PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 10 July 2013, while in the custody of HMP Maidstone

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who died on 10 July 2013, at a local hospital after he had been found hanging in his cell at HMP Maidstone earlier that day. He was 58 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by a senior investigator. A doctor reviewed the clinical care the man received in prison. HMP Maidstone cooperated fully with the investigation.

The man had a history of self-harm which began shortly after his imprisonment in October 2002. Many of these acts were linked to concerns about the provision of kosher and gluten-free food. He sometimes refused to eat in protest about his diet and threatened to kill himself. In 2006, the man had been diagnosed with gluten intolerance. The prison provided him with kosher, gluten-free meals, but the healthcare department was unwilling to prescribe additional gluten-free food products unless he took a blood test to confirm his intolerance. The man refused to do so, on principle, as he believed this had already been established. He also insisted on being provided with one specific meal repeatedly. During a period of suicide and self-harm monitoring in June and July 2013, he started to refuse food, although it is not clear that he stopped eating entirely.

The clinical reviewer concludes that the care the man received was not of an equivalent standard to that he could have expected in the community as the healthcare department at Maidstone failed to recognise his need for a fully gluten-free diet had already been established. The investigation has also identified a number of weaknesses in the prison's management of the man's risk of suicide and self-harm, including not dealing with his food refusal in accordance with national Department of Health guidelines.

The 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 **March 2014**

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SUMMARY

1. The man died on 10 July 2013, at a local hospital after he had been found hanging in his cell at Maidstone prison that morning. He was 58 years old. The man had been in prison since 14 October 2002.

2. The man had a history of self-harm before he arrived at Maidstone on 17 April 2013, including two serious attempts to hang himself. On 22 April, Maidstone wing staff started suicide and self-harm monitoring and support after the man said he felt like killing himself as he had not received his game console after he had transferred. The monitoring remained in place until his death.

3. A gastroenterologist had diagnosed the man with gluten intolerance in 2006 and the man often harmed himself, threatened self-harm or refused food when he was considered that his dietary needs were not being met. At Maidstone, a prison doctor told him that he would have to be tested confirm his gluten intolerance and any other underlying conditions before he would be eligible for gluten-free foods. The man refused to take the tests as he had been previously diagnosed as gluten intolerant and had been receiving gluten-free food at previous prisons. The catering department continued to give him special kosher and gluten-free meals, but he was not able to get additional gluten-free food items unless they were prescribed. The man was unhappy with the choice of meals and usually insisted on one specific meal. He often complained that his meals were not gluten-free, although this was not the case.

4. On 11 June, the man informed staff that he was going on hunger strike as he was not receiving the correct meals. The level of suicide and self-harm observations remained unchanged. The man continued to receive kosher, gluten-free meals but he was unhappy about the meals and the requirement to be tested for gluten intolerance before he could get additional gluten-free food. He repeatedly told staff that he was on hunger strike because of this and complained to the prison's Independent Monitoring Board. The man's solicitors also made representations on his behalf. On 6 July, his brother was worried about his wellbeing when he visited him and spoke to a prison manager about his concerns. The manager arranged a doctor's appointment because the man said he was refusing to eat. A prison doctor examined him on 8 July and advised him against continuing not to eat.

5. At 7.23am on 10 July, the man was discovered hanging from the window bars in his cell. Prison staff quickly called an ambulance and attempted to resuscitate him. Paramedics arrived around ten minutes later and subsequently took the man to hospital where he died later that evening. The man had left a note explaining that the reasons for his actions were the mishandling of his dietary needs and food refusal.

6. The clinical reviewer considered that the standard of care given to the man was not equivalent to that he could have expected to receive in the community as he should have been prescribed a fully gluten-free diet. Doctors at Maidstone had mistakenly interpreted the man's blood test results for gluten intolerance. However, further tests should not have been required as a gastroenterologist

had already established the man's need for gluten-free food. Prison staff did not follow the national guidelines for the management of food refusal and those responsible for managing his risk of self-harm did not hold multi-disciplinary case reviews or discuss the man's care with healthcare staff.

7. We are satisfied that when the man was found hanging, staff responded quickly, but the healthcare assistant who initially led the resuscitation attempts lacked confidence and was not well prepared or trained to deal with an emergency leading to some delay in the administration of oxygen.

THE INVESTIGATION PROCESS

8. The investigator issued notices at HMP Maidstone informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No one responded.

9. NHS England commissioned a doctor to review the man's clinical care in prison and court custody.

10. The investigator visited Maidstone on 15 July. He met the Governor and spoke to staff involved in the man's care. The investigator obtained copies of the man's relevant prison and medical records. He interviewed staff and prisoners at Maidstone on 13 August and 9, 18 and 20 September. He gave initial feedback to the Head of Safer Custody at the prison and followed this up in writing to Maidstone prison. At the draft report stage the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations

11. HM Coroner for Mid Kent and Medway was informed of the investigation and provided the results of the post-mortem examination. A copy of this report has been sent to the Coroner.

