Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael McDonagh, a prisoner at HMP Forest Bank, on 19 February 2019

A report by the Prisons and Probation Ombudsman

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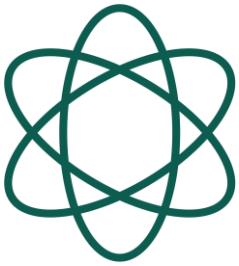
Our vision

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 Michael McDonagh died on 19 February 2019 at HMP Forest Bank. The post-mortem concluded that the most likely cause of his death was bronchopneumonia (inflammation of the lungs) caused by the depressant effects of a combination of medications, most of which had been prescribed to him. Mr McDonagh was 27 years old. I offer my condolences to Mr McDonagh's family and friends.

This is a troubling investigation. A few days before he died Mr McDonagh was prescribed methadone without being seen by a GP and without any subsequent clinical follow-up. In addition, his psychiatrist was not informed and there was no consideration of the impact methadone might have in combination with the medication Mr McDonagh was prescribed for his mental health. Mr McDonagh's mental health nurse also failed to review him appropriately. This was not equivalent to the care he could have expected to receive in the community.

I am also concerned that although a number of prisoners told us that Mr McDonagh seemed ill and tired in the days before he died, no healthcare or prison staff seemed aware of this. Indeed, there is no evidence that staff had any significant engagement with Mr McDonagh during the five months he spent at Forest Bank.

When Mr McDonagh was unlocked on the morning of his death, staff did not look into his cell and it was a prisoner who found him unresponsive 36 minutes later. This was unacceptable.

I am also concerned that Mr McDonagh was apparently able to obtain illicit prescription medication at Forest Bank without difficulty. This issue needs to be tackled in the prison's local drugs strategy.

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 **February 2020**

Contents

Summary

Events

1. Mr Michael McDonagh had a long history of mental health issues including auditory hallucinations, depression, anxiety and panic attacks.

2. He was in prison from October 2013 to April 2017 when he was released on licence. In September 2018, he was recalled to custody and taken to HMP Forest Bank.

3. A GP continued his prescription of medication: olanzapine (an antipsychotic), diazepam (used to treat anxiety), mirtazapine (an antidepressant) and pregabalin (used for anxiety and often abused and traded in prison). He was seen regularly by a mental health nurse and assessed by a psychiatrist who noted that they needed to reduce Mr McDonagh's pregabalin prescription because of the potential side effects.

4. In November, a psychiatrist discussed Mr McDonagh's pregabalin prescription with him. Mr McDonagh said that his risk of suicide and self-harm would increase if this medication was stopped. The next day he told staff that he had thoughts of suicide. Staff started Prison Service suicide and self-harm prevention procedures, known as ACCT, but closed it two days later.

5. In January 2019, Mr McDonagh was sentenced to three years' imprisonment. On 7 February, Mr McDonagh did not attend a psychiatrist appointment. The psychiatrist reduced his prescription of pregabalin in his absence. He noted that the mental health nurse should inform Mr McDonagh and support him following this reduction.

6. On 8 February, Mr McDonagh told a nurse that he had been taking illicit Subutex (used to treat opioid dependence) daily for over three months. The nurse referred him to the substance misuse team. On 14 February, a GP prescribed Mr McDonagh methadone to reduce his withdrawal symptoms from Subutex.

7. Several prisoners said that Mr McDonagh seemed unwell on 18 February and slept all day. Around 7.00pm, another prisoner woke him to collect his medication and he was then locked in his cell for the night. An officer checked Mr McDonagh at 10.11pm on 18 February and at 5.14am on 19 February, but noticed nothing unusual.

8. At 7.07am, an officer unlocked Mr McDonagh's cell but did not look into his cell. A prisoner found Mr McDonagh unresponsive in his cell at 7.44am and called for staff. Officers responded and radioed an emergency medical code. Staff and paramedics tried to resuscitate Mr McDonagh but he was pronounced dead at 8.55am.

9. The post-mortem report said that the most likely cause of Mr McDonagh's death was bronchopneumonia (inflammation of the lungs) caused by acute central nervous system depression resulting from polypharmacy (the mixture of medications that Mr McDonagh had taken).

Findings

Clinical care

10. The clinical reviewer concluded that the care Mr McDonagh received for his substance misuse was not equivalent to that he could have expected to receive in the community.

11. The GP did not see Mr McDonagh before prescribing methadone or liaise with the mental health team to consider its interaction with the other medications Mr McDonagh had already been prescribed.

12. Mr McDonagh was not reviewed by a nurse after he had been prescribed methadone as he should have been, nor was a care plan provided.

13. Mr McDonagh should also have been reviewed by the mental health team on 8 February as his pregabalin prescription had been reduced and he had told a nurse he was taking illicit Subutex.

Meaningful interaction with staff.

14. Several prisoners said that Mr McDonagh looked ill and tired in the days before he died. However, no staff we spoke to were aware of this. We are concerned that Mr McDonagh did not have a personal officer and that there is no evidence that staff had any meaningful interaction with him during the five months he spent at Forest Bank. We hope the new keyworker scheme will mean that staff spend time engaging with prisoners.

Assessment of risk and management of ACCT

15. Although it is not directly connected to Mr McDonagh's death, we are concerned that staff stopped ACCT monitoring in November 2018 without any input from mental health staff. Healthcare staff also failed to explicitly consider the effect of the reduction of Mr McDonagh's pregabalin prescription on his risk to himself in February 2019.

Drug supply

16. We are concerned that Mr McDonagh was able to obtain Subutex and quetiapine illicitly (both prescription-only drugs) without apparent difficulty.

