

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John McKno, a prisoner at HMP Norwich, on 29 September 2019

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 we oversee can improve their work in the future.

Mr John McKno died on 29 September 2019, after choking on his food at HMP Norwich. He was 74 years old. I offer my condolences to those who knew him.

Mr McKno had several health conditions including diabetes, hypertension, heart failure and poor mobility. The clinical reviewer was satisfied that the care he received for his conditions was at least equivalent to that he could have expected to receive in the community.

However, I am concerned about the handling of the incident that led to Mr McKno's death. There was a delay in the attendance of trained healthcare staff, and the decision not to attempt resuscitation was not in line with best practice. I am unable to say whether earlier intervention or attempted resuscitation would have been successful in preventing Mr McKno's death.

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

April 2020

Contents

Summary	1
The Investigation Process	4
Background Information	5
Key Events	6
Findings.....	10

Summary

Events

1. On 13 May 2016, Mr John McKno was sentenced to 14 years imprisonment for sexual offences, and sent to HMP Norwich. He was transferred to HMP Bure on 2 March 2017, but for health reasons, he was returned to Norwich on 28 April. He was placed on L Wing which has 24-hour social care.
2. Mr McKno had several long-term conditions, including type 2 diabetes, hypertension, heart disease and kidney failure. He was obese, doubly incontinent and used a wheelchair.
3. On the morning of 29 September 2019, a healthcare assistant noted that Mr McKno's clinical observations were worse than normal. The healthcare assistant consulted the Lead Nurse who advised her to take the observations again after breakfast.
4. At around 10.00am, while Mr McKno was having his breakfast, a healthcare assistant noticed that he had turned blue in the face and was frothing at the mouth. The healthcare assistant, who was the only member of healthcare staff on that floor at the time, ran over to Mr McKno and called for assistance on his radio. He expected the Lead Nurse and the other healthcare assistant on L Wing, who were upstairs, to attend quickly but they failed to appear. The healthcare assistant gave Mr McKno back slaps and tried to check his airway but his jaw was clenched. He then ran to collect the emergency bag.
5. Two officers arrived by the time the healthcare assistant had returned with the emergency bag, but the Lead Nurse and healthcare assistant from upstairs had still not attended. The healthcare assistant made another call over his radio for assistance. A nurse and healthcare assistant from a different wing attended. They placed Mr McKno in the recovery position, gave back slaps and removed some food from Mr McKno's mouth. The Lead Nurse and healthcare assistant from upstairs attended shortly afterwards. The Lead Nurse found no signs of life and said that Mr McKno had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place so resuscitation should not be attempted. She cancelled the ambulance that had been requested and asked for an on-call doctor to attend to certify death. A doctor certified Mr McKno's death at 3.00pm.
6. The post-mortem report concluded that Mr McKno died from aspiration of gastric content (breathing in the contents of the stomach) due to choking on a food bolus (a mass of food in the oesophagus).

Findings

7. The clinical reviewer was satisfied that the care Mr McKno received at Norwich for his health conditions was of a good standard and equivalent to that he could have expected in the community. However, there were numerous failings in the care Mr McKno received on the day of his death.
8. The healthcare assistant who took Mr McKno's clinical observations on the morning of 29 September, did not calculate a National Early Warning Score

(NEWS – a tool used to measure clinical deterioration in adult patients). The clinical reviewer noted that if a NEWS had been calculated, it would have shown that Mr McKno needed an urgent assessment by a clinical practitioner.

9. Although the healthcare assistant who saw that Mr McKno had turned blue while eating his breakfast called for staff assistance over his radio, he failed to call a medical emergency code as he should have done. This delayed the emergency response.
10. The Lead Nurse on L Wing had her radio turned down so did not initially hear the call for assistance. The healthcare assistant with her did not have a radio because she said she had a bad back. This meant they did not respond as quickly as they should have done.
11. Staff should have attempted to resuscitate Mr McKno. The Lead Nurse directed that staff should not start CPR because Mr McKno had a DNACPR order in place. This was not the correct decision given that Mr McKno had been choking.
12. There were delays in passing relevant information to the ambulance service when the ambulance was requested.
13. The healthcare assistant should not have been alone in the dining room. There should have been one other member of healthcare staff with him. We were told this was due to a staff shortage that day.
14. Significant events were not recorded in the control room log.
15. The Lead Nurse wrote all the statements for the clinical staff. This is unacceptable.
16. Some staff considered they did not receive adequate support following Mr McKno's death.

