



The
**Prisoner
Ombudsman**
for Northern Ireland

**SUPPORTING APPENDICES BOOKLET FOR
THE PRISONER OMBUDSMAN REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF**

STEPHEN PATRICK DORAN

AGED 69

IN MAGHABERRY PRISON

ON 6 JUNE 2008

4 February 2010

INVESTIGATION REPORT

Stephen Patrick Doran

CONTENTS

PAGE

Appendix 1 – Prisoner Ombudsman’s Terms of Reference	3
Appendix 2 – Clinical Review	12
Appendix 3 - Maghaberry Prison and Prison Service Policies and Procedures	20

APPENDIX 1

PRISONER OMBUDSMAN FOR NORTHERN IRELAND

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:
 - **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**
2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will

INVESTIGATION REPORT

Stephen Patrick Doran

therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

INVESTIGATION REPORT

Stephen Patrick Doran

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared,

especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

INVESTIGATION REPORT

Stephen Patrick Doran

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Secretary of State for Northern Ireland (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

16. Annex 'A' contains a more detailed description of the usual reporting procedure.

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.
2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

INVESTIGATION REPORT

Stephen Patrick Doran

3. The Service responds within 28 days. The response:
 - (a) draws attention to any factual inaccuracies or omissions;
 - (b) draws attention to any material the Service consider should not be disclosed;
 - (c) includes any comments from identifiable staff criticised in the draft; and
 - (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)
4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)
5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.
6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

INVESTIGATION REPORT

Stephen Patrick Doran

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.
8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.
9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.
10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the

INVESTIGATION REPORT

Stephen Patrick Doran

Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.
12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.
13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.
14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

Clinical Review

Appendix 2

Report to Prisoner Ombudsman concerning medical issues relating to the death of Mr Stephen Patrick Doran.

Chronology

Mr Stephen Patrick Doran (SD), a 69 year old man, was admitted to HM Prison Maghaberry on 2/6/08. He was initially seen by Nurse at Reception. She noted that he had been complaining of shortness of breath and dizziness whilst in transit to the prison and had been given his inhalers (likely to have been a bronchodilator) and GTN (for angina chest pains). (1)

He was transferred to the hospital ward where a nurse recorded his height and weight at 162cm and 44kg. This represents a Body Mass Index of 15.6 and is considerably underweight. (1)

A past history of COPD was identified, together with angina and depression. He was afebrile, pulse was 103, BP 107/66 and Pulse Oximetry (SPO2) 91 (low but commonly seen in patients with severe COPD).

He slept well on the night of 2/6/08. (2)

On 3/6/08 his pulse was still elevated at 100, BP 118/61, respiration rate 24 (raised) and SpO2 82-92. There was a comment "no cyanosis", he was eating, drinking and mobilising with the aid of a Zimmer frame. A pressure sore was noted on the sacral area (this would not be unusual in a person who had chronic illness and was very underweight). (3)

He had a comprehensive nursing assessment on 3/6/08 with the following problems identified:

1. COPD
2. Angina
3. Prostatic Enlargement
4. Pressure sore
5. Problems with mobility
6. Problems with maintaining personal hygiene.

Effective management plans were put in place to address all of SD's identified needs. In particular with respect to the COPD the plan was to monitor respiratory rate and SpO2 three times per week, encourage SD to report respiratory changes and that if there were changes the doctor should be informed. With respect to the angina he was told how to use the emergency call button, and encouraged to report pain, he had his GTN spray in his possession. (5 and 6)

INVESTIGATION REPORT

Stephen Patrick Doran

SD's GP practice was contacted to ascertain which medication he was taking (8) and these were prescribed by the prison staff with the substitution of Stilnoct 5mg for the Temazepam. (7)

The following medications were prescribed:

