PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 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 a man in December 2013, at HMP Maidstone. He was 53 years old and died from a perforated duodenal ulcer. I offer my condolences to his family and friends.

A clinical reviewer assessed the man's clinical care at Maidstone. The prison cooperated fully with the investigation.

The man had been at Maidstone since April 2013. He had little contact with healthcare staff other than to collect medication for ongoing conditions, including back pain. On the morning of 24 December, he reported having breathing difficulties and chest pain. Later that day, he asked to go to hospital because of continuing pain, but was advised to increase the dose of his pain relief medication. The next day, Christmas Day, he continued to report pain and said he had a swollen stomach. He again asked to see a doctor. The last recorded time he complained of pain was at 8.25pm. Although an out of hours doctor had been consulted the night before, and had advised that he should be telephoned again if his condition did not improve or got worse, no one sought advice from a clinician on the evening of Christmas Day.

The next morning the man was found dead in his cell. Staff did not attempt resuscitation as it was clear he had been dead for some time. Approximately 20 minutes later, a nurse arrived and, despite clear signs of death, began to try to resuscitate him. Paramedics arrived shortly afterwards and declared him dead.

The clinical reviewer was satisfied that the man received appropriate medical care at the prison as there was no evidence to suggest that he had complained of symptoms relating to his condition before 24 December, although better clinical observations should have been taken by both a doctor and a nurse on 24 December. However, I am concerned that on Christmas Day, a member of healthcare staff appears to have advised that there was nothing more they could do for him. This meant that, when he reported increasing pain and a swollen abdomen, staff did not seek further clinical advice when they should have done and he received no more alleviation of his pain before he died.

While it was too late to save the man, I consider that officers should have gone into his cell immediately he was found unresponsive. I am also concerned that a nurse felt obliged to attempt resuscitation when it was clear that he had been dead for some time. This was distressing for all those involved in the emergency response, not all of whom received appropriate support after his death.

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 **July 2014**
Prisons and Probation Ombudsman

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SUMMARY

1. The man was sentenced to 24 months in prison in January 2013 and moved to HMP Maidstone in April the same year. He had previously been a regular user of heroin and had completed a methadone detoxification programme in prison.

2. In February, a prison doctor prescribed the man anti-inflammatory medication for back pain. In April, after he had transferred to Maidstone, a doctor reviewed his medication and prescribed an alternative anti-inflammatory and pain relief cream.

3. On 7 June, he man complained of stomach pains and a prison doctor prescribed him omeprazole to reduce stomach acid. For some months after this, his only contact with healthcare staff was to collect his medication.

4. On the morning of 24 December, the man said he was suffering from breathing difficulties and chest pains. A doctor changed his anti-inflammatory and pain relief medication to ibuprofen. Later that day, he continued to report being in pain and asked to be taken to hospital. His clinical observations were normal and the nurse advised him to take more ibuprofen. Later that night, the orderly officer in charge of the prison, consulted an out of hours doctor who advised that they should ask him to take his pain relief and that prison staff should let him know if his condition did not improve or the pain became any worse.

5. The next afternoon, on Christmas Day, the man asked to see a doctor. The head of healthcare, a mental health nurse, who had seen him earlier that day to give him his medication, noted that this would be reviewed if his condition changed. The wing records show that, later that day, in the afternoon and evening, he continued to say he was in pain and had a swollen stomach. He said he needed to see a doctor. At 3.45pm, an officer noted that he had consulted a member of healthcare staff who said that there was nothing more they could do for him. At 6.15pm, an officer noted that he was still complaining about pain and he had consulted a custodial manager who said that nothing could be done. At 8.25pm, an operational support grade, noted that he was still complaining of pain, but he had told him there was nothing the doctor could do. He noted that he had informed ‘Oscar 1’ – the radio code sign for the senior officer in charge of the prison. No further checks were made on him that night.

6. During a roll check the next morning an officer saw the man sitting on the floor of his cell. He was not moving and she was unable to get a response from him. She radioed for help. When other staff arrived and went into his cell, it was apparent that he was dead. The staff locked the cell and began to follow the prison’s contingency plans for a death. However a nurse, who had just arrived for duty in the prison, attended and asked officers to open the cell. The nurse noted he was cold and stiff with no signs of life, but decided to begin cardiopulmonary resuscitation. Paramedics arrived shortly after and pronounced him dead.

7. The clinical reviewer considers that, as the man's clinical observations were normal on 24 December, there was little to indicate he needed to be taken to hospital at that time and that staff at Maidstone could not have prevented his death. However, we are concerned that no member of healthcare staff saw him after 9.54am on 25 December and that prison staff, relying on what they believed was healthcare advice, did not call a doctor or seek other medical advice when he continued to report increasing pain and a swollen abdomen throughout that day and evening.