Unlock procedures

17. When an officer unlocked Mr McDonagh on the morning 19 February, she did not complete a welfare check as she should have done. Mr McDonagh was discovered unresponsive around 36 minutes later by a prisoner.

Recommendations

- The Head of Healthcare must ensure that, when prescribing methadone, all prescribers:
    - assess the prisoner in person;
    - consider the interaction with other prescribed medication and with any drugs the prisoner is believed to be taking illicitly; and
    - liaise with the mental health team where appropriate and hold a multidisciplinary meeting where necessary.
- The Head of Healthcare must ensure that all staff are aware of, and follow, clinical guidelines relating to opiate substitute therapy, including the need to monitor prisoners after they have been prescribed methadone and provide a care plan.
- The Head of Healthcare must ensure that mental health staff appropriately assess and review prisoners according to their risk.
- The Director should ensure that all prisoners are allocated keyworkers who are given sufficient time to engage with prisoners.
- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
    - a member of healthcare staff should attend all first case reviews and subsequent reviews where relevant; and
    - all known risk factors are considered when determining the level of risk of suicide and self-harm.
- The Director and Head of Healthcare should ensure that there is an effective strategy to identify and reduce trading of prescribed medication.
- The Director should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Director should ensure that procedures are in place to escort paramedics through the prison as quickly as possible in a medical emergency.

The Investigation Process

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

19. The investigator visited Forest Bank on 27 February 2019. She obtained copies of relevant extracts from Mr McDonagh's prison and medical records.

20. The investigator interviewed 11 members of staff and five prisoners at Forest Bank in February and April 2019.

21. NHS England commissioned two independent clinical reviewers to review Mr McDonagh's clinical care at the prison. One clinical reviewer conducted some joint interviews with the investigator.

22. We informed HM Coroner for Greater Manchester West District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

23. One of the Ombudsman's family liaison officers contacted Mr McDonagh's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked the following questions, which we have addressed in the report:

    - What medication was Mr McDonagh prescribed? Was this medication suitable?
    - Was Mr McDonagh receiving appropriate mental health care?
    - Why was Mr McDonagh moved from the vulnerable prisoner unit, when he was still vulnerable?
    - Who was the last person to check Mr McDonagh?

24. Mr McDonagh's next of kin received a copy of the initial report. The solicitor representing Mr McDonagh's next of kin wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Forest Bank

26. Forest Bank is a local prison in Salford, serving courts in north west England. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo provides primary and substance misuse health care services. Mental health services are provided by Greater Manchester Mental Health NHS Foundation Trust (GMMH).

HM Inspectorate of Prisons (HMIP)

27. The most recent inspection of HMP Forest Bank was conducted in May 2019. Inspectors reported that Forest Bank continued to be a reasonably well-ordered and settled prison delivering generally good outcomes. However, levels of violence had doubled since the previous inspection in 2016 and they found that too many vulnerable prisoners did not feel safe.

28. Inspectors found that security arrangements were well managed and drug supply reduction measures were broadly effective with positive mandatory drug testing (MDT) rates lower than in comparable prisons. They found relationships between staff and prisoners were respectful but too few prisoners had a keyworker.

29. Inspectors concluded that primary mental health support for prisoners had improved and secondary mental health care remained good. Inspectors found that substance misuse services delivered a good and responsive clinical and recovery focussed service. They noted that medicine management had improved with good clinical management of prescribing tradable medication.

Independent Monitoring Board

30. 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 31 October 2017, the IMB concluded that Forest Bank was a well-managed, safe and respectful prison, in which prisoners were treated fairly and humanely and generally felt safe and secure. The IMB raised concerns over mental healthcare, and the availability of drugs.

Previous deaths at HMP Forest Bank

31. Mr McDonagh was the tenth prisoner to die at Forest Bank since 2016. Two of the previous deaths were self-inflicted, one was due to drug toxicity and the remaining six due to natural causes. There have been three deaths since that of Mr McDonagh, one due to natural causes, one self-inflicted and the third is, as yet, unclassified. We have previously raised concerns about the poor management of ACCT.

Assessment, Care in Custody and Teamwork

32. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be done at irregular intervals to prevent the prisoner anticipating when he will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.

33. Enhanced case management can be used to support prisoners whose behaviour is so challenging and disruptive that they need additional case management to manage their heightened or exceptional risk of harm to self, others and/or from others. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

34. Psychoactive substances (formerly known as 'new psychoactive substances or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and causing vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

35. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

36. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

37. Mr Michael McDonagh suffered from mental health problems from the age of 17. He had auditory hallucinations, depression, anxiety and panic attacks.

38. In October 2013, Mr McDonagh was sentenced to seven years imprisonment for an offence of aggravated burglary. He spent time at HMP Manchester and HMP Wymott and was prescribed olanzapine (an antipsychotic), diazepam (used to treat anxiety) and mirtazapine (an antidepressant).

39. In January 2016, Mr McDonagh told staff he had taken PS. He was diagnosed with possible schizophrenia (a mental disorder involving a breakdown in the relation between thought, emotion and behaviour). A psychiatrist prescribed pregabalin to try and lessen Mr McDonagh's feelings of anxiety. Over the following months staff had concerns that Mr McDonagh was using PS and selling his medication.

40. In April 2017, Mr McDonagh was released on licence.

2018

41. On 5 September 2018, Mr McDonagh was recalled to prison. On 7 September, he was charged with stealing his former partner's car and setting fire to it. He was taken HMP Forest Bank the next day. He said he had no thoughts of suicide or self-harm. At his own request, due to family issues, Mr McDonagh was located on a unit for vulnerable prisoners who would be at risk from other prisoners elsewhere in the prison. Mr McDonagh was given a single cell due to his mental health issues.

