke's cell to give him a newspaper. He thought that Mr O'Rourke was asleep and went to discuss that with another prisoner. At 2.41pm, the prisoner went into Mr O'Rourke's cell and thought that Mr O'Rourke was dead. He shouted for help from an officer.

34. The officer ran to Mr O'Rourke's cell and found Mr O'Rourke lying in bed, pale and with a fixed stare. He called a code blue and started CPR. After around two minutes, he stopped CPR because he recognised signs of rigor mortis.

35. At 2.45pm, healthcare arrived at Mr O'Rourke's cell. They also identified signs of rigor mortis and did not attempt CPR. A prison GP pronounced Mr O'Rourke's death at 3.00pm.

Contact with Mr O'Rourke's family

36. Mr O'Rourke's next of kin was promptly contacted and Wayland offered to contribute to Mr O'Rourke's funeral expenses in line with national policy.

Support for prisoners and staff

37. After Mr O'Rourke's death, management invited some of the staff involved in the emergency response to a debrief, to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team came to the wing to offer further support.

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

Post-mortem report

39. The post-mortem report concluded that Mr O'Rourke died of ischaemic heart disease (narrowed heart arteries) caused by coronary artery atheroma and thrombus (the complete blockage of the artery by artery plaque).

Findings

Clinical care

40. The clinical reviewer found that the clinical care Mr O'Rourke received was equivalent to that which he could have expected to receive in the community.

41. Mr O'Rourke's post-mortem examination report noted that he was obese. The clinical reviewer could not find any evidence of an obesity care plan in Mr O'Rourke's medical records. She made a recommendation about this in the clinical review annexed to this report, which the Head of Healthcare will need to address.

Welfare checks

42. Prison Service Instruction (PSI) 64/2011 requires prisons to have local systems in place that enable staff to satisfy themselves that prisoners' wellbeing is assured during, or soon after, the unlock process.

43. During our investigation, we asked the Head of Safer Prisons for the local policy at Wayland which covers welfare checks. He provided a policy which covered roll checks but not welfare checks.

44. We interviewed the three members of staff who came into contact with Mr O'Rourke's cell on 19 January before he was found dead. They were aware of the difference between a roll check and a welfare check, but it was clear that they were not aware of when welfare checks should take place and who was responsible for them throughout the daily regime. For example, according to one officer, the morning welfare check should have been done at the same time as another officer's pre-lunch roll check, but she did not know that she was responsible for the welfare check at that time and assumed that another officer, who delivered lunch, had carried out the welfare check. While the delay in discovering Mr O'Rourke would not have prevented his death, the prompt discovery of prisoners who have stopped breathing might positively affect outcomes in future, particularly the timely access to emergency life support. It is essential that staff check on the welfare of prisoners at the earliest opportunity.

45. In response to an internal investigation linked to a previous death, Wayland issued a notice to staff that clearly defined what was required of a roll check, what was required of a welfare check, and when these checks should take place. We are satisfied that, if implemented correctly and appropriately assured, this will help mitigate the risk of what happened in the case of Mr O'Rourke happening in future. If the policy is followed, regular welfare checks will ensure that prisoners who stop breathing or whose deaths are unpreventable, are discovered as soon as possible.

46. It is clear that the management team at Wayland have addressed the PPO's findings in relation to the previous death, have enhanced their own learning from the previous death and Mr O'Rourke's death, and brought local practices in line with PSI 64/2011.

Information sharing

47. Three officers came into contact with Mr O'Rourke's cell on 19 January before he was found to be dead. All three noted that it was unusual behaviour for Mr O'Rourke to be still in bed but, as far as we are aware, none shared this information with other staff. An officer stated in his interview that when he started his shift in the afternoon, Mr O'Rourke's behaviour was not mentioned in the handover. When he saw Mr O'Rourke in bed later on, he assumed that Mr O'Rourke had been seen awake and had gone back to bed and therefore, did not treat Mr O'Rourke's behaviour as requiring urgent attention. He stated that, if he knew that Mr O'Rourke had been in bed all day, he would have tried to get a response from him. Another officer also reflected in interview that he should have checked with the senior wing staff about Mr O'Rourke's behaviour.

48. Wayland's new policy includes requirements that officers check a prisoner's welfare at set points during the regime. If implemented correctly, staff will not rely on information sharing to prompt them to check on a prisoner's welfare or assume that a prisoner does not need a welfare check because staff have not received any information to suggest otherwise. Therefore, we make no recommendation.

Support for staff

49. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes holding a hot debrief to offer support immediately after a death in custody and inviting all staff involved in the incident to attend.

50. During the investigation stage, we were unable to clarify whether Wayland's management team had held a hot debrief for staff involved in the emergency response. Out of the staff members interviewed, one staff member said that they attended one, another said a hot debrief did not take place and the third had finished their shift by the time Mr O'Rourke was discovered and was not invited to a discussion. When we asked for information on the hot debrief, the Head of Safer Prisons told the investigator that a full debrief would be held by a governor at a later date. After we issued the initial report, the governor confirmed that he held a hot debrief, but did not record who attended.

51. In her interview, an officer raised the issue of staff support after Mr O'Rourke's death. She was involved in the emergency response and supported the prisoners on the wing following Mr O'Rourke's death. She said that she was not invited to a hot debrief and that she was visibly upset by Mr O'Rourke's death but was not asked if she wanted to be removed from the wing.

52. We make the following recommendation:

    The Governor should ensure that, in line with PSI 64/2011, all those involved in the incident are invited to attend the hot debrief.

Sharing information with the PPO

53. PSI 58/2010 is clear that the PPO should have unfettered access to relevant documents during investigations and that prisons must provide the information that the Ombudsman requests as part of her investigation.

54. When we asked about the briefings that took place for staff following Mr O'Rourke's death during the investigation stage, we were not provided with clarification on this matter. This impacted on the investigator's ability to progress this element of the investigation. Wayland have now provided clarification, following the issuing of our draft report. Therefore, we make the following recommendation:

The Governor should ensure that, in line with PSI 58/2010, prison staff provide the PPO with prison documentation and information requested as part of a PPO investigation.

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