

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Thomas Maxwell a prisoner at HMP Doncaster on 9 March 2017

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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 Thomas Maxwell died of a heart attack on 9 March 2017 while a prisoner at HMP Doncaster. He was 66 years old. I offer my condolences to Mr Maxwell's family and friends.

Mr Maxwell received a good standard of care at Doncaster, equivalent to that which he could have expected in the community. The first officers to respond to the emergency should have taken over resuscitation efforts from Mr Maxwell's cellmate, although this would have been unlikely to have changed the outcome for Mr Maxwell. Prison and healthcare staff subsequently worked well together in trying to resuscitate him.

Officers and healthcare staff, who tried to resuscitate Mr Maxwell, were not given the opportunity to attend the critical incident debrief.

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

**Richard Pickering**  
**Deputy Prisons and Probation Ombudsman**

**August 2017**

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# Summary

## Events

1. On 20 June 2016, Mr Thomas Maxwell was sentenced to eight years in prison for sexual offences and was sent to HMP Doncaster. At his initial health assessment, healthcare staff found no significant issues.
2. At 01.50am on Sunday 5 March 2017, Mr Maxwell had chest pain and could not breathe. His cell mate helped him to a chair but he became limp and turned blue. He laid him on the floor and started chest compressions. He pressed the cell bell and kicked the door.
3. Two officers attended, immediately unlocked and opened the cell door. The night duty prison manager was called. The officers called a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing) and an ambulance was called promptly. The officers said they did not go into the cell because Mr Maxwell's cellmate was performing chest compressions.
4. A prison manager and an officer arrived about three minutes later, immediately went into the cell and took over from Mr Maxwell's cellmate. They started cardiopulmonary resuscitation. Two nurses and a healthcare support worker arrived with an emergency bag (used for those who are unconscious or not breathing) and took over cardiopulmonary resuscitation.
5. A nurse twice applied a defibrillator, which advised a shock as it detected there was a shockable rhythm. They continued cardiopulmonary resuscitation.
6. At 2.05am, paramedics arrived at the prison. They took over the emergency care and took Mr Maxwell to hospital. He was later transferred to another hospital, where hospital staff fitted a stent (a small tube used to treat narrow or weak arteries).
7. Mr Maxwell's condition deteriorated and at 4.26pm on 9 March, he died of a heart attack.

## Findings

### Clinical care

8. The clinical reviewer was satisfied that the care Mr Maxwell received at Doncaster was equivalent to that which he could have expected to receive in the community.

### Emergency response

9. While the clinical reviewer said it was unlikely that the officers' initial hesitation would have changed the outcome for Mr Maxwell, prison officers are trained in first aid and should have taken over emergency first aid from Mr Maxwell's cellmate. When prison and healthcare staff arrived, they worked well together, taking it in turns to try to resuscitate Mr Maxwell.

## **Response after a death in custody**

10. While the prison held a memorial service for Mr Maxwell, we would have expected the prison to have formally informed other prisoners of Mr Maxwell's death and offered support, in case they were affected by it.
11. Officers and healthcare staff who tried to resuscitate Mr Maxwell were not given the opportunity to attend the critical incident debrief.

## **Recommendations**

- The Governor and Head of Healthcare should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity, and that, unless there are clear signs of death, staff first on the scene of an emergency provide basic life support until qualified health professionals arrive.
- The Governor and Head of Healthcare should ensure that after a serious incident, staff are invited and allowed the time to attend the critical debrief meeting and that prisoners are informed and offered support.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him. A prisoner contacted Mr Crocker and was interviewed on 6 April.
13. The investigator obtained copies of relevant extracts from Mr Maxwell's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Maxwell's clinical care at the prison. The investigator and clinical reviewer jointly interviewed five members of staff and two prisoners at Doncaster on 6 and 7 April. The investigator interviewed a member of staff by telephone on 3 May.
15. We informed HM Coroner for Doncaster of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. The investigator wrote to Mr Maxwell's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
17. We shared the initial report with the Prison Service. They pointed out two factual inaccuracies and this report has been amended accordingly.

# Background Information

## HMP Doncaster

18. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Nottingham Healthcare NHS Foundation Trust provides physical and mental health services, and substance misuse services.

## HM Inspectorate of Prisons

19. The most recent inspection of HMP Doncaster was in October 2015. The Inspectorate found that prisoners were negative about their experience of healthcare and there was evidence that provision had deteriorated, mainly because of staff shortages. They found that prisoners had reasonable access to an appropriate range of primary care services, though the management of prisoners with long-term conditions was underdeveloped. Some prisoners had experienced delays in receiving their medication and too many external hospital appointments were cancelled because of a lack of escort staff.
20. Inspectors noted that cell conditions throughout the prison were very poor, as they were dirty and many had missing windows.

## Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to September 2015, the IMB noted that a shortage of nursing staff meant doctors were taking on nursing duties which had caused delays with appointments to see a doctor. The Board commented that the increase in older prisoners meant there were more complex and chronic health problems to manage. More prisoners had outpatient appointments and the Board acknowledged the challenge of providing escorts for such visits.

## Previous deaths at HMP Doncaster

22. Since March 2016, there have been two deaths from natural causes at Doncaster. There are no significant similarities with these deaths.

