Investigation into the circumstances surrounding the death of a man in January 2011 at outside hospital, whilst in the custody of HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is the report into the death of a man in January 2011, at outside hospital, whilst in the custody of HMP Maidstone. The man was 66 years old when he died. A post mortem showed that he died from septicaemia (blood poisoning), secondary to carcinoma of the bladder. I extend my sincere condolences to the man's family and friends for their loss.

I would like to thank the Governor and his staff at HMP Maidstone for their co-operation throughout the course of the investigation. I am grateful to West Kent Primary Care Trust for appointing a clinical reviewer to conduct a review into the man's clinical care. I apologise for the delay in issuing this report.

The prisoner was a reasonably well man until he began to suffer from urinary tract infections in 2009 and 2010. Treatment for these led to investigations which revealed that he was suffering from cancer in the bladder. Despite the lack of in-patient facilities at Maidstone the man was successfully managed there until he entered hospital for the final time in December 2010. This is a tribute both to the staff and the prisoners who looked after him, and reveals the value of a good 'buddy' system in prisons. At a time of an aging population the system will have to continue to find ways to manage people in similar situations to those of this man.

While the investigation found, on balance, good care provided to the man it is again disappointing to have to draw attention to sub-standard record keeping. Previous investigations at Maidstone have made the same point and it is clearly something that needs addressing. Good record-keeping is not simply reactive. It provides staff with the knowledge they need to make timely and appropriate interventions. The Head of Healthcare must ensure that record-keeping accurately reflects the, often impressive, work undertaken by healthcare staff.

I make six recommendations, all of which have been drawn from the clinical review.

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
Prisons and Probation Ombudsman **February 2012**

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SUMMARY

1. The man was arrested in March 2008 and charged with serious offences that had occurred many years before. He was remanded into custody at HMP Lewes on 12 June 2009, having been convicted and sentenced to seven years imprisonment. He was transferred to HMP Maidstone the following month.

2. During his initial healthcare screening, the man reported having an enlarged prostate gland, reported that he was a smoker and took various medications.

3. The man had little contact with healthcare staff during his first few months in prison until December 2009, when he consulted one of Maidstone's doctors about a urinary tract infection. The doctor treated him with antibiotics.

4. Over the course of the following few months the man suffered further urinary tract infections. This led to doctors at Maidstone referring him to outside hospital for investigation through renal ultrasound examination. The examination was carried out in May 2010 and revealed that he had a tumour in his bladder. Further investigations of the mass confirmed it to be a cancerous tumour that had infiltrated the bladder wall. Following diagnosis, he was treated with chemotherapy to shrink the cancer, prior to planned surgery.

5. The man returned to Maidstone prison in between his various investigations and treatment sessions. Maidstone does not have a healthcare in-patient unit, but it seems that the man preferred to remain at that prison in preference to transferring to one with in-patient facilities. It seems clear that he felt well supported by the staff at Maidstone as well as by his buddy (another prisoner who helped care for him). To help him self-care, he was allowed to keep his prescribed medication in his own possession and this appeared to have generally controlled his symptoms of pain and discomfort.

6. In December 2010, the man went back to hospital for bladder surgery. He suffered complications following the operation and, despite treatment, his condition deteriorated. On 23 December, he was moved to the hospital's intensive treatment unit (ITU). He remained in ITU from this time until his death in January 2011. His family were with him when he died.

THE INVESTIGATION PROCESS

7. The investigator visited Maidstone on 18 January 2011 to formally open the investigation. He spoke with a number of Maidstone's staff including one of the governors, the temporary head of healthcare and a family liaison officer who had had contact with the man's family. He also spoke with a representative of the Prison Officers' Association and the Independent Monitoring Board.

8. The investigator took copies of all relevant documentation about the man and issued notices to staff and prisoners inviting those who wished to provide information about him to make themselves known. No-one came forward in response to the notices.

9. The investigator wrote to West Kent Primary Care Trust (PCT) to commission a clinical review. A clinical reviewer was appointed. The investigator and the clinical reviewer returned to Maidstone to carry out joint interviews with relevant witnesses. They interviewed four members of staff and one prisoner – a friend of the man's and his official 'buddy'[1]. The clinical reviewer wrote a report on the man's clinical care and treatment.

