Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Madin a prisoner at HMP Rye Hill on 12 December 2018

A report by the Prisons and Probation Ombudsman

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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*

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.

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

Mr John Madin died of a heart attack on 12 December 2018 at HMP Rye Hill. Mr Madin was 65 years old. I offer my condolences to those who knew him.

Mr Madin had several long-term medical conditions when he arrived at Rye Hill. Although the care that he received overall was equivalent to that which he could have expected to receive in the community, there were some significant shortcomings. I am particularly concerned that Mr Madin reported symptoms of heart failure that were never investigated.

I am also concerned that, despite several requests, the healthcare team at Rye Hill did not provide some of the information we asked for.

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 **August 2019**

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Summary

Events

1. On 20 December 2016, Mr John Madin was sentenced to 11 years in prison and sent to HMP Nottingham. On 8 February 2018, he was transferred to HMP Rye Hill.

2. Mr Madin had a history of complex medical conditions which included chronic obstructive pulmonary disease (COPD, a lung disease), asthma, osteoarthritis, hypothyroidism, chronic lower back pain and bladder cancer (which was successfully treated in 2016). Healthcare staff saw him frequently to prescribe his medication and monitor some of his conditions. He had an asthma and COPD care plan.

3. On 10 July, Mr Madin complained to a nurse that he had chest pains. She completed an electrocardiogram (ECG) but noted nothing significant. There are no further entries in his medical record about investigating or discussing heart conditions.

4. On 12 December, a prison officer found Mr Madin unresponsive in his cell. He immediately radioed for assistance and began cardiopulmonary resuscitation (CPR). Prison staff, nurses, paramedics and an air ambulance doctor attended but despite resuscitation attempts, Mr Madin died.

Findings

5. Overall, the care that Mr Madin received at Rye Hill was equivalent to that which he could have expected to receive in the community. Healthcare staff created a care plan for his asthma and COPD. Prison GPs prescribed cholesterol-reducing medication and nurses completed regular blood tests to review his cholesterol levels.

6. However, the investigation found that there were some significant shortcomings:

   - Mr Madin had complex medical needs but healthcare staff did not set up care plans for some of his long-term conditions.
   - The prison GPs who reviewed Mr Madin failed to review or monitor all the medications he was prescribed.
   - Mr Madin reported symptoms of heart failure which were never investigated.
   - When Mr Madin was found unresponsive in his cell, the healthcare staff directly involved in the emergency response did not keep full and accurate records of what happened.

7. Despite several requests for information about the full names and qualifications of the nurses involved in the emergency response, and about the maintenance of the defibrillator used, no information was supplied.

Recommendations

- The Head of Healthcare should ensure that all prisoners with identified long-term conditions have a condition-specific management plan in place in line with NICE guidelines and recommendations.
- The Head of Healthcare should ensure that clinical staff assess and manage prisoners with a deteriorating chronic condition effectively to enable good standards of care, including that:
    - all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care; and
    - clinical staff receive up-to-date training on how to review patients with chronic diseases, particularly heart disease, and are aware of the triggers for escalation and when to organise further investigations.
- The Head of Healthcare should provide the Ombudsman with:
    - a copy of the Primary Care Significant Event review of Mr Madin's care in relation to the management of potential heart conditions; and
    - an account of what action (if any) will be taken in response to the findings, by whom and by when.
- The Head of Healthcare should ensure that medication reviews are supported by physical assessment and discussion with the prisoner, and that this is recorded in the prisoner's SystmOne healthcare record to support any continuation of repeat prescribing.
- The Head of Healthcare should ensure that:
    - healthcare staff are appropriately qualified and their details recorded;
    - healthcare staff record all incidents of illness and injury in line with Prison Service Instruction (PSI) 64/2011 and that all staff who are first on scene complete incident report forms as soon as possible; and
    - defibrillator equipment is regularly maintained and records of maintenance are kept.
- The Director and Head of Healthcare should ensure that all staff co-operate fully with all requests from the PPO for information or material in line with PSI 58/2010.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Madin's prison and medical records.

10. The investigator interviewed one member of staff at Rye Hill on 7 February 2019.

11. NHS England commissioned a clinical reviewer to review Mr Madin's clinical care at the prison. She conducted a joint interview at Rye Hill.

