Investigation into the circumstances surrounding the death of a man in hospital, in October 2006 whilst in the custody of HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

November 2008

This report considers the circumstances surrounding the death of a man in October 2006 at the local hospital. The man was in the custody of HMP Maidstone at the time of his death. The post mortem concluded that he died as a result of hepatic failure, caused by a history of alcoholism and hepatitis C which led to cirrhosis (liver disease). The man was 49 years of age.

I extend my personal condolences to the man's family and to all those touched by his death.

One of my colleagues undertook the investigation with the assistance of the clinical reviewer appointed by West Kent Primary Care Trust. I would like to thank the clinical reviewer for providing a thorough clinical review of the care the man received whilst in custody.

I would also like to thank the Governor of Maidstone and her staff for their cooperation during this investigation. In addition, I am grateful to the clinical staff at HMP Elmley, HMP Swaleside and at the hospital who have assisted the clinical reviewer and my investigator in their enquiries.

Although he was a category C prisoner and nearly half way through a three year sentence, the man died while still subject to restraint. My report considers why this was so.

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Prisons and Probation Ombudsman **November 2008**

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SUMMARY

The man had a longstanding history of drug and alcohol abuse before coming into custody. He tested positive for three types of hepatitis – A, B and C. Although there is no record of his taking illegal substances whilst in prison, concerns were raised about a potential dependence on dihydrocodeine (DF118, an opioid analgesic). He was repeatedly prescribed this medication for an injury sustained in 1992 and declined to try other analgesics suggested by doctors.

The man had two hospital stays in 2006. In August 2006, he was diagnosed with a pulmonary embolism (a blood clot on the lung), and in October 2006 he developed cirrhosis of the liver and was diagnosed terminally ill.

Whilst in hospital, the man was accompanied at all times by two prison officers on a bedwatch escort. He was also required to wear an escort chain. Both of these measures are in accordance with security requirements, based on a risk assessment. As the man's condition deteriorated, his family and doctors at the hospital asked for the restraints to be removed. The risk assessment for use of restraints was reviewed on a weekly basis but each time concluded that the escort chain should remain. The situation was revised on 22 October 2006, when a Duty Governor visited the hospital and felt that another assessment might be justified given the man's continuing deterioration. A further assessment should have taken place after this management check, but this did not occur and the man died three days later, still wearing restraints.

His family continue to be unhappy with the security measures in place during the last few weeks of his life. I consider the use of the escort chain in these circumstances to have been both unnecessary and distressing for the man and his family. I would like to have seen a more sensitive approach adopted, given his terminal and deteriorating condition. Although the man was still mobile, he was weak and not deemed an escape risk. It should have been possible to remove the restraints but keep escort staff in place.

The clinical review concludes that, on the whole, the man received a good standard of care based on sound clinical judgement. There are a number of concerns that are highlighted relating to a more coordinated multidisciplinary approach to care planning in prison healthcare.

Based on the clinical review, I make five recommendations and note two areas of good practice. In addition, I make two recommendations of my own relating to security measures.

THE INVESTIGATION PROCESS

1. One of my colleagues opened the investigation on 31 October 2006. She discussed the circumstances surrounding the man's death with Maidstone's Governor. They agreed that all documents relating to the man would be sent to the investigator for her to consider before she visited the prison.

2. My investigator asked a medical practitioner, West Kent Primary Care Trust (PCT), to conduct a clinical review of the healthcare the man received in custody. The investigator and the clinical reviewer agreed to hold joint interviews with the healthcare staff at Maidstone who had provided medical care for the man, as well as a number of discipline officers who had acted as bedwatch escorts. These interviews were held on 10 and 31 January 2007, and 15 February 2007. The clinical reviewer held further interviews with clinical staff from HMP Elmley, HMP Swaleside and at the local hospital.

3. One of my family liaison officers contacted the man's family to explain the purpose of the investigation and arrange a visit. Both the FLO and the investigator visited the man's family on 11 January 2007. During this meeting, the family raised a number of issues regarding security:

   - Despite the man's considerable ill health, he was not at any stage released from restraints while in hospital. The family had requested for over a week that they be removed, including a direct request to the Deputy Governor. The family felt let down that the prison did not respond more quickly in reassessing the security risk, considering the man's terminal illness and obvious deterioration in health and capabilities.

   - The family understood that the man had a possible early parole date of 11 December 2006. They questioned whether this could have been taken into consideration in assessing both the need for restraints and early release on compassionate grounds.

   - Staff had used a double length escort chain so that they could sit outside the man's hospital room. However, the family felt the reason for this had not been properly explained to them by the prison.

4. The family also had specific issues regarding the man's medical care:

   - They questioned why it had taken a week to identify a blood clot during his first inpatient stay at the hospital in August 2006.

   - The family would like clarification whether the man was fit to be discharged from hospital in August 2006. In addition, they asked whether the diagnosis of liver failure could have been made earlier, as his health deteriorated rapidly over the following two months.

   - They would also like clarification why the man was discharged back to Maidstone prison, rather than directly to inpatient facilities at HMP Swaleside.

- They were not happy with the level of support and counselling the man received from nursing staff at the hospital on being told that he was terminally ill. Indeed, the family was also distressed by the lack of support they received in coming to terms with the man's illness and the information given to them. The man's father was asked if his son was "for resuscitation" before he had been told that he was terminally ill.

5. All but one of these issues are addressed in the main body of the report and the clinical review. The clinical reviewer has not specifically commented on the length of time it took to identify the blood clot in August 2006. However, she clearly states that she believes the man received a high standard of appropriate clinical care at the hospital.

HMP MAIDSTONE

6. Maidstone is a Victorian prison that lies close to the town centre. The prison holds up to 589 category C prisoners serving three years or more. There are four main residential wings.

7. Healthcare at Maidstone is provided by West Kent Primary Care Trust (PCT). The prison does not have a 24 hour healthcare facility and has limited scope to care for someone with complex medical issues. Prisoners requiring inpatient (but not hospital care) are usually transferred to HMP Swaleside where 24 hour healthcare facilities and inpatient beds are available.

8. The healthcare unit is open from 7:45am until 8:15pm, Monday to Friday. During the weekend it is open from 8:00am to 5:15pm. There is one person on duty during this time. The same staffing level applies to weekday evenings.

9. Maidstone has a full-time nursing team. In addition, there is a team of GPs shared by the three prisons within the PCT. (The other two prisons are Swaleside and Elmley.) The GPs work on a part-time basis. At Maidstone, GP surgery hours are 9:00am-12:00noon, Monday to Friday. The same GPs do not always attend the same prisons, so it is sometimes difficult to guarantee continuity of care. As part of the service level agreement with the PCT, there is an on-call GP who can attend the prison if there is a medical emergency.

