Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr George McCallum, a prisoner at HMP Nottingham, on 7 November 2018

A report by the Prisons and Probation Ombudsman

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The Ombudsman's 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 George McCallum died of bronchopneumonia in hospital on 7 November 2018, while a prisoner at HMP Nottingham. He was 79 years old. I offer my condolences to Mr McCallum's family and friends.

Mr McCallum was diagnosed with dementia in July 2016 and was referred to the mental health team and psychiatrists. Overall, the care Mr McCallum received at Nottingham was mostly equivalent to that which he could have expected to receive in the community.

However, I am concerned that because of his dementia, Mr McCallum became withdrawn and isolated himself. As a result, he was sometimes reluctant to engage with healthcare staff and his deteriorating physical condition was not identified as quickly as it should have been.

I am also concerned that, as Nottingham does not have an inpatient unit, planning to move Mr McCallum to a more suitable location should have begun earlier.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. On 16 May 2015, Mr George McCallum was recalled to prison after he assaulted another resident at the approved premises (AP) where he lived. He was sent to HMP Nottingham.

2. In 2015, healthcare staff became increasingly concerned about Mr McCallum's mental health and he was referred for a psychiatric review. Following that review, Mr McCallum had a CT scan of his brain, and was reviewed by a psychiatrist specialising in the mental health of older people. In July 2016, he was diagnosed with dementia.

3. As his condition deteriorated and he was less able to move around, Mr McCallum was moved to a cell specially adapted to suit his care needs. He became increasingly withdrawn, his personal hygiene became poor and he sometimes refused to engage with healthcare staff.

4. On 8 September 2018, he was admitted to hospital as healthcare staff at Nottingham considered they could no longer meet his care needs safely. He remained in hospital, to the frustration of hospital staff, because it was not considered safe to return him to Nottingham.

5. There were discussions about transferring Mr McCallum to the social care wing at HMP Exeter or to a secure psychiatric hospital but no final decisions were taken.

6. Mr McCallum's physical condition deteriorated in hospital and on 26 October, hospital staff decided that Mr McCallum would not benefit from any further active treatment and began palliative care.

7. At 6.30am on 7 November, it was confirmed that Mr McCallum had died.

8. A post-mortem gave Mr McCallum's cause of death as bronchopneumonia.

Findings

9. The clinical reviewer found that Mr McCallum received an acceptable standard of clinical care at Nottingham. Healthcare staff assessed his clinical needs and sought advice from secondary care providers, and the clinical reviewer concluded that Mr McCallum's care was mostly equivalent to that which he could have expected to receive in the community.

10. However, although healthcare staff made some efforts to engage Mr McCallum, there were long periods when he became withdrawn and isolated because of his dementia. The clinical reviewer considers that, as a result, opportunities were missed between October 2017 and August 2018 to monitor the deterioration in Mr McCallum's physical condition.

11. We are concerned that there are no robust systems in place at Nottingham to manage the care of prisoners with dementia to lessen the opportunity for self-imposed withdrawal and isolation.

12. We are also concerned that, when it became clear that Mr McCallum's care needs could no longer be managed safely at Nottingham, it took too long to transfer him to an alternative location. As Nottingham does not have an inpatient unit, we consider that planning for a move to a more suitable location should have begun earlier.

Recommendations

- The Head of Healthcare should review the safeguarding and complex care monitoring system to ensure that prisoners with complex care needs are monitored regularly so that any deterioration in their condition is identified promptly and managed effectively.
- The Governor and Head of Healthcare should ensure that where it is clear that a prisoner's care needs are going to increase in future, advance planning for a move to a more suitable location should begin in good time.

The Investigation Process

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

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

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

16. We informed HM Coroner for Nottinghamshire and Nottingham City. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Nottingham

18. HMP Nottingham is a local prison holding a maximum of 1,060 men and young adult prisoners on remand, convicted or sentenced. Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health care. The prison has 24-hour primary healthcare cover. Mental health care is available on weekdays from 8.00am to 5.00pm.

19. In August 2018, Nottingham was selected to be part of the "10 Prisons Project" which seeks to improve safety, security and decency in the prisons involved. The project focuses on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Nottingham was in January 2018. Inspectors noted that while health services were reasonably good overall, there were clear plans in place for further improvements.

21. Primary care services were noted as being good and healthcare staff had worked to develop detailed care plans for those patients with long-term health conditions.

Independent Monitoring Board

22. 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 July 2018, the IMB noted the new initiatives being put in place by the Head of Healthcare for those prisoners with long-term health conditions.

