The Prisoner Ombudsman for Northern Ireland

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 report.

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Please note a separate appendices booklet accompanies this report

PREFACE

Stephen Patrick Doran was born on 7 November 1938. He was 69 years old when he died in his cell in the Healthcare Centre, Maghaberry Prison, on the morning of Friday 6 June 2008.

I took over responsibility for the investigation of Mr Doran's death when I was appointed as Prisoner Ombudsman in September 2008 and I determined that an independent review of Mr Doran's medical care in prison was required. The independent review was carried out by Dr Peter Saul. I am grateful to Dr Saul for his input.

Mr Doran was estranged from his family and, for reasons related to his alleged offences, they confirmed that they did not need to receive further information about his time in prison or the circumstances of his death.

My report contains this preface and a summary followed by an introduction and methodology, leading to my findings and associated recommendations.

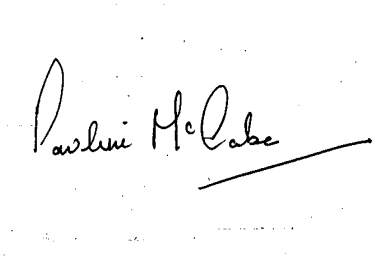
My findings are presented in 3 sections:

- Section 1: Events prior to Mr Doran's death on 6 June 2008
- Section 2: Events on 6 June 2008
- Section 3: Events after Mr Doran's death

In the event that anything else comes to light in connection with the matters addressed in this investigation, I shall produce an addendum to this report and notify all concerned of my additions or changes.

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.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
4 February 2010

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."

[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.

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.

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 this report.

Recommendations

In light of my findings and the observations of the clinical reviewer, I make **eight recommendations** to the Northern Ireland Prison Service in co-operation with its South Eastern Health and Social Care Trust partners. These recommendations cover:

- The recording of observations, measurements and the administration of medicines;
- Arrangements for observing patients during the night in the healthcare centre;
- The policy and practice in respect of admitting very sick patients to hospital;
- Advice from specialist community care teams; and
- Quality assurance/risk assessment arrangements.

Acknowledgement

Whilst this 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.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[2] for Northern Ireland, I have responsibility for investigating the death of Stephen Patrick Doran in Maghaberry Prison on the morning of 6 June 2008. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Annex 1.

2. I am independent of the Prison Service and my investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. As required by law the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives

4. The objectives for my investigation into Mr Doran's death are:

   - to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;

[2] The Prisoner Ombudsman took over the investigations of deaths in prison custody in Northern Ireland from 1 September 2005.

- to examine any relevant healthcare issues and assess clinical care afforded by the Prison Service;
- to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- to ensure that Mr Doran's family have the opportunity to raise any concerns that they may have and that these are taken into account in my investigation; and
- to assist the Coroner's inquest.

INVESTIGATION METHODOLOGY

Notification

5. On Friday 6 June 2008 at 09.10 the Prisoner Ombudsman's Office was notified by the Prison Service about Mr Doran's death in Maghaberry Prison.

6. A member of the Prisoner Ombudsman investigation team attended Maghaberry Prison on 6 June 2008 to be briefed about the events leading up to and following Mr Doran's death. The investigator also visited the scene and met with staff working at the time of Mr Doran's death.

7. A prison chaplain in Maghaberry Prison made contact with Mr Doran's local parish priest, in order that notification of Mr Doran's death could be passed onto his family.

8. Mr Doran was estranged from his family and, in the circumstances, I established that they do not need to receive further information about his time in prison or the circumstances of his death.

Notices of Investigation

9. The investigation into Mr Doran's death began on the morning of the 6 June 2008 when Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison announcing the investigation. The Notices

invited anyone with information relevant to Mr Doran's death to contact the Prisoner Ombudsman's investigation team.

Family Liaison

10. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the deceased's family.

11. It is important for my investigation to learn more about a prisoner who dies in prison custody from any family members, and to listen to any concerns they may have, however, this was not possible in Mr Doran's case.

Prison Records

12. All the prison records relating to Mr Doran's period of custody, including his medical records, were retrieved and analysed.

Staff Communication Sheets and Interviews

13. Staff Communication Sheets completed following Mr Doran's death were retrieved as part of the investigation and investigators interviewed relevant prison and healthcare staff relevant to the investigation.

Post Mortem Report

14. My investigation team liaised with the Coroners Service to retrieve the post mortem report in order to establish the exact cause of Mr Doran's death.

Clinical Review

15. As part of the investigation into Mr Doran's death, a clinical review was commissioned to examine his healthcare needs and medical treatment whilst he was in custody in Maghaberry. I am grateful to Dr Peter Saul, who carried out the clinical review. His clinical review report is attached as Appendix 2.