12. One of the Ombudsman's family liaison officers, contacted the man's family to explain the purpose of the investigation and invite them to raise matters they wished the investigation to consider. Their solicitors replied on their behalf and asked:

    - Whether the prison had accommodated the man's dietary requirements and whether he had received a gluten-free diet?
    - Whether he had been prescribed medication for migraines?
    - What steps had been taken in relation to his hunger strike?
    - What action had been taken to monitor the man's risk of suicide and self-harm; and
    - The action taken by prison staff after the man's act of self-harm was discovered.

    The man's family received a copy of the draft report. The solicitor representing the man's family wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP MAIDSTONE

13. HMP Maidstone can hold up to 600 men and accommodates mainly foreign national prisoners. With the exception of 38 cells, all accommodation is single cells.

14. 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.

HM Inspectorate of Prisons

15. The last inspection of Maidstone took place in September 2011. Inspectors found that low healthcare staffing levels impacted on their ability to be involved in wider prison meetings. The range of primary care services was appropriate, with short waiting times to see a GP and prisoners told inspectors that healthcare staff were polite and respectful. Effective screening in reception identified needs quickly and appropriate referrals were then made. Prisoners with chronic diseases were managed individually as there were no formal clinics. Inspectors were fairly positive about the suicide and self-harm provision but felt that residential and health services staff should be represented at suicide and self-harm monitoring case reviews. Inspectors were impressed with the catering facilities, prisoners were positive about the food and consultation arrangements were good.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In their latest published report, for the period ending February 2013**,** the IMB considered that there were no major shortcomings in healthcare provision and that it compared favourably with that provided in the community. They also noted that members of the Board who attended suicide and self-harm case reviews, were satisfied with the constructive and sympathetic attitude of staff.

Previous deaths at Maidstone

17. The last prisoner to take their own life at Maidstone was in 2008. One of the recommendations made following the death was about better liaison between discipline and healthcare staff.

Assessment, Care in Custody and Teamwork (ACCT)

18. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to

determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner.

KEY EVENTS

19. The man was born in 1955. He was remanded into custody at HMP Pentonville on 14 October 2002, charged with murder and was convicted on 3 July 2003 and sentenced to life imprisonment. He then spent time in several other prisons. The man was born in Israel and was thought to be a foreign national, but it subsequently came to light that he held dual nationality and was a British citizen.

20. On several occasions in prison, the man made threats or attempts to take his life and was monitored under suicide and self-harm prevention procedures. This was usually in response to grievances about prison issues, including his diet and the provision of kosher and gluten-free food. He also sometimes refused to eat as a protest about his diet. In 2004, the man tried to hang himself and said this because his dietary and religious needs were not being met. He also suffered from chronic insomnia, which caused him distress.

21. On 16 November 2007, the man transferred to HMP Gartree. At his first health screen interview, it was recorded that he was intolerant of wheat and was on a gluten-free diet. On 19 November, a prison doctor at Gartree, noted that a gastroenterologist had diagnosed a wheat intolerance in 2006 and had recommended that the man be placed on a wheat-free diet. The man was unhappy about the meals supplied and started to refuse food in December 2007. This was resolved, but he again refused food and said he had thoughts of self-harm for several days in October 2008, when he was not satisfied with the choice of meals.

22. The man was monitored under the Assessment, Care in Custody and Teamwork (ACCT) procedures from 23 April to 30 June 2009, as he suffered from insomnia and was distressed about the difficulties he had working while he was tired. On 6 May 2009, during this period of monitoring, he attempted to hang himself from the landing bars but was saved by another prisoner who supported his weight until staff were able to cut him down. He explained that he had tried to kill himself because of his difficulties with insomnia, migraines and maintaining a kosher, gluten-free diet. The man maintained that the rules and regulations of the Prison Service were unfair and said that he might take further actions to end his life if he was treated unfairly again in the future. Healthcare staff did not consider him to be mentally ill.

23. The man continued to raise problems about his diet and his insomnia and migraines continued. In 2010, he was monitored again as a risk of suicide and self-harm when he repeatedly threatened to kill himself. In August and September 2012, he again refused food owing to what he considered were continuing problems with his meals.

24. On 18 March 2013, the man had a gastroscopy at a local hospital. The result of this and biopsies taken that day indicated that his stomach and duodenum (small intestine) appeared to be normal and there was no evidence of significant inflammation or infection. At that time, the man was receiving gluten-free food.

