

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael O'Donnell, a prisoner at HMP Leeds, on 28 November 2021

A report by the Prisons and Probation Ombudsman



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

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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Michael O'Donnell died in hospital of an ischaemic stroke on 28 November 2021, while a prisoner at HMP Leeds. He was 78 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care Mr O'Donnell received at Leeds was equivalent to what he could have expected to receive in the community. She made two recommendations about care plan audits and completing risk assessments for falls, malnutrition and pressure ulcers, which we do not repeat in this report, but which the Head of Healthcare will need to address.
5. Healthcare staff did not accurately complete Mr O'Donnell's escort risk assessment to reflect his current medical condition and the impact it would have had on his ability to escape. As a result, the senior manager did not have all the information to make a sound decision about the use of restraints.

Recommendation

- The Governor should ensure that decision makers use the escort risk assessment form annexed to the Prevention of Escape Framework – External Escorts Policy Framework to ensure they consider all the relevant factors and provide a record of defensible decision making.
- The Head of Healthcare should ensure that healthcare staff input into escort risk assessments and provide up-to-date medical information that is clear and sufficiently detailed.

The Investigation Process

6. HMPPS informed us of Mr O'Donnell's death on 29 November 2021. The PPO investigator investigated the non-clinical issues relating to Mr O'Donnell's care.
7. NHS England commissioned an independent clinical reviewer to review Mr O'Donnell's clinical care at Leeds.
8. The PPO family liaison officer wrote to Mr O'Donnell's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Leeds

10. In the three years prior Mr O'Donnell's death, 23 prisoners at Leeds died from natural causes. There were also eleven self-inflicted deaths, a drug related death and one death awaiting classification. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

11. On 1 July 2021, Mr Michael O'Donnell was remanded to HMP Doncaster for sexual offences. On 2 July, he was sentenced to four years in prison and was sent to HMP Leeds. He was 78 years old.
12. Mr O'Donnell had pre-existing medical conditions, which included asthma and hypertension. He previously had a stroke in May 2021 and was under the care of the community stroke rehabilitation team. The occupational therapy team visited him at home regularly. He was also referred to the neurological rehabilitation service in the community.
13. On 2 July, a nurse completed an initial health screen. She noted his medical conditions and sent an urgent task for a local authority social care assessment. He was also added to the list to see the GP. Mr O'Donnell said that he used a walking stick and that carers visited him every day.
14. At 1.00pm on 15 July, Mr O'Donnell pressed his emergency cell bell. An officer attended and found that Mr O'Donnell was short of breath and confused. Mr O'Donnell's cell mate told the officer that Mr O'Donnell had collapsed. The officer radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). A nurse attended but was unable to record Mr O'Donnell's blood pressure. She completed a stroke symptom test and thought that Mr O'Donnell had had a stroke. She sent him to hospital by ambulance. The prison was not able to locate the paperwork for this escort, therefore we do not know if Mr O'Donnell was restrained.
15. Hospital staff confirmed that Mr O'Donnell had had a stroke. The next day, Mr O'Donnell was discharged from hospital and was sent back to Leeds.
16. At approximately 1.15pm on 17 July, an officer radioed a code blue after Mr O'Donnell's cell mate said that Mr O'Donnell had fallen over. A nurse went to Mr O'Donnell's cell and saw that he had a right sided facial droop, slurred speech and was unable to use his right arm and thought that he was having another stroke. She noted that Mr O'Donnell had pain down his right side, and that his leg appeared to be shortened and rotated. She also thought that he might have fractured the neck of his thigh bone. She recorded Mr O'Donnell's National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) as five, which indicated a medium to high clinical risk.
17. Ambulance paramedics took Mr O'Donnell to hospital. He was escorted by two officers and restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist). A prison manager approved the use of an escort chain until Mr O'Donnell's mobility was regained and then single handcuff restraints (a set of handcuffs one end attached to the prisoner's wrist and one end attached to the officer's wrist) were to be applied.
18. Hospital staff found that Mr O'Donnell had sprained his ankle. Later that day, they sent him back to Leeds. Hospital staff did not give him a discharge letter.

Healthcare staff at Leeds chased the hospital for the discharge summary, but they did not receive a copy.

