

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ifan McClelland a prisoner at HMP Altcourse on 25 March 2017

**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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ifan McClelland died at HMP Altcourse on 25 March 2017 of hypertensive ischaemic and valvular heart disease and poorly controlled diabetes with morbid obesity. Mr McClelland was 71 years old. I offer my condolences to Mr McClelland's family and friends.

Mr McClelland suffered from a range of serious, long term health conditions, including heart failure, kidney disease and diabetes. He also had memory loss and social care needs. We found that the clinical care provided to Mr McClelland was not equivalent to the care that he could have expected to receive in the community. There was a delay in putting in place a diabetes care plan for Mr McClelland. There were also omissions in Mr McClelland's diabetes management and poor record keeping. It was unnecessary that prison staff attempted resuscitation when it was apparent that Mr McClelland was already dead.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

September 2017

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Summary

Events

1. Mr Ifan McClelland arrived at HMP Altcourse on 19 December 2016, with diagnoses of type 2 diabetes and associated complications, kidney disease, high blood pressure and incontinence. He also had memory loss due to his excessive consumption of alcohol.
2. On 9 February 2017, Mr McClelland was diagnosed with heart failure, with possible aortic stenosis (narrowing of the aortic valve in the heart). Mr McClelland's cardiologist told him that his poor diabetic control and excessive weight were contributing to his condition. He was advised to have a calorie restricted diet, low in fat and salt.
3. Prison healthcare staff created a diabetes care plan on 28 February. This set out that Mr McClelland should be educated on diabetes control; he should follow a low fat diet and keep his blood sugar levels at 4-7mmols. Mr McClelland continued to make poor food choices, and his blood sugar levels were consistently high.
4. Mr McClelland was released from prison on licence on 17 March but the licence was revoked on 21 March when Mr McClelland breached his licence conditions. When arrested by the police, Mr McClelland had a high blood sugar level of 17.1mmols. Mr McClelland was sent back to Altcourse on 22 March, where he was readmitted to inpatient healthcare.
5. At 8.14am on 25 March, an officer called an emergency code blue when Mr McClelland was found unresponsive in his bed. An ambulance was called and a nurse started cardiopulmonary resuscitation (CPR), with another nurse arriving minutes later. The second nurse to arrive wrote in Mr McClelland's medical record that his pupils were fixed and dilated and "limbs [were] stiff and rigid". They continued CPR until the ambulance crew arrived at 8.27am. Ambulance staff told the nurses to stop CPR as rigor mortis was present. Death was confirmed by paramedic staff at 8.33am.

Findings

6. Mr McClelland arrived at Altcourse with poorly managed diabetes but staff did not create a diabetes care plan until 28 February, over 10 weeks after his arrival. Despite this care plan being in place, Mr McClelland's poor food choices resulted in his blood sugar levels being consistently high. Staff failed to create an action plan to address this.
7. When Mr McClelland was recalled to prison on 22 March, the nurse could not record details of the health screen because of computer problems. The nurse noted Mr McClelland's blood pressure and pulse on a post-it-note that was later misplaced. A health screen was recorded the next day and showed an elevated blood sugar level. However, a plan of care was not implemented and daily blood

sugar readings were not taken or documented onto SystemOne (the electronic patient record) after this date.

8. We found that the clinical care provided to Mr McClelland was not equivalent to that which he could have expected to receive in the community. Altcourse had no care plans in place for long term health conditions before 28 February. There was a 10-week delay in putting a diabetes care plan in place for Mr McClelland. There were also omissions in Mr McClelland's diabetes management and incidents of poor record keeping.
9. We found that the resuscitation attempt on Mr McClelland was not in accordance with prison policy or health guidelines.

Recommendations

- The Head of Healthcare should introduce a care plan for management of chronic diabetes in line with NICE guidelines. This template should be readily available to healthcare staff on SystemOne.
- The Head of Healthcare should ensure that all prisoners with diabetes are provided with education and appropriate support on how to manage their condition and to tailor their diet accordingly.
- The Head of Healthcare should ensure that in the event of SystemOne being unavailable staff are aware of the importance of documentation in line with the Nursing and Midwifery Code.
- The Head of Healthcare should ensure that all healthcare staff are aware of the signs of rigor mortis and when it is appropriate to start CPR in accordance with European Resuscitation Council Guidelines.

