The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

'MR J '

WHILE IN THE CUSTODY OF
THE NORTHERN IRELAND PRISON SERVICE

Date finalised: 8 May 2017

Names have been removed from this report, and redactions applied.
All facts and analysis remain the same.

Date published: 10 May 2017

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GLOSSARY

CJI	Criminal Justice Inspectorate
CT Scan	Computerised Tomography Scan
ECG	Echocardiogram
EMIS	Egton Medical Information System
HMIP	Her Majesty's Inspectorate of Prisons
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust
WHO	World Health Organisation

PREFACE

My office is responsible for investigating deaths in prison custody in Northern Ireland. We are completely independent of the Northern Ireland Prison Service (NIPS) and South Eastern Health & Social Care Trust (SEHSCT). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

We make recommendations for improvement where appropriate; and our investigation reports are published subject to consent of the next of kin, in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for investigations of deaths in custody are to:

- establish the circumstances and events surrounding the death, including the care provided by the NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the SEHSCT;
- examine whether any changes in NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation 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 practice is identified, and any lessons from the death are learned.

Methodology

Our investigation methodology is designed to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. In this case a review was undertaken by Dr Jane Rees, a GP with over

40 years' experience in primary care in England, including 11 years working in a variety of prisons and conducting reviews on behalf of NHS England.

This report is structured to detail the events leading up to, and the emergency response to Mr J's death.

I am grateful to the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contributions to this investigation.

Tom McGonigle.

TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
8 May 2017

SUMMARY

Mr J had been in the in the custody of the Northern Ireland Prison Service for four years when he died from a heart attack. He was a life-long smoker who did not take exercise and had previously suffered strokes. Our clinical reviewer commended some aspects of his healthcare but also criticised failings which fell short of the care he would have received in the community. The most significant was missed opportunities to diagnose diabetes despite blood test results; symptoms that indicated diabetes and delay in him receiving medication. This was partly due to inadequate systems in the prison to ensure medical tests which were ordered, were actually completed and the results actioned. The clinical reviewer also said his cardiovascular risk management was poor and that he received sub-optimal cholesterol control.

Dr Rees found no evidence of communication with Mr J by doctors about managing his conditions. He was not seen by a dietician and received inadequate smoking cessation support. She criticised the quality of clinical recording, especially by GPs, and was concerned about records of the resuscitation attempt after he was found in a collapsed state.

While some aspects of the resuscitation process could have been better, Dr Rees said it was clear that strenuous efforts were made to save Mr J when he was found, and she commended individual contributions to the process.

This report makes five recommendations for improvement. Recommendation 1 was previously made to, and accepted by the NIPS.

RECOMMENDATIONS

NIPS

1. **Medication Bullying** – When NIPS officers suspect a prisoner is being bullied for medication they should ensure SEHSCT colleagues are notified. A record of all actions taken by prison staff should be recorded on PRISM. (Page 12)

SEHSCT

2. **Test Results, Hospital Reports and Appointments Monitoring** - The SEHSCT should ensure test results, hospital reports and appointments are monitored and appropriate action taken thereafter, as required. (Pages 11-13)

3. **EMIS records**: All relevant information pertinent to the care and treatment of a patient should be recorded on EMIS, including any health information and advice given. (Pages 11-12)

4. **Chronic Disease Management** – The SEHSCT should ensure the current system of chronic disease management is robust and complies with NICE guidelines and other examples of best practice. (Pages 11-12)

5. **Smoking Cessation** - The SEHSCT should ensure that smoking cessation support is developed in line with best practice, including a full range of medication and psychosocial treatments and regular monitoring of patients' progress. (Page 13)

PRISON BACKGROUND

Responsibility for delivery of healthcare in Northern Ireland prisons transferred from the NIPS to the SEHSCT in 2008. Following a period of transition all Healthcare staff had become Trust employees by April 2012. The Trust subsequently increased the numbers of staff and the range of services provided. Healthcare is planned and delivered in line with primary care services in the community.

The Trust introduced a Primary Care Pathway with a dedicated committals team, providing comprehensive health screening within 72 hours of admission to the prison during 2013. It also introduced a Mental Health Pathway, and an Addictions Team was created in 2014.