12. We informed HM Coroner for Northampton of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The investigator contacted Mr Madin's next of kin, a friend, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. HMPPS also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Rye Hill

15. HMP Rye Hill is run by G4S and it holds more than 600 men convicted of sex offences. G4S Health Services provide primary physical and mental health services, and Northamptonshire Healthcare NHS Foundation Trust (NHFT) provides secondary mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Rye Hill was in August 2015. Inspectors noted that the prison held a complex mix of serious offenders and some frail, older men who needed significant levels of care. Inspectors found that after Rye Hill changed its role to take sex offenders in 2014, services had not sufficiently adapted to meet the needs of the new population.

17. Inspectors noted that there were healthcare staff shortages and that the available healthcare staff were not efficiently deployed. They found that there were long waiting times for most clinics. They noted that a small group of regular GPs had run daily clinics since January 2015, which had improved the consistency of service and prisoners' perceptions of that service. However, they noted that prisoners waited up to three weeks for routine GP appointments. Inspectors found that prisoners had good access to pharmacy staff for advice.

Independent Monitoring Board

18. 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 its latest annual report for the year to March 2018, the IMB reported that for a number of years, healthcare at HMP Rye Hill had struggled under pressure from an older, more infirm population. They noted that a number of major changes had been brought in during the reporting year which had improved the situation on a number of fronts.

Previous deaths at HMP Rye Hill

19. Mr Madin was the twelfth prisoner to die at Rye Hill since December 2016. All were from natural causes. There has been one death since, which is under investigation. There are no similarities between Mr Madin's death and previous deaths at Rye Hill.

Key Events

20. On 20 December 2016, Mr John Madin was sentenced to 11 years in prison for sexual offences and sent to HMP Nottingham.

21. Mr Madin progressed through his sentence and had been at HMP Rye Hill since 8 February 2018. He had several long-term health conditions: asthma, osteoarthritis, hypothyroidism, chronic obstructive pulmonary disease (COPD, a lung disease) and chronic lower back pain. He had had bladder cancer in 2016 which had been successfully treated and continued to have regular check-ups.

22. A nurse completed Mr Madin's healthcare reception screen at Rye Hill. She noted that he had COPD and asthma, chest pain when stressed and took medication for his conditions. She referred him to the prison GP for a medication review.

23. A prison GP completed a medication review and issued prescriptions so that Mr Madin could continue to receive his medications. It is unclear why he was prescribed quinine sulphate (usually prescribed for malaria or muscle cramps/restless leg syndrome) or lansoprazole (usually prescribed before surgery) as he did not have a history of malaria or cramps or any planned surgery. Healthcare staff saw Mr Madin frequently to issue his medications.

24. A physiotherapist assessed Mr Madin on 15 March, and noted that he had a degenerative lower back problem and discomfort to his hips and knees. He noted that Mr Madin needed a gentle exercise programme, aimed at improving the range of movement to his lower back but that he should avoid significant exertion because he had COPD. Mr Madin attended regular pain management sessions with him.

25. On 23 March, a nurse completed an asthma and COPD review and care plan. Mr Madin said that he was eating healthier food and his medication helped.

26. On 9 July, Mr Madin told a nurse that his feet were swollen. She told him to elevate his legs and she checked his blood pressure which was high at 164/109. She arranged for another blood pressure check and noted that if it was still raised, he should see a prison GP.

27. The nurse saw Mr Madin in his cell the next day as he had told wing staff that he had chest pains. She noted that his feet were still swollen. His blood pressure had decreased slightly as it was now 156/95. She completed an electrocardiogram (ECG), which was normal, and Mr Madin told her that the chest pain had subsided. There are no further entries in his medical records about investigating or discussing whether Mr Madin might have a heart condition.

28. On 11 July, a nurse recorded that Mr Madin's chest pain symptoms had resolved and he felt well in himself. He recorded that Mr Madin had a tachycardia (fast heart rate).