The Investigation Process

10. 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
11. The investigator interviewed four members of staff at Altcourse on 15 May 2017.
12. NHS England commissioned a clinical reviewer to review Mr McClelland's clinical care at the prison. She attended all prison interviews and, on 17 May 2017, conducted a telephone interview with an agency nurse who worked at the prison.
13. We informed HM Coroner for Merseyside - Liverpool District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
14. A letter was sent to Mr McClelland's family on 3 April 2017 to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to this letter.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Altcourse

16. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manages the prison and provides primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Altcourse was in June 2014. Inspectors reported that prisoners had satisfactory access to most health services. There was a good range of clinical and screening services. Care was provided over 24 hours with two health care staff based on the inpatient unit overnight. Prisoners were generally positive about the care provided, especially in the inpatient unit.

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 2016, the IMB reported that a new GP practice with wide experience of prisons had improved primary care services. There was a more consistent approach to providing and reviewing medication and GP waiting lists had reduced.

Previous deaths at HMP Altcourse

19. Mr McClelland was the 11th prisoner to die of natural causes at Altcourse since January 2015. We have previously made recommendations about the appropriateness of resuscitation, the introduction of care plans and poor record keeping.

Key Events

20. On 19 December 2016, Mr Ifan McClelland was sentenced to 26 weeks in prison for indecent exposure and was sent to HMP Altcourse. Mr McClelland was a heavy drinker and morbidly obese with a body mass index (BMI) of 49.6. (A healthy BMI should fall between 18.5 and 24.9.) Mr McClelland arrived at Altcourse with diagnoses of type 2 diabetes, diabetic nephropathy (kidney disease), diabetic retinopathy and maculopathy (damage to the eyes caused by poor control of his diabetes), high blood pressure and incontinence. He also had memory loss due to his excessive consumption of alcohol.
21. During an initial health screen the same day, 19 December, it was noted that Mr McClelland had high blood pressure of 195/94 with limited mobility. He was admitted to the prison's inpatient healthcare unit for assessment by the GP the next morning. Mr McClelland was given amlodipine (medication used to reduce blood pressure) and it was recommended that his blood pressure and blood sugar levels be taken daily.
22. Mr McClelland saw a prison GP the next day, 20 December. He had swollen ankles and was unable to give a detailed medical history or the name or area of his community GP. The GP suspected Mr McClelland had possible learning difficulties due to his previous lifestyle. He requested an electrocardiogram (ECG) and a blood test when he found what appeared to be a murmur when he listened to Mr McClelland's heart.
23. A prison GP reviewed Mr McClelland's ECG results on 21 December. The results showed left anterior fascicular block (an abnormal condition) suggestive of ischemic heart disease. Mr McClelland did not have any chest pain or shortness of breath. Mr McClelland's blood results showed an HbA1c of 75mmol (An HbA1c shows a person's overall control of their diabetes over a 3 month period. An ideal level should be less than 41.) The GP prescribed furosemide (to help with fluid retention), gliclazide (diabetic medication), and ramipril for his high blood pressure. On 28 December, the GP sent a letter to the cardiology department at the hospital asking for an opinion on how best to manage Mr McClelland.
24. Mr McClelland was discharged from the healthcare unit on 30 December and moved to a single cell on B wing. However, on 6 January Mr McClelland was readmitted to healthcare due to his double incontinence, lack of personal hygiene and inability to manage his cell. Four days later, on 10 January, a prison GP referred Mr McClelland to the incontinence nurse stating that, "he shows limited understanding around his medical conditions and therefore the history is also very limited but it appears that this is a chronic problem".
25. On 10 January 2017, Mr McClelland had a 'mini mental state examination'. A nurse noted that he did not appear fully orientated, was unable to retain information and had poor reading and writing skills.
26. A prison GP referred Mr McClelland to the nephrology department at hospital on 6 February to review his kidney disease. He asked, "given the co-morbidities in

this patient of poor physical condition and chronically poorly controlled diabetes, I would value your expert opinion as to optimisation of his management". A kidney scan was arranged for 22 March 2017.

