Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher McDermott, a prisoner at HMP Wymott, on 24 September 2021

A report by the Prisons and Probation Ombudsman

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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

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 Christopher McDermott died in hospital of atypical pneumonia on 27 September 2021 while a prisoner at HMP Wymott. He was 61 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the care Mr McDermott received at HMP Wymott was partially equivalent to that which he could have expected to receive in the community. However, she found that the care he received for his long-term condition was not of an acceptable standard and was not equivalent.

I am particularly concerned that the clinical reviewer found issues with the safe dispensing of Mr McDermott's medication. These concerns echo wider issues raised by HM Inspectorate of Prisons in 2020 and HMP Wymott's Independent Monitoring Board (IMB) in 2021. These issues need to be addressed as a matter of priority.

I am also concerned that despite his health, mobility and his assessed level of risk, Mr McDermott was restrained when escorted to hospital on 19 September 2021.

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 **June 2022**

Contents

Summary

Events

1. On 11 August 2017, Mr Christopher McDermott was sentenced to ten years in prison for child cruelty offences. He was sent to HMP Manchester.

2. In August 2020, Mr McDermott was released from prison. He was recalled to prison less than three weeks later and moved to HMP Wymott on 14 September.

3. Mr McDermott had bone marrow cancer, chronic kidney disease, heart failure and chronic obstructive pulmonary disease (COPD).

4. On 19 September, Mr McDermott told prison staff that he was struggling to breathe. His condition deteriorated and a nurse called an ambulance. Paramedics took Mr McDermott to hospital. He was escorted by two prison officers and was restrained using an escort chain.

5. Mr McDermott died in hospital on 24 September.

Findings

6. The clinical reviewer concluded that the clinical care Mr McDermott received at HMP Wymott was partially equivalent to that which he could have expected to receive in the community. She also concluded that the care he received for his long-term condition was not of an acceptable standard and was not equivalent.

7. We found that the decision to restrain Mr McDermott when he was taken to hospital on 19 September 2021 was not justified given his poor mobility and health condition.

Recommendations

- The Head of Healthcare should ensure that prisoners with a long-term condition:
    - are referred to the community matron;
    - are seen in the long-term conditions clinic; and
    - have appropriate care plans in place which are reviewed regularly.

- The Head of Healthcare should ensure that prisoners with a terminal diagnosis have an identified lead nurse who will oversee:
    - the implementation of a care plan which includes advanced care planning and Do Not Attempt Cardio-Pulmonary Resuscitation discussions; and
    - the referral to a palliative care clinical nurse specialist.

- The Head of Healthcare should ensure that a Palliative Care Register is in place to identify prisoners with a terminal diagnosis or advanced disease.

- The Head of Healthcare should ensure that staff undertaking clinical observations, including blood pressure, are aware of abnormal readings and escalate in line with NICE guidance.
- The Head of Healthcare should ensure that staff review prisoners who do not attend clinic appointments.
- The Head of Healthcare should ensure that a risk assessment is completed to assess whether a prisoner should keep and administer his medication.
- The Head of Healthcare should ensure that healthcare staff review a prisoner's medication following an outpatient clinic.
- The Head of Healthcare should ensure that prescribing clinicians review current prescribed medications to avoid duplication.
- The Head of Healthcare should ensure that:
    - record keeping in line with the Nursing and Midwifery Council Code of Conduct and that outcomes of social care assessments, including details of care packages, are documented in the SystmOne medical records; and
    - SystmOne records include details of discussions, actions and outcomes when prisoners are discussed at complex case meetings.
- The Governor and the 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 his actual risk.
- The Governor should revise the prison's escort risk assessment form to ensure that it requires:
    - healthcare staff to detail the severity of a prisoner's illness and say whether the prisoner's current state of health has an impact on his mobility; and
    - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Wymott, 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 McDermott's prison and medical records.