10. Her Majesty's Coroner for Mid Kent and Medway District provided a copy of the man's post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist with his enquiries into the man's death.

11. One of the Ombudsman's family liaison officers contacted the man's wife to inform her of the investigation and to invite her to ask any questions or raise any concerns about the care her husband received while in custody. She raised no specific issues, but instead spoke very highly about the care her husband had received.

12. The investigation assesses the following aspects of the man's care and treatment:

    - The diagnosis of his terminal illness
    - Informing him about his condition and treatment
    - Medical appointments and treatment following diagnosis
    - Pain relief and medication
    - Liaison with the family
    - Appropriateness of his location
    - Consideration of release on temporary licence from prison
    - Restraints, security and bed-watch

13. We apologise for the delay in issuing this report and for any additional distress this may have caused. The delay was caused through workload pressures.

[1] Many prisons operate buddy scheme. Buddies can provide emotional support for other prisoners or might provide social support such as collecting meals for prisoners with disabilities.

HMP MAIDSTONE

14. HMP Maidstone was built in 1819. It accommodates up to 600 adult male prisoners, and provides a therapeutic and rehabilitative programme for offenders.

15. The prison's healthcare unit has no in-patient facilities and does not provide 24 hour care. It is staffed from 8.00am to 5.00pm by nursing staff. Day time doctors' surgeries are provided by a local practice of general practitioners (GPs) and an on call locum service supplies out of hours cover.

Her Majesty's Chief Inspector of Prisons

16. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an unannounced follow up inspection of Maidstone in 2009, which noted:

> "Staff at HMP Maidstone deserve considerable credit for what has been achieved since our last visit …
>
> "Health services met the needs of the current population, and the range of primary care services compared well with those available in the community. There was good access to GPs and nurse-led and specialist clinics.
>
> "The buddy scheme had been implemented on all wings … Buddies … had been appointed for several prisoners with mobility problems. One buddy explained … that he routinely collected the meals for a prisoner with severe mobility problems and helped to clean his cell.
>
> "Staff-prisoner relationships had improved since the last inspection. There was a positive atmosphere on all wings, and prisoners went to staff with their concerns. Many prisoners offered [us] unsolicited positive comments about some staff on their wings …"

Independent Monitoring Board

17. Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community to help ensure that standards of decency and care are maintained. Members of the Board have access to every part of the prison and all prisoners held there. In its report for the period March 2009 to February 2010 the IMB at Maidstone wrote:

> "The [healthcare] staffing level is still below full complement and bank staff are often called upon to cover shifts …
>
> "The Board receives few legitimate complaints from prisoners about healthcare provision."

Previous deaths at Maidstone

18. In the three years prior to the man's death, there were four other deaths from natural causes at Maidstone. In three of those cases the clinical reviewer identified evidence of poor record keeping and made appropriate recommendations. Poor record keeping is also a feature of this case.

ISSUES

The diagnosis of the man's terminal illness

19. The man first arrived into prison custody in June 2009. He was 65 years old at that time. His past medical history included two previous operations dating back many years before. One of these was for the partial removal of his thyroid gland. He reported his current health problems as an enlarged prostate gland and stomach ulcers. He otherwise appeared to be a well man. In December 2009, he reported pain on passing urine at a consultation with a prison doctor. The doctor diagnosed a urinary tract infection and prescribed antibiotics. The man was assessed as being suitable to hold medication in his own possession.

20. At a consultation with the same doctor the following month, the man reported similar symptoms. The same diagnosis was made and treatment with antibiotics was again prescribed. During the consultation, he reported feeling well apart from his urinary symptoms and said that he had not lost any weight. Testing of urine showed a raised creatinine level. Creatinine is a waste product made by the muscles. A high creatinine level indicates impaired renal function (that the kidneys may not be working properly).

