

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony McGuire a prisoner at HMP Featherstone on 24 July 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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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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 Anthony McGuire died on 24 July 2016 of a heart attack while a prisoner at HMP Featherstone. Mr McGuire was 52 years old. I offer my condolences to Mr McGuire's family and friends.

Mr McGuire suffered from high blood pressure and chronic lung disease. Healthcare staff managed his long-term conditions well and reviewed him frequently, prescribing appropriate medication when required. I am satisfied that Mr McGuire received a good standard of healthcare at Featherstone, equivalent to that he could have expected to receive in the community.

I am concerned that the prison did not notify Mr McGuire's family that he had been admitted to hospital. A family liaison officer did not contact Mr McGuire's next of kin to offer ongoing support until three days after a prison manager told them of his 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

January 2017

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Summary

Events

1. In July 2014, Mr Anthony McGuire was sentenced to five years imprisonment for robbery. He was transferred to HMP Featherstone in December 2014. Mr McGuire suffered from high blood pressure and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). He smoked cigarettes and had a history of substance misuse.
2. At an initial reception screen at Featherstone, a nurse noted that Mr McGuire suffered from COPD and high blood pressure. The following day, a prison GP reviewed Mr McGuire's prescription and prescribed appropriate medication to treat his conditions. Over the next 15 months, healthcare staff monitored Mr McGuire's chronic conditions frequently and reviewed his COPD care plan. Mr McGuire started treatment for high blood pressure which was subsequently well controlled. Doctors monitored his medication regularly and prescribed additional drugs to treat exacerbations of COPD when required.
3. On 23 July 2016, at around 12.00pm, Mr McGuire pressed his cell bell and reported chest pain to an operational support grade, who called an emergency medical code. An ambulance was called and additional staff arrived within minutes and entered Mr McGuire's cell. A prison manager suspected Mr McGuire was having a heart attack and tried to make him comfortable while they waited for an ambulance. At 12.39pm, an ambulance arrived and took Mr McGuire to hospital, where he was admitted for a heart attack.
4. On 24 July, Mr McGuire started to experience chest pain while talking to escort officers and subsequently collapsed onto his hospital bed. One of the officers pressed the hospital's emergency call button and moved Mr McGuire so that he was lying flat. In the meantime, the other officer removed the escort chain. Hospital staff attended immediately and attempted to resuscitate Mr McGuire but, a doctor confirmed that he died at 1.50pm.

Findings

5. We are satisfied that healthcare staff managed Mr McGuire's chronic illnesses well. They reviewed him frequently and treated his conditions appropriately. The clinical reviewer concluded that Mr McGuire's clinical care was of a good standard, equivalent to that he would have expected to have received in the community.
6. The investigation found that although there was a slight delay in entering Mr McGuire's cell, the operational support grades' decision to wait for support was reasonable in the circumstances. The emergency protocol was followed in line with national policy.
7. Officers restrained Mr McGuire with an escort chain when he went to hospital on 23 July. A prison manager conducted a full risk assessment and we are satisfied that the level of restraint was appropriate. We are pleased that the escort chain

was removed immediately after Mr McGuire collapsed and did not impact upon the resuscitation attempt.

8. We are concerned that the prison did not notify Mr McGuire's family that he had been admitted to hospital. Although Mr McGuire's next of kin was appropriately informed of his death, the family liaison officer did not make contact with them for a number of days.

Recommendations

- The Governor should ensure that the prison complies with Prison Service guidance about contacting the families of deceased or seriously ill prisoners. Where it has not been possible for the family liaison officer to attend, contact should be arranged as soon as possible afterwards.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.
10. The investigator obtained copies of relevant extracts from Mr McGuire's prison and medical records.
11. The investigator interviewed one member of staff and one prisoner at HMP Featherstone on 30 August 2016.
12. NHS England commissioned a clinical reviewer to review Mr McGuire's clinical care at the prison.
13. We informed HM Coroner for Staffordshire South of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr McGuire's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not want any involvement in the investigation.
15. The initial report was shared with the prison service. The prison service did not find any factual inaccuracies.