10. An unannounced inspection undertaken by Her Majesty's Chief Inspector of Prisons in 2004 reported that, "there are good links with the primary care trust and other healthcare providers, and a very good system of clinical governance had been established."

KEY FINDINGS

11. The man was arrested and taken into police custody on 10 June 2005. He was transferred to HMP Elmley the following day under the direction of the Magistrates' Court.

12. Every prisoner coming into custody is subject to an initial health check. On arriving at Elmley, The man was seen in reception by a nurse. He told her that he had been in Hospital the previous week, but could not remember why. He could not name all the medications he had been instructed to take, but did say that he was currently taking diazepam and dihydrocodeine. (Dihrydocodeine is an opioid analgesic (painkiller), normally used to treat severe pain or a severe cough.) The man referred to his history of alcohol abuse. He also mentioned that he had once been treated at a psychiatric hospital. The man could not explain why he had been a patient there. The nurse noted no physical signs of alcohol withdrawal. The man also said that he was an epileptic, but could not say what medications he took, how often or what dose. He never referred to the epilepsy again whilst in custody.

13. After this initial screening, the man was referred to the medical officer for a second and more in-depth health screen (a requirement for every new reception at prison). During this assessment he was prescribed inhalers and chlordiazepoxide (commonly known as Librium), along with vitamin supplements to manage alcohol withdrawal.

14. He was also referred to the substance misuse team and mental health in-reach.

15. The prison doctor of the substance misuse team saw the man on 14 June. The man saw a nurse from the mental health in-reach team the following day. He showed no signs of mood disorder or psychotic symptoms. Neither did he declare any history or intention of self-harm or suicidal thoughts. He did say that he had not been prescribed any diazepam or dihydrocodeine. It was concluded that he would not need any further input from the mental health team, but he was recommended to see the doctor regarding his prescriptions.

16. The man next saw a nurse on 21 June, complaining of swollen ankles. He told the nurse that this occasionally happened. The nurse noted that his right leg was notably "bigger than the left one" by 2cm in diameter. There were a number of varicose veins on this leg and he experienced pain in his ankle on flexing his foot. The nurse recommended that he see the medical officer the following day. The man did not follow this up.

17. He next saw a member of healthcare on 27 June. Blood tests were ordered and he asked about being prescribed sleeping tablets. It is not clear what was done about his request. He was again referred to the substance misuse team.

18. On 15 July, the man had a doctor's appointment. He complained that his dihydrocodeine dosage was not high enough. He also said that he felt depressed, was not eating properly and was still having difficulty sleeping. However, it was noted in his medical record that he "looked well". The doctor

19. Aside from a chest infection in August, the man had no further health complaints until September. During a triage clinic on 2 September, he asked for one of his inhalers to be changed as he had been experiencing panic attacks on taking a dose. The man also asked for his dihydrocodeine to be given in-possession, rather than having it dispensed daily. This request was granted during an afternoon appointment with the doctor and he was given 28 40mg tablets. A repeat prescription was issued 21 days later.

20. On 7 October, the man told a nurse that he had not been receiving his prescribed medications (namely the dihydrocodeine) since they had gone missing in reception when he went out to court. The nurse who was on reception during the day that the man went to court said that she had issued him with 28 tablets of dihydrocodeine on 30 September and that the man had signed for them on return from court. It was noted in his medical record that he should now receive them on a daily basis. Despite this, on 21 October a further repeat prescription was issued for a month's supply. The doctor's entry in the medical record, accompanying the issue of the prescription said that the man should stop taking this particular medicine, as it was not recommended for asthmatics. This is the first reference to such a caution in his records.

21. On 23 December, a triage nurse referred the man to a medical officer as both of his legs had swollen. He was experiencing "pins and needles" and had a high temperature. The doctor noted that his right leg was bigger than the left, but "not swollen". He was prescribed betnovate cream for a patch of eczema on his lower leg.

22. The man returned to the healthcare unit on 10 January 2006. He said that "his stomach ulcer had burst". A nurse advised him to stay in healthcare and be seen by the doctor. He declined, saying that he felt unwell and just wanted to go back to his cell. The nurse stressed that this was not a good idea and encouraged him to wait. The man ignored the advice and returned to his houseblock. He was next seen on 13 January, when he went back to healthcare complaining of pains in his legs. The doctor prescribed dihydrocodeine and lansoprazole. (The latter is a medicine used to treat stomach ulcers.)

23. On 20 and 31 January, blood tests were taken to assess the condition of the man's liver. It was noted that there was no evidence of liver disease at this time. However, his platelet count was low and he would need another blood test in two months time.

24. On 24 February, the man was sentenced to three years imprisonment and taken back to HMP Elmley. He continued to be prescribed dihydrocodeine (but not in-possession) and his antidepressants. There is no record of him ever being reviewed for depression, or of any further investigation into his occasional leg pains.

25. On 7 April, a doctor from the local hospital wrote to the man, care of his father's home address. The letter said that the man had not been seen for "some time" at the gastroenterology outpatients' department. The doctor was concerned that further investigations had not been undertaken and that he would need to be assessed. The man was not able to attend any scheduled outpatient appointments as the letters had not reached him in prison.

26. On 21 April, a prison doctor examined him. The man said that he was "in dire pain" with his left shoulder. His prescription was altered to reduce the dihdyrocodeine to 30mg and introduce paracetamol to better manage the pain. The man was also referred to a physiotherapist.

27. The man returned to healthcare on 28 April, complaining that his pain had increased due to the reduction in dihydrocodeine. The prison doctor contacted the man's GP in the community to discuss his ongoing pain and see how it had been previously managed. The GP said that the man had only received dihydrocodeine in the past for backache, and he was not aware of a shoulder/upper arm injury. Given this information, it was decided that the man should have an x-ray to better understand his complaint. The GP agreed with the prison doctor that the lowered dose of painkiller should continue at 30mg. The results of the x-ray were made available on 19 June. This confirmed an old injury to his shoulder and upper arm.

28. On 27 June, the man had chest pain and asked to see a medical officer. He asserted it was an infection, but he did not have a cough and asked for dihydrocodeine. A doctor's entry notes that the man did not appear uncomfortable or in pain. Despite this, he insisted he had pains in his legs, shoulder, chest and various other places. The doctor referred back to his colleague's entry on 21 April and wrote:

    "I very much doubt that he needs dihydrocodeine and do not understand why it continues to be prescribed despite several doctors' wish that it be discontinued.

    [The man] did not wait very long after he saw me reading the notes and left saying he would approach another doctor for this.

