PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Maidstone in May 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the death of a man, who died at HMP Maidstone in May 2012. He was 74 years old and died from heart disease. I offer my condolences to the man's family and friends.

The investigation was undertaken by an investigator. NHS Kent and Medway commissioned a clinical reviewer to undertake a review of the man's clinical care. Maidstone prison cooperated fully with the investigation.

The man had undergone heart by-pass surgery some time before his imprisonment in 2009, since when his condition had been stable. He was found unconscious by another prisoner on a morning in May. The emergency response was swift but neither prison staff nor paramedics were able to revive him.

The investigation found room for improvement in medicines management at Maidstone and a need for better emergency procedures and checks on prisoners when they are unlocked. Some aspects of the man's healthcare, such as the management of his diabetes, could have been better, but otherwise he received good care at the prison and it does not seem that his death could have been prevented.

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.

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Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was remanded to HMP Lewes in June 2009 when he was 71 years old. He transferred to HMP Maidstone a week after he was convicted in July 2010.

2. The man had triple heart by-pass surgery in 1999 and was a diabetic. He took several medications for angina, high cholesterol, diabetes and hypertension. An electrocardiograph (ECG, which records the heart's electrical activity) from August 2010 revealed no abnormal findings except an irregular pulse. He did not complain of feeling unwell in the days or weeks before his death.

3. On a day in May 2012, the man was seen sitting in his chair at the early morning count, and all appeared normal. At unlock, 15 minutes later, an officer opened his cell door but did not look in or try to get a response from him. A friend of the man's went to his cell shortly afterwards and saw him sitting in his chair with his head tipped back and his mouth open. He got no response and alerted staff that he thought the man had died.

4. Officers and nurses got to the man's cell very quickly and cardiopulmonary resuscitation (CPR) was started. A defibrillator was applied but advised against administering a shock. Paramedics arrived at the prison within five minutes of the 999 call being placed and took over resuscitation efforts. Unfortunately they were unable to resuscitate him and he was pronounced dead at 9.17am. A post mortem showed that he died from ischaemic heart disease.

5. We make six recommendations as a result of this investigation. The clinical reviewer found that although the overall care provided for the man was good, there were elements of the management of medicines that need to be addressed. While the emergency response was generally good once the man was found, we believe that emergency codes to alert other staff were not used properly and an ambulance was not called as quickly as it could have been. We also recommend that guidance is given to staff who unlock cells in the morning.

THE INVESTIGATION PROCESS

6. The investigator visited HMP Maidstone on 2 July and met the Governor. She visited the man's cell on Medway wing and spoke to staff and prisoners who knew him. She met the chair of the Prison Officers' Association and a member from the Independent Monitoring Board. Maidstone provided copies of the man's prison record, including his medical file. The investigator took copies of relevant documentation and issued notices to staff and prisoners about the investigation. No-one came forward in response to the notices.

7. West Kent PCT commissioned a doctor from Medway PCT to carry out a clinical review. The investigator interviewed several medical staff to assist with the review.

8. The investigator interviewed 11 staff and prisoners. She recorded some interviews and made notes of others. She provided feedback to the liaison governor during the investigation.

9. One of our family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation process and offered her the opportunity to contribute. No issues were raised.

10. The investigator wrote to HM Coroner for Mid-Kent and Medway District to inform her of our investigation and to request a copy of the post mortem report. This report will be sent to the Coroner to assist with her enquiries into the man's death.

HMP MAIDSTONE

11. HMP Maidstone is a category C training prison holding up to 600 men. Medway, the wing where the man spent most of his time holds up to 101 prisoners in single cells.

12. The prison's healthcare unit has no in-patient facilities and does not provide 24 hour cover. GP services are provided by Oxleas NHS Foundation Trust and three GPs provide cover on a rota basis. GP surgeries are held each weekday morning. Healthcare records are kept on SystmOne, a computerised medical record system.

Her Majesty's Inspectorate of Prisons (HMIP)

13. The last inspection of Maidstone was an unannounced inspection from 19 - 23 September 2011. In relation to healthcare, HMIP 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. 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.

14. HMIP found that there was support for older prisoners using a 'buddy' scheme (where other prisoners are paid a wage to help and assist an older person). Inspectors commented that "retirement pay was poor and some older prisoners worked to ensure they had sufficient funds". Older prisoners were unlocked during the core day, although there was often little access to structured activities. (In response to the draft report, Maidstone asked us to point out that the retirement pay there is higher than that prescribed nationally.)

