

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

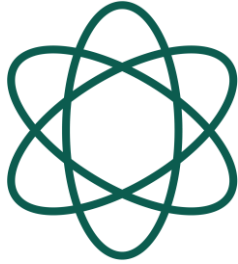
# **Independent investigation into the death of Mr Gary McDonald, a prisoner at HMP Hewell, On 21 July 2021**

**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

**OGL**

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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 Gary McDonald was found hanged in his cell at HMP Hewell on 21 July 2021. He was 49 years old. I offer my condolences to his family and friends.

Mr McDonald was remanded to prison on 25 March 2021. He appeared to have settled well at Hewell, raised few concerns with staff, mixed well with other prisoners and took part in the prison's regime. In the weeks before his death, Mr McDonald gave no indication to staff or prisoners that he was at imminent risk of suicide. Although his family said that he had told them of several anxieties, there is no evidence that he had shared these concerns with staff, and I am satisfied that staff could not reasonably have prevented his death.

However, I am concerned that when an officer unlocked Mr McDonald on the morning of 21 July, she did not check on his welfare as she should have. Despite their best intentions to save Mr McDonald's life, staff inappropriately tried to resuscitate him when they found him in his cell, even though there was evidence that he had already died. I have identified concerns about this issue in two previous investigations at Hewell and the Prison Group Director must ensure that lessons are learnt.

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 2022**

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# Summary

## Events

1. On 25 March 2021, Mr Gary McDonald was remanded into custody at HMP Hewell. When he arrived, he denied thoughts of suicide or self-harm. He appeared to settle at Hewell, mixed well with other prisoners, took part in the regime offered to him and raised few concerns with staff. Mr McDonald had regular contact with his family by telephone.
2. Although Mr McDonald's family have since said that he shared some concerns and anxieties with them before his death, there is no evidence that Mr McDonald told staff at Hewell about them.
3. At around 12.17pm on 21 July, Mr McDonald was found in his cell with a ligature around his neck. Officers tried to resuscitate him, despite indications that he had already died, and paramedics continued with these attempts after they arrived.

## Findings

4. Mr McDonald presented with no known risk factors for suicide and self-harm, and we consider that staff reasonably concluded that he did not need to be monitored under suicide or self-harm prevention procedures (known as ACCT).
5. We are however concerned that when an officer unlocked Mr McDonald on the morning of 21 July, she did not check on his welfare, as she should have.
6. While we understand that staff wanted to save Mr McDonald's life, he had signs of rigor mortis when he was found which indicated that he had been dead for some time. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Staff should therefore not have tried to resuscitate him.
7. The clinical reviewer concluded that the care that Mr McDonald received at Hewell was good and equivalent to that which he might have expected to receive in the community.

## Recommendations

- The Governor should ensure that staff check on the wellbeing of prisoners at unlock.
- The Governor and Head of Healthcare at Hewell should ensure that staff are given clear guidance and understand the circumstances in which resuscitation is inappropriate in line with Resuscitation Council UK and NICE Guidelines.
- The Prison Group Director for the West Midlands should satisfy herself that staff at Hewell understand the circumstances when resuscitation attempts would be futile and should write to the Ombudsman when she has done this.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report, so they are aware of the Ombudsman's findings.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator obtained copies of relevant extracts from Mr McDonald's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr McDonald's clinical care at the prison.
11. The investigator interviewed eight members of staff and one prisoner at Hewell. All the interviews were conducted remotely due to the restrictions imposed as a result of the Covid-19 pandemic.
12. We informed HM Coroner for Worcestershire of the investigation. He provided us with a copy of the post-mortem and toxicology reports. We have sent him a copy of this report.
13. We contacted Mr McDonald's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about his contact with the prison's mental health team and about the circumstances leading to his death. These concerns are addressed in this report and in the clinical review.
14. Mr McDonald's family received a copy of the initial report. They did not make any comments.

## **Background Information**

### **HMP Hewell**

15. HMP Hewell is a large Category B local prison in Worcestershire, holding up to 900 adult male prisoners. Practice Plus Group provides healthcare services at the prison.