    If it is prescribed please explain the clinical indication.

    He probably has more need to address his addiction

    N.B. Says GP prescribed it outside but this is untrue. GP says only codeine.

    We really need to present a concerted approach to his demands."

29. There was a further explicit entry in the man's medical record, written by another prison doctor on 29 June:

"Please will all doctors read entry by my colleague 27 June 2006 because there has not been strong evidence for prescribing dihydrocodeine. Heroin background."

30. The following day, the man was declared fit for transfer and he was taken to HMP Maidstone. A first screen health check was completed by the duty nurse. The man was later seen on 4 July by a locum doctor for a further check up. The doctor correctly noted the previous entry alerting medical staff to the man's demands for dihydrocodeine and he refused to prescribe. He noted that there was no clinical indication for prescribing that particular analgesic and he offered him a different painkiller. The man declined.

31. At Maidstone, the man was initially placed in a double cell. He was not happy sharing and was quickly moved to a single cell. On 30 July, the man complained to healthcare staff of nausea, which he associated with the new painkiller (zydol). The duty nurse noted that he appeared slightly jaundiced. Nothing further was noted on this day. The clinical reviewer and my investigator were told by the head of healthcare that an appointment was made for him to see the doctor the following morning. This is not clear from the notes.

32. By the time the man saw a doctor (it is not clear from the signature which GP attended), he was experiencing right side abdominal pain; this area was tender to touch. He was noted to be passing dark coloured urine. Blood tests were requested and he was admitted to the local hospital, escorted by prison officers and in restraints. This was appropriate and in compliance with prison security requirements, given his assessed risk to the public.

33. The man remained in hospital whilst tests were conducted. He had an ultrasound scan of his kidneys on 2 August, followed by a further scan on 4 August. The head of healthcare telephoned the hospital for daily updates. On 10 August, she was told that the man had been diagnosed with a pulmonary embolism (a blood clot on the lung) and a secondary diagnosis of cirrhosis of the liver. He was treated with the anti-coagulant warfarin, which prevents clotting, and his analgesic was changed. A further update was given on 14 August. The man was now receiving a low protein diet and fluid restrictions were in place. Tests were taken to see if there was any worsening in liver function. The man was discharged back to prison later that day with the following medications:

    - combivalent and seritide inhalers (for his asthma/emphysema)
    - lansoprazole (for his stomach ulcer)
    - warfarin (to prevent further blood clots)
    - lactulose (laxative)
    - spironolactone (diuretic)
    - mirtazapine (antidepressant)
    - zomorph (opioid based analgesic)

38. The discharge instructions from the hospital were for him to continue taking these medications and have an international normalised ratio (INR) test taken

39. On 15 August, the man was called to healthcare to see the GP. He declined to attend. Likewise, he did not attend when called to collect his zomorph and mirtazapine. The man did not feel able to walk the distance to the healthcare unit, and staff therefore offered him the use of a motorised chair to move about the prison. He declined and did not want to get out of his bed. That evening, his medications were brought to his cell. The duty senior officer said he would speak to him the following morning about a transfer to HMP Swaleside, where inpatient bed facilities were available.

40. The Head of Healthcare contacted the local hospital on 16 August to clarify the man's condition, mobility and physical needs prior to discharge. It was confirmed that on discharge he was able to move around and to look after himself. When considering the discharge, they did not expect him to require a great deal of assistance. Given this information, she went to see the man. She noted in his medical records that he walked to the wing unaided, but was unsteady. The man maintained that he was still unwell and refused to walk to healthcare for supervised medication but again declined the offer of a motorised buggy. The head of healthcare explained the importance of keeping mobile especially in light of his recent embolism. She reassured him that his blood test (INR) had been booked in for the following week. It was recorded that he was not happy with any of their discussion and returned to his cell. The head of healthcare asked discipline staff on the man's wing to encourage him to walk to collect his meals and move about for short periods in the day.

41. The man collected his medication on 17 August. He walked unaided and appeared steady on his feet. However, he maintained that he would only make one trip to healthcare each day so would pick up his medications the next day when he went to see one of the prison's part-time GPs.

42. The GP noted in the man's medical record that he appeared pale, weak and lethargic. It was his opinion that the man had been discharged from hospital too soon and required bed rest. He noted that Swaleside had already been contacted about the possibility of taking him as an inpatient; however they were unable to take him at that time. The man again requested dihydrocodeine to manage his pain. Despite former warnings in his medical record, this was prescribed to him - 40mg twice a day. No clinical explanation was given in his medical notes. During interview, the clinical reviewer asked the GP why he had prescribed dihydrocodeine. He said that the man, "had an addiction to dihydrocodeine, but this was irrelevant compared to the severe pain that he was suffering and this was my clinical decision for him to continue dihydrocodeine." The man saw the GP again on 25 August and told him he was still in pain. The dihydrocodeine was increased to three times a day.

43. Entries in the man's wing history sheet by discipline officers record that the man appeared to be coping, but was not one hundred per cent well. He was spending a lot of time alone in his cell, mainly due to his illness. Officers encouraged him to walk about as per healthcare's advice. A letter arrived on 30 August from the outpatients' department at the local hospital, postponing his appointment from 26 October to 15 November. No reason was given.

44. The prison GP next saw the man on 6 September. He noted that the man was breathless, unable to sleep and mildly jaundiced. The man complained that the dihydrocodeine was not working. The GP increased his prescription to four times a day and wrote, "he needs to be an inpatient for sometime until he is on his feet. Unable to walk from wing to the healthcare." The man was transferred to HMP Swaleside as an inpatient later that day. An escort risk assessment was completed. The man's risk of escape and to the public was rated as medium. The assessment also noted that he was only able to walk short distances.

45. On 7 September, Swaleside healthcare telephoned the head of healthcare at HMP Maidstone to ask for the man's last INR reading (to measure blood clotting). It was 3.1, slightly higher than on leaving hospital. An entry in the man's medical notes on 11 September stated that he seemed to be managing well, but was having some trouble sleeping. He was prescribed zopiclone (sleeping tablets) and an iron supplement.

46. An INR reading was taken on 14 September. This showed that the man's level had dropped to 1.1 and his warfarin was increased from 3mg to 5mg. By 21 September, it had increased to 1.9. There were no further entries in his medical record until 2 October. On this date, an entry noted that the man had been asked to collect his medication from the healthcare office. He had refused, saying he felt unwell and his chest was sore. A peak flow meter reading was taken, but his breathing technique was very poor and only gave a very low reading of 250. (A peak flow meter measures the rate at which a person can expel air from their lungs.) It was noted that his ankles appeared swollen. Further examination showed water retention (pitting oedema) which can be linked to renal failure, liver failure and heart disease amongst other illnesses. The examining nurse's concerns were discussed with one of the prison's GPs who said that he would attend to the man.