1. Alfuzosin 10mg once daily To treat prostatic enlargement and promote urinary flow
2. Betahistine 16mg three times daily For dizziness or vertigo
3. Clopidogrel 75mg once daily To reduce the likelihood of blood clots in heart vessels
4. Combivent Inhaler 20/100ug 2puffs four times daily a combination two bronchodilators to treat COPD
5. Combivent Nebules as needed As above
6. Simvastatin 20mg once daily To reduce cholesterol
7. Dosulipen 75mg 2 at night Antidepressant with some sedative effects
8. Dihydrocodeine SR 60mg twice daily Strong analgesic
9. Indapamide 2.5mg once daily Blood pressure treatment
10. Paracetamol 500mg 2 four times a day if needed Analgesic
11. Slozem (Diltiazem)180mg once daily Blood pressure treatment
12. Symbicort 400/12 inhaler one puff twice a day Combination bronchodilator and steroid for COPD
13. Tears Naturelle Eye lubricant
14. Stilnoct 5mg Sleeping tablet
15. GTN Spray as needed For angina
16. Lansoprazole 30mg once daily For indigestion type symptoms
17. Maalox Suspension 10ml four times daily For indigestion type symptoms

A doctor saw him on 3/6/08 and the above noted diagnoses were confirmed. He commented that SD was on a home nebuliser, that despite the angina he had not had a previous myocardial infarction. In addition his chest was said to be no worse than usual and he was not producing sputum. Chest examination revealed scattered rhonchi and his blood pressure and oxygen saturation were satisfactory. (1)

SD was reported to have slept well on the night of the 3/6/08. The next day he was "very breathless on minimal exertion" and needed help with washing and dressing. He ate a good breakfast. Nebulised salbutamol was administered. (3)

It would seem that there were additional concerns with respect to SD's health on 5/6/08. The first entry in (1) was that a full blood count (FBC), blood chemistry (UE) and a blood clotting test (INR) were taken. The report form indicates that these tests were taken at 0915. The second, untimed, entry is when SD saw the prison doctor. His notes indicated that SD felt unwell, he was able to talk but was in a wheelchair. There was shortness of breath on exertion. His cough was described as 'productive'

INVESTIGATION REPORT

Stephen Patrick Doran

but SD reported clear sputum. Clinically there was poor air entry to his lungs, he had cyanosis of his lips and poor capillary 'return' in his fingers.

The doctor ordered 'usual blood screen', a chest x-ray and sputum for culture.

Referral to or advice from the Chest Clinic was to be considered.

The doctor went on to consider the fact that SD had dropped his blood pressure to 82/41 repeated and found to be 88/50. This was felt to be a new problem on its own and labelled 'hypotension'. The doctor queried whether it may have been due to his medication and instructed for the blood pressure drug 'indapamide' to be stopped.

A nurse later spoke to the local COPD team who had previous knowledge of SD. She recorded that he had never had home oxygen therapy, he had severe airway obstruction, there was poor inhaler technique and nebulisers should be given if required. An 'aerochamber' device was given to SD, this is a plastic bubble attached to the end of an inhaler to make use more effective. There is a comment "awaiting nebulisers". (1)

The Nursing Progress Sheet dated 5/6/08 at 1500hr confirmed that SD was "not feeling well", he was unable to eat lunch and was given a high energy sip drink instead. A later entry indicates that he was assisted with his medications. (4)

A further document which appears to be a clinical observation chart is available and which records a single observation on 5/6/08 at 1440. This was difficult to decipher and on further inquiry I am informed that the following parameters were recorded. Pulse 168, BP 90/45, SpO2 90, respiratory rate 24 and the temperature 36.5 degC.

The final entry on (4) states "slept well".

SD was found moribund in his cell at approximately 0845 on 6/6/08. Help was summoned and unsuccessful CPR was carried out by several staff.

A subsequent post-mortem examination identified the cause of death as Pneumonia, secondary to Chronic Bronchitis and Emphysema. Contributory factors were felt to be the presence of dihydrocodeine and dosulipen (dothiepen) which were present in levels above therapeutic and temazepam present in therapeutic levels.

Commentary

The medical history is that of an older man suffering with severe COPD and angina who was seriously underweight being admitted to prison. His condition deteriorated and he subsequently died from respiratory complications.