21. On 4 March 2010, the man consulted a second prison doctor. He again reported urinary problems and on this occasion he was also found to have raised blood pressure. The doctor prescribed medication to deal with the urinary tract infection and the elevated blood pressure. He also ordered a blood test to measure renal function and the following day referred him to outside hospital for a renal ultrasound scan (for examination of the urinary system). A scan was arranged for 12 April but, for reasons that are unclear, the man declined the appointment. He signed a disclaimer for this four days later.

22. The scan was rearranged for 1 June and the report of the procedure showed that the man's bladder wall was distended and a four-centimetre mass was on the bladder wall. The hospital report was noted that the results were passed to the hospital's urology department for urgent discussion.

23. Further examinations, including an examination on 10 June by flexible cystoscopy (a thin flexible telescope passed through the urethra and into the bladder), confirmed cancer of the bladder. A further procedure carried out on 26 July, showed that the cancer had invaded the muscle of the bladder wall. However, further investigations showed that the cancer had not spread to other parts of the body.

24. The clinical reviewer finds that the man's care and treatment during this period was appropriate. She has quoted from a review on delayed diagnosis of cancer carried out by the National Patient Safety Agency (NPSA) which states that: "Whilst greater vigilance is needed, it has been stated that it is important not to routinely over-investigate or make inappropriate referrals."

25. Given the advice from the NPSA, the clinical reviewer considers that treatment with antibiotics was the correct response in the first instance. There was no

visible blood in the man's urine or evidence of red blood cells on urine microscopy that would have prompted an earlier, urgent referral as indicated under NHS guidelines. When the referral was made on 5 March for a renal ultrasound, there was no apparent reason for this to have been made as a two-week rapid access referral.

26. The clinical reviewer is critical of the poor record keeping relating to the man's refusal to attend his first ultrasound appointment on 12 April 2010. She points out that the reason for his non-attendance is not recorded. Nor is there any evidence that staff discussed with him the importance of his attendance. Moreover, he did not sign the medical disclaimer until four days after the missed appointment. The clinical reviewer has made a the following recommendation which we endorse:

    The Head of Healthcare should ensure that staff clearly document instances when a patient declines treatment against medical advice, including the use of disclaimers

Informing the man about his condition and treatment

27. In order to assist in her consideration of the man's care and treatment at HMP Maidstone, the clinical reviewer obtained copies of the records made at outside hospital. These confirmed that discussions took place with him about his diagnosis, treatment and post operative care. These discussions were supported by providing the man with information about his condition and treatment.

28. As mentioned previously, the clinical reviewer is critical of the clinical record keeping at HMP Maidstone. These contained no reference to any advice and psychological support that staff might have offered or provided to the man. During interviews with staff at Maidstone, the clinical reviewer and the investigator were assured that support was offered, although the evidence also indicated that the man was stoical and appeared to cope well with his prognosis. It seems that he maintained a very positive mood even when sometimes feeling unwell following chemotherapy treatment. Accounts from staff regarding this were supported by evidence from the man's friend and official buddy. He spoke very highly of the staff saying that they helped the man as far as they could.

29. A registered mental nurse at Maidstone told the investigation team that he had a number of discussions with the man about his diagnosis and treatment. Some of these would have been in the healthcare unit and others would have been in the man's cell. When asked why these had not been recorded, the nurse spoke about the difficulty of recording all of the conversations he has with prisoners as he walks about the prison each day, especially given the limited healthcare resources at Maidstone. He accepted, however, that he should have made more entries in the man's records about these discussions.

30. The clinical reviewer did not find any evidence to suggest that limited healthcare resources impacted upon the man's care, but it might have been a

factor in record keeping being unsatisfactory at times. Although it appears that the man was well informed of his diagnosis, more information relating to such discussions should have been included in the medical record. The clinical reviewer recommends that:

The Head of Healthcare should ensure that all prisoners suffering a life threatening illness have their healthcare supported through a holistic care plan including a record of discussions about how they are coping with their illness

The man's medical appointments and treatment following diagnosis

31. From the time that the man was diagnosed with a bladder tumour to the date of his final admission to outside hospital, he attended a total of 18 out-patient appointments for investigations, urological follow-ups and chemotherapy. Many of the appointment dates and times were changed. The reasons for these changes were not always noted, but some were for entirely appropriate reasons, such as the need to alter arrangements to accommodate other tests. In the case of chemotherapy appointments, dates were sometimes changed to ensure that he was fit enough to undergo treatment.

