The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF
SAMUEL ALEXANDER SMYTH
AGED 56
WHILE IN THE CUSTODY OF
MAGHABERRY PRISON
ON 18th DECEMBER 2013

[1st September 2015]

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

[Published: 23rd September 2015]

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Glossary

CJI	Criminal Justice Inspectorate
EMIS	Egton Medical Information System
ENT	Ear, Nose and Throat
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
NIPS	Northern Ireland Prison Service
OMU	Offender Management Unit
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust

PREFACE

As Prisoner Ombudsman for Northern Ireland I have responsibility for investigating all deaths in prison custody in Northern Ireland. My investigators and I are completely independent of the Northern Ireland Prison Service (NIPS). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

I make recommendations for improvement where appropriate; and my 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 Prisoner Ombudsman 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 South Eastern Health and Social Care Trust (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 standard investigation methodology aims 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, Professor Jenny Shaw, Forensic Consultant

Psychiatrist with Lancashire NHS Foundation Trust undertook a clinical review of the care provided to Mr Smyth in connection with his mental health. In addition a peer on peer review was undertaken by Dr Rob Hall, a retired GP from Suffolk, who has experience of completing clinical reviews for deaths in custody in England and Wales.

This report is structured to address the concerns of Mr Smyth's family and the sequence of events which preceded his demise.

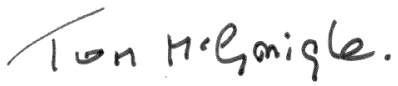
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. I first met with members of Mr Smyth's family in January 2014, and contact has been maintained with them throughout the investigation.

Although this report will inform several interested parties, it is written primarily with Mr Smyth's family in mind.

I am grateful to Mr Smyth's family, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewers for their contributions to this investigation.

I offer my sincere condolences to Mr Smyth's family for their sad loss.



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
1st September 2015

SUMMARY

Alec Smyth was a life sentenced prisoner who spent a total of 34 years in prison, and had been in continuous custody from 1995 until he died in 2013. He was diagnosed with an antisocial personality disorder, and refused to engage with family members or with most prisoners and staff for several years prior to his death.

After entering separated conditions in 2003 he became increasingly reclusive, and his personal hygiene deteriorated considerably from 2007. He was very difficult to motivate or manage and consistently refused offers of help. These factors became more pointed in 2013 when he developed cancer.

Apart from a suggestion that his capacity might have been assessed, no concerns were raised by clinical reviewers about the mental healthcare that Mr Smyth received. However while fully recognising the management challenges that Mr Smyth posed, Dr Hall is critical of his physical healthcare, particularly the fact that it took over seven months to diagnose his lung cancer. Staff shortages and time pressures may contribute to an explanation, but Dr Hall's summary is that Mr Smyth's health needs were neither fully assessed nor properly met in 2013.

The key findings of Dr Hall's clinical review are:

- There were no concerns about Mr Smyth's healthcare in custody until 2013;
- During 2013 six opportunities were missed to reach Mr Smyth's diagnosis of cancer;
- There were no procedures in place to follow up missed medical appointments;
- Once diagnosed with cancer, no plan was put in place to care for him in a more suitable location;
- No symptom control plan was put in place;
- On 22nd November 2013 when a CT scan confirmed Mr Smyth was seriously ill, no action plan was implemented apart from a referral to hospital;
- GPs did not visit Mr Smyth after 22 November 2013, and they prescribed medication without seeing a dying patient.

While healthcare and custody are separate functions, both have an equal duty of care, and considerable improvement is required in their coordination and collaboration at Maghaberry Prison.

This report makes thirteen recommendations for improvement, all of which have been accepted. Two (Recommendation two [in part] and Recommendation six) were previously made to, and accepted by the SEHSCT, in November 2010 (recommendation two) and February 2011, October 2012 and November 2013 (recommendation six).

I wrote to the Ministers of Health and Justice in November 2014 to express my concern about the need to repeat recommendations that had previously been accepted. Both Ministers replied to say the matter was being treated seriously.

The NIPS responded to this report by saying:

"We are sorry to learn of Mr Smyth's illness and his subsequent death, and our thoughts go out to his family. We are determined to use this report to strengthen systems already in operation throughout Northern Ireland's prisons."

The SEHSCT welcomed the findings and responded to this report by saying:

"A number of improvements have been agreed through the Trust's prison healthcare reform project which includes systemising the coordination of clinical care for complex patients and establishing clinical meetings."

