Investigation into the circumstances surrounding the death of a man at HMP Maidstone

Report by the Prisons and Probation Ombudsman for England and Wales

February 2008

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Maidstone. The man had been recalled to prison in 2004 and was transferred to Maidstone a year later. A few days before he died, he spoke to his family and complained of chest pains. He did not seek advice from healthcare. On the morning of his death, he was found collapsed on the floor of his cell and pronounced dead by a prison doctor shortly afterwards. He was 58 years old.

The loss of any family member is distressing, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

The investigation was undertaken by one of my investigators. We would like to extend our thanks to the Governor of Maidstone, and his staff, for their cooperation during the investigation. Particular thanks go to the prison's liaison officer, for gathering all relevant documentation and ensuring it was made available. We would also like to extend our thanks to the prison's family liaison officer, for her assistance.

A representative from West Kent Primary Care Trust carried out a clinical review into the care and treatment the man received whilst in Maidstone. I am indebted to the clinical reviewer and include her review as an annex to this report.

The main focus of my investigation has been in relation to the way staff at Maidstone reacted to the man's collapse. They did so with great professionalism and compassion. Of particular note was the work of the family liaison officer which was of the highest order.

My report does highlight two areas where more attention to detail could be paid. That said, in neither of these areas did the lack of information have an impact on what happened to the man. A further matter was raised with the Governor at the investigation stage and all issues have been fed back more formally since. For this reason my report makes no recommendations. The clinical reviewer makes one recommendation which I endorse, and commends the Head of Healthcare and her staff for their record keeping.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2008**

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SUMMARY

The man was recalled to prison in 2004 following breach of his licence conditions. He was sent to HMP Maidstone in March 2005 to serve the remainder of his six year sentence and settled well at the prison. Following his arrival, he was located on Thanet Wing and allocated a personal officer. He applied for parole and, with the help of his personal officer, also applied for a place on the Enhanced Thinking Skills class. He expressed an interest in pursuing an Open University course.

The reception healthcare screening recorded a history of alcohol misuse, smoking and anxiety. He was referred to a drug counselling service but refused to attend. He was also offered advice from the smoking cessation clinic but declined the offer. The doctor who first saw him checked his blood pressure and asked staff to monitor it for any increase. The doctor also referred him to Maidstone's mental health In-reach team. The man attended some support sessions but not others. Maidstone's healthcare came to regard him as a reluctant patient.

For the next few months, the man continued to resist healthcare involvement. In October 2005, following a high blood pressure reading, he had an electro-cardio graph (ECG) to determine the source of his high blood pressure. The ECG was normal, but the doctor prescribed medication to reduce his condition. The following year, in January 2006, the man was also advised that he increased his risk of a stroke or heart disease if he did not take his medication. He continued to resist the medical help he was offered and, reportedly, forgot to collect his prescriptions.

When the man was not working in the laundry, he spent much of his time playing guitar, painting and attending a Christian church group. He kept himself to himself mostly but did interact with his personal officer on a regular basis. His personal officer changed half way through the year and again in January 2007. Both personal officers noticed that his church involvement and religious beliefs had increased. He declined to attend courses as part of his resettlement plan on the basis that they went against his religion.

The man had a further mental health assessment between November 2006 and January 2007. This was the last time he accessed the health services at Maidstone. Ongoing weekly support was offered to help manage his anxiety but he failed to attend his appointment on 29 January, and no more were made.

On 18 July 2007, the man went to his church group meeting at approximately 6.15pm. When he came back at 7.45pm, he went straight to his cell. A Principal Officer (PO) carried out the evening lock up at 8.15pm and the Night Duty Officer, finished his roll check at 9.15pm. The numbers tallied.

At 7.45am on 19 July, during early morning roll check, the officer looked through the man's observation panel in his cell door, and noticed he was on the floor. After two attempts to attract his attention, the officer called his colleague over and both officers pushed the cell door open. The officer entered first and found the man face down on the floor and motionless. The officer radioed for emergency

help. When healthcare staff arrived at 8.00am, the nurse carried out a series of checks to determine signs of life. The nurse found no pulse or heart beat and noticed that rigor mortis had set in.