25. The man transferred to HMP Maidstone on 17 April. There is no reference to his food intolerances or diet in the notes of his initial health screen but his

medical records show that on 19 April, a number of gluten-free products were prescribed. On 20 April, it was recorded in the wing observation book that, as the man had a number of non-kosher food items in his property from Gartree, staff should be aware that he might have non-kosher food in his cell.

26. On 22 April, the man told a prison doctor, Dr A, that he thought he was wheat intolerant but had been told at his previous prison that it was coeliac disease (a digestive condition in which a person has an adverse reaction to gluten). Dr A recorded "no investigations performed" and planned to investigate and review the man. He told him that he would request tests to see if he had coeliac disease, was gluten intolerant, or had any other allergies. His weight was recorded as 52.8kgs. When interviewed, Dr A said that, although the man claimed he to have coeliac disease, no tests had been conducted and the result of an endoscopy, in March 2013, suggested that he did not have the disease.

27. That afternoon, the man began to be monitored under suicide and self-harm prevention procedures after he told staff that he felt like killing himself. This was because, after his transfer from Gartree, he had not yet received his Playstation which he used to keep himself distracted. Staff were required to observe him at half-hourly intervals.

28. At his ACCT assessment interview on 23 April, it was recorded that the man suffered from insomnia and relied on his Playstation to keep himself occupied. He also had a lot of migraine pains and negative thoughts. He had received his Playstation that day but said he had been unable to use it as he had not slept well. The man said he had suicidal thoughts all the time but they were not strong enough to become "realistic" and, "if he wanted to be dead he would be dead already".

29. The man refused to attend his first ACCT case review on 23 April. A custodial manager went to see him in his cell and found him in bed. In the case review summary, the custodial manager recorded that he had tried his best to engage him in conversation but he refused. Nevertheless, the man had stated that he had no thoughts of suicide or self-harm. Both the initial assessment of risk of self-harm and the likelihood of further risk behaviours were recorded as low. Healthcare staff did not attend this or any of the man's subsequent case reviews.

30. A second case review was held on 26 April, at which it was recorded that the man was given advice on a number of issues, including information on the kitchen and food and accessing healthcare. He said that he knew staff were happy to help him and that he should speak to them if his mood lowered. Staff were expected to have two quality conversations with him each day and observe him five times during the day and three times at night between midnight and 7.00am.

31. A caremap completed on 26 April, after his second case review, recorded that the man had problems with insomnia, work and about receiving a gluten-free diet. He was advised that once he had completed his induction he could apply

for work and he was advised to speak to a member of healthcare about his gluten-free diet.

32. On 2 May, it was recorded the man had refused to have a blood test as he was unhappy with the prison doctor.

33. A third case review was held on 3 May, in which the man was said to be happier than at his last review and that he appreciated the work staff had done for him. His level of observations was reviewed and reduced to two quality observations each day and two observations between the time he was locked in his cell for the night and midnight. The rationale for not having checks after midnight was not given.

34. The man failed to attend blood test appointments on 14 and 15 May. A fourth case review was held on 15 May, it was recorded that the man said he wanted a toaster, as he had one when he was at Gartree. He also said that his Playstation "maintains his stability". His level of observations was reviewed and reduced to one quality observations per day and two observations between when he was locked in his cell for the night and midnight.

35. Further case reviews were held in May and June. A fifth case review was held on 27 May, it was recorded that the man now understood that he could not have his toaster due to electrical limitations and that he was also now going to apply for work. On 6 June, the man reported that he was having trouble sleeping and felt a little stressed.

36. On 11 June, the man told wing staff that his gluten-free meals had been replaced with normal kosher meals and that he was on a hunger strike, although he continued to collect his meals. At a case review on 12 June, he said his diet had been changed and this was making him more depressed. He was due to see a doctor about this the next day. The summary of the review indicated that he had implied that he might start a hunger strike if the problem was not resolved. His level of observations remained unchanged.

37. On 13 June, the man told Dr B, another prison doctor, that he had been on a gluten-free diet for over ten years but had not been allowed this at Maidstone. As a result, he had been on hunger strike since 10 June. Dr B prescribed gluten-free pasta. Dr B also prescribed pizotifen for migraine. Dr B told the investigator that at this consultation, the man had shown him a letter from specialists in Cardiff which had confirmed a folic acid and vitamin B12 deficiency. The doctor did not take a copy of the letter but asked whether the man would allow a copy to be made. This discussion was not recorded in the medical records and the letter was not found among the papers in the man's cell after his death.

38. The same day, wing staff spoke to the catering manager about the man's food. The catering manager said he provided gluten-free kosher meals as required but the man's preferred to have the same meal everyday, poached chicken, which was a specially purchased meal.

