Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John O'Neill, a prisoner at HMP Whatton, on 21 September 2022

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr John O'Neill died on 21 September 2022 of lung cancer at HMP Whatton. He was 64 years old. We offer our condolences to Mr O'Neill's family and friends.

4. The clinical reviewer concluded that the clinical care Mr O'Neill received at Whatton was good and equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr O'Neill's clinical care at Whatton.

7. The PPO investigator investigated the non-clinical issues relating to Mr O'Neill's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr O'Neill's nominated next of kin, a family friend, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr O'Neill's friend did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Previous deaths at HMP Whatton

10. Mr O'Neill was the sixteenth prisoner to die at Whatton since September 2020. Of the previous deaths, 14 were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr O'Neill's death and our investigation findings for the previous deaths.

Key Events

11. On 9 March 1987, Mr O'Neill was sentenced to life imprisonment for arson, sexual offences, theft, handling stolen goods, obtaining property by deception and destroying property. He was sent to HMP Wormwood Scrubs. On 17 March 2017, Mr O'Neill was transferred to HMP Whatton.

12. Mr O'Neill had several medical conditions, including a stroke (which left him with right sided weakness), epilepsy, high blood pressure, kidney disease and limited mobility and used a wheelchair. Healthcare staff reviewed him regularly and adjusted his medication to manage his conditions. Carers visited Mr O'Neill daily to assist him with maintaining his personal care and to oversee his health and wellbeing.

13. On 17 April 2022, Mr O'Neill slipped in his cell. Wing staff asked healthcare staff to attend and check him. A nurse attended and checked his observations and they were all within the normal range. Mr O'Neill said that he did not want to go to hospital. The nurse saw Mr O'Neill later that day and noted that he still appeared unwell and drowsy. She arranged for an ambulance to take him to hospital. Two officers escorted him and he was not restrained.

14. In hospital, Mr O'Neill had a COVID-19 test and the result was positive. Other hospital test results indicated that Mr O'Neill had lung cancer. He told hospital and prison healthcare staff that he did not want any treatment. Healthcare staff made many strenuous efforts to persuade him to have treatment. Prison, healthcare and hospital staff attended multi-disciplinary meetings (MDTs) to consider Mr O'Neill's refusal of treatment. They considered that he had the capacity to make decisions about his care and treatment. On 26 April, Mr O'Neill discharged himself from hospital.

15. As soon as his lung cancer diagnosis was suspected, healthcare staff added Mr O'Neill to the complex care register. They allocated a named GP and nurse to lead on his ongoing care and the nurse attended the weekly MDTs. Healthcare staff also created a cancer care plan.

16. On 7 June, a prison GP saw Mr O'Neill. He told her that he had reconsidered his situation and wanted to go to hospital to see what his treatment options were. The prison GP noted that because Mr O'Neill had a history of smoking, he might also have had chronic obstructive pulmonary disease (COPD). She completed a two week fast track cancer referral. However, on 23 June, Mr O'Neill refused to attend his hospital appointment because the Parole Board had refused his parole application.

17. On 29 June, a nurse visited Mr O'Neill in his cell to check if he was using an inhaler as the prison GP suspected he had COPD. When checking his observations, the nurse noted that Mr O'Neill complained of pain in his right lung area. She arranged for an ambulance to take him to hospital for investigations but Mr O'Neill refused to go.

18. On 6 July, Mr O'Neill told a prison GP, that he had reflected on his decision not to attend his hospital appointments and that he had changed his mind. The prison GP

completed another fast track cancer referral. On 14 July, Mr O'Neill attended hospital. Hospital specialists confirmed that he had lung cancer.

19. On 1 August, Mr O'Neill told a nurse that he did not want to go to any more hospital appointments. The nurse arranged for a prison GP to discuss this with him. A prison GP saw Mr O'Neill and advised him that without treatment the cancer would progress quickly. His options would then be for palliative care only, with a shortened life expectancy. The prison GP discussed his resuscitation options and Mr O'Neill said that he wanted to discuss this with his family. On 10 August, Mr O'Neill said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. He agreed to attend his hospital appointments.

20. In September, Mr O'Neill's health began to deteriorate and he began to cough up blood, had lesions on his leg and experienced chest pains. Mr O'Neill told staff that he wished to spend his remaining days at Whatton, which he considered to be his home.

21. On 21 September, it was confirmed that Mr O'Neill had died at Whatton.

Record of inquest

22. On 16 November 2022, the Coroner held an inquest hearing. The Coroner concluded that Mr O'Neill died of lung cancer. Cerebrovascular accident (stroke), hypertension (high blood pressure) and epilepsy were also listed as contributory factors.

Lisa Burrell **February 2023**
Assistant Ombudsman

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