Background Information

HMP Featherstone

16. HMP Featherstone is a medium security prison that holds nearly 700 men. Care UK provides healthcare services at the prison and there are no inpatient facilities. Doctors consult at the prison from Monday to Friday. Nurses run clinics for chronic conditions, substance misuse and mental health.

HM Inspectorate of Prisons

17. The most recent published inspection of HMP Featherstone was in October 2013. (There has been an unannounced inspection since, but the findings have not been published.) Inspectors reported that although overall clinical care was good, prisoners sometimes waited too long for an appointment, with many external hospital appointments cancelled owing to a lack of escort staff.

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 October 2015, the IMB reported that despite considerable improvements to services provided by the healthcare department, there were concerns over issues relating to cancellation of appointments at outside hospitals.

Previous deaths at HMP Featherstone

19. Mr McGuire was the second prisoner to die from natural cause at Featherstone since January 2014. We have made a recommendation on family liaison before, although the circumstances are different between the two deaths.

Key Events

20. On 4 July 2014, Mr Anthony McGuire was sentenced to five years imprisonment for robbery and was sent to HMP Birmingham. He was transferred to HMP Featherstone on 16 December 2014. Mr McGuire suffered from a number of chronic health conditions, including high blood pressure and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). He was a long-term smoker of cigarettes.
21. At an initial reception screen at Featherstone, a nurse noted that Mr McGuire had a history of substance misuse and was being treated and monitored for COPD and high blood pressure. The next day, a prison GP reviewed Mr McGuire's medication and prescribed ramipril (a blood pressure medication) and inhalers to treat COPD.
22. Over the next 15 months, healthcare staff monitored Mr McGuire's blood pressure which was consistently normal, and reviewed his COPD care plan frequently. Doctors reviewed his medication and prescribed additional antibiotics, steroids and bronchodilators to treat exacerbations of COPD and chest infections when required. Healthcare staff offered smoking cessation advice on numerous occasions but Mr McGuire declined help and support to stop smoking.
23. Between March and May 2016, Mr McGuire presented under the influence of illicit substances on four occasions. A member of healthcare staff reviewed him each time and his observations, including his blood pressure, were documented within the normal limits.
24. On 13 May, a prison GP examined Mr McGuire after he reported ongoing lower back pain. He did not identify any abnormalities and prescribed paracetamol for the pain. On 23 May, Mr McGuire reported a recent dizzy spell to a nurse, but his blood pressure was normal and he did not present with any additional symptoms. Doctors and healthcare staff continued to review Mr McGuire's medication frequently.

Events from Saturday 23 July to Sunday 24 July 2016

25. On 23 July, at around 12.00am, Mr McGuire pressed his cell bell and an operational support grade (OSG) responded. He found Mr McGuire stooped over in the middle of his cell. He spoke to him through the observation hatch and suspecting a stroke, issued an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing problems) at 12.01am. The control room called an ambulance. He monitored Mr McGuire through the observation hatch while he waited for additional staff to respond.
26. Within minutes, a prison manager and an officer arrived. They entered Mr McGuire's cell. He was rolling around on his bed clutching his chest. The manager tried to make Mr McGuire comfortable. At 12.18am, he asked the control room to contact the ambulance service for an update. While waiting for the ambulance to arrive, the officer monitored Mr McGuire and the manager prepared the escort paperwork.

27. The ambulance arrived at the prison at 12.39am and paramedics attended to Mr McGuire. At 1.12am, the paramedics took Mr McGuire to hospital. Two officers escorted him using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer.) Hospital staff diagnosed Mr McGuire with a heart attack and admitted him for treatment.
28. On 24 July, at around 7.45am, two officers took over as Mr McGuire's escort officers. They noted that Mr McGuire appeared to be in good spirits throughout the morning and that he had a shower. At about 1.15pm, while sitting on the edge of his bed talking, Mr McGuire started to experience chest pain and collapsed backwards. An officer pressed the emergency call button and moved Mr McGuire so that he was lying flat on the bed. In the meantime, the other officer removed the escort chain. Hospital doctors and nurses attempted to resuscitate Mr McGuire but were not successful and a doctor confirmed that Mr McGuire had died at 1.50pm.

