

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Susan McGregor a prisoner at HMP Drake Hall on 13 October 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 I oversee can improve their work in the future.

Ms Susan McGregor died in hospital on 13 October 2018 of sepsis, while a prisoner at HMP Drake Hall. This was the result of spinal and chest abscesses, against a background of advanced alcoholic liver cirrhosis. Ms McGregor was 53 years old. I offer my condolences to Ms McGregor's family and friends.

Ms McGregor received continuity of care at Drake Hall, seeing the same prison doctor throughout her stay, and her abscesses were dressed daily by medical staff. Healthcare responded appropriately to her changing care needs and her chronic conditions were managed well in accordance with clinical guidance. Transfer to hospital was swift and communication with secondary services was good.

The prison took Ms McGregor's health and limited mobility into account when assessing her risk to the public and that she was not restrained for hospital appointments or during her lengthy stays in hospital.

I am satisfied that Ms McGregor received a good standard of clinical care while at Drake Hall, equivalent to that which she could have expected in the community. I have made no recommendations.

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 CB
Prisons and Probation Ombudsman

July 2019

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Summary

Events

1. Ms Susan McGregor was serving a life sentence for murder. She had lived at several prisons before moving to HMP Drake Hall in 2013.
2. Ms McGregor had a history of heroin and cocaine abuse and alcohol addiction. She also had many chronic health conditions, including back pain, and often used a wheelchair.
3. From October 2016, she had several admissions to hospital for the removal of abscesses and treatment for infection. In July 2017, she declined the offer of a move to a prison with 24-hour healthcare, saying she wanted to stay at Drake Hall.
4. In March 2018, Ms McGregor was admitted to hospital with back pain. She was diagnosed with a spinal abscess and had extensive spinal surgery. She was discharged back to prison on 6 May.
5. On 31 May she was readmitted to hospital with severe back pain and diagnosed with a spinal abscess. On 8 June she discharged herself from hospital and returned to Drake Hall.
6. On 28 July, Ms McGregor was struggling to stand due to severe back pain and was admitted to hospital by emergency ambulance. On 1 August, she had significant, high risk spinal surgery. The surgery was successful and she remained in hospital receiving physiotherapy and intravenous antibiotics.
7. On 12 September, she was put on the waiting list for transfer to an orthopaedic rehabilitation hospital. However, over the following weeks her physical and mental health deteriorated and she was treated for an acute infection. She became aggressive and uncooperative with medical treatment at times.
8. On 9 October, scans showed a chest lump which was thought to be a tumour. She was becoming increasingly agitated and confused. Hospital staff suspected that her deteriorating mental state and behaviour were the result of an underlying neurological condition but she was too unwell for further tests to confirm these suspicions.
9. On 11 October, Ms McGregor became confused. The hospital contacted her next of kin, her niece, and a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notice was put in place.
10. Ms McGregor's health continued to deteriorate and she died on 13 October.

Findings

11. During 2018, Ms McGregor was in hospital from 7 March to 6 May, from 31 May to 8 June and from 28 July to her death on 13 October. This investigation has not considered her healthcare in hospital.

12. The clinical reviewer is satisfied that Ms McGregor's chronic health conditions and drug dependency were managed in line with NICE guidelines at Drake Hall. Her medications were appropriate and kept under review. Healthcare staff provided timely responsive care and ensured her care needs were met.
13. The prison healthcare team managed the dressing of her complex wound well when she returned from hospital following spinal surgery. There is no evidence in the medical notes that there was ever a complication with the dressing and the clinical reviewer considers that the team should be commended for good practice in a difficult situation.
14. The clinical reviewer is satisfied that Ms McGregor received a good level of clinical care while at Drake Hall, equivalent to that she could have expected in the community.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Drake Hall informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator obtained copies of relevant extracts from Ms McGregor's prison and medical records.
17. NHS England commissioned a clinical reviewer to review Ms McGregor's clinical care at the prison.
18. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. The investigator wrote to Ms McGregor's niece to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She had several questions, which have been answered in the main body of the report. Queries not relevant to the investigation have been addressed in separate correspondence. These were:
 - concerns about the size of Ms McGregor's cell and the fact that she had to wash in the sink and was unable to shower alone; and
 - concerns that Ms McGregor could not use her wheelchair in her room and that the walking frame provided did not help, meaning she had to hold onto the furniture for support.
20. Ms McGregor's family received a copy of the draft report. They did not make any comments.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Drake Hall

22. HMP Drake Hall is a closed prison which holds just over 300 sentenced women. Accommodation consists of 15 house units with mainly single rooms. Each house unit has a small kitchen, a laundry room and a television lounge. There is also a 25-room open unit outside the prison perimeter.
23. Care UK provides healthcare services from 7.15am to 6.30pm on weekdays and 7.30am to 5.00pm at weekends. A local GP surgery provides medical advice out of hours.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Drake Hall was conducted in July 2016. Inspectors found that healthcare provision was a major weakness and a number of areas required improvement. Although there was a range of appropriate primary care clinics, there were delays in accessing services as waiting times were unacceptably lengthy. There was also a high level of non-attendance at medical appointments by prisoners.