An inspection report on the safety of prisoners in Northern Ireland was jointly published by the Criminal Justice Inspectorate and the Regulation & Quality Improvement Authority in October 2014. While inspectors saw evidence of good work in dealing with vulnerable prisoners, they also said joint NIPS/SEHSCT strategies were urgently needed to address the risks of access to illegal and prescribed drugs.

Prisons in Northern Ireland have an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Their 2015-16 annual report highlighted concerns about healthcare within the prison where Mr J was held.

FINDINGS

SECTION 1: INTRODUCTION

Mr J was a sentenced prisoner when he collapsed and died in his cell. The post-mortem recorded his cause of death as *"Coronary artery atheroma and myocardial fibrosis"*.

Further commentary notes: *"The blood supply to the heart had been severely compromised by marked narrowing of all the main coronary arteries due to a severe degenerative process (coronary artery atheroma). As a consequence, the heart muscle would have been prone to injury and the heart susceptible to sudden fatal disturbances of rhythm (arrhythmias) and sudden death could have occurred at any time…. Indeed, there was evidence that in the past he had suffered and survived a heart attack with the damaged heart muscle being replaced by fibrous scar tissue (myocardial fibrosis). This on its own can cause sudden death as it impairs the pumping ability to the heart and also renders it susceptible to arrhythmias."*

An Officer (Officer A) who had known Mr J said that he had noticed a decline in his mobility. He attributed this to age and lifestyle as Mr J was a heavy smoker who remained in his cell most of the time.

SECTION 2: HEALTHCARE

Mr J had a number of health complaints. Some were pre-existing and others only became apparent during his time in prison.

Our clinical reviewer Dr Rees commended the way his high blood pressure was treated, noting it was well controlled with regular tests to ensure kidney functioning remained normal. She also commented positively on the acute care that Mr J received in hospital following a stroke in 2013; and in 2015 he was referred promptly to hospital for an urgent scan of his leg.

However Dr Rees also highlighted several concerns from her review of Mr J's healthcare records:

Committal Screening

When Mr J arrived in prison he was assessed under the committal screening arrangements which were in place at that time.

At initial assessment a Nurse identified that Mr J had previously suffered a stroke and was being treated for hypertension. She referred him to the chiropodist and the mental health team.

A secondary screening examination - to identify issues that may have been missed initially - should have taken place. However there is no record to indicate this took place, or whether it was offered.

Dr Rees suggested a secondary screening would have been an ideal time to conduct a cardiovascular risk assessment and discuss with Mr J the risks of continuing to smoke, the efforts he should make to eat healthily, and to ensure compliance with his prescribed medication.

Subsequent to Mr J's arrival in prison, the committal process was changed to include an initial health screen and a comprehensive health screen within 72 hours of committal. This assessment addresses questions about prescribed medicines as set out in NICE Guideline NG57[1].

Diabetes

Approximately four years before his death Mr J saw a Doctor (Dr A), complaining of skin lesions and weight loss. The doctor suggested he should have a fasting blood sugar test and this was conducted four days later. The test result showed a blood

[1] Physical health of people in prison. NICE Guideline. Published: 2 November 2016.

sugar level of 7.3mmol/l, but there is no reference in Mr J's healthcare records to the result or any subsequent action.

Dr Rees suggested that World Health Organisation and National Institute for Health and Care Excellence guidelines suggest a result of 7.3mmol/l was sufficient to diagnose diabetes in a person who has skin lesions and weight loss.

Four months after the initial appointment, the same Doctor (Dr A) again ordered blood tests, including blood sugar, when Mr J was complaining of chest pain. The tests were done a week later but there was no record of a blood sugar test having been conducted.

A year after the first appointment, Mr J's blood glucose was tested following another stroke. The reading was 8.3mmol/l, which was again above the threshold for diagnosing diabetes, yet no action was taken.

Six months later, a further blood sugar test was taken. The reading was 6.9mmol/l and as the Doctor (Dr B) who saw him on this occasion considered it indicated impaired glucose intolerance, he suggested the test be retaken in within three months. However a further test of Mr J's blood sugar levels was not undertaken until 27 months later.

In the two years prior to his death Mr J reported tingling sensations in his feet and a number of skin disorders and infections. These symptoms are associated with diabetes.

Commenting on the Doctor's assessment when the further blood test was taken, Dr Rees said consideration was not given to the previously abnormal blood sugar level results or Mr J's existing cardiovascular disease. She considered the delay in diagnosing his diabetes constituted a major breach of the duty of care.

