Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan McDonald a prisoner at HMP Preston on 4 March 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 Alan McDonald died of a lower respiratory tract infection, chronic obstructive pulmonary disease and lung cancer on 4 March 2018 while a prisoner at HMP Preston. He was 70 years old. I offer my condolences to his family and friends.

Mr McDonald received a good standard of clinical care at HMP Wymott and HMP Preston, equivalent to that which he could have expected to receive in the community.

However, I am concerned that, although Mr McDonald lived in the healthcare unit at Preston for more than two years before his death, he was never formally transferred to Preston and remained the responsibility of Wymott. This caused problems for family liaison, escort risk assessments and record keeping. I am concerned that when a prisoner is transferred to a regional healthcare bed at Preston, there is no process in place to review whether and at what stage the prisoner should be formally transferred.

I am disappointed with HMP Preston's poor record keeping, and that they could not provide Mr McDonald's escort risk assessments. I am also concerned that HMP Wymott did not reconsider whether Mr McDonald was suitable for early compassionate release after 2017.

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 Ombudsman **March 2019**

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Summary

Events

1. On 9 December 2003, Mr Alan McDonald was sentenced to life in prison for false imprisonment and kidnapping. He was sent to HMP Liverpool. On 14 March 2014, he was transferred to HMP Wymott.

2. During his initial health screen at Wymott, Mr McDonald told a nurse that he had chronic obstructive pulmonary disease (COPD) and depression. He was monitored regularly for both these conditions.

3. In January 2015, Mr McDonald reported to a prison GP that he had a persistent cough. The GP referred him for a chest x-ray which showed a defined mass in the right lung.

4. The prison GP then referred him for investigation under the two-week rule (an urgent referral system for suspected cancer). The initial scan was inconclusive, and a further scan was taken on 30 March, which confirmed an incurable form of lung cancer.

5. Appropriate care plans were put in place to manage his condition, and a prison GP held fortnightly reviews of Mr McDonald's cancer and COPD care.

6. Over the following months, Mr McDonald's health declined, and after he was admitted to hospital on 25 December, healthcare staff at Wymott decided that they did not have the facilities to look after Mr McDonald. On 27 December 2015, he was moved to a regional healthcare bed at HMP Preston which has 24-hour palliative care. Mr McDonald had a prognosis of between one to six months at the time.

7. Throughout 2016 and 2017, Mr McDonald often refused help with personal care but staff reviewed his cancer care daily, and his COPD was reviewed monthly. Despite his short prognosis, there was no sign that he was reaching the end of his life.

8. On 22 February 2018, Mr McDonald was transferred to hospital with a chest infection. When he returned to Preston on 27 February, he was referred to a hospice for end of life care.

9. The next week, Mr McDonald was reviewed regularly, and there was no evidence of a further decline in his health. It was not until 4 March that Mr McDonald's health deteriorated. He was monitored closely that day, and at 3.22pm, a nurse who attended to him, found that he had stopped breathing. An ambulance was called but when paramedics arrived at the prison, they confirmed that Mr McDonald had died.

Findings

10. Mr McDonald's medical care at both Wymott and Preston was equivalent to that which he could have expected to receive in the community. When he first showed potential signs of cancer, he was referred promptly to hospital for diagnosis.

11. Mr McDonald was appropriately transferred to Preston so that he could receive 24-hour healthcare. Although his life expectancy was not believed to exceed six months, Mr McDonald lived at Preston for more than two years. Although he should have been formally transferred to Preston, this did not happen. He remained a prisoner of Wymott and Wymott retained responsibility for him, even though he did not live there.

12. Wymott told the investigator that they had asked for Mr McDonald to be formally transferred, but that Preston refused on the basis that he was using a regional healthcare bed. This adversely affected the continuity of care that Mr McDonald received from Wymott's family liaison officer and various administrative processes, and is reflected in incomplete records.

13. Prison staff at Wymott should have reviewed Mr McDonald's compassionate release status after his last application in 2017.

Recommendations

- The Prison Group Director for Cumbria and Lancashire should ensure that there is a process in place at regional level to review whether and at what stage prisoners who are transferred to a regional healthcare bed in another prison, should be formally transferred.
- The Governor at HMP Preston should ensure that prisoners' documentation is stored securely and can be retrieved, as necessary.
- The Governor of HMP Wymott should ensure that compassionate release for terminally ill prisoners is properly considered and that applications are submitted promptly where appropriate.