8. We are also concerned that the officer who found the man unresponsive did not go into his cell immediately, despite another member of staff being present and there being an evident emergency situation. Finally, we do not consider the nurse should have attempted resuscitation as it was apparent that he had been dead for some time. We make five recommendations.

THE INVESTIGATION PROCESS

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

10. The investigator obtained copies of the man's prison medical records and relevant prison extracts from his prison records. She interviewed three members of staff at Maidstone on 4 April 2014 and gave the Governor initial written feedback about the preliminary findings of the investigation.

11. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

12. We informed HM Coroner for Mid Kent and Medway of the investigation who provided the results of the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. His family did not have any specific concerns for the investigation to consider.

14. The family were informed the draft report was available, but did not wish to receive a copy or make any comment. The prison considered our draft report and recommendations and has accepted these. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP MAIDSTONE

15. HMP Maidstone holds up to 600 foreign national prisoners. Most of the accommodation is single cells. The prison's healthcare unit is open from 8.00am to 6.30pm Monday to Thursday. From Friday to Sunday and on bank holidays, the healthcare unit is staffed by a single member of staff from 8.00am to 5.30pm. Out of hours cover is provided by a local GP surgery. GP services are provided by Oxleas NHS Foundation Trust and surgeries are held each weekday morning.

HM Inspectorate of Prisons

16. The most recent inspection of Maidstone was in September 2011. The Inspectorate found that low healthcare staffing levels impacted on their ability to be involved in wider prison meetings. The range of primary care services was appropriate, with short waiting times to see a GP and prisoners told inspectors that healthcare staff were polite and respectful. Effective screening in reception identified needs quickly and appropriate referrals were then made. Prisoners with chronic diseases were managed individually as there were no formal clinics.

Independent Monitoring Board

17. 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. It its most recently published report for the year to February 2014, the Board noted that there had been some changes in personnel within the healthcare unit, meaning the manager took multiple roles for a period during the year. Despite this, the timeliness of medical appointments and range of services compared well with the services in the community.

Previous deaths at Maidstone

18. The man's death was the fifth from natural causes at Maidstone since the start of 2012. We have raised the issue of appropriate support for staff after a death before, a matter that arises in this case.

KEY EVENTS

19. In January 2013, the man was sentenced to 24 months in prison for drug offences and sent to HMP Lewes. He said he had used heroin regularly and, while he was at Lewes, he completed a methadone detoxification programme. He was prescribed sertraline and amitripyline (both antidepressant medication).

20. On 1 February 2013 a prison GP saw the man, who complained of back pain. He prescribed diclofenac (a non-steriodal anti-inflammatory medication).

21. The man moved to HMP Maidstone on 23 April. On 26 April, a prison GP reviewed him and referred him to a physiotherapist for his back pain and changed his prescription from diclofenac to naproxen (another non-steroidal anti-inflammatory medication) and added a pain relief cream to the prescription.

22. On 7 June, a prison doctor saw the man who complained of a stomach upset which the doctor considered was a side-effect of naproxen. The doctor prescribed omeprazole (a medication that reduces stomach acid) to protect his stomach while taking naproxen. He continued to receive naproxen, omeprazole and sertraline every month until his death. Over the following months his only further contact with healthcare staff was to collect his medication.

Christmas Eve

23. At 1.00am on 24 December, an on call GP attended the prison to see the man, who had complained of pain in his upper back and shoulders. He said he had no chest pain and could sit and walk comfortably. The doctor noted that he had muscle spasm and prescribed a single dose of diclonfenac, diazepam (sedative) and co-codamol (pain relief). He advised him to see a GP the following morning and for staff to call an ambulance if his condition deteriorated during the night.

24. At 9.40am on 24 December, a doctor saw the man, who reported he had pains in his chest which were causing him difficulties in breathing. The doctor did not record any examination findings, but increased his dosage of amitriptyline and replaced his prescription of naproxen with ibuprofen. The doctor noted that it might be necessary to refer him to a neurologist to exclude multiple sclerosis because he also complained of occasional numbness.

25. At 1.16pm, a nurse saw the man in his cell as he said he was having difficulty breathing and could not lie down. He requested additional pain relief. The nurse told him that he was due to get his prescribed medication soon and that it was important to keep to his pain management plan. She recorded his pulse rate as relatively high, but did not record any other clinical observations.

26. At 6.00pm, the duty governor asked the Head of Healthcare, a mental health nurse, to see the man because his condition had deteriorated. The nurse

noted his pulse and oxygen saturation levels were normal and that he was moving without difficulty. He asked to be taken to hospital, but he advised him to take a higher dose of ibuprofen.

