Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart McKay, a prisoner at HMP Wakefield, on 7 March 2021

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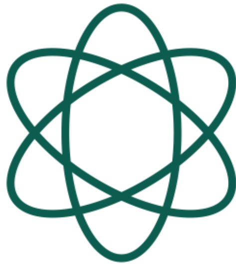
Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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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 Stuart McKay died of multiple organ failure as a result of septic arthritis (a serious joint infection) in his right knee on 7 March 2021 while a prisoner at HMP Wakefield. He was 62 years old. He also had severe left ventricular impairment (a condition that weakens the heart and causes heart failure), hypertension (high blood pressure) and Type 2 diabetes which contributed to but did not cause his death. I offer my condolences to his family and friends.

The clinical reviewer concluded that overall, the care that Mr McKay received was equivalent to that which he could have expected to receive in the community. However, I am concerned that when Mr McKay told healthcare staff that he was unwell on 4 March 2021, he should have been monitored overnight to detect earlier signs of a deterioration in his health.

I am also concerned that when he was in hospital in the days before he died, Mr McKay continued to be restrained despite his heart stopping on several occasions and his health and mobility worsening.

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 **February 2023**

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Summary

Events

1. In 1999, Mr Stuart McKay was sentenced to life in prison for murder and was sent to HMP Wakefield.

2. Mr McKay had a history of heart disease, hypertension and had had many heart attacks. He had Type 2 diabetes and arthritis in his right knee.

3. At 2.00pm on 4 March 2021, Mr McKay told prison staff that he was having dizzy spells. The nurse noted that his blood oxygen saturation was low, that his pulse rate was significantly low and that he had low blood pressure. The nurse noted that his National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 9. (A score above 7 requires an emergency response.) He gave him oxygen, but Mr McKay did not want to go to hospital.

4. The nurse asked two senior nurses to review Mr McKay. At 2.57pm, a senior nurse noted that Mr McKay's blood pressure was significantly low. She noted that he was alert, talking and had good colour. At 4.20pm, she noted that Mr McKay's blood pressure remained low but had improved. She planned for a prison GP to review him the following day.

5. At 2.54pm on 5 March, a prison GP reviewed Mr McKay in his cell and noted that he was pale, he had right hip pain travelling down his right leg, periods of dizziness and that he still had low blood pressure. The GP decided that he should go to hospital. Mr McKay agreed, and ambulance paramedics took him to hospital, restrained with an escort chain.

6. In hospital, prison staff removed the escort chain so that hospital staff could use a defibrillator when Mr McKay's heart stopped beating. Prison staff subsequently re-applied it, and Mr McKay was moved to the intensive care unit. His heart stopped beating and was restarted three more times and each time, prison staff removed and reapplied the escort chain.

7. At 8.45pm, a nurse told prison staff that Mr McKay would need an operation on his right knee. On 7 March, hospital doctors told prison staff that Mr McKay had a septic infection in his knee and told him that he was very unwell and may not survive. At 12.05pm, a prison manager authorised the restraint to be removed.

8. At 5.50pm, Mr McKay died in hospital. A post-mortem examination established that he died of multiple organ failure as a result of a septic arthritic right knee. He also had severe left ventricular impairment, hypertension and Type 2 diabetes which contributed to but did not cause his death.

Findings

Clinical care

9. The clinical reviewer concluded that overall, the clinical care that Mr McKay received at Wakefield was satisfactory and was equivalent to that which he could have expected to receive in the community.

Events of 4 and 5 March 2021

10. The clinical reviewer found that after Mr McKay told healthcare staff that he was unwell, he should have been monitored overnight.

Restraints

11. When Mr McKay went to hospital, he was restrained with an escort chain. We are very concerned that when his heart stopped beating in hospital on four occasions, prison staff removed and reapplied the restraint each time. We are troubled that it was not until six hours before he died that a prison manager authorised that the restraint could be removed despite Mr McKay having a septic right knee and a very poor prognosis.

Recommendations

- The Head of Healthcare should ensure that there is a clear process and care plan in place to monitor prisoners whose condition indicates the potential for deterioration.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

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

15. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer wrote to Mr McKay's brother to explain our investigation. He did not respond.

17. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Wakefield

18. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit which aims to provide a supportive, safe, structured and consistent environment for some of the most challenging prisoners).

19. Practice Plus Group, formerly known as Care UK, provide healthcare at Wakefield. They provide primary healthcare services during normal working hours and overnight and weekend care in the inpatient unit for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wakefield was in June 2018. Inspectors found that clinical governance had improved since the last inspection and prisoner consultation at a monthly patient forum influenced service improvement. They noted that access to healthcare services was good and staffing levels were reasonable to support primary care, although there had been some delays with social care assessments.