### **HM Inspectorate of Prisons**

16. HMIP carried out a full inspection of Hewell in June 2019. Inspectors reported that self-harm at the prison had doubled since their last inspection. They reported that many prisoners said that staff treated them respectfully. Inspectors said that they saw examples of positive interactions between staff and prisoners and that healthcare services had improved since their previous inspection. However, inspectors identified a number of significant concerns, including that PPO recommendations following deaths in custody had not been fully implemented and oversight of their progress was inadequate.
17. The most recent inspection of HMP Hewell was a scrutiny visit in August 2020. Inspectors reported that they did not consider that Hewell was a safe prison. They noted that structures were not robust enough to identify and tackle violence and anti-social behaviour and keywork had stopped for the majority of prisoners, leaving little meaningful interaction.

### **Independent Monitoring Board**

18. In its latest annual report for the year to 30 September 2021, the IMB reported that Hewell had improved since their previous reports and was safer but levels of self-harm were still too high but decreasing. They noted that prisoners were generally treated compassionately.

### **Previous deaths at HMP Hewell**

19. Mr McDonald was the fifth prisoner to take his life at Hewell since May 2019. In our investigations into the deaths of prisoners in May and June 2019, we expressed concern that staff had tried to resuscitate prisoners, even though there were clear indications that they had already died. There were no other similarities between these or any of the other deaths and our findings about Mr McDonald's death.

### **Assessment, Care in Custody and Teamwork**

20. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

## Key Events

### HMP Hewell

21. On 25 March, Mr Gary McDonald was remanded into custody at HMP Hewell, charged with harassment and assault. He had served previous prison sentences. During his first night interview and reception health screen, Mr McDonald denied thoughts of suicide or self-harm and raised no concerns about his mental health.
22. On 26 March, an officer noted that Mr McDonald was happy to share a cell.
23. At his secondary health screen, a nurse noted that Mr McDonald's blood pressure was high but that he otherwise felt well, engaged well and denied thoughts of suicide or self-harm.
24. On 27 March, an officer introduced herself to Mr McDonald as his keyworker. (The keyworker scheme is designed to help reduce violence and self-harm by encouraging meaningful contact and positive relationships between officers and prisoners.) Mr McDonald told her that he had settled at the prison but was worried about his father's health.
25. On 30 March, Mr McDonald received his first COVID-19 vaccine.
26. On 6 April, Hewell received Mr McDonald's community GP records which noted his history of alcohol dependence, depression, anxiety and suicidal thoughts, and noted that he had been discharged from a community mental health team in September 2020.
27. On 9 April, Officer A carried out a keyworker session with Mr McDonald and told him that he would be his keyworker for the foreseeable future. Mr McDonald told him that he had settled at the prison.
28. On 23 April, Officer A noted that Mr McDonald was doing well, got on well with other prisoners and spoke to his family regularly by telephone.
29. On 25 April, Mr McDonald told Officer A that he had got on well with his cellmate, whom he said he tried to help as he struggled with his mental health. The officer commended Mr McDonald's support but reminded him to focus on his own wellbeing too and to ask staff for help if he needed it.
30. On 3 May, Officer A noted that Mr McDonald asked him if he could move cells as his mental health was being affected by "clashing" with his cellmate. He arranged for him to be moved into a cell with a prisoner he knew and noted that he was extremely happy.
31. On 10 May, Officer A noted, after a keyworker session, that Mr McDonald had handled the situation with his previous cellmate extremely well, continued to have good relationships with other prisoners, showed a willingness to change and improve himself and continued to have regular contact with his family. Mr McDonald told him that he hoped soon to be able to apply for bail.
32. At a court hearing on 14 May, Mr McDonald's case was adjourned until 23 August.