47. An ECG was performed and the GP saw the man at 10:50am. No time had been written against the earlier entry, so it is not possible to say how much time had passed between the examinations. The GP requested an updated INR test, but the last blood test was under-filled so it was not possible to give a reading. The test had to be repeated.

48. On 5 October, the man attended an outpatient appointment at the gastroenterology unit at another local hospital. After this, there were no more entries in his medical record until 10 October when the man's condition was reviewed. The GP referred him to the medical registrar at the local hospital "for advice/review" and he was taken to the medical assessment unit in the accident and emergency department. The GP's referral letter gave the man's

49. The man was admitted to a ward for further assessment. A hospital risk assessment form was completed by the duty doctor on 11 October. (This is a standard form which must be completed in all cases when a prisoner is escorted to outside hospital. Its purpose is to ascertain the appropriate level of escort and type of restraint to be used.) In the section to be completed by prison medical staff, it was noted that there were no medical objections to the use of restraints in the man's case. The duty officer assessed him as being a low risk to the public in terms of hostage taking and potential for escape. However, given the nature of his offence and his mobility, he was required to wear an escort chain (a length of chain attached to a single handcuff at each end) at all times and be accompanied by two discipline officers. The escort chain would only be removed in a medical emergency or for medical treatment. (It is worth noting at this stage that the security risk for any prisoner on bedwatch is regularly reviewed. Depending on the person's mobility or level of sickness, it can be reduced or heightened following governor level authorisation based on a risk assessment.)

50. On 12 October, the man was moved to a side room. He was subject to barrier nursing to control any possible spread of infectious disease such as hepatitis. (Barrier nursing means that a patient is isolated in a separate room and nurses wear protective clothing, such as gowns, masks and sometimes rubber gloves to minimise the risk of passing on infection. All equipment, utensils and bedding that have come into contact with the patient are immediately sterilised.)

51. The man received oxygen therapy via a mask to aid his breathing, intravenous fluids and fluid balance monitoring. A computer topography (CT) scan was requested. (This produces a cross section image of the head and body, which is then analysed by computer.) The next day the man refused the paracetamol offered for pain relief. The escort staff telephoned the head of healthcare to advise her that the man's condition had been diagnosed as terminal. The duty governor was informed and the man's next of kin details obtained. Although the man's sister was already aware of his illness – she had been in regular contact with Swaleside's chaplaincy and had seen him in hospital during his previous inpatient stay – it was necessary to officially inform the family. The man's consultant asked the prison to consider releasing him from custody on compassionate grounds.

52. The man remained in the side room with two escorting officers. As he was still able to get out of bed and walk unaided, the risk assessment for security measures remained the same. He continued to wear an escort chain. The other end of the chain was handcuffed to one of the prison officers. The

53. The man continued to refuse paracetamol and only accepted minimal nursing contact on 14 October. It was noted in the bedwatch log that he was refusing all attempts to get him mobile and improve his hygiene. He preferred to remain in bed. He developed left sided chest pain which was treated with glycerine trinitrate spray (GTN).

54. The man's sister visited him in hospital. She expressed concern about his resuscitation status which had been inappropriately raised earlier. On arrival, the man's father had been asked whether the man "was for resuscitation". This question was posed to his father before formally explaining to him that the man was now terminally ill. Senior medical staff were not available for further discussion with the family and arrangements were made for a future meeting with doctors to discuss the issue.

55. The man removed his intravenous drip and neither nursing nor medical staff were able to successfully reinsert the needle. The hospital notes indicated that the man should not be given either opiates, sedatives or dihyrdocodeine. He was prescribed paracetamol for pain management, but he told staff he would not take it. He continued to refuse paracetamol on 15 October, along with all oral medication. He also refused to attend to his personal hygiene.

56. On 16 October, medical staff spoke to him, his father and sister. They discussed the results of diagnostic tests, his poor prognosis, the importance of taking his medications and the implications of his refusal. The man wanted a stronger analgesic than paracetamol, but this was refused due to the condition of his liver. He started to become uncooperative and verbally aggressive towards nursing staff.

57. The hospital records indicate lengthy continuing discussions with the family throughout the day regarding the man's condition and prognosis. At this point his resuscitation status was declared as 'not for resuscitation'. The man was also seen by the Macmillan Palliative Care Team, with a view to commencing the Liverpool Care Pathway. (This is an integrated care pathway developed in the late 1990s by palliative care specialists at Royal Liverpool and Broadgreen University Hospitals with the Marie Curie Hospice in Liverpool. It was created to improve care for dying patients and their families outside of a hospice and is considered to be the gold standard in care for the terminally ill.)

58. Hospital records also show long conversations with the bedwatch officers on duty that day. Further diagnostic tests had revealed severe oesophageal varices. (This is a complication of cirrhosis - the varices are abnormally enlarged veins in the lower part of the oesophagus. They develop when normal blood flow to the liver is blocked. The blood backs up into the smaller, more fragile blood vessels in the oesophagus, causing them to swell. The varices do not present any symptoms unless they rupture and bleed.) As a result of the oesophageal varices, the man could potentially have posed an infection risk to the escorting staff.

59. Given the risk of infection, it was agreed that the officers should be relocated outside the man's room and extended escort chains would be applied. The man's family complained to medical staff about the use of handcuffs. A doctor asked the escorting officer on duty to remove the restraints. The officer explained the prison's security policy. As long as the man was still able to get out of bed and the risk assessment considered him to remain a potential risk to the public, the restraints would remain.

60. A review of the risk assessment took place that day. It took account of his poor prognosis, but noted that he was still capable of moving himself about unaided. The conclusion was that he should remain in restraints for the time being and the decision would be regularly reviewed.

61. Escort officers notes showed that, despite the doctors and family's concerns regarding the restraints, the nursing staff on the ward were content for him to remain restrained due to his infectious state. They felt it was safer for the rest of the ward if the potential for risk of infection could be minimised by restricting his ability to move about the hospital. The clinical reviewer asked nursing staff about this. She was told that all decisions taken regarding how and where to nurse the man were based on clinical need rather than his status as a prisoner. She was also told that consideration had been given to issues of dignity, as well as the potential disruption and distress to both the man and other patients.

62. The ward sister telephoned Maidstone prison healthcare to tell them that the man would need palliative care. Maidstone told her that this could not be provided due to the absence of inpatient facilities, but they would contact Swaleside to see if he could be temporarily transferred into their care.