The Investigation Process

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

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

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

17. We informed HM Coroner for Preston and West Lancashire District of the investigation who provided us with the cause of death. We have sent the Coroner a copy of this report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

19. We have investigated the main issues involved in Mr McDonald's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

Background Information

HMP Preston

20. HMP Preston is a local prison which serves the courts in Lancashire and Cumbria. It holds up to 811 adult male prisoners. Spectrum community health CIC provides the healthcare services at Preston. GPs provide daytime cover between 9.00am and 9.00pm from Monday to Friday and from 3.00pm to 5.30pm on Saturdays. Outside of these hours, a nurse is on duty. An out of hours service is provided by GTD Healthcare.

21. Preston has a regional healthcare facility which takes patients from other prisons, including HMP Wymott. The facility has a 30-bed physical care inpatient unit including 12 physical health beds which also provides palliative care.

22. Prisoners can be transferred from another prison to a regional healthcare bed when they require 24-hour care. While they are cared for in the receiving prison, the prison from where they have transferred retains responsibility for decisions made about them. This includes decisions about compassionate release, completing escort risk assessments, appointing a family liaison officer and informing the next of kin of death. Medical and prison records are transferred to the receiving prison. However, if a prisoner dies, his prison records will be sent to the prison with ultimate responsibility for him.

HM Inspectorate of Prisons

23. The most recent inspection of Preston was in March 2017. Inspectors noted that there was a clean, welcoming and well managed 30-bed inpatient facility for prisoners with severe physical and mental health needs. Twelve beds were designated regional beds for other prisons in the area. Inspectors noted that prisoners were admitted based on clinical need. They stated that physical healthcare beds in the two dormitories were specialist hospital beds, and emergency call bell arrangements were adequate. Inpatients were positive about their care, and all had a named nurse.

Independent Monitoring Board

24. 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 31 March 2017, the IMB reported that despite poor staffing, the healthcare team continued to make valiant efforts to maintain an effective healthcare service, including healthcare assessment as part of prisoner induction. They noted that the high churn in the prison population had made it complicated for staff to follow up issues identified at initial assessment.

Previous deaths at HMP Preston

25. There have been seven previous deaths at Preston since March 2015, six of which were from natural causes. Preston accepted and agreed to implement two previous recommendations we made about the proper storage of prisoners' documentation.

Findings

The diagnosis of Mr McDonald's terminal illness and informing him of his condition

26. On 9 December 2003, Mr Alan McDonald was sentenced to life in prison for false imprisonment and kidnapping. He was sent to HMP Liverpool. On 14 March 2014, he was transferred to HMP Wymott.

27. During his initial health screen with a nurse, Mr McDonald said that in 2003, he had been diagnosed with anxiety, depression and psychosis, for which he took medication. He said that in 2010, he was diagnosed with COPD. Mr McDonald smoked but declined smoking cessation advice.

28. The mental health team and staff nurses saw Mr McDonald. They put care plans in place, and regularly reviewed his conditions.

29. On 12 January 2015, a prison GP saw Mr McDonald who said that he had been coughing at night, and bringing up yellow sputum. The prison GP referred him for a chest x-ray.

30. On 29 January, Mr McDonald had a chest x-ray which showed a defined mass in his right upper lobe (one of the three lobes) in his right lung. A prison GP referred him urgently to the respiratory specialist at a hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

31. On 15 February, a nurse recorded that she could not see a referral in Mr McDonald's medical notes, or that an appointment had been booked for him. She asked the administrative team to chase this urgently.

32. On 2 March 2015, Mr McDonald went to hospital for a computerised tomography (CT) scan. The results were inconclusive but showed a high risk of lung cancer.

33. A nurse discussed the results with Mr McDonald, who said that he was fully aware of the outcome, and that he had been told that if lung cancer was present, it would not be curable. She noted that a positron emission tomography (PET) scan (used to produce detailed three-dimensional images of the inside of the body) should be booked to get a firm diagnosis.

34. On 4 March, Mr McDonald saw a mental health nurse. They discussed the emotional and psychological impact of the potential diagnosis. Mr McDonald spoke openly, and said that he was not afraid of dying.

35. On 12 March, Mr McDonald attended a hospital for the PET scan. This could not be taken as he had not been advised to fast. Mr McDonald was returned to the prison.

