

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David McPherson a prisoner at HMP Bristol on 26 February 2018

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David McPherson died of heart disease on 26 February 2018, at HMP Bristol. He was 44 years old. I offer my condolences to Mr McPherson's family and friends.

The care Mr McPherson received for his raised blood pressure was not equivalent to that which he could have expected to receive in the community. There were numerous failings in monitoring, keeping clinical records, making referrals, assessments and prescribing. The investigation also found that the next of kin records were not accurate.

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

May 2019

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Summary

Events

1. On 28 October 2017, Mr David McPherson was remanded to HMP Bristol after being charged with drug offences.
2. On arrival at Bristol, Mr McPherson presented with raised blood pressure and, although staff monitored it regularly, he did not see a GP until 8 November. The doctor arranged an electrocardiogram (which was borderline abnormal) and prescribed amlodipine to reduce his blood pressure.
3. The GP saw Mr McPherson the following week, increased his medication and arranged to review him in a month. The GP did not ask for his blood pressure to be monitored in the meantime.
4. Mr McPherson presented with raised blood pressure in November and December and he also complained of flu like symptoms. He was given ibuprofen and his symptoms were recorded.
5. On 24 February 2018, a healthcare assistant reviewed Mr McPherson. His blood pressure was 160/80 (ideal blood pressure is 120/80) but he was not referred to a GP for review.
6. On 25 February, an officer locked Mr McPherson in his cell for the evening and did not recall any issues. At 5.30am on 26 February, an operational support grade (OSG) conducted the morning roll check and noticed that the observation panel on Mr McPherson's cell door was obscured. He tried to get a response from Mr McPherson but could not, so he radioed for staff assistance. Other staff arrived and went into the cell.
7. Mr McPherson was on his bed but did not respond to their attempts to rouse him. A member of staff radioed an emergency code blue and staff in the control room called an ambulance straight away. Officers moved Mr McPherson onto the floor and healthcare staff arrived and commenced resuscitation attempts. Paramedics also arrived but attempts to revive Mr McPherson were unsuccessful. At 6.31am, the paramedics confirmed that Mr McPherson had died.

Findings

8. We are not satisfied that the care Mr McPherson received for his raised blood pressure was equivalent to that which he could have expected to receive in the community. We found that healthcare staff had a poor grasp of how to manage an individual who repeatedly presented with varying degrees of raised blood pressure. The clinical reviewer found that on some of these occasions, Mr McPherson's blood pressure was so high that it should have prompted emergency treatment. The clinical reviewer has identified numerous worrying issues with monitoring, keeping clinical records, making referrals, assessments and prescribing medication.
9. The next of kin's details were not accurately recorded and staff were not aware that she was only sixteen years old.

Recommendations

- The Head of Healthcare should ensure all staff know what constitutes a concerning blood pressure reading and how to investigate it effectively.
- The Head of Healthcare should ensure all staff make timely referrals for assessment and treatment of abnormal blood pressure readings and that urgent referrals are dealt with.
- The Head of Healthcare should ensure clinical staff record detailed notes when conducting appointments or assessments.
- The Head of Healthcare should ensure staff are aware of and employ the QRisk2 assessment tool when relevant.
- The Head of Healthcare should review the policy regarding NSAIDS and hypertensive patients, taking account of the advice in the British National Formulary.
- The Governor should ensure that prisoners' next of kin information is accurate and easy for staff to access.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr McPherson's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr McPherson's clinical care at the prison.
13. We informed HM Coroner for Avon and Somerset District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator contacted Mr McPherson's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They have raised some issues which have been dealt with in separate correspondence.
15. Mr McPherson's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and, where we agree, this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Bristol

17. HMP Bristol serves the local courts and holds up to 614 adult men over the age of 18 years old.
18. Healthcare services at Bristol are managed by Inspire Better Health, a partnership of eight providers led by Bristol Community Health. GP services are sub-contracted to Hanham Health Services, and Avon and Wiltshire Partnership provide mental health and substance misuse services. A number of organisations provide other services, including Prisoner Advice and Care Trust (PACT) who offer support to maintain family links.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Bristol was in March 2017. Inspectors reported that most of the residential wings were dilapidated and dirty, that 53% of prisoners said it was easy to get drugs, and that violence towards staff and between prisoners was high. Inspectors also reported that staff-prisoner relationships were quite good, with two thirds of prisoners saying staff treated them respectfully (although this was a decrease from the previous inspection).
20. Following a previous inspection in 2018, Bristol was placed in special measures and remains in special measures at the time of writing (February 2019). 'Special measures' means HM Prisons and Probation Service has determined a prison needs additional, specialist support to improve performance.