Recommendations

- The Head of Healthcare should ensure that clinical staff consistently use assessment tools, in particular the National Early Warning Score (NEWS), to ensure the appropriate and timely escalation of unwell patients.
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.
- The Head of Healthcare should issue guidance to their staff on the deployment and use of radios. This should include a reminder that the medical responders should always be in radio contact.
- The Head of Healthcare should ensure that staff administer CPR in line with best professional practice (such as the guidelines of the Resuscitation Council).
- The Governor and Head of Healthcare should ensure that where there is a medical emergency, staff at the scene provide information about the prisoner's

condition to the communications room, so that they have this information when requesting an ambulance.

- The Governor and Head of Healthcare should review the prison's risk register to ensure that the contingencies to cover unexpected and temporary staff shortages are adequate.
- The Governor should review the training of communications room staff and the instructions to staff that are held in the communications room, to ensure that momentous events are recorded in the log.
- The Head of Healthcare should review the protocols for statement writing for their staff.
- The Head of Healthcare should review the procedures for supporting staff after a major incident.
- The Head of Healthcare should commission an investigation into a nurse's behaviour and actions on 29 September with a view to considering whether disciplinary or other action is appropriate, and report back to the Ombudsman.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
18. The investigator obtained copies of the relevant extracts from Mr McKno's medical and prison records.
19. NHS England commissioned an independent clinical reviewer to review Mr McKno's clinical care at the prison.
20. They jointly interviewed healthcare staff at Norwich on 13 November and 4 December 2019.
21. We informed HM Coroner for Greater Norfolk District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
22. The Ombudsman's family liaison officer contacted Mr McKno's nominated next of kin, his friend, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. His friend did not raise any concerns.
23. We shared aspects of this report with the prison, in line with our advanced disclosure process. The prison identified a factual inaccuracy, which has been corrected in this report.
24. The initial report was shared with the Prison Service. The Prison Service pointed out two minor factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Norwich

25. HMP Norwich is a multi-function prison, which predominately serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services. There is a healthcare centre, which provides 24-hour nursing cover. There is a dedicated unit, L Wing, for prisoners with significant social care needs or requiring palliative care.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Norwich took place in October 2019. The report has not yet been published.
27. The previous inspection was in September 2016. Inspectors reported that health services were reasonably good overall. An appropriate range of nurse-led clinics included provision for long-term conditions such as asthma, diabetes and chronic obstructive pulmonary disease.
28. Inspectors noted that the prison population had a complex range of needs and as a result, permanent healthcare was available at the prison, including continuous nursing support for some men on L Wing where Mr McKno was based. L Wing, which is directly underneath the healthcare centre, offers 24-hour nursing and social care packages for a mainly older group of prisoners with chronic health conditions. The inspectors were impressed with the level of care and care plans provided on L Wing, and prisoners they spoke to valued it. The palliative care pathway was found to be well developed and had achieved external accreditation in recognition of the team's practice standards.

Independent Monitoring Board

29. 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 28 February 2019, the IMB reported that deaths in that period had been handled sensitively and professionally by staff in relation to next of kin and other prisoners. They noted that the care on L Wing continued to be compassionate and sensitive.

Previous deaths at HMP Norwich

30. Mr McKno was the eighth prisoner to die at Norwich since September 2017. Of the previous deaths, four were from natural causes and three were self-inflicted. We have previously identified failings in the emergency response.

