Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Dougherty, a prisoner at Guernsey Prison, on 1 September 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 Sean Dougherty died on 1 September 2019 of an abdominal aortic aneurysm at Guernsey Prison. He was 51 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the healthcare Mr Dougherty received at Guernsey Prison was equivalent to that which 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.

Sue McAllister CB
Prisons and Probation Ombudsman **July 2023**

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Summary

1. On 26 June 2014, Mr Sean Dougherty was sentenced to four years and six months imprisonment for sexual offences against children. He was sent to Guernsey Prison. In October 2017, he was recalled back to Guernsey Prison for breaching his licence conditions.

2. Mr Dougherty had several pre-existing medical conditions, including high blood pressure, an abnormal hernia and he was morbidly obese.

3. In February 2018, results of a hospital computerised tomography (CT) scan showed that Mr Dougherty had developed a bulge in the main blood vessel that supplies blood to his stomach. The hospital did not communicate the CT scan results to prison healthcare staff and the prison did not follow up or ask the hospital about the outcome of Mr Dougherty's appointment as they should have done.

4. In the afternoon of 1 August, Mr Dougherty collapsed. Prison and healthcare staff attempted cardiopulmonary resuscitation (CPR), but Mr Dougherty did not respond. Paramedics arrived ten minutes later and continued with CPR for a further 50 minutes. At 5.08pm, a prison GP confirmed that Mr Dougherty had died.

5. The post-mortem report gave Mr Dougherty's cause of death as an acute abdominal aortic aneurysm.

Findings

6. The clinical reviewer concluded that the clinical care Mr Dougherty received at Guernsey Prison was of an acceptable standard and equivalent to that which he could have expected to receive in the community.

7. She did, however, identify some concerns about Mr Dougherty's care.

8. She was concerned that the hospital did not inform the prison of Mr Dougherty's CT scan results which showed that he had an aneurysm. She also found no evidence that prison healthcare staff made attempts to follow up or ask the hospital about the outcome of Mr Dougherty's outpatient appointment and the results of the CT scan. As a result, Mr Dougherty was not referred to the Regional Vascular Service for ongoing monitoring as he should have been.

9. At the time of Mr Dougherty's death, Guernsey Prison relied on handwritten notes to record prisoners care and treatment. There was no electronic system in place for maintaining, recording, or sharing the clinical history of prisoners. This has since been rectified by the prison.

Recommendations

- The Head of Healthcare should agree a system of communication between Princess Margaret Hospital and Guernsey Prison to ensure prisoners' continuity of care.

- The Head of Healthcare should ensure that:
    - if a prisoner attends a secondary care appointment or procedure, clinical correspondence is followed-up; and
    - if correspondence is not received from secondary care providers in a timely manner, this should be escalated to the healthcare commissioners.

- The Head of Healthcare and the Lead GP should consider carrying out an internal investigation to establish:
    - Why hospital staff did not forward the results of the CT scan carried out on 12 February 2018 in order to update the prison GP;
    - Why Mr Dougherty was not referred to the Reginal Vascular Service for ongoing monitoring of his abdominal aorta aneurysm;
    - Why, following the result of the CT scan carried out 12 February 2018, there was no evidence of correspondence between hospital staff and healthcare staff; and
    - Why healthcare staff did not contact hospital staff to find out the results of the CT scan on 12 February 2018.

The Investigation Process

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

11. This investigation has been delayed for a number of reasons, including the national prison lockdown in response to the COVID-19 pandemic and delay in appointing a clinical reviewer.

12. The investigator obtained copies of relevant extracts from Mr Dougherty's prison and medical records.

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

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

15. The initial report was shared with the Guernsey Home Department. They did not find any factual inaccuracies.

16. We contacted Mr Dougherty's next of kin, his brother, to explain the investigation and to ask if he had any concerns he wanted the investigation to consider. Mr Dougherty's brother did not respond to our letter.

