Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stevie McCormack a prisoner at HMP Altcourse on 13 October 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Stevie McCormack died at HMP Altcourse on 13 October 2015, of complications arising from chronic substance misuse, including liver cirrhosis, pneumonia, chronic obstructive pulmonary disease and cellulitis of his legs. He was 40 years old. I offer my condolences to Mr McCormack's family and friends.

Mr McCormack had longstanding, serious health problems due to his lifestyle. I am satisfied that he received appropriate clinical care and support in prison to help him deal with his dependencies. While the investigation revealed weaknesses in safety checks on prisoners, I do not consider that staff at the prison could have done anything to prevent Mr McCormack's death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

Contents

Summary 1
The Investigation Process 2
Background Information 3
Key Events 4
Findings 9

Summary

Events

1. On 6 October 2015, Mr Stevie McCormack was sentenced to 14 days in prison for breach of a supervision order and sent to HMP Altcourse. Mr McCormack had a long history of alcohol and drug abuse and his general health was poor. He had been diagnosed with chronic obstructive pulmonary disease, hepatitis C, leg ulcers and depression.

2. When he arrived at Altcourse, Mr McCormack began alcohol detoxification and methadone maintenance programmes. A few days later, staff began to support him using Prison Service suicide and self-harm prevention procedures, known as ACCT, after he reported harming himself.

3. On the evening of 12 October, an officer locked Mr McCormack in his cell for the night. The officer said he seemed more drowsy than normal, but thought this was due to his medication. At checks during the night, Mr McCormack appeared to be asleep. The next morning, an officer checked Mr McCormack at 7.00am, as part of the ACCT monitoring process. Another officer unlocked his cell at 7.37am. Neither officer attempted to get a response from him to ensure his wellbeing. Both assumed he was still sleeping.

4. At 8.56am, the officer who had unlocked Mr McCormack's cell earlier went to check him and saw that he had not moved at all. She asked another officer to try to wake him. The officer went into the cell at 9.04am and found Mr McCormack cold and stiff. He called an emergency code blue and other staff responded. Nurses attempted to resuscitate him until the paramedics arrived at 9.15am. After a brief assessment, the paramedics recorded that Mr McCormack had died.

Findings

5. We are satisfied that Mr McCormack received an appropriate standard of healthcare at Altcourse, equivalent to that he could have expected to receive in the community.

6. Staff who checked Mr McCormack and unlocked his cell on the morning of 13 October did not check his welfare adequately, as national and local instructions require. Since Mr McCormack's death, the prison has held a training session and issued further guidance to staff about checking that prisoners are safe and well at unlock and during ACCT observations. We therefore do not make a recommendation about this matter.

7. Mr McCormack had been dead for some time when staff tried to wake him at 9.04am and it is apparent that rigor mortis had set in. When rigor mortis is present, there is no hope of resuscitation and it is inappropriate to attempt it.

Recommendation

- The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

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

9. NHS England commissioned a clinical reviewer to review Mr McCormack's clinical care at the prison.

10. The investigator visited Altcourse on 19 October 2015. She obtained copies of relevant extracts from Mr McCormack's prison and medical records.

11. The investigator interviewed five members of staff and two prisoners at Altcourse on 12 and 13 November 2015. The clinical reviewer joined her for interviews on the second day.

12. We informed HM Coroner for Liverpool and Wirral area of the investigation, who gave us the results of toxicology tests and the post-mortem examination. We have sent the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr McCormack's uncle, to explain the investigation. Mr McCormack's uncle did not have any specific matters for our investigation to consider.

14. Mr McCormack's uncle received a copy of the initial report. He made a few comments about factual accuracy, which we are grateful for, and have changed within the report. He had no further questions about the report but feels concerned about some aspects of his nephew's care at Altcourse and is seeking legal advice.

Background Information

HM Prison Altcourse

15. HMP Altcourse is a local prison in Liverpool which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by G4S custodial services and holds up to 1,133 sentenced and remanded adult and young adult men. G4S runs the company that provides primary healthcare services at the prison.

16. Altcourse is made up of seven houseblocks, divided into individual units. These units hold between 60 and 95 prisoners. Furlong Red is the detoxification unit and a nurse is based on the unit from 7.00am to 8.00pm.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Altcourse was in June 2014. Inspectors found that prisoners had satisfactory access to most health services. There was a good range of clinical and screening services. Prisoners were generally positive about the care provided, especially in the inpatient unit. The clinical management of substance misuse was improving, with a full range of therapeutic options. Prescribing and care were robust and recovery focused, with reviews at appropriate intervals.

