

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of the man in April 2013
at HMP Maidstone**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of man who died from the effects of chronic obstructive pulmonary disease at HMP Maidstone in April 2013. He was 66 years old. I offer my condolences to his family and friends.

A clinical reviewer was commissioned to undertake a review of the man's clinical care.

The man had been diagnosed with chronic obstructive pulmonary disease for a number of years. He did not have any other significant physical medical conditions.

At the beginning of April, before participating in a medically supervised fitness class in the prison's gymnasium, the man told the nurse present that he was experiencing severe chest pains. Soon after, he collapsed and stopped breathing. Attempts by staff to resuscitate him were unsuccessful and he was pronounced dead by the prison doctor. A post-mortem examination concluded that he had died from chronic obstructive pulmonary disease.

The clinical review into the man's death concludes that his medical care in prison was exemplary and I am satisfied that he received a good standard of care at the prison.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2013

CONTENTS

Summary

The investigation process

HMP Maidstone

Key events

Issues

SUMMARY

1. The man was sentenced to seven years in prison in February 2011. On his arrival at HMP Lewes, he told staff he had been diagnosed with chronic obstructive pulmonary disease (COPD) and suffered from depression. He was treated for both conditions.
2. On 6 May 2011, the man transferred to HMP Maidstone where he continued to receive treatment for COPD and depression. During this time he suffered from a number of chest infections, which were treated with antibiotics.
3. The man started a medically supervised fitness class on 19 February 2013 and attended twice-weekly. At the beginning of April, before his fitness class had started in the prison gym, he told the supervising nurse that he was experiencing severe back and chest pains.
4. The nurse immediately called for further medical assistance and for the prison doctor to attend. An ambulance was also requested. Within minutes the man lost consciousness and stopped breathing. The nurse, with the assistance of colleagues and the prison doctor, immediately began cardiopulmonary resuscitation (CPR). They continued until paramedics arrived. Resuscitation was unsuccessful and he was pronounced dead by the doctor.
5. The clinical review into the man's death raises no concerns about the treatment he received while in custody. The clinical review concludes that the healthcare that he received while in prison had been exemplary. We make no recommendations in this report.

THE INVESTIGATION PROCESS

6. The investigator issued notices informing staff and prisoners at HMP Maidstone of the investigation and asking them to contact him with any relevant information. No one responded.
7. The local PCT commissioned a clinical reviewer to conduct a review of the man's clinical care and he received copies of his records. The investigator interviewed several members of healthcare staff to assist with the review. He provided feedback to managers at Maidstone during the investigation.
8. HM Coroner for Mid-Kent and Medway District was informed of the investigation and provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.
9. One of this office's family liaison officers contacted the man's family to explain the purpose of the investigation. They had no specific issues they wished the investigation to consider.

HMP MAIDSTONE

10. HMP Maidstone is a category C training prison accommodating up to 600 men. The prison's healthcare unit has no in-patient facilities and does not provide 24 hour cover. GP services are provided by Oxleas NHS Foundation Trust and GP surgeries are held each weekday morning.

HMP Maidstone pulmonary rehabilitation class

11. Pulmonary rehabilitation classes, which have been trialled at Maidstone Prison, are routinely offered in the community. The eight week course is aimed at prisoners with breathing difficulties, most commonly those with chronic obstructive disease (COPD). COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. Typical symptoms include increasing breathlessness when active, a persistent cough and frequent chest infections. The pulmonary rehabilitation course is made up of a program of education and exercise classes that teach prisoners with COPD about their lungs, how to exercise and do activities suffering less shortness of breath, and how to experience a better standard of life with a lung condition. The class includes light physical exercise and advice covering subjects such as medication, lung health, coping with breathlessness and generally provides a supportive atmosphere for those with COPD. Before being allowed to participate in the course, prisoners are given a full assessment of their fitness to take part.

HM Inspectorate of Prisons

12. HM Inspectorate of Prisons (HMIP) last inspected Maidstone in September 2011. HMIP reported positively about healthcare at the prison. They found that the range of primary care services was appropriate and prisoners told inspectors that healthcare staff were polite and respectful. Effective screening in reception identified needs quickly and appropriate referrals were made.

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its latest published annual report, for 2011/12 the IMB reported no major shortcomings in the provision of healthcare services. The IMB reported that the timeliness of appointments and range of services available was at least as favourable as that experienced by members of the public locally.

Previous deaths at HMP Maidstone

14. In the year prior to the man's death, there were two deaths due to natural causes at Maidstone. There are no similarities between these deaths and that of his.

