

**Investigation into the circumstances surrounding the
death of a man
at HMP Maidstone in January 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2008

This is the report of an investigation into the death of a man who was a prisoner at HMP Maidstone. The man was found dead in his cell one morning in January 2007. A post mortem examination revealed the cause of death to be epilepsy with a secondary condition of ischaemic heart disease. The man's death was particularly sad as, having served over two years in prison, he was less than three weeks away from release on licence. I offer my sincere sympathy and condolences to all of his family and friends for their loss.

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was carried out by the West Kent Primary Care Trust. I am most grateful to the clinical reviewer for her assistance.

I would also like to thank the Governor and staff of HMP Maidstone for their full and ready co-operation during the course of the investigation.

I regret to say that my report does not reflect well on Maidstone. Numerous opportunities were missed for the man to be reviewed, and staff failed to act on the advice from a hospital doctor that he required neurological follow-up to ensure his medication for epilepsy was under control. I report the opinion of the clinical reviewer that, "it is impossible to read [the man's] notes and conclude that he was given healthcare equivalent to that given by a GP (in the community)."

I make no fewer than 14 recommendations.

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

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Prisons and Probation Ombudsman

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SUMMARY

The man who is the subject of this report had been epileptic since adolescence. When he was first received into prison, at HMP Belmarsh on 11 August 2004, he said that he had regular epileptic fits, the last of which was two weeks previously. Within two weeks of arriving at Belmarsh, the man had another fit. He later told the nurse who attended that he had not taken his medication, and was advised to do so in future.

The man had a fit on 5 January 2005, after which he was admitted to Belmarsh's healthcare centre overnight for observation. After another fit on 20 January, during which he hit his head on a bench while falling, the man was admitted to a local hospital overnight. He reportedly had another fit on 26 February, but details of this were not recorded in his medical record.

On 18 May 2005, the man transferred to HMP Maidstone. Despite his recent history of fits, including the emergency admission to hospital, his epilepsy was recorded as being well controlled at his reception health screen.

The man was not reviewed during the remainder of 2005. On an unrecorded date in either January or February 2006, he had a fit after which he was unresponsive for around ten minutes. He returned to his cell after recovering, and was not seen by a doctor until 14 March.

On 17 July 2006, the man had another fit. On this occasion he banged his head on the floor when falling and sustained bruising. He was seen by a nurse, but was not reviewed by a doctor either in the aftermath or in the following months.

The man had another fit on 9 November in which he fell and dislocated his shoulder. In a discharge letter from a local hospital, dated 10 November, a doctor who saw the man wrote, "it would be prudent to ensure that this gentleman has some neuro follow up to ensure that his medication is enough to control his epilepsy." This letter was received at the prison on 20 November, but no action was taken and the man's epilepsy was not reviewed during the remainder of his life.

The man attended healthcare on 2 December 2006, and again on 4 December. On both occasions he complained of pain on the right side of his chest. Other than collecting his medication, this was the last contact that the man had with healthcare.

The man had an epileptic fit some time during the night around six weeks later. At around 8.15am on the following morning, a prison officer unlocked his cell for the morning. She looked in, and saw that the man was lying half on and half off the bed. Her immediate thought was that he was dead. The officer summoned her colleague, a senior officer, who asked her to call for emergency assistance. The senior officer also thought that the man was dead. The response nurse who attended found no signs of life and did not therefore attempt resuscitation. The duty doctor later pronounced death at 9.05am.

A post mortem examination revealed the cause of death to be epilepsy with a secondary condition of ischaemic heart disease.

The clinical reviewer is critical of the lack of reviews that the man had at Maidstone, especially after his fits. She concludes that the standard of care fell below that he would have received in the community.

THE INVESTIGATION PROCESS

The investigation was opened on 23 January 2007 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. Three prisoners came forward as a result.

My investigator was given access to the man's prison files, including the medical record. He visited Maidstone on three occasions, and interviewed six members of staff during the course of the investigation. An independent clinical review of the man's health needs whilst he was in custody was carried out by the West Kent Primary Care Trust.

My senior family liaison officer contacted the man's parents, his nominated next of kin, on 13 February 2007. My senior family liaison officer and investigator subsequently visited the man's parents on 27 February. At the meeting, the man's parents said that they did not feel that the healthcare that he received was as good as it would have been in the community.

