

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Maccuish a prisoner at HMP Featherstone on 5 June 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 Scott Maccuish died on 5 June 2018 at HMP Featherstone from heart disease. He was 44 years old. I offer my condolences to Mr Maccuish's family and friends.

Mr Maccuish had a long history of drug abuse and this may have contributed to his heart disease.

I am satisfied that the care Mr Maccuish received for his drug abuse was in line with the National Institute of Clinical Excellence (NICE) guidelines, and that both prison and healthcare staff responded quickly and appropriately when Mr Maccuish was found unresponsive in his cell.

Overall, the healthcare Mr Maccuish received was equivalent to that he could have expected in the community. I am, however, concerned that he did not have the annual health checks recommended for people taking anti-psychotic medication at HMP Leicester, and that an abnormal blood pressure reading when he arrived at Featherstone was not followed up.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

June 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	5
Findings.....	8

Summary

Events

1. In July 2007, Mr Scott Maccuish was sentenced to an indeterminate sentence for public protection for robbery. He was released on licence in 2016 and was recalled to prison for breaching the terms of his licence in May 2017. He was transferred to HMP Featherstone on 21 May 2018.
2. Mr Maccuish had a long history of drug abuse, mental illness and self-harm. He completed a number of drug detoxifications during his years in prison but found it difficult to stop using drugs. He was prescribed anti-psychotic medication and pain killers.
3. On arrival at HMP Featherstone, the reception medical screening identified that Mr Maccuish had moderately high blood pressure. He saw nurses twice a day to receive his anti-psychotic medication and did not complain of any health problems
4. On 5 June, at approximately 1.50pm, a prisoner told two officers that Mr Maccuish was unwell in his cell. The officers found Mr Maccuish unresponsive and called a medical emergency code. One officer began cardiopulmonary resuscitation. Healthcare staff arrived shortly afterwards and continued resuscitation alongside prison staff. Paramedics arrived at 2.00pm and continued resuscitating Mr Maccuish. CPR was continued whilst Mr Maccuish was transferred to the ambulance.
5. Shortly after leaving the prison, Mr Maccuish suffered another cardiac arrest and the paramedics decided to stop the resuscitation attempts. Mr Maccuish died in the ambulance on the way to the hospital.

Findings

Clinical care

6. The clinical reviewer was satisfied that Mr Maccuish was offered appropriate care and support for his drug abuse problems during his time in prison and that the care he received was in line with National Institute of Clinical Excellence (NICE) guidelines.
7. We agree with the clinical reviewer that the emergency response was well conducted. All members of staff worked well together as a team. The clinical reviewer noted that the resuscitation attempt was at least good as that which would have been available in the community.
8. We are satisfied that, overall, the healthcare Mr Maccuish received in prison was equivalent to that he could have expected in the community. The clinical reviewer did, however, identify two concerns:
 - Mr Maccuish did not have the annual health checks recommended for people taking anti-psychotic medication at HMP Leicester in 2017 – 2018 (before he transferred to Featherstone); and

- an abnormal blood pressure reading when he arrived at Featherstone was not followed up.

Recommendations

- The Head of Healthcare at HMP Leicester should ensure that all patients taking anti-psychotic medication have at least a yearly physical health check in line with NICE guidance.
- The Head of Healthcare at HMP Featherstone should ensure that all staff who carry out reception screenings refer patients with abnormal clinical findings to the appropriate clinician.

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 her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Maccuish's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Maccuish's clinical care at the prison.
12. We informed HM Coroner for South Staffordshire of the investigation and he gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. The investigator wrote to Mr Maccuish's partner to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
14. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies. They provided an action plan in response to our recommendations, which is annexed to this report.

Background Information

HMP Featherstone

15. HMP Featherstone is a medium security, Category C prison, holding around 650 convicted men. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

16. The most recent inspection of Featherstone was conducted in October 2018. The key message from the inspection was one of improvement, and inspectors found that the prison had come a long way since their last inspection in 2016. They found that energy and initiative were evidenced throughout the prison, which resulted in benefits for prisoners. The availability of illicit drugs was still considered to be a challenge for the prison but there was an impressive range of measures in place to try and tackle the problem.

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 October 2018, the IMB was pleased to report that concerns from the previous reporting period had been addressed and felt that the prison was a much safer and more decent place for both staff and prisoners. It felt that more could still be done to improve the poor state of some of the buildings. Cancellations of hospital appointments were too high due to a lack of escort staff.

Previous deaths at HMP Featherstone

18. Mr Maccuish was the ninth prisoner to die at Featherstone since 2015 and the fourth to die of natural causes. There have been two deaths since, both from natural causes. There are no similarities between Mr Maccuish's death and the other deaths.