Healthcare staff decided not to attempt to resuscitate the man, but to wait for paramedics to arrive. The paramedics confirmed that resuscitation should not be attempted and the prison doctor pronounced his death at 9.10am that morning.

THE INVESTIGATION PROCESS

1. On 23 July 2007, my investigator opened the investigation and was briefed about the circumstances leading to the man's death. My investigator requested all prison and medical files in advance of a visit to Maidstone on 3 August. At the prison, she met with the liaison officer, and visited the man's cell. The documents were provided. My investigator began the process of identifying the key issues and the staff who had interacted with the man during his time at Maidstone.

2. My investigator visited Maidstone again on 15 October 2007 and interviewed a number of prison staff. The clinical reviewer, visited Maidstone separately and interviewed nursing staff and the Head of Healthcare. My investigator provided her with a number of questions to raise with healthcare staff, and I am grateful to her for incorporating these into her own enquiries. The clinical review into the care the man received whilst at Maidstone was sent to my office on 15 October. The review and recommendations are attached as an annex to this report.

3. The Coroner was informed of the Ombudsman's investigation. The post mortem report concluded that the man's cause of death was as follows:

   1a. haemopericardium
   1b. ruptured myocardial infarction

4. The inquest took place on 29 August 2007 and the jury returned a verdict of natural causes. The Coroner will receive a copy of this report when it is completed for his information.

5. One of my Family Liaison Officers (FLOs), contacted the man's next of kin shortly after the investigation was opened. My FLO explained her role and that of my office, and provided information about the investigation process. She also offered his family the opportunity to meet her and my investigator to discuss any issues or concerns. The man's family did not wish for a visit but raised one concern about the monitoring of his blood pressure, and whether he saw a member of healthcare staff about this. I address this issue in the appropriate section and hope his family find this report helpful.

6. At the draft report stage, the man's family raised concern over monitoring of his high blood pressure. His family also asked whether his death was unexpected.

HMP MAIDSTONE

7. HMP Maidstone is a category C training prison holding around 482 convicted adult males serving long term sentences (four years or more). Built in 1819, three of the original buildings are grade II listed and are still in use. Maidstone has undergone, and was still undergoing, major refurbishment at the time of my investigation.

8. There are four residential units known as Thanet, Kent, Medway and Weald wings, and each houses a different type of prisoner. The man was located on Thanet wing, a vulnerable prisoner wing, which has 174 cells on three levels. He had a ground floor cell and remained there for the duration of his time at Maidstone.

9. In 2003, Maidstone was re-roled from a category B to a Category C training prison. This change in prisoner population led to a shift in focus for staff. It also resulted in reduced staffing levels. The current population is generally younger, where prisoners serve shorter sentences and are less settled.

10. Maidstone has been inspected by Her Majesty's Chief Inspector of Prisons three times in the last five years. The most recent inspection, conducted in February 2007 and published in April that year, was the second since Maidstone's re-role and drew comparisons with the inspection published in January 2005. The Chief Inspector of Prisons, said that Maidstone had been seeking to adjust to its new role since the re-role and was struggling to provide purposeful activity to prisoners, within its aging buildings.

Healthcare

11. Maidstone has been complimented for its healthcare centre. In 2002, the Chief Inspector of Prisons found evidence that the centre formed an integral part of the prison and was not operating as a wholly separate facility. This integration was demonstrated at both practitioner and management levels. Healthcare staff made contributions to the prisoner induction programme. The effectiveness of this was shown in the prisoner questionnaire where most prisoners said they found it easy to see a doctor or nurse. In 2007, Inspectors also found that clinical governance meetings were chaired by the Governor, and that these levels of representation reflected the importance given to healthcare. The 2007 report also said that healthcare staff were committed to providing good quality care, and used some innovative approaches.

12. West Kent Primary Care Trust took over commissioning responsibility for providing healthcare services in 2004. In the same year, the management structure changed with the appointment of a Head of Healthcare. The healthcare centre has no in-patient facility and currently provides clinic based and triage provision, similar to a GP surgery in the community.

