

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony McKain a prisoner at HMP Belmarsh on 22 February 2018

A report by the Prisons and Probation Ombudsman

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 McKain died on 22 February from coronary artery stenosis (blocked arteries in the heart) at HMP Belmarsh. He was 53 years old. I offer my condolences to Mr McKain's family and friends.

There was no indication that Mr McKain had cardiovascular disease prior to his collapse on 22 February. I am satisfied that the healthcare he received at Belmarsh was equivalent to that which he could have expected to receive in the community.

However, I am concerned that healthcare staff at Belmarsh receive only basic training in life support and some life-saving equipment is not stocked by the healthcare provider. I have previously made a recommendation about this and repeat it here.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

December 2018

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Summary

Events

1. Mr Anthony McKain was sent to HMP Belmarsh in June 2014. He was a heavy smoker and declined help to stop.
2. Mr McKain had normal blood test results in 2014 and 2016. He failed to attend several appointments for blood tests between November 2017 and January 2018.
3. On 22 February 2018, two officers found Mr McKain unresponsive in his cell. One called a medical emergency code over his radio and then started cardiopulmonary resuscitation (CPR). Other staff joined them and continued CPR until the ambulance paramedics arrived. The paramedics continued resuscitation attempts but were unsuccessful and at 4.17pm, they pronounced that Mr McKain had died.
4. The post-mortem report shows that Mr McKain died from coronary artery stenosis (blocked arteries in the heart).

Findings

5. There was no indication that Mr McKain had cardiovascular disease prior to his collapse on 22 February. The clinical reviewer was satisfied that the standard of clinical care Mr McKain received at Belmarsh was equivalent to that which he could have expected to receive in the community.
6. However, we are concerned that the healthcare provider at Belmarsh requires healthcare staff to be trained to only basic level in life support and some life-saving equipment that is used at intermediate level is not stocked by the prison. We have raised this issue in a recent report into another death at Belmarsh.

Recommendations

- The Governor and the Head of Healthcare should ensure that Oxleas Trust's policies on life support training for staff and the provision of life-saving equipment at Belmarsh:
 - are fully risk-assessed in relation to the specific situation at Belmarsh; and
 - accurately reflect the guidance of European Resuscitation Council.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Belmarsh informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited Belmarsh on 27 February 2018. She obtained copies of relevant extracts from Mr McKain's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr McKain's clinical care at the prison.
10. The investigator and the clinical reviewer interviewed five members of staff at Belmarsh on 21 March and seven staff members on 9 April.
11. We informed HM Coroner for Southwark 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 McKain's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised no specific issues.
13. We sent Mr McKain's partner a copy of the initial report, but received no comments. The prison's action plan is included at annex 14.

Background Information

HMP Belmarsh

14. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds approximately 900 men. Oxleas NHS Foundation Trust provides healthcare services. There is 24-hour healthcare cover and a 32-bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Belmarsh was in January and February 2018. Inspectors reported that health services had improved and were now good. Primary care services were comprehensive, and prisoners could see a GP the same day for urgent matters, although too many prisoners did not attend appointments. The provision of emergency medical equipment was good, although not all officers knew where automatic external defibrillators were kept.

Independent Monitoring Board

16. 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 30 June 2017, the IMB remained concerned at the high number of missed healthcare appointments. Often the reason cited was lack of staff to escort prisoners to appointments or other reasons outside healthcare's control.

Previous deaths at HMP Belmarsh

17. Mr McKain was the 12th prisoner to die at Belmarsh since February 2015. Of the previous deaths, six were due to natural causes and five took their own lives. There were no similarities between Mr McKain's death and the previous deaths at the prison.

