Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony McCarthy a prisoner at HMP Whatton on 21 July 2016

A report by the Prisons and Probation Ombudsman
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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 McCarthy died on 21 July 2016 of pneumonia and a neck tumour at hospital. He was 75 years old. I offer my condolences to Mr McCarthy's family and friends.

Mr McCarthy complained about problems swallowing but consistently refused to have examinations. On 2 July, he slipped in HMP Whatton and had to go to hospital for a femur operation. During this admission, oncology specialists diagnosed cancer.

I am satisfied that Mr McCarthy received a good standard of care at Whatton, even though he declined to have tests. However, I am concerned that the prison did not inform Mr McCarthy's next of kin when he was seriously ill. In addition, I am not satisfied that the decision to use restraints when Mr McCarthy went to hospital was made with the required healthcare input. Whatton's practice with regard to restraints on the seriously ill appears inconsistent and I am disappointed to have to raise this matter again.

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 **February 2017**

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Summary

Events

1. In September 2005, Mr Anthony McCarthy was convicted of manslaughter and sentenced to life imprisonment. He had been at HMP Whatton since April 2013. Tests showed that he had mild lung disease that did not require treatment.

2. Healthcare staff at Whatton saw Mr McCarthy frequently to monitor his conditions. Referrals, treatment, and medication were appropriate. He attended hospital outpatient appointments. In March 2016, Mr McCarthy complained about problems swallowing his food and that he was losing weight but he refused to undergo any tests. A prison GP and nurses frequently discussed with him how to improve his diet, exercise and stop smoking. They also made referrals for hospital investigations.

3. At about 8.50am on 2 July 2016, Mr McCarthy slipped in the wing corridor. He was conscious but was unable to move. An officer went to the office telephone to summon help. A passing healthcare assistant arrived and, after telephoning a nurse for advice, she stayed with Mr McCarthy. A nurse then attended and asked the control room to call an ambulance. Paramedics took him to hospital.

4. Hospital tests showed Mr McCarthy had broken his femur. Further tests showed Mr McCarthy had a neck tumour, which was diagnosed on 8 July. Mr McCarthy had a cardiac arrest on 10 July following which hospital staff successfully resuscitated him. The prison did not inform his family in a timely manner of this rapid deterioration.

5. Mr McCarthy's condition deteriorated further. He died in hospital on 21 July.

Findings

6. The clinical reviewer said that she had no reason to believe that Mr McCarthy was incapable of understanding the information he was given about the seriousness of his illness and his decision not to pursue investigations and treatment. We agree with the clinical reviewer that Mr McCarthy's treatment was at least as good as that he would have received in the community.

7. Mr McCarthy was initially restrained by an escort chain when he went to hospital. We are not satisfied this was appropriate. The risk assessment was based on insufficient medical input and information on how his condition affected his risk. Before he went for surgery, a manager reviewed the risk assessment, and authorised that the escort chain should be removed.

8. We are also concerned that the prison did not inform Mr McCarthy's next of kin promptly when he was seriously ill.

Recommendation

- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

11. The investigator interviewed one member of staff and a prisoner at HMP Whatton on 18 August. She conducted a telephone interview with a member of healthcare staff on 24 August.

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

13. We informed HM Coroner for Nottinghamshire 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 McCarthy's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know about the chain of events which led to Mr McCarthy going to hospital.

15. Mr McCarthy's family received a copy of the initial report. They did not make any comments.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Whatton

17. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences.

18. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The healthcare centre is open seven days a week. GPs from a local practice provide specialist clinics for older prisoners and those with chronic conditions and there is an out-of-hours service. There are no inpatient beds, but there is a palliative care suite in the healthcare centre, called The Retreat, for end of life care.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Whatton was in February 2012. Inspectors reported that the quality of healthcare was good, and relationships between healthcare and prison staff were effective.

Independent Monitoring Board

20. 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 May 2016, the IMB reported that the elderly prison population was 37% and was a severe drain on prison resources. They said that the healthcare department struggled to care for the increasingly older population with their variety of complaints and conditions. They said that the healthcare facilities were not fit for purpose and compared badly with those in the community. Over the previous year, a business case to improve physical healthcare facilities was prepared, but was unsuccessful because funding from the NHS was no longer available.