HMP MAIDSTONE

HMP Maidstone was completed in 1819, and lies close to the town centre of what is the county town of Kent. The prison holds category C prisoners serving three years or more and has an operational capacity of 589. There are four main wings, each named after places in the local area. The man mainly lived on Medway wing, which has recently undergone major refurbishment work. All of the cells on Medway wing are singles.

There are no in-patient facilities at Maidstone. A nursing team operates on a shift pattern between the hours of 8.00am and 8.00pm, and GP surgeries are held four mornings a week. A wide range of specialists attend on a regular basis, including a consultant psychiatrist, dentist and optician.

The most recent report by HM Chief Inspector of Prisons, Ms Anne Owers, was published in July 2007, following an announced inspection in February 2007. Ms Owers considered that the health team at Maidstone were “aware of the health needs of the population, particularly those with long-term conditions.”

This is the fifth death that I have investigated at Maidstone since April 2004. All four of the previous deaths have been due to natural causes. The most recent case that I investigated (in December 2006) concluded that the deceased received care “equitable to that he might have expected in the community.”

KEY EVENTS

The man was arrested on 10 August 2004. He was assessed by a doctor on the same day whilst in police custody. It was recorded that he was epileptic since birth (although his parents later clarified to my investigator that the man had been epileptic since adolescence) and had last had a fit three days earlier. The police assessment also indicated that the man had fractured his skull one month previously but was fine now. It is not clear whether this piece of information is correct. There is no mention of a history of a fractured skull in the post mortem report.

The man was remanded to HMP Belmarsh on 11 August. A first reception health screen (a routine health screen for all new arrivals into prison) was carried out when the man arrived at Belmarsh. He now said that his last fit was two weeks earlier. He also said that he fitted around once a month. The man was asked if there was any reason why he might need to see a doctor, and said that there was. No details of this reason were taken, and it does not appear that he saw a doctor either on 11 August or in the following weeks.

A secondary health assessment took place on 12 August. At this, the man said that there was no history of heart disease in his immediate family. He said that his GP had taken blood for testing two weeks previously. It does not appear that the man's GP was contacted for the results of these tests or for details of his medical history.

On 22 August, a nurse was called to the man's cell after his cell mate reported that he had had a fit. On arrival, the nurse found the man lying on the floor. He then got up and sat on his bed. The man told the nurse that he had not taken his medication that evening, and the nurse advised him to do so. He was seen by a nurse at the treatment hatch on the following afternoon and said that he felt alright and had taken his medication.

The man had another fit on 5 January 2005, and was admitted to the healthcare centre overnight for observation. He returned to the wing the following morning. On 20 January, the man had a further fit. He reportedly hit his head on a bench when falling and was taken to hospital by ambulance. He remained in hospital overnight and returned to Belmarsh the next day.

On 11 February, the man was sentenced to five years imprisonment. Around two weeks later, on 26 February, he had a fit in his cell at lunchtime. He did not receive any injuries and was not taken to hospital. Details of this fit were not recorded in the medical record. The man does not appear to have had any further contact with healthcare services (other than collecting his medication) during the remainder of his time at Belmarsh.

The man transferred to HMP Maidstone on 18 May 2005. A reception screening was completed by the Healthcare Manager. She recorded in his medical record that the man's epilepsy was well controlled on his current medication. The man was seen later that day by the Senior Medical Officer (SMO) at Maidstone, and told him that his epilepsy was "no problem". The SMO advised the man to make an appointment to see him if he had any problems or if he felt that any investigations needed to be done. He also advised that the man should have a cell on the ground floor.

On 1 July 2005, the man was involved in a fight with a fellow prisoner in a workshop. He sustained a cut above his left eye and was seen by the SMO. The man's injury was not serious and he returned to the wing after having the wound cleaned. He was not subject to an adjudication (an internal hearing into breaches of discipline by prisoners) following the fight.

In January or February 2006, the man had a fit. The date is not recorded in the medical record, but later entries indicate that it occurred at some time in these months. A nurse was called to the wing and found the man in the clonic phase (when the patient is experiencing muscle spasms) of an epileptic seizure. She recorded that this phase lasted for around 40 seconds, after which the man was unresponsive for around ten minutes. His observations (blood pressure, pulse etc) were noted to be satisfactory during this time, and he returned to his cell on recovery.

The man did not see a doctor following this fit until 14 March when he saw the SMO. He suggested to the SMO that the nicotine patches he had recently started using could be inducing his fits. The SMO therefore agreed to stop the patches. He saw the man again on 22 March, at which time it was noted that he had experienced no further attacks since stopping the patches.