On arrival at the prison there is evidence of a comprehensive nursing and medical review with measures put in place to address the identified health needs. With respect to his chest condition his oxygen saturation was checked and found to be at a level consistent with stable moderate to severe COPD. With the exception of a raised pulse rate there were no other alarming features noted with respect to his other vital signs. I

INVESTIGATION REPORT

Stephen Patrick Doran

was surprised that a urinalysis was not performed because of his reported urinary symptoms. The blood test done on 5/6/08 showed a raised random blood glucose (8.5 mmol/l), this may have been due to his illness but undiagnosed type2 diabetes cannot be excluded.

He had some prescribed drugs in his possession but it is not clear if he received his medication on the day of admission because his drug chart was not written up until the next day.

Matters seemed stable the next day, vital signs were essentially unchanged, he was getting around with a zimmer and he was eating and drinking. It was good practice for the ward to contact SD's GP practice to ascertain his medication and, with the exception of the sleeping medication, no changes were made.

Temazepam has greater potential for abuse than Stilnoct which is likely to explain why the latter drug was substituted. The fact that the temazepam is not likely to have been given for at least 72 hours prior to death raises questions about how therapeutic concentrations were present at death.

SD saw the doctor again on 5/6/08. There were some worrying signs and symptoms. SD reported a productive cough and felt unwell, he was brought in a wheelchair, which may have indicated reduced mobility, he was eating less, BP had dropped markedly. Central cyanosis was recorded and capillary return slowed, there were increased abnormal chest signs.

Some appropriate measures were taken, in particular a Chest X-ray was ordered and sputum for culture. Blood tests were taken, these came back after death but would not have been helpful even if they had been reported straight away. It is surprising that no further diagnostic or therapeutic action was taken. A number of potential explanations should have been considered. The first, a possible infective episode complicating the COPD, and the second a 'silent' MI. In any case the severity of SDs condition was not recognised despite a clear change. Instead there was a focus on medication being the cause of the low BP. The intention was to stop the Indapamide but this was not crossed out in the prescription chart.

More immediate action should have been taken to try to establish the reason for the clinical change. This might have included performing an ECG, taking an urgent troponin estimation (a screening test for MI), commencing antibiotic treatment, commencing oral steroids and ensuring that bronchodilator by nebuiser was regularly administered and administration of oxygen started. NICE guidance on COPD (11) recommends starting oral steroids at the first sign of an exacerbation and antibiotics if infection is suspected. In a civilian setting the presence of new central cyanosis, hypotension and poor peripheral perfusion would normally result in hospital admission but there was clearly a degree of expertise in nursing ill patients at the prison. The main critical absences would be the access to immediate radiology and

INVESTIGATION REPORT

Stephen Patrick Doran

therapeutic options such as intravenous support, physiotherapy and laboratory services.

I am unclear if SD was receiving nebulised therapy on 5/6/08, if not this would be a critical omission. There is reference on 5/6/08 to nebulisers being awaited (1), yet on the 4/6/08 there is a reference to the administration of salbutamol by nebuliser (3). This was an appropriate measure but there is no record of it having been prescribed. I wonder if in fact the reference (1) refers to a supply of 'combivent' nebuliser capsules and that the ward were in fact using stock 'salbutamol' items.

There must have been sufficient concern to start an observation record but it is very surprising that no entries were made on it after 1440. This record shows a pulse rate of 168 which is very abnormal and would raise the question of potential serious illness. Basic nursing practice would be for this to be repeated at the very least and for the doctor to be informed.

It is puzzling that there was an entry seeming to relate to the night of the 5-6/6/08 indicating that SD "slept well". It is not clear if SD woke up on the morning of the 6/6/08 later to be found moribund or whether he never properly awoke.

With respect to the drugs present at death in SD's body it is difficult to explain why Temazepam was there. This drug has a half life of 14 hours, (10) there is considerable variations between individuals and an intercurrent illness would prolong this.