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 their latest annual report, for the year to July 2018, the IMB reported that the staffing headcount had exceeded the published benchmark, but that training, detached duty and sick leave had immediately reduced it back below the benchmark. Staff were regularly unable to run a normal, basic daily regime resulting in cancelled appointments and activities. Facilities were described as shocking and unfit for purpose. The Board was concerned that incidents of violence were under-reported and the true picture was not really known.
22. Access to clinical appointments needed improvement, and there seemed to be limited follow-up when prisoners did not attend appointments. The healthcare unit was seeking to align itself with the community and aiming to deliver a nurse-led model of care in order to reduce the volume of routine work that was being undertaken by GPs.

Previous deaths at HMP Bristol

23. Mr McPherson's is the thirteenth death at Bristol since February 2015. Six of these have been self-inflicted, four from natural causes, one from drugs and one from 'other' non-natural causes. There has been one self-inflicted death since Mr McPherson's death. We have made recommendations about family liaison before.

Key Events

24. On 28 October 2017, Mr David McPherson was remanded to HMP Bristol after being charged with drug offences.
25. A nurse conducted Mr McPherson's first night health screen. She noted he had not been in prison before (although the records indicated he had). Mr McPherson said he did not drink and he tested negative for cocaine, cannabinoids and opiates. (It was later recorded that he drank heavily in the community). He said he had not previously used drugs. His blood pressure was 186/100 (ideal is 120/80) and his heart rate 51-90 beats per minute (normal resting rate is 60-100). His weight was 92 kilograms (14½ stone) and his height 1.778 metres, meaning his Body Mass Index (BMI) was 29.1 (indicating that he was at the top end of the 'overweight' range).
26. The nurse arranged for Mr McPherson's blood pressure to be checked the next day. A healthcare assistant recorded that it was still raised although he did not record the actual reading. He noted that Mr McPherson occasionally struggled to breathe although he was not diagnosed with asthma.
27. On 30 October, a pharmacy technician recorded that she had given Mr McPherson nicotine patches and lozenges. A healthcare assistant reviewed Mr McPherson's blood pressure, which was 185/105, and his heart rate, which was 105 beats per minute. Entries made every other day indicated that staff were monitoring Mr McPherson closely and that on each occasion his readings were high/above normal.
28. On 1 November, a healthcare assistant sent an electronic message via SystemOne (the electronic medical records system) asking for GP advice but he did not make a GP appointment. Mr McPherson's blood pressure was 176/108. (On 3 November it was 184/100, on 5 November 190/108 and on 7 November 160/97.) The GP responded to the advice asking for an appointment to be made for Mr McPherson. The appointment was arranged the same day it but did not occur until a week later.
29. On 8 November, a prison GP reviewed Mr McPherson. He arranged for a nurse to do an electrocardiogram (which measures the heart's electrical activity and rhythms). The GP recorded the results as 'borderline abnormal'. On 10 November, the GP prescribed amlodipine (a medication for high blood pressure), and planned to review Mr McPherson again. No blood pressure readings from this review were recorded.
30. On 15 November, a prison GP reviewed Mr McPherson again and recorded his blood pressure as 156/94. The GP increased Mr McPherson's amlodipine prescription to 10mg from 5mg and recorded that he would review him in one month. He did not request any interim blood pressure measurements to be done.
31. On 28 November, an onsite paramedic recorded that he had seen Mr McPherson after being asked to by a member of prison staff. He recorded that Mr McPherson was feeling weak and cold and his blood pressure was 160/110. His pulse was 114, and his temperature 37.5. All readings were abnormally raised.

32. The paramedic reviewed Mr McPherson again that day and recorded that his blood pressure and heart rate had reduced to 130/80 and 36.7 respectively. Mr McPherson was prescribed ibuprofen and paracetamol for flu symptoms.
33. On 29 December, Mr McPherson again complained of flu like symptoms. He was given ibuprofen (and again on 31 December). On 29 December, a nurse recorded that Mr McPherson's blood pressure was 147/85 and on 31 December 134/90.
34. On 24 February, a healthcare assistant carried out a review. Mr McPherson declined another referral to the smoking cessation service and said he was currently using a vape pen. He accepted a hepatitis B vaccination offer. His respiratory rate was 14 breaths per minute, his heart rate 114 beats per minute and his blood pressure 160/80. He was not referred to a GP for review.

