Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William McKee, a prisoner at HMP Channings Wood, on 22 April 2023

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

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.

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.

Mr William McKee died of heart disease on 22 April 2023 at HMP Channings Wood. He was 71 years old. I offer my condolences to Mr McKee's family and friends.

The clinical reviewer concluded that the care Mr McKee received at Channings Wood was partially equivalent to that which he could have expected to receive in the community. She found that Mr McKee's cholesterol levels had not been checked since March 2021 and despite having a heart condition, he had no care plan in place to manage his cardiovascular health.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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Summary

1. On 14 July 1989, Mr William McKee was convicted of arson and sentenced to life imprisonment. On 9 February 2016, he was moved to HMP Channings Wood.

2. In 2019, Mr McKee had a heart attack. He had a cardiac stent fitted (a thin tube inserted into the arteries to help increase the blood flow to the heart).

3. On 22 April 2022 at approximately 9.10am, a prison officer found Mr McKee lying unresponsive on the floor of his cell. He pressed the general alarm to alert staff. Officers responded and at 9.15am, they called a medical emergency code (which alerts healthcare staff and prompts the control room to call an ambulance immediately). Officers started CPR while they waited for healthcare staff to arrive.

4. At 9.20am, three nurses arrived. One of the nurses noted that Mr McKee was cold and had signs of rigor mortis. Despite this, they continued CPR. At 9.36am, paramedics arrived and told the nurses to stop CPR as Mr McKee was clearly dead.

5. The post-mortem report concluded that Mr McKee died from heart disease.

Findings

6. The clinical reviewer found that the care Mr McKee received at Channings Wood was partially equivalent to that which he could have expected to receive in the community. She found that Mr McKee's cholesterol levels had not been checked since March 2021 and that there was no care plan in place to manage Mr McKee's cardiovascular health.

Recommendations

- The Head of Healthcare should ensure that staff follow the NICE guidelines [CG181] on cardiovascular disease: risk assessment and reduction, including lipid modification, and that:
    - patients with high cholesterol have annual lipid checks; and
    - patients with cardiovascular disease have a long-term condition review and care plan.

The Investigation Process

7. HMPPS notified us of Mr McKee's death on 22 April 2023.

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

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

10. NHS England commissioned a clinical reviewer to review Mr McKee's clinical care at the prison. The investigator and clinical reviewer interviewed a nurse on 31 July 2023.

11. We informed HM Coroner for Plymouth of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. Mr McKee had no recorded next of kin so there was no family involvement in this investigation.

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

Background Information

HMP Channings Wood

14. HMP Channings Wood is a category C training and resettlement prison near Newton Abbot in Devon. It holds up to 710 male prisoners who have been sentenced. Practice Group Plus provides mental health, physical health and substance misuse treatment.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Channings Wood was in July 2022. Inspectors reported that arrangements for providing a rapid and skilled response to medical emergencies were comprehensive and overseen by the paramedic team. Staff were trained in the use of immediate life support skills and resuscitation equipment was appropriate and regularly checked. Prison staff provided the first response once the health care team had left the site, and most staff had received first aid training and could access automated external defibrillators (AEDs) on the wings.

16. Inspectors reported that not all patients with complex health needs had a care plan reflecting their current care or conforming to national clinical guidance. Two nurses with an interest in the care of patients with long-term conditions were assigned to review patients.

Independent Monitoring Board

17. 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 August 2022, the IMB reported that some prisoners from one wing said that waiting conditions in healthcare were inadequate and unsuitable for men with health conditions and disabilities. They reported that whilst access to emergency care had been maintained at a high level, long waiting times for routine appointments still occurred.

Previous deaths at HMP Channings Wood

18. Mr McKee was the tenth prisoner to die at Channings Wood since April 2020. Of the previous deaths, six were from natural causes, one was drug related and two were self-inflicted.

19. We have previously made a recommendation about care plans for patients with long-term health conditions. We were told that in September 2022, a care plan champion had been identified to work alongside primary care nurses to identify patients with care plans and ensure they were in place.