Personal Officer Scheme

13. Maidstone operates a personal officer scheme for all prisoners. In 2002, the Chief Inspector of Prisons was critical of the lack of guidance and training given to officers to prepare them for the role. The report made a recommendation for the introduction of personal officer training. It also found that the level of interaction between personal officers and prisoners could vary greatly from regular, positive contact to little contact. Despite the lack of training, there were many examples of well written contributions and good use of wing history records from some personal officers.

14. The follow up inspection found that the recommendation had not been achieved. A training booklet was available and had been incorporated into the induction programme for new members of staff, but there had been no personal officer training since April 2004. In January 2007, the scheme had been relaunched and improvements made. However, the Chief Inspector of Prisons recommended ongoing management checks to assess the quality of the scheme.

Faith and Religious Activity

15. There is a multi-faith chaplaincy team at Maidstone and the man was a regular attendee. In 2002, the Chief Inspector of Prisons said that prisoners should be encouraged to attend religious group activities, and that unnecessary clashes with other activities should be rescheduled. On her return in 2004, the chief Inspector of Prisons said "… changes to the core day had not produced the anticipated clashes between early evening activities. Prisoners were still able to attend the chapel between 6.15pm and 7.30pm and the new free-flow system of prisoner movement meant that they were not delayed in getting there." In 2007, the Chief Inspector of Prisons reported that the chapel continued to be used by all faiths and that the Chaplaincy team was engaged in wider prison work, including deaths in custody procedures.

KEY FINDINGS

The man's arrival at HMP Maidstone

16. When the man arrived at Maidstone, his medical record from HMP Lewes said he had no outstanding medical appointments. His reception healthcare screening assessed him as medically fit and made a note of his history of chronic alcohol use. He was referred to the drug counselling service. His smoking habit was also recorded but he refused help with smoking cessation. His blood pressure was taken. A note was made for healthcare staff to take it again in one week and, if raised, to consider treatment for the condition.

17. Within two days of the man's arrival on Thanet House, he was allocated a personal officer. The officer introduced herself and commented that he had settled in well. He completed his induction week and told staff on the wing that he thought it was good.

18. It is not clear whether the man's blood pressure was taken the following week. The next continuous entry in his medical records was made by a prison doctor on 14 April. His blood pressure was recorded as normal (110/80) and the doctor requested another check up in six months time.

19. For the next few months, the man had no contact with healthcare. He appeared to respond well to his licence recall and completed an application form to make an appointment to see one of the education tutors. He told his personal officer that he was keen to continue studying towards a degree. His record was updated to reflect his positive approach. He joined the church group and began working in the laundry.

20. A prison doctor saw the man again on 11 August. The doctor made a note of his history of anxiety and hallucinogenic episodes. He told the doctor that his mind went blank at times and that he had thought about taking his own life whilst in HMP Lewes. The doctor wrote a plan in his medical record for an F2052SH (now ACCT) self harm file to be opened. The doctor also referred him to the Mental Health In-reach team.

21. The man saw the In-reach team the following day. He spoke openly about his anxiety and the difficulty he had in relaxing and finding coping mechanisms. He described symptoms of panicking and cold sweats. The Registered Mental Health Nurse (RMN) who assessed him arranged to contact his Community Psychiatric Nurse (CPN) and offered weekly support meetings.

22. The man's first support session took place on 24 August. He kept another appointment on 5 September and spoke openly again. He said that he had not had further thoughts of self harm and was coping well. He kept himself to himself on the wing and was happy to be medication free.

23. Over the next few months, the man's personal officer made a number of entries relating to his attitude in his wing history. The personal officer also

told him that his parole application had been unsuccessful. They agreed to discuss the application but he appeared uninterested when the time came. His personal officer attempted to speak to him again on 12 October. He said he was fine and seemed to draw comfort from his religious beliefs. The personal officer became worried about his behaviour and preoccupation with his beliefs. His wing history was updated. His personal officer spoke to a member of healthcare about his preoccupation and they confirmed they knew about it.