Independent Monitoring Board (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community, who help to ensure that prisoners are treated fairly and humanely. In the most recent IMB report for the year ending 29 February 2012 the IMB said about healthcare:

> "there are no major shortcomings ascertained in the provision of healthcare to the prisoners in custody at Maidstone. The timeliness of appointments and range of services available in general is at least as favourable as that experienced by the public locally.
>
> "Most clinics (hepatitis, asthma, dressings and 'stop smoking') have taken place… Self help mental health courses have been run".

Previous deaths at HMP Maidstone

16. In the three years before this man's death, there were nine deaths due to natural causes at Maidstone, four of which were in the previous 12 months. Two of our investigations into deaths at the prison in January and September 2010 included recommendations about the in possession medication policy. This is again an area of concern in this man's case.

KEY EVENTS

17. The man was remanded to HMP Lewes on 17 June 2009 charged with serious offences. As part of his reception process he was seen by a nurse. The man said he took several prescribed medications and that he had had heart by-pass surgery 11 years earlier. Blood tests were taken, including a full diabetic screen and PSA (prostate specific antigen) to assess his prostate which came back as normal. He was referred to see the doctor the next day. His prescribed medications were continued. It is noteworthy that he could not read or write but asked other prisoners to help him out.

18. During the next few months the man had a full podiatry check because of his diabetes. His cholesterol level was controlled.

19. In February 2010, the man was treated for a urinary tract infection. In April, he reported dizziness when he stood up and was advised to take his medication at a different time. In May, the man's HbA1c was measured. (An HbA1c of 7% or less shows that diabetes is controlled. His result came back as 7.2 %.) His cholesterol result was 5.3, which is high. He was already on medication for his cholesterol. His blood pressure and pulse were measured regularly and were within normal ranges.

20. On 14 July 2010, the man was sentenced to eight years in prison, with an earliest release date of June 2013. He transferred to Maidstone on 21 July where he was seen by a nurse practitioner at 4.25pm as part of the reception screening process. It was recorded on System One that the man had type II diabetes, rheumatoid arthritis, "disorder of heart", hypertension and no known allergies. A form entitled "Offender Medication Policy" was signed by the man and the nurse practitioner. The form lists a prisoner's responsibilities if medication is held in his own possession. The form also asks the prisoner to provide details of the next of kin that they wish to be contacted in the event of a medical emergency, but this part of the form was not completed.

21. Another form, entitled "Checklist for Assessment of Suitability for In-possession Medications" dated 29 July 2010 was not properly completed. It indicated that the man had read and understood the medication leaflet, yet he could not read or write. There was no doctor's input about the decision to give the man his medication in possession, although the form suggested this was required.

22. A prison GP saw the man on 22 July and discussed his urinary condition. An officer met the man the same day and introduced himself as his personal officer.

23. A pharmacy technician wrote up the man's prescription as follows: Isosorbide mononitrate 60mg modified release tablets (a drug used principally in the treatment of angina by dilating the blood vessels to reduce blood pressure); atorvastatin 40mg tablets (a statin drug, used for lowering blood cholesterol); aspirin 75mg dispersible tablets (used to relieve minor aches pains, and fevers or as an anti-inflammatory); lansoprazole 15mg capsules (a drug which

inhibits the stomach's production of gastric acids and can be used to treat ulcers and acid reflux disease); senna 7.5mg tablets (an aid to treat constipation); metformin 500mg tablets (an oral anti-diabetic drug used in the treatment of type II diabetes which works by suppressing glucose production by the liver); isinopril 5mg tablets (a drug used in the treatment of hypertension, congestive heart failure and heart attacks and in preventing renal and retinal complications of diabetes); and paracetamol 500mg tablets (a widely used pain reliever and fever reducer).

24. The nurse practitioner noted that the man failed to attend a Well Man appointment arranged for him on 28 July 2010. She saw him just after 10.00am the next day. The man said his mother and father both had cardiovascular disease and diabetes. His pulse rate was 86bpm. The man's body mass index was recorded as 26.06, which is in the overweight range. His blood pressure was 130/80 mmHg, which is within the normal range. The nurse practitioner recorded that the man did not use drugs, smoked about 1oz of tobacco a week, was fit for work with restrictions and that cholesterol screening should be done. Later that day he was seen in the Well Man clinic. It was noted that his mobility was slow, but that he could get around reasonably well.