16. Dr Saul's clinical review report was forwarded to the Prison Service for comment. Prison Service healthcare staff responded and I have reflected these comments at the appropriate places in this report.

Working together with interested parties

17. An integral part of any investigation is to work together with all interested parties involved. My investigation team worked closely with the PSNI and the Coroner's Service for Northern Ireland.

Maghaberry Prison

18. Included at Appendix 3 is some background information describing Maghaberry Prison and the Prison Service policies and procedures relevant to this investigation.

Factual Accuracy Check

19. I submitted my draft report to the Director of the Northern Ireland Prison Service on 16 September 2009 for a factual accuracy check.

20. The Prison Service responded on 17 December 2009 with a list of comments for my consideration.

21. I have fully considered these comments and made amendments where appropriate. This is, therefore, my final report.

FINDINGS

SECTION 1: EVENTS PRIOR TO MR DORAN'S DEATH ON 6 JUNE 2008

1. Mr Doran's Committal to Maghaberry on 2 June 2008

Mr Doran was committed to Maghaberry Prison on 2 June 2008. He was remanded into custody after attending court and was awaiting trial.

On route to the prison, Mr Doran complained to the escorting officers of shortness of breath and dizziness in the escort van.

The escorting officers gave him his inhaler and GTN[3] spray. On arrival at Maghaberry Prison, the escorting officers communicated Mr Doran's medical complaints to staff in the prison reception area who process committals.

A note made by a nurse in Mr Doran's EMIS[4] medical record on 2 June 2008 reads: *"Seen in reception on arrival to Maghaberry. Had been complaining of shortness of breath and dizziness in van. Escorting staff gave him his inhaler and GTN Spray with limited effect…"*

[3] GNT Spray definition - Nitrolingual pump spray contains the active ingredient glyceryl trinitrate, which is a type of medicine called a nitrate. It is used to help the heart work more easily and for the treatment of angina.

[4] EMIS definition – Electronic Medical Information System used to keep a computerised record of each prisoner's medical consultations and interventions with a nurse and doctor.

1a. Mr Doran complained to escorting officers of shortness of breath and dizziness when he was being driven to Maghaberry Prison on 2 June 2008.

1b. The escorting officers reported Mr Doran's medical complaints to healthcare staff when they arrived at Maghaberry Prison.

2. Mr Doran's Health Screening and Healthcare on 2 June 2008

Mr Doran was medically examined by a nurse in the prison reception area as soon as he arrived in Maghaberry Prison on 2 June 2008. This is part of the normal prison committal procedures and in line with Prison Rule 21. The nurse then completed an Initial Health Screening Assessment Form.

The nurse, because of Mr Doran's medical condition, made immediate arrangements for him to be transferred to the prison healthcare centre and he was taken to the inpatient ward for further medical assessment.

In the inpatient ward, the nurse made a further note in Mr Doran's EMIS medical record saying:

"Brought to inpatient ward, poor mobility, feet examined extremely poor condition of skin, scaly and packed with dead skin. States he hasn't had a bath in possibly a year, personal hygiene being attended to for bath and change of clothes later today. Chiropody to attend. Weight and height still to be obtained"

2a. Mr Doran was clinically assessed on arrival at Maghaberry Prison and relevant information was recorded.

2b. Following assessment, Mr Doran was immediately transferred to the prison healthcare centre.

On the afternoon of 2 June 2008, a nurse noted in Mr Doran's EMIS medical record that he attended the prison chiropodist and had his toe nails cut. He was also assisted with a bath, and his weight and height were measured.

Mr Doran's height was recorded as 162cm and his weight was 44kg. This represents a Body Mass Index of 15.6 and is considerably underweight.

A past history of COPD was identified, together with angina and depression. Mr Doran was apyrexial[5], pulse was 103, BP 107/66 and Pulse Oximetry (Sp02) 91. The clinical reviewer, Dr Peter Saul, appointed to review Mr Doran's healthcare treatment in prison, advised that this was low, but commonly seen in patients with severe COPD.

Mr Doran had reported urinary symptoms but no analysis was undertaken.

The nurse who had assessed and attended to Mr Doran earlier in the day completed a Nursing Progress Sheet[6] towards the end of her shift.
The Nursing Progress Sheet reads:

[5] Apyrexial definition – an absence or remission of fever.

[6] Nursing Progress Sheet definition - a nursing progress sheet is completed on every in-patient in the in-patient unit. The nurse will at some time near the end of his/her shift reflect the activity or generally how the patient has been. The Healthcare Centre advised that the nurse would only write up a summary of the significant things that happen, such as an incident or case conference – it is used to inform the next group of staff.