Five months prior to Mr J's death, when diabetes was suspected, blood tests were again ordered. They were not conducted until a month later and their abnormal result was not commented upon for a matter of weeks. Mr J was seen by a doctor at that point to inform him that diabetes was confirmed, and Metformin was prescribed. However the record of this consultation does not indicate that he was informed of the implications or how his diabetes should be managed.

Mr J received his medication a week later. It therefore took 13 weeks from diabetes being suspected until he began to receive treatment.

A referral was made for diabetic retinopathy screening to ensure Mr J did not suffer damage to his eyes, and he was also referred to a dietician. However he was not seen by a dietician before his death and there is no evidence of advice being given on how to manage his diet.

Dr Rees highlighted the failure to examine Mr J's feet as another omission. Although he had frequently seen podiatrists in prison, he was not referred following the diagnosis of diabetes, and the blood and nerve supplies to his feet were not tested.

Cardiovascular Care

Mr J was already being treated with cholesterol-reducing medication when he arrived into prison. His medical records contain several references to blood tests for cholesterol levels, but there is no evidence that these tests actually took place.

Dr Rees noted the discharge summary from outside hospital following his second stroke in 2013 recorded that Mr J's cholesterol control was on target. However as no blood test results were included, she could not determine whether this comment was based on evidence or assumption.

Angina, medication reviews & nicotine replacement

Mr J was diagnosed with angina approximately three and a half years before his death. Dr Rees found the diagnosis was correct but said more clinical information should have been recorded - about the nature of his chest pain and any physical examination other than pulse and blood pressure - to support the diagnosis. Dr Rees said this was an unacceptably low level of detail upon which to base a potentially life-changing diagnosis, well below the standard of care that would be provided in the community. In light of the normal ECG recorded, a discussion about further cardiac investigations would have been appropriate.

Dr Rees concluded that Mr J's medication reviews were inadequate as they did not assess compliance. Had this been done the doctors would have learned that, despite his denials, Mr J was using a 180 dose Glyceryl Trinitrate (GTN) spray for angina every few weeks. One implication of this was that he could have had more cardiac symptoms than he was disclosing, which might have required further investigation.

Another possible implication arises from the fact that GTN spray can be abused for sexual gratification. Records suggest Mr J may have been bullied for his medication, and this was investigated by the Prison Service. The Healthcare Department should have been informed by NIPS about the bullying incident so that they could review his medication.

Dr Rees also noted that Mr J was prescribed nicotine replacement patches for six weeks, whereas the recommended length of a course is 8 – 12 weeks. There was no indication of his carbon monoxide levels being monitored to ensure he had stopped smoking. Nor was psychological support provided as recommended; and he did not have an opportunity to explore alternative medications to assist cessation.

Smoking cessation clinics were due to commence in the prison at the end of April 2017.

External Hospital Appointments

While in hospital some three years before his death, Mr J had a CT scan of his brain and an ultrasound examination of the arteries in his neck. Neither revealed any abnormality. Appointments were later made for an echocardiogram[2] and a 24-hour ambulatory ECG[3]. However there is no evidence that he attended these appointments, and no related results appear in his medical records. Dr Rees said the failure to follow-up on these tests again meant Mr J's care fell below that which he would have had in the community.

The Trust suggests this issue should no longer occur as their staff now have access to the Electronic Care Record (ECR) where test results are centrally recorded, and are not filed until actioned and cleared from the electronic system.

[2] An **echocardiogram** is a still or moving image of the internal parts of the heart.
[3] **24 Hour Ambulatory ECG** Monitoring is a continuous digital recording of an **ECG** over a **24 hour** period.

Clinical Reviewer's Conclusions

Dr Rees suggested the undiagnosed diabetes and sub-optimal cholesterol control were likely to have contributed to atheroma - fatty deposits on the walls of Mr J's arteries. It is not possible to determine whether this led to an early death. The only way in which his cardiovascular health could have been significantly improved following a diagnosis of angina would have been to undergo coronary artery surgery. However it is not known whether he would have agreed to major surgery as there is no recorded communication by medical staff about the diagnosis of angina and his long-term prognosis.

