Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael McAlindon a prisoner at HMP Durham on 3 April 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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael McAlindon died of renal failure and severe sepsis on 3 April 2018 while a prisoner at HMP Durham. He was 70 years old. I offer my condolences to his family and friends.

The investigation found that the care that Mr McAlindon received at Durham was of a good standard and equivalent to that which he could have expected to receive in the community.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **September 2018**

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Summary

Events

1. On 8 December 2017, Mr Michael McAlindon was sentenced to 16 years imprisonment and sent to HMP Durham.

2. Mr McAlindon had several long-term health conditions. He was held in the prison's inpatient unit where healthcare staff focused on his symptoms and pain management.

3. When Mr McAlindon's condition deteriorated on 2 April 2018, a prison GP arranged for him to be admitted to hospital, where he died the next day.

4. Mr McAlindon's family told the prison that they were pleased with the care and support that he received.

5. The prison's family liaison log noted that Mr McAlindon's son had wanted to stay with him during his final hours, but that the family had not been allowed to do so. However, the escorting officer told us that this did not happen and, although the family were given permission to stay with Mr McAlindon, they decided to leave the hospital together.

Findings

6. The clinical reviewer acknowledged that staff at Durham provided a high standard of care to Mr McAlindon. She said that Mr McAlindon's care was responsive and equivalent to that which he could have expected to receive in the community. We agree and make no recommendations.

7. There are differing accounts of whether or not the family were allowed to stay with Mr McAlindon during his final hours. In the absence of further information, we cannot reach a conclusion about what happened.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Durham 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 McAlindon's prison and medical records.

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

11. We informed HM Coroner for County Durham and Darlington of the investigation who gave us the cause of death. We have sent the Coroner a copy of this report.

12. The investigator wrote to Mr McAlindon's son to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He did not respond to our letter.

13. 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.

Background Information

HMP Durham

14. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It holds approximately 1,000 men. G4S provides primary healthcare. The prison's inpatient unit has six beds with 24-hour healthcare, and provides a regional service for HMP Durham, HMP Northumberland and HMYOI Deerbolt.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that the provision of healthcare was reasonable, with some excellent mental healthcare. Primary care service was assessed as reasonably good and secondary care as very good. Inspectors found that the inpatient healthcare unit provided compassionate care in a good environment. They noted that interactions between healthcare staff and prisoners were very good. They reported that nurse-led clinics for lifelong conditions, such as asthma, diabetes and heart disease, did not take place due to staff shortages, although a senior nurse ensured that physical checks and referrals were made, where necessary. External health appointments were well managed.

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 October 2017, the IMB reported that the recruitment of nurses to the healthcare unit continued to be a significant issue, with agency nurses and overtime used as cover. Despite the staff shortages, primary care services delivered a good standard of care.

Previous deaths at HMP Durham

17. Mr McAlindon was the nineteenth prisoner to die at HMP Durham since January 2015, and the eleventh to die from natural causes. There have been three deaths since which are under investigation.

Key Events

18. On 8 December 2017, Mr Michael McAlindon was sentenced to 16 years imprisonment for sexual offences and sent to HMP Durham.

19. Mr McAlindon had various health problems, including ischaemic heart disease, angina, hypertension (high blood pressure), reduced kidney function, an enlarged spleen, chronic kidney disease, diverticulitis (gastrointestinal disease), a bowel resection and colostomy (which was reversed in 2005), surgery to remove cancerous cells in the pancreas, heart failure, Paget's disease (weakened and deformed bones), lumbar spine stenosis (which caused spine pain and walking problems) and depression. He had reduced mobility and used a walking stick or Zimmer frame, and a wheelchair for longer distances. He was a smoker who accepted help to stop smoking.

20. Mr McAlindon lived in the healthcare wing where healthcare staff reviewed him regularly and ensured that he took his medications appropriately.

21. On 12 December, a Macmillan palliative care specialist was appointed. She discussed proposed care plans with Mr McAlindon and he said that he did not want anyone to resuscitate him if his heart or breathing stopped. He signed an order to that effect.

2018

22. On 18 February 2018, Mr McAlindon told a healthcare support worker that he felt like he had flu and a sore throat. The support worker encouraged him to drink fluids. The next day, a nurse examined him. She noted that the right side of his chest had a distinctive wheeze and crackled. She noted that he had a productive cough of green sputum and referred him to a prison GP. Later that day, a prison GP saw Mr McAlindon and prescribed a penicillin antibiotic.