Independent Monitoring Board

18. 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 June 2015, the IMB considered that in general Altcourse was a good establishment but there were challenges and room for improvement.

Previous deaths at HMP Altcourse

19. There have been seven deaths from natural causes at Altcourse since the beginning of 2014. Mr McCormack’s was the fifth. There were no significant similarities with the circumstances of the previous deaths.

Key Events

20. Mr Stevie McCormack was released on licence from Altcourse on 25 August 2015. On 6 October, he was sentenced to 14 days in prison for breach of a supervision order and he went back to Altcourse. Mr McCormack had been in prison several times.

21. Mr McCormack had a long history of substance misuse, including heroin, cannabis, crack cocaine and benzodiazepines and was well known to the drug treatment service at HMP Altcourse. His drug misuse, particularly injecting drugs, had led to serious health problems, including deep vein thrombosis (a blood clot in the veins of the legs); and pulmonary embolism – a blockage in the blood vessel that carries blood from the heart to the lungs, causing severe breathing difficulties. Mr McCormack had hepatitis C - a blood borne virus, usually transmitted through needle-sharing. It leads to liver cirrhosis (scarring) and reduces the ability of the liver to remove toxins from the blood. Mr McCormack did not show any acute symptoms of the disease and was not receiving treatment for it. He had been diagnosed with depression and chronic obstructive pulmonary disease (a progressive lung disease which makes it difficult to breathe).

22. A nurse assessed Mr McCormack at his initial health screen. He tested positive for cocaine, cannabis, benzodiazepines and morphine and was referred to the GP. Mr McCormack asked for methadone treatment (for opiate dependency) and treatment for withdrawal from alcohol. He said he had not had any methadone for a few days. She thought Mr McCormack looked very thin and unkempt. He was of slight build and his weight, 8st 0lb, was significantly lower than his last recorded weight of 9st 8lb in July 2015.

23. Mr McCormack went to Furlong Red, the detoxification unit for new prisoners and a prison GP assessed his needs. Mr McCormack said he drank seven cans of strong lager a day and smoked eight bags of heroin. He told the GP he had leg ulcers but was too tired to have them cleaned that night. The GP prescribed chlordiazepoxide (Librium) to prevent seizures related to alcohol withdrawal.

24. The next day, a nurse completed an opiate withdrawal assessment, which indicated Mr McCormack had clear signs and symptoms of opiate withdrawal. He referred him to a GP, who prescribed a methadone stabilisation and maintenance programme, starting that evening. Mr McCormack attended the normal induction programme for prisoners on Furlong Red.

25. At 11.00am on 8 October, Mr McCormack told a prison GP that he felt depressed and was not sleeping or eating well. The GP prescribed an antidepressant (citalopram) and paracetamol. Mr McCormack said he had tried to burn his face with a lighter the day before and that he had cut his wrists and burnt his hands in the past. The GP began Prison Service suicide and self-harm prevention procedures, known as Assessment, Care in Custody and Teamwork (ACCT) and referred him to the mental health team. Mr McCormack cut himself at lunchtime. Staff continued to support him under the ACCT procedures until his death.

26. Around 5.00pm, while waiting in the queue for his meal, a prisoner hit Mr McCormack on the back of his head with a plastic tray. A nurse examined Mr

McCormack and noted he had injuries on the back of his head and left ear. (Another prisoner suggested that a prisoner on another wing had paid someone to assault Mr McCormack because of drug debts outside prison.)

27. At 6.00pm, a prison GP reviewed Mr McCormack and noted he had a cut on his left ear lobe, but no head wound or loss of consciousness. Mr McCormack could not be monitored in the healthcare unit as there were no beds available, so he went back to Furlong Red. Nurses were asked to carry out four-hourly observations (pulse, blood pressure and pupil reactions) and Mr McCormack was booked to see the GP the next day. His observations were within normal limits when checked at 7.00pm and before he returned to the wing at 8.25pm. A nurse reviewed Mr McCormack at 12.30am. He told her he had vomited once but his observations were normal and he was fully orientated. There should have been further checks at 4.30am and 8.30am but none were recorded.

28. At 1.55pm, a prison GP carried out another set of observations and decided these should continue. He prescribed codeine tablets for pain relief and liquid meal supplements. He described Mr McCormack as emaciated. A nurse dressed Mr McCormack's leg ulcers. There is no record of further clinical observations.