"New admission to wards via committals for physical and mental health assessment. Has a history of chronic COPD, Angina and some history of previous depression. Appears very unkept – feet were in a bad condition requiring urgent attention /dry flaking skin ++++ plus long toe nails which the Chiropodist urgently attended to. Observations T 36.8, Pulse 103, BP107/66, Sats 91% R/A. He is a smoker. He still needs to see the doctor and to get all his medications written up. He was also assisted to have a bath as he is unable to attend to own hygiene."

Dr Saul, the clinical reviewer, commented on Mr Doran's care on 2 June 2008, saying:

"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. 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."

Overall, Dr Saul concluded that Mr Doran's *"initial health care and planning was reasonable"* and that *"staff were clearly concerned to meet Mr Doran's medical and nursing needs."*

2c. An initial nursing and medical review was carried out with measures put in place to address Mr Doran's identified health needs.

2d. Staff took care of Mr Doran's personal hygiene needs. He received treatment for his feet and skin and was assisted to have a bath.

2e. There is no record on Mr Doran's medical notes to indicate whether he received his medication on the day of his committal, 2 June 2008.

A Nursing Progress Sheet entry completed in the late hours of 2 June 2008 by a nurse officer recorded Mr Doran as having *"appeared to sleep well."*

3. Mr Doran's Care on 3 June 2008

On the morning of 3 June 2008, a nurse contacted Mr Doran's general practitioner to arrange for details of his medication to be faxed to the prison.

A note by the nurse in Mr Doran's EMIS medical record on 3 June 2008 states: *"GP surgery contacted and will fax medication. Has been seen previously by COPD Team Nurse at Daisy Hill Hospital on a home visit. This was a service Mr Doran did not want."*

Details of Mr Doran's medication were faxed to the prison and were then prescribed by healthcare staff with the substitution of Stilnoct 5mg for Temazepam. Temazepam has greater potential for abuse in prison than Stilnoct, which explains why Temazepam was substituted.

Mr Doran's healthcare records showed that he received his medication as prescribed on 3 June 2008. The full list of the medications prescribed to Mr Doran is contained in Dr Saul's clinical review report at Appendix 2.

Dr Saul commented that the early contact with Mr Doran's general practitioner was appropriate and that this was good practice.

3a. Mr Doran's general practitioner was contacted the day following his committal for confirmation of his medication and information about his medical condition.

3b. Mr Doran's prescribed medication was administered on 3 June 2008.

A Nursing Progress Sheet dated 3 June 2008 written by a nurse recorded Mr Doran's blood pressure as 118/61, pulse as 100 and respiratory rate as 24bpm.

Mr Doran was also seen by a doctor on 3 June 2008. The doctor noted that Mr Doran was a new committal and was a frail man. He recorded Mr Doran's health problems as:

- COPD
- Angina
- Prostatic Enlargement
- Pressure sore
- Problems with mobility
- Problems with maintaining personal hygiene.

The doctor further noted that Mr Doran had his inhaler and GTM spray in his possession; was coughing but had no sputum; was on a low air loss mattress; had been eating well from admission but needed encouraging to take fluids and was moving around with a zimmer frame, but needed assistance to get into bed and wash and dress.

Care Plan

A comprehensive five stage care management plan was developed and written up by the nurse. The care plan included the following:

1. *Has COPD and has difficulty breathing on exertion. Risk of chest infection - objective: relieve breathlessness and observe for deterioration in breathing – the advice given included: monitor SpO2 three times weekly; give inhalers in possession and provide nebuliser pm; encourage to inform staff if any expectorant and send sputum to lab; use wheelchair for transfer of long distances; inform GP of any deterioration; position in an upright position when in bed to maximise breathing function.*

2. *Has Angina - objective: to report chest pain - the advice given included: ensure Mr Doran is aware of emergency call button; ensure Mr Doran is compliant with taking medication; ensure GTN spray is kept in possession and Mr Doran can use spray; to monitor observations three times weekly; encourage Mr Doran to report any chest pain; check ankles for swelling.*

3. *Mr Doran has waterflow score of 17 and grade ½ sore on sacrum - objective: to encourage skin healing and prevent further breakdown - the advice given included: monitor waterflow weekly; monitor for any deterioration in skin and apply appropriate dressing; assist to the dining room and*

monitor food intake; ensure Mr Doran always has water in his cell and is offered drinks at all tea times; encourage mobility as much as is possible and position changes when out to sit in a chair.