23. The IMB also noted that mental health care provision was improving with extra funding being put in place to provide mental health care cover seven days a week. Healthcare staff were also implementing a Mental Health Awareness Peer Support scheme (MAPS). The scheme was designed to offer those prisoners who are experiencing mental health issues immediate access to a group of trained volunteer prisoners who offer support in addition to the services provided by the healthcare department.

Previous deaths at HMP Nottingham

24. Mr McCallum was the 16th prisoner to die at HMP Nottingham since December 2015. Thirteen of the previous deaths were self-inflicted, one is still unascertained and two were from natural causes. There has been one further self-inflicted death since.

Findings

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

19. On 12 March 2015, Mr George McCallum was released on life licence from HMP Stocken to a probation Approved Premises (AP). (APs, formerly known as probation or bail hostels, are residential units which house ex-offenders in the community.) On 16 March, Mr McCallum was recalled to prison after drinking heavily and assaulting another resident at the AP. He was sent to HMP Nottingham.

20. Throughout his time in custody, healthcare staff had been concerned that Mr McCallum had experienced memory loss and periods of confusion. They suspected that he was displaying early signs of dementia. (Dementia is not a disease itself, but rather a collection of symptoms that result from damage to the brain caused by different diseases.) They had referred him to secondary care providers for further review. However, it had not been possible to obtain a definitive diagnosis because his symptoms fluctuated.

21. In 2015, healthcare staff became increasingly concerned about Mr McCallum's mental health. He was referred to a visiting psychiatrist for a review.

22. In August, Mr McCallum was reviewed by a social worker from Nottinghamshire Social Services. He told her that he had no significant issues apart from some minor memory loss and he refused any further assistance from Social Services.

23. In September, a nurse reviewed Mr McCallum after it was noted that his personal hygiene was poor. She noted that he had no disabilities, had no issues with collecting meals and that his cell was clean and tidy. She advised Mr McCallum how to contact healthcare staff if he needed to.

24. Also in September, a GP carried out a Mini Mental State Examination (MMSE) to test for possible dementia. Mr McCallum's score indicated mild cognitive impairment. Mr McCallum told the GP that while serving in the Royal Marines, he had sustained head injuries which had affected his memory. The information about the previous head injury and the borderline MMSE result meant that the GP was unable to give a definitive diagnosis. She noted that a visiting consultant psychiatrist, had been asked to review Mr McCallum as part of the parole review process. She informed him of her findings and asked him to take them into account in his review.

25. In December, the visiting consultant psychiatrist reviewed Mr McCallum. He also carried out a MMSE test and noted that while Mr McCallum displayed memory issues, his test score was within the normal range. He considered that if Mr McCallum did have dementia, it was at a mild stage.

26. He referred Mr McCallum for a CT scan of his brain to gauge the extent of the injuries he had previously sustained and to establish if those injuries were the cause of his memory issues. He planned to review Mr McCallum in a six weeks once the results of the CT scan were available. He also planned to refer Mr McCallum to a consultant psychiatrist who specialised in mental health issues in

older persons. However, when he returned to review Mr McCallum as planned, Mr McCallum refused to attend the appointment.

27. Healthcare staff put care plans in place to manage Mr McCallum's mental health needs and both healthcare and the prison's mental health team continued to review him regularly over the months that followed. There is evidence that mental health staff explained Mr McCallum's condition to him and, where appropriate, they involved him in his care.

28. In April 2016, a nurse who was part of the prison's mental health team at Nottingham, reviewed Mr McCallum. She carried out a MMSE test and Mr McCallum's score indicated that his condition had deteriorated. She made visiting consultant psychiatrist aware of the result.

29. In July, a GP reviewed Mr McCallum. She carried out a Addenbrookes Cognitive Recognition (ACE-R) test (which tests attention span, memory, fluency, language skills and visuospatial screening). The results indicated that he had significant impairment, and the GP concluded that Mr McCallum was suffering from dementia.

30. We are satisfied that healthcare staff appropriately investigated Mr McCallum's symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him.

Mr McCallum's clinical care

31. In November 2016, Dr Bickle reviewed Mr McCallum. He noted that the results of the CT scan showed a deterioration in the tissues in the front and side of the brain. He also noted the results of Dr Junaid's review, and carried out a further ACE-R test.

32. The visiting consultant psychiatrist, considered that because the ACE-R test results had remained stable over a four-month period, and because Mr McCallum was coping well on his wing, although avoiding other prisoners, it was not necessary to admit him to a psychiatric hospital under the Mental Health Act. He planned to review Mr McCallum again in four months' time. However, when he returned, Mr McCallum refused to attend the appointment.

33. Although Mr McCallum would often not engage with healthcare and mental health team staff, they continued to review regularly him over the months that followed. They noted that Mr McCallum continued to be forgetful, that his personal hygiene was deteriorating and that he was becoming withdrawn. Staff encouraged him to attend the gym or education, but he refused.

