INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF
"MR H"
AGED 34
ON 21st SEPTEMBER 2014
FOLLOWING HIS RELEASE FROM
MAGHABERRY PRISON
ON 30th JULY 2014

[8th September 2015]

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

[Published: 29th September 2015]

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Glossary

CJI	Criminal Justice Inspectorate
EMIS	Egton Medical Information System
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
NIPS	Northern Ireland Prison Service
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, to the extent appropriate, deaths which occur following release from 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.

This investigation was undertaken due to the particular concerns raised by Mr H's family about the care he received prior to his release

Objectives

The objectives for this investigation are as follows:

- Establish the care provided to Mr H while he was in the NIPS' custody;
- 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 in future; and
- Ensure that Mr H's family have an opportunity to raise any concerns they may have and take these into account in the investigation;

Methodology

Our 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 Dr Robert Hall, a retired GP from Suffolk, who has experience of completing clinical reviews for deaths in custody in England and Wales, undertook a clinical review of the care provided to Mr H.

This report is structured to provide contextual information about Mr H's final period in prison and address the concerns of his family.

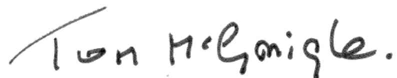
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating such cases. I first met with Mr H's father in December 2014, and contact has been maintained throughout the investigation.

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

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

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



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
8th September 2015

SUMMARY

Mr H died from an inoperable brain tumour in September 2014. He had exhibited a variety of symptoms while in custody, prior to being released at the end of July, and his family were concerned about the level of care he received during his final period in Maghaberry Prison.

This investigation found that several NIPS and SEHSCT personnel, particularly residential staff, showed compassion in their care for Mr H, once his symptoms were manifested.

Mr H was not always compliant with the care he was offered and it is possible that his attempts to manipulate the type of medication he was prescribed did not assist his diagnosis. Treatment was also delayed when he refused to attend a hospital Accident & Emergency Department.

However a doctor missed opportunities to diagnose his condition and care plans were not initiated when dehydration and malnutrition concerns were raised. While this would not have changed the final outcome, his distress could have been reduced and palliative care could have been provided sooner. An unnecessary level of security and bureaucracy was also applied to his hospital visitors.

While multi-disciplinary fora were not as effective as they should have been in delivering an appropriate care plan, residential staff were appropriately concerned about him and worked hard to monitor his wellbeing.

This report makes fifteen recommendations for improvement. Some of these are procedural, but a gap in clinical leadership is once more noted at Maghaberry. This is especially important in a prison environment where patients who refuse treatment need someone to actively take charge and manage their care. One recommendation (10) has previously been made to, and accepted by the SEHSCT, in February 2012.

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

The NIPS responded to this report by saying, *"We are sorry to learn of Mr H'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 NIPS will accept, without reservation, each of the recommendations made to us, and will work closely with the South Eastern Health & Social Care Trust to deliver the joint recommendation."

The SEHSCT accepted all of the recommendations stating they are committed to implementing improvements as a result of the lessons learned from all investigations.

RECOMMENDATIONS

SEHSCT –

1. **Doctor's Consultations** – The SEHSCT should ensure that the lessons learned in this specific case will be addressed with the involved GP to identify any training or developmental needs. (Pages 11, 12 & 19)

2. **Triage System / Doctor's Appointments** – The SEHSCT should ensure the triage system allows for urgent doctor's appointments to be made and, where necessary, provide doctors with the flexibility to see a patient in their cell if they are too ill to attend the medical room. (Pages 15, 16 & 21)

3. **Multi-Disciplinary Team (MDT) 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 21)

4. **Nurses Consultations** – The SEHSCT should ensure that lessons from this specific case are addressed with the nurse who saw Mr H on 5th July, and any training or developmental needs addressed. (Page 13)

5. **Nursing Care Plans** – The SEHSCT should review the training requirements for Nursing Staff in relation to the identification and management of dehydration and malnutrition. The SEHSCT should also consider the development of a procedure for staff guidance that reflects a multidisciplinary approach to the management of dehydration and malnutrition. (Pages 14 & 15)

