Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan McGrath a prisoner at HMP Wymott on 24 October 2016

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*

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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 Ryan McGrath died on 24 October 2016 of a heart attack while a prisoner at HMP Wymott. He was 46 years old. I offer my condolences to Mr McGrath's family and friends.

I agree with the clinical reviewer that Mr McGrath's care was not equivalent to that he could have expected to receive in the community. Healthcare staff at Wymott did not conduct a full first night assessment on Mr McGrath's arrival or request his community health records which would have shown a family history of heart disease. They also failed to refer Mr McGrath to hospital to test the health of his heart, after he complained of ongoing chest pains and they were unable to obtain blood samples themselves.

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 **May 2017**

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Summary

Events

1. On 8 April 2016, Mr Ryan McGrath was sentenced to four years imprisonment for drug related offences. He had been recalled on licence on 27 November 2015 and sent to HMP Swansea before transferring to HMP Wymott on 15 September 2016.

2. When Mr McGrath re-entered custody on 27 November 2015, a nurse recorded he had a history of drug use and he started a drug detoxification programme on 29 November. He only presented with very minor health complaints thereafter. There is no record that anyone took his blood pressure. His medical record from his previous period in custody showed his blood pressure on occasion was high, although healthcare staff never diagnosed him with high blood pressure.

3. Mr McGrath transferred to Wymott on 15 September 2016. On arrival, the nurse who saw him had no concerns regarding his physical heath but noted a past history of asthma. There is no record of his weight or blood pressure and the screen did not constitute the full first night screen criteria.

4. On 20 October 2016, Mr McGrath told a nurse he had had shoulder pain for a week, pins and needles, chest pains and felt clammy and nauseous all the time. His blood pressure was 134/112 and the nurse arranged an ECG (an electrocardiogram measures the electrical rhythm of the heart) and a doctor's review.

5. The GP examined Mr McGrath the same day but felt his pain was muscular and the ECG did not suggest heart disease. He asked a nurse to take a blood sample to run some tests which would indicate if he had had a heart attack but attempts to do so were not successful until 24 October.

6. That same day, at approximately 2.00pm, Mr McGrath collapsed in his cell. An emergency code blue was broadcast and healthcare staff attended but were unable to resuscitate Mr McGrath. Paramedics also attended and were unable to revive him. They pronounced him dead at 3.05pm.

Findings

7. The clinical reviewer concluded that the care Mr McGrath received in prison was not equivalent to that he could have expected to receive in the community but it was not possible to say whether this impacted on the outcome for Mr McGrath. During a previous period in custody, his high blood pressure was not followed up. He did not have a full first night screen when he arrived at Wymott (the prison has now amended its procedures to ensure this always happens). His community healthcare records were not requested when he first arrived at Wymott and he was not sent to hospital when staff were unable to take blood to perform urgent blood tests.

Recommendations

- The Head of Healthcare at HMP Swansea and HMP Wymott should ensure that community health records are requested for all new prisoners, as per PSO 3050, and that past medical history is appropriately considered.
- The Head of Healthcare at Wymott should ensure that staff do not delay arranging urgent blood tests for patients where healthcare staff are unable to complete them themselves.

The Investigation Process

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

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

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

11. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr McGrath's ex partner, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked if:

- Before his death, Mr McGrath had told healthcare staff he had pins and needles in his neck and that he did not feel well.
- If Mr McGrath did report the above, should healthcare staff have done more in response to these symptoms rather than just return him to his cell.

13. Mr McGrath's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

14. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HM Prison Wymott

15. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company, Indigo Locum Agency, provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24-hour nursing cover.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that Wymott remained a reasonably safe prison, staff-prisoner relationships were generally respectful but healthcare provision was weak and in some areas potentially unsafe. They felt that the care of prisoners with chronic conditions was not good enough.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2016, the IMB reported that although there had been some improvement in health services since 2015, there were still serious problems with providing medication. This was exacerbated by staff shortages, although the report noted that staffing levels had also improved.

Previous deaths at HMP Wymott

18. Mr McGrath was the eighth prisoner to die of natural causes at HMP Wymott since January 2015. There are no significant similarities between the investigations.