Key Events

20. On 14 July 1989, Mr William McKee, was convicted of arson and sentenced to life imprisonment.

21. On 9 February 2016, Mr McKee was moved to HMP Channings Wood.

22. In 2019, Mr McKee had a heart attack and went into cardiac arrest (where the heart stops beating). He was taken to hospital and had a cardiac stent fitted (a thin tube inserted into the arteries to help increase the supply of blood to the heart). Mr McKee also had chronic obstructive pulmonary disease (COPD, the term for a group of serious lung diseases). He was prescribed a range of medication, including statins to lower blood cholesterol (high cholesterol can increase the risk of heart attack and stroke) and medication for high blood pressure.

23. In March 2021, a GP at Channings Wood checked Mr McKee's cholesterol levels and found they were normal. He did not have any further cholesterol level checks before his death.

Events of 22 April

24. At approximately 9.10am, during a routine cell check, an officer found that when he pushed the door of Mr McKee's cell, it would not open fully. He managed to get the door to open slightly and saw that Mr McKee was lying motionless on the floor directly behind the door. In his statement, he said that he thought Mr McKee was dead as he was not breathing, and his eyes were fixed. He pressed the general alarm to alert staff.

25. Officers responded and arrived at Mr McKee's cell. A supervising officer (SO) pushed his way into the cell and at 9.15am, called a code blue (a medical emergency code used when a prisoner is unconscious that alerts healthcare staff and tells the control room to call an ambulance immediately). The SO found no sign of breathing or pulse, so started CPR.

26. While waiting for healthcare staff to arrive, another SO used an anti-barricade key to enable the door of Mr McKee's cell to be opened outwards. Once the door was opened, the SOs moved Mr McKee onto the landing and attached a defibrillator (used to identify a heartbeat and give an electric shock to restore the heartbeat to a normal rhythm).

27. At 9.20am, three nurses arrived. At interview, one nurse said that Mr McKee was cold to the touch, his jaw was stiff, and that signs of rigor mortis were present (stiffening of the body that occurs around two to six hours after death). The nurses applied a different defibrillator, but it could not find a heartbeat so did not give an electric shock. The nurses continued to give chest compressions until paramedics arrived.

28. At 9.36am, paramedics arrived and told the nurses to stop resuscitation attempts as Mr McKee was clearly dead.

Support for prisoners and staff

29. After Mr McKee's death, a hot debrief was held with 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.

Post-mortem report

30. The post-mortem report concluded that Mr McKee died of ischaemic heart disease (where the blood vessels supplying the heart are narrowed or blocked). Chronic obstructive pulmonary disease (COPD, a lung condition that causes breathing difficulties) was a contributing factor.

Findings

Clinical care

31. The clinical reviewer found that the care Mr McKee received at Channings Wood was partially equivalent to that which he could have expected to receive in the community.

32. Mr McKee was prescribed a range of medication for heart and cardiovascular conditions. The clinical reviewer found that Mr McKee last had his cholesterol levels checked in March 2021 and they were found to be normal, but after this he did not have any further cholesterol tests.

33. The clinical reviewer also found no evidence that Mr McKee had an annual long-term condition review or care plan specific to his cardiovascular health. We recommend:

    The Head of Healthcare should ensure that staff follow the NICE guidelines [CG181] on cardiovascular disease: risk assessment and reduction, including lipid modification, and that:

    - **patients with high cholesterol have annual lipid checks; and**
    - **patients with cardiovascular disease have a long-term condition review and care plan.**

Governor to Note

Emergency response

34. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, says that staff discovering a prisoner who is unresponsive must call an emergency code (code blue) without delay and convey the nature of the medical emergency to the control room.

35. We found that there was a delay of approximately five minutes between Mr McKee being found unresponsive on his cell floor and the ambulance being called. The officer who found Mr McKee pressed the general alarm rather than calling a code blue as he should have done (which would have prompted the control room to call an ambulance). The code blue was not called until five minutes later when other staff arrived.

36. We found that this delay did not affect the outcome for Mr McKee as he was dead when found. However, a similar delay in the future could have a significant impact on the outcome for a patient who is in a life-threatening condition, and who needs urgent medical assistance. We bring this to the Governor's attention.

Inquest

37. The inquest, held on 22 January 2025, concluded that Mr McKee died from natural causes.

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