42. A GP assessed Mr McDonagh and prescribed him mirtazapine, olanzapine and pregabalin (as he had been in the community). His medication was not in his possession and Mr McDonagh had to take it while being observed by healthcare staff.

43. Mr McDonagh provided a urine sample in reception and tested positive for Subutex, benzodiazepines (sedatives) and cannabinoids. He said he did not want to be referred to the clinical substance misuse team. Staff referred him to the recovery team which provides psychosocial support for those with drug use issues.

44. On 10 September, clinical staff verified details of Mr McDonagh's mental health treatment in the community. They were told that Mr McDonagh did not have a definitive diagnosis but that he might have a mental and behavioural disorder due to substance misuse, as well as possible schizophrenia. Mr McDonagh was referred to the prison's mental health team and regularly seen by Mental Health Nurse. He told the nurse he experienced negative auditory hallucinations. She told the investigator that she did not have any concerns about Mr McDonagh, he settled well at the prison and looked after himself. He worked on the wing. She never had any concerns he was taking illicit drugs.

45. On 4 October, a psychiatrist assessed Mr McDonagh, with a trainee psychiatrist, and a mental health nurse. The psychiatrist explained the prison policy on the prescription of pregabalin to Mr McDonagh, since guidelines by the Royal College of General Practitioners (RCGP) recommended this drug was not prescribed to

treat anxiety in prisons. Mr McDonagh said he would self-medicate illicitly and take an overdose if his prescription of pregabalin was stopped. No changes were made to the prescription at that time. Mr McDonagh said he had no thoughts of suicide or self-harm. The psychiatrist told the investigator that Mr McDonagh's anxiety about his pregabalin prescription dominated this and subsequent meetings.

46. On 10 October, a recovery worker assessed Mr McDonagh. Mr McDonagh told him that he had been using cocaine and cannabis in the community. He said he had not used any drugs since returning to prison. The recovery worker met with Mr McDonagh monthly. He told the investigator that he had no concerns about Mr McDonagh and did not suspect that he was using illicit drugs.

47. On 19 November, Mr McDonagh told the mental health nurse that he was having auditory hallucinations which told him to kill himself and harm others. The nurse noted that he said he had no current thoughts of suicide and did not appear distressed and she did not assess that he was an imminent risk to himself unless his mental health deteriorated or he used drugs.

48. On 22 November, the trainee psychiatrist discussed Mr McDonagh's prescription of pregabalin with him. Mr McDonagh said that his risk of suicide and self-harm would increase if this medication was stopped. The trainee psychiatrist then asked the psychiatrist's advice. The psychiatrist said that they needed to make a plan to reduce Mr McDonagh's prescription of pregabalin safely.

49. Later that day, Mr McDonagh told staff that he had thoughts of suicide and auditory hallucinations telling him to harm himself and others. Staff opened an ACCT. On 23 November, during the ACCT assessment, Mr McDonagh said that he was concerned about the length of sentence he would receive. During the subsequent review, staff noted that a mental health nurse should attend the next review as Mr McDonagh had concerns that his depression was worsening as his court date got nearer. On 25 November, staff closed Mr McDonagh's ACCT. No mental health staff were present. The prison staff present noted that Mr McDonagh said he was feeling much better now he was employed as a cleaner, and that he said he had no thoughts of suicide or self-harm.

50. The mental health nurse told the investigator that, over the time she worked with Mr McDonagh, she did not have any concerns that he was a risk to himself. She said that when he spoke about having thoughts of suicide he did not seem distressed. She was aware that his mother and partner visited every week, he was working on the wing and got on well with staff and other prisoners.

51. On 29 November, the psychiatrist decided to maintain Mr McDonagh's current prescription of pregabalin until after he had been sentenced. The psychiatrist recognised sentencing was a stressful time for any prisoner and that altering Mr McDonagh's medication could have destabilised his mental state.

2019

52. On 4 January 2019, Mr McDonagh was convicted of two offences. A third remained outstanding. On 16 January, Mr McDonagh's next of kin told prison staff that she was concerned for his welfare after his offender manager had visited him the day before. Staff spoke to Mr McDonagh who said he was concerned about the length

of sentence he would receive as his offender manager considered him “dangerous to the public”. Mr McDonagh said he felt calmer than the day before and had no thoughts of suicide or self-harm. Mr McDonagh said that he would call his mother to reassure her.

53. On 24 January, Mr McDonagh moved from D wing to C wing at his own request. This was also a unit for vulnerable prisoners. A Custodial Operations Manager (COM), the unit manager said prisoners on the wing have access to education, employment and exercise like other prisoners. He said Mr McDonagh was an enhanced prisoner who was respected by other prisoners. His employment as a cleaner meant he was unlocked for much of the day. The COM never had any concerns about Mr McDonagh.

54. On 25 January, Mr McDonagh was convicted of the third offence. He was sentenced to a further three years imprisonment. When he returned to Forest Bank, he declined to see a nurse. A prisoner told the investigator that he had known Mr McDonagh since he had been recalled to Forest Bank. He said had been concerned about the length of his sentence in advance and was “over the moon” when sentenced as it was much shorter than he was expecting. The prisoner said that Mr McDonagh had used PS occasionally at Forest Bank until November 2018 when he stopped following a visit from his mother. He said that Mr McDonagh enjoyed his cleaners job but was “a little bit depressed” and wanted to transfer to HMP Wymott.

55. Other prisoners also said that Mr McDonagh was relieved at the length of his sentence and was looking forward to moving prisons. Some said he took PS, others said not. Staff and prisoners both said that Mr McDonagh was relatively quiet and presented no issues to staff.