27. The records show that the night orderly officer in charge of the prison contacted an out of hours GP at around 8.15pm on the evening on 24 December. The doctor noted that he was complaining of pain again, but had no difficulty breathing. The doctor advised the orderly officer to ask him to take his pain relief and that prison staff should let him know if his condition did not improve or the pain became any worse.

Christmas Day

28. At 9.54am on 25 December, the Head of Healthcare saw the man and gave him his medication. He noted that he was moving normally. At 3.40pm, wing staff informed the Head that he was asking to see a doctor because he was in pain. The Head did not go to see him, but noted that he would be reviewed if there was any change in his condition. The corresponding entry in the wing observation book noted that "healthcare have said there is nothing more they can do for him here and he had been prescribed meds…" The Head went off duty at 5.30pm. He did not leave any instructions for wing staff overnight.

29. An entry in the wing observation book shows that the man complained to wing staff of further stomach pains at 6.15pm and the officer referred this to a custodial manager, who had told him that there was nothing more could be done until he complied with what "healthcare said beforehand". At 8.25pm, a further entry by an operational support grade (OSG) noted that he said that he was in pain and that his stomach was swollen. He again said that he needed to see a doctor. The entry indicated that the OSG told him that there was nothing more the doctor could do and that the OSG had informed the senior officer in charge of the prison.

30. The investigator spoke to the OSG by telephone, who told her that when the man had asked to see a doctor he had sought advice from a senior officer (SO). The SO had told him that the man was refusing to take a higher dose of pain relief and it was not necessary to call a doctor. The OSG said the man did not press his cell bell again and he did not check him during the night. We spoke to the SO, who told us that he had been briefed by a manager that he had not been taking the medication he had been given and not to contact the out of hours doctor.

Boxing Day

31. At 6.50am on 26 December, the OSG told an officer, before she started the early morning count, that the man had pressed his cell bell at 8.25pm complaining of stomach pains and he had advised him to continue taking his prescribed medication. He told the officer that he had not heard from him again.

32. The officer told the investigator that she had started the early morning roll check on the third floor landing and worked down. The man was in the last cell on B spur of the first landing. She said that when she opened the door observation hatch he was not in bed, which she thought was unusual. She then saw his legs. He appeared to be in a sitting position on the floor, but was not moving. She said she banged on the cell door and called out his name. When she did not get a response she radioed for immediate assistance.

33. A custodial manager and the SO said they received a radio call to attend the wing at approximately 7.20am. When the manager arrived, he was also unable to get a response from the man, so he unlocked the cell door and he, the SO and officer went in. They found him lying on the floor with his shoulders propped up against a small locker. The manager told the investigator that his arms were out in front of him, his eyes were open and his fists were tightly clenched. His body felt extremely cold and his skin was discoloured. He was unable to find a pulse. He said it was clear that he had been dead for some time. The staff left the cell and locked it to preserve evidence, as required for a death in custody, until the police arrived.

34. The manager initiated the prison's contingency plan for a death. The control room log records that paramedics were called at 7.55am to verify the man's death.

35. A specialist nurse practitioner arrived at the prison gate to start his duties at approximately 7.40am. Gate staff asked him to go to the wing immediately, but did not explain why. The nurse told the investigator that when he arrived on the wing the manager had told him that the man was dead and that his cell had been locked. The nurse asked for the cell to be unlocked so he could assess him. He went to get emergency equipment from the healthcare department and asked for a defibrillator.

36. When he returned to the wing the nurse asked the custodial manager and the SO to help move the man into a position where he could begin cardiopulmonary resuscitation (CPR). The nurse told the investigator that the man was cold to touch, did not have a pulse and rigor mortis was present. He attached the defibrillator and began CPR, assisted by the manager. Paramedics arrived at the prison at 8.05am. When they got to the cell the paramedics instructed that CPR should stop and declared him dead at 8.15am.

37. The prison was unable to contact the man's next of kin, his brother, who lived in Portugal, as the listed telephone number was incorrect. However, the contact number for his ex-wife was in the record. At 11.50am, an operational manager rang her, who said she would try and find a number for his brother. At 4.40pm, a family friend rang the prison and said he had papers belonging to the man which might contain contact details for his brother. The papers revealed an email address.

38. On 27 December, the operational manager tried to obtain the assistance of the Portuguese Consulate, but there was no one available due to the bank

holidays. She contacted the man's brother by email on 28 December and asked for a telephone contact. She subsequently informed him of his brother's death by telephone. His family had been unaware he was in prison. A prison family liaison officer contacted the family to offer guidance and support.