Previous deaths at HMP Whatton

21. Mr McCarthy was the ninth prisoner to die from natural causes at Whatton since January 2015. There has been one other death since. There were similarities between the circumstances of Mr McCarthy's death and previous deaths at the prison where we have made recommendations about the use of restraints on frail, prisoners with limited mobility.

Key Events

22. On 8 September 2005, Mr Anthony McCarthy was sentenced to life imprisonment for manslaughter. Mr McCarthy moved to HMP Whatton on 4 April 2013. At his initial reception medical screen, he told a nurse that he was a moderate drinker and smoker and had no ailments. He declined smoking cessation advice.

23. Shortly after arriving at Whatton, prison staff noted he had difficulty remembering appointments and how to keep himself and his cell clean. He was described as looking dishevelled and dirty. On 29 May 2013, a mental health triage nurse completed an assessment. Mr McCarthy told her that in previous prisons he had had contact with mental health services, as he was sometimes forgetful. She noted he did not need any mental health assistance.

24. On 4 November, Mr McCarthy told a nurse that he had chronic obstructive pulmonary disease (COPD – the name of a collection of progressive lung diseases, including chronic bronchitis and emphysema). There was no record of a diagnosis for this so she arranged a spirometry test (to diagnose COPD and measure lung efficiency). The results showed that some of his airways were mildly blocked. Mr McCarthy told her that he did not want to use any inhalers, as he did not have any shortness of breath or a tight chest. He was reluctant to stop or reduce his smoking.

25. The nurse conducted another spirometry test on 17 March 2014. The results again indicated a mild obstruction. Using these results, a prison GP diagnosed COPD. Mr McCarthy refused help to stop smoking and did not want to use any inhalers or do any exercise. Nurses scheduled annual reviews of his COPD and offered seasonal vaccinations.

26. In 2015, prison staff frequently described Mr McCarthy as being unkempt and dishevelled. In May, a nurse arranged for a mental health assessment, but Mr McCarthy did not attend his mental health appointments in June or July.

27. Prison staff continued to be concerned about Mr McCarthy's appearance and memory problems so a nurse completed a dementia test with Mr McCarthy on 13 August. She noted that Mr McCarthy struggled to find words he needed. She said he kept saying he had dandruff when he meant dementia. The results indicated he had mild memory problems. She arranged blood tests but Mr McCarthy refused them. She said she would continue with reviews in the dementia clinic and he should have a dementia service referral. This was made on 23 August.

28. On 17 August, a healthcare assistant completed a falls risk assessment. Mr McCarthy said he had not had a fall in the last two years. His observations were checked and were all in the normal range. She made a GP referral and a prison GP reviewed Mr McCarthy later that day. She noted he was unkempt and confirmed that he needed a referral to the dementia services as she suspected Mr McCarthy could have dementia. However, the hospital delayed arranging the dementia appointment and placed him on a waiting list.

29. A nurse completed a mental health and dementia review on 14 October. Mr McCarthy told her that his memory had not deteriorated and he had no issues.

30. At his annual COPD review on 27 October, a nurse had discussions with Mr McCarthy about health promotion in relation to smoking, diet and exercise.

31. On 11 November, a nurse examined Mr McCarthy. He struggled to recall the names of the nurses who he frequently saw and could not recall his planned dementia appointment. Six days later, a healthcare administrator checked the progress of the dementia referral. Mr McCarthy was still on the waiting list for assessment. On 31 December, the Mental Health Services for Older People at the hospital notified the prison that they would deal with the referral. They added Mr McCarthy to their waiting list.

32. A nurse completed a dementia health screen on 4 March 2016. Mr McCarthy told her he was having difficulty swallowing when eating and drinking, and had lost weight. She noted that he had lost weight, as he weighed 62.9kg, compared to 78.4kg in March 2014. As Mr McCarthy was constantly trying to clear his throat, she referred him to a GP.