Independent Monitoring Board

25. 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 many of the women at Drake Hall had complex health needs. Overall, the board was satisfied with the standard of healthcare at the prison. Waiting times for treatment had improved and the prison had put in place new procedures to address the high level of non-attendance for medical appointments.

Previous deaths at HMP Drake Hall

26. There have been four previous deaths at HMP Drake Hall since this office began investigating deaths in custody in 2004. Two of these were from natural causes, one was a self-inflicted death in 2016 and one an unclassified death which is still under investigation at the beginning of 2018. There are no similarities with this death and the previous deaths at Drake Hall.

Key events

27. Ms McGregor was serving a life sentence for murder and had been at HMP Drake Hall since 2013. She had several chronic conditions including chronic obstructive pulmonary disease, chronic hepatitis C and recurring deep vein thrombosis. Ms McGregor also had a history of substance misuse and was prescribed controlled methadone for her addictions. These conditions were managed by prison medical staff and her medication was reviewed regularly.
28. Ms McGregor also had a history back and leg pain, requiring a walking aid and wheelchair. She was prone to abscesses and infection, and from October 2016 to May 2017 was admitted to hospital for treatment on four occasions. She had a history of refusing to attend medical appointments in prison and at hospital and of discharging herself from hospital.
29. On 7 March 2018, Ms McGregor was admitted to hospital. She was diagnosed with a re-occurrence of a spinal abscess and had an operation on 15 March. Antibiotics were administered through a Hickman line (a tube inserted into a vein in the chest for the administration of long term medication) to reduce the risk of infection. Ms McGregor was also given physiotherapy.
30. On 1 May, a prison mental health nurse visited Ms McGregor for assessment prior to discharge. Ms McGregor told the nurse that she would only need a wheelchair to visit prison healthcare and was happy to use a walking frame for general use. She said that she could manage in her current room and did not want to move. On 6 May, Ms McGregor was discharged back to Drake Hall.
31. On 31 May, Ms McGregor was seen by a prison GP as she was complaining of severe lower back pain. She was transferred to hospital the same day and diagnosed with a spinal abscess. She was admitted to hospital and given antibiotics to reduce the abscess and to tackle potential infection.
32. On 7 June, a hospital nurse told a prison nurse that Ms McGregor's abscess had not reduced and that her case would be discussed with the doctor the following day to review her treatment plan.
33. On 8 June, Ms McGregor self-discharged from hospital and returned to Drake Hall. She was reviewed by a nurse the following day and reported that she felt well.
34. On 25 July, Ms McGregor was seen by a prison GP following a fall the previous day. Ms McGregor had developed pain and swelling over her left lower leg and ankle. This was gradually getting worse, so she was transferred to hospital by ambulance. She was diagnosed with a fracture ankle and returned to Drake Hall the same day. She was given an appointment to return to the fracture clinic.
35. On 28 July, Ms McGregor was seen by a nurse. She was in considerable pain and unable to stand. She was also unable to feel her bowels open or herself passing urine. She was transferred to hospital as an emergency. Examination by the spinal team confirmed that Ms McGregor required a further operation.

36. On 1 August, Ms McGregor underwent surgery for primary decompression and fusion of the thoracic spine. (This was to treat compressed nerves and to stabilise the spine.) Ms McGregor also had her fractured ankle placed into a plaster cast. She remained in hospital receiving antibiotics via a Hickman line. She also received physiotherapy.
37. On 12 September, Ms McGregor was put on the list for transfer to an orthopaedic hospital, for intensive spinal rehabilitation. However, her condition deteriorated over the following weeks while waiting for an available bed. She also stopped complying with treatment and became aggressive and uncooperative. The escorting prison officers recorded increasing concerns about Ms McGregor's behaviour, including refusing to engage with physiotherapy, tampering with her Hickman line, throwing her bedding on the floor, knocking food and drink over, taking her clothes off, repeatedly pressing the bell for nurses, shouting at nurses and, on occasions, hitting nurses. Hospital and prison staff thought this might be because she did not want to transfer to the other hospital.
38. On 24 September, Ms McGregor showed signs of an acute infection and required further antibiotics. Hospital doctors suspected the infection was caused by Ms McGregor deliberately tampering with the Hickman line, which was removed.
39. On 8 October, Ms McGregor's mental health began to deteriorate. On 9 October, Ms McGregor was found to have a chest infection. A chest x-ray showed a mass in her chest which was thought to be a tumour. The diagnosis could not be confirmed by MRI scan due to Ms McGregor's declining health. It was also suspected that her deteriorating mental state and behaviour were because of an underlying neurological condition.
40. On 11 October, Ms McGregor was visited by her niece (her next of kin), supported by the prison family liaison officer (FLO). Hospital doctors discussed Ms McGregor's condition with her niece and it was agreed that a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order should be put in place. (A DNACPR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made.)
41. Ms McGregor's condition continued to deteriorate and she died on 13 October.