24. Between October 2005 and December 2005, the man's blood pressure and anxiety levels were monitored. He underwent a number of medical examinations to determine the cause of his increasingly high blood pressure, including an electro-cardio graph (ECG). The result of this was normal but he was still prescribed medication (bendrofluraside) to control his blood pressure. He refused to take medication for anxiety and, on a number of occasions, said that he forgot to collect the medication.

25. On the wing, the man's personal officer continued to monitor his behaviour. The officer spoke to him at length about his parole and a hearing planned for January 2006. In December, she produced a parole assessment for the security department. The man's hearing was postponed until 2 May 2006 and his personal officer continued to work with him on his application throughout the months leading up to the re-arranged date. When his application for parole was rejected, the she spoke to him again at length. This time, she found the conversation unsettling and spoke to healthcare. An appointment was made for him to see a member of healthcare staff the following day.

26. The man's non-compliance with healthcare advice continued. From October 2006 to January 2007, his medical records documented a further mental health assessment, this time at his own request. Regular support sessions were arranged as before but the CPN found no evidence of anxiety, depression or psychosis. On Thanet House, he was allocated a new personal officer. His new personal officer made regular entries in his wing history which described him as "in a world of his own". The officer's last entry on 27 December explained that the man had decided not to attend courses because it went against his beliefs.

27. The man turned up for one of the In-reach support sessions on 8 January 2007 but decided not to attend the one planned for 29 January. No further appointments were made for him. During this time, his wing history remained empty.

28. On 9 February, another officer introduced himself as the man's new personal officer. He remained in contact with him for two months until, on 7 April, he said that he was no longer in the role. Unfortunately, the man was not allocated a replacement personal officer and his wing history contained no entries for the next three months. The last entry was made on 4 July by another Thanet House officer and simply recorded a routine cell search.

Evening of 18 July

29. On 18 July 2007, an officer saw the man go to his church group as usual. This was at approximately 6.15pm. He returned at 7.45pm for evening lock up. He went into his cell for the night and a PO carried out the evening roll check. The PO recorded the number on the appropriate sheet, signed for it, and passed it to the Night Orderly Officer, a Senior Officer (SO), for counter-signing.

30. The night duty officer, an Operational Support Grade (OSG), came on duty at 8.45pm. He tested the alarm bell and began his own roll check which finished at approximately 9.15pm. One of the officers told my investigator that he stayed on as 'late stop' until 9.00pm to help out with any remaining jobs. The OSG recorded the numbers which were the same as the PO's, and signed for them. The police asked the OSG whether he remembered seeing the man when he did his check. His statement said that he did not specifically remember seeing him, but if he had seen anyone in a collapsed state when he looked through the observation panel he would have remembered that.

31. At approximately 11.45pm, another prisoner who was located in a cell directly above the man said that he heard a crash "like a cupboard falling over". He did not press his cell bell. The OSG carried out his 'pegging' (meaning that he patrolled the wing and recorded his movements with a pegging gun) as normal, informing the SO that he was patrolling at regular intervals. The OSG made no mention of any further activity during the night.

Morning of 19 July

32. The following morning, the same OSG's shift officially finished at 7.30am. An officer from another wing was detailed to carry out the early morning roll check in order for the OSG to go home. One of the officers on Thanet House, who was on early morning duty, made her way to the wing for 7.30am. The officer started the roll check on the third landing in her colleague's absence. This delayed the OSG who was not permitted to leave the wing until the roll check numbers were confirmed. Two other officers started work at 7.45am. When they arrived, both officers began checking cells on the ground floor to help out the officer. The officer detailed to carry out the role check arrived some time between 7.30 and 7.45am, and went straight to the second floor landing to check cells.