56. On 31 January, Mr McDonagh told the recovery worker that he wanted to stop seeing him as he felt he no longer needed his support. He discharged Mr McDonagh from his caseload.

57. On 1 February, the mental health nurse reviewed Mr McDonagh. He told her he felt unwell and was aching, and the nurse noted his face was puffy. Mr McDonagh agreed he would book an appointment with the GP. (There is no record that he did). The nurse noted that Mr McDonagh appeared tense and angry, and said he did not want to stay at Forest Bank now he had been sentenced. He wanted to transfer to Wymott but had been told he could not transfer due to being on “parole hold” (meaning that his parole review hearing was within the next few months and he could not move before then).

58. The mental health nurse noted that Mr McDonagh appeared stable but he said he was not sleeping well and was depressed and anxious. Mr McDonagh said that he constantly heard voices and recently a voice had been telling him to hurt himself and others. Mr McDonagh said he was “fed up” and the prison was making him “ill and angry”. She told the investigator that Mr McDonagh was angry and tense and noticeably different at this appointment. She booked Mr McDonagh for a medication review with the psychiatrist.

59. On 7 February, the psychiatrist tried to meet Mr McDonagh to discuss reducing his prescription of pregabalin. Mr McDonagh refused to attend, telling wing staff that he

knew the psychiatrist wanted to stop his pregabalin. The psychiatrist noted that the prescription needed to be reduced as he was concerned that the combination of drugs Mr McDonagh was taking could have a detrimental effect of on his heart. The psychiatrist reduced Mr McDonagh's pregabalin medication by 25%. He told the investigator that this was a very "cautious" reduction. The psychiatrist said he hoped that by making this reduction, Mr McDonagh would eventually engage with him.

60. The psychiatrist discussed the plan with the mental health nurse, recording that she needed to inform Mr McDonagh. The psychiatrist was concerned that the reduction may lead to an increase in Mr McDonagh's risk to himself or becoming aggressive with others. the psychiatrist asked the team to reassure and support Mr McDonagh and provide him with an information leaflet. He noted that he would also attempt to see him in the meantime and would review the reduction in two weeks. The mental health nurse noted that she spoke to a wing officer, advising them of this reduction and Mr McDonagh's possible reaction. She noted that she would see Mr McDonagh as soon as possible to discuss the plan and provide him with information about the reduction.

61. On 8 February, Mr McDonagh told a nurse that he had been taking illicit Subutex daily for over three months. He said he had been getting the Subutex from his friends on the wing. Mr McDonagh told the nurse that he wanted to stop taking it but was concerned about the withdrawal symptoms. She passed this information to another nurse from the substance misuse team. The nurse from the substance misuse team spoke to Mr McDonagh on the wing. She noted that Mr McDonagh would be referred to the substance misuse team so that he would be allocated a recovery worker and nurse to provide him with structured input. She told Mr McDonagh that he did not need to be prescribed methadone at that time.

62. The mental health nurse updated Mr McDonagh's risk assessment that afternoon. Because she accessed his record to do this, she became aware by chance that he had engaged with the substance misuse team. Her risk assessment noted that Mr McDonagh's risk to himself was "amber". This meant that he was a moderate risk to himself and that the team should "*monitor more closely and manage with urgency and intensity. Review more frequently than routine*".

63. A nurse completed Mr McDonagh's secondary screening that afternoon. He told the nurse that he had outstanding hospital appointments for a nose reconstruction at hospital. This was the first that staff knew of this issue.

64. On 12 February, the recovery worker and a nurse from the substance misuse team assessed Mr McDonagh. His urine tested negative for Subutex. Mr McDonagh said he had not used Subutex for two days. The recovery worker told the investigator that Mr McDonagh said he felt ashamed of his drug use, which was why he said he had not been honest with him previously. Mr McDonagh said that he wanted to see a GP as he wanted to be prescribed methadone. The nurse told Mr McDonagh that they could not prescribe him methadone as he had not tested positive. She told him that she would retest him soon and if that test was positive, she would refer him to the GP to be prescribed methadone. The nurse gave Mr McDonagh some work to complete in his cell on substance misuse. She told the investigator that she did not have any concerns about him.

65. On 14 February, around 2.30pm, a nurse assessed Mr McDonagh. He tested positive for Subutex. He scored 14 on the Clinical Opiate Withdrawal Scale (COWS) indicating moderate withdrawal symptoms. The nurse told the investigator that Mr McDonagh seemed "very agitated" and sweaty. He again asked to be prescribed medication to lessen his withdrawal symptoms. The nurse sent an electronic task to a GP to prescribe Mr McDonagh methadone. A prison GP prescribed Mr McDonagh methadone at 3.00pm. It was too late for Mr McDonagh to receive methadone that day but he received it the next four mornings in line with his prescription.

66. A prisoner said he first met Mr McDonagh when he moved to C wing. He told the investigator that Mr McDonagh told him that he did not take PS but had been prescribed methadone as he had been taking illicit Subutex. The prisoner said that after Mr McDonagh was prescribed methadone, he slept a lot more.

67. A prisoner told the investigator that, on 16 February, Mr McDonagh was "very pale" and "wasn't the same Michael". When he asked Mr McDonagh what was wrong, he replied that he had tested positive for Subutex and had been prescribed methadone. He said Mr McDonagh's eyes were "like a red dot" and he seemed much more tired than usual. He also said he was a bit "grouchy" whereas before he had been very "bubbly" and "polite". He said Mr McDonagh told him he was feeling "rough".