RECOMMENDATIONS

SEHSCT –

1. **Multi-Disciplinary Team Meetings** - The Healthcare Leads at Maghaberry should establish a regular multi-disciplinary team (MDT) meeting for GPs and nurses to plan and coordinate care for complex patients. Where required, the multi-disciplinary care plan should make explicit the process for engagement of residential staff, to ensure they are aware of the support needs of the patient and how these will be met by both organisations. (Page 18)

2. **Missed Appointments -** The SEHSCT should initiate a procedure whereby missed appointments or missed investigations are treated as a significant event and discussed at a weekly multi-disciplinary team meeting. Where necessary the prisoner should be informed of the risks of missing the appointment, and a record should also be made on EMIS. (Page 17)

3. **Staff Performance –** The SEHSCT should share the learning from the investigation with the involved clinical staff and ensure that this is addressed in training and appraisal.

4. **Allocation of GP Services** - The SEHSCT should ensure GPs have adequate time allocated to fully meet the needs of all patients based on their clinical judgement. (Pages 19 & 25)

5. **Professional Responsibility** –

    - The SEHSCT should ensure that any member of staff should be clear about their role and responsibilities when attending serious case reviews.
    - The SEHSCT should monitor attendance rates at safer custody fora and SPAR reviews. The effectiveness of these fora should be reviewed with the NIPS to ensure their effectiveness in supporting patient care plans. (Page 16)

6. **Medical Records Standards** – The SEHSCT should ensure that all Healthcare staff who are required to make entries in medical records, do so in accordance with best practise standards. (Page 24)

7. **Mental Capacity Assessments -** Mental capacity assessments should be recorded for all prisoners who persistently refuse important medical investigation. (Pages 14 & 17)

SEHSCT and NIPS: -

8. **Release Provisions for Terminally Ill Prisoners** – The NIPS and SEHSCT should ensure that the procedure for releasing terminally ill prisoners is expedited in a timely way. (Page 21)

9. **Palliative Care Plans** – The SEHSCT should ensure palliative care plans are prepared and implemented upon a GP establishing a working diagnosis of cancer. Clinicians should engage with the NIPS to ensure they can contribute as appropriate. (Page 23)

10. **Communication** – The SEHSCT and NIPS should identify opportunities for improving their information-sharing in relation to all aspects of prisoners' healthcare. (Page 25)

NIPS -

11. **Consideration of Mental Capacity Assessments:** When OMU or PSST staff are concerned about institutionalisation and mental health of a prisoner who persistently refuses to engage in the prison regime, rehabilitation programmes, and / or maintain links with friends and family, they should communicate their concerns to the Healthcare Department and request that the prisoners mental capacity be assessed. (Page 14 & 17)

12. **Avian Welfare** – Governor's Order 7-17 should be enforced to ensure protection of prisoners' and staff health, and the welfare needs of prisoners' pet birds. (Page 26)

13. **End of Life Care –** Prison managers should be encouraged to exercise discretion in relatively low level decisions which can significantly improve end of life care. (Page 26)

MAGHABERRY PRISON

Maghaberry is a high security prison which holds male adult sentenced and remand prisoners. It was opened in 1987.

Maghaberry established a Prisoner Support and Safety Team (PSST) in 2011. The team comprises a governor and three members of staff. They have several responsibilities including a role to support vulnerable prisoners. Serious case reviews in relation to Mr Smyth were being undertaken by the PSST in the months leading up to his death.

There have been two deaths in Maghaberry since Mr Smyth died.

The CJI / HMI Prisons inspection of Maghaberry conducted in March 2012 and published on 17th December 2012 made several findings and recommendations in relevant to healthcare provision.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Maghaberry IMB's 2012-13 annual report made recommendations about Healthcare, personality disordered prisoners and missed medical appointments that are relevant to Mr Smyth's circumstances. The report also highlighted the Board's concern about *"…. continued short staffing and low staff morale, lack of preventative clinics and diminution in the service provided to patients… healthcare staff are doing their best but struggling to provide even a minimum service."*

FINDINGS

SECTION 1: INTRODUCTION

Samuel Alexander Smyth, know to his family and friends as Alec, was remanded in custody in October 1977 and sentenced to life imprisonment in 1978. He remained in prison until being released on license in March 1993. In June 1995 his license was revoked and he remained in custody until his death on 18th December 2013 – a total of 34 years. He had no immediate prospect of release at the time of his death.

Mr Smyth died of lung cancer which had spread throughout his body. His family raised concerns in relation to the healthcare he received, particularly during his last twelve months. These concerns were located in a context of disquiet about how his reclusive behaviour was managed, his institutionalisation, and capacity to make decisions regarding his future.

SECTION 2: INSTITUTIONALISATION, RECLUSIVENESS AND MENTAL CAPACITY

Mr Smyth's family raised concerns about him having served nine years longer than the 25 year tariff that was imposed in conjunction with his life sentence. They believed the Prison Service had not fulfilled their duty of care in securing Mr Smyth's release either back into the community or to a secure unit. The family understood Mr Smyth to have been diagnosed with a *"psychotic"* condition, and had become a recluse and institutionalised. They queried whether he had the capacity to make decisions about his custodial progression and, in more recent times, about the healthcare he was prepared to accept.