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

11. We informed HM Coroner for Lancashire & Blackburn with Darwen of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

12. We wrote to Mr McDermott's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Wymott

14. HMP Wymott is a medium security prison with capacity to hold 1,176 adult men, located near Leyland, Lancashire.

15. Healthcare services are provided by Greater Manchester Mental Health NHS Trust. There is 24-hour nursing cover although between 9pm and 7am there is one nurse on duty. This means that during the night, controlled drugs cannot be dispensed.

HM Inspectorate of Prisons

16. The last full inspection of HMP Wymott was in October 2016. Inspectors reported that Wymott remained a reasonably safe prison and staff-prisoner relationships were generally respectful. Healthcare provision was weak and, in some areas, potentially unsafe. The inspectors considered that the care of prisoners with chronic conditions was not good enough.

17. The prison was subject to a short scrutiny visit (which replaced full inspections during the COVID-19 pandemic) in August 2020. Inspectors reported that the prison had, to date, managed and mitigated the spread of COVID-19 well. However, the inspectors were concerned that the lack of senior leadership, staffing, weak governance arrangements and the poor pharmacy working environment resulted in delays in delivering medication to prisoners and created unnecessary risks.

Independent Monitoring Board

18. 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 1 June 2020 to 31 May 2021, the IMB reported that the healthcare centre was too small with insufficient treatment rooms.

19. They found that the pharmacy relied on agency staff and that there were delays in the distribution of medication. They also found that the supervision of dispensing services was inadequate which increased the risk of bullying.

Previous deaths at HMP Wymott

20. Mr McDermott was the thirteenth prisoner to die at Wymott since September 2019. Of the previous deaths, 11 were from natural causes and one was drug-related.

21. We have previously made recommendations about the use of restraints. We were particularly concerned that the medical sections on the escort risk assessments had not been completed. We were also concerned that the prison's decision to restrain a prisoner who was elderly, had multiple health problems and poor mobility was flawed. The prison accepted our recommendations and said that healthcare staff and security staff completing the assessments now fully understood the policy.

22. We have also previously made recommendations about the need to address the lack of care plans and record keeping. The prison healthcare team accepted our recommendations and said that healthcare staff had received further guidance on creating care plans and records keeping. In addition, they said that managers would carry out audits to improve practice.

23. It is disappointing that we are having to raise similar issues and make the same recommendations again in this report.

Key Events

24. On 11 August 2017, Mr Christopher McDermott was sentenced to ten years in prison for child cruelty offences. He was sent to HMP Manchester. In April 2018, his sentence was reduced to seven years and six months imprisonment on appeal.

25. In 2019, while at HMP Manchester, Mr McDermott was diagnosed with hypertension (high blood pressure). He was prescribed medication to manage his condition.

2020

26. In January 2020, Mr McDermott stopped taking his blood pressure medication.

27. In August, Mr McDermott was released from prison. He was recalled to prison after breaking the conditions of his licence and moved to HMP Wymott on 14 September.

28. An initial health screen identified that Mr McDermott had high blood pressure. Mr McDermott did not attend an appointment with healthcare staff on 11 November. There is no evidence to indicate that healthcare staff followed up his failure to attend the appointment. There is also no record that he had a GP appointment or that his blood pressure was reviewed before February 2021.

2021

29. On 20 February 2021, Mr McDermott told staff that he was struggling to walk without pain and was breathless. A nurse assessed him, and his blood pressure was high. The nurse told Mr McDermott that he needed to attend hospital and stressed the importance of going. He refused to go and signed a disclaimer to this effect.

30. A few days later, a prison GP saw Mr McDermott to review his high blood pressure. His blood test results were abnormal. Mr McDermott agreed to restart his blood pressure medication. The GP prescribed him pain relief and arranged for him to have a CT (computed tomography) scan of his abdomen. Later that day, Mr McDermott told staff that he was coughing up bright red blood. Although healthcare staff gave him a sputum pot, they did not take any samples and the appointment booked to review this was cancelled. Repeat blood tests results were abnormal. Healthcare staff referred him to the hospital nephrology (kidney) team.