6. **Missed Nurses Appointments** – The SEHSCT should remind staff that when patients, who are known to be ill, do not attend an appointment, the reason for their non-attendance should be discussed with the patient and recorded. (Page 15)

7. **EMIS** – The SEHSCT should remind all clinical staff of the need to review a patients EMIS record prior to or during every consultation, to ensure changes to care plans are not overlooked. (Page 14)

8. **Seizure Investigations** – The SEHSCT should ensure that any patient reported to them as having possibly suffered a seizure should be referred for further investigation. When such investigations are being undertaken, the NIPS should also be notified so that the necessary protocols can be instigated. (Page 19)

9. **Action following a refusal to attend A&E** – The SEHSCT should ensure there are robust follow-up procedures in place for patients who refuse to attend A&E, so that they are

seen by a doctor at the earliest opportunity to discuss the risks of not attending, assess mental capacity and implement an appropriate care plan. (Pages 14 & 17)

10. **Administration of Discretionary Medication** – The SEHSCT should review the current SOP for the Supply of Discretionary Medications and ensure all staff are made aware of the revised procedure and the requirement for compliance with it. (Page 22)

NIPS -

11. **PSST Action Points** – PSST staff should be reminded of the importance of identifying and addressing all concerns raised by prisoners upon assessment, particularly when they relate to the prisoners health. (Page 12)

12. **SPAR Reviews & Care Plans** – The NIPS should remind staff who chair SPAR reviews, of their responsibility to ensure Care Plans fully address all concerns that are raised. The review should always consider SPAR observation logs and where the Healthcare Department are required to assist in delivering care plans, this should be accurately reflected in records. (Page 18)

13. **Hospital Visits for Terminally/Gravely ill Prisoners** – The NIPS should revise their policy on visits to prisoners who have been admitted to hospital when they are gravely or terminally ill, to ensure discretion is applied in relation to the number of visits a prisoner can have, and the number of visitors allowed. (Page 23)

Joint NIPS & SEHSCT –

14. **PSST Referrals to Healthcare** – The NIPS and SEHSCT should ensure the process for PSST referrals to Healthcare is robust and fully traceable. It should ensure all referrals are acknowledged and date stamped, all concerns raised are fully acted upon, and the PSST are updated within the restrictions of patient confidentiality. (Page 13)

15. **Discharge Liaison** – The NIPS and SEHSCT should ensure their process for sharing information about prisoners who are to be released imminently is effective in providing continuity of healthcare when they return to the community. (Page 22)

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 Safety and Support 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. Mr H was known to the PSST - further details are provided later in the report.

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

The last CJI / HMI Prisons inspection of Maghaberry was conducted in March 2012 and published on 17th December 2012. Several of the findings and recommendations in that report are 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 also made recommendations about healthcare provision in the prison.

FINDINGS

SECTION 1: INTRODUCTION

Mr H was committed to Maghaberry Prison on remand in January 2013. He was sentenced in November 2013 to a three year determinate sentence[1] comprising of one year in custody and two years on license.

He was released on licence on 9th April 2014 having spent most of his sentence on remand, but returned to Maghaberry on 28th April 2014 for breaching his licence conditions.

Due to an inoperable brain tumour the Parole Commissioners granted Mr H early release on license on 30th July 2014.

On 21st September 2014 Mr H died at a relative's home.

[1] A sentence to confinement for a fixed or minimum period that is specified by statute.

SECTION 2: EVENTS THAT LED TO MR H'S DIAGNOSIS AND RELEASE

When Mr H was recommitted to Maghaberry on 28th April 2014 he was seen by a nurse and his screening was unremarkable. In early May 2014 there were two contacts with a doctor in relation to his medication, in particular his pregabalin. These appointments were typical of many in Mr H's previous medical history, when he disputed the medication he had been given or not. During his previous custodial period it had been assumed that a seizure in March 2013 was caused by taking too many of his pregabalin tablets and as a result they were stopped.