63. The man's family remained with him during the evening. His sister again asked for the restraints to be removed and this was noted in the bedwatch log. The escort officer again explained why they could not be removed and that he did not have the authority to make the decision.

64. During the early hours of 17 October, it was noted in the bedwatch log that one of the ward nurses told the officers that she would not feel safe around the man if he was not restrained due his "rude and threatening" attitude at times. The officer added that the man had been civil at all times during the evening.

65. Later that day, the man's consultant again raised concerns about the use of restraints. He was told by an escort officer that the prison had instructed that they remain. There was also further reference to nursing staff wanting the man to remain restrained to minimise the risk of infection. The wing senior officer told the escort officer that the consultant had now made two requests to remove the escort chain and "this is not to happen". The escort officer was told that all requests for their removal were to be logged and the prison informed.

66. The consultant spoke to the GP at HMP Maidstone about the possibility of the man's early release from custody on compassionate grounds. An officer emailed the relevant forms, extracted from chapter 12 of Prison Service Order 6000 (early release on compassionate grounds), to the Governor, healthcare and probation. She requested completion and return to her in the custody office for collation.

67. The man did not fully comply with his medications, refusing all oral medicines after teatime on 18 October. He had told a nurse earlier that day that he did not have long left to live, and did not want to prolong it, but made it clear that he had no intention of taking his own life. A Macmillan nurse visited him and it was noted in the bedwatch log that he did not require her assistance.

68. The consultant again telephoned the prison GP. He reported that the man was lucid but refusing treatment. He confirmed that the man was terminally ill, but commented that it was difficult to predict how long he had to live. There was a high possibility that severe internal bleeding could happen at any time. At this time, the man was still able to walk around and fully aware of his environment.

69. The prison GP wrote to the consultant and to another doctor (at the local hospital) enclosing the early compassionate release forms. He asked them to complete their section and return it to him. The prison's GP stressed that both the man and his family were pressing for early compassionate release so that he could be made more comfortable without the restraints. He highlighted that, before agreeing to the early release, the medical team at the hospital had to feel sure that death was imminent.

70. Meanwhile, a prison probation officer completed his section of the report. This was done purely as a paper exercise based on previous probation reports as he had never met the man. The probation officer concluded that the risk of re-offending and harm on release on licence remained high. He noted that during his sentence the man had done little to address his offending behaviour or substance misuse issues. Neither had he proved to be cooperative or positive in attitude in discussions with his probation officer. He felt that the man could still potentially be violent to others.

71. The man's family visited him every day and continued to request that his restraints be removed. On 19 October, the escort officer again explained at length that he was unable to remove the restraints and that only the duty governor had the authority to order their removal.

72. The man became increasingly restless and rude towards nursing staff, particularly at night. His behaviour was to be reported to the prison and the man was cautioned by escort staff. However, staff acknowledged that his behaviour was linked to his increasing discomfort and frustration caused by his illness. His pain was becoming unmanageable on his current dose of morphine and so it was increased. On 21 October, the restraints were removed briefly to place a bandage underneath to stop it rubbing against his wrist.

73. The deputy governor visited the man on Sunday 22 October to undertake a bedwatch management check and assess the security situation. She spoke with a staff nurse who told her that the man was deteriorating and that it could be two to three weeks before he died if the decline in his health continued. She said there was a risk of infection to staff if he left the room and collapsed, as staff might not be aware of his hepatic status. In light of this, the nursing staff were happy for the man to remain in restraints. The deputy governor noted that the man's escape risk at this time was very low. Based on her assessment, she recommended that the restraints remain, but that the escort chain be doubled in length to be more comfortable. On return to the prison, she wrote to Governor outlining the situation and recommending a risk assessment review. The deputy governor wrote:

> "The man is in a side ward on the second floor. The windows can be fully open and a fit man could attempt to climb out of the window, however to do this he would have to climb onto the window sill and also successfully drop from the window without injury from quite a height. He states that he has a history of back problems and received disability allowance before entering prison.
>
> He is conscious, but the nurse stated that he falls in and out of being alert and is sometimes confused. Whilst I was present he got out of bed and sat in the chair, however this was a struggle for him and he had to be propped up with three pillows. He is obviously very uncomfortable as he got back into bed after a short time, and then whilst I was talking to the staff, got himself out of the bed and back onto the chair again, which is next to his bed. He continuously moans and groans because of his pain…
>
> … I talked through the possibility of uncuffing him but staff remaining outside the door. The staff nurse stated that she felt it was unlikely that his health would allow him to move far, although she couldn't totally commit herself to his condition.
>
> He had been able to walk to the toilet, which is just opposite his room, however the hospital have stopped him using it for fear of infection and therefore he remains in his room. Whilst I was there he complained that his feet and legs hurt. They are very swollen and completely white.
>
> His escort risk assessment shows that he is enhanced with no concerns regarding his behaviour.
>
> The sister has asked staff if he can come off his chain and they suggested that she speak to the Governor.
>
> I believe that there is a very low risk of this offender trying to escape. I suggest that there is also a low risk of the family attempting to take him

away from the hospital should he be uncuffed. He has made no effort to try to move or do anything that the hospital say he can't do.

Should we direct that he be uncuffed, there is a window leading into the room where staff can have full view of the offender. Hospital staff have stated that he will remain in that room for the rest of his time at the hospital. Whilst I appreciate that security is paramount, I believe that there would be a low risk of escape should we leave him uncuffed with staff remaining outside his room. I am happy to speak to the sister to assess the risk of him attempting to leave, prior to us making the decision should you wish.

His PED [parole eligibility date] is December 2006 and his condition and decline is very undignified for the family members that do visit him."

74. This document was left for Governing Governor to consider on the morning of 23 October. It is not clear what was done with the information. My investigator interviewed the Governor and the deputy governor. They both remembered discussing the issue during the morning operational meeting, but could not recall what action had taken place as a consequence. The Governor told my investigator that she would normally instruct an urgent risk assessment review to consider the deputy governor's recommendations. Unfortunately, she could not remember asking for this to be done. My investigator checked with the prison's security department to see if a review was requested at the time. They had no record of the request.

75. Later that day, the head of healthcare contacted the ward nurse for an update on the man's condition. She was told that his condition was very poor. The head of healthcare noted in his prison medical record that "efforts continue to facilitate compassionate release".

76. The man's family visited him again that evening. His sister asked to whom she needed to speak to get the restraints removed. She was advised by an escort officer to contact the prison. Her request was again noted in the bedwatch log book. During the night, the man became increasingly restless and was noted to be talking to himself continuously throughout the night. At 6.00am on 24 October, he tried to leave his side room. He told officers "you won't stop me going to the toilet", but was told to go back in his room and that the nurse would attend with the commode. The commode was brought in and removed, as and when required.

