Prisons & Probation Ombudsman
Independent Investigations

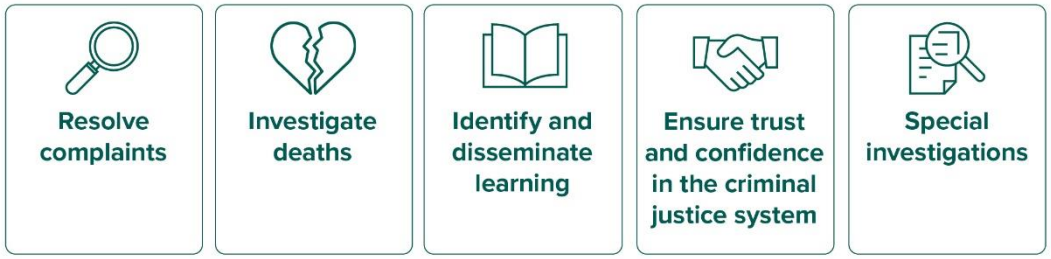
Independent investigation into the death of Mr Peter McCall, a prisoner at HMP Wakefield, on 8 January 2023

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

Summary

1. 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.

2. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Peter McCall died in hospital on 8 January 2023, of a myocardial infarction (a heart attack) while a prisoner at HMP Wakefield. He was 71 years old. We offer our condolences to Mr McCall's family and friends.

4. The clinical reviewer concluded that the clinical care Mr McCall received at Wakefield was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. Based on our review of the medical risk assessments for the use of restraints, we have identified that, on occasions, the forms were not completed correctly, and crucial information was not included.

6. Considering the information contained within the security risk assessment, along with Mr McCall's age, multiple serious health conditions and that he was a wheelchair user, we have concluded that the use of restraints was not justified.

Recommendations

- The Head of Healthcare should ensure that healthcare staff complete the medical risk assessment form in full, providing the authorising manager with sufficient information to make informed decisions.

- The Governor should ensure that prison staff involved in completing escort risk assessments give adequate consideration to a prisoner's presenting health, alongside the factors associated with public protection.

The Investigation Process

7. We were notified of Mr McCall's death on 8 January 2023.

8. NHS England commissioned an independent clinical reviewer to review Mr McCall's clinical care at Wakefield.

9. The PPO investigator investigated the non-clinical issues relating to Mr McCall's care.

10. The PPO family liaison officer wrote to Mr McCall's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

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

Previous deaths at HMP Wakefield

12. Mr McCall was the twenty-seventh prisoner to die at HMP Wakefield since 8 January 2020. Of the previous deaths, 23 were from natural causes and three were self-inflicted. There are no similarities between our findings in this investigation report and those of the previous deaths.

Key Events

13. On 22 December 2016, Mr Peter McCall was sentenced to 20 years imprisonment for sex offences. He was transferred to HMP Wakefield on 17 July 2017. He was a category C prisoner.

14. Mr McCall had a number of medical conditions, which included, but were not limited to, ischaemic heart disease (reduced blood supply to the heart), angina (chest pain caused by reduced blood flow to the heart muscles), chronic obstructive pulmonary disease (COPD, abnormalities in the lungs that limits airflow in and out), atrial fibrillation (irregular heart rate), and left sided weakness. He had also had four previous heart attacks.

15. On 7 November 2018, following a discussion with a GP at Wakefield, Mr McCall signed a DNACPR (order stating that medical staff should not attempt to resuscitate in the event of the heart failing).

16. On 14 September 2022, Mr McCall was moved to the healthcare unit due to recurrent falls. This was linked to postural hypotension (a drop in blood pressure when you stand up after sitting or lying down).

17. On 12 October 2022, the prison completed a Personal Emergency Evacuation Plan (PEEP) assessment. It was recorded on the assessment form that Mr McCall had limited mobility and he was a wheelchair user. It was also documented that he was in a disabled access cell within the healthcare centre.

18. On 23 November 2022 at approximately 1.20pm, a code blue was called as Mr McCall had been found unresponsive by an officer. (A code blue alerts the control room to call an emergency ambulance.) A nurse attended, and she completed Mr McCall's physical observations. She calculated a National Early Warning Score (NEWS2) as zero. (NEWS2 is a tool to detect and respond to clinical deterioration. A score above seven indicates the need for an emergency response.) She decided that an ambulance was not required, and that an electrocardiogram (ECG, a test to check the hearts rhythm and electrical activity) would be done, along with regular physical observations.

19. Later in the afternoon, Mr McCall was again seen by the nurse, as he was complaining of chest pain. The ECG was carried out which was "abnormal" and his NEWS2 had increased to two. Subsequently, a decision was made to call for an ambulance.

20. The ambulance arrived at approximately 4.26pm, and the paramedics carried out an ECG. They were unable to obtain an adequate ECG and they decided that Mr McCall should be taken to hospital. Mr McCall was taken to the ambulance on a stretcher, escorted by two prison officers and restrained using a single cuff and escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

21. The medical risk assessment was completed by a nurse. She recorded that there were no medical objections to the use of restraints and that Mr McCall's medical condition did not restrict his ability to escape unaided. The form was not completed in full and the section concerning impaired mobility was left blank.