Mr Smyth's first period of imprisonment between 1977 and March 1993 was unremarkable. There were no signs of institutionalisation, reclusiveness or questionable mental capacity. He had intermittent diagnoses of depression and anxiety which were treated with antidepressants.

Mr Smyth married in February 1989 and records indicate that this relationship was a positive influence and gave him impetus for his release in March 1993. Upon release he moved to Dublin to live with his wife, but the marriage broke down after six months and he returned to Northern Ireland.

Following an incident at the home of a family member, Mr Smyth's life license was revoked and he was returned to Maghaberry in July 1995. Shortly after his return he was seen by a psychiatrist who noted that there was no evidence of endogenous depression[1] but an impression of severe personality disturbance.

Between 1995 and 2002 Mr Smyth was assessed on eighteen occasions by four different psychiatrists, two of whom were independent of the Prison Service. During this period eight detailed psychiatric reports were produced for the Parole Commissioners.

Essentially the psychiatric reports concluded that there was no evidence that Mr Smyth's reoffending, which resulted in his recall to prison, was attributable to any form of mental illness. Rather his behaviour and symptoms were in keeping with a severe personality disorder. He was deemed unable to cope effectively and consistently with a range of day to day situations and difficulties, had deeply ingrained problems and was resistant to change.

Within a short period of returning to prison Mr Smyth had become physically and verbally demanding. He failed to acknowledge shortfalls in his personality and refused to engage in any meaningful psychotherapeutic interventions[2].

[1] Endogenous depression is an outdated term to describe a depression which came from within, implying that there was no discernible cause for the depression.

[2] Psychotherapeutic intervention is an all-encompassing term for behavioural, cognitive and psychoanalytical therapies.

While psychiatric assessments in 1998 and 1999 suggested Mr Smyth had engaged intermittently with most elements of his therapeutic programme, the psychiatrist's opinion was that he showed little overall improvement that could be sustained; and failure to contain his aggression within the prison suggested there remained a high risk of serious physical injury to members of the public and his family if he was to be released into the community.

By January 2001 Mr Smyth had spent over 12 months in Maghaberry's Care and Supervision Unit (CSU), due to bullying of staff and prisoners. This triggered a case management conference to consider how he might be returned to a normal location. References were again made to Mr Smyth's refusal to engage with his family or cooperate with the Lifer Governor and the psychologist. It was agreed that he required a structured programme which would last at least two years.

From July 2003 to November 2003 Mr Smyth was again in the CSU due to bullying. During this time he applied for separated prisoner status, which was granted, and he moved to Bush House on 19th November 2003. There is much less interaction with the general prison population or staff for prisoners who live in separated conditions.

Thereafter Mr Smyth engaged with mental health services when it suited him i.e. when he wanted different types of medication. His situation was discussed at lifer reviews, and the Maghaberry Safer Custody group also had oversight of his situation. Although invited, Mr Smyth did not participate in these events.

On one occasion (3rd November 2006) Mr Smyth admitted to a mental health nurse that he liked isolating himself; on another (29th May 2008), the mental health nurse recorded that he self-isolated in order to remove himself from the "system" rather than to annoy staff or other prisoners. GPs determined there was little medical intervention that would assist, and the emphasis was placed on psychotherapeutic interventions. However Mr Smyth's limited motivation to engage in these interventions was the biggest challenge.

In 2007 the first file entries of unclean living conditions in Mr Smyth's cell were recorded. He spent most of his time in cell, with curtains closed, playing a PlayStation, with only the company of a budgie. His self-isolation, poor hygiene and lack of engagement with any services continued, and it is clear that this left the Prison Service and South Eastern Trust at a loss as to what further could be done.

As Mr Smyth did not complete the necessary programmes, the Parole Commissioners deemed him to be too dangerous to return to the community.

A governor told this investigation that residential staff and some prisoners tried to encourage Mr Smyth to clean his cell, but to no avail. Instead he was persuaded to periodically move cells so that a deep clean could be carried out. The governor assessed that to force him out of his cell, or to charge and adjudicate him for

breaching Prison Rules, would have resulted in a further downward spiral in Mr Smyth's behaviour.

Professor Shaw reviewed Mr Smyth's extensive medical notes and reports. In her clinical review report she states *"… Periodically he complained of low mood, indeed one report noted that he said he had had low mood on and off since the age of 16. This appeared to be reactive and related to his circumstances. There was no clear evidence of clinical depression at any point."*

In discussing whether Mr Smyth's reclusive behaviour was linked to any mental illness, Professor Shaw said there was no evidence to indicate this, or that his behaviour was indicative of self-harm.