On 17 July, the man reported to wing staff that he had experienced another fit. He was seen by a nurse, and told her that he had fallen during the fit and banged his head on the floor. The man sustained a bruise to the side of his head, and another to the side of his neck. The nurse noted that the man appeared to be fully awake and alert when she examined him. The man told her that, apart from a headache, he felt okay. He was consequently given paracetamol, and advised to rest for the remainder of the day and to report back to healthcare if he was feeling ill. The man was not seen by a doctor on this occasion or in the three months following.

The man experienced another fit on the evening of 9 November 2006. He was examined by a nurse who noted that he was confused for some time afterwards. On this occasion, the man also sustained more severe physical injuries than previously. He appeared to have banged his head whilst falling and was noted to have cuts and swelling to the right side of his head. The man also had a painful right shoulder which was noted by the nurse to be "obviously displaced". He was therefore referred to Accident and Emergency at a local hospital for investigation.

The man returned to A&E on the following day, after being examined at the prison by the SMO. He complained of severe pain in his right shoulder and the SMO noted that the shoulder was difficult to examine on account of this pain. The SMO also noted that there was no discharge letter sent by the local hospital to accompany the man and detail the investigations and findings that had taken place. He therefore wrote to A&E at the hospital to request a discharge summary.

Two letters were subsequently sent to the prison from the hospital. Both were dated 10 November and both addressed to 'Dr Locum'. The first letter referred to Spencer's visit to A&E on 9 November. The doctor wrote that an x-ray had excluded a dislocation or fracture. He also said that, "it would be prudent to ensure that this

gentleman has some neuro follow up to ensure that his medication is enough to control his epilepsy.” The letter was signed by the Healthcare Manager as having been received on 20 November. However, the letter does not appear to have been seen by a doctor at Maidstone and the follow up suggested by the hospital doctor did not take place.

The second of the letters was from another doctor and followed the man’s examination at A&E on 10 November. In his letter, the doctor said that an x-ray now showed that the man had dislocated his shoulder. The man subsequently attended the fracture clinic at the hospital on 15 November. He was seen by a Consultant Orthopaedic Surgeon, who confirmed that the man had dislocated his right acromioclavicular joint (a joint at the top of the shoulder).

On his return from hospital on 15 November, the man moved from a cell on the third floor to one on the first (there are no ground floor cells on Medway wing at Maidstone). This followed a discussion between the man and the safer custody co-ordinator at Maidstone. The safer custody co-ordinator also worked on Medway wing at the time and so knew the man quite well. She felt that he would be better suited in a cell closer to the wing office so that staff could help him more quickly if he were to have another fit in future. The man agreed to the move, although reluctantly as he was settled in his previous cell.

The man attended healthcare on 2 December and 4 December. On each occasion he complained of pain and discomfort on the right side of his chest. He was reassured both times and advised that he had an appointment to see a consultant in January 2007. On 13 December, the man put in an application to see the doctor. An appointment was made for him on 19 December, but he declined to attend.

Other than collecting his medication, the man had no further contact with healthcare staff during the remainder of his life. One prisoner said that the man was feeling dizzy and having headaches around three days before his death, although Spencer does not appear to have reported these symptoms to healthcare staff.

At around 5.00pm one afternoon in mid-January 2007, a prison officer locked up the prisoners on the first floor landing on Medway wing for the night. He spoke to the man to say goodnight, to which the man responded in kind. The officer recalled that the man appeared to be physically well at the time and that there was nothing to give him any cause for concern.

At around 8.15am on the following morning, a senior officer and prison officer unlocked the prisoners on the first floor landing on Medway wing. The officer unlocked the man’s cell and said “good morning” to him. However, the man did not respond. The officer looked into the cell and saw the man lying half on and half off the bed, with his head on a chair beside the bed. His left arm was hanging down and was blue. At interview, the officer said that she could see no sign that the man was breathing and thought it was clear that he was dead.

The officer therefore alerted the senior officer who was unlocking cells across the corridor from her. She then went down to the wing office on the ground floor and asked them to telephone healthcare for immediate assistance. At the same time, the

senior officer entered the man's cell. He also made a radio call for healthcare assistance, and was told that someone was on the way. At interview, the senior officer said that he also thought that it was clear that the man was dead at this stage.