Events of 25/26 February

35. On 25 February, an officer locked Mr McPherson in his cell for the evening. She said that Mr McPherson told her about a visit he had had that day, that he seemed content and that there were no issues.
36. On 26 February, at approximately 5.30am, an operational support grade (OSG) started the roll check and noticed the observation panel on Mr McPherson's door was obscured. He could not get a response from Mr McPherson despite kicking and banging the door. He contacted Officer A by radio.
37. Officer A told the OSG that he would collect other staff on his way to the wing. He immediately collected Officers B and C and they went to Mr McPherson's cell. Officer A opened the door and went into the cell. Mr McPherson was on his front, on the bed with his head tilted to his left. Officer A and Officer C tried to wake him. Officer C said that Mr McPherson's arm was warm. Officer A tried to find a pulse and could not, so he asked one of the other officers to call a code blue emergency (indicating a prisoner has breathing difficulties or is unconscious). At 5.40am, the OSG radioed a code blue and the staff in the control room called an ambulance straight away. Officer A and Officer C moved Mr McPherson to the floor.
38. The onsite paramedic and a nurse responded and brought an emergency bag and an oxygen cylinder. Officer A and Officer B took turns doing chest compressions. When the paramedic and nurse arrived, they took charge of the resuscitation attempts. The paramedic attached a defibrillator and the machine advised that he deliver Mr McPherson a shock. They then continued with chest compressions.
39. The nurse went to 'Urgent Care' to get more equipment and drugs to assist with the resuscitation attempt. At 5.52am, the ambulance crew arrived at the prison and were at Mr McPherson's cell one minute later. The crew continued with resuscitation attempts. They were unsuccessful and at 6.31am, confirmed that Mr McPherson had died.

Contact with McPherson's family

40. At 7.30am, a prison manager telephoned the family liaison officer (FLO) and asked him to attend the prison. The FLO established that the prison did not hold any next of kin details for Mr McPherson.
41. At an unrecorded time, Mr McPherson's ex-partner called the prison and spoke to the FLO. She asked if it was true that Mr McPherson was dead - an unknown source had been in touch with her and told her that this was the case. The FLO told her that he could not give her any information as she was not the next of kin. Mr McPherson's ex-partner telephoned back and gave the FLO the next of kin's contact details (Mr McPherson's daughter) and said that she was already aware of her father's death.
42. The Governor telephoned Mr McPherson's daughter at 1pm, but her mother took the majority of the call, and according to the FLO log, informed him that Mr McPherson's daughter was only 16. The mother said that she and her daughter were going to visit HMP Bristol the next day. The Governor offered to travel to their home but they declined this offer.
43. The next day, Mr McPherson's daughter, two other relatives and a friend visited HMP Bristol. The Governor said that it was at this point he became aware that the next of kin was only 16 and sought policy advice from HMPPS on whether it was appropriate for him to liaise with her as the next of kin given her young age. He was advised that as long as she had support, it was appropriate.
44. Mr McPherson's funeral was held on 6 April 2018, and the FLO attended. The prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

45. After Mr McPherson's death, prison managers debriefed the staff involved in the emergency response. There were no minutes of the meeting but there was a handwritten list of who had attended. The staff care team also offered support.
46. The prison posted notices informing other prisoners of Mr McPherson'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 McPherson's death.

Post-mortem report

47. The post-mortem report gave the cause of death as ischaemic and hypertensive heart disease (heart disease caused by narrowed arteries and high blood pressure).

Findings

Clinical care

48. The clinical reviewer concluded that the care Mr McPherson received was not equivalent to that which he could have expected to receive in the community. We agree. The clinical reviewer has highlighted a catalogue of shortcomings in the management of Mr McPherson's high blood pressure. In addition, he was not adequately assessed for general cardiovascular risk.
49. On admission to HMP Bristol (28 October 2018), Mr McPherson's blood pressure reading was very high at 186/100. The nurse did not recheck it after a period of rest, in different arms or make a same day GP appointment.
50. The clinical reviewer asked the Head of Healthcare about this. She said that prisoners' blood pressure readings are often slightly elevated when they are first admitted to prison. The clinical reviewer believes that this reading was not 'slightly' elevated but constituted severe hypertension.
51. The Head of Healthcare agreed that what had happened was not normal or best practice, and that they should retake an elevated blood pressure reading after a period of rest, in different arms or request a same day GP appointment. In the light of these failings, we make the following recommendation:

The Head of Healthcare should ensure all staff know what constitutes a concerning blood pressure reading and how to investigate it effectively.