39. Managers did not hold a debrief for the staff involved in the emergency response as Prison Service instructions require. We were told this was because it was a bank holiday.

40. Prisoners and staff were informed of the man's death and prayers were said in the prison chapel. The funeral was held on 5 February and Maidstone contributed to the costs of the funeral and, in line with national guidance, paid for his remains to be repatriated to Portugal,

Post-mortem

41. A post-mortem examination found the cause of death was a perforated duodenal ulcer.

ISSUES

Clinical care

42. The clinical reviewer noted that the man had a 17 year history of intravenous heroin use when he arrived at HMP Lewes in January 2013 and underwent detoxification. He also received ongoing medication for back pain and depression.

43. The clinical reviewer found that the man was appropriately prescribed omeprazole in June 2013 to protect his stomach, as non-steroidal anti-inflammatory drugs such as diclofenac can irritate the stomach and gut lining, causing bleeding. The clinical reviewer considers that this should have been taken into account when he was first prescribed diclonfenac in January 2013.

44. There was no evidence in the man's medical record to suggest that he had complained of symptoms suggestive of a duodenal ulcer before 24 December 2013. The clinical reviewer believes that because he was prescribed omeprazole, clinicians were reassured that his stomach and gut were appropriately protected.

45. The clinical reviewer was concerned that when a doctor saw the man on 24 December there was no record that he examined his chest and abdomen to provide reassurance that no serious medical or surgical condition was developing. The clinical reviewer said he would expect any reasonably competent doctor to do this.

46. When a nurse saw the man later that day she recorded a pulse rate of 100bpm (which is the high end of normal), but no other observations were recorded. The clinical reviewer said he would have expected that in the case of a male patient in his 50s with lower chest pain and difficulty breathing, that a nurse would document basic observations including blood pressure, oxygen saturation and temperature. The clinical reviewer suggests that the Head of Healthcare should consider introducing early warning score, such as the National Early Warning Score (NEWS) which would have ensured a full set of observations were recorded on each occasion and might have led to further action. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff appropriately examine and record their assessment of prisoners presenting with acute symptoms and take full clinical observations.

47. The Head of Healthcare saw the man at 6.00pm on 24 December and recorded a normal pulse and oxygen saturation. The clinical reviewer says these did not suggest that he required emergency admission to hospital and therefore considers that he received clinical care equivalent to that he could have expected in the general community and staff at Maidstone could not have prevented his death.

48. However, we are concerned that the man was not seen by any healthcare staff after 9.54am on Christmas day, when he gave him his medication. Although, at 4.00pm the Head noted in the medical record that he would be reviewed if there was any change in his condition, the wing staff noted in the observations book that the Head had said that there was nothing more that could be done for him. He left no instructions for wing staff if his condition changed overnight. When the man reported continuing pain and a swollen stomach during Christmas evening, the staff did not seek advice from the out of hours GP. The operational support grade on his wing said that he sought advice from the senior officer in charge of the prison, who told him it was not necessary to call a doctor. The senior officer told us that a custodial manager had told him that the man was to take his medication and that he did not need to contact the out of hours doctor.

49. We are concerned that the records indicate that staff did not appear to believe that the man was actually in pain and that this led to a reluctance to seek further help when they should have done. The observation book entries show that prison staff believed that the healthcare advice was that there was no need to seek further healthcare input. We consider that this was misleading advice. Prison staff are not qualified to make judgements about prisoners' health conditions and they should have sought advice from the out of hours service as he reported further pain. We make the following recommendation:

The Governor should ensure that prison staff contact healthcare staff or the out of hours service when prisoners report pain or other symptoms suggesting they are unwell

Emergency response

Opening the man's cell

50. Local instructions at Maidstone state that a cell will only be opened at night with the authorisation of the night orderly officer (NOO) and in the presence of at least three members of staff. However, the instructions provide one exception to this rule:

> "Where there is or appears to be immediate danger to life, cells may be unlocked without the authority of the NOO and an individual member of staff may enter the cell on their own.
>
> "Staff have a duty of care to prisoners and to themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger."

51. When an officer called for assistance at 7.20am on 26 December after finding the man unresponsive, the prison was still in night state. The OSG joined her at the man's cell. However they decided to wait until two additional officers arrived before they opened the cell. Both the officer and OSG were aware that he had been complaining of stomach pains the previous evening. As he

was on the floor and unresponsive, we consider that the officer should have opened his cell immediately. While this would not have affected the outcome for him, in other circumstances this could be vital and it is essential that staff are aware of local procedures. We make the following recommendation:

The Governor should ensure that all staff are aware of the local procedures for entering a cell at night and understand that they may open a cell immediately if there are serious concerns about the health of a prisoner

Resuscitation

52. It was apparent from the evidence of the staff who found the man that he had been dead for some time. A custodial manager said that he had tried to move his body to begin resuscitation, but it was evident that this would not be possible because of rigor mortis and other signs of death. The staff locked the cell door until the police could check that there was no evidence of criminal activity. This is usual practice with a death in prison.