32. The man declined to attend a urology appointment on 9 August 2010. The healthcare administrator at HMP Maidstone wrote a file note to explain that the man's wife was visiting him that day and he considered her visit more important than a hospital appointment that he understood was for discussion of the results of his recent surgery. A telephone call was made to the hospital to inform them that he would not be attending and the file note then explained that the appointment had been to show him how to self-insert a catheter to keep his bladder open. The note suggested some displeasure on the part of the hospital staff who insisted that the man had been clearly advised of the reasons for the appointment and added that the hospital was becoming stricter with patients who missed appointments. Due to this, a new appointment for this procedure to be taught would not be issued.

33. The man's clinical records contain no copy of a letter from the hospital to the prison to explain the purpose of the appointment scheduled for 9 August. Nor is there any record of a discussion between healthcare staff and the man about the importance of the appointment. The clinical reviewer discussed this issue with the registered mental nurse. He explained that, depending on the purpose of an outpatient appointment, a member of the nursing staff would spend time with the prisoner discussing the importance of the appointment. It seems clear that this must have occurred ahead of the majority of his appointments as the evidence shows that the man was compliant with the need to fast and/or drink specified amounts of fluid in advance of appointments. The nurse did not think that it was the administrator who telephoned the hospital to cancel the man's appointment; he thought instead that it was more likely that it was one of the nurses who did so.

34. It is not clear whether it was a nurse who made the telephone call. Whether or not this was the case, the clinical reviewer considered that better practice would

have been for a nurse to make the telephone call and to act as the man's advocate in attempting to re-arrange the appointment for an alternative date. One might also expect a nurse to attempt to dissuade the man from cancelling the appointment and to have written a note documenting such a discussion. In the case that he had been insistent on cancelling the appointment contrary to clinical advice; again that should have been documented. Taking into account this episode, along with the appointment that he declined to attend in the previous April, the clinical reviewer makes a number of recommendations in her review. These are not all repeated here as they are covered by the recommendation made in paragraph 26.

35. The clinical reviewer explored at interview the procedure undertaken at Maidstone when prisoners return to prison following treatment at outside hospital. The registered mental nurse said that once returning prisoners have been taken through the standard reception process, they are then brought to the healthcare unit. The healthcare staff will check any medication that has been prescribed at hospital to ensure the prisoner is safe to keep it in their own possession. The staff will also collect from the prisoner any discharge letter and letters about further outpatient appointments.

36. The man's clinical condition following return from hospital was not always clear from his healthcare records. The clinical reviewer highlights in particular that there was little written evidence of the psychological support provided. A recommendation is made earlier in the report regarding record keeping but the clinical reviewer makes a specific recommendation regarding prisoners returning from hospital:

    The Head of Healthcare should ensure that all prisoners returning from hospital following treatment have an entry made in their records to denote care given in hospital, their condition on return, medication given on discharge and whether this has remained in the prisoner's possession

37. Despite the absence of an in-patient facility at Maidstone, the clinical reviewer considers that the man received appropriate care and support from prison healthcare staff who were mindful of his dignity and personal preferences.

38. Although recommendations regarding specific instances of record keeping have previously been made, the clinical reviewer is so concerned about the general quality and comprehensiveness of the man's medical record, a broader recommendation is included below:

    The Head of Healthcare should ensure that healthcare staff document in full contact with patients in accordance with the record keeping standards required by their professional bodies

The man's pain relief and medication

39. The man appeared to be a reasonably fit and well man at the time of his arrival into prison custody in June 2009. He had minimal contact with healthcare staff during his first six months in prison but then suffered a number of urinary tract infections from December 2009. Doctors prescribed antibiotics to treat the infection and prescribed analgesics for pain relief. He was permitted to keep his medication in his own possession having previously been assessed as suitable to do so. There is no evidence that pain was an ongoing issue for him.