Key Events

19. Mr Ryan McGrath was recalled on licence on 27 November 2015 and sent to HMP Swansea. He was sentenced to four years imprisonment for drug related offences on 8 April 2016 and transferred to HMP Wymott on 15 September.

20. During his previous period in custody (4 October 2012 to 5 June 2014 - spent at Swansea and Parc prisons) it was noted that he had a history of drug misuse, had hepatitis C and asthma. Healthcare staff measured his blood pressure on a number of occasions and although it was sometimes above 140/90 they did not diagnose hypertension even though his readings fell into that bracket.

21. When Mr McGrath re-entered custody on 27 November 2015, a nurse at HMP Swansea recorded he had a history of drug use and that his asthma was well controlled. He started a drug detoxification programme on 29 November and only presented with very minor health complaints thereafter. There is no record that anyone took his blood pressure.

22. Mr McGrath transferred to Wymott on 15 September 2016. On arrival, a nurse recorded that Mr McGrath had no concerns regarding his physical heath but had a past history of asthma. There is no record of his weight or blood pressure and the screen did not meet the criteria of a full first night screening. Mr McGrath did not attend for a health assessment which was booked for 11 October. Healthcare staff did not record his reasons for not attending.

23. On 20 October 2016, Mr McGrath saw a nurse and complained of pain in his right shoulder which he said he had had for a week. He also said he had had pins and needles intermittently, crushing chest pain and felt nauseous and clammy at times. She took his blood pressure which was high 134/112 (ideal is 120/80), and arranged for a colleague to conduct an electrocardiogram (an ECG measures the electrical rhythm of the heart) for a doctor to review.

24. A prison GP examined Mr McGrath that day but felt that the pain Mr McGrath had experienced was muscular and the ECG did not suggest heart disease. He asked a nurse to take a blood test to see if his troponin levels were raised (raised levels indicate if someone has had a heart attack). The nurse was not able to get any blood from Mr McGrath and told the GP this. (The GP has since said he was unaware the attempts to take blood samples had failed.) He recorded that he would make a referral for Mr McGrath to be seen in hospital

25. On 21 October, a nurse recorded that she tried on multiple occasions to take blood from Mr McGrath but was unsuccessful. She intended to try again the following Monday (24 October). She managed to do so on 24 October and recorded she sent all samples to the laboratory.

26. A little before 2.00pm, a prisoner was talking to Mr McGrath in his cell. Mr McGrath was sat on a chair conversing normally when he suddenly made groaning and gurgling noises and fell forwards off the chair. The prisoner tried to rouse him and, although Mr McGrath was still breathing and making noises, he did not respond verbally. He asked another prisoner to attend to Mr McGrath while he found some officers. Two officers were in the wing office and he asked them to attend.

27. The officers went straight away and two other prisoners were attending to Mr McGrath when they arrived. One of them told an officer that Mr McGrath was fitting and the officer called a code blue over his radio immediately – the time was 1.55pm. A code blue broadcast lets healthcare know that they need to attend the scene immediately and bring equipment with them to deal with an individual having severe breathing difficulties and/or chest pains. Staff in the control room should also call an ambulance immediately.

28. The control room log shows that at 1.55pm staff requested an ambulance and healthcare staff arrived at the cell shortly thereafter. In the meantime, both officers tried to keep Mr McGrath in the recovery position, he was making occasional gurgling noises and they tried unsuccessfully to get a response from him.

29. Healthcare staff arrived. Mr McGrath was in the recovery position when they arrived, had no pulse and his pupils were fixed. The health care staff rolled him over and attempted CPR (cardio pulmonary resuscitation – a life saving technique) but to no effect. They tried to insert several different airways unsuccessfully and were unable to find a suitable vein to administer an adrenalin shot. Other nurses and prison staff were at the scene by this point and an unidentified nurse got a defibrillator from the wing office with an officer.

30. Paramedics arrived at the prison at 2.24pm and tried for some time to revive Mr McGrath. They were unsuccessful and pronounced him dead at 3.05pm.