39. The catering manager told the investigator that shortly after the man arrived at Maidstone, he had met him to discuss his dietary requirements and that all his meals had been gluten-free and kosher. He had contacted the company that supplied the kosher meals, which confirmed that they did not use gluten and had suggested suitable menus for the man. The catering manager had ordered 120 of the poached chicken meals at a cost of over £1200. As this meal was more expensive than others, he also ordered other meals from the kosher, gluten-free menu. The catering department kept records of the meals given to the man each day, all of which were kosher and gluten-free.

40. During the afternoon of 18 June, staff recorded in the wing observation book that the man had written to say that he was starting a hunger strike and that he was not going to comply with a request to have blood tests completed.

41. At an ACCT case review on 19 June, the man continued to complain about his meals. He said that as a matter of principle, he refused to have a test to confirm he required gluten-free meals and he would continue refusing food until the healthcare department resolved the situation. Staff were instructed to monitor his food intake.

42. On 21 June, after a consultation with the man, Dr B recorded that he was still on hunger strike but there was no evidence to substantiate this.

43. The healthcare department kept a food refusal log for prisoners who were refusing food. The first entries relating to the man were made between 25 and 29 June. Nothing was recorded about him from 30 June to 4 July, but there were further entries between 5 and 9 July. Most indicated that he had refused meals but some stated that he had collected his canteen (items, including food, bought from the prison shop.)

44. At an ACCT case review on 26 June, the man was described as being in a belligerent mood about his food and said that he would not eat until the issues relating to his diet were resolved. Staff encouraged him to eat. The man's level of risk was assessed as remaining low. The level of observations continued to be one quality observation each day and two random observations between being locked in his cell for the night and midnight.

45. On 26 June, an entry in the healthcare food refusal log indicated that he was not collecting his meals but wing staff believed he had "canteen" in his cell. Subsequent entries in the log stated that the man had refused his meals.

46. On 28 June, a nurse manager responded to a letter received from the man's solicitors on 14 June, querying why he was no longer receiving gluten-free kosher food. The nurse manager explained that the man was receiving kosher, gluten-free meals and that, in spite of his reported food refusal, he continued to collect his food and there was no indication that he was on a hunger strike. The nurse manager added there was no evidence that the man was gluten intolerant and as he had refused to undertake tests to confirm this, the prison was unable to prescribe additional gluten-free food products.

47. It was recorded in the food refusal log, on 29 June that the man had refused his meals but had collected his canteen.

48. The man refused to attend his (eleventh) ACCT case review on 4 July. He told a supervising officer that he was tired and that his issues were with healthcare. He said that he had decided to refuse to eat but the supervising officer recorded that a prisoner had told staff that he had observed the man eating and drinking.

49. During the morning of 5 July, a custodial manager persuaded the man to attend a case review that day. The man continued to complain about his diet. He said he was not eating and that after his family visited at the weekend he would stop taking fluids but he had no thoughts of suicide or self-harm. His level of risk remained assessed as low and no change was made to his level of observations. The man's next review was scheduled for 12 July.

50. When interviewed, the custodial manager said that the frequency of observations and case reviews were not revised as the man had told him that his hunger strike was not about him dying but was a protest about his diet. He said that the man had presented as rational and spoke frankly and information from the wing had suggested that he was eating and drinking. After the case review the custodial manager spoke to the nurse manager about monitoring the man's food intake.

51. The same day, an entry was made in the wing observation book instructing staff to complete the food refusal book in the healthcare department daily. It was also noted that, "The man continues to state he is not eating. Please monitor the man to see if he is eating and drinking". The man refused his meals that day but collected his canteen.

52. At around 2.00pm on 6 July, the man wrote to the healthcare department to say that he was aware they had received his solicitor's letter stating that he did not wish to be fed intravenously or resuscitated and that he intended to stop taking fluids from 7 July. The nurse manager responded later that day, to say he would arrange a consultation to confirm that he had the capacity to make this decision. There is no indication that this took place, but the medical records show that the man was due to attend an appointment with a psychiatrist on 10 July, the morning of his death.

53. During a family visit on the afternoon of 6 July, the man's brother spoke to an operational manager, Ms D. He was concerned that the man had told his family that he had not eaten anything since 13 June and that he was surviving on coffee and sugar. The man had said that he was not happy with the way he was being managed and felt very aggrieved that he was not receiving kosher, gluten-free meals. The man's brother said that he had been given gluten-free meals at previous prisons and he did not understand why this had not been the same at Maidstone.

54. Ms D was unaware that the man had been receiving gluten-free meals and explained that in order for the healthcare department to provide them, he would

have to follow the usual Prison Service procedures and be tested to confirm his eligibility. She could not make an exception for him. His family was aware that he had refused the test. They were concerned that the prison's actions were to save money and that he was being ignored because he was shortly due to transfer to another prison. Ms D said that this was not the case and that the prison would treat everyone the same regardless of their length of stay. She also explained the support mechanisms available to the man.