Key Events

31. On 13 May 2016, Mr McKno was sentenced to 14 years imprisonment and was sent to HMP Norwich. He was moved to HMP Bure on 2 March 2017, for assessment for the Sex Offender Treatment Programme (SOTP). However following falls which resulted in the attendance of ambulance crews, he was transferred back to Norwich on 28 April, because 24-hour social care was available there. He was returned to L Wing where he had been prior to his move to Bure, and remained there until his death.
32. Prior to entering prison, Mr McKno was already in poor health, with a history of excessive alcohol intake, falls, swollen lower limbs, arthritis, diabetes, kidney disease, obesity, and urinary tract infections (UTIs). In 2016, he was diagnosed with heart failure (a progressive condition affecting the pumping power of the heart muscles), and in December 2018, he was fitted with a pacemaker (an implanted device which can track and adjust an irregular heart rate). He had the help of a carer before his conviction, and arrived at Norwich with a high degree of dependency due to his continence and mobility problems. His initial assessment at Norwich said that he had trouble transferring to and from his wheelchair and needed help getting in and out of bed. He was only able to walk very short distances with a walking frame. He was moved to L Wing very shortly after arriving at Norwich.
33. As well as requiring daily help with getting up in the morning, and with his incontinence and mobility, he regularly had skin problems associated with his lack of mobility and lower limb problems and had frequent treatments for UTIs.
34. In November 2016, staff discussed end of life options with Mr McKno, and he signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, saying that he did not wish to be resuscitated in the event of a cardiac arrest. This was placed on his health record.
35. In September 2017, the DNACPR order was reviewed and a new form placed on his file, once again saying that Mr McKno did not wish to be resuscitated in the event of a cardiac arrest. This DNACPR order was recorded as having no expiry date.
36. On 10 November 2018, Mr McKno was taken to hospital by ambulance after a sudden deterioration in his health, which followed a period of confusion and a UTI. The hospital determined that it was necessary to fit a pacemaker, but were unable to do so until his UTI and a bacterial infection (MRSA) had been brought under control.
37. Mr McKno told the hospital that he wished to be resuscitated if there were problems with his heart during surgery. A photocopy of his DNACPR order was sent with the paramedics when he was taken to the hospital, but hospital staff were not happy with not having the original copy. Norwich felt that Mr McKno's confusion was affecting his decision making and sent in his advanced care plan which included his DNACPR order.
38. After nearly a month in hospital, Mr McKno returned to Norwich with a pacemaker having been fitted.

Events of 29 September 2019

39. On 29 September 2019, on getting up in the morning, Mr McKno reported feeling unwell and a little faint to a Healthcare Assistant (HCA). His blood pressure and blood sugar levels were low for him but were within normal clinical limits. He was taken to the dining room at 9.30am, and the HCA asked an orderly to prepare toast and jam to bring up his blood sugars. The HCA spoke to the L Wing Lead Nurse about Mr McKno's observations. The nurse advised her to take his observations again after breakfast to see if there had been an improvement.
40. Mr McKno proceeded to eat his breakfast. There are differing accounts of what happened next. The SystmOne (the electronic medical record) notes from the Lead Nurse and the second statement from another nurse, say staff were called by other prisoners when they noticed a change in Mr McKno's colour. However, the first responder, an HCA said that he was not alerted by other prisoners and that he went over to Mr McKno when he noticed that he was blue in the face. There is no CCTV on the wing to see what actually happened, but it seems unlikely that prisoners alerted staff. This is because the only other prisoner thought to have been in the dining room with Mr McKno, was someone who had Alzheimer's (he died three weeks after Mr McKno). The police officer who attended on the day, said he was told that Mr McKno was alone in the dining room, and he told the PPO that is why he had checked that he had the capacity to be left alone with his breakfast.
41. In his interview with the PPO, the HCA said that he was the only staff member on the wing at the time of the incident, and had been attending to other prisoners. He said that he came back to the kitchen attached to the dining area to wash his hands, and made a visual check on Mr McKno at around 10.00 am. He saw that Mr McKno's face was blue, with some froth at the margins of his mouth, and with jerkiness to his arms. He radioed for help, and checked to see if anything was blocking Mr McKno's airway, but because of his clenched teeth, he could not open his jaw. He administered back slaps and attempted an abdominal thrust while Mr McKno was in his wheelchair. He then ran to get to the emergency bag which he thought might be of help to nursing staff who he expected to arrive on the scene shortly after his initial radio call.
42. After about a minute, two officers who were in the healthcare centre immediately above L Wing, arrived as the HCA returned with the emergency bag. They helped the HCA, who attempted abdominal thrusts again, and unbuckled Mr McKno's wheelchair belt. The HCA tried unsuccessfully to operate a suction machine, but it is not thought that this would have helped anyway given the nature and location of the food blockage.
43. The HCA and the prison officers continued to expect the nursing staff from the healthcare centre to attend and take charge of the situation. When this did not happen, the HCA made a second radio call for help. Although this second call was not logged by the communications room, both a nurse on another wing and the duty governor said they heard this call and it was the reason why they went to the dining room on L Wing. The duty governor said that she had asked for information about what kind of help was required. The other nurse said that she had not responded to the initial call because she thought there would have been

enough staff close by to respond. However, with the second call, because of the urgency in the voice of the HCA, she packed away the medications she was dealing with in her area, and attended L Wing with another HCA who was working with her.