33. Two of the officers started checking cells on the left and right hand side of the ground floor. When one of the officers got to the man's cell, he looked through the observation panel and saw him, from the waist down, on the floor. This was at approximately 7.50am. The officer told my investigator that he could not see the man's head and upper body because he was positioned with his head closest to the door. The officer tried to attract his attention by kicking the door and calling his name. When he did not get a response, the officer called his colleague, who was on the opposite side of the landing. This officer also attempted to get a response from the man, but when he heard nothing he decided to enter the cell. The officer who first discovered the man,

told my investigator that he knew from his basic training that it was usual for three officers to go in. He added that he knew the man was not a problematic prisoner, and that he was in a single cell, so they decided to go in together.

34. The officer described the difficulty they had in getting into the cell because the man had fallen with his head and upper body directly behind the door. The other officer unlocked the door but it took both men to open it sufficiently for the officer to squeeze through and go in. By this time approximately two minutes had passed and it was 7.52am. The officer checked the man's pulse and 'felt it was too late' according to the recollection of his colleague. The officer who checked the man, got on his radio and called the control room for emergency assistance. The other officer also went into the cell and helped his colleague turn the man over in order to make it easier for healthcare to work. The officer told my investigator that he remembered how 'squashed' his face and hand was when he and his colleague turned him. He said that this was due to the man's body weight bearing down on them.

35. When an SO from the healthcare centre and a Registered General Nurse (RGN), heard the emergency call, they grabbed the emergency bag and oxygen and immediately made their way to Thanet House. The log said that they arrived at 8.00am, which was approximately 10 minutes after the first officer found the man. On arrival, they both went into the cell and the officers left. Extensive entries were made in his medical records to record what they found. The nurse checked to see if he was breathing and said he was motionless. The man did not respond to pain stimuli, and the nurse did not detect a pulse or heart beat. His pupils were also fixed and dilated and, in the nurse's opinion, haemostasis had set in. Neither the SO nor the nurse felt it was appropriate to administer Cardio Pulmonary Resuscitation (CPR). The nurse asked one of the officers to call an ambulance.

36. Another Thanet House officer came on duty at 8.00am and saw one of his colleagues in the lobby area of the wing. He told my investigator that he knew something was wrong. The wing manager from Medway House, an SO, had already made his way to Thanet House to co-ordinate a response to the emergency. The SO asked the officer to act as log keeper and briefed him as to what had happened. The officer went to the man's cell and positioned himself outside. The cell door was already shut and security sealed with healthcare staff inside. The officer began his log at approximately 8.10 am and proceeded to record who entered and left the cell and at what time.

37. Paramedics arrived on the wing at approximately 8.20am. They went into the man's cell and checked for signs of life. Approximately five minutes later, the paramedics left the cell. According to the incident log, his death was pronounced at 8.20am.

38. The morning regime on Thanet House was inevitably disrupted. Prisoners on Thanet House were due to be unlocked at 8.15am to go to work or education but this was delayed.

39. A PO, who is also a trained family liaison officer (FLO), was contacted by the deputy governor who told her that the man had died. The PO immediately made her way to his wing to check the computer system for further information about his next of kin. The system showed that his sister lived a long way from Maidstone, in the south west of England. On seeing this, the PO contacted the nearest prisons to his sister's home and spoke with their respective FLOs. The PO arranged with the FLOs at two other prisons, for the news to be broken in person. The PO followed up in writing what had been agreed and provided the FLO's with further information about the man's collapse. The PO also arranged for a police liaison officer to be on stand by in case the prison FLOs ran into any difficulties.

40. At 8.35am, the man's cell was secured with a security lock supplied by the wing manager. The officer keeping a log was also placed in charge of the key. He continued to keep a log outside the cell door until approximately 9.05am when he was instructed by the wing manager to hand over log keeping duties to another officer. The officer who kept a log, told my investigator this was because he was better deployed as a wing officer to help return the wing to as normal a regime as possible. He handed the security lock key over to his colleague and then began to unlock prisoners. The officer told my investigator that no prisoners approached him about the man's collapse. They just seemed to want to return to normal.