55. Immediately after the meeting, Ms D spoke to Nurse E about the procedures for food refusal. Nurse E told her that each day that a prisoner refuses food, a member of wing staff should complete the food refusal log held in the healthcare department. After three entries in the log, the prisoner is referred to the doctor. If it is verified that they are not eating, they are monitored and referred to the mental health team if the food refusal continues.

56. Ms D examined the log entries (by then, there had been six relating to the man) and asked Nurse E to book a doctor's appointment. Although the man had said that his refusal had started mid-June, the first entry had been recorded on 25 June. It is not clear if this was due to an oversight by wing staff or because the man's food refusal had been sporadic. Ms D did not speak to the man after her meeting with his family but she said that she ensured that wing staff were aware of the man's family's concerns about him and that the process for food refusal was being followed.

57. Later that afternoon, healthcare staff received a written request from the man asking them to confirm that they had received a letter from his solicitor letter advising that he should not be fed intravenously. The nurse manager replied that he would arrange to meet him to discuss the letter once he received it.

58. The man applied to see a member of the IMB on 7 July. On the application form, he stated that he had been refusing food since 10 June but officers and healthcare staff had ignored this. He said he was going to stop taking fluids as well, as he had been pushed to his limits. An IMB member spoke to him the next day and recorded, "No resolution as blood test would confirm diet requirements".

59. On 8 July, the man told Dr B that he had been on hunger strike from 7 July onwards but was taking fluids. Dr B advised him not to continue refusing food and recorded that the man was aware of the implications of his actions. His weight was 49.9kgs. When interviewed, two of the man's friends said they both informed staff in the days leading up to his death that they were concerned about him and the possibility of self-harm. There was no record of these conversations in the man's prison records and when interviewed staff said they had not been warned or approached by prisoners with concerns about him.

60. The next day, the man was asked to go to healthcare for his weight and blood pressure to be checked in view of his continuing food refusal, but he refused to do so. An entry in the wing observation book instructed the cleaning officer to make a daily entry in the healthcare log book when the man did not collect his

meal. Another entry said: "The man came to the office this evening saying that the kitchen have sent the wrong meal again and he states he is on hunger strike until this is sorted out".

61. An operational support grade (OSG)[1] was on night duty on 9 July. He noted in the suicide and self-harm observation record that the man was lying in bed at 8.10pm and 11.05pm. On the first occasion, he was watching television and the second time, he was writing. The OSG had no further dealings with the man as no observations were required after midnight.

62. At around 7.10am on 10 July, Officer F arrived to conduct a roll check to ensure that all prisoners are accounted for. She arrived at the man's cell at approximately 7.23am and discovered him hanging from the window bars by a bed sheet. She shouted to the OSG to come to the cell and used his radio to call the control room to inform them of a code blue emergency (code blue is where someone is unconscious or not breathing). As the OSG appeared to be in a state of shock, she sent him to the office area of the wing to direct staff to the man's cell. Officer F then opened the cell door and asked for the OSG's anti-ligature knife but she was unable to cut the man down as to the sheet was tied too high for her to reach and she would not have been able to bear the man's weight by herself.

63. The Head of Security and Operations and a custodial manager then arrived. The Head of Security and Operations and Officer F lifted the man while the custodial manager cut the sheet. Together, they placed the man on his bed and started cardiopulmonary resuscitation (CPR). A healthcare assistant responded to the code blue call and went to the man's cell taking an oxygen cylinder with her. When she got there she said that in the panic she had been unable to open the cylinder, so she put it to one side and used a bag-valve mask to administer air instead. Officer F brought a defibrillator from the wing staff room but it was not used.

64. Paramedics arrived quickly at 7.34am and took over the man's care including using the oxygen cylinder the healthcare assistant had brought. They then left the prison at 8.56am to take him to the local hospital. Two prison staff remained with him.

65. The prison appointed a family liaison officer. He contacted the man's brother just after 9.00am, to inform him that he had been admitted to hospital and agreed to meet him there.

66. The man arrived at the Accident and Emergency Department at around 9.05am. He was moved to the Intensive Trauma Unit at around 10.30am and place on a life support machine. This was removed at 8.50pm and the man's death was pronounced at 9.11pm. The man's family were at his bedside when he died.

[1] An Operational Support Grade (OSG) is a basic grade member of staff who will not have received the same level of training as a prison officer and he/she will have much less interaction with prisoners.

67. While staff were removing the man's clothing they discovered a note addressed to the Coroner and Police. He had written in some detail about the reasons for his actions. The man felt that the prison had failed in their duty of care towards him in their handling of his dietary requirements and his food refusal. He said that healthcare staff had told him that wing staff had not informed them when he had started his food refusal but wing staff had denied this.

68. Notices were issued to staff and prisoners informing them of the man's death. Prisoners subject to suicide and self-harm monitoring were reviewed in case they had been affected by the man's death.