36. The PET appointment was rescheduled for 30 March when it was confirmed that Mr McDonald had inoperable lung cancer. A locum GP asked for the respiratory consultant to be contacted to provide further information, including a prognosis.

37. On 30 April, the consultant contacted a nurse and told her that he could not give a prognosis but that it was likely to exceed three months.

38. On 6 May, after a multidisciplinary team (MDT) meeting about Mr McDonald's diagnosis, a prison GP met him to discuss this in detail. He recorded that Mr McDonald had taken the news well.

39. The clinical reviewer concluded that Mr McDonald's cancer had been diagnosed in line with NICE guidelines, and was of a standard equivalent to that which he could have expected to receive in the community.

Mr McDonald's clinical care

40. After Mr McDonald was diagnosed with lung cancer, care plans were put in place and MDT meetings took place, with general and mental health nursing input.

41. On 14 May 2015, a nurse manager noted that Mr McDonald had fallen out of bed. She told the lead nurse for elderly prisoners and cancer care, and asked for Mr McDonald to be referred to the social care team and to have a falls risk assessment.

42. On 19 May, a nurse reviewed Mr McDonald, completed a falls assessment, and referred him to see a social worker to assess if he needed assistance. She put in place fortnightly cancer and COPD reviews with a prison GP.

43. Mr McDonald was prescribed daily pain relief. However, on 18 August, he complained to a nurse that he had not been given any. She apologised and gave him his medication immediately.

44. An MDT meeting took place on 28 August 2015, and concluded that Mr McDonald's health was in severe decline, and that he had asked to speak to Listeners on the wing most evenings.

45. A Macmillan cancer care specialist, attended the meeting to advise on how to maintain appropriate care for Mr McDonald. She said that Mr McDonald's needs would be better met at HMP Preston, where they had an inpatient facility with 24-hour nursing care. Staff noted that Mr McDonald would probably not be happy with this transfer as Preston was further from his family. It was recorded that MDT meetings would take place every fortnight to ensure appropriate care.

46. On 4 September 2015, a nurse noted that Mr McDonald's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order should be reviewed regularly, that his pain relief should be given on time, that his nutritional intake should be monitored, and that he should be given appropriate emotional and psychological support. The next monthly palliative care review was booked for 16 October.

47. On 4 November, Mr McDonald attended an appointment at a hospital due to an exacerbation of his COPD. He was told that he needed oxygen therapy, and that if he did not receive it, it would shorten his prognosis.

48. Healthcare and wing staff continued to monitor Mr McDonald. On 25 December, he reported having breathing difficulties. A nurse took his observations, and noted that his oxygen level was at 62% (values under 90% are considered low).

With oxygen therapy, his level was raised to 90% but this dropped to 66%. Mr McDonald was then sent to hospital in a non-emergency ambulance. During his admission, a chest x-ray was taken, which showed no change.

49. During his hospital admission, a nurse at Wymott recorded that Mr McDonald now needed oxygen for prolonged periods, and that Wymott could only facilitate oxygen therapy for short periods of time. There was concern about Mr McDonald being administered continual oxygen therapy because he smoked in his cell, and this posed a risk of explosion.

50. The nurse spoke to the healthcare department at HMP Preston, who agreed to take Mr McDonald that day into one of Preston's regional healthcare beds. (This meant that Mr McDonald would remain a prisoner of Wymott but live in the regional healthcare facility at Preston.) Mr McDonald did not want to move but had to do so for clinical purposes.

51. On 27 December, Mr McDonald was transferred from hospital to Preston. All relevant medical records were sent to Preston before he arrived. On arrival, a prison GP completed a thorough initial healthcare assessment, including an assessment of his physical health and his mental health and wellbeing. (Mr McDonald had been monitored under suicide and self-harm prevention procedures, known as ACCT, four times at Wymott, most recently on 23 December 2015.) He also reviewed his medication and confirmed that Mr McDonald had been placed on the Gold Standard Framework (which ensures evidence-based practice for those approaching the end of life). He arranged for the palliative care team to review him and for a review of the DNACPR order which was last agreed at Wymott. Mr McDonald also received smoking cessation advice, and was given nicotine patches.

52. On 30 December, a nurse referred Mr McDonald to the prison mental health team as he was threatening to take his life. Staff started ACCT monitoring, which continued until mid-January 2016.