68. Prisoners told the investigator that Mr McDonagh seemed even more unwell on 18 February. They said that he slept all day, which was very unusual for him since he was usually out of his cell cleaning the wing. One prisoner said that he did not collect his food that day. He said that when he saw him, Mr McDonagh was shaking, shivering, his eyes were bloodshot and he looked very ill. The prisoner said that Mr McDonagh looked obviously ill to anyone who saw him. He told Mr McDonagh that he needed to get some sleep, so he went back to bed.

69. Around 5.00pm, a prisoner who lived next door to Mr McDonagh, said that Mr McDonagh told him that he had not slept the night before because he had taken Subutex and was tired as a result. He told him to go to sleep and he would call him when the evening medication was being given out. He told the investigator that Mr McDonagh "looked a mess" and was much more tired than normal. Another prisoner said that Mr McDonagh's skin looked "grey".

70. By contrast, another prisoner told police that Mr McDonagh seemed "fine" that evening. None of the staff the investigator had contact with noticed a difference in Mr McDonagh in the last few days of his life.

71. Shortly before 7.00pm, a prisoner called into Mr McDonagh's cell to tell him to go to collect his medication. He told the investigator that it was hard to wake Mr McDonagh and he had to shout a few times.

72. A Prison Custody Officer (PCO) was providing cover on the wing that evening. He first met Mr McDonagh when he was going to collect his medication. The PCO said he had no concerns about him and did not think he looked unwell. At 7.23pm, the PCO locked Mr McDonagh back in his cell. He then did his roll check of all prisoners, along with another officer shadowing him. The PCO said that when he unlocked Mr McDonagh's door to check on him, Mr McDonagh said to him, "Good

night boss, God bless." He said that Mr McDonagh did not look unwell or tired. He was standing up near his door. The PCO then locked the door.

73. CCTV shows that at 10.11pm, an Operations Supports Officer (OSO) checked Mr McDonagh by looking through his observation panel. The OSO did not specifically recall checking Mr McDonagh and said that this meant that he had no concerns about him. A prisoner told the investigator that he could hear Mr McDonagh snoring at 11.00pm.

Events of 19 February

74. On 19 February at 5.14am, CCTV shows that the OSO checked Mr McDonagh by looking through his observation panel using a torch. Again, the OSO could not specifically recall completing this check.

75. At 7.07am, a PCO unlocked Mr McDonagh's cell. She did not look into his cell. At 7.16am and 7.18am a prisoner looked into Mr McDonagh's cell. He told police that it was dark in the cell but he thought Mr McDonagh was sleeping. At 7.29am, He went into Mr McDonagh's cell as he was concerned that Mr McDonagh would miss the opportunity to collect his canteen (items he had purchased) that morning. He said he shouted to Mr McDonagh who did not respond and he assumed he was still asleep.

76. At 7.42am, the prisoner returned to see Mr McDonagh and thought he was still asleep. He said he then heard the last call for the canteen and told another prisoner, who was nearer Mr McDonagh's cell, to tell him. At 7.44am, the prisoner went into Mr McDonagh's cell to tell him that canteen was finishing. He stayed in the cell for over 30 seconds. He told police that he tried to rouse Mr McDonagh and touched his leg which was stiff. He then noticed that Mr McDonagh's face was blue. He thought that Mr McDonagh was dead. CCTV shows another prisoner who was walking past the cell, then go into the cell. Both prisoners came out of Mr McDonagh's cell at 7.45am.

77. A prisoner told a PCO, who was on the landing, that he thought Mr McDonagh was dead and to go to his cell. The PCO shouted to a second PCO on the landing below to assist him. The PCO and the two prisoners went into Mr McDonagh's cell together. The PCO said Mr McDonagh was unresponsive. He told the investigator that he thought Mr McDonagh was dead as his face was blue.

78. The second PCO said that she immediately ran to Mr McDonagh's cell, reaching it seconds later. As she went into Mr McDonagh's cell, the first PCO told her that he thought that Mr McDonagh was dead. She told him to radio a code blue. He did so and control room staff called an ambulance. She checked Mr McDonagh for any signs of life and told the prisoners to leave the cell. She told the investigator that she did not think that Mr McDonagh was dead but noted that his lips were blue and his skin pale. She was unsure whether he was breathing.

79. A nurse got to the cell at 7.47am with the emergency bag, defibrillator and oxygen. She noted that Mr McDonagh was lying on his right side, was blue and had a vape in his hand. Due to his appearance, her first impression was that Mr McDonagh was dead. She checked for signs of life and started chest compressions. She said that Mr McDonagh was cold but not stiff. Other nurses arrived and attached the

defibrillator and inserted an airway. They administered oxygen. She was concerned that Mr McDonagh may have used illicit drugs and therefore administered naloxone which reverses the effects of opioids.

80. The ambulance got to the prison at 8.08am. Paramedics arrived at the cell at 8.20am and took over Mr McDonagh's care. At 8.55am, Mr McDonagh was pronounced dead by paramedics.

81. The police seized items relating to Mr McDonagh's vape from his cell due to intelligence from prisoners that Mr McDonagh may have been using them to smoke PS.

Contact with Mr McDonagh's family

82. One of the prison's family liaison officers (FLO), and the Director, went to Mr McDonagh's next of kin's address at 10.00am. She was not home, so the FLO telephoned her. She insisted that the FLO told her the purpose of their visit over the telephone, so the FLO broke the news of Mr McDonagh's death. They agreed to wait for her at her address. They met with Mr McDonagh's next of kin and her partner, offered their condolences and left the house. The FLO stayed in contact with them and offered a contribution to funeral expenses in line with Prison Service policy.