27. Mr McClelland saw a consultant cardiologist at hospital on 9 February, where he confirmed a diagnosis of heart failure with possible aortic stenosis (narrowing of the aortic valve in the heart). He explained that Mr McClelland's poor diabetic control and excessive weight were contributing to his condition. Mr McClelland was told to have a low fat, low salt, calorie restricted diet. He suggested a change in medication (to increase his frusemide and to start metformin to help manage his diabetes better) and asked that he have a diabetic review to ensure he was complying with a strict diabetic diet.
28. On 13 February, a prison GP wrote to the prison kitchen instructing them that Mr McClelland needed a low salt and low fat diet for medical reasons. He referred Mr McClelland to a dietician the same day. Three days later, on 16 February, he made a note in Mr McClelland's medical record to remind staff of the plan dated 28 December, writing that "it would be wise to continue with daily fasting BM [blood sugar] checks".
29. After a mental health assessment on 17 February, Mr McClelland was referred to the prison psychiatrist for further assessment of his learning disability.
30. Nursing care plans for personal hygiene, hypertension and diabetes were created for Mr McClelland on 28 February. The diabetes care plan said that Mr McClelland should be educated on diabetes control; he should follow a low fat diet and keep his blood sugar level at 4-7mmols.
31. Mr McClelland was released from prison on license on 17 March. Four days later, on 21 March, Mr McClelland was arrested for an offence of indecent exposure and his licence was revoked. Police custody paperwork showed that Mr McClelland had a high blood sugar level of 17.1mmols.
32. Mr McClelland was sent back to Altcourse on 22 March. A nurse saw Mr McClelland at 7.30pm that night. He did not record an initial health screening, writing, "issues with SystemOne. Only been out a couple of days. Admitted to healthcare".
33. The nurse completed an initial health screen with Mr McClelland at 1.12pm on 23 March. He had a blood sugar level of 15.5mmol and told the nurse that he drank roughly 30 pints of beer per day. The nurse noted poor personal hygiene and problems with his memory. A prison GP was unable to review Mr McClelland that afternoon as he was in the dining room at the time of the planned consultation. Mr McClelland's previous medication was re-prescribed and the GP asked that a blood test be done and clinical observations taken.
34. A nurse checked on Mr McClelland throughout the night of 24 March. She wrote in his medical records at 5.36am that he appeared to have had a settled night and slept well.

35. At 8.14am on 25 March, a nurse went to give Mr McClelland his morning medication. Mr McClelland was lying on his back in bed and did not respond when the nurse called his name. The nurse entered the cell with a Prison Custody Officer and found Mr McClelland unresponsive and not breathing. The Officer made a code blue emergency call (indicating that a prisoner is unconscious or having difficulties breathing) on his radio while the nurse started cardiopulmonary resuscitation (CPR). An ambulance was called at 8.18am.
36. Another nurse arrived at the cell a few minutes later after hearing the code blue. The nurse found Mr McClelland's pupils were fixed and dilated and his limbs stiff and rigid. He attached a defibrillator to Mr McClelland's chest but a heart rhythm could not be found. The nurses continued CPR until paramedic staff arrived at 8.27am. North West Ambulance paperwork shows that on arrival they advised staff to discontinue CPR as rigor mortis was present. Death was confirmed by paramedic staff at 8.33am.

Contact with Mr McClelland's family

37. Mr McClelland's next of kin was his brother. Mr McClelland had not provided up to date contact details, so following his death on 25 March the prison asked North Wales Police to help locate his brother. North Wales Police informed Mr McClelland's brother of the death the same day.
38. A family liaison officer telephoned Mr McClelland's brother on 27 March, to offer his condolences and answer any questions he may have. Mr McClelland's funeral was held on 18 April 2017. The prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

39. After Mr McClelland's death, the Duty Director debriefed 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.
40. The prison posted notices informing other prisoners of Mr McClelland'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 McClelland's death.

Post-mortem report

41. The post-mortem report shows that Mr McClelland died of hypertensive ischaemic and valvular heart disease, and poorly controlled diabetes with morbid obesity.

Findings

Clinical care

42. Mr McClelland was appropriately located on the inpatient healthcare unit to monitor him more closely and because of issues with personal hygiene, memory issues and an inability to undertake the activities of daily living. However, we agree with the clinical reviewer that, overall, the clinical care provided to Mr McClelland was not equivalent to that which he could have expected to receive in the community. Up to 28 February 2017, there was a complete lack of healthcare plans for prisoners with long term conditions. The delay in putting in place a diabetes care plan for Mr McClelland was unacceptable. There were also omissions in Mr McClelland's diabetes management and incidents of poor record keeping.

Diabetes care

43. Mr McClelland arrived at Altcourse on 19 December 2016, with poorly controlled diabetes. There was a delay of over ten weeks before a diabetes care plan was created, on 28 February. The Head of Healthcare told us that Altcourse had no care plans in place for long term health conditions prior to 28 February.
44. The care plan stated that Mr McClelland should be educated on diabetes control; he should follow a low fat diet and keep his blood sugar levels at 4-7mmols. (This care plan was paper based and kept in Mr McClelland's file and not available on his online medical record.) Despite this recommendation (and healthcare staff being aware that Mr McClelland had problems retaining information), Mr McClelland was allowed to continue making poor food choices with nursing staff documenting in SystemOne that he was eating fish and chips, full English breakfast and sponge cake and custard. The Head of Healthcare said at interview that she was unaware how Mr McClelland was able to make these food choices, but would have expected nursing staff to approach him in the dining area to re-educate him on what he should be eating.
45. While in prison Mr McClelland's records indicate his blood sugar levels were consistently elevated above the recommended range (4-7mmols) with readings ranging from 9-19mmols. Staff had no action plan to address these elevated blood sugar readings.
46. When Mr McClelland was recalled on 22 March, police custody paperwork showed that he had a high blood sugar level of 17.1mmols. A nurse completed an initial health screen with Mr McClelland the following day, 23 March, which showed a blood sugar level of 15.5mmols. A plan of care was not implemented and daily blood sugar readings were not taken or documented onto SystemOne after this date.
47. The pathologist in his post mortem report on Mr McClelland stated that, "In my opinion, his cardiac disease was of such severity that it would have placed him at high risk of sudden death at any time. His chronic poorly controlled diabetes would have been a factor in the development of his vascular disease".