On 1st June 2014 Mr H's father visited his son for the last time in prison. He found nothing of concern about his son's health or wellbeing, nor did Mr H make any complaints in this regard.

The following timeline of events illustrates when the decline in Mr H's health started to become apparent and recorded.

4th June 2014

Mr H saw a doctor who recorded he had developed a squint. Despite the nurse who booked this appointment having recorded the reason for the appointment as being pain and discomfort in his eye, there is no evidence that pain was discussed or addressed.

At this appointment Mr H again raised concerns about the medication which he was receiving to relieve pain in his feet and hands (that was caused by old injuries), and said that he wanted to stop smoking. The doctor wrote a further prescription for co-codamol and a new prescription for nicotine patches. A regular referral to an ophthalmologist was also made for his reported squint.

In his clinical review report, Dr Hall was critical of this consultation stating this was possibly the first missed opportunity to diagnose Mr H's tumour.

7th June 2014

Staff noted in a PREPS[2] report that Mr H was staying in his cell quite a lot, which was out of character. Mr H had been described as someone who previously kept himself and cell tidy and integrated well with other prisoners.

[2] PREPS – **P**rogressive **R**egimes and **E**arned **P**rivileges. There are three levels of regime - Basic, Standard and Enhanced. The purpose of the PREPS system is to increase participation in constructive activities, encourage good behaviour and thus prepare prisoners for release. This is achieved by rewarding those prisoners who engage positively. Weekly reports are written by staff to monitor progress.

12th June 2014

On 9th June a doctor’s appointment was arranged for 12th June in order for Mr H to request stronger nicotine patches.

The same doctor who had seen Mr H on 4th June saw him again. Mr H requested stronger nicotine patches and described that he was experiencing dizziness when he stood up. The patches were prescribed and the doctor noted that he had developed a nystagmus[3] when looking left and prescribed medication for his dizziness.

Dr Hall was again critical of this consultation stating it was the second missed opportunity to diagnose Mr H’s tumour.

24th June 2014

Following a phone call from residential staff who were concerned about Mr H self-isolating, a member of PSST (Prison Safety and Support Team) interviewed him. It was recorded that Mr H was feeling sick and light-headed and that the doctor was not giving him the medication he needed. He reported that he was keen to get back to interacting with fellow prisoners in association and attending classes, but felt that he was too unwell to do so at present. The officer nominated Mr H for a number of education classes, which he agreed to attend. There were no recorded actions in respect of Mr H’s reported ill health.

5th July 2014

Further correspondence was sent to the PSST, this time by the senior officer of Bush House where Mr H resided, requesting an urgent referral and assessment by the PSST. The senior officer recorded that he had also requested the house nurse to see Mr H to assess his physical and mental health as his behaviour had changed; he was feeling continuously nauseous and had been finding it difficult to eat solid food. The senior officer noted that both he and landing staff had grave concerns about his behaviour as it was so unusual.

Mr H was seen by the house nurse as requested by the senior officer. She found him curled up in bed and he had difficulty in conversing with her. He reported having not eaten for days, having drunk very little fluid and said he felt sick all the time. Mr H was encouraged to drink hourly and eat little and often, which he said he would try to do.

Landing staff informed the nurse that Mr H would have previously had regular contact with his father but had declined to speak to him when they offered Mr H the use of the phone. He was reported to be in low mood with poor motivation to change.

[3] Nystagmus – involuntary side to side movement of the eye.

The only action recorded by this nurse was that she was going to discuss with the senior nurse the possibility of referring Mr H to the mental health team. There was no urgency placed on completing this referral as it was not done by the nurse until the following morning. In addition the referral form was not fully completed as it did not include Mr H’s previous contact with the mental health team.

There was also no consideration given to placing Mr H on the doctors list for a physical health assessment, to request a prescription of nutritional drinks / rehydration solution or to open a SPAR[4] given his low mood.

7th July 2014

A further PREPS report noted Mr H’s dramatic change in demeanour and physical health, which had been reported to the Healthcare Department.