40. At the end of July 2010, the man was admitted to outside hospital where he underwent a resection of his bladder tumour to determine the extent to which it had spread. At the operation it was found that the tumour had invaded the muscle wall. He was returned to Maidstone with co-codamol tablets (an analgesic for mild to moderate pain). He was again allowed to keep the medication in his own possession.

41. Once the extent of the spread of the man's bladder cancer was determined, clinicians discussed with him his treatment options. It was agreed that he would undergo bladder surgery following a course of chemotherapy to shrink the tumour. His cycle of chemotherapy ran from the middle of September through to early November. He experienced the usual symptoms associated with chemotherapy treatment. He had previously been made aware of the symptoms he might experience and appropriate medication was prescribed to deal with these symptoms, including those of nausea and vomiting.

Liaison with the man's family

42. Throughout his time in Maidstone, the man received regular visits from his wife. She continued to visit him after he was transferred to hospital in December 2010. The records indicate that hospital staff involved the man's wife in the discussions about his treatment. He underwent an operation on 13 December, following which his immediate post-operative recovery was good. Unfortunately, he began to develop wound problems and other complications. On 21 December, he was moved to the hospital's intensive treatment unit (ITU) and provided with oxygen therapy and a ventilator.

43. A note in the man's prison healthcare records made in the late morning of 8 January 2011 indicated that he was showing signs of improvement. He remained in the ITU but was no longer receiving artificial ventilation. His condition deteriorated suddenly that afternoon. It seemed at first that a further operation might be attempted, but a little later the prison was advised that, following multi-professional discussion and discussion with the family, all active treatment had been withdrawn.

44. A senior officer was appointed to act as the prison's family liaison officer (FLO) in this man's case. When he was informed that the hospital had withdrawn active treatment he went to the hospital that afternoon to meet the man's wife and one of his sons. He introduced himself and explained his role.

45. On 10 January, a nurse indicated to one of the escorting officers (the bed-watch officer) that the man probably had less than 24 hours to live. The family had also been informed of this news by hospital staff. The man's wife and daughter arrived at the hospital around midday. Although his wife left later that afternoon, his daughter remained at his bedside and his other son arrived later. The bed-watch log shows that the officer periodically checked with the family whether they wanted his support or whether they preferred to be alone with their father. To be left alone was always their choice.

46. The man's daughter and son remained at the hospital through the night and were joined by their mother and other son early the following morning. All of the man's immediate family were with him when he died at just after midday on a day in January. The bed-watch officer told the family that they could sit with him as long as they wished.

47. The prison FLO was not on duty that day, but he telephoned the man's wife the following day to offer his condolences. He arranged to visit her at her home a few days later to return her husband's belongings. She accepted an invitation to attend a memorial service at the prison. The prison FLO informed her that the prison would make a reasonable contribution towards the funeral costs.

48. Staff contact with the man's family following his death was compassionate and appropriate.

The man's location

49. HMP Maidstone does not have an in-patient facility. If a prisoner requires in-patient care he will be transferred to outside hospital if his condition warrants that. Otherwise he could be transferred to one of the nearby prisons with in-patient facilities.

50. At interview with the clinical reviewer, the registered mental nurse said that, before the commencement of the man's cancer treatment, staff discussed the possibility of a possible transfer to a prison with in-patient facilities. The man was included in these discussions. Healthcare staff at Maidstone believed they were able to manage him and he also made it clear that he wanted to remain in Maidstone. The nurse believed that this was due to the support the man received from the staff and his friends in the prison.

51. A reception officer told the investigators that he met the man when he first arrived in Maidstone. The officer later transferred to Medway wing where the man was located so they had daily contact from that time. The officer said that Medway was a small wing so it is possible to gain reasonably intimate knowledge of the prisoners while carrying out an officer's general duties. When the man became unwell, the officer went with him to outside hospital on more than one occasion and also spent time speaking with him in the evenings. He described the man as a positive person and he remained that way even after his diagnosis and treatment. He said that the man remained mobile throughout his time in Maidstone, although he usually remained in his cell as his symptoms meant that he needed to use the toilet frequently. The officer said that, had he

been concerned at any time that he was in need of moving to a prison with an in-patient facility, he would have spoken to the healthcare team about that.