Background Information

Guernsey Prison

17. Guernsey Prison is the only prison on Guernsey and has capacity to hold 134 remanded and sentenced male, female and young offender prisoners. Guernsey Prison is accountable to the Committee for Home Affairs on Guernsey (Home Department).

18. Guernsey Health and Social Care provides staff and clinical governance to the prison. Healthcare staff are on duty seven days a week between the hours of 7.00am to 7.15pm. A reduced hours service is provided on Saturdays, Sundays and Bank Holidays.

Guernsey Home Department Inspection

19. Prisons in England and Wales are routinely inspected by Her Majesty's Inspectorate of Prisons (HMIP). However, HMIP only carry out inspections on Guernsey Prison at the prison's request. The last such inspection was in 2014 and was part of a wider inspection of not only the prison, but also police and border custody suites.

20. Guernsey Prison is inspected annually by the Home Department. The most recent inspection was in 2020. Inspectors found that there were a number of nurse-led clinics at the prison that covered a range of health issues including smoking cessation, well man and women clinics, chronic disease management, drug treatment and mental health services.

21. Inspectors also noted that the Island Prescribing Advisor (IPA) visited the prison regularly to offer appropriate training and support to nursing and medical staff. In addition, the IPA regularly audited the prison's prescribing practices and assisted with the development of the prison's pharmaceutical policies.

Independent Monitoring Panel

22. Guernsey Prison has an Independent Monitoring Panel (IMP) authorised by the Prison (Guernsey) Ordinance, who help to ensure that prisoners are treated fairly and decently. In its report for the year to June 2021, the IMP reported that the improvements to the healthcare department they had observed in 2019 had continued, and that the healthcare team's ethos was one of empathy and care

23. However, the IMP repeated the concern they had highlighted in their report year ending 2018 (and repeated in the reports for 2019 and 2020) that the prison should be given funding to have access to EMIS (Egton Medical Information Systems), an electronic medical notes system which would enable healthcare staff to record their interactions with prisoners electronically, as opposed to compiling handwritten notes as is the current practice. This would also facilitate the sharing of a prisoner's medical notes and appointments, electronic prescribing, clinical governance and assist with health audits.

Previous deaths at Guernsey Prison

24. Mr Dougherty was the first prisoner to die at Guernsey since August 2017.

Key Events

25. On 26 June 2014, Mr Sean Dougherty was sentenced to four years and six months imprisonment for sexual offences against children. He was sent to Guernsey Prison.

26. When he arrived into prison custody, Mr Dougherty was noted to be morbidly obese and weighed 190 kilograms. Healthcare, gym and prison staff worked with him to encourage him to lose weight and improve his health.

2017

27. In June 2017, Mr Dougherty was released on licence. However, in October, he was recalled to Guernsey Prison for breaching his licence conditions.

28. On his arrival at Guernsey Prison, a prison nurse carried out an initial health screen. She noted that in 2008, Mr Dougherty had been diagnosed with hypertension (high blood pressure) and had developed an abdominal hernia shortly before he was recalled to prison. She took his observations, and they were all within a normal range. She recorded his weight as 130kg. The nurse also noted that Mr Dougherty had undergone a surgical procedure in 2011 to have a gastric band fitted. (A gastric band is a type of weight-loss surgery which involves restricting the upper part of the stomach to reduce food intake.) Prior to the procedure, he weighed 220kg.

29. As a result of his weight loss, Mr Dougherty had a large apron of skin (overhang of the abdominal skin), which needed regular wound care. He was also under the care of a plastic surgeon and was being considered for an apronectomy (the surgical removal of the excess skin on the abdomen).

30. Mr Dougherty attended Princess Margaret Hospital, Guernsey, for an outpatient appointment in relation to his plastic and reconstructive surgery. He was referred for a CT scan. The results showed that he had developed a hernia in his abdomen. Hospital staff considered he would need a surgical procedure to repair the hernia.

31. Following a wound care review, prison healthcare staff noted that Mr Dougherty had developed an infection. They prescribed a course of antibiotics.