77. The man's father visited him during the afternoon. On leaving at 4.30pm, the father told the escort officers that he believed that the man was not fully aware of his surroundings. At midnight, the man pressed his alarm bell and a nurse attended. It was noted that he was incoherent. Nursing staff tried to make him more comfortable and commented that they believed his condition had deteriorated. Hospital staff informed his sister of the situation.

78. The man passed away at approximately 1.10am on 25 October. The man's sister arrived at the hospital at 1.35am and was informed of his death by the staff nurse. A site practitioner pronounced the man's death at 2.50am. The duty governor was notified and the bedwatch escort returned to the prison.

79. The next morning, the principal officer (PO) who is also the family liaison officer at Maidstone prison, notified the Coroner's office of the man's death. The Coroner's officers had not been aware of the death until this time. The PO then telephoned the man's listed next of kin, his father, who had already been informed of the man's passing by his sister. The PO next rang the man's sister on the instruction of Governing Governor. His sister was very angry due to the unresolved issue of the man remaining in restraints at the point of his death. Her contact with the prison and the issue of restraints had been, from the family's point of view, deeply unsatisfactory. The man's sister told the PO that she had telephoned the prison three times and had been unable to speak to anyone, aside from a chaplain who advised her to write to the Governor about the matter. The PO took note of her concerns and offered to visit the family. This was declined. The PO then agreed that she would telephone the man's sister in a few days.

80. Unfortunately, the PO had to telephone the man's sister 10 minutes later to inform her that the Coroner needed a member of the family to identify the body, before a post mortem could take place. The PO explained why a post mortem was required. She also offered to attend the hospital with the man's sister for support, but this too was declined.

81. A couple of days later, the PO again contacted the man's sister to arrange the return of his belongings. She also offered assistance in arranging the funeral, including a financial contribution towards the cost. A visit to the prison took place on 30 October.

ISSUES

Clinical review

82. A medical practictioner conducted the clinical review on behalf of West Kent Primary Care Trust. This section summarises her findings and recommendations.

Medical History

83. The man had a long-standing history of drug and alcohol abuse. Assessments throughout the early days of his time at HMP Elmley established that he was being prescribed chlordiazepoxide for alcohol withdrawal, had no history of self-harm, and had previously tested positive for hepatitis A, B and C. The man complained of inability to sleep due to constant pain for which he requested dihydrocodeine (DF118) and sleeping tablets. He was also prescribed a combivent inhaler to manage episodes of breathlessness. Some years previously, the man had suffered a bone injury to his left upper arm and shoulder.

84. Prison healthcare records show that the man was referred appropriately to the substance misuse team, and the in-reach team at the psychiatric hospital, as part of his initial assessment at Elmley.

85. Between June 2005 and June 2006, the man attended prison healthcare on many occasions. In the majority of instances he complained of pain either in his shoulder or in his lower limbs. The man was heavily reliant on DF118 for pain control, and had been prior to his last conviction.

Findings

86. The man’s family asked the investigator to find out whether his liver disease could have been identified at an earlier stage. Owing to his longstanding drug and alcohol abuse, the man was susceptible to liver disease. Although the clinical review did not consider his earlier medical history, the clinical interventions during his time in custody would have covered the risks of liver disease as a result of his substance abuse (through the referral to the substance misuse team) and his hepatic status.

87. The man was diagnosed as having hepatitis A, B and C – all of which are liver diseases. Patients with these conditions can be symptom free and therefore not diagnosed until the disease is well established and further complications have occurred. They can also present with inflammation of the liver, and jaundice which could have masked any symptoms indicating onset of any further liver disease. The scans and medical care that the man received were appropriate, given that his use of alcohol and drugs had been curtailed in prison and his liver would therefore have had time to recover. The liver is one of the few organs which is capable of natural regeneration of lost or damaged cells. However, for patients who have been relatively symptom free, the long term complications, including cirrhosis, could be well established before symptoms occur.

88. On several occasions, the date of the man's next hospital outpatient appointment was checked by prison healthcare staff to ensure that it was appropriate for his presenting physical condition. When his condition was deemed to require an earlier appointment, this had been arranged. The degree of his jaundice and any sign of it getting worse were taken into account and informed this decision.

89. The man was appropriately referred to medical staff each time he specifically complained about his swollen and painful legs. However, it appears that during most of the subsequent examinations the man indicated that the pain had moved to another part of his body, such as his shoulder or arm, with his leg no longer being of concern. Ideally, nursing staff should have undertaken a Doppler test prior to the doctor seeing him at both Elmley and Maidstone prisons. The Doppler test is an ultrasound scan. A probe that emits ultra sonic waves is held over the lower part of the leg where you would expect veins and arteries. The speed at which the waves bounce back gives an indication of blood flow in the area. Elmley do not have the equipment to do this test, but could have asked a district nurse to come in and conduct it for them.

90. During the man's time as an inpatient at the local hospital, decisions taken about how and where to nurse him were based on clinical need rather than his status as a prisoner. The man's dignity, and the potential disruption and distress to both the man and other patients were factors considered in the decisions made by both ward sisters to nurse the man in a side room.

91. Issues of concern about the discharge planning process are noted below. However, the reviewer is satisfied that the decision to discharge him from hospital to HMP Maidstone was made using the same clinical and social care criteria as would be used for any patient. From that perspective, there was equity of service provision. However, a disparity arises as the home circumstances of a patient in the general community differ greatly from those of the prison population. The most pertinent difference is that a patient in the general population has easy access to their medication. By comparison, medication of any kind is valuable currency within prison, to the extent that some medications are deemed not suitable to be held in possession. Due to the size and layout of some establishments, the prisoner may have a considerable walk and potentially a number of staircases to negotiate. The reviewer says these kinds of issues should be considered when making decisions about the discharge destination for patients coming back into the prison community.

92. The man's family asked whether the length of time taken (approximately one week) to identify the blood clot on his first admission to the local hospital on 31 July 2006 was acceptable. The clinical reviewer raised this with a sister (Local Hospital) during interview. The sister said that a blood clot was already suspected by the time he had reached the ward. Having been taken to hospital on 31 July, the man arrived on the ward on 2 August from the medical assessment unit where initial assessments had been carried out which led to the diagnosis of a blood clot. The clinical reviewer concluded that this was not an unreasonable length of time.

93. The reviewer judges that all infection control, equality, diversity, and clinical governance policies were adhered to by both the local hospital and prison healthcare staff.

Issues of concern

94. The clinical reviewer says that, although the man received a high standard of clinical care based on sound clinical judgement, some areas of concern required improvement:

- Some entries in the continuous medical record were illegible.

