Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Duncan McGee a prisoner at HMP Doncaster on 10 November 2018

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*

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 Duncan McGee died in hospital on 10 November 2018 of chronic obstructive pulmonary disease, cerebrovascular disease and a hip fracture, while a prisoner at HMP Doncaster. He was 80 years old. I offer my condolences to Mr McGee's family and friends.

On 30 September, Mr McGee fell out of bed and fractured his hip. He was taken to hospital and had an operation to repair his hip fracture, but his condition subsequently deteriorated and he remained in hospital until his death on 10 November.

Mr McGee had a number of pre-existing health conditions. I am satisfied that overall, the care he received at Doncaster was equivalent to that which he could have expected to receive in the community.

However, I am concerned that when Mr McGee fell out of bed and fractured his hip on 30 September, there was a delay of almost two hours in calling an ambulance and he was left lying on the floor of his cell for that time because there were insufficient staff to escort him to hospital. I do not consider that this was acceptable.

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

Sue McAllister
Prison and Probation Ombudsman **June 2019**

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Summary

Events

1. On 13 January 2014, Mr Duncan McGee was sentenced to 25 years in prison for sexual offences. He was sent to HMP Doncaster.

2. Mr McGee had several long-term health conditions including heart disease and chronic obstructive pulmonary disease (COPD – a collection of lung diseases including chronic bronchitis and emphysema). Nurses and prison GPs monitored Mr McGee's medical conditions frequently.

3. Mr McGee had a history of falls and was provided with a Zimmer frame. On 25 September, he fell as a result of a dizzy spell. A nurse reviewed him and found that his vital signs were normal.

4. On 30 September at 5.20am, Mr McGee fell out of bed. A prison paramedic attended and said that Mr McGee needed to go to hospital by ambulance. However, the prison's orderly officer said that Mr McGee would not be able to go out to hospital until day staff arrived. Mr McGee was given pain relief but left lying on the floor of his cell. Staff called an ambulance at 7.14am and Mr McGee was taken to hospital by ambulance at 8.10am. Two prison officers accompanied him and no restraints were used.

5. On 1 October, Mr McGee had an operation to repair his fractured hip. He remained stable in hospital until 9 November when his condition rapidly deteriorated. On 10 November at 12.46am, a doctor declared that Mr McGee had died.

6. The post-mortem report found that Mr McGee died from COPD, cerebrovascular disease (conditions that affect the blood supply to the brain) and osteoporotic fracture of the neck of femur (hip fracture).

Findings

7. The clinical reviewer found that overall, Mr McGee's care was equivalent to that he could have expected to receive in the community. However, she found that staff did not review his cardiovascular care plan as regularly as they should have done and they did not complete a falls risk assessment as recommended by National Institute for Health and Care Excellence (NICE) guidance.

8. We are concerned about the delay in Mr McGee being taken to hospital on 30 September. We do not consider that it was acceptable to leave an 80 year old man with a broken hip lying on a cell floor for two hours before an ambulance was called. Although Mr McGee did not require an emergency ambulance, he still needed an urgent transfer to hospital.

Recommendations

- The Head of Healthcare should ensure that a falls risk assessment is incorporated into the older person's care plan, and that staff review all care plans in a timely manner.

- The Director should ensure that when healthcare staff request a non-emergency ambulance to transfer a prisoner to hospital urgently, prison staff arrange a hospital escort promptly, regardless of the time of day.
- To achieve this, the Director and Head of Healthcare should establish a clear written process to be followed by prison and healthcare staff which avoids doubt about whether a hospital transfer is urgent, and includes escalation procedures if necessary.

The Investigation Process

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

10. The investigator visited HMP Doncaster on 3 December 2018. She obtained copies of relevant extracts from Mr McGee's prison and medical records.

11. The investigator interviewed two members of staff by telephone on 3 January 2019.

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

13. We informed HM Coroner for Doncaster of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. There was no family involvement in the investigation. Mr McGee had not named a next of kin.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Doncaster

16. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Nottingham Healthcare NHS Foundation Trust provides physical and mental health services, and substance misuse services. HMP Doncaster directly employs qualified paramedics as part of their healthcare team, who respond to emergency calls within the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Doncaster was in July 2017. Health services had improved considerably since the previous inspection in October 2015 and overall, were reasonably good. A wide range of primary care services was available and waiting lists were generally short, although too many patients failed to attend appointments. The management of prisoners with long-term conditions had improved, with several trained staff available to patients. The 24-hour in-house paramedic service was an example of good practice.