22. The security risk assessment was completed by an officer on 24 November. Mr McCall was assessed as a high risk to the public, a medium risk to hospital staff, medium risk of escape and low risk of hostage taking and receiving outside assistance. There was no current specific intelligence recorded and in regard to specific factors of concern, his offence was identified as well as an incident in 2017, when Mr McCall had been out on escort and had been seen "messing" with the escort chain and ratchet part of the cuffs.

23. The officer recommended that Mr McCall should be restrained, and the escort chain was authorised by a prison manager. The manager noted on the form that he had considered Mr McCall's mobility and medical condition and no mobility concerns had been raised.

24. On 2 December, Mr McCall returned to Wakefield following treatment for atrial fibrillation and low potassium.

25. On 10 December, at approximately 12.40pm, Mr McCall used his emergency call bell, and he was seen by a nurse. Mr McCall told her that he was experiencing chest pain and felt unwell. She carried out physical observations and recorded a NEWS2 score of six. She concluded that he was clinically unwell and ambulance was required.

26. At 1.00pm, a Supervising Officer (SO) recorded in Mr McCall's Prisoner Escort Form (PER) that the prison manager had agreed that Mr McCall should not have restraints applied, but they could be applied once medical staff had advised it was safe to do so and/or if there was an improvement in his condition.

27. The medical risk assessment was completed at 1.40pm. The name of the staff member who completed the form was not included. They recorded on the form that there were no medical objections to the use of restraints, but Mr McCall's medical condition did restrict his ability to escape and that restraints could be removed to facilitate treatment. It was also recorded that Mr McCall had impaired mobility and required a wheelchair.

28. At 1.48pm, a nurse carried out an ECG and further physical observations. She concluded that he was tachycardic (a heart rate over 100 beats a minute) and his NEWS2 score had increased to eight. Mr McCall continued to be monitored by her until the paramedics arrived at 3.20pm and took him to hospital.

29. On 11 December, a SO completed the security risk assessment. The information recorded was unchanged from the assessment completed on 23 November and the recommendation was that Mr McCall should be restrained.

30. The authorising manager recorded that he had considered the Graham judgment (a legal decision related to the use of restraints on prisoners), Mr McCall's mobility, medical condition and that he was a wheelchair user. He concluded that restraints should not be used but that this decision should be reviewed if his condition improved or stabilised.

31. At approximately 5.00am, the escort officer applied a single cuff and escort chain to Mr McCall and noted that Mr McCall was now mobile.

32. At 4.20pm, following a management check by the authorising manager, restraints were removed due to Mr McCall's limited mobility, frailty and serious underlying health issues. The manager stated that this decision should be reviewed daily following management checks.

33. On the evening of 12 December, Mr McCall returned to HMP Wakefield.

34. On 13 December, a prison GP and a nurse met Mr McCall. They recorded that they tried to discuss the deterioration in his condition and that he had been diagnosed with heart failure. They arranged an appointment for Mr McCall to see another GP to begin the Gold Standards Framework (GSF) process. (GSF is an approach for care providers to follow for people in their final phase of life.)

35. On 15 December, healthcare staff took Mr McCall's physical observations a number of times during the day. A NEWS2 score of three was calculated and concerns were noted about his blood pressure and that he had not been able to pass urine. At 2.30pm, a decision was made that Mr McCall should be admitted to hospital for review.

36. A nurse completed a medical risk assessment and recorded that there were no medical objections to the use of restraints, but that Mr McCall's medical condition restricted his ability to escape unaided. No information was given about his medical condition, and it was noted that Mr McCall was a wheelchair user.

37. A Custodial Manager (CM) completed the PER. He recorded that Mr McCall left Wakefield at 6.02pm and was restrained using an escort chain. The record does not indicate if a senior manager was involved in the decision about restraints.

38. At 7.15pm, the officer who had accompanied Mr McCall to hospital called the duty governor at Wakefield about Mr McCall's restraints and deteriorating health. The officer recorded on the PER that the removal of the escort chain was refused.

39. An officer completed the security risk assessment on 16 December. He recorded the same information as the previous assessments and recommended that Mr McCall should be restrained.

40. On 17 December at 2.00am, an officer, who was with Mr McCall at the hospital, recorded that a hospital doctor had tried to fit Mr McCall with a new canula, but had been unable to do it.

41. At 6.20am, the officer recorded that the doctor was still unable to fit a canula and had asked for the restraints to be removed. The duty governor authorised the removal of restraints.

42. On 22 December at 1.45pm, a CM carried out a management check and authorised for the escort chain to be reapplied after Mr McCall's condition improved. Mr McCall returned to Wakefield at 3.05pm.

43. On 6 January at approximately 2.00pm, Mr McCall reported chest pain to a prison GP, who called an ambulance. A nurse undertook Mr McCall's physical observations and recorded a NEWS2 score of five.