19. At approximately 11.00pm, staff called a code blue because Mr O'Donnell said that he had reduced muscle tone in his left side and slurred speech (symptoms associated with a stroke). Control room staff called an ambulance. A nurse recorded a NEWS2 score of zero, which indicated a low clinical risk. She had to leave Mr O'Donnell and attend another code blue, and when she returned to Mr O'Donnell's cell, he was asleep in bed. She woke him up and found that his symptoms had fully resolved. Mr O'Donnell asked to stay in prison. Due to staffing levels the decision was made to cancel the ambulance. Staff told Mr O'Donnell to rest in his cell and that he would be reviewed by a nurse in the morning. It was agreed that both healthcare staff and the landing officer would monitor Mr O'Donnell regularly overnight.
20. The next day, a nurse reviewed Mr O'Donnell and told him to continue resting in his cell. She asked his cell mate to raise the alarm if he was concerned about Mr O'Donnell's health.
21. At approximately 12:30pm, an officer radioed a code blue because Mr O'Donnell had right sided weakness, right side facial droop, and slurred speech. A nurse went to Mr O'Donnell's cell. She recorded a NEWS2 score of six, which indicated a medium to high clinical risk. Ambulance paramedics took Mr O'Donnell to hospital. Mr O'Donnell was escorted by two officers and restrained using an escort chain. A prison manager again recorded that the escort chain would be reviewed if Mr O'Donnell's mobility increased, and then single handcuffs were to be applied. Hospital staff confirmed that Mr O'Donnell had had another stroke and had a fractured ankle. Mr O'Donnell was admitted to hospital.
22. On 22 July, a prison manager authorised Mr O'Donnell's handcuffs to be removed. There were no restraints used for the duration of Mr O'Donnell's hospital admission.
23. On 3 August, Mr O'Donnell was discharged from hospital and was sent back to Leeds.
24. On 2 September, a healthcare administrator booked an appointment for Mr O'Donnell to see the community rehabilitation stroke team. That day, an officer radioed a code blue because Mr O'Donnell's facial droop and arm weakness had worsened. A nurse recorded a NEWS2 score of 10 (which indicated a high clinical risk) and he was sent to hospital by emergency ambulance. On 13 October, hospital staff discharged Mr O'Donnell and he returned to Leeds.
25. Healthcare staff at Leeds felt that Mr O'Donnell should not have been discharged from hospital because he had become bedbound and needed assistance with all his care needs. The next day, they sent him to a different hospital. Mr O'Donnell was taken there by taxi. He was escorted by two officers and was not restrained.
26. In hospital, Mr O'Donnell's health deteriorated, and he received end-of-life care. On 28 November, it was confirmed that Mr O'Donnell had died in hospital.

Cause of death

27. The coroner accepted the cause of death as provided by a hospital doctor and no post-mortem was carried out. The doctor gave Mr O'Donnell's cause of death as an ischaemic stroke.
28. At the inquest held on the 14 September 2023, the Coroner concluded that Mr O'Donnell died of natural causes.

Non-clinical findings

Restraints, security and escorts

29. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
30. The investigator reviewed the escort risk assessment for the 17 and 18 July (the prison could not locate the documentation for 15 and 16 July). Healthcare staff were concerned that Mr O'Donnell was having a stroke as well as suffering an injury to his leg. Mr O'Donnell used a wheelchair day to day and was in considerable pain after his fall and clearly unwell.
31. In both of the healthcare sections of the escort risk assessments, a nurse marked 'No' to the question 'Are there any medical objections to the use of restraints?' but then recorded that he had reduced mobility and could not speak at the time due to a possible stroke. On both occasions, healthcare staff did not complete the escort risk assessment accurately. This meant that the authorising managers were not fully aware of Mr O'Donnell's state of health and how this affected his risk of escape, which meant that the level of restraints authorised for Mr O'Donnell was not proportionate to the risk he posed.
32. We recommend:

The Governor should ensure that decision makers use the escort risk assessment form annexed to the Prevention of Escape Framework – External Escorts Policy Framework to ensure they consider all the relevant factors, including healthcare input about the prisoner's current state of health and mobility, and provide a record of defensible decision making.

Governor to note

Retention of evidence

33. PSI 58/2010 on the Prisons and Probation Ombudsman requires prisons to ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO.
34. We asked Leeds to provide us with the family liaison officer's log. The prison told us that the new computer system had lost a lot of the work saved and therefore they could not provide the family liaison officer's log. We therefore do not know if a family

liaison officer was promptly appointed and provided support to Mr O'Donnell's family.

35. We also asked Leeds to provide us with the escort risk assessments for the 15 and 16 July. They were not able to locate those risk assessments. We therefore are not able to assess whether the restraints used during the escorts were appropriate for Mr O'Donnell.
36. We bring these matters to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman

September 2023

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