44. This nurse and the HCA arrived at about 10.04am. With the assistance of the L Wing HCA and the prison officers, they put Mr McKno in the recovery position. They gave him some more back slaps and the recently arrived HCA managed to remove some food debris from Mr McKno's mouth. They also applied oxygen.
45. In her statement, the L Wing Lead Nurse says she arrived at 10.06am, but from other statements and the ambulance call handling records, it is thought that it could have been a few minutes later than this. She had been initially unaware of the incident as she was working upstairs and the volume of her radio was too low for her to hear the calls put out by the HCA. In addition, the alarm system on the wing had not been working for several months. It is agreed by other staff present, that Mr McKno was unconscious and possibly dead by the time the Lead Nurse arrived. She identified that there were no signs of life and said that given the DNACPR order in place for Mr McKno, no further treatment should be attempted. Other members of staff at interview said that they were unhappy with the decision not to attempt resuscitation, but felt overruled by a more senior member of staff.
46. The ambulance call handler had been trying to establish for several minutes whether Mr McKno was choking or not, having been told that he was by people she spoke to from L Wing. The Lead Nurse came to the wing office telephone at about 10.13am and said he had not choked. She said that he had "arrested" and had stopped breathing about five minutes previously. She told the call handler that his death was expected and that there was a doctor on site who could certify the death, and that the ambulance could be stood down.
47. At 10.15am, the Lead Nurse made a 111-telephone call asking for an on-call doctor to come to the prison to certify the death of Mr McKno. His death was certified by an on-call doctor at 3.00pm.

Contact with Mr McKno's next of kin

48. Mr McKno said he had no living relatives, and had nominated a friend as his next of kin. Mr McKno had no visitors at Norwich, but was in regular contact with his friend by telephone.
49. A Custodial Manager (CM) was appointed as the prison's family liaison officer (FLO). As she was not available until 4 October, representatives from the prison visited Mr McKno's friend's address on the day of Mr McKno's death. He was not there, but they spoke to his mother about Mr McKno.
50. A Band 4 – Business Administrator, was appointed as the temporary FLO, and conducted the significant functions of contacting the next of kin, funeral directors and the coroner. She telephoned Mr McKno's friend on 30 September, and followed this up with a visit on the following day. He told the temporary FLO that Mr McKno had said that he had received outstanding care and treatment on L Wing.

51. The prison made arrangements for Mr McKno's funeral, which took place on 25 October. His friend and nominated NOK was involved in decisions about the ceremony. Norwich contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

52. Norwich have a checklist for use by the duty governor in the case of a death at the prison, entitled, "Contingency plan – Handling a Death in Custody – Reporting Requirements". This records that on the day of the death, all staff, including medical staff, were spoken to and offered support. It also said that all prisoners on L Wing had been personally spoken to about the death. Because of the segregated nature of L Wing, it was not thought necessary to issue generalised notices to staff and prisoners elsewhere in the prison.
53. The prison officer who was interviewed as part of the investigation, said that he was happy with the support that had been offered. Two of the healthcare staff said that they were not satisfied with the support they had received at the time. One of them said at interview that she was sent back to work on the wing where she had come from after the incident and no support had been offered to her. The healthcare staff said they had subsequently sought support from the clinical lead of the healthcare team and had found this helpful.

Post-mortem report

54. A post-mortem examination showed that Mr McKno died from aspiration of gastric contents (breathing in of the contents of his stomach) and choking on a food bolus (a mass of food stuck in the oesophagus). Congestive cardiac failure (progressive reduction of the ability of the heart muscles to pump blood) was a contributory factor, but did not cause the death.