In summary she states *"Mr Smyth had significant contact with mental health services within the prison over the years and had several in-depth psychological and psychiatric assessments. The most likely diagnosis was antisocial personality disorder. He was offered assessment and treatment but failed to engage, particularly in the year or so prior to his death.*

In my view, the prison staff had an understanding of his condition and tried to encourage him to engage. The only criticism would be that there is no documented capacity assessment in the case notes and this should have been conducted given the marked change in his behaviour and in particular his refusal to have (medical) *investigations* (as discussed later in this report).

However, from my reading of the case notes and the testimonies from fellow prisoners, there is no evidence that he lacked capacity to make that decision."

Dr Hall concurred that a mental capacity assessment should have been undertaken, while recognising that Mr Smyth's increasing reclusive behaviour would have been a challenge for any prison in the UK.

SECTION 3: DIAGNOSIS AND MISSED OPPORTUNITIES

Mr Smyth's family were concerned that he had not received appropriate healthcare or been admitted to hospital at the earliest opportunity. This section provides a chronology and accompanying clinical analysis of Mr Smyth's treatment, diagnosis and admission to Belfast City Hospital.

Mr Smyth died of lung cancer. NICE[3] guideline 121 Lung Cancer, published in April 2011, states that *"only about 5.5% of lung cancers are currently cured"*.

Dr Hall said that on presentation, lung cancer has usually spread to such an extent that curative treatment (such as a combination of surgery, chemotherapy and radiotherapy) is impossible.

In late 2012 and early 2013 at varying times Mr Smyth presented with cough symptoms and was treated with Simple Linctus.

On 9th April 2013, Mr Smyth's medical records show that although he was not listed to see the GP, he had a brief discussion with one in relation to difficulties with his throat. He was advised to see a nurse the following day in order to be placed on the GP's list. Mr Smyth was seen on 10th April by a nurse but he declined a place on the GP's list.

Following a further appointment with the nurse on 15th April, Mr Smyth agreed to see a GP, and did so on 16th April. It is recorded that Mr Smyth reported hoarseness for five days. The GP also found an enlarged lymph node in the supraclavicular fossa (the dipped area above the collar bone) and treated him with antibiotics. The GP planned to review him in two weeks' time, and if he was no better, to order blood tests and a chest x-ray.

Dr Hall stated that some GPs, at this point, would have conducted investigations in view of the presence of the node, whereas others would have treated Mr Smyth and seen him again in two weeks' time. He said that both are normal practice, but potentially this was the first missed opportunity to ensure a diagnosis.

Mr Smyth returned on 30th April and saw a different GP. Blood tests were requested along with a chest x-ray.

Blood tests were taken on 2nd May 2013. They revealed a slight rise in the ESR[4]. The GP who arranged these blood tests said that if he had seen this elevated result he

[3] NICE – National Institute for Clinical Excellence (NICE) provides national guidance and advice to improve health and social care.

[4] Erythrocyte Sedimentation Rate (ESR) is a measurement to indicate inflammation somewhere in the body. A rise in ESR is indicative of inflammation.

would have expected them to have been followed-up by another appointment with Mr Smyth. However no further action was taken on the foot of these results. The reason for this failure is unknown.

The process at the time was that administrative staff would receive a paper copy of the results and pass them to the onsite GP to review and action as required, before being scanned onto the system. The GP said his practice was to sign and date any results he reviewed. These results had not been signed and dated, which the GP said indicates that he did not receive them. He could not account for the practice of the other GPs at the time. The process for reviewing blood test results is now done electronically and provides a full audit trail of how they have been processed.

Mr Smyth refused to attend his chest x-ray (in Maghaberry) on 8th May 2013. While a person has the right to refuse to attend, no follow-up action was taken to review his failure to attend such an important appointment, or whether he had capacity to refuse an x-ray.

Dr Hall stated this was the second missed opportunity to make a diagnosis.

A Serious Case Review was convened on 18th June 2013 at the request of the Governing Governor, after concerns were raised by a local councillor about Mr Smyth. The chair noted *"….serious concerns regarding Mr Smyth, his self-isolating and the recent deterioration in his wellbeing."* Those in attendance included three governors, and representatives from PSST, Healthcare, Probation, Offender Management Unit, Psychology, Chaplaincy, IMB, a senior officer and a landing officer from Bush House, where Mr Smyth resided.

Various agencies expressed anxiety about Mr Smyth's deteriorating health, but the senior nurse who attended did not register any concern. She told this investigation she was only at the meeting to provide information, and not to proactively take the lead in respect of Mr Smyth's healthcare.

Mr Smyth's refusal to attend the x-ray was mentioned, but there was no discussion about the consequences of his refusal, or any proactive effort to persuade him to attend a rescheduled appointment. In contrast to the limited healthcare contribution, there is evidence that a psychologist tried on numerous occasions to encourage and explain the importance of him engaging with their services. Discipline staff also expressed concern about Mr Smyth's deteriorating health, and it was noted that two fellow prisoners had volunteered to be unofficial carers due to his deteriorating health.