53. On 13 February, a healthcare support worker noted that Mr McDonald was smoking in his cell while using his oxygen. A nurse noted that he was moving around the wing with some ease, a locum GP decided to remove his oxygen, and noted that it would be administered if his level fell below 90%. The GP reviewed him more than twice a week to make sure that he was getting oxygen, as needed.

54. On 21 March, a nurse completed a falls risk assessment and Mr McDonald's Waterlow pressure score was taken. (The Waterlow score estimates the risk of a pressure sore developing.) These scores were reviewed monthly and on 18 May, he was provided with an electric bed and specialist mattress.

55. Mr McDonald often declined help with his personal care but healthcare staff reviewed his cancer care daily and his COPD care monthly. When needed, he was given oxygen therapy and his diet, comfort and pain relief was monitored. When he threatened to harm himself or said that he felt suicidal, he was appropriately monitored under ACCT procedures.

56. Throughout the first half of 2017, healthcare staff regularly monitored Mr McDonald. His medical records indicate that he was demanding of healthcare staff and on occasion, used his cell bell repeatedly and unnecessarily.

57. On 18 June, Mr McDonald's oxygen saturation levels dropped and could only be lifted to 70% with oxygen therapy. He was taken by emergency ambulance to a hospital, where he was diagnosed with pneumonia.

58. On 20 June, a nurse contacted the hospital, and a consultant told her that Mr McDonald showed no signs of improvement. She visited Mr McDonald in hospital later that day, and again on 27 June.

59. He remained in hospital until 7 July, when he was returned to Preston, where staff continued to monitor and care for him. Over the following months, Mr McDonald told staff that he felt suicidal. ACCT procedures were again appropriately used to monitor his risk.

60. On 22 February 2018, a locum GP saw Mr McDonald who said that he had back pain and difficulty breathing. His SATS (oxygen saturation levels) were taken, and his oxygen level remained low at 85% after oxygen therapy. Mr McDonald was admitted to hospital, where he received intravenous antibiotics for a chest infection.

61. On 27 February, Mr McDonald was discharged from hospital to Preston, with a five-day course of antibiotics. Mr McDonald was referred to a hospice for end-of-life care.

62. On 2 March, Mr McDonald's health deteriorated and a nurse noted that he was dehydrated, drowsy and was refusing fluids. He was regularly reviewed throughout the day and night, and his oxygen saturations were maintained at around 91%.

63. On 4 March, a healthcare support worker noted that Mr McDonald's health had deteriorated rapidly over the course of the day, and reported her concerns to a nurse. The nurse reviewed Mr McDonald at 2.55pm, and recorded that his wife should be advised to visit him.

64. When the nurse checked on Mr McDonald at 3.22pm, he had stopped breathing. Paramedics were promptly called, and confirmed Mr McDonald's death at 3.52pm.

65. The clinical reviewer concluded that Mr McDonald received a good standard of medical and nursing care at Preston. In addition, healthcare staff demonstrated good use of the National Early Warning System (NEWS) tool to support their decision making about Mr McDonald's condition.

Mr McDonald's location

66. When Mr McDonald was first diagnosed with cancer, he lived on a residential wing at Wymott. At a MDT meeting on 28 August 2015, a Macmillan cancer care specialist suggested that he would benefit from being transferred to Preston, which had 24-hour palliative care services.

67. When he returned from hospital on 4 November 2015, a healthcare manager noted that Mr McDonald was refusing to move to Preston as it was a distance from his family.

68. On 25 December 2015, Mr McDonald was sent to hospital with breathing difficulties. Prison healthcare staff agreed that Mr McDonald's needs could no longer be met at Wymott, and when he was discharged from hospital on 27 December, he was sent to HMP Preston, where he lived in the healthcare unit.

69. When Mr McDonald was discharged from hospital to Preston on 27 February 2018, he was referred to a hospice for end of life care. As Mr McDonald's condition deteriorated very rapidly, a place in the hospice had not become available before he died.

Transfer from Wymott to Preston

70. In 2015, Mr McDonald was given a prognosis of one to six months, and was believed to be nearing the end of life. As Preston had 24-hour healthcare, he was appropriately transferred to their healthcare unit on 30 December 2015. In line with standard practice, he remained a Wymott prisoner in a regional healthcare bed at Preston.

71. Despite a prognosis of one to six months in April 2016, Mr McDonald did not show signs of reaching the end of his life. However, he remained a Wymott prisoner at Preston for over two years. There is no policy to say when prisons should review prisoners who are using regional healthcare beds, and when they should decide whether to transfer them formally.

