Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason McDonagh, on 4 December 2023, following his release from HMP Five Wells

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Jason McDonagh died on 4 December 2023 following his release from HMP Five Wells on 1 December 2023. He died from ketoacidosis (a condition which can be caused by starvation and results from the body producing too many ketones). He was 36 years old. I offer my condolences to those who knew him.

5. Mr McDonagh refused to access the support and services available to him in prison and to prepare him for release into the community. We are satisfied that prison, probation and healthcare staff took all reasonable steps to get Mr McDonagh to engage both in the prison regime and to access the support and services available to him. We therefore make no recommendations. However, it is tragic that Mr McDonagh's lack of engagement resulted in him being released vulnerable, homeless, without access to community services, and ultimately resulted in his death.

6. Homelessness on release from prison is a significant and complex challenge which we see in a number of our investigations into post-release deaths. It is made all the more challenging when those whom services are designed to support refuse to engage and cannot access services they need. Partners working in this space face an ongoing challenge to improve engagement to prevent such deaths.

The Investigation Process

7. HMPPS notified us of Mr McDonagh's death on 11 December 2023.

8. The PPO investigator obtained copies of relevant extracts from Mr McDonagh's prison and probation records.

9. We informed HM Coroner for Northamptonshire of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

10. The Ombudsman's family liaison officer contacted Mr McDonagh's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of the report.

11. Mr McDonagh's family received a copy of the draft report. They did not make any comments.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Five Wells

13. HMP Five Wells is a category C male prison in Wellingborough which opened in 2022. The prison is operated by G4S. Healthcare services are provided 24 hours a day by Practice Plus Group.

Probation Service

14. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board. The Probation Service has links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

15. Mr Jason McDonagh was a registered sex offender. On 15 February 2023, he was convicted of a failure to comply with notification requirements, and he was sentenced to thirty months in prison.

16. Mr McDonagh was initially sent to HMP Bullingdon but was later transferred to HMP Five Wells on 22 February.

17. When he arrived, Mr McDonagh declined to see healthcare staff for his initial health screen. He was noted to be very unkempt and would not engage with anyone. Subsequently, Mr McDonagh was referred to the mental health team for review.

18. On 23 February, a nurse tried to carry out a mental health review. She recorded that Mr McDonagh would not respond verbally to her questions but instead would nod or use hand gestures. When asked if he wanted mental health support, Mr McDonagh shook his head.

19. Later that day, following a multidisciplinary meeting (MDT), a decision was made that healthcare staff would carry out daily welfare checks on Mr McDonagh.

20. On 1 March, a nurse carried out a further mental health assessment. She noted that Mr McDonagh would not speak and waved his hand to indicate that he did not want to speak. However, he was assessed as having mental capacity to make decisions for himself. It was noted that his capacity should be assessed on a regular basis.

21. During the following five months, the mental health team continued to monitor Mr McDonagh and his case was discussed on multiple occasions at the MDTs.

22. On 18 July, following an MDT, it was recorded in the medical records that Mr McDonagh was still refusing to engage with the healthcare team. A decision was made that he would no longer be discussed on a regular basis but instead would be discussed if any issues arose.

23. On 23 July, at a mental health review, it was recorded that Mr McDonagh unequivocally had mental capacity to make decisions.

24. Mr McDonagh would not engage with prison officers and did not fully participate in prison life.

Pre-release planning

25. On 31 October, a Community Offender Manager (COM) contacted a Prison Offender Manager (POM), to find out if Mr McDonagh's pre-release work had started. The POM responded and advised that he had refused to engage.

26. On 22 November, the COM and POM discussed Mr McDonagh and it is recorded that they were concerned about his lack of engagement. The COM said that in relation to his housing needs, she wanted to refer him for a place at an approved premises and to the local authority's homelessness team, but she was unable to do so without his consent. (Under the Homelessness Reduction Act 2017, public

authorities have a duty to refer service users whom they believe to be homeless or threatened with homelessness to the local authority. However, this requires the consent of the service user.)

27. Later that day, the POM tried to obtain Mr McDonagh's consent. She recorded that she explained to Mr McDonagh what they were trying to do but he still refused to provide consent.

28. On 1 December, Mr McDonagh was released from HMP Five Wells. The prison contacted the COM and told her that that Mr McDonagh had refused to participate with the release process, and he had refused to sign his licence agreement.

Post-release

29. Mr McDonagh did not attend the probation office for his appointment with the COM, which had been scheduled for 3.00pm on the day of release. Subsequently, she asked for Mr McDonagh to be recalled into custody for failing to adhere to one of his licence conditions.

Circumstances of Mr McDonagh's death

30. On 4 December, Northamptonshire Police were contacted by a member of the public who had found Mr McDonagh lying among some bushes in Croyland Gardens, Wellingborough. Both the police and paramedics attended the scene and Mr McDonagh was confirmed dead by paramedics at 9.41am.

Post-mortem report

31. The post-mortem report concluded that Mr McDonagh died of ketoacidosis. (There is no evidence in Mr McDonagh's medical records that he had diabetes.)

Coroner's inquest

32. We were advised by the coroner on 12 February that they were closing their investigation into Mr McDonagh's death, and an inquest would not take place.

Findings

33. We are satisfied that prison, probation and healthcare staff took all reasonable steps to get Mr McDonagh to engage both in the prison regime and to access the support and services available to him in prison and on release. He was considered to have the mental capacity to refuse mental health support and there was little staff could do except continue to encourage him to engage, which they did.

34. Due to his persistent lack of engagement and consent, Mr McDonagh's COM could not make referrals to the relevant agencies and as a result, Mr McDonagh was released from prison homeless. Homelessness on release from prison is a significant and complex challenge. This was particularly the case for Mr McDonagh who declined all the services and support potentially available to him (from healthcare to accommodation services) both in prison and to prepare him for release into the community.

Adrian Usher
Prisons and Probation Ombudsman **June 2024**

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