Key Events

19. In July 2007, Mr Scott Maccuish was sentenced to an indeterminate sentence for public protection for robbery and spent time in various prisons. He was released on licence in 2016, and was recalled to prison for breaching the terms of his licence in May 2017. He was at HMP Leicester from July 2017, apart from a few weeks in early 2018, and he transferred to HMP Featherstone on 21 May 2018.
20. Mr Maccuish had a history of mental ill health and was prescribed olanzapine (an anti-psychotic medication) throughout his time in prison.
21. Mr Maccuish also had a long history of drug abuse in prison and in the community, and used heroin, cocaine, cannabis and psychoactive substances (PS). He had extended periods of treatment with opiate-substitute treatment, including buprenorphine in the community and methadone in various prisons. He undertook a number of detoxification programmes to stop using methadone in prison, but found it very difficult to stop using opiates for sustained periods. He was enrolled on several courses to help him cope with the psychosocial aspects of drug abuse but did not complete any of them.
22. From August 2017, there are five recorded episodes of Mr Maccuish being under the influence of PS at Leicester.
23. Mr Maccuish had had a number of injuries, including to his neck, leg and lower back, and was prescribed painkillers in various prisons, including pregabalin (a medication which is often illicitly traded in prisons). There are several entries in his medical records suggesting that Mr Maccuish may have been trying to divert his pregabalin (that is, to hide it and then sell it). He was warned about this behaviour but the medication was not stopped.
24. In September 2017, Mr Maccuish saw a prison GP about his back pain. He became angry when she refused to prescribe him opiate-based medication and threatened legal action. The doctor recorded his behaviour as 'drug-seeking'. Mr Maccuish was taking methadone at the time which, although prescribed for drug dependence, is an opiate which has a painkilling effect.
25. Mr Maccuish completed a detoxification course off methadone on 9 February 2018 at Leicester. Despite his requests to go back on to it, he was not prescribed methadone again.

HMP Featherstone

26. When Mr Maccuish arrived at HMP Featherstone in May 2018, the reception medical screening identified that he had moderately high blood pressure. There is no evidence that this was followed up prior to his death. Mr Maccuish's existing medication – pregabalin and olanzapine - was prescribed by the prison GP.
27. He was also seen by a Recovery Champion (a specially trained prisoner who provides peer support for other prisoners with drug problems) in reception and was referred to the substance misuse service, although he was not seen before his death a fortnight later.

28. Mr Maccuish was seen by nurses twice a day when he took his anti-psychotic medication, but had no other contact with medical staff at Featherstone. Healthcare staff said that he did not complain of any physical symptoms during those contacts.

Events of 5 June 2018

29. On 5 June, at approximately 1.40pm, two officers began unlocking the prisoners living on Mr Maccuish's wing. About ten minutes later a prisoner told them that they needed to check on a prisoner who was turning blue. The officers went to Mr Maccuish's cell where they found Mr Maccuish unresponsive in a chair, with three or four prisoners around him trying to get him to respond. At 1.54pm, one of the officers called a code blue medical emergency.
30. The same officer asked the prisoners to leave the cell. After examining Mr Maccuish and finding no pulse, he began cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards and continued CPR alongside prison staff. A defibrillator was applied but it stated that Mr Maccuish had no shockable rhythm. Paramedics arrived by ambulance at 2.00pm and took over Mr Maccuish's CPR. They gave him adrenaline and his circulation returned. He had further cardiac arrests at approximately 2.22pm and 2.50pm. CPR was continued while Mr Maccuish was transferred to the ambulance.
31. Shortly after leaving the prison, Mr Maccuish suffered another cardiac arrest in the ambulance. It was decided to discontinue resuscitation attempts. Mr Maccuish died in the ambulance on the way to the hospital.

Post-mortem report

32. A post-mortem examination concluded that the cause of Mr Maccuish's death was ischaemic heart disease (narrowed arteries caused by a build up of fatty deposits).
33. The toxicology report showed no alcohol in Mr Maccuish's blood and only therapeutic levels of his anti-psychotic medication. The report noted that there was a trace of cocaine in his system, although this was not thought to have contributed directly to his death.

Contact with Mr Maccuish's family

34. On 5 June, at 3.06pm, the Deputy Governor telephoned Mr Maccuish's partner and informed her that Mr Maccuish had suffered a suspected cardiac arrest. He told her that Mr Maccuish would be taken to hospital and that she could also attend the hospital. Mr Maccuish's partner said that she would make her own way there and she was provided with the necessary contact number should she need to contact the prison.
35. At 3.40pm, the Deputy Governor telephoned Mr Maccuish's partner again to tell her that Mr Maccuish had died on the way to the hospital. He provided her with the details of the prison family liaison officer who would be supporting the family.