- Lack of compliance, mainly by medical staff, with record keeping policy requirements. At each entry the prison establishment, date and time and name of person making the entry should be stated clearly at the beginning of the entry.

Standards of record keeping and documentation should be included as a specific item in the performance monitoring and appraisal system for medical staff employed by PCTs to work in prison healthcare.

- Lack of multi disciplinary care planning in prison healthcare. This led to:

    - Lack of a co-ordinated approach to management of the man's well documented and long standing drug dependency, particularly in relation to his use of dihydrocodeine.

    - Poor discharge planning after first admission to the local hospital, compounded by a lack of appreciation and understanding of the security issues facing prison healthcare when patients are being transferred back to their care. As a result, prison healthcare staff were unable to make an informed assessment of the man's mobility and healthcare needs prior to his return to HMP Maidstone. This gave them nothing to compare his behaviour and ability to once he was back on the wing.

    - General lack of awareness and understanding amongst hospital and community based medical and nursing staff of the security issues relating to the care of offenders.

The clinical reviewer makes the following recommendations in regard of these specific issues:

Introduction of a requirement to hold a multidisciplinary case conference to take place as soon after reception into a prison of any offender with a known long-standing medical problem or condition. This case conference would agree the management plan to be followed by all medical and nursing staff.

A review of documentation with a view to developing a format for the recording and transmitting of the agreed management plan to all staff, especially in the event that the offender is transferred from one establishment to another.

Development of a specific discharge protocol related to the safe discharge of a patient back to a prison establishment.

The National Health Service in conjunction with the Prison Service should consider awareness raising training for staff working in traditionally non-secure environments caring for offenders. Alternatively, depending on the likely frequency of offenders requiring care outside the prison healthcare settings, the development of shared guidelines for best practice that can be issued to all staff wherever the situation arises.

Good practice

95. Throughout the clinical review, a number of areas of good professional practice are identified. There are two in particular worthy of repeating here.

Tracking of appointments

Throughout all transfers between prison establishments, details of outpatient appointments for the man were checked to ensure none was missed or that alternative dates were reasonable in terms of length of waiting time, depending on the urgency of need.

Quality and detail of bedwatch record.

In all cases the bedwatch officer's notes in the bedwatch records were extremely detailed, correctly timed and signed. The only additional improvement that would make following them easier would be the inclusion of a date at every first entry after 23.59hrs.

Findings related to prison policy and procedure

Transfer from hospital

96. I would like to comment further on the last two observations made in the clinical review. The head of healthcare at Maidstone prison maintained during interview with my investigator that it is part of her duty to facilitate an appropriate transfer from hospital back into custody. She said that the healthcare department actively try to get involved as soon as the hospital begins developing a discharge plan. The aim is to get a prisoner who needs a recovery period (that does not require a bed in hospital) transferred directly to Swaleside's inpatient facilities. Despite these good intentions, this did not happen in the man's case. Although he was admitted to hospital on 31 July, it was noted in his prison medical record that by 14 August there was still no discharge plan. Yet, later on in the day, a further entry was made indicating that he was to be discharged and returned to

97. On his return to Maidstone, it was soon acknowledged that, contrary to the hospital's recommendations, the man would be better cared for at Swaleside as an inpatient. Although healthcare staff at Maidstone made every effort to accommodate his needs, at times he still struggled to walk to healthcare to pick up his medications and he was visibly pale and weak. The man was said to be very unhappy with his situation and felt that being on a normal wing he was not receiving the level of care that he needed. The Head of Healthcare telephoned the hospital to discuss the discharge plan. The hospital maintained that the man was able to walk and care for himself.

98. Measures were put in place to make the man's recovery at Maidstone easier. Some medications were given to him in-possession. However, he was still required to make his way to healthcare to collect his painkillers as they were opiate based. The head of healthcare noted that some days the man would collect his medications and others not. She told my investigator that, when a prisoner does not collect analgesic medication, there is no follow-up. That would only happen if it was a supervised medication. It is simply assumed that the prisoner did not need a painkiller. If it transpired that the prisoner could not physically attend, the medications would be taken to them on the wing. In his case, a motorised buggy was offered to help him to move about the prison but he refused it.

99. At this stage, discussions were restarted about transferring the man to Swaleside for a period of recovery. The decision to request a transfer was correct, however I wonder whether this could have been resolved before his discharge had more detailed communication taken place in managing his care plan. Greater prison healthcare input in the discharge plan would have provided the opportunity to explain that HMP Maidstone does not have the facilities to manage a prisoner requiring bed rest.

The use of the escort chain

100. The Prison Service National Security Framework gives guidance on the procedures for escorting prisoners outside prison and the use of restraints. There is particular advice on hospital escorts, bedwatches and when restraints should be applied or removed during medical treatment. Maidstone's local operating policy for bedwatch duties and escorting a prisoner reflects those outlined in the Security Framework.

101. The section relating to hospital escorts says that the prison must first undertake a risk assessment to decide the level of escort and restraint required for the safe custody of each prisoner. This should be done before movement to hospital except in an emergency situation (when it should be completed within 24 hours). Factors to be taken into account include:

- the prisoner's medical condition
- the prisoner's security category

- the nature of their offence
- their risk to the public and hospital staff
- their motivation to escape.

101. The Security Framework stipulates that the normal arrangements for prisoners being escorted from closed establishments are that they will be accompanied by two officers and "restraints must be used unless there are medical objections". Restraints can be removed at the point of medical consultation or treatment unless the risk of escape is too high. Although this is the normal arrangement, the section on 'escorting options' states that other options are available to prison managers. Two of these are:

    - "an escort with two officers or more with no restraints"
    - "an escort with one officer and no restraints (appropriate where the prisoner's medical condition of lack of mobility is such that he or she cannot escape unaided and there is no evidence that an escape attempt is likely)."

102. In instances where restraints are not applied and escort staff remain, officers should be positioned between the prisoner and any exit and as close to the prisoner as is practical.

103. The section on reviewing escort arrangements says that, "the level of security necessary in all cases must be kept under review to take into account the prisoner's developing medical condition, the physical surroundings in which the prisoner is located and any emerging intelligence."

104. The section on restraints lists the circumstances in which handcuffs are usually not necessary. The one specifically related to medical treatment states:

    "On prisoners attending for medical treatment outside the prison, if the prisoner's medical condition renders restraints inappropriate or a risk assessment demonstrates they are unnecessary in all the circumstances. Restraints will not normally be necessary when the prisoner's mobility is severely limited, e.g. when he or she is on crutches …."