Despite the high level impetus that initiated this Serious Case Review, and the external interest, no action point arose in respect of his deteriorating health, nor was a clinical lead identified to oversee Mr Smyth's healthcare.

Mr Smyth was seen by a GP on 20th June 2013. This appointment had been requested by the senior officer for Bush House, who reported that Maghaberry's Governor had received a letter from Mr Smyth's solicitor. However there is no record of this letter being received and there is no evidence to suggest Mr Smyth engaged his solicitor. During this appointment Mr Smyth reported hoarseness for the previous eight weeks, and said he had difficulty with swallowing. The GP recorded that he could not feel any neck nodes but as a result of the consultation, an urgent "red flag"[5] referral to an Ear, Nose and Throat (ENT) specialist was made the same day.

The appointment was scheduled for 2nd July 2013 but Mr Smyth did not attend. The non-attendance and reason for it were not recorded.

Dr Hall stated this was the third missed opportunity to make a diagnosis.

A follow-up Serious Case Review (SCR) took place on 3rd July 2013. There were only four in attendance - a different governor, who chaired the meeting, the senior nurse, a PSST member and the landing officer who attended the previous SCR. The ENT referral was mentioned by the nurse but as there was no record in Mr Smyth's notes to indicate he had missed the appointment (see footnote)[6], she was unaware of the failure to attend. This was however a "red flag" referral which meant the patient should have been seen within two weeks, so it should have been more actively pursued.

New procedures have since been implemented to ensure all red flag referrals receive an appointment within the expected timeframe. When red flag appointments are not attended the administration team give a letter to the prisoner. This letter asks for the reason, and queries whether they would like another appointment. While this new process would have alerted the Healthcare Department to Mr Smyth's missed appointment, it would not have helped him understand the possible consequences for missing the appointment and it does not prompt GPs to consider whether a mental capacity assessment is required.

Dr Hall stated that hoarseness that lasts some weeks can indicate a cancer of the larynx and is also a serious indicator of lung cancer. He stated *"with some certainty"* that at this stage Mr Smyth had a lung cancer which had already spread, and would be inoperable.

Dr Hall also explained that it is not uncommon for prisoners to refuse to attend outside hospital or accept certain health advice, but emphasised that in such cases follow-up action should have been taken. He would have expected the

[5] Red flag referrals are used where GP's suspect their patients of having cancer.
[6] In November 2010 it was recommended to, and accepted by, the SEHSCT, that all missed appointments should be recorded on EMIS along with the reason. This is an example of an accepted recommendations not being implemented.

following action, which he has witnessed in other prisons:

- An alert that an ENT appointment had been missed;
- A multi-disciplinary team meeting with participation by GPs, Head of Healthcare, Nurses, Chaplains and discipline officers;
- GP visit to cell to fully explain why the referral had been made, that they suspected cancer and that the diagnosis needed to be confirmed to arrange the most appropriate treatment. The risk of doing nothing should have been explained to Mr Smyth and the full consultation recorded in his medical records;
- Based on Mr Smyth's lengthy psychiatric history and his prescription for antidepressant medication, mental health and mental capacity assessments should have been undertaken;
- In view of Mr Smyth's poor health, consideration should have been given to moving him to a healthcare unit or supported living unit within the prison estate (NB: the clinical reviewer was unaware that such provision does not exist in Maghaberry Prison. An earlier diagnosis would also have provided the opportunity for the NIPS to apply for Mr Smyth's release under Article 7 of the Life Sentences Northern Ireland Order 2001);
- A detailed nursing care plan should have been developed and implemented;
- If Mr Smyth continued to refuse to go to hospital, the ENT consultant could have been asked to undertake a domiciliary visit;
- If Mr Smyth still refused to go to hospital, with a working diagnosis of cancer of the larynx, the local palliative team and consultant should have been asked to assess him. From the palliative care assessment, a symptom control plan would have been created and his medication reviewed frequently;
- A GP should have seen Mr Smyth regularly, as GPs in the community would have done if the patient remained at home;
- Mr Smyth should have been discussed weekly at the MDT.

None of the above was done in Mr Smyth's case and he did not see a GP again for over four months.

On 1st November 2013 a GP saw Mr Smyth for a routine medication review. The record of this consultation indicates that Mr Smyth was complaining of nausea, and on examination he had chest sounds. As a result a course of antibiotics were prescribed and the GP was to see him again if necessary. The planned medication review was not done; and the missed "red flag" ENT appointment from July was not noticed by the GP, or mentioned by Mr Smyth either.

Dr Hall viewed this as a poor consultation, and the fourth missed opportunity to make a diagnosis.