We make the following recommendations:

The Head of Healthcare should introduce a care plan for management of chronic diabetes in line with NICE guidelines. This template should be readily available to healthcare staff on SystmOne.

The Head of Healthcare should ensure that all prisoners with diabetes are provided with education and appropriate support on how to manage their condition and to tailor their diet accordingly.

Cardiac care

48. An ECG conducted at Altcourse on the 21 December 2016 showed left anterior fascicular block. After reviewing the results, a prison GP appropriately referred Mr McClelland to the cardiology department at hospital on 28 December. The GP reviewed Mr McClelland regularly in the meantime.
49. The prison GP subsequently followed the cardiologist's advice and referred Mr McClelland to the dietician, and wrote to the prison kitchen to request a special diet. We agree with the clinical reviewer that prison GPs consistently ensured that follow up blood tests, medication and outcomes from hospital consultants were followed through and this is clear throughout the SystmOne records.

Record keeping

50. Mr McClelland was returned to Altcourse on 22 March 2017 after breaching his licence conditions. An initial health screen was not completed due to issues with SystmOne. A nurse documented "Issues with S1. Only been out a couple of days. Admitted to healthcare".
51. During a telephone interview, the nurse explained there were problems with the SystmOne template and he was unable to save the healthcare screening once completed. He wrote Mr McClelland's blood pressure and pulse onto a post-it note and put it in the tray of documents to be scanned. This was not scanned onto Mr McClelland's records. There are no further entries from the day staff that received Mr McClelland into the healthcare unit that evening.
52. The Nursing and Midwifery Code (2015) states that "nurses and midwives should keep clear and accurate records which are relevant to their practice". These should be completed in a timely manner and information should be available for continuity of care.
53. The nurse said that he spoke to members of the healthcare inpatient unit to tell them that Mr McClelland was back in custody. There is no record of this conversation as this was again not recorded in the SystmOne records. We make the following recommendation:

The Head of Healthcare should ensure that in the event of SystmOne being unavailable staff are aware of the importance of documentation in line with the Nursing and Midwifery Code.

Emergency response

54. North West Ambulance paperwork shows that when the paramedics arrived at Mr McClelland's cell (nine minutes after the emergency call was made) they told staff to stop CPR as rigor mortis was present. (Rigor mortis is the stiffening of the body after death that normally appears around two hours after the deceased has died.)
55. G4S, the healthcare provider at Altcourse, introduced a resuscitation policy in January 2017. This policy identifies seven conditions when resuscitation should not be attempted, the presence of rigor mortis being one. Following the introduction of the new policy, the Head of Healthcare held a meeting on 16 March to ensure all staff were aware of the new resuscitation guidelines. Both nurses who attempted resuscitation on Mr McClelland confirmed at interview that they were aware of the new policy but had not read it.
56. During interview the nurse said that when he arrived at the cell Mr McClelland looked 'comfortable' lying in the bed and his limbs were not rigid, which is why he decided to start CPR. He wrote in SystmOne that when he entered the cell Mr McClelland's limbs were stiff and rigid. Explaining his entry, he said at interview that Mr McClelland was "cold but he wasn't rigid". He said that towards the end while they were carrying out CPR his body started to stiffen with his hands were becoming quite constricted.
57. Due to the discrepancies with the ambulance and nursing staff's record of events, the pathologist was asked for the approximate time of death of Mr McClelland and the presence of rigor mortis. He stated, "regarding the presence of rigor mortis, if correct, then clearly there was no chance of CPR being successful as he had been dead for some time (exactly how long is impossible to say, particularly as almost certainly there will be no core body temperature or ambient temperature recorded)".
58. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison, IRC or residential short term holding facility, and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". In light of this we make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are aware of the signs of rigor mortis and when it is appropriate to start CPR in accordance with European Resuscitation Council Guidelines.

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