## Key Events

23. On 20 June 2016, Mr Thomas Maxwell was sentenced to eight years in prison for sexual offences and was sent to HMP Doncaster. At his initial health assessment, Mr Maxwell said he did not drink alcohol and was a light smoker.
24. At 01.50am on 5 March 2017, Mr Maxwell had chest pain and could not breathe. He stood by the cell window. His cellmate helped him to a chair, but he became limp and turned blue. His cellmate laid him on the floor and started chest compressions. After five or six compressions, Mr Maxwell took a gasp of breath so the cellmate turned around and pressed the cell bell on the wall and kicked the door a number of times. He resumed chest compressions and shouted for help.
25. The cellmate said that due to the narrow width of the cell, he stood astride Mr Maxwell and performed chest compressions on the left side of his breast in a rhythm of about 15 at a time. He did not tilt Mr Maxwell's head back or check the airway and did not use any breaths. Prisoners in nearby cells pressed their cell bells and kicked their doors.
26. Two officers went to the cell. They saw through the cell window that the cellmate was performing chest compressions. An officer broke the seal on her night pack which contained a key, and unlocked and opened the cell door. They called a medical emergency code blue and an ambulance was called promptly. The officers said they did not go into the cell because the cellmate was performing chest compressions.
27. A prison manager and two other officers heard the emergency code on the radio and went together to the cell, which took them about three minutes. They went into the cell and started cardiopulmonary resuscitation. An officer performed chest compressions and the manager performed rescue breaths. The cellmate left the cell and officers consoled him.
28. Two nurses and a healthcare support worker arrived with an emergency bag and took over resuscitation efforts. A nurse applied a defibrillator which advised a shock as it detected a shockable rhythm. The healthcare team twice administered a shock. Healthcare staff, supported by prison staff, continued resuscitation attempts and gave him oxygen.
29. At 2.05am, paramedics arrived at the prison and took over the emergency care. At 3.11am, Mr Maxwell was taken to the intensive care unit at the hospital by ambulance. Hospital staff transferred him to another hospital, where they fitted a stent (a small tube used to treat narrow or weak arteries). Prison officers escorted him, and they did not use restraints.
30. Mr Maxwell's condition deteriorated. At 4.26pm on 9 March, he died of a heart attack.

### Contact with Mr Maxwell's family

31. On 6 March, Doncaster appointed an officer as the family liaison officer. Prison staff telephoned Mr Maxwell's daughter, who went to the hospital to see him.

The next day, she met Mr Maxwell's family at the hospital to offer support. She remained in regular contact with Mr Maxwell's daughter and family.

32. On 9 March, Mr Maxwell died in hospital. His daughters and their families were with him at the time. The family liaison officer was present at the hospital to offer her support and condolences. Mr Maxwell's funeral took place on 5 April, and Doncaster contributed to the cost in line with national guidelines.

### **Support for prisoners and staff**

33. After the emergency response on 5 March 2017, a prison manager spoke to the cellmate to ensure he had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
34. After Mr Maxwell's death, two prison managers debriefed the bedwatch officers and the family liaison officer to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
35. The prison did not post notices informing other prisoners of Mr Maxwell's death, and offering support, though staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Maxwell's death. Prisoners were offered the opportunity to attend a memorial service for Mr Maxwell, where they were offered support.

### **Post-mortem report**

36. A post mortem examination established that the cause of Mr Maxwell's death was a myocardial infarction (a heart attack). This was caused by coronary atheroma (which is commonly known as a 'hardening' or 'furring up' of the arteries, a condition which reduces blood supply to the heart).

# Findings

## Clinical care

37. The clinical reviewer was satisfied that the care Mr Maxwell received at Doncaster was equivalent to that which he could have expected to receive in the community. Mr Maxwell did not see the healthcare team regularly and there was no evidence to suggest that he had previously had chest pain.

## Emergency response

38. The first aid trainer at Doncaster said that all prison officers are trained in administering emergency first aid at work. He said that officers were expected to give rescue breaths during cardiopulmonary resuscitation.
39. The cellmate was carrying out chest compressions when two officers arrived at Mr Maxwell's cell. We are concerned that although the officers were trained in emergency first aid, they did not take over from him, regardless of whether or not they believed that he was doing chest compressions correctly. While, as the clinical reviewer concluded, it is unlikely that this would have changed the outcome for Mr Maxwell, particularly as prison and healthcare staff arrived around three minutes later and took over from the cellmate, the officers should have carried out emergency first aid (including chest compressions and rescue breaths) until healthcare staff arrived and not allowed a prisoner to continue. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity, and that, unless there are clear signs of death, staff first on the scene of an emergency provide basic life support until qualified health professionals arrive.**

40. While we are pleased that prison and healthcare staff worked well together before paramedics arrived, maintaining resuscitation efforts on a rotational basis, they tried to resuscitate Mr Maxwell on the floor of his cell, which was a confined space and made treatment more difficult. Staff should have considered moving him from the cell to the landing to ensure that there was sufficient space to resuscitate him. The prison manager said he did not want to waste time by moving him. We do not make a recommendation as it did not affect the outcome for Mr Maxwell.

## Response after a death in custody

41. Doncaster did not post notices informing other prisoners of Mr Maxwell's death and offering them support, as they should have done. We note that the cellmate was offered support, that prisoners were invited to attend a memorial service held for Mr Maxwell, where support was available, that staff reviewed those prisoners at risk of suicide or self-harm and that prisoners are able to call the Samaritans from their in-cell phones. While we recognise that those prisoners who required support ultimately received it, we are concerned that notices were not immediately posted and that this delayed the provision of support.

42. We note that prison managers debriefed prison staff after the death of Mr Maxwell. However the officers and healthcare staff who tried to resuscitate him were not able to attend as the debrief was held when the officers were on a rest day. These officers and healthcare staff were involved in a traumatic incident and should have been given the opportunity to attend the debrief. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that after a serious incident, staff are invited and allowed the time to attend the critical debrief meeting and that prisoners are informed and offered support.**

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