Contact with Mr McGuire's family

29. At 3.50pm that day, a prison manager arrived at Mr McGuire's sister's house to inform her of his death. He offered his condolences and gave her the contact details for the family liaison officer. On 27 July, the family liaison officer contacted Mr McGuire's next of kin to offer her condolences and support. She remained in frequent contact with the family.
30. Mr McGuire's funeral took place on Wednesday 24 August. The prison contributed towards the costs of the funeral in line with national policy.

Support for prisoners and staff

31. After Mr McGuire's death, the prison debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. There is no documented record of the meeting; a prison manager told the investigator that it took place informally.
32. The prison posted notices informing other prisoners of Mr McGuire'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 McGuire's death.

Cause of death

33. The coroner confirmed that Mr McGuire died of a heart attack. High blood pressure and lung disease were contributory factors.

Findings

Clinical care

34. Mr McGuire had long-term health problems and risk factors associated with heart disease, including high blood pressure, COPD, and he smoked cigarettes. Healthcare staff treated his conditions with appropriate medication and regularly monitored his blood pressure, which stabilised after treatment. The clinical reviewer concluded that healthcare staff managed Mr McGuire's chronic conditions well. They gave him advice to stop smoking and reduce his risk of cardiovascular disease but he refused to stop or accept support. Doctors reviewed Mr McGuire's prescriptions frequently and prescribed additional medications to treat exacerbations of COPD when required.
35. We are satisfied that Mr McGuire received a good standard of care at Featherstone, equivalent to that he could have expected to receive in the community.

Emergency response

36. The OSG responded quickly to Mr McGuire's cell bell and called the correct emergency code. In his statement, he said that he waited for support to arrive in line with Featherstone's local policy for entering cells at night. This states that while no cell should be opened unless a minimum of two officers are present, the preservation of life must take precedence. Although his decision not to enter the cell caused a short delay in Mr McGuire receiving attention, Mr McGuire was responsive and did not need immediate life saving treatment such as cardio pulmonary resuscitation (CPR). He also maintained visual and verbal contact with him while waiting for additional staff to arrive. We are satisfied that his decision not to open Mr McGuire's cell did not affect the outcome and was reasonable in the circumstances.
37. The control room called an ambulance immediately after the emergency code blue was issued, in line with prison service instructions. The prison manager made arrangements that allowed for Mr McGuire's swift escort to hospital and requested an update following concerns about the amount of time the ambulance was taking. Although the paramedics arrival was delayed, this was not a prison fault and we are satisfied that prison staff responded appropriately and did all they could to ensure that Mr McGuire received emergency medical treatment as quickly as possible.

Use of Restraints

38. When prisoners have to travel outside prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility. Decisions should be kept under review as circumstances change.

39. When Mr McGuire was taken to hospital on 23 July, the prison manager decided that he should be escorted by two officers and restrained by an escort chain. A full risk assessment indicated that Mr McGuire presented a medium risk to the public and should be restrained by single cuffs, in line with Featherstone's local security strategy. The manager told the investigator that he re-visited the assessment prior to discharge and authorised the use of an escort chain as Mr McGuire had chest pains and the paramedics needed space to attend to him. He was mobile and conscious when he went to hospital. We are satisfied that this decision was reasonable in the circumstances.
40. Featherstone's local policy states that a prisoner's initial risk assessment should be reviewed within 72 hours of admission to hospital or when there has been any relevant change in circumstances. We are pleased that the escort officer acted promptly and removed Mr McGuire's escort chain immediately after he collapsed.

Family contact

41. Prison Rule 22 states that if a prisoner dies or becomes seriously ill then the governor should 'at once' inform a prisoner's spouse or nominated next of kin. PSI 64/2011 Safer Custody, requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death.
42. There is no indication that the prison told Mr McGuire's next of kin that he had been admitted to hospital and we are concerned that this may have been a missed opportunity for his family to see him before he died. While we recognise that a prison manager broke the news of Mr McGuire's death to his next of kin in person, we are also concerned that the family liaison officer did not make contact to offer additional information and support until a further 3 days had passed. We make the following recommendation:

The Governor should ensure that the prison complies with Prison Service guidance about contacting the families of deceased or seriously ill prisoners. Where it has not been possible for the family liaison officer to attend, contact should be arranged as soon as possible afterwards.

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