29. On 9 September, officers reported to healthcare staff that Mr Madin was having chest pain. A nurse saw him in the healthcare centre. He told her that that he was having lower back pain, not chest pain. He said that he had a burning

sensation when urinating, he thought he had a cyst near his groin, he needed a CAT scan and wanted to know the date for his asthma review. She booked him a GP appointment to discuss his concerns. The urine sample tested negative for abnormalities and a prison GP saw him on 19 September. Mr Madin told her about his health concerns and she completed hospital referrals for an x-ray and a urology check.

30. Mr Madin banged his head on a shelf in his cell on 24 September. A nurse examined him and noted a small superficial cut on the side of his head. She told him that he should report any deterioration in how he felt to the healthcare team.

31. At his asthma and COPD review on 14 November, Mr Madin told a nurse that his asthma was worse at night. A nurse arranged an appointment with a prison GP. The prison GP completed the examination and suspected a urine infection. He prescribed a course of antibiotics and arranged for a urine test, the results of which were normal.

32. There are no entries about discussions with Mr Madin about his repeat medications in his medical record, and no evidence that anyone arranged for him to have any follow-up assessments for bladder cancer.

Events on 12 December 2018

33. A Prison Custody Officer (PCO) unlocked Mr Madin's cell at approximately 7.30am. Mr Madin went to work in a workshop but returned to his cell as there were enough workers there and he was not needed. The PCO was unclear when this was but the wing records indicate that this would have been between 7.30am and 8.30am.

34. The PCO said that after prisoners were unlocked, he completed routine cell checks at around 10.40am. When he reached Mr Madin's cell, he saw him lying on the floor. He shouted for his colleague, another PCO to join him. The PCO said that he went into the cell, checked Mr Madin's pulse and used his radio to call a medical emergency code blue (used when a prisoner is unconscious, not breathing or has breathing difficulties).

35. Staff in the control room immediately called for an ambulance at 10.40am. Both PCO's carried out CPR until nurses arrived. A first line manager and the duty operations manager, arrived and assisted with resuscitation efforts.

36. A nurse noted that he heard the code blue and when he arrived at the cell, two prison custody officers were performing CPR. The nurse said that a senior nurse and a healthcare assistant arrived with a defibrillator. The nurse noted that the reading from the defibrillator initially indicated not to shock Mr Madin but to continue with CPR. There were then six shocking cycles which had no effect, after which the defibrillator indicated to continue with CPR.

37. The air ambulance doctor arrived at 10.56am. Paramedics arrived at 10.58am and with the nurses and prison custody officers, continued resuscitation attempts. At 11.12am, the air ambulance doctor confirmed that Mr Madin had died.

38. The investigator asked the Head of Healthcare for details of the healthcare staff who attended the emergency response but never received a response. The

clinical reviewer also requested dates for maintenance of the defibrillator, which she did not receive.

Contact with Mr Madin's family

39. On 12 December, the prison appointed a prison manager, as the family liaison officer (FLO). She contacted Mr Madin's friend, who he had named as his next of kin, to tell him that Mr Madin had collapsed and was seriously unwell. After Mr Madin died, she visited his friend with a senior prison manager who was Head of Activities, to break the news of Mr Madin's death and to offer her condolences and support.

40. Rye Hill arranged and paid for Mr Madin's funeral, which was held on 18 January 2019.

Support for prisoners and staff

41. After Mr Madin's death, the Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

42. The prison posted notices informing other prisoners of Mr Madin'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 Madin's death.

Post-mortem report

43. The post-mortem examination established that Mr Madin had died from haemopericardium (blood in the pericardial sac of the heart) caused by a ruptured wall of the left ventricle of the heart caused by an acute myocardial infarction (a heart attack). This in turn was caused by coronary artery thrombosis (a blood clot inside a blood vessel in the heart).

44. The post-mortem report noted that the haemopericardium would have caused cardiac tamponade (a build-up of fluid in the pericardium), acute heart failure and sudden death.

45. It also noted evidence of severe atherosclerosis (a disease in which plaque builds up in the arteries) and a blocked left artery.

Findings

Clinical review

46. The clinical reviewer, found that, overall, the care that Mr Madin received for the management of his long-term conditions was equivalent to that which he could have expected to receive in the community. She noted that he had reviews and regular blood tests to monitor his cholesterol levels.