Support for prisoners and staff

83. After Mr McDonagh's death, the Deputy Director, 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.

84. A COM and another unit manager told each prisoner on the unit individually of Mr McDonagh's death. The prison also posted notices informing other prisoners of Mr McDonagh'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 McDonagh's death.

85. Most staff and prisoners felt well supported following Mr McDonagh's death. One prisoner said that he had not been followed up by a mental health nurse as promised. The investigator raised this with staff at the time. A nurse said that she felt blamed for Mr McDonagh's death and was not kept adequately informed regarding her associated disciplinary investigation.

Post-mortem report

86. Toxicology tests found the presence of methadone, olanzapine, mirtazapine, pregabalin and quetiapine in Mr McDonagh's bloodstream at the time of his death. These had all been prescribed to him, apart from quetiapine, an antipsychotic drug, which he must have obtained illicitly. All the drugs were at a level consistent with the therapeutic range, meaning that Mr McDonagh had not taken an overdose.

87. In the case of methadone, although the concentration was within the range associated with therapeutic use when prescribed as an opiate substitute, the

toxicologist noted that the concentration could be fatal in an individual with no/limited tolerance to the drug.

88. All of these drugs can have a depressant effect on the central nervous system, leading to decreased rate of breathing, decreased heart rate, and loss of consciousness. The toxicologist said that the combination of drugs may have enhanced the depressant effects.

89. No PS or Subutex was detected in Mr McDonagh's system.

90. The post-mortem report found that the most likely cause of Mr McDonagh's death was bronchopneumonia.

91. The pathologist said that bronchopneumonia is relatively unusual in young people and there is usually a reason it develops. She noted that reduced consciousness can lead to the development of pneumonia due to the lack of movement, depressed breathing and possibly the loss of the cough reflex. The pathologist concluded that it was most likely that Mr McDonagh developed bronchopneumonia due to the depressant effects of the combination of medication he had taken.

92. The pathologist also said that she could not comment on how tolerant Mr McDonagh was to opiates but that, if he had not been exposed to methadone for some time prior to its prescription on 14 February, and if he had been an irregular user of illicit Subutex, he may not have had much tolerance to methadone. She concluded that low tolerance to methadone may, therefore, have been a factor in Mr McDonagh's death, particularly if that methadone were combined with the cumulative central nervous system depressant effects of anti-psychotic and psychoactive medications.

Findings

Clinical care

93. The clinical reviewer concluded that the care Mr McDonagh received in relation to his substance misuse, namely the prescribing of methadone and subsequent monitoring, was not equivalent to that he could have expected to receive in the community.

94. This is a cause of significant concern given that it appears that the combination of the drugs Mr McDonagh was prescribed led to his death.

Substance misuse assessment

95. The clinical manager of the substance misuse team at Forest Bank, told the investigator that when a nurse first spoke to Mr McDonagh about his Subutex use on 8 February, she would have expected her to do a full assessment using the COWS, taking a urine sample and basic observations, such as blood pressure. When the clinical manager spoke to the nurse, she said that she had just gone to check that Mr McDonagh was generally "okay" and was intending to forward this information to his allocated nurse in the substance misuse team.

96. The clinical manager acknowledged that the nurse had gone to see Mr McDonagh very quickly and that it was unusual for this to happen the same day as someone admitted to illicit drug use. She said it could normally take up to five days for a prisoner to see a nurse, though if a prisoner was clearly experiencing withdrawal symptoms, they would be seen quicker than this. Since the nurse did not have any concerns about Mr McDonagh she referred him to his nurse and recovery worker. In these circumstances, we are not critical of the nurses' actions.

Prescription of methadone

97. We are concerned that a prison GP prescribed Mr McDonagh methadone on 14 February without seeing him in person and without any evidence that he considered whether it was safe to prescribe methadone in combination with Mr McDonagh's other prescribed medications.

98. The clinical manager said that the specialist substance misuse GP was on leave and a prison GP therefore prescribed the methadone. She said that the substance misuse GP always assessed a prisoner in person before prescribing methadone. The prison GP did not do this but prescribed methadone based on a nurse's observations. The clinical manager said that, since Mr McDonagh's death, she has changed this process so that a prisoner must be assessed by a specialist substance misuse GP before being prescribed methadone. This is in line with the Department of Health's policy, *Drug misuse and dependence: UK Guidelines on clinical management,* which says that it is best practice for the prescriber to see the patient when prescribing methadone.

99. The mental health nurse was not aware that Mr McDonagh had been prescribed methadone before he died. She said that the substance misuse use team should

have informed her. If she had known, she would have gone to see him the same day and booked him an urgent medication review with the psychiatrist.

100. The psychiatrist also said that he should have been informed that Mr McDonagh had been prescribed methadone as it could have enhanced the cardio-toxic combination of all the drugs he had been prescribed. He said that Mr McDonagh's prescribed medications needed to be considered as a whole. The psychiatrist also said that, ideally, a multidisciplinary meeting should have been held to consider the medication and treatment Mr McDonagh was receiving both from the substance misuse team and mental health team, although he recognised that these were sometimes difficult to convene in prisons in practice.

101. The clinical reviewer concluded that the mental health team should have been involved in the decision to start prescribing Mr McDonagh methadone. We make the following recommendation:

The Head of Healthcare must ensure that when prescribing methadone, all prescribers:

- **assess the prisoner in person;**
- **consider the interaction with other prescribed medication and with any drugs the prisoner is believed to be taking illicitly; and**
- **liaise with the mental health team where appropriate and hold a multidisciplinary meeting where necessary.**

Clinical observations and follow up

102. We are also concerned that Mr McDonagh was not reviewed by a nurse after he was prescribed methadone. The Department of Health's guidelines say that after a prisoner should be reviewed twice a day after being prescribed methadone and a care plan should be set up. If there are any clinical signs of overdose, the methadone should not be administered until the prisoner has been assessed by a GP. A nurse omitted to book Mr McDonagh for these reviews and, as a result, no healthcare staff reviewed Mr McDonagh after he had been prescribed methadone and he did not have a care plan.