25. The man held his medication in his cell and had a week's supply at a time. His tablets were kept in a special box with the days of the week on them (known as a dosset box) to help him remember to take his tablets at the right time. One of his friends on Medway wing said he reminded the man if he had forgotten to take his tablets. There were no routine checks by healthcare staff to ensure the man was taking his medication appropriately.

26. A doctor saw the man on 4 August because he was experiencing occasional, short episodes of dizziness when he stood up. Orthostatic hypotension is where a person's blood pressure suddenly falls when standing up or stretching. It is quite common and occurs more among the elderly and those with low blood pressure. The doctor found nothing abnormal except an irregular pulse. He was advised to take things slowly when changing his posture or position. An ECG was also carried out. This confirmed the man's previous heart attack and occasional benign extra beats. Atrial fibrillation was ruled out (atrial fibrillation is the most common irregular heart beat).

27. In September, the man moved into a shared cell with another man of a similar age. Although he had difficulty reading and writing, the man was confident about asking for help from staff and prisoners.

28. Between August 2010 to October 2011, the man was treated successfully for two urinary infections and three chest infections. In April 2011, an optician also carried out an assessment of his retina for diabetic damage and found that all was well. The nurse practitioner saw the man on 18 April after he reported having dizzy spells. After taking some medical observations, she advised him to return to his cell to rest and to eat and drink something as he had not eaten that day. She was not sure he was taking his medication correctly and gave him advice about this. The next morning the man's blood

pressure was checked and was within the normal range. He said he felt much better. His dosset box was checked by a pharmacy technician.

29. At the end of June, the man moved to Medway wing. His new personal officer wrote that "he is very happy to be on Medway wing as he knows several people here". The officer said he had a network of people to assist him with reading and writing. He worked in the print finishing workshop in the mornings and attended education in the afternoon.

30. On 20 January, the GP saw the man who had a sore throat and prescribed amoxicillin (a common antibiotic). He complained of feeling dizzy several days later and so was switched onto a different type of antibiotic. By the end of January his cough was noted to have improved and the medication was stopped. A week later, he saw a GP and said he had ongoing throat discomfort. The GP noted that there was no swelling, his throat and neck were normal and there were no nodes. Co-magaldrox (a combination antacid used in the treatment of indigestion and heartburn) and Gaviscon advance (also to treat heartburn) were prescribed. A review by another GP two weeks later noted that the night reflux had not improved. After doing a physical check of the man, he advised him to elevate the head end of his bed and avoid food or drinks late in the evening.

31. On 8 March, the man saw a GP and requested nicotine replacement patches to help him stop smoking. The GP noted that he was waiting to join a smoking cessation group and advised him to cut down in the interim. The man did not attend the group that started on 25 April.

32. A fellow prisoner said that a few nights before he died, the man told him he had been "sweating" in his cell, but he had seemed fine during the day. He said the man had "the shakes" and also felt dizzy sometimes, but that he always liked to be out and about during the day. He felt the man might not have told staff if he had any pains because he liked working and would not have wanted any restrictions to be placed on that.

33. The man had regular contact with one of his sisters when he was in Maidstone and telephoned her on 28 May at 8.11am. The conversation lasted for a few minutes and they spoke about arranging a visit. He said he was very hot in the jumper he was wearing and had been sweating a lot.

34. A fellow prisoner was a friend of the man on Medway wing whose cell was diagonally opposite around a corner, which enabled them to talk easily through the windows. His friend said the man usually got up quite early, around 6.30am. He then washed, got dressed, made himself a cup of tea and watched television. Around 8.00am, he usually called out to his friend that the kettle was on. At unlock 10 or 15 minutes later, they would have a cup of tea and a cigarette together before going on to their normal day's activities.

35. The weekday routine on Medway wing is for a staff briefing at 8.00am followed by unlock about 15 minutes later, when prisoners can shower, exercise or get ready for work. At 8.45am prisoners go to their place of work.

The day of the man's death

36. The early relief for the night officer support grade (OSG) came on duty soon after 7.00am and shortly after started a count of the prisoners on Medway. She said when she looked through the observation flap of the man's cell, he was sitting in his chair, fully dressed, watching television as usual. The officer said she does not speak to or seek a response from prisoners at this count, so could not be certain that the man was still alive at that time.