69. A debrief was held later that day for the staff involved in the emergency and they were offered the support of the prison's care team. No issues were identified in relation to the handling of the resuscitation attempts.

70. The prison's family liaison officer maintained contact with the man's family and offered support. He made arrangements for them to visit the prison and returned his belongings. In line with national policy, the prison offered financial assistance towards the cost of the man's funeral, which took place on 18 July 2013.

ISSUES

Medical care

71. The clinical reviewer considered the man's healthcare in prison, including the management of his clinical care, food refusal and risk of self-harm. He concluded that the man's care was not equivalent to that which he could have expected to receive in the community and his report is attached as an annex.

The man's medical condition and dietary needs

72. The man had a documented history of dietary problems and concerns about the provision of kosher, gluten-free food in prison. On 22 April, a few days after he arrived at Maidstone, he told Dr A that he had been diagnosed with coeliac disease. Dr A explained that he had to take a coeliac screening test, to confirm that he had the disease to support the prescription of a gluten-free diet. He ordered a full blood count and a range of tests to check for additional allergies. However, the man persistently refused to have the blood tests as he was unhappy that staff did not believe that he needed a special diet. Dr B said he had encouraged the man to undergo the coeliac screening and the other tests arranged by Dr A.

73. The clinical reviewer considers that the request for the test for coeliac disease was unnecessary as a gastroenterologist had already recommended a gluten-free diet and the prescription of this should have continued. However, the other tests were appropriate and necessary for someone with the man's medical history. Although the man was aware of the reason for the coeliac screening, it appears that the reasons for the tests might not have been fully explained to him, which might have led to his continual refusal to have them.

74. In spite of the dispute about the tests, the catering manager continued to provide kosher, gluten-free meals. As it was not possible for Maidstone to prepare the meals, ready-prepared kosher food was ordered from an outside supplier who confirmed that their meals did not contain gluten. However, as the healthcare department had not authorised a gluten-free diet, the man did not receive additional gluten-free food items such as bread. The catering manager said that the only meal the man wanted to eat was poached chicken. Although he felt that eating this every mealtime was unhealthy, he ordered 120 portions soon after the man arrived at the prison. The catering manager said the healthcare department then advised him not to order any further supplies of the special order chicken so long as the man refused the tests. The man had been unhappy about this. Invoices from the food suppliers and prison records show that the man was given other kosher meals which were also gluten-free.

75. The man's solicitors wrote to Maidstone in June and his family spoke to an operational manager after visiting him in July to complain that he was being denied appropriate meals as he had refused a medical assessment. The solicitors pointed out that the tests were unnecessary as they had already been done at a previous prison and that the man had given healthcare staff copies of the relevant documents. They stated that the man had started a hunger strike

and that he did not wish to be fed intravenously at any point. Dr B recalled that he had seen a copy of the medical letter stating that the man required folic acid and vitamin B12 supplements, but it had not been kept with his medical records. Accordingly, he prescribed some gluten-free pasta. The clinical reviewer confirmed that coeliac disease can be one of the many causes of vitamin B12 deficiency.

76. After seeking advice from Dr A, the nurse manager replied to the man's solicitors. He told them that there was nothing in the man's medical record to indicate that he had coeliac disease and advised that his duodenal biopsy in 2013 had been normal. The clinical reviewer points out the irrelevance of this information to the diagnosis of coeliac disease as the biopsy would show a normal result in someone on a gluten-free diet and the man was on such a diet at that time. However, it does not appear that the doctor was aware that the man was on a gluten-free diet at the time the biopsy was taken.

77. The nurse manager had been trained as a mental health, not a general nurse and said that he was unaware that the duodenal biopsy would be normal in those circumstances. The clinical reviewer felt it was not unreasonable, given his training and background, that the nurse manager did not know the details of a condition like coeliac disease. However, he had discussed the case with Dr A, who had assured him that the negative duodenal biopsy meant that it was not necessary for the man to have a gluten-free diet.

78. Ms D, the prison manager who spoke to the man's brother advised them that healthcare staff could not provide gluten-free meals unless the man completed the coeliac screen. At the time, the man had been receiving kosher meals which happened to be gluten-free meals but needed a healthcare prescription for a full gluten-free diet.

79. The clinical reviewer considers that the man's healthcare was not equivalent to that he could have expected to receive in the community. Although a gluten-free diet had already been recommended by a gastroenterologist, prison doctors had incorrectly assumed that the normal duodenal biopsy showed that he did not have coeliac disease and had inappropriately insisted that he should have a coeliac screening blood test before they would recommend a gluten-free diet. We agree with the clinical reviewer's view that on the evidence available, the prison doctors should have endorsed the man's request for a gluten-free diet.

