Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward McCulloch, a prisoner at HMP Isle of Wight, on 25 June 2021

A report by the Prisons and Probation Ombudsman

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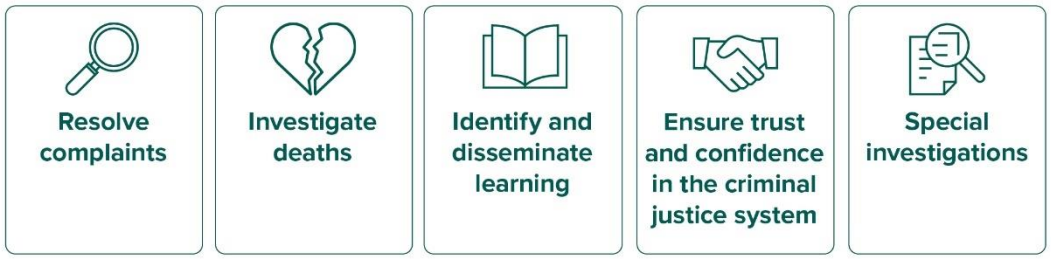
OUR VISION

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

3. Mr Edward McCulloch died on 25 June 2021 of lung cancer at HMP Isle of Wight. He was 83 years old. We offer our condolences to Mr McCulloch's family and friends.

4. The clinical reviewer concluded that the clinical care Mr McCulloch received at HMP Isle of Wight was equivalent to that he could have expected to receive in the community. He made one recommendation.

5. We found that the decision to restrain Mr McCulloch when he was taken to hospital in May was not justified given his advanced age and poor mobility.

6. We also found that there was a delay in assigning a family liaison officer (FLO), which was not done until after Mr McCulloch died.

Recommendations

- The Head of Healthcare should ensure that staff use a coordinated care plan approach to manage long-term conditions, and accurately record care plans and the outcomes in the medical records.
- The Governor should ensure that a family liaison officer is appointed for prisoners who are seriously or terminally ill and that the next of kin is kept informed of the prisoner's condition, in line with PSI 64/2011.
- 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

7. NHS England commissioned an independent clinical reviewer to review Mr McCulloch's clinical care at HMP Isle of Wight.

8. The PPO investigator has investigated non-clinical issues, including Mr McCulloch's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr McCulloch's next of kin, his son, to explain the investigation. He did not respond to our letter.

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

Previous deaths at HMP Isle of Wight

11. Mr McCulloch was the 16th prisoner to die at HMP Isle of Wight since June 2019. Of the previous deaths, ten were from natural causes and five were self-inflicted.

12. We have previously made a recommendation to Isle of Wight about ensuring the use of restraints on sick and elderly prisoners is justified. We were told that the Governor would remind staff of their responsibilities by January 2022.

Key Events

13. In December 2014, Mr Edward McCulloch was sentenced to 18 years in prison for sexual offences. In May 2015, he was moved to HMP Isle of Wight.

14. Mr McCulloch had several serious health conditions including heart disease, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases), osteoarthritis (a condition which causes joints to become stiff and painful), an amputated lower right leg, and dementia. Healthcare staff saw him frequently to monitor these conditions.

15. On 23 March 2021, a multi-disciplinary meeting was held to discuss Mr McCulloch's frailty and need for increased social care.

16. Between 8 April and 20 May, Mr McCulloch was admitted to the prison's Inpatient Healthcare Unit (IHU) four times and declined to be admitted to the IHU once despite a prison GP's advice.

17. On 20 May, a GP admitted Mr McCulloch to the IHU after diagnosing him with a chest infection. Another multi-disciplinary meeting was held, where it was decided to begin end of life management for Mr McCulloch.

18. On 28 May, a GP noted Mr McCulloch's condition was appearing to become terminal and prescribed anticipatory medications (medicines that are prescribed for symptoms that might develop in the future) delivered by syringe driver (a small battery powered pump which delivers medication through a tube into the skin).

19. On 3 June, a GP noted that despite some initial improvement, Mr McCulloch was continuing to deteriorate and appeared to be approaching the end of his life.

20. On 17 June, a meeting was held where assigning a family liaison officer (FLO) and enquiring about any next of kin (NOK) were discussed. The next day, the prison chaplain visited Mr McCulloch.

21. On 23 June, a GP reviewed Mr McCulloch and noted he was weaker and struggling to swallow pills. Mr McCulloch declined any treatment, and all his unnecessary medication was stopped. He continued receiving painkillers.

22. Mr McCulloch died on 25 June in the IHU.

Post-mortem report

23. The post-mortem report concluded that Mr McCulloch died of carcinoma of the lung (lung cancer) as a result of cigarette smoking. The post-mortem also showed that cerebrovascular disease, ischaemic heart disease, hypertension, and old age were contributory factors.

Non-Clinical Findings

Liaison with Mr McCulloch's family

24. Prison Service Instruction (PSI) 64/2011, about safer custody, says that prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill.

25. On 3 June, the prison GP noted that Mr McCulloch was nearing the end of his life. On 17 June, a meeting was held where assigning a FLO and enquiring about any NOK were discussed. The next day, Mr McCulloch was visited by the prison chaplain. However, a FLO was not appointed until 25 June, after Mr McCulloch died. We recommend:

    The Governor should ensure that a family liaison officer is appointed for prisoners who are seriously or terminally ill and that the next of kin is kept informed of the prisoner's condition, in line with PSI 64/2011.

Restraints, security and escorts

26. 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. 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 suffering from 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.

27. The investigator reviewed Mr McCulloch's escort risk assessment from 9 May 2021, for one of his hospital appointments. The risk assessment noted that Mr McCulloch was experiencing declining physical and mental health and was becoming increasingly frail and confused. It also said that Mr McCulloch was only partially mobile, requiring use of a wheelchair, and that his medical condition (below knee amputation) would restrict his ability to escape unassisted. Despite this, staff assessed Mr McCulloch's escape potential as 'normal' and his risk to staff and the general public as 'high', and a manager authorised the use of an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

28. We are not satisfied that the use of restraints on Mr McCulloch was proportionate to the risks he posed. Mr McCulloch was an elderly prisoner with reduced mobility who had a very low risk of escape and who was accompanied by two prison officers. We are not satisfied that the authorising manager took this into account when authorising restraints. We do not consider that the use of restraints was justified. We also note that two months before, in March, no restraints were used on Mr McCulloch when he was taken to hospital. We do not understand therefore

why restraints were used in May, when his condition had deteriorated, and he was even less of an escape risk. We recommend:

The Governor should ensure that authorising mangers take account of all the information in escort risk assessments and that all decisions to use restraints on prisoners taken to hospital are proportionate to their risk.

Louise Richards **May 2022**
Assistant Ombudsman

Inquest

At the inquest, held on 6 August 2025, the Coroner concluded that Mr McCulloch died from natural causes.

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