4. *Unable to mobilise independently due to COPD - objective: to promote mobility with assistance of staff and aids - the advice given included: refer to physiotherapy for mobility assessment; to use zimmer frame to mobilise from cell to dining room; assistance to transfer from chair to zimmer and chair to wheelchair, bed to chair; use wheelchair for longer transfers; ensure tight fitting non-slip shoes are worn when mobilising.*

5. *Unable to maintain personal hygiene independently due to poor mobility - objective: to ensure Mr Doran is able to wash and dress daily - the advice given included: place bowl/water/toiletries and shaving daily in front of Mr Doran, assist with one shower at least weekly with assistance of one person; apply moisturising cream to skin daily; assistance with one nurse to dress and undress ensuring dignity at all times; encourage oral hygiene; refer to podiatrist.*

Dr Peter Saul, the clinical reviewer, commented that the nursing assessment on 3 June 2008 was comprehensive and that effective management plans were put in place to address all of Mr Doran's identified needs.

Dr Saul did say that he was surprised that a urinalysis was not performed because of Mr Doran's reported urinary symptoms.

A Nursing Progress Sheet entry completed in the late hours of 3 June 2008 by a nurse officer recorded Mr Doran as having *"slept well."*

3c. Mr Doran was comprehensively assessed by a nurse and doctor on 3 June 2008.

3d. A comprehensive care management plan was put in place.

3e. Although Mr Doran had reported urinary symptoms, a urinalysis was not carried out.

4. Mr Doran's Care on 4 June 2008

There are no notes of any healthcare action in Mr Doran's EMIS medical record for 4 June 2008.

An entry by a nurse on a Nursing Progress Sheet on 4 June 2008 notes that, at 11.00, Mr Doran was assisted with washing and dressing and that he ate a good breakfast. It also notes that he was very breathless on minimal exertion and that a nebuliser was given and "*ventolin [inhaler] 2.5mg, awaiting script from Boots.*"

There is no evidence on records that a nebuliser was prescribed but Dr Peter Saul, the clinical reviewer, stated that it was, nevertheless, good practice to provide one.

Visit records show that Mr Doran went to the visits area at 11.00 on 4 June 2008 to receive a visit from two friends. The visit lasted until 12.49, after which Mr Doran returned to the healthcare centre.

An untimed Nursing Progress Sheet entry completed some time during the night 4/5 June 2008 by a nurse officer notes Mr Doran as having *"slept well."*

4a. It is noted that Mr Doran was breathless on minimal exertion on 4 June 2008 and was given a nebuliser. No other medical concerns or interventions are recorded.

4b. Mr Doran received a visit from two friends on 4 June 2008 between 11.00 and 12.49.

5. Mr Doran's Care on 5 June 2008

Healthcare Records for 5 June 2008

The entries in Mr Doran's healthcare records on 5 June 2008 were as follows:

(untimed)	Entry on EMIS	Record of doctor consultation (assumed to have taken place Prior to blood tests being taken)
09.15	Entry on EMIS	Full blood count, blood chemistry and a blood clotting test were taken
14.40	Observation Chart started	Pulse, blood pressure, SpO^2, respiratory rate and temperature noted
15.00	Nursing Progress Sheet	Written up by nurse who saw Mr Doran in cell early morning
(untimed)	Nursing Progress Sheet	Further entry by a different nurse

Interventions and Treatment on 5 June 2008

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 the Nursing Progress Sheet that Mr Doran was not feeling well. It is recorded that Mr Doran was assisted to wash and clean his teeth. The nurse also noted that Mr Doran had a sore on the middle of his back and that treatment was provided. Whilst she was with Mr Doran, the nurse asked the prison doctor to see him.

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

The doctor's note indicates that Mr Doran felt unwell, was able to talk but was in a wheelchair. Mr Doran 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 was requested, along with a referral to the Chest Clinic in Belfast City Hospital for advice. His COPD team in his local hospital were also to be contacted for advice.

The doctor went on to consider the fact that Mr Doran's blood pressure had dropped to 82/41. It 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 this may have been due to Mr Doran's medication and instructed the blood pressure drug Indapamide to 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 was recorded on Mr Doran's EMIS medical record.

5a. There were additional health concerns in respect of Mr Doran on 5 June 2008. A doctor was brought to see him and blood tests were taken.

5b. The doctor instructed an adjustment to Mr Doran's medication. He also determined that advice should be sought from the chest clinic.

A clinical observation chart was opened at 14.40 by the nurse and records a single observation.

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 the temperature 36.5 degC.

An interview, some time later, with the nurse who completed the chart corrected the pulse reading to 90. Dr Peter Saul, the clinical reviewer, who had originally been provided with the advice received from the healthcare centre, was informed of the corrected reading.

No further entries were made on Mr Doran's clinical observation chart after 14.40.

A further, 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.

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"*.