33. A prison GP reviewed Mr McCarthy on 7 March and noted he had been a smoker for 60 years. Mr McCarthy said he had no problems with fluids and a soft diet but struggled to eat bread and meat and always felt hungry. She noted his weight loss and suspected he had upper gastrointestinal cancer so made an urgent referral to the hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

34. Mr McCarthy attended the hospital the next day and had a chest x-ray. The hospital consultant radiologist said Mr McCarthy had a lung infection and there was no evidence of cancer. The prison GP noted this.

35. At 8.45am on 22 March, Mr McCarthy was due to have an endoscopy. However, Mr McCarthy was reluctant to attend and told hospital staff that he had not fasted before the examination, despite having advance notice of his appointment. Hospital staff could not perform the procedure so rescheduled it for 27 May. Mr McCarthy insisted to prison nurses that he felt well but admitted that he had lied to hospital staff about not fasting. Healthcare staff gave him a letter that explained that he should not eat for at least six hours before his endoscopy.

36. On 13 April, Mr McCarthy had a blood test, which showed mild anaemia, and a follow up blood test was arranged. A week later, Mr McCarthy refused further blood tests and signed a disclaimer to this effect.

37. On 27 May, Mr McCarthy attended his endoscopy appointment but refused to consent to the procedure.

38. A nurse completed a COPD review on 15 June and noted he weighed 53.8kg (underweight). She referred him to the prison GP and recommended he increase his fluid intake. Mr McCarthy did not attend the GP appointment on 22 June.

39. A prison GP saw Mr McCarthy on 27 June. She had a frank discussion about her concerns that he had refused examinations to check whether he had cancer. Mr McCarthy told her he would consider having a scan and consented for her to contact the gastroenterology department at the hospital for further investigation. She sent an urgent letter to the hospital. Mr McCarthy said that he did not want to worry or contact his family.

Fall on 2 July

40. At 8.52am, Mr McCarthy slipped in the prison corridor, when he was carrying two bags, and was unable to stand up. Another prisoner saw Mr McCarthy fall so went to the wing office and told an officer. An officer went to assist at 8.53am. Another officer arrived at 8.55am.

41. At that moment, a healthcare assistant was walking past the wing office, so an officer asked her to look at Mr McCarthy. She thought that he was not distressed but he said he was unable to stretch his leg. She spoke with the Matron on the telephone and asked her to come to the wing. She stayed with Mr McCarthy and covered him with a blanket as she waited for the Matron to arrive.

42. When the Matron arrived, she found that Mr McCarthy was unable to straighten his leg or put any weight on it and it was tender to the touch. She thought that he had fractured his hip so asked the communication staff to call for an ambulance. Records show that an ambulance was called at 9.21am and arrived at the prison at 10.02am. At 10.47am, paramedics took Mr McCarthy to hospital. Two officers escorted him and he was restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and another to an officer).

43. Once in hospital, they found that Mr McCarthy had a closed fracture of his left femur. He remained in hospital for tests, including a CT scan. On 8 July, oncology specialists reviewed the CT results, which showed a tumour in his throat, and told him it was likely that he had cancer.

44. The following day, Mr McCarthy had a cardiac arrest. Hospital staff resuscitated him and Mr McCarthy said he did not want anyone to resuscitate him again. He signed an order to that effect. The hospital informed Mr McCarthy's family of his condition following his cardiac arrest and they were able to visit him. Mr McCarthy remained in hospital but doctors decided that no further treatment was possible. His condition deteriorated and he died on 21 July at 11.40am.

Contact with Mr McCarthy's family

45. On 10 July, the prison appointed a prison manager as the family liaison officer (FLO) after Mr McCarthy had a cardiac arrest in hospital. She said that the deputy FLO contacted Mr McCarthy's family to inform them that he was seriously ill. The deputy FLO went to the hospital, met the family and explained his role.

46. When Mr McCarthy died, the prison manager telephoned Mr McCarthy's daughter at 12.00pm. This was after the hospital had made the telephone call to inform Mr McCarthy's daughter of her father's death. The family were given the opportunity to see Mr McCarthy at the hospital but they declined the offer. She offered the family support after his death.