103. The clinical manager said she had spoken to the nurse who was "devastated" to have made such a mistake. The nurse was suspended pending an internal investigation. This investigation recommended further training for the nurse and for her to shadow another substance misuse nurse until she was confident in her role.

104. After Mr McDonagh's death, the prison's substance misuse team audited their services between 22 February 2019 and 5 March 2019. They found that of those prescribed opiate substitution treatment, 182 prisoners were correctly reviewed for the first five days, and that 17 prisoners did not have all their reviews. Of these 17, in 15 cases there was an explanation as to why the reviews had not occurred, and in two there was no explanation.

105. The clinical manager said that since Mr McDonagh's death, all prisoners undergoing a detox are moved to a stabilisation wing to enable observations to be carried out. They have also amended their processes and now use SystmOne (a prisoner's electronic clinical record) to ensure that anyone who has been prescribed

methadone is added to a list for a review the next day. She had also introduced a rota so that a designated member of healthcare staff is responsible for ensuring all the observations are carried out on a certain day. The clinical manager said she had also discussed the issue at a team meeting and was in the process of updating guidelines for the team.

106. We recognise that the clinical manager is taking action in response to Mr McDonagh's death. Nevertheless, we consider it necessary to make the following recommendation:

The Head of Healthcare must ensure that all staff are aware of, and follow, clinical guidelines relating to opiate substitute therapy, including the need to monitor prisoners after they have been prescribed methadone and provide a care plan.

Reduction of pregabalin prescription and mental health care

107. The psychiatrist told the investigator that prescribing Mr McDonagh pregabalin in combination with the other medication meant he was at risk of "an abnormal cardiac event". It was for this reason, and because pregabalin is highly tradeable in prison, that he wanted to stop Mr McDonagh's prescription. The psychiatrist said he was also concerned about the possibility of Mr McDonagh taking illicit drugs and the interaction of these with pregabalin.

108. The clinical reviewer concluded that appropriate efforts were made to reduce Mr McDonagh's pregabalin prescription. Discussions about the reduction took place in November 2018 but, as Mr McDonagh was clearly anxious about this, the psychiatrist appropriately decided to delay the reduction until after he had been sentenced. The psychiatrist subsequently tried to discuss the medication reduction with Mr McDonagh but he refused to attend the appointment, and so, on 7 February 2019, he reduced his prescription without seeing him.

109. The mental health nurse told the investigator that she had considered opening an ACCT when Mr McDonagh's pregabalin was reduced but did not consider that this was necessary as he was still receiving 75% of this medication, he was still working on the wing and she did not have any concerns about his mental health. She also knew that he had support from his mother and partner. She said that she had meant to assess Mr McDonagh over the next few days to ensure that he was alright, assess his risk and give him the information about his medication reduction. She told the investigator she had not had the opportunity to do so.

110. However, when she updated Mr McDonagh's risk assessment on 8 February, she became aware that he had told clinical staff that he was using Subutex. Her assessment indicated that Mr McDonagh was a moderate risk and needed to be monitored more closely. We agree with the clinical reviewer's conclusion that considering this assessment, the mental health nurse or another member of her team should have reviewed Mr McDonagh on 8 February. We make the following recommendation:

The Head of Healthcare must ensure that mental health staff appropriately assess and review prisoners according to their risk.

Secondary healthscreen

111. Mr McDonagh's secondary healthscreen took place on 8 February 2019, around six months after he had arrived at Forest Bank. This should have taken place within seven days of him arriving at the prison. The clinical reviewer spoke to the Head of Healthcare about this issue which had already been identified. A daily audit now takes place of any outstanding secondary healthscreens. We therefore make no recommendation about this.

Meaningful contact with staff

112. After Mr McDonagh returned to prison in September 2018, there is very little evidence that wing staff engaged with him or got to know him. Staff all said that Mr McDonagh caused them no issues. We are concerned that although several prisoners said that Mr McDonagh was different and unwell during the last few days of his life, no prison staff the investigator spoke to were aware of this. Moreover, it was difficult for the investigator to identify any prison staff who had any contact with Mr McDonagh over the last few days of his life.

113. At that time Forest Bank were operating the personal officer scheme, but Mr McDonagh did not have a personal officer. Since that time, the keyworker scheme has been introduced. This is designed to provide each prisoner with regular personal contact with an identified member of staff who they can approach in the first instance with any difficulties. We note that HMIP were concerned how few prisoners had keyworkers when they inspected Forest Bank in May 2019.

114. If wing staff had engaged with Mr McDonagh more, they may have noticed a deterioration in his condition. We hope that the new keyworker scheme will mean that prison staff spend more time engaging with prisoners, and we recommend:

The Director should ensure that all prisoners are allocated keyworkers who are given sufficient time to engage with prisoners.

Assessment of risk and management of ACCT

115. In November 2018, Mr McDonagh had told a nurse that he was hearing voices telling him to harm himself and others. They did not open an ACCT as they did not assess that he had any intention to harm himself. When the psychiatrist discussed stopping Mr McDonagh's prescription of pregabalin with him a few days later, Mr McDonagh said that his risk to himself would increase if this occurred. Later that day, he said he had thoughts of suicide and staff opened an ACCT. They closed it a few days later without input from mental health staff.