44. At approximately 2.30pm, Mr McCall used his call bell to request assistance from staff as he was experiencing a sharp pain in his chest. The nurse recorded that Mr McCall had two episodes where he became unresponsive before paramedics arrived.

45. The nurse completed the medical risk assessment. She recorded that there were no medical objections to the use of restraints and that Mr McCall's medical condition restricted his ability to escape unaided. No information was given about his medical condition but it was recorded that Mr McCall was a wheelchair user.

46. Mr McCall left Wakefield at 3.05pm. He was restrained using an escort chain, which had been authorised by a prison manager.

47. On 7 January at 5.15pm, a prison manager carried out a management check. She recorded that a full prisoner risk assessment was required.

48. At approximately 11.25pm, a medical emergency was called due to a deterioration in Mr McCall's condition. The restraints were removed to facilitate treatment.

49. At 11.45 the duty governor approved the removal of restraints for the rest of the night.

50. On 8 January at 12.15am, Mr McCall died.

Post-mortem report

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 McCall's cause of death as a myocardial infarction (a heart attack – decreased blood flow to the heart).

Inquest

52. The inquest into Mr McCall's death was held on 27 January 2023 and a verdict of natural causes was recorded. The Coroner concluded that Mr McCall's death was due to a myocardial infarction.

Findings

Clinical Findings

53. The clinical reviewer found that the care that Mr McCall received at Wakefield was of a good standard and was at least equivalent to that which could have been expected to be received in the wider community.

54. He identified that there was good written evidence to show that medications for both pain and long-term conditions were managed appropriately, which was good practice and over and above what was expected.

Restraints, security and escorts

55. 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.

56. A judgment in the High Court in 2007 (the Graham judgement) 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 suffering from a serious medical condition. It said 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.

57. Prison Service Instruction *Prevention of Escape – External Escorts*, defines the policy and guidance for the external escort of prisoners. It says that a risk assessment must be undertaken to decide whether restraints must be used on an escort. It also says that restraints will not normally be used when a prisoner's medical condition, advanced age or physical impairment renders restraints inappropriate.

58. In the case of an admission to hospital, healthcare staff are required to complete a medical risk assessment which is then considered alongside all other relevant intelligence and information.

Medical risk assessments

59. The risk assessment completed for Mr McCall's admission to hospital on 23 November was not completed correctly. There was no information concerning Mr McCall's presenting health and medical conditions. The nurse had also failed to record that Mr McCall was a wheelchair user and therefore had limited mobility.

60. Given that Mr McCall was a wheelchair user and had a number of significant health conditions, we have concluded that on this occasion the nurse incorrectly indicated that Mr McCall's health would not have restricted his ability to escape unaided.

61. The medical risk assessment for the admission on 10 December did not contain the name, grade, or signature of the person completing the form. No details of Mr McCall's medical condition were noted. However, it was recorded that Mr McCall's mobility was impaired and he needed a wheelchair.

62. High quality information provided by healthcare staff in the medical risk assessment is crucial to making informed, proportionate and justified decisions about the use of restraints. It is therefore imperative that they are filled in correctly. We make the following recommendation:

The Head of Healthcare should ensure that staff complete the medical risk assessment form in full, providing the authorising manager with sufficient information to make informed decisions.

Use of restraints

63. Mr McCall was restrained on three of the four occasions that he was admitted to hospital. The security assessments that were carried out identified that Mr McCall was a high risk to the public due to his location within the high security estate, the length of his sentence and his offence type. His risk to hospital staff was assessed as medium as he was located in a high security prison. However, it was noted that there was no current intelligence to suggest that he posed a risk to hospital staff. There was no intelligence to indicate a risk of hostage taking, potential to escape or the likelihood of external assistance. There was also no current intelligence to suggest there was a risk to prison staff.

64. Mr McCall was a category C prisoner (deemed at low risk of escape) at Wakefield (a high security prison). In terms of escape history, it was recorded that in July 2017, while on an escort to hospital, Mr McCall had been seen interfering with the escort chain and cuffs.

65. Mr McCall had a number of significant medical conditions which affected his general health and mobility. In September 2022, he was moved into the healthcare inpatient unit due to reoccurring falls linked to hypotension. Mr McCall was a wheelchair user, and he was in the process of being considered for specialist care because he was beginning the final phase of his life.

66. Given this, that he was accompanied by two prison officers at hospital and the absence of current intelligence that suggested that he posed a high risk of escape, the use of restraints was not justifiable in the circumstances. We therefore make the following recommendation:

The Governor should ensure that prison staff involved in completing escort risk assessments give adequate consideration to a prisoner's presenting health, alongside the factors associated with public protection.

Governor to note

67. The PER completed on 15 December did not include which manager had made the decision about the use of restraints and the full risk assessment was not signed off within the 18-hour timescale.

68. A full risk assessment was also not completed for Mr McCall's admission on 6 January 2023.

Adrian Usher **July 2023**
Ombudsman

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