At around 8.25am, the Healthcare Manager attended the man's cell in response to the call. She noted that he was cold to the touch, there was no sign of life and that rigor mortis had set in. At 9.05am, the duty doctor attended the cell and confirmed death. A post mortem later confirmed the cause of death to be epilepsy, with a secondary condition of ischaemic heart disease.

The man's parents were informed of his death by the police on the morning of 22 January. A representative of the prison did not break the news as the Governor was unsure how long it would take to get to their house due to the traffic. The Governor, and prison family liaison officer visited the man's parents in the afternoon to give them further details.

The man's funeral was held on in the first week of February 2007. The prison offered help with organisation and costs, but these offers were declined by the man's parents because they felt that the money would be better spent on serving prisoners.

A collection was held on Medway wing, to which most of the prisoners contributed. The money raised was used to send flowers to the funeral and to purchase a rose bush for the Buddhist garden at Maidstone, with the remainder being donated to charity.

ISSUES

Issues raised by the clinical review

The clinical review was conducted on behalf of the West Kent Primary Care Trust. The clinical reviewer comments that, “it is impossible to read the man’s notes and conclude that he was given healthcare equivalent to that given by a GP (in the community).” She goes on to say that, “if the man had been treated by a GP (in the community) he would have been monitored more closely and reviewed under NICE (National Institute for Clinical Excellence) guidelines.”

Despite this, the clinical reviewer concludes that, “it is impossible to know if the man’s death could have been prevented”, as it is documented that “1,000 sudden deaths occur each year as a result of epilepsy.” However, she raises a number of issues with regard to the man’s care during his time in prison.

On 20 January 2005, whilst at Belmarsh, the man had a fit and was taken to hospital by blue light ambulance. Despite having another fit a little over a month later, there are no entries in his continuous medical record until 16 May 2005 (when he was passed fit for transfer to Maidstone). On the hospital discharge letter following the man’s emergency admission on 20 January, it is noted that his epilim level is 40.2mg/L. The clinical reviewer notes that this is only fractionally inside the normal therapeutic range (which is 40-80mg/L). She notes that the man was not properly reviewed following this emergency admission. Had he been reviewed under NICE guidelines, the clinical reviewer concludes, “it is likely that he would have been sent for referral to a specialist and/or his medication would have increased.” She describes these events as “unacceptable clinical practice”.

The clinical reviewer also notes that there was no “exit plan” following the man’s discharge from healthcare at Belmarsh on 6 January 2005. She says it would have been helpful to have introduced “some kind of risk assessment and chronic disease action plan at this time”.

When the man was transferred to Maidstone on 18 May 2005, he was seen shortly after his arrival by the Head of Healthcare and later by the Senior Medical Officer. The Head of Healthcare noted in the medical record that the man’s epilepsy was “well controlled” at the time. At interview with my investigator, she added that the man thought that he was well controlled and did not have any concerns and, as such, she was happy to note that his epilepsy was well controlled. The clinical reviewer considers it to be “surprising” that the Head of Healthcare would reach this conclusion, given the man’s recent history of fits including an emergency admission to hospital. She goes on to say that, despite being assessed by both the Head of Healthcare and the Senior Medical Officer on the day of his arrival at Maidstone, “no one saw fit to make a risk assessment or care plan for the man”.

The man had another fit in either January or February 2006. The exact date is not recorded in the medical record. Despite being described as “unresponsive for ten minutes”, the man was returned to his cell for bed rest. He was not taken to hospital for further checks and was not seen by a doctor for some weeks afterwards.

The man then had another fit on 17 July 2006. On this occasion he banged his head on the floor when falling and sustained bruising. Again, he was not seen by a doctor, did not attend hospital for investigation, and was not reviewed in the following months.

Following a fit on 9 November 2006 in which he dislocated his shoulder, the man attended the local hospital for x-rays. In his discharge letter, a hospital doctor in the emergency care centre wrote that it would be prudent for the man to have neurological follow up to ensure that his medication was sufficient to control his epilepsy. On 20 November, the Head of Healthcare signed this letter as having been received. At interview, she said that it would then have been passed onto a doctor to follow up. However, this did not happen. The Head of Healthcare commented that this was because “nobody actioned it”. As previously, the man had no further follow up or reviews in the weeks and months after the fit. The clinical reviewer comments that this is “regrettable”.