47. Mr McCarthy's funeral was held on 11 August and the prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

48. After Mr McCarthy's death, a prison manager debriefed the staff involved in the bed watch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

49. The prison posted notices informing staff and prisoners of Mr McCarthy's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr McCarthy's death.

Cause of death

50. The Coroner gave the cause of death as aspiration pneumonia and neck tumour, arising from a left hip fracture and Chronic Obstructive Pulmonary Disease (COPD).

Findings

Clinical care

51. The clinical reviewer said that the healthcare assistant had completed a comprehensive falls risk assessment in August 2015, which identified suspected dementia and COPD as his only risks. The clinical reviewer said there was nothing in his medical records to suggest that his mobility had diminished in the weeks prior to his fall and there were no previous falls documented.

52. The clinical reviewer said Mr McCarthy had COPD assessments, which indicated his condition was mild. He did not report any distress and he did not require any treatment. She said the treatment of his COPD was equivalent to that he would have obtained in the community.

53. The clinical reviewer said Mr McCarthy did not present as someone with rapidly progressive dementia and his memory problems were managed in a normal location in the prison. She said the prison GP had a frank discussion with Mr McCartney about the possibility of cancer. There was no reason to believe that he was incapable of understanding the information and he was able to make decisions to not pursue investigations and treatments. The tumour in Mr McCarthy's throat was only discovered when he was in hospital for treatment for his fracture.

54. When Mr McCarthy collapsed, we note that neither the officer nor the healthcare assistant called a code red emergency code, despite that Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes' states that this code should be used when a prisoner has a suspected fracture. While this code was not called, we agree with the clinical reviewer that Mr McCarthy was promptly taken to hospital.

55. We agree with the clinical reviewer that Mr McCarthy's treatment was at least as good as that he would have received in the community.

Liaison with Mr McCarthy's family

56. When Mr McCarthy was admitted to hospital on 2 July, his family was not contacted. The prison manager, appointed as the family liaison officer, said that Mr McCarthy had not been in contact with his family for approximately ten years. She said it was not the prison policy to contact families every time a prisoner was admitted into hospital and he would have been given the opportunity to telephone them himself if he wished to.

57. However, the prison did not contact Mr McCarthy's family on 8 July when doctors diagnosed him with cancer and only made contact on 10 July, after he had a cardiac arrest, because hospital staff had contacted them.

58. PSI 64/2011 'Safer Custody' requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22 also requires the governor to inform the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill. After

being taken to hospital on 2 July, there was no evidence, that Mr McCarthy was asked about or given the opportunity to contact his family.

59. We consider that when Mr McCarthy was admitted to hospital on 2 July, the prison should have asked him if he wanted his next of kin informed. We are also concerned that no one from the prison contacted his family after his cancer diagnosis and did so only after his cardiac arrest. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.

Restraints, security and escorts

60. 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. The judgment indicated 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.

61. When the nurse called for an ambulance, she also completed an escort risk assessment. For medical input, she ticked a box to state that there were no medical objections to Mr McCarthy being restrained. However, she noted that he was a wheelchair user and added, "Neck of femur". She did not provide any other information about Mr McCarthy's condition and whether it affected his ability to escape. Security staff assessed Mr McCarthy's level of risk to the public, hostage taking, escape potential, lilkelihood of outside assistance, risk to females and risk to hospital staff as low. Based on this information, a prison manager authorised the use of an escort chain and two officers during the escort.

62. Medical opinion about the prisoner's ability to escape requires a full written explanation about their condition at the time of the escort and how that affects the level of risk they pose. The prison manager made a decision to restrain Mr McCarthy without a fully considered risk assessment. At the time of escort, Mr McCarthy had a suspected fracture and reduced mobility. We are not satisfied that there was appropriate and considered healthcare input into the risk assessment or that managers appropriately considered his condition at the time and how this affected his risk.

63. Later that day, when he was going for surgery, the prison manager decided restraints were unnecessary, and they were never used again. It was good to see that the decision was reviewed and took into account Mr McCarthy's medical condition at that time. However, we do not consider that the prison manager appropriately considered Mr McCarthy's risk when he was taken to hospital. We make the following recommendation about the use of restraints:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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