9th July 2014

In response to the senior officer’s referral of 5th July, and prior to interviewing Mr H, the PSST manager referred Mr H to the Donard Programme[5] and wrote (via email and internal post) to one of the clinical leads in Maghaberry, requesting that Mr H be assessed as a matter of urgency in relation to his mental and physical health.

Prison Healthcare was unable to advise when, and if, this letter was received and what, if any, subsequent action was taken as there is no record in EMIS.

The PSST confirmed that they do not routinely receive acknowledgements or updates from Prison Healthcare following such a referral.

10th July 2014

Mr H was interviewed by the PSST manager who noted that he had uncharacteristically poor hygiene, was shaking and confused and had poor eyesight. Pending the outcome of their request for a mental/physical health assessment, the PSST’s next action was to discuss Mr H on 16th July 2014 at a multi-disciplinary case conference.

[4] SPAR – **S**upporting **P**risoners **a**t **R**isk is a mechanism for staff to support and monitor vulnerable prisoners through multi-disciplinary management.

[5] The Donard Unit/Programme is a bespoke unit specifically designed to facilitate purposeful activity for poor coping prisoners.

11th July 2014

A nurse saw Mr H around midnight due to his nausea. His observations were noted. He was given Lactulose (to aid constipation) and Peptac (to aid indigestion), and was noted to have been listed in the nurse's diary to be reviewed in the morning and request a doctor to prescribe Ensure nutritional drinks.

Despite Mr H being seen later that morning by the house nurse, he was never prescribed Ensure drinks.

The nurse who saw Mr H later that morning recorded that as a result of his dehydration, high blood pressure and fast heart rate, an ambulance was requested to take him to A&E. An A&E referral letter was prepared which noted the nurse's clinical observations and that he had not eaten for over a week. The nurse also opened a SPAR booklet due to his low mood.

An ambulance arrived about an hour later. However Mr H declined to attend the hospital and a Northern Ireland Ambulance Service's 'Refusal to Treatment' form was completed by the paramedics. As a result of his non-attendance, the nurse ordered blood samples to be taken, and the SPAR remained open with hourly observations being carried out by landing staff. Details of why Mr H declined treatment or being taken to hospital were not recorded on EMIS or by the paramedics who completed the form.

No care plan was initiated to deal with Mr H's dehydration.

As a result of the mental health referral by the nurse who saw Mr H on 5th July, his case was discussed on 11th July at the multi-disciplinary mental health meeting where all new referrals are deliberated. The outcome was that an urgent mental health assessment[6] should be undertaken. The consultant psychiatrist who chaired the meeting noted the ongoing medical concerns that the primary health team were trying to address (i.e. referring him to A&E and Mr H's decline to attend) and requested that the mental health team be kept informed of any developments regarding his physical health.

Later that afternoon during a SPAR observational check, an officer asked Mr H if he would like to speak to his father. He declined the offer but asked her to speak to him on his behalf, which she did. A comprehensive record was made in the SPAR booklet.

12th July 2014

At the request of the senior officer, Mr H was seen by a nurse in his cell as he was too ill to attend the medical room. Mr H reported the same symptoms as before, and the nurse placed him on the next available weekly GP clinic, which was on 17th July 2014.

[6] Crisis intervention referrals require the patient to be seen within three days, urgent assessments are undertaken in ten days and routine referrals are assessed within nine weeks.

It is of concern that despite Mr H's presentation and his non-attendance at A&E the previous day, an urgent GP appointment was not arranged, nor was there further attempts made to persuade him to attend A&E. Prison doctors do not work at the weekend but it would have been possible to speak to the out of hour's service provider, LaganDoc.

A SPAR entry noted how Mr H was feeling no better and complaining of dizziness. When he was asked why he didn't go to A&E he told the officer that he was *"mentally drained"* and was still complaining of a headache.

The initial SPAR review also took place on 12th July and those in attendance agreed that the SPAR would remain open until he was assessed by a doctor, which was expected to take place on the same day. However there was no clinic in Bush House on 12th July as it was a Saturday which the nurse who attended the review ought to have known.