33. On 17 May, Mr McDonald told Officer A that he felt good, having received positive news about his court case. This was the last keyworker session that Mr McDonald had with him.
34. On 21 May, a prison GP saw Mr McDonald and noted that his mental health was stable but that he had a history of depression.
35. On 26 May, Mr McDonald applied for a wing job and his name was added to the waiting list. On 4 June, a Supervising Officer (SO) noted that Mr McDonald remained happy to share a cell.
36. On 9 June, Mr McDonald declined a second dose of the COVID-19 vaccine.
37. On 18 June, intelligence noted that Mr McDonald appeared to be posting regular updates on Facebook, and it was thought that he may have a mobile phone. His cell was searched the next day, but no phone was found.
38. On 23 June, it was noted that Mr McDonald's Facebook account had again been updated. His cell was searched on 25 June, but nothing was found. Mr McDonald had told staff that he had asked someone in the community to update his Facebook page. Staff told him that he should not do this.
39. The SO said she recalled speaking to Mr McDonald on either 15 or 16 July about the Covid-19 pandemic and how the virus had ended so many lives. He told her that he was eager to get his second vaccine. She chased healthcare staff and Mr McDonald's name was added to the list of prisoners awaiting a second dose.
40. On 16 July, Mr McDonald's cellmate was released from prison. The SO said that staff checked on prisoners whose cellmates had moved out and Mr McDonald was identified as a prisoner who needed a welfare check as he now occupied a cell on his own. She said that she asked Mr McDonald if he was okay now that this cellmate had moved on, but she forgot to note her contact in his prison record. She said that she had known Mr McDonald for several months, and described him as "level-headed", polite and that he never gave any indication that he might have felt low or was at risk of suicide or self-harm.
41. Officer A said that Mr McDonald was well liked, got on with other prisoners, took part in the prison regime, was never any trouble and never asked for much. He said that Mr McDonald never talked about self-harm and he was shocked to learn of his death.
42. A SO said that Mr McDonald was a quiet, polite and respectful man who kept to himself and was liked by other prisoners. He said that he often talked to Mr McDonald, and Mr McDonald would say that "everything is fine, boss". He said that Mr McDonald gave no indication that he may harm himself.
43. An officer said that Mr McDonald was polite, kept his cell clean and came out of his cell when he could. She said that Mr McDonald interacted well with other prisoners and had a small group of friends who lived next to his cell. She said that Mr McDonald never talked of self-harm and she noticed no change in his demeanour in the days leading to his death.

44. Two prisoners, who occupied the cell next to Mr McDonald, said that they went to the gym with him and that they would “hang around” together. They said that Mr McDonald appeared fine in the days before his death and that Mr McDonald never talked about self-harm.
45. Mr McDonald’s family said that in telephone conversations with his mother in the days before his death, Mr McDonald had said that he had been alone in his cell since his previous cellmate had moved out and that he did not have much time out of his cell due to Covid-19 restrictions. Mr McDonald had told his mother that he was frightened but did not say why. His family said that he had found it traumatic that he had been asked to provide additional information for his court case on 23 August but that he could not recall dates. The family said that he told them that he felt low and was desperate to go home.
46. On 19 July, Mr McDonald received his second COVID-19 vaccination. A prisoner and Mr McDonald’s family said that he had told them that he felt ill afterwards. His family said that the temperature in his cell had also been “unbearable” due to the hot weather and lack of ventilation.
47. On 20 July, Mr McDonald spoke several times by telephone to his mother and partner. He told them both that he felt very unwell from his COVID-19 vaccination. In a call to his partner at 9.45am, he also said that he needed to find a place to live for his bail application. He told his mother at 10.26am that he still felt unwell, had just returned from exercise and that his partner was going to look for a hotel for him to use as a bail address. His partner told him at 11.01am that she was still trying to find a hotel and not to stress about it too much.
48. At around 11.30am, Mr McDonald collected his lunch with two prisoners. At around 2.00pm, both prisoners talked to him in his cell shortly before they left for the gym. Mr McDonald remained in his cell.
49. Mr McDonald spoke to his mother again at 2.47pm. He told her that he had just woken up, that the weather was very hot and that he still felt unwell. In a call to his partner at 3.14pm, he again discussed his need for a bail address, which she said she would do. Towards the end of the call, Mr McDonald raised his voice, in apparent frustration, and ended the call.
50. At around 4.40pm Mr McDonald collected his evening meal with his friends and was then locked in his cell for the night.
51. Mr McDonald told his mother at 5.09pm that he still felt “rough”. He became tearful when he told her about an officer, who had asked if she could call him by his first name (as other officers called him by his surname). Mr McDonald talked about the charges against him and that his partner had annoyed him about finding a bail address. His mother told him to relax. At 6.08pm, Mr McDonald spoke to his partner about his need for a bail address. Towards the end of the call, Mr McDonald raised his voice before ending the call. In two short calls to his partner at 6.10pm and 7.38pm, Mr McDonald again ended the calls in apparent frustration.
52. Mr McDonald spoke to his mother again at 8.08pm and told her that he had not slept well because of the temperature. Mr McDonald also expressed frustration about his partner.