47. However, she had some significant concerns about shortfalls in a number of areas, which we share.

48. With the exception of an asthma care plan, Mr Madin did not have care plans in place for all his long-term health conditions. The clinical reviewer found that, in this respect, his care fell short of the expected standard of care. We therefore make the following recommendation:

The Head of Healthcare should ensure that all prisoners with identified long-term conditions have a condition-specific management plan in place in line with NICE guidelines and recommendations.

49. Given the findings of the post-mortem (including that Mr Madin had severe atherosclerosis), we are concerned that Mr Madin had symptoms of heart failure which were never explored. The clinical reviewer noted that Mr Madin had reported episodes of chest pain, back pain (which can be the way angina is perceived), swollen feet and ankles, a tachycardia and raised blood pressure. The clinical reviewer said that these were potentially signs of heart failure and would usually have prompted further investigation, including a chest x-ray and a blood test. There is no evidence in Mr Madin's healthcare notes that these signs and symptoms were further investigated.

50. The clinical reviewer has recommended that prison GPs and the Head of Healthcare should undertake a Primary Care Significant Event review of Mr Madin's care in relation to the management of potential heart conditions and identify if there is any learning that can be gained and disseminated. We recommend:

The Head of Healthcare should ensure that clinical staff assess and manage prisoners with a deteriorating chronic condition effectively to enable good standards of care, including that:

- **all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care; and**
- **clinical staff receive up-to-date training on how to review patients with chronic diseases, particularly heart disease, and are aware of the triggers for escalation and when to organise further investigations.**

The Head of Healthcare should provide the Ombudsman with:

- **a copy of the Primary Care Significant Event review of Mr Madin's care in relation to the management of potential heart conditions; and**

- **an account of what action (if any) will be taken in response to the findings, by whom and by when.**

51. We are also concerned that Mr Madin appears to have been prescribed unnecessary medication. The clinical reviewer noted that it was not known why Mr Madin was receiving a repeat prescription of quinine sulphate (a medication that carries significant potential side effects) or lansoprazole (usually prescribed before surgery) as there was nothing in his medical records to suggest he required these drugs. Healthcare staff did not review these prescriptions to check that Mr Madin still needed them. The clinical reviewer noted that this aspect of Mr Madin's care was not equivalent to that which he could have expected to receive in the community. We recommend that:

The Head of Healthcare should ensure that medication reviews and changes are supported by physical assessment and discussion with the prisoner, and that this is recorded in the prisoner's SystmOne healthcare record to support any continuation of repeat prescribing.

Record keeping

52. The Nursing and Midwifery Council's guidance requires effective record keeping and says that records should be written up at the same time or as close to events as possible.

53. PSI 64/2011 on Safer Custody says that staff directly involved in an incident, particularly those who were first on scene, must complete incident report forms (Form F213) as soon as is practicable.

54. When Mr Madin was found unresponsive in his cell on 12 December, the prison staff involved in the emergency response completed written statements about what happened. However, we are concerned that not all the clinical interventions during the emergency response were recorded in Mr Madin's medical record. A nurse was the only nurse who completed an entry in the healthcare record, which briefly outlined events. This meant that there is no record of the role that each member of the healthcare team played during the emergency response.

55. PSI 58/2010, *Prisons and Probation Ombudsman*, requires that the PPO is given "unfettered access" to the documents it requires to carry out an investigation and that "all staff must co-operate fully with all requests from the PPO for information, material or access to establishments and prisoners".

56. We are, therefore, concerned that, despite several requests, the healthcare team did not provide the PPO or the clinical reviewer with information about the full name, professional qualifications or training of the nurses involved in the emergency response, or about the defibrillator used. We do not, know, therefore, whether the nurses were registered and up to date with life-saving training, or whether the defibrillator was in correct working order at the time. We therefore make the following recommendations:

The Head of Healthcare should ensure that:

- **healthcare staff are appropriately qualified and their details recorded;**
- **healthcare staff record all incidents of illness and injury in line with PSI 64/2011 and that all staff who are first on scene complete incident report forms as soon as possible; and**
- **defibrillator equipment is regularly maintained and records of maintenance are kept.**

The Director and Head of Healthcare should ensure that all staff co-operate fully with all requests from the PPO for information or material in line with PSI 58/2010.

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