On 4 December 2006, the man was assessed by a doctor after he had complained of recent chest pain. The clinical reviewer notes that he was asked no questions of his family history (the man’s twin brother had died of a heart attack at the age of 19, although he did not mention this at his secondary health screening at Belmarsh on 12 August 2004), no cardiac investigations were performed, and no ECG or blood tests were requested. She describes this as “regrettable” in the light of the post mortem report.

As I have already commented, the clinical reviewer concludes that the man did not receive healthcare equivalent to that available in the community whilst at HMP Maidstone. She therefore makes the following recommendations:

West Kent PCT, as overall commissioners of the prison healthcare services, should ask the Governor of HMP Maidstone to conduct their own internal investigation to address why the prison medical and nursing teams failed to review the man’s care on so many different occasions. This should address why no care plan or risk assessment was produced during the man’s entire stay in the prison. It should also address why the advice given by two different A&E departments on two different occasions went largely unheeded.

HMP Maidstone should produce an action plan, the implementation of which is reported to the PCT’s Clinical and Corporate Governance Committee. This action plan should include how the prison aims to address the issue of accurate record keeping.

HMP Maidstone should audit its care of prisoners with chronic conditions.

HMP Maidstone should be more proactive in its monitoring of prisoners with chronic conditions and place a far greater emphasis on disease prevention. NICE guidelines should be implemented in the care of all prisoners with chronic diseases. This should form part of the action plan and be reported back to the PCT’s Clinical and Corporate Governance Committee.

Arrangements should be made to ensure that a system is devised that allows for the clinical appraisals of both medical and nursing staff. Where individuals are found to be failing they should be supported, trained and monitored appropriately.

I also make the following recommendations to Belmarsh:

The Head of Healthcare at HMP Belmarsh should review the systems for caring for prisoners with epilepsy. They should ensure that all epileptic prisoners are reviewed regularly by a prison doctor, particularly in the aftermath of a fit or hospital admission.

The Head of Healthcare at HMP Belmarsh should ensure that the medical history is obtained from the prisoner's GP for all new receptions into custody who have a chronic disease.

The clinical reviewer notes that there are a number of locum healthcare workers at Maidstone, and throughout the Prison Service. She considers that, "if healthcare workers are given 'ownership' of identified areas of care (then) the standard of that care will improve."

HMP Maidstone should make named individuals accountable for care administered to prisoners. These people should receive training to enable them to deliver this, and this should be done through personal development plans.

The exact date of the fit that the man experienced in early 2006 was not recorded in the medical record. His observations were described as "satisfactory" by the nurse who was called out to see him on that occasion, but are not recorded. The clinical reviewer also comments that it is not recorded anywhere in his notes how many or how often the man suffered petit mal fits (also known as an absence seizure, in which consciousness is lost momentarily and the patient may appear to be staring into space).

The clinical reviewer notes that the 'Vamp Vision' computer system is currently installed at HMP Maidstone, but is not generally used. This system has most NICE guidelines built into its management programmes. The clinical reviewer considers that the immediate and widespread use of this system would improve the quality of care given to prisoners with chronic conditions overnight, at no extra cost to the Prison Service. She therefore makes the following recommendation:

HMP Maidstone should adopt the practice of using computerised record keeping by its entire medical and nursing staff.

Following his fit on 9 December 2006 in which he dislocated his shoulder, the man moved from a cell on the third floor landing on Medway wing to one on the first floor. This followed a discussion with the safer custody co-ordinator, in which she advised him that if he moved closer to the wing office then staff would be able to help him more quickly if he were to have another fit in future.

The safer custody co-ordinator said that she asked night staff to keep an eye on the man during the night following his move to the first floor. However, she did not know if this actually happened. There is no evidence to suggest that it did. The safer custody co-ordinator also said that wing staff were not at any time given advice from healthcare on how best to manage the man, what to do if he had a fit, or how to keep him safe.

The clinical reviewer notes that “there is no evidence of partnership working either between the nursing and medical teams or the medical and prison officer teams.” She goes on to say, “it is vital to have effective communication and liaison between these teams.”

The Governor should ensure that stronger working relationships are built between prison officers and healthcare staff so that patients with chronic conditions are monitored closely throughout the whole day.

At no point during his time on Medway wing was the man offered the opportunity of sharing a cell. For someone with a history of unpredictable fits, including several in which he had suffered physical injury, it would have been advisable for him to be in a shared cell where the alarm could be raised quickly should he have a fit in the night.