She said the delay in Mr J receiving his medication was totally unacceptable, with nothing in his medical records to explain the delay. She concluded that the standard of his diabetic care fell short of national guidelines and good practice. She cited the lack of recorded communication with him as a *"major deficiency"* and noted there was only one limited conversation about the implications of being diabetic or how he could manage the illness. This was contrary to NICE guidance as sub-optimal care is likely if a patient does not understand their diabetes.

Dr Rees expressed concern about the lack of systems in the prison to ensure that tests which are ordered are actually completed and the results actioned. She considered this is the responsibility of the doctor who ordered a test.

She suggested Mr J received inadequate smoking cessation support; and said his cardiovascular care in the prison fell short of what he would have received in the community where chronic disease management clinics are well established in most GP practices.

SECTION 3: DAY OF MR J'S DEATH

Mr J had requested a move to a smaller cell because it would be less tiring to clean. His mobility was limited and he was becoming breathless on exertion. Staff put this down to his age and lifestyle as he smoked and never exercised.

The request was granted and after lunchtime on the day he died his cell was unlocked and he started to move his belongings into a smaller cell on the same landing. Staff were mindful of his physical state and he was told to take his time. Mr J used a trolley and an Officer (Officer A) helped move some heavier items.

At 15.44hrs Officer A went to Mr J's cell as he was locking the landing. He found Mr J collapsed between two beds, lying flat on his back. The Officer stood over him and shouted his name, but as he did not receive a response he administered 2-3 chest compressions and then raised the alarm.

On hearing the call for assistance, Officer B immediately rang the Emergency Control Room and requested medical attendance. She ran to Mr J's cell and checked for a pulse while Officer A was checking his airways to establish if he was breathing. No pulse was found so Officer B retrieved a defibrillator from the office. When she returned to the cell, a senior nurse had arrived and was conducting chest compressions. Officer B started to apply the defibrillator while other nurses also arrived. The officers stepped aside as the nurses took over the resuscitation efforts.

Nine minutes after the alarm was raised, CCTV footage shows two prison Doctors (Dr A & Dr C), a Healthcare Manager (Nurse A), and two inspectors from the Regulation & Quality Improvement Authority (Dr D & Nurse B), who happened to be on the landing, entering Mr J's cell.

Thereafter the RQIA Inspectors (a Doctor and a Nurse) took control of the resuscitation efforts, with the Doctor taking the lead. He led the resuscitation team through Immediate Life Support (ILS) protocols, including administration of adrenaline. ILS was continued for approximately 20 minutes and the RQIA doctor wanted to cease the resuscitation efforts as no signs of life were present. However the Nurses requested the efforts should continue until paramedics arrived. They arrived at 16.08hrs and at 16.12hrs life was declared extinct.

The Clinical Reviewer raised the following concerns about the resuscitation process:

- Prior to the RQIA inspectors intervening, two prison doctors in attendance were not leading the resuscitation process. The Trust explained that in prison, nurses are first responders and it is they who lead resuscitation procedures.
- Blood sugar level analysis was not timely. The Trust, while acknowledging the measurement of blood sugar is recommended in the resuscitation guidelines,

commented that Mr J was not being treated with any drugs that were likely to cause hypoglycaemia.

- A cannula could not initially be found in the emergency response bag. Although one was retrieved from nearby, this caused a delay in adrenaline being administered. The Trust explained that use of adrenaline for cardiac arrest is only recommended in the Resuscitation Council's Advanced Life Support guidelines. Following Mr J's death a 'look back' exercise was held and it was agreed that a supply of adrenalin for cardiac arrest will be held centrally on each prison site for use in circumstances where it was clinically indicated and an appropriately trained healthcare professional is on site.
- Inconsistent accounts were documented of who did what during the resuscitation process.

The actions of the Nurse (Nurse C) who maintained Mr J's airways throughout the entire resuscitation attempt are commendable. She had recently attended Immediate Life Support training and the RQIA inspectors praised her confidence and technique.

Although Dr Rees noted concern about the varying accounts of the attempt to resuscitate Mr J, she said it was clear from the medical records and from the accounts provided by NIPS staff and the RQIA inspectors that strenuous efforts were made to resuscitate Mr J. She also said some elements of the process, in particular the insertion of the airway and the 30/2 CPR process, were well conducted.

NIPS officers said nothing would have alerted them to Mr J's imminent collapse as there was no physical change in his appearance and he had not complained of feeling unwell.