37. The man did not call out to his friend that the kettle was on as he normally did. His friend said he was a little bit concerned about this. Just before 8.15am, an officer began to unlock the man's landing. She said it was not usual practice to open the door wide because the toilets are just inside the door and are not screened off. The officer said she does not usually speak to prisoners as she is unlocking as some might still be in bed, but she does talk to them if they speak first. She said the man normally said something like "Morning lovely" but that morning he did not say anything. She thought nothing of this and continued unlocking. As she walked back down the spur she could see inside the gap in the man's door and saw him sitting in his chair and all appeared normal.

38. The man's friend went to see him just after unlock. He said he opened the cell door and he was sitting, fully dressed, in the chair next to his bed. His head was tipped back and it looked as though he had fallen asleep. His eyes were shut and his mouth was open. The man's friend called his name but got no response. He sensed that the man might have died so went to get an officer. He saw an officer and said he thought that the man might have died. The officer went to the Senior Officer's (SO) office and told the SO. This was about 8.20am. The two officers and the prisoner went to the man's cell, which was nearby.

39. The SO tried to get a verbal response from the man and felt for a pulse in his wrist. He could not find one, although he said he still felt warm to the touch. He described the man as sitting in his chair with his eyes closed and his mouth open. His lips were dark in colour. The SO radioed for an immediate healthcare response. This message was made at 8.22am according to the incident log kept by the control room. Maidstone uses a colour code to alert medical staff to the type of emergency they are being asked to attend, "Code Blue" indicating a breathing problem. The senior officer said he did not use Code Blue because he forgot which colour was the right one for that situation, but asked for immediate assistance from healthcare. Officers in the communication room clarified the nature of the emergency and called a Code Blue alert. Two nurses responded, grabbed the red emergency bag (containing resuscitation equipment) and hurried to Medway wing, only 80 metres or so from healthcare.

40. The early relief officer said she heard the SO's radio call. She went to the landing and saw an officer outside the man's cell and was told they could not get a response from him. The SO said he would have started chest

compressions but healthcare staff arrived very quickly. One of the nurses checked for signs of life and described the man as “grey” with purple lips. The early relief officer helped the nurse move him to the floor. The nurse asked for an ambulance and a defibrillator. An officer brought a defibrillator from the SO’s office. The two nurses started CPR taking turns to give chest compressions and oxygen without success. The defibrillator instructed not to shock and to continue CPR. An SO rang the control room at 8.31am and asked them to call an ambulance. A 999 call was made at 8.32.

41. A first rapid response paramedic arrived at 8.35am and an ambulance (with two more staff) a few minutes later. The nurses had continued CPR with the assistance of the SO. The ambulance crew took over CPR in the cell, gave the man drugs (adrenaline and sodium chloride) in order to help with the resuscitation efforts and inserted an airway. A prison GP went to the man’s cell at 9.09am. He felt that it was appropriate for the paramedics to continue the resuscitation efforts as they have expertise. At 9.17am, the paramedics decided to stop CPR and pronounced the man’s death.

42. An officer went to see the man’s friend and told him that he had died. He thought the doctor also came to tell him. He said he knew already and thought his friend had probably just passed away quietly without any warning.

43. A notice informing staff and prisoners of the man’s death was issued. A hot debrief was held at 10am for staff who had been involved.

44. One of the man’s sisters was listed as his next of kin on his prison record, although not the one he had been in most regular contact with at Maidstone (the entry was made in 2009.) An SO and an officer, who are both trained family liaison officers, went to her address. There was a delay as the officer had to be called in from a day off and a further delay was caused while prison staff made some checks with the police. They arrived at her home at 2.00pm but no one was in. The officers agreed with one of the managers at Maidstone that they should go to the address of another sister, but as they were about to leave, the man’s sister arrived home.

45. At the man’s sister’s request the prison staff telephoned one of the man’s brothers and explained what had happened. His brother then came to the house to support his sister, who also asked that they contact her other sister to break the news.

46. The Governor wrote a letter of condolence to the man’s sister, his nominated next of kin. A Memorial Service was held in the multi-faith centre on 11 June. Staff and prisoners attended this service and members of the man’s family were also invited. The prison contributed towards the cost of the funeral.

ISSUES

Clinical Review

47. The man had a history of heart disease and type II diabetes. He had a coronary artery by-pass graft (CABG) in 1999 and was on medication for diabetes, angina, cholesterol, kidneys (for the effects of diabetes), blood pressure, the suppression of acid production in his stomach and constipation.