41. The officer who relieved his colleague of log keeping duty, had arrived on Thanet House just before 9.00am. He told my investigator that he worked in the Education Department and had arrived that morning to find his classes cancelled. He was told to make his way over to the man's wing to help with the contingency plans. When the wing manager asked him to take over log keeping duties, the officer did as his colleague had done and placed himself outside the man's cell. At around 9.20am, the nurse returned, this time with a prison doctor. The officer unlocked the cell and they entered. The prison doctor pronounced the man dead at 9.25am.

42. Within 30 minutes, two police officers and the Coroner's officer arrived at the man's cell and the officer keeping log let them in. At 10.10am, all three left the cell and it was resealed. The man's cell was not reopened until the funeral directors arrived at approximately midday. The police officers took a statement from the officer who found the man. This acted as a combined statement for both he and his colleague. The OSG, who was still unable to leave the wing, also spoke to the police and provided a statement. The police did not take statements from anyone else who responded to the man's collapse, including healthcare staff.

43. A hot de-brief took place and all staff involved in responding to the man's collapse were offered support by the prison care team. The officers who found him were told to go home and were offered ongoing support.

Informing the man's next of kin and ongoing support

44. At the request of the PO with FLO responsibilities, the FLO's from the two prisons closest to where the man's family lived, visited their home and broke the news of his death in person. They offered immediate support in their capacity as FLOs and took with them an information pack with advice and guidance on sudden death experiences. They explained what type of ongoing support Maidstone could offer, including help with arranging the funeral.

45. During the visit, the man's sister said she had spoken to him a few days before he died. He had complained of feeling unwell and said he was "having the most violent pain that he had ever experienced". His sister told him to see the healthcare staff at Maidstone. The visiting FLO's informed him sister that, according to the information they had, he did not approach healthcare.

46. The man's sister rang the PO at Maidstone in the afternoon. She was naturally upset and explained that she had not been aware of the reason for his latest imprisonment. The PO felt that this was not the right time to clarify why he had returned to custody. They spoke about the post mortem and the PO explained why this was a mandatory procedure for all deaths in custody. The man's sister said that she did not want to discuss funeral arrangements yet, but did enquire about the inquest procedure. The PO offered her help in contacting his daughter if other family members felt unable to do so. The man's sister agreed to let her know if help would be needed and said she was happy for the PO to contact her with the post mortem results.

47. For the next few days, the PO updated her colleagues at Maidstone and kept in contact with the Coroner's officer for news of the post mortem. On 25 July, she rang the Coroner's office again and obtained the post mortem results. The PO then told her senior management team that the man had a heart attack and that the inquest would be opened and adjourned the following day. She then rang his sister. They discussed his death and the inquest procedure. The PO also explained that a memorial service would take place at Maidstone, and that his family were welcome to attend.

48. They also discussed the man's funeral arrangements and his property. The PO explained that Maidstone could contribute towards the cost of the funeral and had collated all of his property. The PO offered to travel to the south west to return the property to his family in person. His sister was grateful for the offer and said she would discuss a funeral contribution with her solicitor.

49. The PO spent the next day arranging the funeral and rang the man's sister. During the conversation she asked if a member of staff from Maidstone's chaplaincy could attend, to which his sister had no objections. On 27 July, the Coroner's office told the PO that the inquest was scheduled for 29 August. She telephoned his sister to confirm both the funeral arrangements and the date of the inquest. The PO also agreed to travel to the south west on 8 August to return his property.

50. On 31 July, one of the FLOs wrote a summary of the family visit for the PO's records. The letter was married up with the PO's family liaison log. The final funeral arrangements were also logged, including another telephone call to the man's sister to confirm his favorite hymn for the service. The funeral took place on 6 August. A member of staff from Maidstone's chaplaincy attended and flowers were also sent from the prison. The PO returned the man's property in person two days later.

ISSUES CONSIDERED IN THE INVESTIGATION

51. It is pleasing to issue a report where the investigation has revealed nothing that should be the subject of my own formal recommendations. Nevertheless, I have identified two areas where improvement would strengthen Maidstone's policies and procedures and deal with these below. The clinical reviewer makes one recommendation.