52. The man's friend confirmed that the man felt well supported by the staff at Maidstone. When he started to deteriorate, staff had wanted to move him from the second floor down to the ground floor as that would make it easier for him to collect his food. However, the man told staff that he wanted to remain on the second floor and his friend said that he would take responsibility for collecting his food.

53. The man went to hospital on 10 December 2010 to receive a blood transfusion ahead of a planned operation for removal of his bladder and prostate. Unfortunately his condition deteriorated after this and he remained in outside hospital until his death one month later.

54. Despite the lack of an in-patient facility at HMP Maidstone, it does seem that the prison was able to provide an acceptable level of care to the man until his final move to outside hospital. It was the man's wish to remain in Maidstone if possible, in preference to moving to a prison with an in-patient facility.

Consideration for compassionate release or release on temporary licence

55. On 3 December, the man underwent a cystoprostatectomy (surgical removal of the bladder and prostate gland). His immediate post-operative recovery was good, but he then began to develop complications, including a serious wound infection (MRSA – methicillin resistant staphylococcus aureus). He remained in hospital and was treated for his various complications. His condition continued to deteriorate and on 23 December he was moved to the hospital's intensive treatment unit. At this point the prison began to consider the possibility of granting release on temporary licence (ROTL) on compassionate grounds.

56. ROTL is a temporary release from custody that can be granted in a number of different circumstances. One circumstance is to allow a prisoner to remain in hospital for essential treatment. The benefit of ROTL to the prisoner is that security conditions can be reduced allowing him to spend more time in private with his family. Before ROTL can be granted, assessments must be made of the potential risk to the public of approving the application. Having considered various risk implications, the decision was made that the man should be granted ROTL from 29 December to 4 January 2011. (Further decisions were made extending his time on ROTL, and this continued until his death in January.) At the point ROTL was granted, the decision was made that only one bed-watch officer would need to remain at the hospital. The decision to grant ROTL was appropriate, given the man's condition.

Restraints, security and bed-watch

57. The Prison Service has a duty to protect the public when prisoners are in public places, such as hospitals. To help achieve this restraints and escort staff are routinely used when prisoners are taken out of the prison for any reason. Individual risk assessments are completed on each occasion. The

assessments consider the offences involved, the risk of further offending and the prisoner's health and mobility. Regular management checks are made on prisoners admitted to outside hospitals to ensure that the security arrangements in place are appropriate taking into account their condition at the time.

58. When the man was taken to hospital for outpatient appointments, he was accompanied by two escorting officers and restraints (handcuffs) were used. This was appropriate to the circumstances.

59. The final time that the man was to taken to hospital was on 10 December 2010. He was due to have an operation on 13 December but was admitted to hospital early as he was found in need of a blood transfusion ahead of his surgery. He was again identified as requiring two escorting officers who would use single cuffs or an escort chain. (Single cuffs are used to cuff one arm to an escorting officer. An escort chain is 1.8 metres in length cuffing the prisoner by wrist to one of the escorting officers. The length of the chain allows greater access for treatment by hospital staff as well as greater comfort for the prisoner.) These arrangements were again appropriate.

60. When the man's condition deteriorated on 23 December, the restraints were taken off and one of the escorting officers was removed. (This coincided with the decision to grant ROTL). This, again, was the appropriate decision given the severity of the man's condition.

Other issues

61. While the man was at HMP Lewes he was identified as requiring a Hepatitis B vaccination. (Hepatitis B is a viral infection of the liver. An aim within preventative medicine is vaccination against this infection and this is delivered through a course of three injections given at intervals.) The man received the first two injections at HMP Lewes, but before his final (booster) injection was due he had already been transferred to Maidstone. The clinical reviewer finds no evidence that Maidstone completed the vaccination course by providing the final injection.