31. On 17 March, a nurse saw Mr McDermott for pain in his ribs. A prison GP saw him later that day and arranged an urgent CT scan and blood tests. The blood test results showed that his red blood cell count was low, and he went to hospital for a blood transfusion. Hospital doctors diagnosed Mr McDermott with an acute kidney injury and multiple myeloma (a type of bone marrow cancer).

32. On 1 April, Mr McDermott returned to Wymott with some prescribed medication, but he did not have a copy of his hospital discharge summary. Healthcare staff assessed him as being suitable to keep and administer his medication (except for his injection medication). They also told him when he should take it.

33. The next day, a nurse saw Mr McDermott after he complained of chest pains. He told the nurse that he had not taken any of his medication because he was not sure what to take. Healthcare staff were concerned about this and removed all his medication. There is no evidence to indicate that healthcare staff completed an in-possession medication risk assessment.

34. On 8 April, Mr McDermott attended a cancer therapy appointment, and he was prescribed an opiate painkiller. At around 5.57am on 9 April, he pressed his emergency cell bell as he was unable to move. A nurse attended and helped him back to bed. The nurse could not administer the opiate painkiller because two members staff had to be present, and he was working alone. On 12 April, a prison GP amended Mr McDermott's opiate painkiller prescription so that it was administered when there were at least two nurses on duty.

35. On 16 April, healthcare staff reviewed Mr McDermott's cancer treatment plan. They took his blood pressure which was high. Healthcare staff recorded that this would be re-checked later in the day. There is no evidence that this happened.

36. On 13 May, Mr McDermott's red blood cell count was low again. Doctors decided to increase his medication instead of giving him a blood transfusion. Later that day, the hospital told healthcare staff that Mr McDermott needed a blood transfusion as well as an increase in his medication.

37. The next day, Mr McDermott attended a hospital haematology appointment and returned to prison with a prescription for a cycle of chemotherapy medication. However, healthcare staff did not prescribe all of Mr McDermott's medication.

38. On 20 May, Mr McDermott received his second daily dose of his opiate painkiller three and a half hours too early. Nursing staff contacted the out-of-hours GP for advice and monitored him. On 26 May, Mr McDermott did not receive at least one dose of his opiate painkiller. Healthcare staff also noted that he did not receive all of his chemotherapy medication. A prison pharmacist sent a second request for the medication to be prescribed. On 27 May, a prison GP prescribed the outstanding medication.

39. On 11 June, healthcare staff gave Mr McDermott two doses of his blood thinning medication. This was an error as he should only have received one. A nurse took his observations and called the out of hours GP for advice. There is no record to show what advice the out of hours GP gave to the nurse.

40. On 25 July, Mr McDermott told prison officers that he had been coughing up blood. A nurse saw him. Mr McDermott had a NEWS-2 score of 8, which indicated that he needed emergency medical care. The prison called an ambulance, and he was taken to hospital.

41. In hospital, Mr McDermott was diagnosed with a chest infection, COPD and borderline heart failure. A few days later, he was discharged from hospital and returned to Wymott.

42. On 9 September, Mr McDermott had some blood tests. The results showed that his kidneys were deteriorating. At around 8.00pm, hospital staff told the prison's healthcare team that Mr McDermott needed to be admitted to hospital urgently. Two prison officers escorted him to hospital by taxi. He returned to Wymott on 17 September.

43. At around 3.15am on 19 September, Mr McDermott pressed his emergency cell bell and told the night staff that he was struggling to breathe. They radioed a code blue, and the control room called an ambulance. A nurse assessed Mr McDermott and recorded his NEWS-2 score as one. This indicated that he needed regular monitoring and the ambulance was stood down.