72. A hub manager in the Safer Living and Residence Team, told the investigator that from June 2017 until a week before Mr McDonald's death, they repeatedly asked Preston to transfer Mr McDonald formally to Preston. However, Preston refused to do so because they maintained that Mr McDonald had transferred to a regional bed and was not their responsibility. Wymott also escalated their request for a formal transfer to the regional safer custody team who said that they would look into the matter but we have seen no evidence that they reached a conclusion.

73. Wymott told the investigator that this affected the continuity of contact that Mr McDonald received from Wymott's family liaison officer (FLO) as Preston had to facilitate any visits from Wymott's FLO. It also affected the ease at which Wymott could liaise with Mr McDonald's family after his last admission to hospital as Preston held his prison records, including his next of kin's details. While Preston had already informed his next of kin of his decline in health, after Mr McDonald died the same day, it became the responsibility of Wymott to inform Mr McDonald's family of his death. The investigator also had difficulties obtaining Mr McDonald's prison records which Preston returned to Wymott after his death. The unnecessary transfer of documents led to a delay and information going missing which was never found. We make the following recommendation:

The Prison Group Director for Cumbria and Lancashire should ensure that there is a process in place at regional level to review whether and at what

stage prisoners who are transferred to a regional healthcare bed in another prison, should be formally transferred.

Restraints, security and escorts

74. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

75. After Mr McDonald's death, the investigator asked Wymott for his prison records. A hub manager provided all the documentation that HMP Preston had forwarded to them. These records did not contain any escort risk assessments. The investigator contacted HMP Preston directly but was told that they did not hold any of the documents and that they had all been transferred to HMP Wymott.

76. The investigator spoke to an administrator in the Safer Living Team at Wymott, who said that while they sent officers from Wymott to the hospital to staff the bed watch, it was HMP Preston's responsibility to produce and complete the escort risk assessments, and these would then be held at HMP Preston as their documents

77. We are concerned that Preston did not provide us with a copy of the escort paperwork for Mr McDonald, and in the absence of documentation, we are unable to make a finding about restraints. Preston has previously agreed to implement two recommendations about the need to store prison records securely, and we repeat our recommendation:

The Governor at HMP Preston should ensure that prisoners' documentation is stored securely and can be retrieved, as necessary.

Liaison with Mr McDonald's family

78. On 22 February 2018, when Mr McDonald went into hospital, a reverend who was a manager of the chaplaincy at Wymott, was appointed as the FLO and contacted Mr McDonald's wife that day.

79. The FLO met Mr McDonald's wife at hospital on 23 February, after which they had no further contact until his death. The family liaison log was closed on 26 February after Mr McDonald was discharged to Preston.

80. Although Preston told Mr McDonald's wife of his deterioration at approximately 3pm on 4 March, it was Wymott's responsibility to inform her of his death. At 6.30pm on 4 March, the FLO and the duty governor at Wymott, arrived at Mr McDonald's wife's house and broke the news of his death.

81. The FLO remained in contact with her until after the funeral. In line with national instructions, Wymott contributed towards the costs of the funeral which took place on 23 March.

Compassionate release

82. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. Prison Service Order (PSO) 6000 sets out the criteria for early release on compassionate grounds, including that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison and release would benefit the prisoner and his family. A compassionate release application must be submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prisons and Probation Service (HMPPS).

83. Wymott appropriately completed an application for compassionate release in 2015 but it was refused on 4 August 2015.

84. A second application was made in April 2016, when Mr McDonald received a prognosis of one to six months. Wymott appropriately started the process for compassionate release but Mr McDonald was not assessed as suitable as he was considered to remain a high risk of harm to the public and reoffending. There is no evidence that compassionate release was considered after this date.

85. Despite his prognosis in 2016, Mr McDonald lived for nearly two years after his last compassionate release application in 2016. Although Mr McDonald's circumstances were unusual, we would have expected Wymott to reconsider the possibility of early release.

86. The prison provided further information following the consultation period, which evidences that a further application was made for early release in July 2017. We still would have expected the prison to have made a further application for compassionate release after this date. We make the following recommendation:

The Governor of HMP Wymott should ensure that compassionate release for terminally ill prisoners is properly considered and that applications are submitted promptly where appropriate.

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