23. On 23 February, a nurse noted that Mr McAlindon appeared to be deteriorating. She arranged for the duty prison GP to review him. The GP completed the review, told the nurse that Mr McAlindon may have pneumonia and arranged for him to go to hospital.

24. In hospital, specialists noted that Mr McAlindon had a shadow on his lung, probably caused from his previous pancreatic cancer. He remained in hospital for treatment with intravenous fluids and antibiotics until 8 March.

25. When Mr McAlindon returned to Durham on 8 March, a nurse completed the examination. She noted that hospital staff had diagnosed a lower respiratory tract infection. She asked for staff to review his heart rate and blood pressure and consider appropriate medication. A senior nurse practitioner completed a review, in line with the hospital discharge summary. She noted that the dosage for some of his medications had been reduced, so she asked a prison GP to review the changes. The GP completed the review and issued all medications as prescribed.

26. On 2 April, Mr McAlindon was vomiting, feeling nauseous and complained of neck pain. A prison GP reviewed him and diagnosed low blood pressure (hypotensive) and dehydration. He arranged his transfer to hospital.

27. Mr McAlindon's condition deteriorated and he died in hospital at 4.55am on 3 April.

Contact with Mr McAlindon's family

28. When Mr McAlindon was admitted to hospital with suspected pneumonia on 23 February, prison staff arranged for his brother to visit him. On 9 March, Mr McAlindon told a nurse that he wanted prison staff to contact his son if his health declined again.

29. On 2 April 2018, the prison appointed the prison chaplain as the family liaison officer when Mr McAlindon was in hospital. The chaplain telephoned Mr McAlindon's brother and son to tell them that he was seriously ill in hospital. He arranged for them to visit him. The escorting officer said that the family arrived at approximately 4.00pm. He said that at approximately 5.30pm, Mr McAlindon's son asked if he could stay the night. He told the investigator that that neither he nor the hospital staff had any objections. He also checked with the prison. He spoke to the day orderly officer, who confirmed that this was okay. However, after a family discussion, the family decided to leave at approximately 6.30pm.

30. After Mr McAlindon died, the escorting officer contacted Mr McAlindon's brother to break the news to him. He said that Mr McAlindon's son should be contacted and be the next of kin.

31. The family liaison log records that when the escorting officer spoke to Mr McAlindon's son, he said that he had visited him the previous day and had asked the escorting officer if he could spend the night at his father's bedside. The escorting officer had telephoned the prison and someone at the prison had said that he could not stay the night. He asked the escorting officer why and he said that he would look into the issue.

32. The escorting officer told the investigator that he could not recall who he asked or their response.

33. The prison arranged and contributed to Mr McAlindon's funeral in line with national instructions, which was held on 17 April 2018.

Support for prisoners and staff

34. After Mr McAlindon's death, a prison manager debriefed the officer who was the hospital escort to ensure that he had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Cause of death

36. The Coroner gave the cause of death as renal failure and severe sepsis. Mr McAlindon also had congestive cardiac failure, chronic obstructive pulmonary disease (COPD), myocardial infarction (heart attack) and coronary artery bypass graft.

Findings

Clinical care

37. The clinical reviewer said that Mr McAlindon's clinical care was of a good standard and equivalent to that which he could have expected to receive in the community. She noted that as Mr McAlindon was cared for in the inpatient unit, he had a close level of observation and received support with daily activities.

38. We agree with the clinical reviewer that the healthcare team worked hard to deliver a high level of compassionate care.

Family liaison

39. Prison Rule 22(1) states that when a prisoner becomes seriously ill, the Governor should inform the prisoner's next of kin at once. Prison Service Instruction (PSI) 64/2011 on safer custody requires that prisons ensure that an appropriate member of staff engages promptly with the next of kin of prisoners who are seriously ill. PSI 64/2011 adds that if prisoners have a terminal illness or their physical health deteriorates unpredictably and/or rapidly, they must be encouraged to engage with their families or nominated person, where appropriate, and the prison should record their attempts to contact the family or their representatives.

40. The prison's family liaison log noted that during Mr McAlindon's final hours in hospital his son said that he had asked to spend time with him, but the prison refused to let him. The escorting officer could not recall what happened or to whom he spoke to at the prison, and Mr McAlindon's son did not respond to our attempt to contact him at the outset of this investigation. However, the escorting officer said that permission was given for the family to remain, but after discussions they decided to leave the hospital together.

41. There are differing accounts of what happened and, in the absence of any further information, we cannot conclude whether or not Mr McAlindon's family were prevented from staying with him. We note, though, that the family told the prison that they were pleased with the care and support that Mr McAlindon had received.

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