SUMMARY AND RECOMMENDATIONS OF THE REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

STEPHEN PATRICK DORAN

AGED 69

IN MAGHABERRY PRISON

ON 6 JUNE 2008

4 February 2010

Please note that where applicable, names have been removed to anonymise the following summary.

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SUMMARY

Mr Doran was remanded into the custody of Maghaberry Prison on 2 June 2008 awaiting trial. He died in prison on 6 June 2008, five days later.

When he arrived in the reception area of Maghaberry on 2 June 2008, he was medically examined by a nurse as a normal part of the committal process.

The nurse immediately transferred him to the prison healthcare centre due to his bad state of health and hygiene.

There is evidence of an initial nursing and medical review taking place with measures identified to address Mr Doran's immediate healthcare needs.

Mr Doran received treatment for his feet and skin, was assisted to have a bath and his personal hygiene was looked after. It is not clear from records whether Mr Doran received his medication that day.

Mr Doran was reported to have slept well on his first night in prison.

The next day, 3 June 2008, Mr Doran had a further medical assessment by a doctor and a nurse.

Mr Doran's state of health was poor. The doctor recorded that he was a frail man with a history of chronic obstructive pulmonary disease

(COPD[1]), angina, prostatic enlargement, pressure sores, problems with mobility and problems with maintaining his personal hygiene.

Mr Doran's general practitioner was contacted to confirm his medication and ongoing treatment.

A very comprehensive five stage care management plan was developed and was written up by a nurse. The care plan listed Mr Doran's medical problems, noted risks, stated objectives for the management of each problem and detailed the required interventions and the advice given to Mr Doran.

Mr Doran was reported to have slept well on the night of 3 June 2008.

Dr Peter Saul, the clinical reviewer, whom I commissioned to examine Mr Doran's healthcare treatment in Maghaberry, commented that:

"Effective management plans were put in place to address all of Mr Doran's identified needs. Matters seemed stable the next day (3 June 2008), 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 Mr Doran's GP practice to ascertain his medication."

4 June 2008, was largely uneventful for Mr Doran. It is recorded that he ate a good breakfast and was assisted with washing and dressing. He was, however, reported to be very breathless on minimal exertion.

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[1] COPD definition – Chronic obstructive pulmonary disease refers to chronic bronchitis and emphysema, a pair of two commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air to and from the lungs causing shortness of breath.

He had a visit from two friends that day and was reported to have slept well that night.

It would seem that there were additional concerns in connection with Mr Doran's health on 5 June 2008.

A nurse was with Mr Doran at some time in the early morning. The nurse later noted in Mr Doran's Nursing Progress Sheet that he was not feeling well and had slept all night upright in his clothes. It is recorded that Mr Doran was assisted to wash and clean his teeth.

The nurse also noted that treatment was provided for a sore on the middle of Mr Doran's back. Whilst she was with Mr Doran, the nurse asked the prison doctor to see him. At interview, she said that Mr Doran *"was a very sick man, probably the worst I have ever seen while I was in Maghaberry."*

An untimed entry in Mr Doran's computerised medical record (EMIS] on 5 June 2008, by the prison doctor, records his consultation with Mr Doran that day.

The doctor's note indicates that Mr Doran felt unwell. He was able to talk but was in a wheelchair and he had a shortness of breath on exertion. His cough was described as 'productive' but Mr Doran 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 blood tests and a chest x-ray, along with a referral to the Chest Clinic at Belfast City Hospital for advice. Mr Doran's COPD team in his local hospital were also to be contacted for further advice.

The doctor went on to consider the fact that Mr Doran's blood pressure had dropped to 82/41. The measurement was repeated and found to be 88/50. This was felt to be a new problem, on its own, and was recorded as 'hypotension'. The doctor queried whether it may have been due to Mr Doran's medication and instructed that the blood pressure drug Indapamide be stopped.

At 09.15, the nurse took a full blood count (FBC), blood chemistry (UE) and a blood clotting test (INR) from Mr Doran. This is recorded on Mr Doran's EMIS medical record.

An untimed entry in Mr Doran's EMIS medical record reports that the nurse spoke to his local COPD team, who had previous knowledge of him, for further advice as requested by the prison doctor.

The nurse noted that Mr Doran *had "never had home oxygen therapy, he had severe airway obstruction, a poor inhaler technique and nebulisers should be given if required."* An 'aerochamber' device was given to Mr Doran. This is a plastic bubble attached to the end of an inhaler to make use more effective. The nurse also recorded *"awaiting nebulisers".*

No other observations or interventions are recorded until 14.40 when a clinical observation chart was opened for Mr Doran by the same nurse.