29. On 12 October, Mr McCormack collected his medication as normal. A substance misuse worker completed a drug recovery unit compact with him and he later attended an alcohol awareness session. A prison GP reviewed Mr McCormack's drug chart and stopped citalopram because there was a possibility of an adverse interaction with methadone (potentially causing a disturbance in the heart rhythm). The GP arranged to review Mr McCormack the next day to see if he wanted an alternative antidepressant.

30. That evening, Mr McCormack went back to his cell at 7.40pm and an officer locked him up for the night. The officer said he seemed all right, but a little drowsy, which he thought might be due to the detoxification medication. Officer A took over at 8.35pm.

Events of 12/13 October

31. As part of the ACCT suicide and self-harm prevention procedures, staff were expected to check Mr McCormack twice an hour, day and night. He was awake for the first few checks but by 10.02pm was asleep, fully clothed, on the bed (Officer A said prisoners sometimes slept in their clothes, so he did not find this unusual). Mr McCormack appeared to be asleep throughout the night. The officer said he would usually record if a prisoner had moved position during the night and shortly after 3.00am, he recorded in the ACCT document that Mr McCormack had moved). Around 5.45am, he did a routine early morning count of all the prisoners on the wing, but did not wake prisoners during this count.

32. At 7.00am, Officer B took over from Officer A. She checked Mr McCormack at 7.02am and thought he was asleep. She thought the light was still on in the cell and that Mr McCormack was lying in his bed, facing the wall with his legs drawn up. She did not try to get a response from him, or observe him breathing, although this was a requirement of the suicide and self-harm prevention

procedures. A short while later, Officer C came on duty and was responsible for ACCT checks.

33. All prisoners are normally unlocked at around 7.20am. At 7.37am, Officer C unlocked Mr McCormack's cell, but did not check his wellbeing or get a response from him.

34. At 7.54am, another prisoner, responsible for handing out milk and breakfast packs, went to Mr McCormack's cell and looked in, as he had not collected his breakfast. He did not alert staff to any concerns. Officer C checked Mr McCormack at 8.18am. She briefly opened the unlocked cell door and stepped into the doorway. She wrote in the ACCT document, "Appears asleep, small movements".

35. CCTV shows that at 8.35am, Officer C went into Mr McCormack's cell and stayed there for 20 seconds. She recorded this in the ACCT document at 8.48am and wrote, "Appears asleep". She told us she had watched Mr McCormack to check whether she could see him breathing and thought his shoulders had moved.

36. At around 8.40am, officers locked up prisoners who had collected their medication, but were not going to an induction session or work. Officer D locked Mr McCormack's cell at 8.45am and went to the centre office at 8.56am.

37. Shortly afterwards, Officer C went to the ground floor and looked briefly into Mr McCormack's cell. She said that Mr McCormack was lying in the same position he had been in since the start of her shift and she had an uneasy feeling.

38. CCTV shows Officer C left the landing and went to the centre office at 8.58am. She spoke to Officer D, who could not remember the exact words, but said she had told him she had been into Mr McCormack's cell and looked at him to see if he was breathing. She asked him to go and check Mr McCormack was all right and added that they needed to wake him up anyway. Officer D said it was clear Officer C was worried and he had a feeling that Mr McCormack had died. When asked by the investigator, he said that she did not check Mr McCormack herself as she did not want to be the one to touch his shoulder, although she said she did not think he was dead.

39. At 9.03am, Officer D went to check Mr McCormack, who was lying in bed, facing the wall. His knees were bent up, with one leg hanging over the side of the bed. The officer called his name, but Mr McCormack did not respond. The officer put his hand on his shoulder and felt it was very cold. He tried to rouse him by shaking him, but got no response, so tried to turn Mr McCormack onto his back. His body felt stiff. He radioed a code blue emergency at 9.05am and the control room called an ambulance immediately.

40. Officer D said he tried again to put Mr McCormack onto his back so he could begin resuscitation, but could not get him into a suitable position because his body was too stiff. He said the front of Mr McCormack's body was warm, but his back was very cold. Officer C was at the cell door, and gave him her resuscitation face mask. A prison manager arrived around ten seconds later. He and Officer D tried to place Mr McCormack on the floor. Officer D said he

thought Mr McCormack was probably dead, but wanted to do his best to try and save him. A nurse who was working on the unit arrived a minute after the prison manager.

41. The nurse started chest compressions, although she wondered if it was already too late as Mr McCormack was very cold. She said that they had been unable to lay him flat because his body was stiff. The unit manager and another nurse arrived and together they moved Mr McCormack outside the cell into the central area where there was more space. The nurses continued the resuscitation efforts, gave Mr McCormack oxygen and applied the defibrillator, which found no shockable heart rhythm. Paramedics arrived at the prison at 9.10am and reached Mr McCormack at 9.15am. They assessed him, but did not attempt resuscitation. At 9.21am, the paramedics recorded that Mr McCormack had died.