He also informed Mr Maccuish's sister of her brother's death and she was offered support.

36. The following day, the prison's family liaison officer and a prison manager visited Mr Maccuish's partner. They were able to answer some of her immediate questions and maintained regular and good communication with Mr Maccuish's family.
37. The funeral took place on 26 June and the prison made a contribution in line with Prison Service instructions.

Support for prisoners and staff

38. While Mr Maccuish was being taken to hospital, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising. During the meeting staff were told that Mr Maccuish had died on the way to the hospital. Staff were offered support.
39. The prison posted notices informing other prisoners of Mr Maccuish'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 Maccuish's death.

Findings

Clinical care

Substance Misuse

40. Mr Maccuish had a long history of drug abuse and was prescribed methadone (an opiate-substitute) for extended periods at various prisons. After he completed a detoxification course at Leicester in February 2018, his methadone was stopped and it was not prescribed again.
41. The clinical reviewer said that NICE guidelines on opiate-prescribing recommend that it should not be necessary to maintain prisoners on opiate-substitute medication in prison. This means that, although the treatment Mr Maccuish received for his drug abuse in prison, may not have been equivalent to that he would have had in the community (where maintenance methadone is sometimes prescribed), it was in line with NICE guidance.

Physical health

42. The clinical reviewer was, however, concerned that the monitoring of Mr Maccuish's physical health was not equivalent to that he would have had in the community.
43. Mr Maccuish died of ischaemic heart disease (IHD). People with high blood pressure have an increased risk of developing IHD. The clinical reviewer says it is possible that Mr Maccuish's long-term use of illicit drugs may have contributed to his heart disease, since cocaine in particular is known to increase blood pressure.
44. Mr Maccuish's blood pressure was slightly high when taken in HMP Stocken in February 2018, but the level was within the normal range in HMP Leicester in March 2018. It was slightly high again when he arrived at Featherstone in May 2018, which should have been followed up. The clinical reviewer says that there is no evidence that Mr Maccuish suffered from persistently raised blood pressure over a long period of time of sufficient magnitude to have damaged his heart. Nevertheless, we make the following recommendation:

The Head of Healthcare should ensure that all staff who carry out reception screenings refer patients with abnormal clinical findings to the appropriate clinician.

45. The clinical reviewer also noted that Mr Maccuish was prescribed two medications - olanzapine and pregabalin - which can both have potentially serious side effects. Olanzapine can affect liver function, lipid levels and the electrical activity of the heart. Pregabalin can also occasionally have cardiac side effects.
46. NICE guidelines state that all patients taking antipsychotic medication should have a yearly physical check, which should include a number of blood tests and, where indicated, an electrocardiogram (ECG). These tests were carried out in prisons between 2011 and 2015, and in January 2016, Mr Maccuish had a blood test at Leicester that showed mild anaemia. There is no record of treatment for

the anaemia or of any further investigations or follow-up. Mr Maccuish had no further blood tests and did not have an ECG at Leicester in 2017-2018.

47. The clinical reviewer says that it is, therefore, not possible to say whether Mr Maccuish had signs of heart disease prior to his death, although she notes that there is no record that he ever complained of chest pain or shortness of breath in prison.
48. We make the following recommendation:

The Head of Healthcare at HMP Leicester should ensure that all patients taking anti-psychotic medication have at least a yearly physical health check in line with NICE guidance.

49. Mr Maccuish was not at Featherstone for long enough for the routine monitoring of his mental health medication to have taken place. At interview the prison GP was clear that, if Mr Maccuish had stayed at Featherstone, he would have been referred to the Safer Prescribing team for review of his medication and routine blood tests and an ECG would have been arranged.

Informing Mr Maccuish's family of his death

50. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, says, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death ...If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable."
51. After Mr Maccuish was taken to hospital, the prison appropriately contacted Mr Maccuish's partner by telephone to let her know. Due to the seriousness of his condition, she was advised to make her way to the hospital as soon as possible. A short time afterwards, the prison told Mr Maccuish's partner by telephone that he had died on the way to the hospital.
52. PSI 64/2011 is clear that the news of a prisoner's death should be delivered in person, unless there is clear evidence that his next of kin have agreed to another method. However, in this case we accept that Mr Maccuish's partner was on her way to the hospital and that it would, therefore, have been difficult for prison staff to have informed her in person before she arrived. In the circumstances we accept, on balance, that it was preferable to let her know by telephone before she reached the hospital.

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