2018

32. On 12 February 2018, Mr Dougherty had a CT scan at Princess Margaret Hospital. The results showed that he had developed a tortuosity (twisting or distortion) of an artery with an acute abdominal aortic aneurysm (a bulge or swelling in the main blood vessel that runs from the heart through the chest to the stomach) measuring 4.8cm. (anything under 5.5cm is not considered suitable for surgical intervention but requires ongoing monitoring).

33. There is no evidence in Mr Dougherty's medical records to indicate that the hospital informed prison healthcare staff of the results of the CT scan nor is there any evidence that prison healthcare staff followed up Mr Dougherty's outpatient appointment and asked the hospital for the outcome of his CT scan. Given the size of the aneurysm, Mr Dougherty should also have been referred to for monitoring. It is not clear from his medical records if hospital staff made the referral.

34. Aside from regular wound care, Mr Dougherty had little significant contact with healthcare staff in the months that followed.

Events of 31 August - 1 September 2019

35. On 31 August 2019, a nurse saw Mr Dougherty because he had been experiencing head and chest pains for the past three days. She took his observations, and they were within a normal range. His chest sounded clear and there were no signs of infection. She advised Mr Dougherty to take paracetamol, drink plenty of fluids and to tell healthcare staff if his condition worsened. The next day, she spoke to Mr Dougherty when he collected his prescribed medications. He told her that his condition had improved and that he felt better.

36. At 4.15pm, while collecting his evening meal, Mr Dougherty collapsed face down onto the floor. A nurse responded immediately. She told prison officers to radio a code blue (indicating that a prisoner is unconscious or is having breathing difficulties) and to collect the emergency grab bag (a bag containing emergency lifesaving equipment) which they did. Staff in the prison control room telephoned for an emergency ambulance.

37. The nurse noted that Mr Dougherty was unresponsive and that his breathing was laboured. Assisted by prisoners and prison officers, the nurse turned Mr Dougherty over on to his back and checked for signs of a pulse but there were none. She noted he was becoming cyanosed (a bluish-purple discoloration indicating insufficient oxygen level). She opened his airway and started CPR. She applied a defibrillator, but no shockable rhythm was indicated.

38. At 4.25pm, paramedics arrived at the prison and took over Mr Dougherty's care. They inserted an intravenous line into his left leg to enable them to administer fluids and adrenalin. Despite there being evidence of vomit in Mr Dougherty's mouth, they were also able to intubate him (a tube inserted through a patient's mouth or nose to open the airway and enable oxygen to be administered directly to the lungs). Despite their best efforts, he remained unresponsive.

39. Paramedics continued with CPR for a further 50 minutes, but they were unsuccessful. At 5.08pm, a prison GP confirmed that Mr Dougherty had died.

Contact with Mr Dougherty's Family

40. On 1 September, Guernsey Police informed Mr Dougherty's next of kin, his mother, of her son's death.

41. The following morning, the prison appointed a Family Liaison Officer (FLO). The FLO noted that Mr Dougherty's next of kin was listed as his mother and that she lived in Summerland Nursing Home, Guernsey. He visited her to offer support and to offer details of her son's death. However, nursing home staff told him that due to her poor condition, she would not understand what was being said to her.

42. The following day, the FLO telephoned Mr Dougherty's brother. He told the FLO that although he did not live in Guernsey, he would be acting as Mr Dougherty's next of kin and would be arranging his funeral. The FLO remained in contact with Mr Dougherty's brother offering him support and information.

43. The prison offered a financial contribution toward the cost of Mr Dougherty's funeral, in line with policy.

Support for prisoners and staff

44. After Mr Dougherty's death, a prison manager debriefed the staff who were involved in the emergency response, giving 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 Dougherty'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 his death.

Post-mortem report

46. The post-mortem report gave Mr Dougherty's cause of death as an acute abdominal aortic aneurysm (a bulge or swelling in the main blood vessel that runs from the heart through the chest to the stomach).