Dihydrocodeine and dosulipen were prescribed at the upper end of therapeutic doses (10) and may have been raised because of delayed excretion due to illness and/or the fact that SD was so thin. Their presence in the above levels would not represent inadequate care by ward staff.

Conclusions

1. Initial care and planning was reasonable, there was appropriate and early contact with SD's GP. Staff were clearly concerned to meet SD's medical and nursing needs.
2. The deterioration in SD's condition was not properly recognised on 5/6/08 and appropriate action was not taken. This was certainly an error of judgement on the part of the doctor with respect to management of the deterioration.
3. Contact with the specialist respiratory team was delayed until there had been a marked deterioration in his condition.
4. Monitoring of SD's condition was inadequate. It was recognised that he was less well on 5/6/08 and an observation chart had been initiated. There is a record of a further check that day but no entry on the chart. Good practice would have been to institute regular checks at between one and three hourly intervals. Had this been done further deterioration might have been recognised.

INVESTIGATION REPORT

Stephen Patrick Doran

5. What medications were given and when, with particular reference to nebulised treatment has not been recorded on a drug chart. [Note: It has since been established that a prescription sheet recorded all the medications which were administered to Mr Doran, with the exception of nebuliser treatment]

Recommendations

1. There should be more consistent and planned recording of vital signs when dealing with ill individuals. Adverse changes should be notified to senior staff.
2. Better awareness on the part of medical staff in recognising deterioration and identification of factors which may be responsible for this is needed.
3. Which drug has been administered and when it was given should be recorded for all patients in the ward unit.
4. Where a prisoner is known to currently be under the care of specialist nurses in the community (eg Respiratory, Cardiac, Stroke) their telephone advice should be sought as soon as possible following admission.

References

1. Computer print out of medical record dated 2/6/08 to 6/6/08
2. Nursing progress sheet dated 2/6/08 (part of this is obscured)
3. Nursing progress sheet dated 3/6/08
4. Nursing progress sheet dated 5/6/08
5. Nursing Intervention and Outcome dated 3/6/08
6. Care plan sheets 1-6 dated 3/6/08
7. Prison Prescription Chart dated 3/6/08
8. Faxed GP prescription record dated 3/6/08
9. Chart headed NIPS Health
10. British National Formulary 53
11. Management of chronic obstructive pulmonary disease in adults in primary and secondary care. NICE 2004

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INVESTIGATION REPORT

Stephen Patrick Doran

Further to more information being obtained by the Ombudsman's investigation team I have found it necessary to prepare the following addendum to the above report:

A nurse in her statement to the Ombudsman's Office related further information and made a number of pertinent clarifications. She stated that:

"Mr Doran was a very sick man, probably the worst I had ever seen while I was at Maghaberry Prison"

"I remember that I had difficulties in getting a reading from the pulse oximeter when I placed it on Mr Doran's finger."

"I noted his blood pressure as 90 over approximately 42, heart rate of 90, temperature of 36.5°C and pulse oximeter reading of 24."

"In the prison set up observations are either written on EMIS or on an Observation chart so it is not uncommon that the chart was not filled out further. The Prison doctor only requested blood pressure be taken daily which it already had been and Mr Doran subsequently died the next day so that is why I am guessing no further details were on the chart or EMIS."

It would appear that on the chart the pulse reading was 90 rather than 168. This is more normal, although still raised (normal is regarded as between 60 and 80) and actually reflects the fact that his heart rate remained consistently elevated since admission to the prison.

The nurse's statement about SD being very ill is seminal. The fact that she had difficulty measuring his oxygen levels indicates peripheral shutdown. I think the oximeter reading of 24 she quotes is mistaken and probably refers to the respiratory rate. Oxygen saturation which is measured by this machine is 95 or more in a healthy person, it can drop to 70 or 80 in severe disease but levels much lower than this are incompatible with life.

It was good practice to start an observation chart in what was a very ill person. Such charts may be initiated by doctor or nurse and their objective is to allow staff (who may later be different) to track what is happening with a patient. It would not be good practice to have mixed recordings on paper and on the EMIS computer system. In any case I have seen no evidence that such later recordings were made on the computer.