52. After two further occasions where Mr McPherson's blood pressure was raised (29 and 30 October), a healthcare assistant sent an electronic message to a GP but did not make an urgent appointment for Mr McPherson and the GP did not ask for one to be made. This meant that Mr McPherson was not seen by a doctor until 8 November, and between the message being sent and the appointment, his blood pressure was recorded as raised on a further three occasions (3, 5 and 7 November). Mr McPherson had also complained of headaches and feeling dizzy.
53. In total, eleven days passed between Mr McPherson first presenting with raised blood pressure and a doctor seeing him for review. On some of the intervening occasions where his blood pressure was not normal, the clinical reviewer said that Mr McPherson would have been on the brink of severe hypertension – a situation which should have prompted emergency treatment. We make the following recommendation:

The Head of Healthcare should ensure all staff make timely referrals for assessment and treatment of abnormal blood pressure readings and that urgent referrals are dealt with.
54. The Head of Healthcare told the clinical reviewer that Mr McPherson was monitored by nurses over these eleven days but they did not always record blood pressure readings at the time. She agreed with the clinical reviewer that these omissions did not reflect best practice. We make the following recommendation:

The Head of Healthcare should ensure clinical staff record detailed notes when conducting appointments or assessments.

55. On 8 November, a prison GP assessed Mr McPherson, eleven days after he had arrived at the prison. Although he requested an ECG and prescribed medication, he did not carry out a QRisk2 assessment (which assesses cardiovascular risk and investigates whether someone may have high cholesterol which can then be treated).
56. The clinical reviewer found that given that the post-mortem showed atheroma (furring) of all three major cardiac arteries, with one reduced to only a pin point opening, a cardiovascular risk score would have been highly relevant. The Head of Healthcare agreed that omitting this assessment when managing someone with hypertension did not reflect best practice. We make the following recommendation:

The Head of Healthcare should ensure staff are aware of and employ the QRisk2 assessment tool when relevant.

57. Mr McPherson had consistently raised blood pressure and it was almost always above the normal thresholds. The clinical reviewer found that his blood pressure was uncontrolled and yet he was given ibuprofen on four occasions. The clinical reviewer said that the British National Formulary advises caution in prescribing NSAIDS (non-steroidal anti-inflammatory drugs used to relieve pain, reduce inflammation, and bring down a high temperature), such as ibuprofen, to individuals with uncontrolled hypertension. On three of those occasions where it was given to him, there is no evidence in the notes that Mr McPherson's blood pressure was assessed.
58. The Head of Healthcare said that Mr McPherson's blood pressure was being effectively managed and controlled under the 'Minor Ailments Policy'. The clinical reviewer disagrees. Only one or two normal blood pressure readings against a backdrop of so many abnormal ones, and a catalogue of instances where blood pressure was not recorded at all, does not constitute effective management. We make the following recommendation:

The Head of Healthcare should review the policy regarding NSAIDS and hypertensive patients taking account of the advice in the British National Formulary.

59. The Head of Healthcare said that Mr McPherson did not give consent for his community health records to be shared with them and this compromised their ability to care for him. The records that they did have available, however, showed that during a previous prison sentence, Mr McPherson had had hypertension since 2012. The clinical reviewer does not agree that a lack of community health records precluded Bristol from caring for Mr McPherson more effectively. We agree.

Family contact

60. The next of kin in this case was only 16 years old but the prison said that their records (obtained from their 'visitors' system) had her recorded as 18. However, the visitors' section of Mr McPherson's NOMIS record (prison record) does not

show any date of birth for the next of kin. We understand that the next of kin had already received the news and went on to share responsibility for next of kin duties with her mother. However, it is important that prisons endeavour to collect and record prisoners' next of kin information and ensure that it is accurate and up-to-date. We make the following recommendation:

The Governor should ensure that prisoners' next of kin information is accurate and easy for staff to access.

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