The Head of Healthcare should ensure that all prescribing for a gluten-free diet is in line with best practice, as recommended in the British National Formulary and by the National Institute for Health and Care Excellence.

The man's refusal of food

80. Guidance to staff on prisoners who refuse food is contained in Prison Service Instruction (PSI) 64/2011, which states:

> "Some prisoners may decide to refuse food and/or fluids, or medical treatment for a variety of reasons. These decisions will be valid provided that the prisoner is deemed to have the mental capacity to make the decision. Mental capacity can only be assessed by a healthcare professional."

81. The PSI notes that the decision to refuse food is not considered in law to be a form of self-harm and states the following about mental capacity:

> "The Mental Capacity Act 2005 provides clear guidance that any individual has the legal right to refuse any treatment including food and/or fluid or resuscitation if they are mentally capable. The Act states that a person is assumed to have capacity unless it is established that they lack capacity and must not be considered unable to make a decision merely because they make an unwise decision."

82. In January 2010, the Department of Health issued "Guidelines for the clinical management of people refusing food in immigration removal centres and prison". This guidance states:

> "A thorough assessment of nutritional status should be undertaken at the outset of the fast, including establishing levels of recent food intake and usual body weight and performing a specific nutritional examination. Regular reassessments of a food-refusing individual's physical and mental state should be undertaken within limits dictated by the individual's compliance. Soon after an individual is identified as embarking on a period of refusing food, a case conference should be considered to explore further any ameliorating factors and assist care planning.
>
> "Full documentation of the individual's wishes is essential to demonstrate that the individual is not only refusing all forms of feeding but understands the likely consequences of doing so."

83. It is unclear exactly when the man started to refuse food as he gave differing dates when he spoke and wrote to staff and the IMB. He also continued to collect his food on some days when he was said to be refusing food. Wing staff first noted his decision to go on hunger strike on 11 June and when he saw Dr B on 13 June, he told him that he had been on hunger strike since 10 June. On 18 June, he submitted a formal application to state he was going on hunger strike but there was no formal recording of his food refusal in the log in the healthcare centre until 25 June. Dr B saw him again on 21 June and 8 July and he repeated that he was on hunger strike. It is unclear whether he discussed the man's reasons for this at those appointments.

84. Although Nurse E explained to Ms D the procedures for handling prisoners who refuse food, there is no formal local policy. It is also clear that staff did not adhere to the procedure described by Nurse E in which a referral should be made to the doctor after three incidents of food refusal, followed by monitoring.

85. The procedures in the national guidelines emphasise that early identification and assessment is essential to establish the reasons and nutritional status, followed by regular reviews of the individual's physical and mental state. It is also recommended that mental health and mental capacity assessments are conducted within seven to ten days of the start of food refusal; information is provided about the possible effects; a case conference and regular reviews are held to understand and resolve the issues that triggered the food refusal; and that the individual's wishes are documented.

86. Maidstone did not follow the steps outlined when the man reported his food refusal and this was not coherently managed throughout. It seems that they did not believe he had stopped eating. The limited action taken was rather ad hoc and staff do not appear to have communicated well with each other or dealt with the man's problems holistically. The extent of the man's food refusal is unclear and there is little evidence that he suffered any physical detriment – he was seen by a doctor on 8 July who did not note any concerns. However, the lack of appropriate monitoring does not help to establish this. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with the Department of Health guidelines for the clinical management of people refusing food in immigration removal centres and prison.

Management of the man's risk of suicide and self-harm

87. The man had a long history of self-harm throughout his imprisonment from 2002, including two incidents of attempted hanging. He was monitored under Prison Service suicide and self-harm prevention procedures several times. His self-harm was usually prompted by perceived difficulties with the prison system, often in relation to his diet, sleep problems and having to work in the mornings. He had previously refused food and had frequently threatened suicide.

88. Soon after he arrived at Maidstone, the man threatened to harm himself if he did not receive his game console. A suicide and self-harm prevention plan was started to support him and was regularly reviewed. During this period of monitoring, he started to refuse food and later again threatened to kill himself. Prison Service Instruction (PSI) 64/2011 which governs safer custody procedures, indicates that the act of refusing food is not viewed as self-harm but is comparable to refusing medical treatment. It advises that the effective management of prisoners who refuse food should be through a multi-disciplinary approach, that it is important to involve the prisoner's family in the ongoing support and a prisoner's wishes to either refuse food and/or fluids should be taken seriously and properly recorded.

89. Although regular ACCT case reviews were held in relation to the risk of self-harm, the caremap was not revised or updated and the actions listed – to complete induction and apply for afternoon work and speak to the healthcare centre about the man's diet - were noted as ongoing. The case reviews were not multi-disciplinary and, in spite of the food refusal, healthcare staff were not represented. In the report of an inspection of Maidstone in 2011, the Inspectorate were concerned about the lack of multi-disciplinary representation at ACCT reviews, including health services and recommended this should improve. This does not appear to have happened in the man's case.