KEY EVENTS

15. The man was born in 1946. In October 2010, he appeared at Magistrates' Court, was remanded into custody and taken to HMP Lewes. During his initial health screen at the prison it was noted that he smoked and had been diagnosed with chronic obstructive pulmonary disease (COPD). He was taking medication to ease his symptoms of shortness of breath and coughing. His medication included carbocisteine, used to loosen mucus on the chest, and a number of inhalers to assist with his breathing, all standard treatments for COPD. He had difficulty in walking and often used a mobility scooter. A disabled prisoner review and evacuation plan was completed which were regularly reviewed.
16. On 7 February 2011, the man was convicted of a number of serious offences and on 1 March was sentenced to seven years imprisonment. While in prison he was treated for depression. He was referred to a bereavement counsellor after the death of a close relative. He continued to suffer from varying degrees of depression and prison mental health staff reviewed him frequently.
17. The man transferred to HMP Maidstone on 6 May. Over the following weeks and months he was offered smoking cessation advice, but frequently failed to attend meetings. In August 2011, he told staff that he did not wish to be resuscitated should he fall ill. He suffered from a number of chest infections through 2011, which were treated with antibiotics.
18. In August 2012 the man was given niquitin, a drug used to assist smokers to stop smoking. Although he failed to stop completely, he reduced his use of cigarettes. He continued to suffer from a number of chest infections and coughs, related to his COPD and was appropriately prescribed antibiotics. He continued to receive treatment for depression.
19. On 19 February, the man started the prison's newly introduced pulmonary rehabilitation class. Before he began he was assessed as suitable to take part in the programme. He subsequently attended the class twice a week until his death on 5 April. The nurse who ran the course told the investigator that he was, "... actually doing really well and he was really enjoying it ... managing to walk a lot further than he could before".

Events of the incident

20. At the beginning of April 2013, the man and other prisoners went to the prison's gym for a pulmonary rehabilitation class. Although he often used a motorised disability vehicle to move around the prison, he had walked from his wing that day.
21. At approximately 10.05am the nurse who ran the class asked the man if he was okay, as he was sitting on the rowing machine with his head in his hands. He told the nurse that he had severe pain in his back which he had been experiencing for several days. He had not previously drawn this to the attention

of staff. She said he "... looked really clammy and quite pale". Soon after he got onto the floor and curled up into a ball, and told the nurse and the Physical Education Instructor (PEI) that he was experiencing chest pains.

22. The nurse immediately called for further emergency medical assistance and for the prison doctor to attend. Within a minute another nurse and a pharmacy technician arrived with the emergency response kit, which included oxygen, insulin and a defibrillator. The class nurse noted that the man's overall condition and breathing was deteriorating and gave him oxygen and attached a defibrillator¹ to his chest while he was still conscious. At 10.08am, a nurse asked the prison's control room to call an ambulance.
23. The prison doctor arrived soon after and asked the man to lie down so he could assess him further. The class nurse told the investigator that at this point his pupils became fixed and dilated and he stopped breathing. The healthcare staff and the PEI immediately began cardiopulmonary resuscitation (CPR), taking it in turns to administer compressions to the chest until the arrival of paramedics. At no point during the attempt to resuscitate him did the defibrillator advise that CPR should stop for an electric shock to be applied.
24. Paramedics arrived at the prison at 10.27am and were immediately escorted to the gym. They took over in their attempts to resuscitate the man at 10.31am. However, all resuscitation efforts were unsuccessful and he was pronounced dead by the prison doctor at 10.55am.

Support for staff and prisoners

25. After the man's death, a staff debrief was held. No concerns were identified about how the emergency incident had been managed. Staff were made aware of the prison's care team should they require support. The Governor issued a notice to prisoners about his death, reminding them of the support available in the prison. A memorial service was held at the prison on 16 April, and was attended by staff and prisoners.

Family liaison

26. There were no contact details for the man's nominated next of kin, who was one of his brothers. However, another brother was informed of his death and gave the prison family liaison officer contact details for his siblings and his daughter who were also informed of his death that day. The funeral took place on 30 April, led by the prison chaplain. The prison contributed to funeral expenses in line with national guidance.

¹ A defibrillator is a piece of medical equipment which detects electrical rhythms in the heart and indicates whether to deliver a shock in order to re-start the heart

ISSUES

27. In his clinical review the clinical reviewer reports on the treatment of the man's COPD and depression. The clinical reviewer notes that his mental health needs were addressed by both regular support and medication and that both approaches had been helpful to him.
28. The clinical reviewer reports that during the man's time in custody his COPD was diagnosed and treated appropriately. He notes that the care and treatments that he received, such as attending the prison's pulmonary rehabilitation clinic, was as good as the care that he could have expected in the community. He concludes that his medical care while in prison had been exemplary.
29. The clinical reviewer reports that the man's collapse, which led to his death, was entirely unrelated to any activity in the gym because the pulmonary rehabilitation clinic had not started. He considers that the attempts made to resuscitate him were entirely appropriate and that the situation was handled with dignity.
30. The clinical reviewer notes that although the man had previously indicated he did not wish to be resuscitated if he became ill, it was understandable that in the emergency health professionals responded in the way that they had been trained. Because of the circumstances, he made no criticism of staff's attempt at resuscitation.