5c. Advice was sought from Mr Doran's local COPD team who had previous knowledge of him.

5d. A nurse opened a clinical observation chart at 14.40 on 5 June 2008 and recorded Mr Doran's pulse, temperature, blood pressure and respiration. No further entries were made on the chart.

The nurse wrote up Mr Doran's Nursing Progress Sheet at 15.00, towards the end of her shift, 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."*

The nurse who opened the observation chart at 14.40 and completed the Nursing Progress Sheet went off duty shortly afterwards.

At interview, the healthcare manager explained that handovers take place when shifts change. He advised that staff get together to discuss the in-patients and how the night/day went for them. They also identify in-patients with particular problems who may need more attention.

After shift handover, two untimed entries were recorded by nurse officers in Mr Doran's Nursing Progress Sheet. The first untimed entry recorded that Mr Doran was assisted with his medication and that he was changed and assisted to bed. The second untimed entry records that Mr Doran *"slept well"*.

The next note is at 07.30 on 6 June 2008 when a senior nurse carried out a cell check through a flap in Mr Doran's cell door.

5e. An untimed note by a nurse on the evening of 5 June 2008 recorded that Mr Doran was given his medication, changed and assisted into bed.

5f. Further to the completion of Mr Doran's Nursing Progress Sheet at 15.00 on 5 June, the untimed note and one further untimed note stating *"slept well"*, are the only entries on any healthcare record until 7.30 on 6 June 2008.

Healthcare Centre Night Time Observation Arrangements

At interview, the healthcare manager at Maghaberry healthcare centre explained the night time observation arrangements for the in-patient unit. In doing so, he said that the healthcare centre functions as a prison sick bay rather than a hospital.

The healthcare manager explained that, in line with normal Prison Service Policy, checks are carried out during the night by looking through the flap on each cell door five times. The intention of the checks is to confirm that the prisoners are in their cells and that there are no visible concerns for their wellbeing or safety.

He said that prisoners in the healthcare centre are normally locked down at around 19.30 to 20.00 and prisoners remain in their cells until unlock at approximately 08.00 the next morning.

The healthcare manager also explained that there are two healthcare staff on duty at night to cover the whole prison, including call outs and emergencies. He added that if night time clinical observations are ordered, these can be carried out by contacting the Emergency Control Room to facilitate the unlock required. Prison Service Policy requires that no less that three officers must be present when a cell is unlocked during the night in a non emergency situation. This is the same process that applies in the normal residential houses across the prison.

The investigation was informed that the required checks on Mr Doran on the night of 5 June 2008 would have been carried out by nurse officers looking through the flap on his door. On the night of 5 June 2008, apart from one untimed note *"slept well"*, the checks on Mr Doran were not recorded.

5h. Prison Service Policy requires that all prisoners must be checked, through door flaps, at approximately two hourly intervals during the night.

5i. Healthcare staff do not routinely carry out night time clinical observations but can do so, if required, by requesting the Emergency Control Room to assist with a non emergency unlock.

5j. Three staff must be present for any non emergency unlock during the night.

Additional Information Provided by Staff in Respect of Mr Doran's Healthcare on 5 June 2008

At interview, the nurse who saw Mr Doran on 5 June 2008 and completed his Nursing Progress Sheet made the following points to explain further the information recorded in Mr Doran's medical notes.

- *I remember Mr Doran was a very sick man, probably the worst I had ever seen while I was at Maghaberry Prison.*

- *I would have seen Mr Doran in the morning after unlock and from looking at the nursing progress sheet I note that Mr Doran wasn't feeling well that morning, and for that reason I requested a doctor.*

- *I would have spent quite a bit of time with Mr Doran that morning because I would have undressed him to clean and attend to his sore that he had on his back, and then I would have helped him get dressed again.*

- *Mr Doran had cyanotic tinges of the lips and poor capillary return on his digits. I remember that I had difficulties in getting a reading from the pulse oximeter when I placed it on Mr Doran's finger.*

- *Mr Doran would have been locked from around 1200hrs to 1400hrs, and after he was unlocked I carried out observations on him and noted them on a chart. I noted his*

blood pressure as 90 over approximately 42, pulse of 90, temperature of 36.5˚C and pulse oximeter reading of 24.

- *I cannot recall my reason for taking these observations but coming from a hospital background it would be common practice for me to carry out routine observations and write them on a chart. 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.*

- *There were no instructions for 4 hourly observations to take place and I can't recall this ever occurring while I was in Maghaberry, because if a patient required 4 hourly observations then they would probably have been sent to an outside hospital if they were that sick, and this is a decision usually made by a doctor.*

At interview, the healthcare manager provided some further information in respect of Mr Doran's medical records and treatment.