Two prisoners told my investigator that they thought the man should not have been in a single cell due to his epilepsy. They remarked on how popular he was on the wing, and that many of his fellow prisoners would have been happy to share a cell with him.

There are no double cells on Medway wing at Maidstone. The only doubles are on Kent wing, which is the induction wing. This wing is busy and noisy, with a constantly changing population. The consensus of those staff and prisoners to whom my investigator spoke was that the man would not have wanted to give up his single cell on Medway for a shared cell on Kent wing. To have insisted that the man share a cell would have been contrary to his personal dignity. However, it would have been appropriate to have offered him this opportunity.

The Governor should ensure that all prisoners with fragile chronic conditions are offered the opportunity of sharing a cell.

Completion of ‘Report of Injury to Inmate’ forms

The man experienced three fits during his time at Maidstone. On the first occasion, in January/February 2006, he was apparently unresponsive for around ten minutes. On the second occasion, in July 2006, he sustained bruising to his head and neck. On the third occasion, in November 2006, he dislocated his shoulder.

On none of these occasions was a form F213 ‘Report of Injury to Inmate’ completed. The only occasion on which such a form was completed during the man’s time at Maidstone was in July 2005 when he sustained a cut above his eye during a fight with a fellow prisoner.

Form F213 contains an account of how the injury was sustained, a diagram of a body on which the area of injury should be highlighted, and a report by the Medical Officer detailing the injury received and treatment given. Such a form should be completed whenever a prisoner has sustained an injury in prison. In the man's case, completion of this form would have ensured that he had seen a prison doctor, which was not the case after some of his fits.

The Head of Healthcare should ensure that staff complete form F213 whenever a prisoner sustains an injury.

Emergency response

When the man was discovered one morning in January 2007, two emergency calls were made for healthcare assistance. The first of these was by telephone by staff in the wing office after they were alerted by the officer who discovered the man. The second was by the senior officer who was on the corridor with the officer when she unlocked the man's cell, and who made a call over the radio. The call was responded to promptly by the Head of Healthcare.

In interview, the officer said that she asked the staff in the office to call for immediate and urgent assistance. The senior officer said that when he made his call he was told that assistance was on the way. Both of them thought that the man was clearly dead at that time.

Neither the senior officer nor the officer were aware of a system of emergency codes being in place at Maidstone. Such a system (for example, code black to signify that the patient is unconscious or code red to signify that the patient is bleeding profusely) would help a response team to prepare for the action that they need to take on arrival at a medical emergency. The Head of Healthcare said that there was such a system at Maidstone, but that it had not yet been publicised to wing staff.

I consider it essential that healthcare staff are able to respond to a medical emergency as quickly as possible. It is particularly advantageous if healthcare staff have an idea of the type of emergency that they are facing prior to their arrival so that they can prepare accordingly.

The Governor should ensure that the system for summoning emergency medical assistance enables the healthcare team to have some understanding of the type of emergency they are attending and the likely emergency equipment needed. This system must be communicated to all staff.

A debrief was held later on the day of the man's death in which the staff who were involved in the discovery of the man were able to discuss their experiences and confirm a timeline of events. Unfortunately, the healthcare staff involved were not invited. At interview, the Head of Healthcare said that this was probably an oversight as she has attended other debriefs in the past. I make no formal recommendation, but the Governor will wish to ensure that healthcare staff are always invited to debriefs in future.

Staff were in the main content with the support they received. The officer who discovered the man, who had only graduated from the Prison Service College around a month previously, said that she was very pleased with the support that she received.

The man's transfer to hospital on 9 November 2006

The man's parents have expressed concern that he had to change out of his tracksuit top and into prison clothing in order to go to outside hospital after his fit on 9 November 2006. They said that, as he had dislocated his shoulder, he would have been in pain and this would have increased when he changed tops. They felt that some flexibility could have been applied in these circumstances.

My investigator spoke to the Security Manager at Maidstone. She referred to section 2.23 of Maidstone's Local Security Strategy which says that a prisoner should wear prison clothing when on a hospital escort. The Security Manager added, however, that staff would normally have discretion over the wearing of clothing to outside hospital. If in doubt, she said that staff should refer to healthcare for guidance.

The man was seen by a nurse after his fit. He noted in the man's medical record that his shoulder was "painful and obviously displaced." Despite this, the man apparently had to change his top before going to hospital. It is not clear why this was the case.