Registered Nurses are independent professionals, as such they would normally make their own judgements about certain aspects of patient management including observation recording. The decision to start an observation chart falls within this responsibility irrespective of what had been instructed by the doctor (the healthcare centre manager acknowledged this in his interview). Having started the chart in this case it is surprising that it was not continued. One has to speculate as to whether this was because its existence and rationale was not made clear at handover or a

INVESTIGATION REPORT

Stephen Patrick Doran

subsequent decision was made to discontinue the chart. Had observations been continued at regular intervals it is likely that deterioration would have been noted in SD overnight and he could have been transferred to hospital.

The interview with healthcare centre manager recorded :

“Trevor said that in respect of hospitalisation, the doctor would have considered this when he saw Mr Doran that day on 5 June 2008, if the situation had been significantly been deteriorating. Trevor said that the doctor would always consider this as a course of action as this is not a hospital, it is only a sick bay. Trevor said that Mr Doran was a very frail unwell man when he came into prison and he didn’t significantly change when he was in the in patient unit to indicate that hospitalisation was required.”

In my view the evidence is at variance with the last sentence in the paragraph above. The healthcare centre manager identifies that the facilities in which SD was nursed had limitations. A critical feature is that SD was locked up from the afternoon until next morning with no appropriate clinical observations having been made.

In summary we have further information of a less abnormal pulse, but more regarding the critical nature of PDs state.

There was evidence of significant change since entry to the prison namely the drop in blood pressure, decreased mobility and reported cyanosis supported by the pulse oximetry.

I would like to suggest a further recommendation should be considered to the effect that:

If it is likely that appropriate clinical observations would prove difficult to perform transfer to hospital should be considered.

Peter Saul

31/8/09

APPENDIX 3

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a relatively modern high security Prison which accommodates male long-term sentenced and remand prisoners, in both separated¹ and integrated² conditions.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. The complex includes four Square Houses - Bann, Erne, Foyle and Lagan. Roe and Bush Houses were built in the late 1990's and were used for several years for 'ordinary' remand and sentenced prisoners, before half of each block was set aside for separated accommodation in 2004.

Roe House also has a separate wing dedicated to accommodating prisoners on committal where they undergo an induction programme before being transferred to an appropriate residential location within Maghaberry. Before prisoners are moved to the committal wing of Roe House, they are processed through the Prison Reception Area.

¹ Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.

² Integrated – general residential accommodation houses accommodating all prisoners

INVESTIGATION REPORT

Stephen Patrick Doran

There are two lower risk houses within the Mourne Complex of Maghaberry Prison, called Wilson and Martin Houses. These are used specifically to house life sentence prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU) located at Crumlin Road, Belfast.

There is also a Landing called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Lagan House, called the REACH³ Landing. The REACH Landing is a service which identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working.

Maghaberry Prison is one of three prison establishments managed by the Northern Ireland Prison Service, the others being Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre.

Maghaberry Prison was built to accommodate 682 prisoners, however, there were over 800 prisoners in Maghaberry on the day that Mr Doran died.

A recent joint inspection of Maghaberry Prison by Criminal Justice Inspectorate Northern Ireland and the HM Inspectorate of Prisons England and Wales was carried out in January 2009. The report of this inspection was published on 21 July 2009.

³ REACH Landing definition – **R**eaching out to prisoners through **E**ngagement, **A**ssessment, **C**ollaborative working **H**olistic approach.

Healthcare Centre – Maghaberry Prison

A Healthcare Centre incorporates the prison hospital. The Healthcare Centre has an inpatient unit and a primary care facility. The primary care unit comprises a pharmacy room, a large treatment room, various consulting rooms, an X-ray room, a dental surgery and offices.

There are 20 beds in the inpatient unit. This includes a six-bed bay, which is used for prisoners with mental health conditions, and a four-bed ward for prisoners with physical illnesses or disabilities.