105. With regard to the removal of restraints, the Security Framework says that they can only be removed in certain circumstances during hospital treatment. It does not list the circumstances but refers to the section on hospital escorts. It says that restraints may be removed "when a medical professional requests their removal on health grounds". If necessary, escorting officers should first obtain the permission of the duty governor before agreeing to such requests.

106. I remain concerned about the lack of a risk assessment review after the submission of the deputy governor's memorandum to the Governing Governor on 23 October. My investigator asked the Governing Governor what action had been taken in response to the memorandum. The Governing Governor recalled reading the memo but could not say for sure what action was suggested or taken. She also recalled the matter being raised during the operational meeting held on the morning of 23 October. These meetings are

107. The Governing Governor told my investigator that the normal course of action in response to a request to reconsider security measures would be to conduct a review of the risk assessment. Normally, she would ask for this to be done as soon as possible. She could not recall if she had made this request. There is no indication in the risk assessment or bedwatch log that the review took place.

An auditable record must be made of key actions or decisions relating to security.

108. Despite the concerns raised by doctors and the family regarding the restraints, escorting officers noted that the nursing staff were content for the man to remain restrained due to his infectious state. They felt it was safer for others in the ward if the risk of infection could be minimised by restricting his movement around the hospital. The clinical reviewer asked nursing staff about this. Both the clinical reviewer and my investigator pointed out that restraints are not used for medical reasons on non-prisoner patients so why was this a proper justification for keeping him handcuffed. The clinical reviewer was told that all decisions taken regarding how and where to nurse the man were based on clinical need rather than his status as a prisoner. She was also told that the issues of his dignity, and the impact on other patients, were also considered. I regret to say I find this rather difficult to believe.

109. I understand the critical importance of security on bedwatches and that the Prison Service is properly risk averse. The Service has an admirable recent record in preventing escapes, and hospital bedwatches are an evident security weak spot. However, the man was a terminally ill man, with a short life expectancy (albeit undetermined). He was also a category C prisoner approaching his Parole Eligibility Date. His health was deteriorating. He was uncomfortable, in pain and, although mobile, it was a struggle for him to move around. I question the need for this man to have remained in escort chains up to the point of his death. The assessment undertaken by the deputy governor on 21 October concluded that he was an unlikely escape risk and that consideration should be given to on revisiting the need for restraints. It was an undignified situation for him and distressing for his family (and, I imagine, for the bedwatch staff), particularly as the process of seeking early release on compassionate grounds was already underway.

110. In recent investigations into deaths of prisoners in custody at HMP Birmingham and HMP Gartree, I have been critical of the lack of flexibility in local policy on bedwatches. I have also commented that the problem is more deep rooted than local policy. The Security Framework does not give explicit advice on procedures for dealing with gravely ill or dying prisoners in outside hospitals or hospices. There is no provision for prison staff to make a decision to remove restraints on compassionate grounds when the risk of escape is clearly much reduced. Yet I know of cases where Governors have given permission for restraints to be removed on compassionate grounds and have always commended them for doing so. I think that consideration should be given to

The Prison Service should ensure that a review of the escorts, restraints and bedwatch sections of the National Security Framework takes place with a view to providing advice to staff on the removal of restraints from gravely ill or dying prisoners on compassionate grounds when their risk of escape is much reduced.

Early release on compassionate licence

111. Early release on compassionate grounds can be granted in medical cases and where a Governor supports the application. A form is submitted, with medical and probation reports, to the Early Release and Recall Section of the Ministry of Justice. Early release is granted only in the most exceptional circumstances.

112. An application may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months might be considered to be an appropriate period. It is essential to try and obtain a clear medical opinion on the likely life expectancy. The Secretary of State also needs to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison.

113. I am pleased to see that an application for early compassionate release was begun as soon as the man was diagnosed terminally ill. However, in the man's case the consultants at the hospital were reluctant to put a time frame on his life expectancy which could have been anything from three weeks to three months. Nevertheless, in the PSO three months is considered to be an "appropriate period". It would therefore have been possible for the consultants to submit a medical report supporting the application.

Post mortem

114. In the 'history' section of the port mortem report, it is recorded that the man was buying and selling subutex in prison. It is not clear where this information was obtained. My investigator has seen no evidence to suggest this happened.

Family liaison

115. HMP Maidstone has good family liaison processes in place. The family liaison officer (FLO) is linked with other FLOs from three other prisons in the Kent area. Regular meetings are held to provide support and to discuss developments in their respective establishments. I think that this coordinated and supportive approach to family liaison work is commendable.

116. The family liaison officer at Maidstone provided a high level of support to the man's family. It was unfortunate that the prison's links with the family were not as effective during the man's illness. However, the efforts of the family liaison

Support and counselling

117. After being diagnosed terminally ill, hospital staff spent a day discussing the implications of his illness with both the man himself and his family. The man's family expressed concern to my family liaison officer that neither they nor the man felt adequately supported by the hospital or prison in coming to terms with the news. My investigator noted the bedwatch log records that a Macmillan nurse did try to offer services to the man, but he declined assistance. Interviews with hospital staff also indicate that the discussions held with the man and his family covered the implications of his resuscitation status.

RECOMMENDATIONS

Clinical

- **Standards of record keeping and documentation should be included as a specific item in the performance monitoring and appraisal system for medical staff employed by Primary Care Trusts to work in prison healthcare.**

The Prison Service has accepted this recommendation, however request that it "must be noted that the majority of healthcare staff at HMP Maidstone are still directly employed by the Prison Service and not the Primary Care Trust."

- **Introduction of a requirement to hold a multidisciplinary case conference, to take place as soon after reception into a prison of any offender with a known long-standing medical problem or condition. This case conference would agree the management plan to be followed by all medical and nursing staff.**

- **A review of documentation, with a view to developing a format for the recording and transmitting of the agreed management plan to all staff, especially in the event that the offender is transferred from one establishment to another.**

- **Development of a specific discharge protocol related to the safe discharge of a patient back to a prison establishment.**

- **The National Health Service in conjunction with the Prison Service should consider awareness raising training for staff working in traditionally non-secure environments caring for offenders. Alternatively, depending on the likely frequency of offenders requiring care outside the prison healthcare settings, the development of shared guidelines for best practice that can be issued to all staff whenever and wherever the situation arises.**

General

- **An auditable documented record must be made of key actions or decisions to take place relating to security.**

- **The Prison Service should ensure that a review of the escorts, restraints and bedwatch sections of the National Security Framework takes place with a view to providing advice to staff on the removal of restraints from gravely ill or dying prisoners on compassionate grounds when their risk of escape is much reduced.**

The Prison Service has accepted all of the recommendations made in this report. No action plan has been submitted to date to outline how the recommendations will be addressed.