53. A prisoner said that at around 9.00pm, he banged on the cell wall that he shared with Mr McDonald and talked about a film that they were watching.
54. At 9.10pm, Mr McDonald spoke to his mother by telephone for the last time and told her that he was just getting over the vaccination side effects. He told his mother that he loved her and ended the call.
55. At around 9.30pm an Operational Support Grade (OSG) completed the evening roll check. He said that when he looked through Mr McDonald's cell door observation panel, he was standing by his desk and seemed a little surprised that he had said good evening to him.

## **Events of 21 July 2021**

56. At around 6.15am, the OSG carried out his morning roll check. He said that he could not remember checking on Mr McDonald, but said that if something had concerned him, he would have investigated further. He left the wing at around 7.30am. (The next roll check was not due until around 12.30pm.)
57. At around 8.35am, Officer A unlocked the cells on Mr McDonald's landing but did not look into Mr McDonald's cell when she unlocked it. The prisoners in the next cell left their cell around five minutes later.
58. At around 9.03am, Officer A completed a fabric check of Mr McDonald's cell. One prisoner said that the officer walked into the cell to check it but did not go into the toilet area. He said that the toilet door was closed and that the officer did not check behind it. The officer said that she could not recall seeing Mr McDonald at the time.
59. At around 9.15am, a prisoner looked through Mr McDonald's cell door observation panel. At around 9.30am, another prisoner also looked into the cell and appeared to gesture to other prisoners by shrugging his shoulders that he did not know where Mr McDonald was. Officer A then locked Mr McDonald's cell door to ensure that other prisoners did not go in as they had earlier joked that as Mr McDonald did not appear to be in his cell, they would go in and "mess it up".
60. A prisoner again looked through the observation panel several more times at around 10.50am and 10.56am. He said that he and another prisoner asked Officer A and other officers on the wing where Mr McDonald was that morning as they were concerned about his safety. He said that the officers told them that they did not know where he was, and that he may be attending a healthcare or other appointment.
61. At around 12.17pm, Officer B unlocked Mr McDonald's cell so that he could collect his lunch. He then moved on to unlock the other cells on the wing. Several seconds later, he returned to Mr McDonald's cell as he felt that something was not right. He went into the cell, called out for Mr McDonald and opened the cell's toilet door. He said that as he did so, Mr McDonald's body fell to the ground from a ligature made of bedding, attached to the toilet door. The officer said that the ligature appeared to have been wrapped several times over the upper hinge of the door.

62. Officer B said that he could see that Mr McDonald was not responsive. He tried to radio a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties) but was unable to do so as a radio transmission was coming through from the communication suite (due to a fire alarm sounding in another part of the prison). He went to the cell door and called out to Officer A, who was on the other side of the landing. He then went back into the cell.
63. Officer A arrived seconds later and called an emergency code blue. Officer B cut the ligature from around Mr McDonald's neck. They checked Mr McDonald for signs of life but found none. Officer B said that he instinctively and immediately started cardiopulmonary resuscitation (CPR) by giving chest compressions, although he and Officer A believed that Mr McDonald had probably already died. A Supervising Officer (SO) arrived around a minute later and helped. He noted that Mr McDonald's body was cold, and that rigor mortis was present.
64. A Custodial Manager (CM) and another SO arrived at the cell at around 12.19pm. They brought a defibrillator which was attached to Mr McDonald. The CM said there was no response from the defibrillator which advised no shock.
65. At around 12.21pm, a nurse and a prison paramedic attended with further equipment. The nurse said that there were no clear signs of cyanosis, and that they were "able to, sort of, administer CPR". The nurse said that he thought it was the right decision to continue with resuscitation attempts. A prison GP arrived and also helped with resuscitation efforts. At around 12.54pm, ambulance paramedics arrived and continued with resuscitation attempts. However, they pronounced at 1.11pm that Mr McDonald had died.

### **Contact with Mr Gary McDonald's family**

66. On the afternoon of 21 July, the Managing Chaplain and the Head of Early Days, Safety and Equalities, visited Mr McDonald's family to break the news of his death. Hewell offered to meet the funeral expenses in line with national instructions.