34. In June 2017, the visiting consultant psychiatrist, reviewed Mr McCallum in his cell. He noted that Mr McCallum's cell appeared tidy and that he had a number of library books. When he asked Mr McCallum about the books, his answers suggested he was reading them. He carried out an MMSE test and McCallum's score was within the normal range. Following the review, he suggested that consideration should be given to exploring the use of social care providers and occupational therapists for Mr McCallum at the next healthcare multi-disciplinary team meeting. However, it is not clear from Mr McCallum's medical records if

healthcare staff actioned this advice. He planned to review Mr McCallum again in three months' time.

35. In addition to the regular multi-disciplinary team meetings held about his care, Mr McCallum was the subject of a Care Programme Approach (CPA) meeting in October 2017 to ensure that his physical and mental health needs were being met.

36. Mr McCallum continued to be reviewed by a nurse and the visiting consultant psychiatrist, over the months that followed. His care plans were regularly reviewed and updated. However, it was noted in Mr McCallum's medical record that he was becoming increasingly forgetful and that his personal hygiene continued to deteriorate. He spent most of his time alone in his cell, choosing not to interact with other prisoners or staff unless necessary. His reluctance to engage with healthcare staff meant that he sometimes missed routine physical health checks.

37. On 18 August 2018, prison officers noticed a wound on Mr McCallum's leg and asked a nurse to review him. The nurse noted that Mr McCallum had developed a significant arterial ulcer (a skin lesion caused by reduced blood flow). He cleaned and dressed the wound and considered a full wound assessment was needed. He requested that Mr McCallum be discussed at the next complex care meeting. He also noted that Mr McCallum's personal hygiene was poor and that he was becoming more withdrawn.

38. By 27 August, Mr McCallum's mobility had deteriorated noticeably. To assist him, he was moved to a cell on the ground floor of the wing. His personal hygiene continued to be poor. Prison officers regularly encouraged him to shower and change his clothes, but he refused.

39. On 4 September, Mr McCallum was discussed at a complex care meeting attended by both healthcare staff and prison officers. They discussed his poor personal hygiene and his increasing confusion and memory loss. They also noted that an airflow mattress, designed to ease the discomfort caused by bedsores, was yet to arrive. Mr McCallum's care plans were reviewed and updated and a daily washing and dressing care plan was devised. Following the meeting, Mr McCallum was moved to a cell specially adapted for prisoners with mobility issues and special care needs.

40. The following day, a nurse reviewed Mr McCallum. She completed a pressure care assessment and noted that he had pressure sores on his buttocks and elbows and was at risk of developing further sores on his spine and shoulders. She continued to review Mr McCallum regularly and attend to his medical needs.

41. On 6 September, a nurse noted that she had had to help Mr McCallum on four occasions during the night after he had fallen out of bed. She also noted that he had been incontinent of urine and faeces.

42. After reviewing Mr McCallum, the next day, a nurse noted that he was not getting the right level of nutrition, his skin appeared to be very thin and broke easily, and he was becoming increasingly unsteady on his feet. She expressed her concerns in Mr McCallum's medical notes and recorded that she felt he was not

safe in prison and that he should be transferred to hospital for further review. She contacted the Acute Medical Receiving Unit at a Medical Centre, and they agreed to review Mr McCallum. However, there were no prison officers available to accompany him to hospital.

43. The next day, 8 September, Mr McCallum was taken the Medical Centre. He was accompanied by two prison officers and was not restrained. A nurse contacted the Safer Custody Group at Nottingham and told them that in her opinion, it would be unsafe for Mr McCallum to return to the prison because of his deteriorating mental and physical condition.

44. Mr McCallum was admitted to hospital as an inpatient. He was not restrained. Healthcare staff remained in daily contact with hospital staff and kept updated on his condition. Mr McCallum's health continued to deteriorate.

45. On 10 September, the visiting consultant psychiatrist, reviewed Mr McCallum's medical notes and concluded considered that he should be transferred to a psychiatric hospital under the Mental Health Act. He made a referral to the Specialist Commissioning Team (SCT) at NHS England in the East Midlands, with a view to him being admitted to Arnold Lodge, a medium secure unit in Nottingham. However, it was later agreed that Mr McCallum should be referred to the South West area SCT for future care as that was the area he had lived in before being sent to prison. The referral to Arnold Lodge was cancelled.

46. On 25 September, healthcare staff suggested that Mr McCallum should transfer to the social care wing at HMP Exeter while he waited for a permanent solution. Healthcare staff at Exeter requested a recent referral by a psychiatrist and social care needs assessment. A nurse agreed to collate the information.