    The Head of Healthcare should ensure that procedures for delivery of Hepatitis B vaccinations are robust. Full vaccination should be provided to all eligible and consenting prisoners

62. During his interview with the investigator and the clinical reviewer, the man's friend and buddy reported that he continued to grieve following his friend's death. He received some support following his death but he considered that he needed more. The following recommendation is made:

    The Governor should ensure that appropriate support is available to prisoners following a death in custody. Special consideration should apply to prisoners who have acted as buddy, or were close friends, with the deceased prisoner

CONCLUSION

63. Following complaints from the man about recurring urinary tract infections from late 2009 to early 2010, a prison doctor referred him to outside hospital for a renal ultrasound scan. The referral was in line with NHS guidelines for patients suffering persistent urinary symptoms. Investigations revealed presence of a growth on the bladder that proved to be cancerous.

64. The man was treated at outside hospital with chemotherapy and extensive surgery. Unfortunately, he deteriorated and he was moved to the hospital ITU where he died on a day in January 2011. His family were kept aware of his condition at all times and, when it became apparent that his death was approaching, prison staff made every effort to respect their wishes to remain with him in privacy.

65. The clinical reviewer finds no serious failings with the quality of healthcare provided at Maidstone but is concerned by the quality of record keeping. This performs a vital purpose as up to date and accurate knowledge of a prisoner is essential to providing appropriate care. Given this has become a recurring theme during investigations at Maidstone, it is hoped that this matter is addressed as a matter of urgency.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Head of Healthcare should ensure that staff clearly document instances when a patient declines treatment against medical advice, including the use of disclaimers.

   Response: recommendation accepted and already implemented via staff briefing and instructions on this topic. Date completed: 31 December 2011.

2. The Head of Healthcare should ensure that all prisoners suffering a life threatening illness have their healthcare supported through a holistic care plan including a record of discussions about how they are coping with their illness.

   Response: recommendation accepted and already implemented via staff briefing and instructions on this topic. All relevant conversations are now recorded on SystmOne database under the heading of "healthcare" or "social care" as appropriate. Date completed: 31 December 2011.

3. The Head of Healthcare should ensure that all prisoners returning from hospital following treatment have an entry made in their records to denote care given in hospital, their condition on return, medication given on discharge and whether this has remained in the prisoner's possession.

   Response: recommendation accepted and already implemented via reminder to discipline staff to liaise with healthcare on return from escort immediately. Improved healthcare staffing levels as 2012 progresses mean that the risk of lack of a thorough handover of hospital discharge information between escort and healthcare staff is now diminishing. Date completed: 31 December 2011.

4. The Head of Healthcare should ensure that healthcare staff document in full contact with patients in accordance with the record keeping standards required by their professional bodies.

   Response: recommendation accepted. Initial induction and refresher training packages for all healthcare staff will emphasise the importance of adhering to correct professional standards. Target for completion: 31 March 2012.

5. The Head of Healthcare should ensure that procedures for delivery of Hepatitis B vaccinations are robust. Full vaccination should be provided to all eligible and consenting prisoners.

   Response: recommendation accepted. An improved healthcare administrative system for oversight and action based on induction health screening information, including Hep B status, is being implemented. Target for completion: 31 March 2012.

6. The Governor should ensure that appropriate support is available to prisoners following a death in custody. Special consideration should apply to prisoners who have acted as buddy, or were close friends, with the deceased prisoner.

Response: recommendation accepted. This recommendation will be written into HMP Maidstone's Death In Custody Contingency Planning Action Sheets. Target for completion: 30 April 2012.

RESPONSE TO DRAFT REPORT FROM THE MAN'S FAMILY

In response to the draft report, the man's wife provided some comments:

> She referred to comments made by staff during interview in reference to her husband having lost all of his hair. She asked that it be noted that her husband was not bald, although his hair was thinning.
>
> The man's wife referred to mention in the report about her husband having missed a hospital appointment on 12 April 2010 for an unknown reason. His wife explained that she was visiting her husband that day and because details of appointments are only divulged on the morning, it would have been impossible for her husband to notify her while she was on her way to the prison. She visited on a weekly basis and their time together was very important to them both. He did not want to miss the visit, so he declined the hospital appointment.
>
> The man's wife concluded by explaining that she was satisfied with the care her husband had received.'