The Governor should amend the Local Security Strategy to ensure that there is scope for flexibility in wearing prison clothes to hospital if a prisoner has suffered a serious injury.

Liaison with the man's family following his death

On the day of the man's death, the Governor asked the police to break the news to his parents. The man's parents live around 30 miles from Maidstone, and the Governor was concerned that the traffic at the time of day would be heavy. However, the police were caught up in another incident whilst on the way and were unable to visit the man's parents until early afternoon. By then, the Governor had decided to go herself, and she and a prison family liaison officer arrived shortly after the police had left.

Prison Service Order (PSO) 2710, which provides instructions for the aftermath of a death in custody, says that Governors must:

"Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened."

The accompanying Family Liaison Officer Guidance recommends that:

"The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated Family Liaison

Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain.”

Whilst the man’s parents were pleased with the contact that they had with the prison, it is best if first contact with the next of kin is made in person by an informed member of prison staff. As well as being better qualified to answer the family’s questions than a police officer, such an approach also helps to show that a death in custody is a matter of proper concern to the establishment in question. The Governor should bear this in mind should there be a future death in custody at Maidstone.

The Governor should ensure that, where possible, the news of a death in custody is broken to the next of kin by a member of prison staff, face to face.

RECOMMENDATIONS AND GOOD PRACTICE

West Kent PCT, as overall commissioners of the prison healthcare services, should ask the Governor of HMP Maidstone to conduct their own internal investigation to address why the prison medical and nursing teams failed to review the man's care on so many different occasions. This should address why no care plan or risk assessment was produced during the man's entire stay in prison. It should also address why the advice given by two different A&E departments on two different occasions went largely unheeded.

Partially accepted - West Kent PCT, as overall commissioners, have worked with HMP Maidstone during 2007 to ensure that appropriate internal investigations take place through the Prison's Clinical Governance meeting following serious untoward incidents such as a death in custody. The SUI documentation was cited as an example of best practice in the HMIP / HealthCare Commission visit of February 2007. These Investigation procedures were followed after the man's death, and lessons learned have been fed into HMP Maidstone's Health Delivery Development Plan, which was signed off at the West Kent PCT Prison Health Partnership Board Meeting of 21 July 07, feeding into the PCT Clinical Governance meeting. All Offenders attending A&E are offered the opportunity of seeing a GP after the event.

Following Healthcare's own Clinical review of the man's care, all incoming mail is date stamped and actioned/annotated by the head of healthcare, thus ensuring external Hospital advice is heeded.

However, West Kent PCT are not commissioners of healthcare at HMP Belmarsh, and HMP Maidstone cannot be held responsible for healthcare issues in HMP Belmarsh, or influence their future practice.

HMP Maidstone should produce an action plan, the implementation of which is reported to the PCT's Clinical and Corporate Governance Committee. This action plan should include how the prison aims to address the issue of accurate record keeping.

Accepted - HMP Maidstone's Health Delivery Development Plan was signed off at the Partnership Board Meeting of 21 July 07, and is monitored by HMP Maidstone's Clinical Governance Committee, feeding in to the Prison Health Partnership Board, reporting in to the PCT Clinical Governance Committee. This Development Plan addresses the issue of accurate record-keeping through the introduction of clinical IT systems: and liaison meetings between GP and Nursing staff, which have been implemented.

All Healthcare Workers adhere to NMC Guidelines on Record Keeping. Doctors likewise have BMA advice, and are reminded by the head of Healthcare and Doctor Team Leader (minuted) in respect of importance of accurate, full and legible record keeping.

HMP Maidstone should audit its care of prisoners with chronic conditions.

Accepted - A Quality & Outcomes Framework audit, mirroring that used in GP Surgeries, will be carried out as soon as all Offender Individual Medical Records are uploaded on to the clinical IT system.

Documented in HNA 2007-2010 and PHDP. Chronic Disease Register in place since November 2005.

Training needs analysis last completed July 2007, identifying areas where training needed once sufficient staff recruited to vacant posts.

HMP Maidstone should be more proactive in its monitoring of prisoners with chronic conditions and place a far greater emphasis on disease prevention. NICE guidelines should be implemented in the care of all prisoners with chronic diseases. This should form part of the action plan and be reported back to the PCT's Clinical and Corporate Governance Committee.

Accepted - Shared protocols in line with NICE guidelines and National Service Frameworks for the treatment and monitoring of chronic disease have been in place since March 2007. (Minuted at HoHc meeting 13th March 07).