Key Events

18. Mr Anthony McKain was remanded into custody at HMP Belmarsh on 20 June 2014 and on 10 December that year, he was sentenced to ten years imprisonment for robbery and theft.
19. When he arrived at Belmarsh, Mr McKain was on medication for injuries he had suffered in a car crash over 20 years earlier, which prison GPs continued to prescribe. He had a long history of drug and alcohol misuse. He was also a heavy tobacco smoker but declined help to stop. He continued to smoke heavily until Belmarsh became smoke free in September 2017. During 2017, there were several occasions when he was suspected of smoking psychoactive substances (PS).
20. In April 2017, after Mr McKain complained of pain in his spine and pelvis, staff gave him a wheelchair and located him in a disabled cell on the ground floor. He could still move independently from chair to bed, and could stand.
21. Mr McKain had blood tests in 2014 and 2016, the results of which were normal. Blood test appointments were made for him on 7, 14, 21 and 28 November 2017, but he failed to attend. He also failed to attend his blood test appointments on 19 and 29 December, and on 2 and 9 January 2018. On 16 January, Mr McKain told a nurse that he did not want a blood test and asked to be removed from the list.
22. On 22 February 2018, Officer A was showing Mr McKain's disabled cell to a new prison officer. He looked through the observation panel and could not see Mr McKain, only his wheelchair. Officer A asked the new prison officer to call over Officer B, who was nearby, as he thought something was wrong. Officer B joined him as he was opening the cell door and as they both went in, they saw Mr McKain slumped over the toilet. Officer B radioed a code blue medical emergency (indicating that a prisoner is unconscious or having problems breathing) at 3.21pm. Control room staff called an ambulance immediately.
23. The two officers laid Mr McKain flat on the floor. Officer B began cardiopulmonary resuscitation (CPR). Another officer responded to the emergency call along with two managers. The other officer took over CPR as he was a trained first-aider. He began chest compressions and used a defibrillator (a device that can give the heart an electric shock in some cases of cardiac arrest) which advised that no shock was required. Oxygen was delivered using a facemask and later a mask and bag (the emergency bag did not contain an artificial airway). A prison GP took over chest compressions, rotating with the other officer and a manager. The first paramedics arrived at Mr McKain's cell at 3.27pm, and took over CPR, with assistance from officers. They were unable to resuscitate Mr McKain and declared his death at 4.17pm.

Contact with Mr McKain's family

24. The prison chaplain and a supervising officer visited Mr McKain's partner on 22 February, to break the news of Mr McKain's death. The prison chaplain maintained regular contact with Mr McKain's partner until Mr McKain's funeral on 1 May. The prison contributed to the costs in line with national guidance.

Support for prisoners and staff

25. After Mr McKain's death, a manager 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.
26. The prison posted notices informing other prisoners of Mr McKain'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 McKain's death.

Post-mortem report

27. Mr McKain's post-mortem report shows the cause of death as coronary artery stenosis (blocking of the arteries in the heart). Mr McKain's toxicology report shows that he had only prescribed medication at therapeutic levels in his system. There was no trace of PS or any other illicit substances.

Findings

Mr McKain's healthcare at Belmarsh

28. Mr McKain's last blood test results, in 2016, were normal. He failed to attend subsequent blood test appointments. His normal blood test result included his cholesterol level and therefore it did not suggest Mr McKain needed to take any preventative action or require additional therapy, such as being prescribed statins to reduce his cholesterol. Mr McKain's medical records do not reveal any complaints of chest pain, shortness of breath or difficulty breathing. There was no indication that he had cardiovascular disease. The clinical reviewer concluded that Mr McKain died from a sudden and catastrophic cardiac event. The British Heart Foundation notes that many people with blocked arteries are unaware they have them until they develop symptoms, and sometimes the first time they realise is when they have a heart attack.
29. The clinical reviewer was satisfied that the clinical care provided to Mr McKain was equivalent to that which he could have expected to receive in the community.

Emergency response

30. Although the approach to Mr McKain's resuscitation followed acceptable guidelines, a change in policy at Belmarsh means that all staff are trained in basic life support rather than intermediate life support. This means that staff carrying out CPR were unable to use an I-gel airway or adrenaline, because Oxleas does not stock them, so they were not included in the emergency bag. While we cannot say whether the lack of immediate access to these affected the outcome for Mr McKain, we are concerned that not training staff in intermediate life support or stocking these pieces of life saving equipment could have an impact in the future. It is unclear to us if Oxleas' policy on staff training and equipment has been fully risk assessed in relation to the situations found in a prison with an in-patient unit and on-site teams of clinicians, as opposed to the environments in which the Trust operates elsewhere. The clinical reviewer makes a recommendation which we endorse:

The Governor and the Head of Healthcare should ensure that Oxleas Trust's policies on life support training for staff and the provision of life-saving equipment at Belmarsh:

- are fully risk-assessed in relation to the specific situation at Belmarsh; and
- accurately reflect the guidance of European Resuscitation Council.

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