Contact with Mr McCormack's family

42. An officer was appointed as the prison's family liaison officer. After a briefing, she and a prison chaplain went to see Mr McCormack's father, and arrived at 11.55am. They informed him of his son's death and offered condolences. His father told them that his brother was regarded as his next of kin. The staff went to his home, but no one was there. The next day, the officer tried again, but there was still no answer and learnt from a neighbour that he was on holiday. She left a letter, asking him to ring Altcourse as soon as he got back. At 4.10pm that day, Mr McCormack's uncle telephoned the prison and spoke to the safer custody manager, who told him about his nephew's death.

43. In line with national guidance, the prison contributed towards the cost of Mr McCormack's funeral.

Support for prisoners and staff

44. After Mr McCormack's death, the Head of Security debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

45. Staff informed all prisoners of Mr McCormack's death and offered the support of prisoner carers. Staff reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr McCormack's death.

Post-mortem report

46. A post-mortem examination found evidence of severe liver cirrhosis, indicative of end stage disease. Mr McCormack's lungs showed pulmonary emphysema (smoking-related disease), active infection and incomplete healing.

47. The toxicology tests showed the presence of methadone, citalopram, chlordiazepoxide, paracetamol and codeine (all prescribed to Mr McCormack) and small traces of diazepam and an opioid medication (neither of which had been prescribed to Mr McCormack). None of the substances found were at toxic levels.

48. The cause of death was liver cirrhosis, pneumonia, chronic obstructive pulmonary disease and cellulitis of the legs with ulceration. The pathologist did

not consider that the head injury Mr McCormack suffered on 8 October had contributed to his death.

Findings

Clinical care

49. The clinical reviewer considered that Mr McCormack received appropriate treatment from the prison healthcare team. He had regular input from the substance misuse team and mental health services when required. She concluded that Mr McCormack received a standard of care equivalent to that he could have expected in the community and we are satisfied that Mr McCormack received appropriate care at Altcourse.

50. The clinical reviewer's only concern was that nurses did not record the four-hourly neurological observations requested by two GPs on 8 and 9 October. She has made a recommendation in her review which the Head of Healthcare will need to address. We do not repeat this here, as this was not directly related to the circumstances of Mr McCormack's death.

Unlocking prisoners

51. When officers unlock cells they should take active steps to check on a prisoner's well-being. The Prison Officer Entry Level Training (POELT) manual states that, "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

52. Prison Service Instruction (PSI) 75/2011, covering residential services states that:

> "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 has died. This is not acceptable…
>
> "The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being 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."

53. A Safer Custody Bulletin issued by Altcourse in July 2014, reflects the PSI and drew attention to the recommendation from PPO investigations.

53. Mr McCormack was subject to twice-hourly ACCT checks. Neither Officer B, who took over responsibility for his ACCT checks at 7.00am on 13 October, nor Officer C, who unlocked him thirty-five minutes later, ensured that he was safe and well, either by observing him breathing or getting a response of some sort.

54. Although it would not have prevented Mr McCormack's death (as it is evident that he had been dead for several hours by 9.00am), Officer C should have tried to

get a response from McCormack herself at 8.35am and at 8.56am when she saw he had not moved at since the beginning of her shift.

55. After Mr McCormack's death, the Safer Custody Department issued a bulletin (in October 2015), reminding staff at handovers and unlock to "visually identify" that prisoners subject to ACCT checks are safe and well. The bulletin also reminded staff that, when they unlock the cell of a prisoner who is being monitored under ACCT procedures, they must ensure he is safe and well. The prison held additional training for staff, with a focus on getting a response from all prisoners at unlock and accurately recording observation times. We are satisfied that the prison had taken appropriate steps to address this concern and therefore do not make a formal recommendation.

Emergency response

56. European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation.

57. We consider the resuscitation attempt was unnecessary. There were objective signs that Mr McCormack had been dead for some time. His skin was discoloured, he was cold and his muscles were rigid, showing that rigor mortis had set in. Despite this nurses attempted cardiopulmonary resuscitation.

58. We understand that the natural inclination of prison and healthcare staff is to begin emergency first aid by giving life support, but attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. Staff should be given clear guidance that when rigor mortis has set in, resuscitation should not be started. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

Prisons &
Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141