44. Mr McDermott's oxygen saturations dropped, and he began wheezing. The nurse recorded his NEWS-2 score as nine, which meant that he needed emergency medical care. At 3.56am, the control room called an ambulance which arrived at 4.40am.

45. At 5.23am, Mr McDermott was taken to hospital by emergency ambulance. Two prison officers restrained him using an escort chain. He was diagnosed with acute respiratory failure and on 22 September, he was moved to the hospital's Critical Care Unit.

46. At 9.59am on 24 September, Mr McDermott died in hospital.

Contact with Mr McDermott's family

47. Mr McDermott had no named next of kin. The prison's family liaison officer (FLO) worked with the police and social services to identify an appropriate next of kin. On 27 September, the FLO contacted Mr McDermott's brother.

48. Mr McDermott's funeral was held on 15 October 2021. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

49. After Mr McDermott's death, a custodial manager debriefed the staff who were at hospital with Mr McDermott to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

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

Cause of death

51. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr McDermott's cause of death as atypical pneumonia unknown aetiology (an infection of the lower respiratory tract caused by pathogens not commonly associated with pneumonia). He also had multiple myeloma (a type of bone marrow cancer) which did not cause but contributed to his death.

Findings

Clinical care

52. The clinical reviewer concluded that the clinical care Mr McDermott received at HMP Wymott was partially equivalent to that which he could have expected to receive in the community. She concluded that the care he received for his long-term conditions was not of an acceptable standard and was not equivalent.

Management of long-term health conditions and palliative care planning

53. The clinical reviewer found that healthcare staff did not manage Mr McDermott's high blood pressure in line with NICE guidance NG136, Hypertension in adults: diagnosis and management. There is no evidence in his medical record that he was referred to a community matron for an annual review of his high blood pressure and COPD as he should have been.

54. The Palliative Care Register is a programme used by GPs to improve the organisation and quality of care that is offered to patients in their last 6-12 months of life, or who have clinical indicators of advanced disease. The register can be used as a tool to facilitate discussion and care planning for patients with monthly multi-disciplinary team discussions being held. The clinical reviewer found no evidence that Mr McDermott was named on a Palliative Care Register or that a referral to a palliative care specialist nurse had been considered to review and discuss symptom control and pain management.

55. The prison's primary care manager said Mr McDermott was discussed at the weekly complex case meeting. The primary care manager was unable to provide evidence of any discussions relating to Mr McDermott and there is no evidence in his medical record that this took place.

56. In addition, the clinical reviewer found no evidence that a DNACPR order was discussed with Mr McDermott, despite his poor health. We recommend:

The Head of Healthcare should ensure that prisoners with a long-term condition:

- **are referred to the community matron;**
- **are seen in the long-term conditions clinic; and**
- **have appropriate care plans in place which are reviewed regularly.**

The Head of Healthcare should ensure that prisoners with a terminal diagnosis have an identified lead nurse who will oversee:

- **the implementation of a care plan which includes advanced care planning and Do Not Attempt Cardio-Pulmonary Resuscitation discussions; and**
- **the referral to a palliative care clinical nurse specialist.**

The Head of Healthcare should ensure a Palliative Care Register is in place which identifies prisoners with a terminal diagnosis or advanced disease.

Clinical assessment, escalation and review

57. The clinical reviewer found that there were a number of occasions, including on 4 and 9 November 2020 and 2 March 2021, when Mr McDermott's blood pressure was noted to be high. There is no evidence that this was escalated as it should have been. The clinical reviewer considered that persistent high blood pressure can increase the risk of developing health conditions including heart disease, strokes and heart failure.

58. NEWS-2 is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. It also supports a clear, easily communicated and well understood physiological score that other clinical staff understand. The clinical reviewer found that healthcare staff did not use NEWS-2 assessments consistently. However, she did find that the use of NEWS-2 assessments increased from April 2021 onwards. The primary care manager said that a mandatory training package was introduced at that time.