Independent Monitoring Board Previous deaths at HMP Doncaster

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 September 2016, the IMB noted that Doncaster held a high number of ageing prisoners and expressed concerns that the healthcare team did not have any specialist older or palliative care available onsite. They noted that mental health care was only available in office hours and there was no on-call system, leaving prison staff and physical healthcare staff to do work that the mental health team should be doing.

Previous deaths at HMP Doncaster

19. Mr McGee was the 12th prisoner to die at Doncaster since November 2015. Of the previous deaths, eight were from natural causes and three were self-inflicted. There have been two deaths since, one from natural causes and one self-inflicted. There were no similarities between the circumstances of Mr McGee's death and the previous deaths at the prison.

Key Events

20. On 13 January 2014, Mr Duncan McGee was sentenced to 25 years in prison for sexual offences. He was sent to HMP Doncaster.

21. Mr McGee was aged 80 and had several long-term health conditions including chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema), angina, coronary heart disease, and was documented to have had a previous stroke. Healthcare staff created multiple care plans including an older person's care plan, although there is no evidence that this included a falls risk assessment. Doctors prescribed appropriate medication, including salamol and a spiriva respimat inhaler (used to prevent narrowing of the airways in people with COPD).

22. Mr McGee had limited mobility and required a Zimmer frame to get around, although he did not always use this. He was located in the social care unit at HMP Doncaster and received daily support with his care needs.

23. On 17 June 2017, a nurse saw Mr McGee to review his heart disease care plan. She did not record any concerns and recommended a review in 12 months. However, there is no evidence of a further review taking place. On 28 June, a nurse conducted an annual COPD review and noted that Mr McGee had not had any exacerbation over the last 12 months.

24. Over the next eight months, healthcare staff monitored and reviewed Mr McGee frequently and discussed his care needs during multidisciplinary meetings.

25. On 26 February 2018, a prison paramedic saw Mr McGee for a review and noted that he was wheezing and had a chesty cough. Mr McGee said he felt short of breath. She examined him and advised him to sleep sitting up to help his breathing. The prison paramedic saw him again later that evening for repeat observations, and noted he appeared to be settled and there were no further concerns.

26. On 21 March, a prison GP examined Mr McGee and noted that he still had a chronic cough and acid reflux. He requested a chest X-ray and prescribed alginate and metoclopramide (medications used to treat acid reflux) and noted that his chest was clear.

27. On 16 April, prison staff noticed that Mr McGee appeared unwell and asked a prison paramedic to see him for a review. She suspected a chest infection and arranged for a prison GP to see him the following day. On 17 April, he was seen by the GP. He recorded that a recent chest X-ray was normal, but due to wheezing he prescribed salbutamol nebuliser. He noted that if there was further deterioration, a hospital admission may be required. However, later in the day he was seen by a prison paramedic and she noted that he appeared to be much better.

28. On 18 July, a nurse saw Mr McGee for an annual COPD review. She noted that he was struggling to clear his chest, possibly due to bad inhaler technique. She changed his inhaler to respimat in the hope that this would be more effective and easier for him to use. He was documented to be generally well at this time.

29. On 25 September, Mr McGee suffered a fall which occurred after a dizzy spell. A nurse was asked over the radio to attend the annex as Mr McGee had fallen over. When she arrived, Mr McGee was fully coherent with a normal blood pressure of 143/72 mm/Hg. She took his vital signs and recorded them as being within normal limits. The plan was for him to be reviewed by the GP due to a thumb injury caused by the fall. However, there is no record that this took place or that a falls risk assessment was completed.

30. On 27 September, further monitoring of Mr McGee found that his blood pressure and pulse were fluctuating so plans for an assessment with an Advanced Nurse Practitioner were put in place. Mr McGee was seen several times throughout the day and during the evening by various members of healthcare. At 9.49pm, a prison paramedic noted that his pulse was now stable and regular.

31. On 30 September, at 5.20am, an officer responded to Mr McGee's emergency panic alarm and found that he had fallen out of bed and was lying on the floor in a lot of pain. A nurse attended and Mr McGee was given intravenous paracetamol for pain relief and made comfortable with padding. She informed prison staff that he needed to go to hospital due to a possible fracture of his left femur (a broken hip). A Custodial Operations Manager (COM), the orderly officer that night, told the nurse that due to low staffing levels Mr McGee would not be able to go out to hospital until day staff arrived. An ambulance was called at 7.14am, which arrived 15 minutes later. At 8.10am, Mr McGee left the prison by ambulance. He was escorted by two officers and no restraints were used.