The chart was difficult to decipher and, on enquiry to the healthcare centre, advice was provided that the following parameters were recorded: Pulse 168, BP 90/45, SpO2 90, respiratory rate 24 and temperature 36.5 degC. An interview some time later the nurse, who completed the chart, corrected the pulse reading to 90. The nurse

also recalled that she had difficulty that day in getting a reading from the pulse oximeter when she placed it on Mr Doran's finger.

The nurse finished her period of duty shortly afterwards and no further entries were made on Mr Doran's clinical observation chart.

Dr Saul described this as *"surprising"*. He stated that good practice would have been to initiate regular checks at between one and three hourly intervals. He also said that *"had observations been continued at regular intervals it is likely that deterioration would have been noted in Mr Doran overnight and he could have been transferred to hospital."*

Before completing her shift, the nurse wrote up Mr Doran's Nursing Progress Sheet at 15.00, summarising the contacts and interventions with Mr Doran throughout the day.

The sheet notes that Mr Doran was *"not feeling well today*", *"slept all night upright in clothes"*, *"was unable to eat lunch but was given a high energy sip drink.*"

A later, untimed entry on the sheet indicates that Mr Doran was assisted with his medication, was changed and helped to bed.

All prisoners in Maghaberry are, in line with Prison Service policy, checked throughout the night by officers looking through the flap on each cell door. This takes place at approximately two hourly intervals. The intention of the check is to confirm that the prisoners are in their cells and that there are no visible concerns for their wellbeing or safety.

At interview, the healthcare manager said that prisoners in the healthcare centre are normally locked down at around 19.30 to 20.00

and cell doors can only be opened during the night in a non emergency situation, in line with prison service policy, if at least three officers are present. Prisoners remain in their cells until unlock at approximately 08.00 the next morning. This is the same process as applies in the normal residential houses across the prison.

He also explained that if night time clinical observations are ordered, these can be carried out by contacting the Emergency Control Room to facilitate the unlock required.

The investigation was informed that checks on Mr Doran, on the night of 5 June 2008, would have been carried out by the nurse officers looking through the flap on his door, as part of the usual checking process. At some point, a night nurse wrote *"slept well"* on Mr Doran's Nursing Progress Sheet. Other than this, no night time checks were recorded.

Further to the completion of the Nursing Progress Sheet at 15.00 on 5 June, the untimed note *"slept well"* and the note stating that Mr Doran was given his medication and assisted into bed, are the only entries on any healthcare record until 07.30 on 6 June 2008.

Healthcare staff said at interview that the healthcare centre functions as a prison sick bay rather than a hospital. Patients considered to require regular monitoring of vital clinical signs would, therefore, normally be admitted to outside hospital.

In the case of Mr Doran, admission to hospital did not appear to have been judged as necessary. Dr Peter Saul, the clinical reviewer, concluded that: *"the deterioration in Mr Doran's condition was not properly recognised on 5 June 2008 and appropriate action was not taken."*

Dr Saul also noted that: *"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".*

He notes, however, that *"a critical feature is that Mr Doran was locked up from the afternoon of 5 June 2008 until next morning with no clinical observations having been made."*

At 07.30 on 6 June 2008, a headcount check was carried out by a duty senior nurse through the flap in Mr Doran's cell door. The senior nurse later recorded that when she carried out this check, she observed Mr Doran breathing.

After the day staff came on duty, prisoners started to be unlocked to have their breakfast.

A nurse who went to unlock Mr Doran's cell at 08.42 observed him lying on his right side. He was not moving and she reported that there was no sign of him breathing. She believed that she felt an extremely weak pulse and she said that his limbs were warm to touch.

The nurse immediately called for assistance and commenced cardio-pulmonary resuscitation (CPR). Moments later she was assisted by two other nurses and a healthcare officer and CPR was continued. Two senior nurses also attended.

It is recorded that an agreement was reached shortly after to cease CPR when there was no chest movement, spontaneity of respiration or sign of a pulse. At 09.12, the prison doctor arrived at the scene and pronounced Mr Doran dead.

An autopsy carried out on 7 June 2008 established the cause of Mr Doran's death as being from *"pneumonia, chronic bronchitis and emphysema".*

It is also recorded in the autopsy report that other contributory factors to his death "*were felt to be the presence of Dihydrocodeine and Dosulipen (Dothiepen) which were present in levels above therapeutic and Temazepam present in therapeutic levels."*

In considering the *"above therapeutic levels"* of Dihydrocodeine and Dosulipen, Dr Peter Saul, the clinical reviewer, advised that these doses may have been raised because of delayed excretion due to illness and/or the fact that Mr Doran was so thin. He concluded that their presence above a therapeutic level would *"not represent inadequate care by ward staff."*

Temazepam has a half life of 14 hours, but this varies significantly between individuals and an intercurrent illness would prolong this. There is no evidence that Mr Doran had been given Temazepam for at least 72 hours before his death. The Prison Service had substituted an alternative drug for Temazepam. It is, therefore, unclear how Temazepam came to be present in Mr Doran's blood.