Contact with Mr McGrath's family

31. Mr McGrath had given his ex partner's mother as his next of kin and, on 24 October at 7.40pm, a family liaison officer (FLO) went to her house, to break the news of Mr McGrath's death in person. The FLO and the next of kin also went to his ex partner's house to give her the news. The next day, another FLO took over FLO duties and stayed in touch with the family offering support and advice.

32. Mr McGrath's funeral was on 15 November and the FLO attended. In line with national policy the prison contributed towards the cost of the funeral.

Support for prisoners and staff

33. After Mr McGrath's death a governor held a hot debrief and staff were given the opportunity to discuss any issues arising and offered support.

34. The prison posted notices informing other prisoners of Mr McGrath'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 McGrath's death.

Post-mortem report

35. The coroner has told us that the provisional cause of death was a ruptured myocardial infarction (a heart attack with a tear in the heart wall), caused by coronary artery thrombosis (a blood clot in an artery of the heart).

Findings

Clinical care

36. The clinical reviewer does not feel that the care Mr McGrath received in prison was equivalent to that he could have expected to receive in the community, but he says it is not possible to say whether this impacted on the outcome for Mr McGrath. No one identified his family history of heart disease, high blood pressure and obesity, all of which increased his risk of ischaemic heart disease. The clinical reviewer is also critical of healthcare staff for not transferring Mr McGrath to hospital immediately on 20 October to have his troponin levels tested after they had failed to get a blood sample.

37. During a previous period in custody, in Swansea and Parc, healthcare staff sometimes recorded his blood pressure as exceeding 140/90 - but he was never diagnosed with hypertension even though his readings fell into that bracket. Given this relates to a previous period in custody from some time ago, we do not make a recommendation. However, Mr McGrath's medical history should have been considered once he re-entered prison in 2015.

38. The clinical reviewer identified that Mr McGrath's GP community records are annotated that his father, uncle and grandfather had all had heart attacks but this does not seem to have been picked up on by prison healthcare staff during this period in custody. We asked the Head of Healthcare at Wymott about this but she said that they did not have Mr McGrath's community records as they do not routinely request them. They only request them if they have any concerns or if a GP at the prison asks them to.

39. Prison Service Order (PSO) 3050 'Continuity of Healthcare for Prisoners' stipulates that 'Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with. The prisoner's explicit consent should be obtained before doing this, although in exceptional circumstances information may be requested and disclosed without consent'.

    The Head of Healthcare at HMP Swansea and HMP Wymott should ensure that community health records are requested for all new prisoners, as per PSO 3050, and that past medical history is appropriately considered.

40. Mr McGrath transferred to Wymott on 15 September 2016. On arrival, a nurse recorded that Mr McGrath had no concerns regarding his physical heath but had a past history of asthma. There is no record of his weight or blood pressure and the screen does not seem to have been very thorough. We asked the Head of Healthcare why this was and she said that at the time Wymott operated a 'Meet and Greet' style assessment when prisoners first arrived. These were not as thorough as a first night screen, but the intention was that a full screen would be done soon afterwards. In Mr McGrath's case this did not happen. The 'Meet and Greet' assessment has since been abolished and all prisoners get a full assessment when they first arrive.

41. During this most recent period in custody, Mr McGrath's weight was recorded as 101kg by a nurse on 28 November 2015. As earlier notes in his record say his

height was 1.8 meters his body mass index must have been approximately just over 31, which is obese. His blood pressure was only recorded once during this custodial period - while he was at Wymott and shortly before he died. On 20 October, his blood pressure was 134/112 but at the time, other investigations were taking place including ECG readings and attempts to test his troponin levels.

42. On 20 October, a prison GP asked a nurse to take a blood sample from Mr McGrath so they could test his troponin levels. She had problems accessing a vein. He said he was unaware that attempts to take blood samples had failed. It is the clinical reviewer's opinion that Mr McGrath should have been taken to hospital as a matter of urgency that day for them to take the sample. We agree that the prison should have taken further action and make the following recommendation:

The Head of Healthcare at Wymott should ensure that staff do not delay arranging urgent blood tests for patients where healthcare staff are unable to complete them themselves.

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