Findings

Clinical care

55. The clinical reviewer concluded that the care that Mr McKno received at HMP Norwich for his health conditions was equivalent to that which he could have expected to receive in the community. She found several positive aspects to his clinical care and said that, although he was challenging at times, he was managed with compassion and cared for by confident, competent staff.
56. However, the clinical reviewer found failings with healthcare staff's response to Mr McKno's deterioration on the day of his death, and their response to the choking incident.
57. On the morning of 29 September, an HCA took Mr McKno's observations. She noted that they were worse than normal, and discussed them with the Lead Nurse. She told her to check them again after breakfast. The clinical reviewer noted that the HCA did not use an assessment tool, such as the National Early Warning Score (NEWS - tool used to assess clinical deterioration in adult patients), when taking Mr McKno's observations. The clinical reviewer found that if a NEWS had been calculated, it would have prompted an urgent assessment by a clinical practitioner.
58. We make the following recommendation:

The Head of Healthcare should ensure that clinical staff consistently use assessment tools, in particular the National Early Warning Score (NEWS), to ensure the appropriate and timely escalation of unwell patients.

Emergency response

Failure to call medical emergency code

59. The HCA made two radio calls asking for staff assistance when he realised Mr McKno was choking, but he did not call a medical emergency code blue as he should have done. (Medical emergency code blues and code reds alert staff that there is a life-threatening situation that requires immediate attention and that an ambulance should be called immediately.)
60. Norwich have a policy document, "Protocol for Healthcare Emergency Response Codes", which is based on Prison Service Instruction (PSI) 03/2013, which itself was created in response to findings from PPO investigations. This instruction very clearly sets out that a code blue should be called over the radio if a prisoner is choking and/or having difficulty in breathing (both of which applied to Mr McKno).
61. At interview, the PPO investigator and the clinical reviewer were told that as there are never behavioural control issues on L Wing, everyone knows that a call for assistance from there would relate to a medical issue. Although that might be sufficient to alert other healthcare staff that they need to attend, the purpose of the code blue is to communicate the nature of the medical emergency and for an ambulance to be called straightaway. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.

Delay in healthcare staff attending

62. When the HCA made a call over his radio for staff assistance, he expected the Lead Nurse on L Wing, who was on the floor above, to respond immediately and take over. This was also the expectation of the two officers who did respond to the HCA's initial call. However, there was a significant gap of a few minutes before the Lead Nurse attended. In the meantime, the HCA made a second call for assistance, which prompted the duty governor and another nurse and another HCA to attend from different parts of the prison. This nurse and HCA say that they were alerted by the worried tone of the L Wing HCA's voice.
63. The reason that the Lead Nurse did not attend was because she was handing out controlled drugs to prisoners on the floor above, and she said at interview that it was her practice to turn her radio down, so that it did not interrupt her concentration and lead to mistakes in handing out drugs.
64. The Lead Nurse was accompanied by an HCA in dispensing the drugs and it is standard practice to have a second pair of eyes for this. This HCA said she had decided not to carry a radio that day because she was suffering from a bad back. This meant that with the Lead Nurse's radio turned down, neither of them was aware of the emergency until they returned to L Wing following the completion of the dispensing of the drugs.
65. We make the following recommendation:

The Head of Healthcare should issue guidance to their staff on the deployment and use of radios. This should include a reminder that the medical responders should always be in radio contact.

Failure to attempt resuscitation

66. The clinical reviewer's most significant concern was the decision not to attempt to resuscitate Mr McKno. She found that there was a failure to follow the Resuscitation Council's guidelines which make it clear that choking is not a reason for not attempting resuscitation. She considered that the Lead Nurse's decision not to attempt resuscitation was based on the DNACPR that was in place, and she did not seek enough information from the other staff who had arrived on the scene before her. The clinical reviewer's opinion was that resuscitation should have been attempted, although this might have been unsuccessful.
67. The staff who were attending to Mr McKno before the Lead Nurse arrived thought that he was choking. This was the information initially given to the emergency call handler, but following the Lead Nurse's arrival in the dining room, other members of staff who spoke to the call handler showed some reluctance to clearly answer her repeated questions for confirmation about choking. There were some long gaps in responses to the call handler, including one of two minutes, although the office where the telephone was very close to the dining

room where Mr McKno died. Finally, the Lead Nurse spoke to the call handler and told her that Mr McKno had not choked, but that he was dead and resuscitation was not appropriate.