Timing of EMIS Entries

In respect of the untimed entries on the EMIS medical records, the healthcare manager said that EMIS is a daily record of actions which happened on the day, like a general practitioner would make. He confirmed that, as with a general practitioner, the time of the consultation is not recorded.

Approach to Hospitalisation

In respect of hospitalisation, the healthcare manager said that the doctor would have considered this when he saw Mr Doran on 5 June 2008, if his situation had been significantly deteriorating. He said that the doctor would always consider this as a course of action as the healthcare centre functions as a prison sickbay, not a hospital.

He added that Mr Doran was a very frail, unwell man when he came into prison and, in his opinion, he did not significantly change when he was in the in-patient unit to indicate that hospitalisation was required.

Opening of Clinical Observation Chart

In respect of the clinical observation chart which the nurse opened for Mr Doran, the healthcare manager said that the doctor or the nurse could have commenced it because of their concerns about Mr Doran. He explained that an observation chart is opened and used when there is a clinical indication that

it needs to be used to monitor a patient. He said that the chart is timed, but it was unusual that there was no further entry after it was started at 14.40.

6. Findings of the Clinical Review in Respect of Mr Doran's Healthcare on 5 June 2008

Having fully considered all of the information available from healthcare records and staff interviews, Dr Peter Saul, the clinical reviewer, reached the following conclusions in respect of Mr Doran's healthcare treatment on 5 June 2008:

1. There were some worrying signs and symptoms. Mr Doran 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.

2. 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.

3. 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 myocardial infarction (heart attack).

4. There must have been sufficient concern to start an observation record but it is very surprising that no entries were made on it after 14.40.

5. The severity of Mr Doran's condition was not recognised despite a clear change.

6. There was a focus on medication being the cause of the low blood pressure. The intention was to stop the Indapamide. 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 a heart attack), commencing antibiotic treatment, commencing oral steroids and ensuring that bronchodilator by nebuliser was regularly administered and administration of oxygen started.

7. NICE[7] guidance on COPD recommends starting oral steroids at the first sign of an exacerbation and antibiotics if infection is suspected.

8. 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 therapeutic options such as

[7] NICE – National Institute for Health and Clinical Excellence is an independent organisation for providing national guidance on promoting good health and preventing and treating ill health.

intravenous support, physiotherapy and laboratory services.

Having been provided with a corrected record of Mr Doran's pulse reading, Dr Saul made the following additional observations in his Addendum:

- 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 Mr Doran's heart rate remained consistently elevated since admission to the prison.

- The nurse's statement about Mr Doran 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 a 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 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 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 Mr Doran overnight and he could have been transferred to hospital.

- The healthcare manager said that in respect of hospitalisation, the doctor would have considered this when he saw Mr Doran on 5 June 2008, if the situation had been significantly deteriorating. He also said that Mr Doran was a very frail unwell man when he came into prison and he did not significantly change when he was in the in-patient unit to indicate that hospitalisation was required.

- In my view, the evidence showing Mr Doran's continual deterioration is at variance with the last sentence in the paragraph above.

- 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 until next morning with no appropriate clinical observations having been made.

Clinical Review Findings: 5 June 2008 – Prison Doctor Comments

The prison doctor who saw Mr Doran on 5 June 2008 was asked to consider the findings of the clinical review. In responding he made the following points:

- Mr Doran did not complain of chest pain of cardiac origin. It can be assumed, however, that he had experienced such in the past on the basis of having a nitrolingual spray.

- When Mr Doran was seen on 5 June 2008, he was a frail man with evidence of neglect. He had been known to be in poor health from the time of his arrival.

- Mr Doran was brought into the clinic room in a wheelchair and talked clearly and with a relatively strong voice.

- Mr Doran described having a clear sputum. Had there been a significant chest infection at that stage, one could have expected it not to be so. However, there was evidence of poor reserve of respiratory function in that the activity associated with being examined led to marked shortness of breath.

- It was considered that if Mr Doran had not been taking his medication, in particular the Indapamide for lowering blood pressure, in the time prior to his committal that the re-introduction of same could have contributed to the lowering of blood pressure.

- There was no knowledge of Mr Doran's kidney function at that stage. Tests were requested in an attempt to get a clearer picture of the state of this man's (a) chest and (b) kidney function.

- In the meantime the Kardex [prescription card] was endorsed with regard to withholding the Indapamide.

- While in the ward the routine would be for monitoring /observation/further information gathering. There is an out of hours medical service cover available if there had been mounting concerns.

SECTION 2: EVENTS FROM 6 JUNE 2008

7. Staff Response after Mr Doran was found

An entry on the Nursing Progress Sheet for Mr Doran on the night of 5 June 2008 includes a note by a nurse officer stating *"slept well"*.