59. The clinical reviewer found that on 11 November 2020 Mr McDermott did not attend a planned clinic appointment and that there was no recorded follow up or escalation. We recommend:

The Head of Healthcare should ensure that staff undertaking clinical observations, including blood pressure, are aware of abnormal readings and escalate in line with NICE guidance.

The Head of Healthcare should ensure that staff review prisoners who do not attend clinic appointments.

Medication management and risk assessments

60. The clinical reviewer found five incidents between early April and mid-June 2021, where there were issues with Mr McDermott's medication, including over-medicating, delays in medication and the risk assessment of medication in-possession.

61. On 1 April 2021, Mr McDermott's medication was taken away from him without a risk assessment being completed. On 14 May, he returned from hospital with a range of medication for a cycle of chemotherapy. However, not all of it was prescribed to him. It was twelve days before this was noticed, and Mr McDermott was not able to start the cycle of chemotherapy until 27 May.

62. On 20 May, Mr McDermott received the second dose of his daily dispensed opiate painkiller too early. On 26 May, he did not receive at least one dose of his opiate painkiller and, on 11 June, he received two doses of an anti-coagulant medication instead of one. We recommend:

The Head of Healthcare should ensure that a risk assessment is completed to assess whether a prisoner should keep and administer his medication.

The Head of Healthcare should ensure that healthcare staff review a prisoner's medication following an outpatient clinic.

The Head of Healthcare should ensure that prescribing clinicians review current prescribed medications to avoid duplication.

Record keeping

63. The clinical reviewer found that clinical record keeping was inconsistent and that these gaps included key areas of Mr McDermott's care, such as social care assessments and responses to medication errors.

The Head of Healthcare should ensure that:

- **record keeping is stringent and in line with NMC Code of Conduct and that outcomes of social care assessments, including details of care packages are documented within the SystmOne medical records**
- **SystmOne records include details of discussions, actions and outcomes when prisoners are discussed at complex case meetings.**

64. The clinical reviewer also made a recommendation about staff access to SystmOne (the NHS electronic medical record system), which we do not repeat in this report but which the Head of Healthcare will need to address.

Use of restraints

65. 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 the prisoner's health and mobility.

66. 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 (and 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.

67. This is reinforced in the *National Security Framework – External Escorts*. Sections 5.7 and 5.8 sets out the circumstances when restraints would not be appropriate. They say:

> "Handcuffs will not normally be used … if the prisoner's medical condition or advanced age or physical impairment renders restraints inappropriate. Restraints will not normally be necessary for example, when the prisoner's mobility is severely limited, e.g., due to advanced age or disability unless there are grounds for believing that an escape attempt may be made with external assistance."

68. On 19 September, when prison and healthcare staff responded to a code blue, they found that Mr McDermott had deteriorated, and his oxygen levels had dropped. He

was receiving treatment for cancer and was suffering from chronic obstructive pulmonary disease and kidney failure.

69. In the person escort record (PER) risk assessment, the duty healthcare staff member recorded that Mr McDermott's condition was life-threatening and that "he can only walk short distances". There was no information reflecting his current state of health or his long-term conditions. However, healthcare staff raised no objection to the use of restraints.

70. The prison staff member completing the risk assessment noted that Mr McDermott needed only to be restrained by use of an escort chain due to "his current medical condition and his age". This implied that the level of handcuffing was reduced by these factors. However, Mr McDermott was a category C prisoner, which meant that a single handcuff was the default level of restraint.

71. We assess that given his poor health and his identified reduced mobility Mr McDermott should not have been restrained when he was taken to hospital on 19 September. We note that later that day, the duty Operational Manager approved the removal of the handcuffs at around 11.20am, following a request from hospital staff. We make the following recommendations:

The Governor and the 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 his actual risk.

The Governor should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to detail the severity of a prisoner's illness and say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

Inquest

72. The inquest, held on 26 September 2023, concluded that Mr McDermott died from natural causes.

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