The GP agreed this was a missed opportunity and explained that as he has a maximum of ten minutes to carry out a consultation, he does not have time to routinely review a patient's history on the electronic recording system. He simply assessed Mr Smyth's symptoms of nausea when eating and bilateral basal creps[7](chest sounds) and treated him for a suspected chest infection.

On 14th November 2013 Mr Smyth saw the GP whom he had met on 20th June 2013. Mr Smyth complained of hip pain and was treated with a non-steroidal anti-inflammatory medication. This GP recalled making the "red flag" ENT referral, noted the patient's ongoing hoarseness and that he had now developed ptosis[8] in his left eye. The GP asked a nurse to pursue the ENT referral. The nurse's enquiries established that Mr Smyth had refused to attend his appointment on 2nd July 2013 and as a result she placed him on the next available GP's list, which was on 19th November.

Dr Hall stated this was the fifth missed opportunity to make a diagnosis.

Mr Smyth's health deteriorated further and landing staff again raised concerns with the prison Healthcare Department. As a result he was triaged twice by a nurse on 15th and 19th November 2013 and a subsequent GP appointment took place later that day, with the same GP who had seen him on 1st November. The ptosis remained. The GP faxed an urgent CT scan referral; and he again planned to pursue the ENT referral. If the ENT appointment did not take place, he intended to once more refer Mr Smyth as a "red flag" referral.

Dr Hall stated that due to such a *"sinister"* symptom as ptosis, some GPs would have admitted Mr Smyth to hospital for immediate investigations rather than request a scan, wait for the result and act on the result. He viewed this as the sixth missed opportunity to obtain a diagnosis.

On 22nd November 2013 Mr Smyth had a CT scan which confirmed he had lung cancer. A prison GP informed Mr Smyth of his diagnosis and told him a referral to the respiratory department of Belfast City Hospital had been made. The GPs expectation was that Mr Smyth would be seen by the consultant within two weeks.

Both of the GPs who saw Mr Smyth on 14th, 19th and 22nd November told this investigation they felt he was *"not ill enough"* to send to outside hospital.

[7] Bilateral basal creps – Lung noise suggestive of congestion.
[8] Ptosis – drooping of the upper or lower eye lid.

Dr Hall stated that by 22nd November the diagnosis was clear and that if Mr Smyth had been his patient he would have admitted him to hospital immediately, or stressed the importance of being admitted. He said if Mr Smyth had refused to go, he would have seen him on a daily basis to try to persuade him to go to hospital.

In summary Dr Hall's opinion was the cancer had almost certainly spread by April 2013 when the lymph node was detected in Mr Smyth's neck, and it had definitely spread by June 2013 when he had developed hoarseness. Dr Hall therefore assessed that the late diagnosis made no difference to the final outcome. However he stated that an earlier diagnosis could have provided an opportunity for chemotherapy or radiotherapy, which may have shrunk the tumour(s), eased Mr Smyth's symptoms and extended his life.

The GP who saw Mr Smyth on 22nd November said he did not visit Mr Smyth because he had not been requested to do so by a nurse. He stated that if required, Mr Smyth could have asked to see the nurse every day – the onus was on Mr Smyth to make such a request.

Between 22nd November and 3rd December 2013, when Mr Smyth was admitted to hospital, he had been seen by a nurse on a total of seven occasions - on 25th, 28th and 30th November, 2nd and 3rd December 2013.

On the morning of 2nd December a nurse who saw Mr Smyth noted she had reiterated to him that he did not have to suffer, and that it was *"our duty"* to try to get him pain free. Mr Smyth told the nurse that he did not want to go to hospital at that point. The nurse noted that Mr Smyth was scheduled to attend an appointment with a consultant the following day and having persuaded him to attend, she was hopeful that if he needed to be admitted, he would agree to it if he was in front of the consultant rather than through A & E.

The following day Mr Smyth did attend his appointment and was admitted to hospital for spinal cord compression[9] testing in an attempt to alleviate his pain.

Dr Hall described the nurse who saw Mr Smyth on the morning of 2nd December as being the only member of Healthcare staff during Mr Smyth's illness to recognise their duty of care.

He goes on to state that the lack of GP care of Mr Smyth between 22nd November and 3rd December 2013 is one of the major findings of his review. In particular he commented on the fact that despite a nurse noting Mr Smyth being in severe pain, the GP who prescribed a stronger pain killer (Tramadol) did not visit Mr Smyth – which he described as poor practice.

[9] Spinal cord compression happens when there is pressure on the spinal cord. This pressure may be caused by a cancer that started in, or has spread into, the bones of the spine.