32. Hospital staff diagnosed a fractured hip and on 1 October, Mr McGee had an operation to repair the fracture. Prison healthcare staff kept in regular contact with the hospital for updates on Mr McGee's condition and attended a multidisciplinary meeting on 30 October, to discuss his ongoing care needs.

33. On 9 November, Mr McGee's condition deteriorated rapidly and hospital staff advised that end of life care would commence. On 10 November, at 12.46am, a doctor declared that Mr McGee had died.

Contact with Mr McGee's family

34. On 1 October, due to Mr McGee's condition deteriorating, the prison appointed a family liaison officer (the engagement and communications officer at Doncaster). She checked Mr McGee's prison record and tried to contact his next of kin using the number that was held on file. This number was unobtainable. The family liaison officer contacted the probation service, police service and victim support to see if she could obtain any other next of kin details. There were no details held, and no next of kin was identified.

35. The prison arranged and paid for Mr McGee's funeral in line with national guidelines. The funeral took place on 27 November.

Support for prisoners and staff

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

37. The prison posted notices informing other prisoners of Mr McGee's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr McGee's death.

Post-mortem report

38. The post-mortem report found that Mr McGee died of chronic obstructive pulmonary disease, cerebrovascular disease (a variety of medical conditions that affect the blood vessels of the brain) and a fracture of the neck of the femur (hip fracture).

Findings

Clinical care

39. Mr McGee was an elderly man who suffered from a number of chronic health conditions including COPD and heart disease. Healthcare staff monitored and reviewed Mr McGee frequently, prescribed appropriate medication and discussed his care needs during regular multidisciplinary meetings. The clinical reviewer considered that Mr McGee's COPD was well managed by healthcare staff who were responsive during acute exacerbations and appropriately sent him to hospital, as required.

40. We are satisfied that, overall, Mr McGee received appropriate care and treatment at Doncaster which the clinical reviewer considered was equivalent to that he could have expected to receive in the community. However, we are concerned that healthcare staff did not review his cardiovascular care plan in line with NICE guidelines or complete a falls risk assessment. We therefore make the following recommendation:

    The Head of Healthcare should ensure that a falls risk assessment is incorporated into the older person's care plan, and that staff review all care plans in a timely manner.

Transfer to hospital on 30 September

41. A nurse attended swiftly when an officer alerted her that Mr McGee had fallen, and shortly after 5.20am, she told the COM that she needed an ambulance to take Mr McGee to hospital. However, the COM said that he did not have enough prison staff available to facilitate an escort, causing a delay of over two hours. At interview, the COM told the investigator that he decided to wait for the day staff to arrive as it was not an emergency and had not been called as one.

42. As Mr McGee did not require an emergency ambulance to take him to hospital, the COM took this to mean that his transfer to hospital was not urgent. However, not all prisoners who need to be taken to hospital urgently require an emergency ambulance. Mr McGee had a condition that required him to be taken to A&E as soon as possible, but did not require the kind of paramedical intervention (such as cardio-pulmonary resuscitation or assistance with breathing) on the journey to hospital which an emergency ambulance provides.

43. It is important that prison staff understand this and that healthcare staff are able to explain it to ensure that prisoners are taken to hospital urgently when required.

44. Doncaster has a clear policy about what should happen when a prisoner needs to go to hospital as an immediate emergency. However, there is no clear policy which sets out what should happen when a prison GP, senior nurse or paramedic identifies that a prisoner needs to be transferred urgently to hospital, but not as an immediate emergency.

45. Mr McGee was 80 years old, with a number of chronic health conditions, and had fallen out of bed causing a serious and painful injury. He required urgent admission to A&E with a view to possible surgery. While we recognise that

healthcare staff kept him comfortable with pain relief, we do not consider it appropriate to have left him on a hard floor for two hours before an ambulance was called. We consider this delay to be unacceptable.

46. We make the following recommendations:

The Director should ensure that when healthcare staff request a non-emergency ambulance to transfer a prisoner to hospital urgently, prison staff arrange a hospital escort promptly, regardless of the time of day.

To achieve this, the Director and Head of Healthcare should establish a clear written process to be followed by prison and healthcare staff which avoids doubt about whether a hospital transfer is urgent, and includes escalation procedures if necessary.

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