Inquest into Mr Dougherty's death

47. The inquest into Mr Dougherty's death was held on 1 September 2019 and a verdict of natural causes was recorded.

48. The coroner concluded Mr Dougherty's death was due to a ruptured abdominal aortic aneurysm.

Findings

Clinical care

49. The clinical reviewer concluded that the care Mr Dougherty received at Guernsey Prison was of an acceptable standard and equivalent to that which he could have expected to receive in the community.

50. The clinical reviewer considered that Mr Dougherty was managed with compassion and was cared for by competent and confident staff during his time at Guernsey Prison. She noted that the contact and continuity of his care were of a good level. There was also evidence of clear care plans being used to manage his care, and that regular wound assessments were carried out to a good standard.

51. The clinical reviewer did, however, identify some shortcomings in Mr Dougherty's care.

The diagnosis of Mr Dougherty's abdominal aortic aneurysm and the sharing of information

50. When Mr Dougherty attended hospital for a CT scan in February 2018, the results showed that he had an aneurysm measuring 4.8 cm. The hospital did not pass this information on to the prison's healthcare department.

51. The clinical reviewer noted that any aortic aneurysm measuring under 5.5cm would not require surgical intervention. However, Mr Dougherty should have been referred to the Regional Vascular Service to be reviewed within 12 weeks of diagnosis. There is no evidence to indicate that the hospital referred him to the Regional Vascular Service. Had he been referred he would have been subject to a surveillance program, which may have noted any changes in the aneurysm's size.

52. The clinical reviewer found no evidence that the prison received any correspondence from the hospital or other secondary care providers in relation to Mr Dougherty's aneurysm. It is not clear why the prison's healthcare department was not alerted by hospital staff to the aneurysm. In fact, there is no evidence of any correspondence from hospital staff to the prison between 12 February 2018 and Mr Dougherty's death on 1 September 2019.

53. The clinical reviewer was equally concerned that Guernsey Prison failed to follow up the outcome of Mr Dougherty's outpatient appointment or ask the hospital for the results of his CT scan.

54. The clinical reviewer also found that, at the time of Mr Dougherty's death, there were no administrative processes in place at Guernsey Prison to monitor or follow up the outcomes of prisoner's medical outpatient appointments.

55. Although the Head of Healthcare at Guernsey Prison told us that there is now a system in place to follow up all outpatient appointments and clinical correspondence, we make the following recommendations:

The Head of Healthcare should agree a system of communication between Princess Margaret Hospital and Guernsey Prison to ensure a prisoner's continuity of care.

The Head of Healthcare should ensure that:

- **if a prisoner attends a secondary care appointment or procedure, clinical correspondence is followed-up; and**
- **if correspondence is not received from secondary care providers in a timely manner, this should be escalated to the healthcare commissioners.**

The Head of Healthcare and the Lead GP should consider carrying out an internal investigation to establish:

- **Why hospital staff did not forward the results of CT scan carried out on 12 February 2018 in order to update the prison GP**
- **Why Mr Dougherty was not referred to the Reginal Vascular Service for ongoing monitoring of his abdominal aorta aneurysm**
- **Why, following the result of the CT scan carried out 12 February 2018, there is no evidence of correspondence between hospital staff and healthcare staff**
- **Why healthcare staff did not contact hospital staff to find out the results of the CT scan on 12 February 2018**

Electronic Clinical Records

56. In our initial report into Mr Dougherty's death, we made a recommendation in respect of the lack of a system at the prison for the electronic recording and sharing of a prisoner's medical records. This was not in keeping with the States of Guernsey's Health and Social Care Service or prisons in England and Wales and had been highlighted in IMP reports for the years 2018, 2019 and 2020.

57. However, during the consultation period for our initial report, The Home Department informed us the healthcare department at the prison were to be given access to an electronic patient record system already in use within Guernsey's community healthcare system. We have therefore removed the recommendation we made in our initial report about this matter.

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