47. On 2 October, a psychiatrist reviewed Mr McCallum and recommended that he be admitted to a secure psychiatric hospital. A mental health case manager for the South West Social Care Team, asked a GP to clarify the level of risk posed by Mr McCallum. She said that it was difficult to establish a level of risk due to the fluctuating effects of his dementia. However, she said that she had approved Mr McCallum's transfer to a secure psychiatric hospital with the Ministry of Justice on 15 October.

48. Healthcare staff remained in daily contact with staff at the Medical Centre, who were becoming increasingly frustrated by the lack of progress in securing a suitable placement for Mr McCallum. Prison healthcare staff assured them that they were doing all they could to ensure he was transferred as quickly as possible.

49. On 26 October, a nurse noted that Mr McCallum's condition was deteriorating rapidly and that hospital staff had decided to start palliative care. Mr McCallum's condition continued to deteriorate.

50. At 6.30am on 7 November, the prison officers accompanying Mr McCallum noticed that he had stopped breathing. At 8.30am, a hospital doctor confirmed that Mr McCallum had died.

51. The clinical reviewer concluded that overall, Mr McCallum's clinical care at the prison was mostly equivalent to that which he could have expected to receive in the community.

52. The clinical reviewer noted, however, that Mr McCallum was a vulnerable prisoner who isolated himself for long periods and that there was evidence in Mr McCallum's medical records to suggest that opportunities to monitor the deterioration in his physical condition had been between October 2017 and August 2018.

53. However, once Mr McCallum's physical condition had been identified, the standard of care he received was acceptable. Healthcare staff also appropriately identified that Mr McCallum required admission to hospital on 8 September 2018.

54. The clinical reviewer concluded that although Mr McCallum was appropriately managed by several multi-disciplinary forums at Nottingham, a review of those systems was needed. He was concerned that, although it is clearly difficult to manage prisoners with complex care needs such as Mr McCallum's in prison, there are no robust monitoring systems in place at Nottingham to prevent ageing prisoners becoming withdrawn and isolated. Although this did not affect the outcome for Mr McCallum, it could be critical in future cases. We make the following recommendation:

The Head of Healthcare should review the safeguarding and complex care monitoring system to ensure that prisoners with complex care needs are monitored regularly so that any deterioration in their condition is identified promptly and managed effectively.

Mr McCallum's location

55. Mr McCallum was located in a single cell on B wing. As his level of mobility deteriorated, he was moved to a ground floor cell in August 2018, and then on 4 September, to a cell specially adapted for prisoners with mobility issues and special care needs.

56. However, by 8 September, Mr McCallum's health had deteriorated to the point at which healthcare staff became concerned for his safety. He was admitted to hospital where he received a more intensive level of care. His condition continued to deteriorate and he received palliative care until his death.

57. We are satisfied that Mr McCallum was transferred to hospital in early September 2018 when healthcare staff identified that they could no longer manage his care needs in a prison setting. However, we are concerned that a suitable alternative location had still not been identified when he died two months later.

Nottingham does not have an inpatient unit and, as Mr McCallum's condition deteriorated, it should have been obvious that he would need to be transferred somewhere more suitable at some point. We consider that planning for this should have taken place before it did and should not have been left until it became urgent. We recommend:

The Governor and Head of Healthcare should ensure that where it is clear that a prisoner's care needs are going to increase in future, advance planning for a move to a more suitable location should begin in good time.

Restraints, security and escorts

58. When prisoners must travel outside 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 must 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 considering factors such as the prisoner's health and mobility.

59. When Mr McCallum was taken to hospital and during his stay in hospital, he was not restrained. This was appropriate given his poor health and mobility.

Liaison with Mr McCallum's family

60. On 2 November 2018, the prison appointed an officer to act as family liaison officer (FLO) as it was clear Mr McCallum did not have long to live. There were no contact details for Mr McCallum's next of kin (his ex-wife) in his prison records, but the FLO managed to obtain her telephone number and contacted her. She said that she had not had any contact with Mr McCallum for a number of years and that neither she nor their daughter wanted any involvement with him. She asked to be informed by telephone when he died.

61. The FLO arranged Mr McCallum's funeral, which was held on 12 December. The prison paid for the cost of the funeral in line with national policy.

Compassionate release

62. 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.

63. On 29 October 2018, a nurse spoke to Deputy Governor. A nurse was concerned at the deterioration in Mr McCallum's condition and asked if the process for an application for release on compassionate grounds could be started on his behalf. The Deputy Governor told her that in order to process the application, they needed a letter from a hospital doctor confirming Mr McCallum's prognosis. However, Mr McCallum died before hospital staff could supply the prison with a letter.

64. We are satisfied that there was not sufficient time for an application to be made for compassionate release.

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