### **Support for prisoners and staff**

67. Senior managers debriefed staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
68. The prison posted notices informing other prisoners of Mr McDonald's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr McDonald's death.

### **Post-mortem report**

69. The post-mortem examination found that Mr McDonald died from hanging by ligature. Post-mortem toxicology results found no substances in his body.

# Findings

## Assessment of risk

70. Mr McDonald was not being monitored under ACCT procedures at the time of his death and he had not previously harmed himself at Hewell. None of the staff we interviewed considered that he was at an increased risk of suicide or self-harm in the weeks leading to his death. Mr McDonald denied thoughts of suicide and self-harm and he did not present with mental health needs. Both staff and prisoners were shocked to learn of Mr McDonald's death.
71. However, from his family's accounts and telephone calls, we note that he might have been stressed in the days leading to his death and it is possible that this influenced the action that he took. There is no evidence that staff were aware of these issues or of any information to indicate that Mr McDonald was at risk of suicide or self-harm.
72. There is no indication that Mr McDonald's behaviour changed significantly or that his demeanour worsened in the weeks before his death. We therefore consider that prison staff could not reasonably have prevented his death. Overall, staff at Hewell had good interaction with Mr McDonald in the weeks before his death, despite the challenging circumstances and restrictions resulting from the COVID-19 pandemic.

## Cell unlock procedures

73. When officers unlock cells, they should take active steps to check on a prisoner's wellbeing. Staff at Hewell are required to check on the wellbeing and safety of prisoners at unlock.
74. Officer A unlocked Mr McDonald's cell at around 8.35am on 21 July. She did not check on him (or on any of the prisoners on the landing). She told us that for her own safety, she should have opened the cell door observation panel and checked on Mr McDonald when unlocking his cell door. She agreed that she should also have completed a welfare check.
75. Mr McDonald was not found until Officer B unlocked his cell. We cannot know whether Mr McDonald's death could have been prevented if Officer A had checked on Mr McDonald, but he would have been found earlier. We understand that Hewell discussed with Officer A her failure to check on Mr McDonald's welfare, and she accepted and understood what she should have done. Nonetheless, we make the following recommendation:

**The Governor should ensure that staff check on the wellbeing of prisoners at unlock.**

## Clinical care

76. The clinical reviewer concluded that the clinical care that Mr McDonald received was of a good standard and equivalent to that which he could have expected to receive in the community. However, the clinical reviewer made several

recommendations in her review, which did not impact directly on the circumstances of Mr McDonald's death, which the Governor and Head of Healthcare will need to address.

## Resuscitation

77. In September 2016, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons to introduce new guidance to support staff on when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address concerns about inappropriate resuscitation following a sudden death in a prison. It was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The European Guidelines were updated in November 2017, but the same principles apply.
78. Staff responded promptly to the medical emergency code on 21 July. However, officers said that they believed Mr McDonald was probably already dead when he was found. The SO said that Mr McDonald's body was cold, and that rigor mortis was present, both indicators that Mr McDonald had likely been dead for some time. The officers started CPR, and healthcare staff (including a prison GP) and paramedics continued resuscitation efforts.
79. We understand the commendable wish of staff to attempt resuscitation, but they should also be aware of situations when the continuation of CPR is likely to be unsuccessful and that they are not required to do so in such circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.
80. We raised this as an issue in two previous investigations into the deaths of prisoners at Hewell in May and June 2019. Although we make no personal criticism of the staff involved, particularly as healthcare staff and paramedics also continued with attempts to resuscitate Mr McDonald, we repeat the recommendation that we have made on two previous occasions and also escalate our concerns to the Prison Group Director for the West Midlands:

**The Governor and Head of Healthcare at Hewell should ensure that staff are given clear guidance and understand the circumstances in which resuscitation is inappropriate in accordance with Resuscitation Council UK and NICE Guidelines.**

**The Prison Group Director for the West Midlands should satisfy herself that staff at Hewell understand the circumstances when resuscitation attempts would be futile and should write to the Ombudsman when she has done this**

## Learning lessons

81. We consider it is important that staff learn from our findings. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report, so they are aware of the Ombudsman's findings**

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