Patients on Chronic Disease registers are called for review in line with these guidelines. As in the community, patients may choose not to attend.

HMP Maidstone has re-launched the multi-disciplinary Health Promotion Action Group. This was part of HMP Maidstone's Health Needs Assessment and ensuing Prison Health Development Plan, which is monitored by the Prison Health Partnership Board, reporting in to the PCT Clinical Governance Committee.

Arrangements should be made to ensure that a system is devised that allows for the clinical appraisals of both medical and nursing staff. Where individuals are found to be failing they should be supported, trained and monitored appropriately.

Accepted - Arrangements are in place to clinically appraise medical and nursing staff. All individuals have personal development plans addressing support, training and monitoring. SPDRs linked to Job Descriptions and Job Specifications (for HCWs) allowing for poor performance in all aspects of appraisal. Doctor Team – PCT pay for 'Prison' element of annual appraisal for Doctor Team plus quarterly Doctor Team Meetings and ad hoc performance management meetings with Dr Singh (Team Leader) and PCT.

The Head of Healthcare at HMP Belmarsh should review the systems for caring for prisoners with epilepsy. They should ensure that all epileptic prisoners are reviewed regularly by a prison doctor, particularly in the aftermath of a fit or hospital admission.

The Head of Healthcare at HMP Belmarsh should ensure that the medical history is obtained from the prisoner's GP for all new receptions into custody who have a chronic disease.

HMP Maidstone should make named individuals accountable for care administered to prisoners. These people should receive training to enable them to deliver this, and this should be done through personal development plans.

Accepted - This point is addressed in PHDP and Prison and PCT already recognise the need for Lead nurses, afforded recognised training, for areas within Chronic Diseases. This can only be achieved once optimum planned staffing levels are achieved.

HMP Maidstone should adopt the practice of using computerised record keeping by its entire medical and nursing staff.

Accepted - This action was already under way in January 2007. Clinical IT systems were installed in HMP Maidstone shortly before the man's death, and some staff had received initial training. The GP Team Leader has confirmed that all GP staff are fully trained to use this system. Assessment concluded that mixing computerised and manual record keeping would present an unacceptable level of risk, therefore full implementation will happen when all patient records are uploaded. Delay in adopting the practice of using computerised records by all medical and nursing staff is due to the volume of work involved in uploading patient records for a changing population with higher than average levels of health problems.

The Governor should ensure that stronger working relationships are built between prison officers and healthcare staff so that patients with chronic conditions are monitored closely throughout the whole day.

Accepted - This closer working has been improving since the appointment of a Full time Disability Liaison Officer. (DLO). The use of a DLO formulated Care Plan means much more sharing and awareness of disabilities and chronic diseases, for Officers and others who work with these offenders.

However, we also need to bear in mind equivalence with care in the community and the need to promote independence for resettlement. A Prison is not a Hospital or a Care Home. In addition the launch in October 2007 of a comprehensive Decency Strategy by the Governor with its focus on staff/prisoner relationships should also help to improve the ethos of general care and safer custody.

The Governor should ensure that all prisoners with fragile chronic conditions are offered the opportunity of sharing a cell.

Partially accepted - This is not what would happen in the community, but we could consider it if offender felt it was needed. It must be recognised that there are possible (unacceptable) expectations placed on the person sharing a cell with a chronically ill prisoner. In addition there are no shared cells on Thanet House, where most of our chronically ill prisoners are located. The only option if a cell share was requested would be to move the prisoner to Houseblock 4 at HMP Elmley. Cell sharing risk assessment (CSRA) would also be a consideration.

The Head of Healthcare should ensure that staff complete form F213 whenever a prisoner sustains an injury.

Partially accepted - Maidstone does not accept that the Head of Healthcare is responsible for ensuring staff complete form F213. However, the Head of Security and Operations will review of our incident reporting systems which will focus on the information required from an incident and include who is responsible for collating the information.

The Governor should amend the Local Security Strategy to ensure that there is scope for flexibility in wearing prison clothes to hospital if a prisoner has suffered a serious injury.

Accepted - Head of Security to review this Section of the LSS.

The Governor should ensure that, where possible, the news of a death in custody is broken to the next of kin by a member of prison staff, face to face.

Accepted - Two trained FLO's are in place. A recent death received very positive feedback from the PPO, on our FLO response