Dr Peter Saul, the clinical reviewer, commented on the nurse officer's entry saying: *"It is puzzling that there was an entry seeming to relate to the night of the 5-6/6/08 indicating that Mr Doran "slept well". It is not clear if Mr Doran woke up on the morning of the 6 June 2008 later to be found moribund or whether he never properly awoke."*

Apart from the nurse officer's comment, there were no other recorded observations carried out on Mr Doran from the time he was helped to bed on 5 June 2008 until 07.30 on 6 June 2008, when a headcount check was carried out by a duty senior nurse through the flap in his cell door.

The senior nurse's journal records that, when she was carrying out her checks of prisoners and cells within the inpatient unit of the Healthcare Centre, she carried out a full body count, that the keys and count was correct, and that she communicated this to the Emergency Control Room, in line with normal prison roll count procedures.

After Mr Doran's death, the nurse was asked to write a note of her contacts with him on 6 June 2008. She wrote: "*On 6 June 2008 at 07.30 I was checking the cell doors and prisoners within the inpatient unit. I noticed that prisoner Doran was lying in the bed with his head against the wall. On observation, he was breathing.*"

After the day staff came on duty on 6 June 2008, prisoners started to be unlocked to have their breakfast.

A nurse who went to unlock Mr Doran's cell on 6 June 2008 at approximately 08.42 observed that he was lying in bed on his right side facing the wall of the cell.

The nurse examined Mr Doran and said that *"he was not moving nor could she observe any chest movement."* She immediately examined Mr Doran for signs of a pulse. The nurse said that she believed she *"felt an extremely weak pulse, his limbs were warm to touch and his pallor was extremely pale."*

The nurse called for staff to assist and proceeded to physically move Mr Doran onto his back in preparation for emergency intervention. At this stage it is reported by the nurse that there was an expellation of air from Mr Doran.

A nurse entered the room and they called to a healthcare officer and another nurse to get additional help and get emergency equipment.

The two nurses placed Mr Doran's head flat on the bed, removed his dentures and commenced CPR. At this stage two senior nurses arrived.

All the nurses present said that a professional agreement was made to cease CPR when there was no chest movement, spontaneity of respiration or further sign of pulse.

In order to respect Mr Doran's dignity, they placed a sheet up to his neck and placed a pillow under his head. They then waited for the doctor to arrive.

At 09.12 the prison doctor attended and at 09.15 he pronounced Mr Doran dead.

The doctor recorded in Mr Doran's EMIS medical record: "*no evidence of DSH[8], ligatures. No rigor mortis.*"

All staff on duty at the time of Mr Doran's death were asked to complete a staff communication sheet, outlining their actions before and after Mr Doran was discovered.

7a. The emergency medical response after finding Mr Doran at 08.42 was carried out in a way that was consistent with the requirements of the policy for responding to a medical emergency.

[8] DSH – Deliberate Self Harm

7b. A senior nurse carried out a check through Mr Doran's cell door flap at 07.30 on 6 June 2008. She said that Mr Doran was breathing.

7c. When Mr Doran was found at 08.42, the nurse who found him said she believed that she felt a weak pulse. CPR was commenced.

7d. CPR ceased when there was no chest movements, spontaneity of respiration or further sign of a pulse.

7e. The emergency medical response, upon finding Mr Doran at 08.42, was consistent with Prison Service policy.

8. Autopsy

An autopsy was carried out on Mr Doran's body on 7 June 2008. The cause of death was recorded as:

I (a) Pneumonia
II Chronic Bronchitis and Emphysema
Effects of Dihydrocodeine, Dothiepin and Temazepam

The Autopsy report concluded that: "*Death was due to pneumonia, a serious acute inflammatory condition of the lungs caused by bacterial infection.*"

The autopsy report also stated 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."*

8a. The cause of Mr Doran's death was (i) Pneumonia; (ii) Chronic Bronchitis and Emphysema; and the effects of Dihydrocodeine, Dothiepin and Temazepam.

Autopsy Report – Findings in Respect of Temazepam, Dihydrocodeine and Dosulipen

The autopsy report identified the presence of Dihydrocodeine and Dosulipen (Dothiepen) in Mr Doran's blood above the therapeutic level and Temazepam present at a therapeutic level.

From the medical records available, and consistent with Prison Service medication policy, there is no evidence that Mr Doran had been given Temazepam for at least 72 hours before his death.