53. We are concerned that approximately twenty minutes after the man had been found a nurse attempted resuscitation and asked the manager to help. This continued until paramedics arrived and requested them to stop. The clinical reviewer considered that it was appropriate for the nurse to ask for the cell door to be unlocked so he could satisfy himself that the man was dead, but he should then have withdrawn.

54. We consider the attempted resuscitation of the man was inappropriate in the circumstances and was unnecessarily distressing for those involved. A similar situation arose in another death we are currently investigating at Maidstone as the nurse believed that as he was not qualified to pronounce death, he was obliged to attempt resuscitation. The European Resuscitation Council Guidelines 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" It is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate

Support for staff

55. The officer and custodial manager told the investigator they had been sufficiently supported following the incident. The nurse said that on the day the man died he was the only member of healthcare staff on duty because it was a bank holiday. He had been unable to discuss the incident with anyone, which he found difficult.

56. Prison Service instructions require a debrief to be held immediately after all deaths in prisons that all staff directly involved in the incident, including

healthcare staff, should be invited. A debrief should have been held, irrespective of the bank holiday. A debrief gives staff the opportunity to talk about the incident, to raise any issues and to be offered the support by the prison's care team. We make the following recommendation:

The Governor should ensure that, in line with Prison Service instructions, after a death in the prison, a debrief is held for all the staff involved.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff appropriately examine and record their assessment of prisoners presenting with acute symptoms and take full clinical observations.

2. The Governor should ensure that prison staff contact healthcare staff or the out of hours service when prisoners report pain or other symptoms suggesting they are unwell.

3. The Governor should ensure that all staff are aware of the local procedures for entering a cell at night and understand that they may open a cell immediately if there are serious concerns about the health of a prisoner.

4. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

5. The Governor should ensure that, in line with Prison Service instructions, after a death in the prison, a debrief is held for all the staff involved.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that healthcare staff appropriately examine and record their assessment of prisoners presenting with acute symptoms and take full clinical observations.	Accepted	Healthcare staff will appropriately examine prisoners. A system is now in place to ensure that when a patient presents acute symptoms a record is made on SystmOne of all clinical observations. This will be reinforced at staff briefings by the healthcare manager.	Complete and ongoing Healthcare Manager	
2	The Governor should ensure that prison staff contact healthcare staff or the out of hours service when prisoners report pain or other symptoms suggesting they are unwell.	Accepted	A review of 'out of hours' contact has been undertaken, taking into account other findings from deaths in custody in the last 12 months. A new process has now been introduced so that out of hours GP contact is recorded together with any resulting action and subsequent expectations in terms of observation, until the prisoner is seen by the onsite GP. A notice to staff will be published reminding all staff that they should contact healthcare or the out of hours service when a prisoner reports being in pain or has other symptoms suggesting they are unwell. This also forms part of the orderly officer pack.	31 July 2014 Head of Security	
3	The Governor should ensure that all staff are	Accepted	The night procedures will be reviewed to include clear guidance about entering a cell at	31 July 2014	

	aware of the local procedures for entering a cell at night and understand that they may open a cell immediately if there are serious concerns about the health of a prisoner.		night. It will be made clear that staff are able to open a cell immediately if there are serious concerns about the health of a prisoner. This will be implemented immediately, but will be reinforced in a revised policy for nights and patrol state. This is reflected in the local security strategy.	Head of Security	
4	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.	Accepted	All nursing staff are made aware of the resuscitation council guidelines as part of their training. In addition to the instructions contained in Prison Service Instruction 64/2011, NOMS will be developing further guidance in conjunction with NHS England for emergency responses to include the non-resuscitation of prisoners where there are clear signs of rigor mortis. This will be issued to all prisons.	Head of Healthcare 31 December 2014 NOMS Equality, Rights & Decency Group	
5	The Governor should ensure that, in line with Prison Service instructions, after a death in the prison, a debrief is held for all the staff involved.	Accepted	Debriefs will be held when deaths in custody occur at HMP Maidstone in the future. A death in custody template pack will be produced to ensure that all staff involved in the incident have had the opportunity to speak to a manager before going off duty and are offered appropriate support.	31 July 2014 Head of Residence and Safety	