Dr Hall added *"There was no attempt made in these last few days to make sure a dying man had the best possible medication."*

Until the day before Mr Smyth was transferred to hospital he had been receiving 30/500 co-codamol (paracetamol and codeine combined medication) for pain relief. On 2nd December 2013, tramadol (treatment for moderate to severe pain) was added to his pain relieving medication. Upon admission to Belfast City Hospital he was prescribed MST (morphine tablets), Oramorph (liquid morphine taken orally), pregabalin (used for treating nerve pain and anxiety), Amitriptyline (antidepressant and nerve blocker). Intravenous diamorphine (morphine) and oral midazolam (for seizures) were added later.

Dr Hall stated that in the absence of a palliative care plan, there was no symptom control. He described Mr Smyth's pain management as *"…poor, scanty and not organised."*

The concerns of discipline staff for Mr Smyth's deteriorating health are noted in landing journals and on PRISM notes since August 2013 and are made on an almost daily basis from 1st November 2013. The records demonstrate that staff encouraged him to see a nurse or GP and that other prisoners provided assistance for him.

Prisoners and discipline officers described to this investigation their frustration at Mr Smyth's situation. They recognised his reclusiveness and intransigence, but were critical of the lack of proactive action by Healthcare staff to reduce his suffering, which they guessed was due to cancer.

Mr Smyth's family questioned why, given the duty of care placed upon the NIPS, they did not challenge the SEHSCT to ensure he received the correct medical treatment. However since 1st April 2008, when responsibility for prisoners' healthcare transferred from the NIPS to the South Eastern Health & Social Care Trust, there has not been any overarching duty for the NIPS to assure the quality of healthcare provided. Rather the Trust is accountable to the Health & Social Care Board for the quality of all the services they deliver, irrespective of where the patient lives.

Release under Prison Rule 27

On 17th December 2013 Mr Smyth was released under Prison Rule 27 *"To enable him to have healthcare"* at a hospital in the community. Once there was a confirmed diagnosis of cancer, more prompt communication and discussion between Healthcare and the Prison Service could have enabled an earlier release under Rule 27. While the family complimented staff who undertook bedwatch duties at hospital,

the delay between 3rd December and 17th December to arrange this release could have been reduced.

Had an earlier diagnosis occurred, more prompt consideration could also have been given to apply for Mr Smyth to be released under Article 7 of the Life Sentences (NI) Order 2001. This option could also have been used to encourage Mr Smyth to attend his exploratory healthcare appointments.

SECTION 4: PALLIATIVE CARE

The Department for Health, Social Services and Public Safety's 'Service Framework for Cancer Prevention, Treatment and Care' requires palliative and end of life care to focus on all aspects of care needed by patients and their families - physical, emotional and spiritual. It involves relief of symptoms, making thoughtful decisions, supporting families and providing ongoing care in the appropriate setting. It emphasises the importance of people who are in the last phase of life getting the appropriate care, at the right time, in the right place, in a way that they can rely on.

Standard 50 states: *"Early identification of the palliative and end of life care needs of patients, their care-givers and family, through a holistic assessment, maximises quality of life for all in terms of physical, emotional, social, financial, and spiritual health and wellbeing. Patients and carers highly value face-to-face communication with skilled health and social care professionals who are able to engage with patients on an emotional level, to listen, to assess how much information a patient wants to know, and to convey information with clarity and empathy."*

Dr Hall found that no palliative care plan was implemented for Mr Smyth, although one should have been put in place from 2nd July 2013 when he refused to the attend the ENT clinic. The only care plan in place was initiated on 15th November 2013 when he was having difficulty swallowing and the plan enabled him to have liquid food.

He states that a palliative care plan would have addressed all of Mr Smyth's symptoms and not just the problems with eating and swallowing. It would have included pain control, help with his breathing, skin care, personal hygiene, bowel care, sleeping, psychological care, the most appropriate location to care for him and involvement of the family. The plan would have been reviewed regularly to ensure the best possible care was being given to a dying patient, and included a section on end of life matters such as resuscitation and antibiotic prescription.

While Maghaberry prison does not have a palliative care nurse, the South Eastern Health and Social Care Trust can bring in specialist care. Even without such provision, a care plan that addressed symptom control, pain management and family links could have been co-ordinated within the prison.

SECTION 5: DR HALL'S OTHER FINDINGS

In addition to his clinical findings Dr Hall also highlighted the following concerns from his analysis of Mr Smyth's medical records:

Quality of medical record entries

Dr Hall found that Mr Smyth's medical records were satisfactory until 2013, at which stage gaps began to appear and recording was of poor quality. He gave the following examples of material that was missing from the records prior to 22nd November 2013:

- Information to Mr Smyth that he may have a serious problem or cancer of the larynx;
- Discussion about the risks of refusing treatment, or an indication that there was a full and frank discussion about the risks of not being investigated, and encouragement of Mr Smyth to reflect on the implications;
- Recognition of Mr Smyth's past refusals to attend, which should have been followed by specific appointments to ensure he was followed up.