90. Wing staff involved in the man's ACCT monitoring noted, in case reviews and the ongoing record, conversations with the man about his food refusal. However, they do not appear to have actively addressed it (possibly because of a belief that he was still eating) or engaged with the healthcare department to try and resolve the situation. Neither did they take account of, or draw a parallel with, his previous serious acts of self-harm and threats of self-harm in response to disputes about his diet and meals. The man's family approached the prison for assistance but no consideration seems to have been given to involving them in supporting him while he was refusing food.

91. We do not believe that the man was appropriately managed under the suicide and self-harm provisions in the weeks before he died. Wing staff should have been more proactive in engaging with healthcare staff to address his needs and find a solution to his grievance. His threats of suicide should have been treated with greater seriousness given his significant history of self-harm and healthcare staff involved in his care should have been invited to case reviews or at least consulted if they were unable to attend. We are surprised that there was no requirement for any ACCT observation to take place at all during the night after 12.00am. We therefore make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care;**
- **Considering all known risk factors when determining the level of risk of self-harm; and**
- **Revising caremaps to reflect changes in circumstances and needs**
- **Setting appropriate levels of observations to reflect identified risk.**

The emergency response

92. Officer F discovered the man hanging in his cell at around 7.23am. She immediately asked a colleague nearby to assist and radioed an emergency code to the control room, who immediately called an ambulance. Officer F was unable to cut the man down immediately as her colleague was in shock and could not assist her. Regrettably this led to a further short delay in cutting the man down. A healthcare assistant and other staff quickly went to the cell and

attempted to resuscitate the man. The paramedics arrived at the cell at around 7.35am and continued the resuscitation attempts. They then took the man to hospital.

93. The clinical reviewer considered that the man's first aid treatment should have included oxygen therapy as soon as possible. The healthcare assistant had taken an oxygen cylinder but was unable to turn it on. She explained that because of the tension of the situation she had found it difficult to turn the switch on the cylinder on and decided that it would be better not to waste time and to use the back up of a bag-valve mask. The paramedics were able to use the oxygen cylinder when they arrived but we agree with the clinical reviewer's view that staff who have responsibility for using equipment should be able to do so correctly, particularly in an emergency situation.

The Head of Healthcare should ensure that healthcare staff are familiar with and competent to use emergency equipment.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all prescribing for a gluten-free diet is in line with best practice, as recommended in the British National Formulary and by the National Institute for Health and Care Excellence.

2. The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with the Department of Health guidelines for the clinical management of people refusing food in immigration removal centres and prison.

3. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care;
    - Considering all known risk factors when determining the level of risk of self-harm; and
    - Revising caremaps to reflect changes in circumstances and needs.
    - Setting appropriate levels of observations to reflect identified risk**.**

4. The Head of Healthcare should ensure that healthcare staff are familiar with and competent to use emergency equipment.

ACTION PLAN: The man on 10 July 2013 at HMP Maidstone

No	Recommendation	Accepted/Not accepted	Response	Target date for completion
1	The Head of Healthcare should ensure that all prescribing for a gluten-free diet is in line with best practice, as recommended in the British National Formulary and by the National Institute for Health and Care Excellence.	Accepted	In consultation with the GP provider, the provision of all special (medical) diets will be formulated into one policy. This will be in line with best practice as indicated in the British National Formulary, NICE and local CCG guidelines.	31 March 2014
2	The Governor and Head of Healthcare should ensure that prisoners who refuse food are managed in accordance with the Department of Health guidelines for the clinical management of people refusing food in immigration removal centres and prison.	Accepted	The food refusal register is located within healthcare with a copy of PSI 64/2011and a healthcare policy document attached which will be reviewed to better reflect the contents of The DOH guidelines. Healthcare and prison to review current procedures for the recording and monitoring of food refusal.	31 March 2014
3	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: a) Holding multi-disciplinary case reviews which include all relevant people involved in a prisoner's care; b) Considering all known risk	Accepted	Band 4 OS are responsible for ACCT reviews on a daily basis. Additional training is planned to up skill and reiterate the need for a holistic approach, covering all known risk factors and the importance of an active, current care map. Duty Governor / manager checks of ACCT reviews to include a check and comment in the care plan	Initial session to be completed by 31 March with the remainder being part of a rolling training programme supported by CSL.

	factors when determining the level of risk of self-harm; and c) Revising caremaps to reflect changes in circumstances and needs. Setting appropriate levels of observations to reflect identified risk			
4	The Head of Healthcare should ensure that healthcare staff are familiar with and competent to use emergency equipment.	Accepted	All staff have re-familiarised themselves with emergency equipment.	Immediate