116. The subsequent reduction of Mr McDonagh's pregabalin on 7 February 2019 was therefore significant and staff needed to explicitly consider the effect of this on Mr McDonagh's risk to himself. There is no evidence that this occurred.

117. On 8 February, Mr McDonagh told a nurse that he had been taking Subutex for three months. Despite the mental health nurse becoming aware of this the same day, she did not review Mr McDonagh before he died.

118. Although these failings did not contribute directly to Mr McDonagh's death, they could make a difference in other cases. We, therefore, make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:

- **a member of healthcare staff should attend all first case reviews and subsequent reviews where relevant; and**
- **all known risk factors are considered when determining the level of risk of suicide and self-harm.**

Drug supply

119. The toxicologist detected no PS or Subutex in Mr McDonagh's system, indicating that he had not taken these drugs in the hours leading up to his death. However, quetiapine was found in his system which he had not been prescribed. Mr McDonagh also told staff that he had taken illicit Subutex regularly over a three month period, and he tested positive for Subutex less than a week before he died. While we cannot be sure how he obtained these medications, it is possible that they were diverted and traded by other prisoners to whom they were prescribed.

120. Some prisoners also said that Mr McDonagh used PS while he was at Forest Bank.

121. The Head of Security and Safer Custody told the investigator that in January 2019 HMPPS had identified several issues regarding illicit drug supply in Forest Bank. She said the prison was working on shutting down these routes of drug supply. They had put netting over all the exercise yards, bought a body scanner and a paper scanner. They tested mail according to any intelligence received. She was also satisfied that staff submitted intelligence reports as required.

122. Despite these measures, we are concerned that Mr McDonagh was apparently able to obtain Subutex and quetiapine illicitly at Forest Bank. We note that HMIP found that a high number of prisoners (61%) said it was easy to obtain illicit drugs in Forest Bank when they inspected in May 2019 (that is, three months after Mr McDonagh's death).

123. We consider that further work is required to reduce the availability of illicit drugs and diverted medication, and we make the following recommendation:

The Director and Head of Healthcare should ensure that there is an effective strategy to identify and reduce trading of prescribed medication.

Roll check and unlock procedures

Roll check

124. A roll check is primarily a security check to count prisoners to ensure they are present in their cells, but it is also an opportunity for any immediate concerns about prisoners' safety to be identified and addressed. The OSO checked Mr McDonagh at 10.16pm on 18 February and 5.14am on 19 February. He could not specifically

recall these checks and therefore said he must have had no concerns about Mr McDonagh. Mr McDonagh was found the next morning by prisoners who initially thought he was sleeping. We do not think it is reasonable to expect staff to wake prisoners up during the night and early morning to check on their wellbeing, and we accept that it would have been difficult for the OSO to identify any concerns about Mr McDonagh and we make no criticisms.

Unlock

125. At morning unlock, officers should take active steps to check on a prisoner's wellbeing. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

126. The PCO unlocked Mr McDonagh's cell at 7.07am on 19 February. She did not look into his cell. She told the investigator that she accepted that she should have done so. She could not account for why she did not look into Mr McDonagh's cell and did not seek to excuse her actions. However, she said she felt under pressure at the time, with only two officers on the wing and prisoners asking her about their canteen which was due to be issued that morning. We understand that she received a written warning for gross misconduct for failing to look into Mr McDonagh's cell.

127. Mr McDonagh was found unresponsive by another prisoner around 36 minutes after the PCO unlocked him. We know that Mr McDonagh was alive around 7.30pm on 18 February when an officer spoke to him, and that another prisoner heard him snoring at about 11.00pm, but we cannot say when he died. If an effective unlock check had been carried out, he might have been found sooner. We cannot say whether this would have changed the outcome for Mr McDonagh, but it might have done.

128. On 19 February, the Director issued a notice to all staff that when unlocking prisoners, staff must check that they are in their cell and obtain a response from them. Once all prisoners on the wing are unlocked, staff must record in the wing observation book that they have completed a welfare check on all prisoners.

129. Since Mr McDonagh's death, weekly audits have been carried out of welfare checks when prisoners are unlocked three times each day. For the week beginning 9 June 2019, only one houseblock had completed all their welfare checks, with many completing less than half. Out of a total of 326 sets of welfare checks which should have been completed that week, staff had completed only 182. Staff on the wings were spoken to about the need to do these checks, but clearly improvement is still needed to adhere to policy. We, therefore, make the following recommendation:

The Director should ensure that when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

130. A PCO was clear about the emergency codes used at the prison. He said that when he found Mr McDonagh, he did not immediately radio a code blue due to shock. He radioed a code blue seconds later, after the second PCO also got to Mr McDonagh's cell. Given the unexpected situation in which he found himself and the lack of a substantial delay in the emergency response, we are not critical of the PCO's actions.

131. It took the paramedics 12 minutes to get from the gate to Mr McDonagh's cell. The Operations Manager said this was not an excessive amount of time as there were five gates to open and close. We recognise this but we consider that it should have been possible to get to Mr McDonagh's cell more quickly. We recommend:

The Director should ensure that procedures are in place to escort paramedics through the prison as quickly as possible in a medical emergency.

Inquest

132. The inquest into Mr McDonagh's death concluded on 8 September 2023. They gave a narrative verdict stating that clinical errors in the assessment and observation of Mr McDonagh along with a lack of communication between staff had probably contributed to his death. The inquest also noted that a lack of adequate welfare checks had possibly contributed to his death.

Sue McAllister, CB
Prisons and Probation Ombudsman **February 2020**

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