Independent Monitoring Board

21. 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 30 April 2020, the IMB reported that Wakefield was a calm environment, despite its challenging prisoner mix and changing population profile. The IMB reported that the healthcare inpatient unit building was not fit for purpose and of grave concern to the healthcare team. Despite this, they noted that the nursing team continued to provide a high standard of care.

Previous deaths at HMP Wakefield

22. There were 21 deaths from natural causes, four of which were from COVID-19, and two self-inflicted deaths at Wakefield in the two years before Mr McKay's death. Four prisoners have died at Wakefield since Mr McKay's death, three from natural causes, two as a result of COVID-19 and one self-inflicted death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

23. In 1999, Mr Stuart McKay was sentenced to life in prison for murder and was sent to HMP Wakefield.

24. Mr McKay had a history of heart disease, hypertension and had previously had many heart attacks. He had Type 2 diabetes and arthritis in his right knee. Mr McKay frequently refused treatment for his long-term conditions and was assessed as having capacity to make those decisions.

25. At 11.00pm on 9 January 2021, a nurse noted that Mr McKay had a high pulse rate (161 beats per minute). Mr McKay had had an internal defibrillator fitted in 2016 and he said that it had stopped working. At 11.25pm, she spoke to an out-of-hours GP, who advised that Mr McKay should be transferred immediately to hospital if his heart rate remained fast. At 1.45am on 10 January, she arranged for Mr McKay to be taken to hospital by ambulance as his heart rate remained fast.

26. On 13 January, Mr McKay returned to Wakefield after hospital staff had treated him for a lower respiratory tract infection. A nurse saw Mr McKay, who told her that his internal defibrillator was shocking him and that it was very painful. She telephoned the Hospital Coronary Care Unit, where Mr McKay had stayed, and a member of staff advised her to send him back. Ambulance paramedics took him back to hospital. On 16 January, Mr McKay returned to Wakefield and moved to the inpatient unit. On 3 February, Mr McKay went back to a standard wing.

Events of 4 and 5 March 2021

27. At 2.00pm on 4 March, Mr McKay told prison staff that he was having dizzy spells. A nurse saw Mr McKay who was sitting in his chair. He was alert and said that he did not have chest pains or shortness of breath and had no symptoms, other than 'dizziness' and 'everything going blue'. The nurse noted that Mr McKay's blood oxygen saturation was low, that his pulse rate was significantly low and that he had low blood pressure. He noted that Mr McKay's NEWS score was 9 and gave him oxygen.

28. A nurse asked a Developmental Advanced Nurse Practitioner, a senior clinical nurse with additional training and academic qualifications, and an Advanced Nurse Practitioner to review Mr McKay because he did not want to go to hospital.

29. At 2.57pm, the senior clinical nurse noted that she saw in Mr McKay's medical records that he was taking lots of medication to lower his blood pressure. She noted that Mr McKay's blood oxygen saturation, his respiratory rate, pulse rate and temperature were normal but that his blood pressure was significantly low. She noted that he was alert and talking. She noted that his NEWS score was 3, indicating a low risk of deterioration.

30. At 4.20pm, the senior clinical nurse noted that Mr McKay's observations were normal, that his blood pressure remained low but had improved. She noted that his NEWS score was 3. She noted that his lungs sounded good, with air entry and no crackles or wheezes. She planned for a prison GP to review him and his blood pressure medication the following day. She told the clinical reviewer that she did

not note anything untoward with Mr McKay's right knee when she carried out an ECG and that in her opinion, Mr McKay's presentation related to his medication.

31. At 2.54pm on 5 March, a prison GP reviewed Mr McKay in his cell. She noted that he was lying on his bed and appeared pale. She noted that he had ongoing right hip pain travelling down his right leg and periods of dizziness and that he still had low blood pressure. A nurse noted that Mr McKay's NEWS score was 3. The GP decided that despite this score, he looked pale and should go to hospital. Mr McKay agreed, and ambulance paramedics took him to hospital.

32. Before Mr McKay went to hospital, prison staff completed an escort risk assessment. A nurse completed the escort risk assessment and did not object to the use of restraints. A Supervising Officer (SO) completed Mr McKay's security assessment and noted that he posed a high risk to the public, a medium risk to hospital staff and a medium risk of escape. She noted that he should be escorted by two officers and restrained. The Head of Business Assurance authorised that Mr McKay should be restrained with an escort chain if his medical condition allowed. He noted that if Mr McKay's health deteriorated, the prison staff at the hospital should contact the Duty Governor to consider the removal of the restraint. When he went to hospital, Mr McKay was restrained with an escort chain.