Post-mortem

42. The post-mortem found that Ms McGregor died of sepsis, caused by spinal and chest abscesses, against a background of advanced alcoholic liver cirrhosis.

Findings

Clinical Care

43. Ms McGregor had complex, multiple chronic healthcare needs. The clinical reviewer is satisfied that these were all well managed on medication.
44. Ms McGregor's opioid drug dependency was well controlled on daily methadone and the clinical recovery team reviewed her mental state every 12 weeks. There were no concerns about Ms McGregor's mental health while she was cared for in prison, and the clinical reviewer is satisfied that her care was equivalent to what would be expected in the community.
45. Ms McGregor also had complex physical needs exacerbated by her wound management following surgery. This was managed without problems during the time that Ms McGregor was at HMP Drake Hall. The clinical reviewer adds that Ms McGregor was managed by the same GP throughout the time under review. This is an example of good practice by the healthcare team at Drake Hall.
46. We agree with the clinical reviewer that Ms McGregor's clinical care at Drake Hall was equivalent to that she could have expected to receive in the community. Ms McGregor was transferred to hospital swiftly, able to access outpatient appointments and received the treatment prescribed by her consultants. There were appropriate care plans put in place and consideration was given to her wishes.

Ms McGregor's location

47. In July 2017, Ms McGregor was offered a transfer to a prison with 24-hour healthcare, but declined saying she wanted to stay at Drake Hall.
48. Ms McGregor lived in the St David's housing unit at Drake Hall, which is designed for prisoners with additional needs. Shower units have hand rails and wider doors for wheelchair access and the cells have hand rails. Ms McGregor had the use of a walking frame, crutches and a wheelchair, which she would use to attend healthcare. She was also allocated a prison 'buddy' to assist with washing, cleaning and wheelchair-pushing.
49. Ms McGregor was given the option of moving rooms to be closer to the shower facilities but declined.
50. We are satisfied that Ms McGregor's location was appropriate and that she had the necessary aids to allow her to remain independent.

Restraints, security and escorts

51. 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.

52. From 2016, Ms McGregor was granted accompanied release on temporary licence (ROTL) for all her hospital appointments and stays and was not restrained. She was accompanied by one officer who stayed outside her room.
53. The prison regularly reviewed Ms McGregor's risk to the public. Despite her changeable and uncooperative behaviour toward the end of her life, it felt able to manage her risk and she remained on ROTL, without restraints, allowing her to die with dignity.
54. We are satisfied that Ms McGregor's health and mobility were appropriately taken into account and regularly reviewed when she was in hospital.

Liaison with Ms McGregor's family

55. On 1 August 2018, a prison officer was appointed as the prison's family liaison officer (FLO) after Ms McGregor was admitted to hospital for spinal surgery. When asked, she said that she did not want her next of kin informed. She reiterated this on 19 August when the FLO visited her in hospital. On 30 August, a nurse manager again asked Ms McGregor whether she would like her next of kin to be contacted. Again, she refused.
56. The same day, a meeting was held to discuss whether a family liaison log was still needed, given Ms McGregor's recovery. The decision was made to close it. Ms McGregor remained in hospital to recover but then developed an infection and her health deteriorated very quickly.
57. On 11 October, due to Ms McGregor's limited capacity to make decisions and her deterioration in health, the hospital contacted her next of kin, her niece, to discuss a DNACPR. The same day, the family liaison log was reopened and a FLO was appointed.
58. The FLO contacted Ms McGregor's niece at 4.50pm to introduce herself and offer her support. Ms McGregor's niece raised concerns about not being contacted earlier. The FLO explained that it had been Ms McGregor's wish not to have her next of kin contacted.
59. On 13 October, at 11.00am, the FLO contacted Ms McGregor's niece by telephone to inform her that Ms McGregor's condition had deteriorated. She agreed to meet her at the hospital to support her. The FLO continued to provide support after Ms McGregor died.
60. In line with national guidance, the prison made a financial contribution to Ms McGregor's funeral, which was held on 9 November.

Compassionate release

61. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
62. Compassionate release was not considered in Ms McGregor's case. She was not given any prognosis and her health deteriorated quickly.

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