PRISON RULES, POLICIES AND PROCEDURES

The following is a summary of Prison Service policies and procedures relevant to my investigation. They are available in full from the Prisoner Ombudsman’s Office upon request.

Prison Rules

Rule 20 of the Prison and Young Offenders Centres Rules (Northern Ireland) 1995 relates to baths:

20. *Every prisoner on his reception shall have a hot bath or shower as directed by the governor or medical officer unless exempted by either from doing so.”*

Rule 21 of the Prison and Young Offenders Centres Rules (Northern Ireland) 1995 relates to medical examination upon reception into prison:

INVESTIGATION REPORT

Stephen Patrick Doran

21. – (1) *Subject to paragraph (2) the medical officer or other approved medical practitioner shall separately examine every prisoner as early as practicable on the day of his reception and shall record the result.*

(2) *If a prisoner is received too late on the day of his reception, or if he is received on a day when the medical officer is not on duty at the prison, he shall be seen following his reception by an officer, or any other person, acting with the authority of the medical officer, and then be examined by the medical officer as soon as possible on the next day or where that is not possible within 48 hours of his reception.*

(3) *The medical officer shall not authorise anyone to see a prisoner under paragraph (2) unless he is satisfied that they are adequately trained.*

(4) *If any prisoner is found to have any infectious disease or to be in any condition which may threaten the health or well-being of others, the medical officer shall report the matter to the governor and the chief medical officer and steps shall at once be taken to treat the disease or condition appropriately.”*

Standing Orders

Northern Ireland Prison Service Standing Order 1.2.4 provides:

“Every prisoner,

- a) on first committal into custody, (Prison Rule 21(1);*
- b) on re-committal from a Magistrates’ Court after being in Police Custody;*
- c) on return from any absence not under prison escort;*
- d) on re-committal from court on conviction or sentence or if his status has otherwise changed;*

INVESTIGATION REPORT

Stephen Patrick Doran

e) on return from court or elsewhere if there have been signs of stress during the period of absence or other special circumstances have arisen which makes a medical examination desirable;

f) on return from court or elsewhere if he complains of illness, injury, or appears to the reception officer to be so;

g) on transfer from another establishment;

shall be seen by a Hospital Officer or Burse on committal (Rule 21) and their findings recorded in writing in the Inmate's Medical Record (IMR) file. As soon as possible after this each prisoner shall be separately examined by a Medical Officer. Prisoners committed late on the day of reception shall be seen and medically examined the next day by the medical officer or in any case where this is not possible within 48 hours of reception, (Rule 21)."

Governor's Orders

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners.

Governor's Order 3-12 'Preservation of Evidence': sets out the procedures to be followed on discovery of a serious incident, what considerations need to be addressed to ensure evidence is preserved and the avoidance of contamination and overall scene management.

Governor's Order 7-19 'Body Checks/Roll Checks': provides information and instructions to staff on how prisoners should be checked at specific times of the day and night and to ensure there are no defects in the fabric of the establishment. By doing the check, this confirms that the prisoners in the cells are alive and there is no visible concern for their wellbeing or safety.

Self Harm and Suicide Prevention Policy

The Prison Service's Self Harm and Suicide Prevention Policy deals with prisoners at risk of suicide or self harm, but also provides guidance for management and staff on handling a natural death in custody.

Contingency Plan Forty Four – Death of a Prisoner

'Contingency Plan 44 – Death of a Prisoner' provides guidance to the Emergency Control Room on the actions to take immediately following a death in custody between the hours of 08.00 – 17.00.

Contingency Plan Forty Five – Death of a Prisoner

'Contingency Plan 45 – Death of a Prisoner' provides guidance to the Emergency Control Room on the actions to take immediately following a death in custody between the hours of 17.00 – 08.00.

Operational Performance Standards

This manual contains a set of Operational Performance Standards across all the operational areas of the Prison Service which staff are required to maintain. Section F. 5 deals with the actions to take following a death in custody.

INVESTIGATION REPORT

Stephen Patrick Doran