33. At 9.30pm that day, Mr McKay's heart stopped beating and prison staff removed the escort chain so that hospital staff could use a defibrillator. Prison staff subsequently re-applied the restraint when his heart started beating. Mr McKay was moved to the intensive care unit. At 12.30am on 6 March, prison staff again removed the escort chain so that hospital staff could use a defibrillator and subsequently re-applied it. Hospital staff carried out the same procedure at 4.00am and at 5.05am, and the restraint was again removed and re-applied each time. At 11.50am, prison staff noted that Mr McKay was in a lot of pain. At 2.00pm, an officer at the hospital updated the Head of Business Assurance, who authorised that the escort chain could be removed if Mr McKay's heart needed to be restarted. At 5.50pm, prison staff noted that a hospital doctor removed fluid around Mr McKay's knee to send to the laboratory for testing. At 8.45pm, a nurse told the prison staff at the hospital that Mr McKay would need an operation on his right knee. At 11.30pm, prison staff noted that nursing staff lifted Mr McKay from his bed onto a commode and that his mobility was affected by his infected right knee.

34. At 9.20am on 7 March, hospital doctors told the prison staff at the hospital that Mr McKay had a septic infection in his knee and that he was not well enough to have surgery. At 11.15am, hospital doctors told Mr McKay that he was very poorly and may not survive. At 12.05pm, an escort officer telephoned the Head of Operations and told him that Mr McKay had a poor prognosis. The Head of Operations authorised that the restraint should be removed. At 5.50pm, Mr McKay died in hospital.

Contact with Mr McKay's family

35. On 7 March, a SO appointed an officer as the family liaison officer. She telephoned Mr McKay's brother and told him that Mr McKay was seriously ill in hospital. At 6.30pm, she telephoned Mr McKay's brother, told him that he had died and offered her condolences.

Support for prisoners and staff

36. After Mr McKay's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

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

Post-mortem report

38. A post-mortem examination established that Mr McKay died of multiple organ failure as a result of a septic arthritic right knee (an infection of the knee joint). He also had severe left ventricular impairment (a condition that causes a weakening of the heart and heart failure), hypertension (high blood pressure) and Type 2 diabetes which contributed to but did not cause his death.

Findings

Clinical care

39. The clinical reviewer concluded that, overall, the clinical care that Mr McKay received at Wakefield was satisfactory and was equivalent to that which he could have expected to receive in the community.

40. The clinical reviewer is satisfied that Mr McKay's long-term conditions were appropriately managed and monitored despite him not attending appointments and frequently not accepting medical treatment.

41. Healthcare staff had care plans in place in relation to Mr McKay's diabetes and heart disease.

Events of 4 and 5 March

42. Sepsis is a potentially fatal condition caused by the body's response to an infection. The clinical reviewer found that on 4 March, there was no indication that Mr McKay showed signs of sepsis and there is no record that healthcare staff saw any sign of infection in his right knee.

43. The clinical reviewer found that the clinical opinion of the advanced nurse practitioners was not unreasonable, but that Mr McKay's condition should have been monitored overnight on 4 March to detect the early signs of a deterioration in his health which may have resulted in an earlier transfer to hospital.

44. The Advanced Nurse Practitioner told the clinical reviewer that there may not have been beds available in the inpatient unit, as otherwise she might have considered transferring Mr McKay there.

45. We accept that even though Mr McKay was not monitored overnight on 4 March, there was no increase in his NEWS score from 4.20pm the previous evening and that at that time, he refused to go to hospital.

46. Healthcare staff completed a 72-hour report which has identified learning related to the care provided to Mr McKay on 4 March. They said that when a prisoner displayed worrying symptoms and a high NEWS score which are suspected to be as a result of a medication change, he should be considered for admission to hospital or the inpatient unit for monitoring until an appropriate review can take place.

47. We acknowledge that even though the healthcare provider has identified this learning, it is important that we understand how they plan to implement it. We therefore make the following recommendation:

    The Head of Healthcare should ensure that there is a clear process and care plan in place to monitor prisoners whose condition indicates the potential for deterioration.

Use of restraints

48. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account a prisoner's health and mobility.

49. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit, including the risk to the public in the event of an escape, and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The judgement found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

50. It was not until 12.05pm, six hours before he died, that the restraint was removed.

51. We are concerned that Mr McKay continued to be restrained by an escort chain after his heart had stopped beating on four separate occasions and his health was failing. Mr McKay was unable to walk to the toilet and was lifted on to a commode to go to the toilet. The prison staff on duty in the hospital completed a contemporaneous record of their duties which shows that Mr McKay's health was deteriorating and that they had discussed his health with senior managers. He had a septic knee and was extremely unwell. We are troubled that it was not until six hours before he died that the restraint was finally removed. In these circumstances, we see no justification for the continued use of the restraint and make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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