68. Following this, the Lead Nurse told the call handler that there was a doctor on site who could pronounce Mr McKno's death, and she stood down the ambulance at 10.15am (it had arrived at the prison gates at 10.14am). A doctor does not attend the prison on Sundays (29 September was a Sunday), so shortly after the emergency services call was ended, the Lead Nurse made a 111-telephone call to request a doctor. The doctor arrived about five hours after the death. At interview, she said that she had got her days mixed up. We make the following recommendation:

The Head of Healthcare should ensure that staff administer CPR in line with best professional practice (such as the guidelines of the Resuscitation Council).

Lack of clear information passed to ambulance service

69. The clinical reviewer was critical of the quality of information passed from staff at the incident to the call handler, and recommended that Norwich consider using the ERIC emergency response tool, which has been developed to improve the efficiency and effectiveness of emergency response procedures in prisons in the North of England.

70. We make the following recommendation:

The Governor and Head of Healthcare should ensure that where there is a medical emergency, staff at the scene provide information about the prisoner's condition to the communications room, so that they have this information when requesting an ambulance.

Staffing numbers

71. L Wing has a normal staffing level of one nurse and two HCAs, and this was the case on 29 September. There are no prison officers assigned to the wing, but they attend as necessary for escorting duties, etc. This is because the prisoners on the wing all have a high degree of social care needs, which makes it very unlikely that there would be violent incidents requiring the control intervention of prison officers.
72. The healthcare centre upstairs has one member of healthcare staff, a nurse, assigned to it. Prison officers are also present as would be the case on a standard prison wing. On 29 September, the nursing role was due to be covered by a permanent member of staff on overtime. They cancelled their attendance on Friday 27 September. On 28 September, the only cover that could be arranged for the Sunday, was for an agency nurse to start working at 11.00am.
73. In normal circumstances, one of the three members of staff on L Wing would have gone upstairs to help with the distribution of the controlled drugs, leaving two staff downstairs. On 29 September, an HCA and the nurse went upstairs, leaving an HCA by himself. At interview, the PPO investigator and the clinical

reviewer were told that this situation was not uncommon when there were staff shortages.

74. It is highly unusual for there to be only one member of staff on a prison wing when prisoners are unlocked. This is because it has implications for the safety of staff and prisoners. It may be that because nothing had happened previously and because the absence was expected to be short (15-20 minutes to administer the drugs and complete the paperwork), and because the expectation of violence on L Wing was low, that staff had become complacent about the risk. It is not clear that there was any risk assessment around this eventuality. Both the HCA and Mr McKno were left in a vulnerable situation. We make the following recommendation:

The Governor and Head of Healthcare should review the prison's risk register to ensure that that the contingencies to cover unexpected and temporary staff shortages are adequate.

Record keeping

75. The communications room log is expected to record significant events. In the log for 29 September, an officer recorded at 10.00am, "Assistance required L. Wing." The next entry on the log was at 10.20am, which recorded that Mr McKno had died. The second request for assistance from the HCA was not recorded. The calling of an ambulance was not recorded, nor is its arrival at the prison. We make the following recommendation:

The Governor should review the training of communications room staff and the instructions to staff that are held in the communications room, to ensure that significant events are recorded in the log.

Statements from staff

76. Following Mr McKno's death, statements from the healthcare staff were given to the police and the PPO. The PPO was also given statements from the two prison officers who responded to the HCA's first radio call. We have concerns about the statements from healthcare staff. Firstly, an HCA who removed food from Mr McKno's mouth, was sent back to her wing and not given an opportunity to make a statement. All the other statements were written by the Lead Nurse. She told us that the staff dictated their statements to her. This is surprising, and not best practice. It is at considerable variance with, for example, the protocols for use of force paperwork mandated to prisons. We do not consider this was acceptable and we make the following recommendation:

The Head of Healthcare should review the protocols for statement writing for their staff.

Support for staff

77. One of the healthcare staff was sent back to work and received no support at all. Another was quite affected by Mr McKno's death and how it was handled and did not feel that there had been adequate follow up support. We make the following recommendation:

The Head of Healthcare should review the procedures for supporting staff after a major incident.

Nurse (Name)

78. We have identified a number of concerns about the nurse's performance on 29 September. We recommend:

The Head of Healthcare should commission an investigation into the nurse's behaviour and actions on 29 September with a view to considering whether disciplinary or other action is appropriate, and report back to the Ombudsman.

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