Overall Findings of the Clinical Reviewer

Dr Peter Saul, the clinical reviewer, commenting on Mr Doran's death said: *"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".*

Dr Saul's overall findings are as follows:

1. Initial care and planning was reasonable, there was appropriate and early contact with Mr Doran's general practitioner. Staff were clearly concerned to meet Mr Doran's medical and nursing needs.

2. The critical nature of Mr Doran's state in that there was evidence of significant change since entry to the prison, namely, a less abnormal pulse reading of 90 [than the originally advised 168], the drop in blood pressure, decreased mobility and reported cyanosis supported by the pulse oximetry, would raise the question of potential serious illness.

3. The deterioration in Mr Doran's condition was not properly recognised on 5 June 2008 and appropriate action was not taken. This was, Dr Saul said, certainly an error of judgement on the part of the prison doctor with respect to management of the deterioration.

4. Contact with the specialist respiratory team was delayed until there had been a marked deterioration in Mr Doran's condition.

5. Monitoring of Mr Doran's condition was inadequate. It was recognised that he was less well on 5 June 2008 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.

6. There is reference to nebuliser treatment but this has not been recorded on any drug chart.

7. The healthcare manager identifies that the facilities in which Mr Doran was nursed in the healthcare centre had limitations. A critical feature is that Mr Doran was locked up from the afternoon on 5 June 2008 until next morning with no appropriate clinical observations having been made.

The prison doctor and healthcare manager were given the opportunity to consider the findings of the clinical review and their responses are fully documented in the relevant sections of the report.

Acknowledgement

Whilst the report raises a number of areas of concern in connection with Mr Doran's healthcare, I wish to acknowledge the efforts of the nurse who produced a very comprehensive and thoughtful care management plan for Mr Doran; was very responsive to his care needs on the morning of 5 June 2008; asked a doctor to see Mr Doran and opened an observation chart before going off duty that day.

RECOMMENDATIONS TO THE PRISON SERVICE

As a result of my investigation, I make **eight recommendations** to the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust. These recommendations have all been accepted. In responding to the recommendations, the Trust said *"The Trust accepts the recommendations outlined in the report. We recognise that the standard of care and treatment fell below what we would normally expect and a Service Improvement Board has been put in place in Maghaberry Prison to develop and drive forward the quality of healthcare services in Prison."*

We welcome this response.

Recommendation 1

The Prison Service, in co-operation with the South Eastern Health and Social Care Trust, should review the arrangements for ensuring that there is consistent and planned recording of vital signs when dealing with ill individuals. They should ensure that revised arrangements include the need for adverse changes to always be notified to the duty doctor or senior staff.

Recommendation 2

The Prison Service, in co-operation with the South Eastern Health and Social Care Trust, should remind all healthcare staff of the need for all patient clinical observations and measurements to be recorded.

Recommendation 3

All entries made on the healthcare recording systems, such as EMIS medical records and nursing progress sheets, should contain the date and time of the consultation.

Recommendation 4

Healthcare staff should be reminded that full details of all drugs administered, and when each was taken, must be recorded.

Recommendation 5

The Prison Service, in co-operation with the South Eastern Health and Social Care Trust, should review its capability to carry out night time clinical observations of prisoners located in the Healthcare Centre and make adjustments if needed.

Recommendation 6

The Prison Service, in co-operation with the South Eastern Health and Social Care Trust, should review its policy for defining in what circumstances a patient should be admitted to outside hospital. This should take full account of restrictions on free entry into cells in the Healthcare Centre during the night to carry out clinical observations. Policy adjustments should be communicated to all healthcare staff.

Recommendation 7

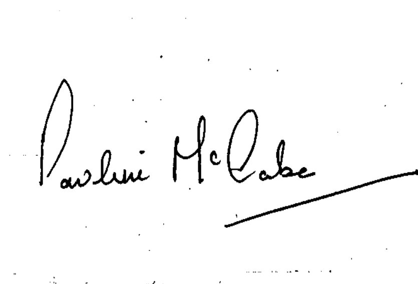
Where any prisoner is known to currently be under the care of specialist nurses in the community (e.g. respiratory, cardiac,

stroke) arrangements should be in place to ensure that telephone advice about the patient's medical and care history is sought as soon as possible following committal. Where a patient is admitted to the Healthcare Centre, this should be treated as urgent.

Recommendation 8

The Prison Service, in co-operation with the South Eastern Health and Social Care Trust, should review the adequacy of their quality assurance/risk assessment arrangements in connection with the recommendations above.

I shall request updates on the implementation of these recommendations in line with the action plan provided by the Prison Service.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
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