48. In his clinical review, the doctor wrote,

> "It is important to note that [the man] was… at very high risk of heart attack and stroke. His family history, his diabetes and smoking were risk factors on their own and the fact he had a previous history of heart attack increases the risk even further".

49. Overall, the clinical reviewer did not feel any more could have been done to prevent the man's death. However, he considered that some aspects of his health care did not meet the standard he would expect.

Medication management

50. The Clinical Nurse Manager said a decision about a prisoner holding medication in their cells is usually made by a nurse, although the form includes a space for a doctor. An RGN completed the "Checklist for Assessment of Suitability for In-Possession Medications" on 29 July 2010 and decided that the man could keep his medication in his cell. The Clinical Nurse Manager said this decision would be based on the medication the man was prescribed (how 'sought after' it might be by other prisoners) and how he had managed his medication in the past.

51. We have no concerns about the decision to allow the man to keep his medication in his cell and he appears to have been given appropriate support to help ensure he took it. However, the assessment on which the decision was made was not completed accurately. The man could not read and therefore is unlikely to have been able to understand the medication leaflets unless they were read to him. There was no indication that this was done. The assessment was not signed by a doctor as the form requires. We accept that in a category C prison like Maidstone there will usually be a presumption that most medications can be held in the prisoner's possession as they would in the community. So long as there is an appropriate risk assessment by a nurse that should usually suffice. In cases of doubt, a referral to a doctor should be made. The form used at Maidstone did not appear to reflect their practice and the process used did not ensure that the man understood what he needed to know about the medications he was taking.

The Head of Healthcare should ensure that there is an appropriate process to assess the risk of allowing prisoners to hold medicines in their possession which is explained to all prisoners.

52. The Clinical Nurse Manager said it is usual for prisoners to be given a 28 day supply of medication, as they would in the community. In this man's case he was given 7 days at a time. The clinical reviewer considered that the man was largely compliant with taking his medication. The prisoners who knew him said he usually took his medication and they reminded him if they thought he might have forgotten.

53. One of the prison's GP's view was that the man's combination of medication managed his various medical issues very well – his blood pressure was not high and his diabetes was well controlled. However, there were no routine GP reviews of his medication as would be best practice in the community. This is particularly relevant for older people who take more than one medication, where six monthly or annual reviews are the ideal.

54. Overall, we consider that the man was given the appropriate medication at Maidstone and was given support to ensure that he took it. However, there is a need for more systematic medicines management and we make the following recommendation:

The Head of Healthcare should ensure that doctors carry out and document medication reviews at least annually.

The man's heart condition

55. The man had heart by-pass surgery in 1999. This can be less effective over time as arteries clog up again or angina progresses. The sudden death of someone of this man's age (and with similar medical problems – a smoker, diabetes, and heart disease) is not uncommon and there are often no obvious symptoms. He did not report feeling unwell to medical staff, officers or friends on Medway in the days before his death. We are satisfied that there were no obvious further signs of heart disease which should have been identified.

Diabetes management

56. The clinical reviewer said in his review that there was no evidence of any routine diabetic blood tests taken while the man was at Maidstone. Frequent mention was made of random blood sugars, presumably taken by finger prick testing. While this is good, the ideal would be annual HbA1c testing. Cholesterol and kidney function tests should also be reviewed. The clinical reviewer said it was good that the man's eyes were checked regularly at Maidstone but there was no sign that his feet had been checked.

57. The Clinical Nurse Manager indicated that staff shortages had made it difficult to arrange routine clinics and that there were no diabetic or cardiovascular clinics running at the time. The clinical reviewer said the primary care model in the community is often based on formal nurse or doctor run clinics, but this is not essential. Patients could be booked to see a doctor for a routine appointment to carry out diabetic checks. We make the following recommendation:

The Head of Healthcare should draw up and implement a policy for annual reviews of patients with chronic diseases such as diabetes.

Emergency Response

58. Prison staff responded immediately when his friend alerted staff to his concerns about the man. Two officers went straight to his cell and called for an emergency medical response. Two nurses arrived within a minute of that call.

59. Maidstone operates a system of colour coded emergency call codes so that medical staff know the type of emergency they are being asked to respond to and thus bring the correct equipment. (There are different emergency medical bags to take depending on the nature of the emergency). Prison staff should use the code system when they make an emergency healthcare message over the radio.