The Prison Service had substituted Stilnoct for Temazepam. Temazepam has a half life of 14 hours, though Dr Saul, the clinical reviewer, noted that this varies significantly between individuals and an intercurrent illness would prolong this. It is not, however, clear how therapeutic concentrations were present in Mr Doran's blood at the time of his death. The possible options would appear to be that Mr Doran brought Temazepam into prison with him and managed to conceal it or that it was provided by another prisoner or visitor.

In respect of the 'above' therapeutic levels of Dihydrocodeine and Dosulipen, Dr Saul noted 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.

8b. At the time of Mr Doran's death, therapeutic levels of Temazepam and above therapeutic levels of Dihydrocodeine and Dosulipen were found to be present in MrDoran's blood.

8c. The above therapeutic levels of Dihydrocodeine and Dosulipen present at death could be explained by delayed excretion and the fact that Mr Doran was so thin.

8d. It is not clear how therapeutic concentrations of Temazepam were present in Mr Doran's blood at the time of his death.

9. Overall Conclusions of the Clinical Reviewer in respect of Mr Doran's Care 2 June 2008 – 6 June 2008

Dr Peter Saul, the clinical reviewer, commenting on Mr Doran's state of health 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 were 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 earlier interpretation of 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, he 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.

Clinical Review Findings - Healthcare Manager Comments

Having considered the content of the clinical review report, the healthcare manager re-iterated the thought and care that went into dealing with Mr Doran's complex needs following his committal and emphasised that care management plans were put in place to address all of his identified needs.

The healthcare manager said that Mr Doran was frail and did appear to be unwell. He said there was evidence of neglect when he came into prison and he certainly presented challenges to staff. He added that nursing staff had carried out a range of tasks and observations and housed Mr Doran in a single room for his comfort and to provide easy access to toilet facilities. He was seen and treated by a podiatrist. The healthcare manager also pointed out that contact was made with Mr Doran's general practitioner within hours of his committal, all the medications indicated by his general practitioner were administered and Mr Doran's local respiratory team were contacted within 72 hours.

SECTION 3: EVENTS AFTER MR DORAN'S DEATH

10. Action to be taken Following a Death in Custody

The documents 'Contingency Plans Forty Four and Forty Five – Death of a Prisoner' clearly details the roles and responsibilities of all members of staff upon notification of a possible death.

Using the contingency plans, the Emergency Control Room, which controls and records all movements around the prison, immediately notified the appropriate personnel of the time and preliminary assessment of cause of death. This included, amongst others, the Police, the Coroner's Service and my Office. The Emergency Control Room incident log records this action.

10a. The Emergency Control Room immediately notified the appropriate personnel of the time and preliminary assessment of cause of death.

11. De-Brief Meetings

The Prison Service's policy for managing deaths in custody, outlined in its Self Harm and Suicide Prevention policy (revised September 2006) Section 6.11 – Impact on Staff states:

"Any staff involved in discovery of the deceased's body may find the experience difficult and distressing. Governors will address any post incident needs of staff by ensuring that support is available and staff are made aware of the full range of internal and external professional help available. A hot de-brief should be carried out with all staff involved in the incident. Governors should exercise flexibility in accommodating staff needs. This professional help will also extend to relevant professionals working within the prison environment. In the interests of good communication, a "Notice to Staff" will be issued following a death in custody, informing them of the relevant details. A more comprehensive de-brief should take place within 14 days."

Following Mr Doran's death, the Governing Governor and Duty Governor attended the scene and spoke to the staff involved about what had occurred.

All relevant staff were asked to complete Staff Communication Sheets, but there is no written record of the hot de-brief. It was not, however, a requirement of the Prison Service policy in place at the time to record the de-brief. Revised death in custody procedures, issued in January 2009, now require a note of the hot de-brief to be recorded.

11a. A verbal 'hot' de-brief was carried out in line with the Prison Service policy in place when Mr Doran died.

11b. There is no evidence that a more comprehensive 'cold' de-brief took place within 14 days of Mr Doran's death.

12. Preservation of Evidence

When any prisoner dies it is important that the Prison Service take all necessary steps to ensure the preservation of a scene and evidence. Governors Order 3-12 sets out what procedures should be followed in the event of such an emergency.

From examination of events following the alarm being raised and consultation with the PSNI, it is clear that prison and healthcare staff carried out their duties in line with Prison Service policy and procedures.

In addition, an investigating officer from the Prisoner Ombudsman's Office was in attendance soon after Mr Doran's death and was able to observe the procedures being executed by staff.

12a. Prison Service policy and procedures for managing the scene of an incident were adhered to.

RECOMMENDATIONS TO THE PRISON SERVICE

I make **eight recommendations** to the Prison Service and its South Eastern Health and Social Care Trust partners. I shall request updates on the implementation of these recommendations in line with the action plan provided by the Prison Service.

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.