52. The man's death was sudden and unexpected. As I mention in the foreword to this report, staff at Maidstone responded well. From the moment he was found, the local emergency contingency plans were put to the test and staff followed them efficiently and effectively. I also mentioned the strength of family liaison support that his family received after his death. There is much in this report of which Maidstone can feel justly proud.

53. The man had high blood pressure and displayed symptoms of anxiety at Maidstone. On the whole he chose not to comply with the treatment he was offered. This did not go unrecognised. He was monitored by healthcare staff and the mental health In-reach team regularly and his non-compliance with prescribed medication was always recorded. These were interventions that the clinical reviewer feels were equitable to and consistent with those offered within the wider community.

54. Throughout his time at Maidstone, the man's history of alcoholism, high blood pressure and anxiety was documented by healthcare staff. Regular monitoring was evidenced and appropriate interventions were offered but he was reluctant to take the advice. The clinical reviewer did not feel that his healthcare was anything other than what he would have received in the community. As with a patient in the community, medical professionals cannot force someone to comply. What they can do is record any non-compliance that a patient displays. Healthcare staff at Maidstone did exactly that.

55. Prison was not a barrier to the care the man received before his death. In fact, the communication between his personal officer, and healthcare staff in relation to his behaviour demonstrated a holistic approach to working with him. His personal officer's approach to the personal officer role brought two sides of the prison together and reduced the likelihood of any concerns being missed. I am disappointed that staffing changes in Thanet House broke the consistency of this work. However, it did not have any bearing on the outcome for the man.

Personal officer scheme

56. The personal officer scheme generally works well at Maidstone. Within two days of arrival, the man was allocated his personal officer and he settled in well. From then on, he interacted with his personal officer regularly. His prison records were updated after each discussion, development or concern that either the man or his personal officer had, and any action to take as a result of discussions was carried out in a timely and effective way. I am in no doubt that his personal officer's approach to the scheme and her record

keeping gave her colleagues all the information they needed about him. There are obvious benefits to prisoners when the personal officer scheme works well. There are also prison wide benefits in providing both positive and negative information about individual prisoners. In addition, his personal officer's records have helped to tell the man's story in this report.

57. The man's personal officer changed on two occasions during his last year in prison. The level of interaction remained consistent enough. One of the officer's told my investigator that changes in personal officer were usually due to staff shortages or movement, and could not always be avoided. I accept the need to redeploy staff. I also accept that promotions and transfers are an inevitable development affecting staffing. However, I am saddened that, for whatever reason, the man did not get another personal officer after the last conversation recorded on 7 April 2007. The man's wing history was left blank for three months and it does not appear that management checks were carried out to pick up on the lengthy gap in recording. I do not suggest that the personal officer scheme needs to be reviewed. However, I know the Governor will wish to reflect upon what happened on this occasion to ensure that the high standards of the personal officer scheme do not lapse.

58. The Chief Inspector of Prisons made a recommendation for personal officer training in her 2002 and 2004 inspections. The most recent report in 2007 recommended ongoing management checks. I make no recommendation of my own, but I do urge the Governor to consider the benefits of training. I also bring to his attention the absence of entries and management checks in the last few months of the man's life.

Roll check 18 July

59. The night OSG came on duty at 8.45pm. He carried out a roll check, according to Maidstone's local instructions, and this was recorded appropriately. When interviewed by the police, the OSG could not remember specifically seeing the man between 8.45pm and 9.15pm when the roll check was complete. However, he did say that he would have remembered seeing a prisoner on the floor. A night duty OSG's role is fairly specific and he or she is not expected to look through observation panels to check on prisoners throughout the night. An OSG is expected to physically observe prisoners who are subject to ACCT checks, but the man was not one of them. An OSG is also expected to respond to cell bells, but again there is no evidence to suggest that he used his cell bell during the night. The OSG carried out his patrols and did not record any significant events.