60. The last time staff were reminded of the emergency call codes was on 20 December 2010. The SO could not remember which code he should use when he found the man. This did not lead to any delay because the communications officer clarified what the emergency call related to and then called a Code Blue but it is important that all prison staff use the system as intended. We make the following recommendation.

The Governor should ensure that all staff understand the colour code system for use in emergencies.

61. The two nurses took the correct emergency bag with them to the man's cell and were at the cell by 8.24am at the latest. Both nurses were up to date with their basic life support training and attempted to resuscitate the man very quickly. They continued their efforts until the paramedics arrived, about ten minutes later.

62. One of the nurses requested a defibrillator and ambulance. The defibrillator was brought very quickly. However, there appears to have been a delay in calling the ambulance. The nurse requested it about 8.25am. An SO called the communication room (to ask them to dial 999) at 8.31am. Although it is unlikely to have made a difference to the man's chances of surviving his heart attack, it is important that ambulances are called as soon as possible in an emergency. We make the following recommendation:

The Governor should ensure that, when required, ambulances are requested as quickly as possible.

63. The clinical reviewer noted in his clinical review that:

> "Ideally, everyone in the prison should be confident in resuscitation and should have regular updates. It seems to me that in general the response to [the man's] collapse was excellent…"

Morning checks on prisoners

64. Most of the officers interviewed agreed that, when doing the early morning roll count at 7.00am, they do not wake prisoners up or seek a response. There was a variation in practice when officers unlocked the cells at 8.10am. Some said they just unlocked prisoners but did not seek a response from them or talk to them unless the prisoners spoke to them. The man's personal officer said that, during morning unlock at 8.10am, he always spoke to the prisoners to check they were okay. The Head of Residence said she expected officers to get a response from prisoners during the morning unlock.

65. We accept that the primary focus of the early morning roll check at 7.00am is security and it would not usually be necessary for officers to seek a response from a prisoner unless there was some indication that something was wrong. However, we agree with the head of residence that when unlocking a cell door an officer should always seek to get a response from a prisoner.

66. We believe that all officers should check prisoners for signs of life when they unlock the cell and ensure their wellbeing. Had a fellow prisoner not gone into the man's cell and raised concerns, it is possible that his death would not have been discovered for some time. While recognising that such a check would not have changed the outcome for the man, this is unacceptable. In other circumstances a more active check could save a life.

67. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

The Governor should ensure that when a cell door is unlocked, officers satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention

CONCLUSION

68. The man was elderly and was at high risk of further heart problems because of his medical history, current medical conditions, family history and lifestyle. The medical team at Maidstone were aware of his history and his heart problems, diabetes and other medical issues were mostly well controlled by his prescribed medication. He did not complain of feeling unwell in the days before his death. The clinical reviewer concluded that much of the care the man received was above community primary care standard but monitoring arrangements were not. This did not directly affect the likelihood of the man's heart failing, but it would have been better practice if annual reviews of his medication had been completed, and of his diabetes and his cardio-vascular health.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there is an appropriate process to assess the risk of allowing prisoners to hold medicines in their possession which is explained to all prisoners.

   NOMS accepted the recommendation and commented: "The Primary Healthcare provider will review the current process. The provider shall ensure that the policy includes a process for those offenders who are identified as having reading difficulties. Those offenders with identified difficulties will have a review with the Pharmacy Technician to read through their medication information leaflets."

2. The Head of Healthcare should ensure that doctors carry out and document medication reviews at least annually.

   NOMS accepted the recommendation and commented: "The Primary Healthcare provider shall ensure that patient medication reviews are undertaken in line with services offered in the community. (this is every six months)."

3. The Head of Healthcare should draw up and implement a policy for annual reviews of patients with chronic diseases such as diabetes.

   NOMS accepted the recommendation and commented: "This is now current practice"

4. The Governor should ensure that all staff understand the colour code system for use in emergencies.

   NOMS accepted the recommendation and commented: "A reminder notice to staff clarifying this issue was published in October 2012 and will be used in staff induction training and republished annually henceforth."

5. The Governor should ensure that, when required, ambulances are requested as quickly as possible.

   NOMS accepted the recommendation and commented: "This is now current practice (notice to all staff issued in October 2012 and also Control Room staff briefed accordingly)."

6. The Governor should ensure that when a cell door is unlocked, officers satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention

   NOMS accepted the recommendation and commented: "The Head of Decency and Residence is to ensure all relevant staff are briefed and local procedures amended to be even more explicit on this issue. "