Dr Hall also stated that the record made on 22nd November 2013 - when the GP told Mr Smyth the results of his CT scan - was very poor and gave no details of the discussion which he considered must have taken place.

The entry on 22nd November stated, "*Informed him* (Mr Smyth) *of the diagnosis and the wish to get him seen within 2 weeks but hopefully next week."* The GP told this investigation *"The pertinent thing on that particular day was to inform him of his diagnosis and also inform* (him) *of what we planned to do within the next two weeks for him. Now if something else had developed from that…well then I would have put it down."* The GP described Mr Smyth's response to the news as being very matter of fact and quite unlike the usual emotional response. These details were not included in the medical records, even though they may have been informative for his future care.

Mr Smyth's Neck Nodes

Dr Hall highlighted the fact that the GP who saw Mr Smyth in April 2013 recorded that a node in his neck was also felt by prisoners who described it as being the size of a 50 pence piece. Not only did the CT scan that was carried out in November 2013 pick up this enlarged node, but further nodes in his neck and armpits were also identified, the largest being 3cm in his neck and 3.2cm in his armpits. As there was no mention of the nodes in his armpit in any of his consultations and the neck node was not felt or detected again since April 2013, Dr Hall questioned whether

Mr Smyth was ever fully examined because the palpable nodes could not have gone away and returned.

Clinical Leadership in Maghaberry Prison

Dr Hall suggested there was a lack of clinical leadership at Maghaberry, in comparison to other prisons. He based this opinion on lack of reference to a Head of Healthcare – a post usually held by a nurse – in documents such as minutes of the Safer Custody meetings held from 2003 onwards. Dr Hall asserts these meetings needed a strong medical input, either from a GP or the Head of Healthcare, but he found this was lacking.

In fact Maghaberry has two clinical leads – for Primary Healthcare and Mental Health; and a senior nurse was present at the Safer Custody meetings about Mr Smyth. However as previously outlined, the clinical leads do not participate in Safer Custody meetings, mainly due to time pressures; and the senior nurse made clear that her role in attending Safer Custody meetings was limited to providing information, and did not extend to providing leadership.

The onset of Mr Smyth's illness in 2013 was a situation where in Dr Hall's estimation a clinical lead was clearly required i.e. "*A doctor or nurse grasping the nettle' and saying I will ensure I see him again and follow him up - I will take responsibility for Mr Smyth's care.*"

Poor Communication

Dr Hall's perusal of the documentary evidence led him to conclude there were three groups of people – discipline officers, nurses and GPs – working in parallel but failing to share information about a prisoner who was causing all of them concern. He cites as an example the fact that the SEHSCT knew Mr Smyth's cancer diagnosis on 22nd November 2013, but discipline staff only became aware of this five days later when told by the prisoner. They immediately wrote to the Healthcare Department, who confirmed his diagnosis two days later, on 29th November 2013, upon receipt of signed consent from Mr Smyth.

Dr Hall attributes the poor communication primarily to the Trusts approach, and is especially critical of their non-participation in established forums such as PSST meetings and Serious Case Reviews, and lack of local Healthcare leadership in Maghaberry.

SECTION 6: OTHER ISSUES

Mr Smyth's Budgie

Maghaberry Governor's Order 7-17 states that a prisoner serving a sentence of eight years or more may apply to have a pet bird in his cell. Mr Smyth was permitted to keep a budgie under the provisions of this order. One of those stipulations is as follows:

"Prisoners must ensure that their cell is kept clean from bird droppings at all times. For reasons of health and safety a prisoner who allows his cell to become contaminated with bird droppings may have the privilege removed."

Mr Smyth's living conditions were unclean due to his poor personal hygiene. His cell was covered in bird droppings, to the extent that searches were not undertaken to protect the health of officers entering the cell. Documents indicated the birdcage was unclean and the budgie was nicotine stained and unlikely to have been exposed to natural light since Mr Smyth's curtains were permanently closed.

Beyond this avoidance approach, the welfare issues for Mr Smyth, prison staff and the budgie were never addressed.

PlayStation

Once Mr Smyth had been persuaded to allow his family to visit on 5th December 2013, they were with him every day. The family spoke highly of the officers who were on guard at the hospital and of the care and compassion that was shown to him by his landing officers.

Mr Smyth's family described witnessing him in considerable distress as hospital staff worked to control his pain. In an effort to distract him, a request was made to a governor for Mr Smyth's PlayStation to be brought into the hospital.

This request was refused on the basis that the governor did not know whether it would be allowed in the ward, and also because of the risk of contraband being smuggled inside the console. The governor said that at the time, the family member understood this position and did not press the issue further. However the family do not accept the governor's account stating they could not understand why a dying man was not permitted the use of a PlayStation.

More careful consideration could have been given to granting this request, in light of the circumstances, and on compassionate grounds.