Roll check 19 July

60. During the investigation, the Governor was made aware that officers not strictly detailed to carry out the morning roll check on Thanet House had done so. This was in the absence of the officer who had been allocated the duty. The Governor told my investigator that he was already aware that one officer did not read the printed detail and that this delayed the roll check, albeit not in any significant way. I am grateful to the Governor for his swift action to

remedy the oversight. He said that he would produce a reminder to staff to check the printed detail and that this would be circulated in the internal newsletter issued on a monthly basis.

Administering first aid in cell

61. When both the nurse and the SO entered the man's cell, the nurse examined him for signs of life before asking an officer to call an ambulance. He did not respond and a decision was taken not to perform CPR. The nurse noticed that rigor mortis was present and said that the decision not to resuscitate was in line with Maidstone's death in custody policy. The clinical reviewer spoke to the nurse and the Head of Healthcare, about the resuscitation policy at Maidstone. The Head of Healthcare confirmed that Maidstone did not have a separate resuscitation policy and that healthcare staff took guidance from PSO 2710 which covers resuscitation, emergency equipment and how to preserve a cell after a death. The Head of Healthcare stressed that the policy advises medical staff to administer CPR, if there are no signs of breathing, unless rigor mortis has set in.

62. Responding to an emergency is a highly stressful and difficult part of the job for both officers and healthcare staff. The nurse who responded, is fully trained in advanced life support and, in her professional judgement, the man presented as someone beyond resuscitation due to the presence of rigor mortis. The clinical reviewer is satisfied that the healthcare response was appropriate and in line with local guidance. So am I. The reviewer further commends the Head of Healthcare and her staff for their record keeping, and the significant events analysis following the man's death. This is designed to identify good practice and how responses can be improved in future. The clinical reviewer notes that the Head of Healthcare will anonymise his records and use them as a future training tool. The review makes one recommendation as follows (I have re-worded this slightly):

The Head of Healthcare should consider reviewing the death in custody policy to include a format for recording observations and actions such as the ambulance life extinct form.

Deaths in Custody contingencies

63. I have already said that the staff at Maidstone responded well to the local instructions governing life threatening situations. All three officers interviewed by my investigator reflected that the prison handled the man's death well. What I have not said is that this was the first experience of a death in custody for the officer who found him. As newly qualified officers, both officers checking the ground floor that morning, responded professionally and exactly as their recent training had prepared them to do. Prison officers never know what they may be faced with from one shift to the next and must be prepared to respond to a wide range of situations. I congratulate both officers for their response to the man's collapse.

64. I am also impressed with the way officers on the wing ensured that the regime went back to normal as soon as possible. This was carried out under the wing manager's instructions and with minimum disruption to prisoners.

65. I am surprised that the officers and healthcare staff who responded to the man's collapse did not appear to record their individual statements. The wing manager said in his own incident report that he had asked the two officers who found him to make incident reports. PSO 2710 lists the need for a record of events explicitly. However, in interview, the officer who found him told my investigator that he was not asked to make a prison statement. The only statement he did make was to the police, jointly with his colleague. The absence of prison statements in no way suggests that important information went unreported. Both the nurse and the SO made extensive notes in his medical record and, as I have already said, the Head of Healthcare produced a significant events analysis which focused on the healthcare response. That said, my investigator was not given copies of any prison statements. This did not come to light until after my investigator's feedback session with the Governor. If not already explicit in Maidstone's local contingency plans, I urge the Governor to ensure that it is amended to reflect the requirement for statements as soon as possible.

The prison's Family Liaison Officer

66. The PO and trained FLO has already been recognised in this report for the sensitivity and compassion she showed in providing support to the man's family. During the investigation, it became clear to my investigator that the PO's colleagues had also recognised the contribution she made. Furthermore, during the feedback session with the Governor, the PO's role as FLO was discussed and recognised again. I would like to echo the commendations she has already received from the Governor and her colleagues. The family liaison support she offered is a measure of the quality of the FLO training, and the compassion and commitment that she evidently brings to the role. I urge other prisons to replicate Maidstone's approach, which is one of the best examples of family liaison work I have seen.

RECOMMENDATIONS

1. The Head of Healthcare should consider reviewing the death in custody policy to include a format for recording observations and actions such as the ambulance life extinct form.