14th July 2014

Another SPAR review was conducted. It was carried out in the medical room and attended by Mr H, a nurse, senior officer and landing staff. Mr H reported that his appetite was still very poor and clearly stated that he was not on hunger strike. He was trying to eat and drink small amounts, but due to constant nausea he had no interest in food. He had still not been seen by a doctor and again there was no consideration to commence him on nutritional drinks. The review decided to keep the SPAR open pending the doctor's assessment.

Again no consideration was given to escalating the matter to an urgent GP appointment.

15th July 2014

Mr H's EMIS records note that despite having been seen on the landing by staff at breakfast and lunch time, Mr H refused to attend the medical room to provide a blood sample. The nurse did not visit Mr H and the reason for his non-attendance is therefore unknown.

There are however, entries in the SPAR booklet indicating his poor appetite and lack of food intake, along with Mr H's admission that he constantly felt sick and his whole body felt sore, which could explain why he did not want to attend the treatment room.

Given Mr H's symptom history, consideration should have been given to the nurse visiting him in his cell.

16th July 2014

The multi-disciplinary PSST review of Mr H took place, which included representatives from PSST, Residential, Chaplaincy (via email), Healthcare, and Donard. Actions arising from this meeting included a referral to Ad:Ept and follow up of the urgent healthcare referral, which had still not been actioned.

There is no evidence that those attending this meeting were aware of Mr H's doctor's appointment which was in fact scheduled for the following day. The senior officer who attended the review had been advised by the house nurse that he had not yet received his doctor's appointment because the appointment, which was booked by the nurse who saw him on 12th July, was not marked as an emergency.

Separately from this review, a prison officer who was carrying out a SPAR check spoke with Mr H and encouraged him to complete a doctor's appointment card, which is recorded as having been done.

17th July 2014

Mr H saw a doctor and provided a blood sample, which came back as normal. The doctor's impression was that Mr H was dehydrated and strongly advised him to attend A&E. Mr H refused again, giving no specific reason. He requested medication to aid his nausea and returned to his cell. The doctor requested increased observations of Mr H and indicated that if he was no better, hospital intervention would be required.

There is no evidence that the doctor's request for increased observations were acted upon, or indeed what their intended frequency or purpose was, as it is not clear from the EMIS entry.

The SPAR booklet does however show that prison officers spent time with Mr H, stressing the importance of going to outside hospital. At the end of the conversation with one particular officer, Mr H agreed to go to hospital the following morning.

18th July 2014

The following morning, the house nurse saw Mr H in his cell to take his observations. The nurse spoke to him about the doctor's recommendation that he attend outside hospital and he agreed to go.

Shortly after seeing the house nurse, Mr H had a lengthy mental health assessment. The mental health nurse made a comprehensive record of her assessment which queried whether his presentation was being caused by his physical or mental health and noted that he reported his symptoms had been ongoing for six weeks. The nurse spent a significant

amount of time discussing his non-attendance at outside hospital and observed him taking approximately 200mls of coffee.

Less than an hour after Mr H's mental health assessment he was transported to A&E at Lagan Valley hospital on the basis of concerns about dehydration, malnutrition and his general presentation. A CT scan showed that he had a lesion in the left frontal lobe of his brain.

19th July 2014

Mr H was transferred to the Royal Victoria Hospital (RVH) where further scans and tests were undertaken.

21st July 2014

Mr H underwent a mini-craniotomy (removal of a small area of the skull) and a biopsy of the lesion was taken. This was later confirmed to be an inoperable brain tumour.

24th July 2014

Mr H discharged himself against the advice of the doctors and returned to Maghaberry because he had not had been able to smoke for four days. Nicotine patches had been provided but they had not suppressed his craving. However following persuasion by the nurse who assessed him upon his return to Maghaberry, he returned to the RVH within a few hours of leaving.

30th July 2014

Mr H was released on licence as the Parole Commissioners deemed that, because of his ill health he no longer posed a danger to the general public.

SPAR Procedures

A SPAR booklet was opened by the nurse who saw Mr H on 11th July due to his low mood. He was placed on hourly observations and a review of the booklet shows that it was completed in accordance with the SPAR procedures.

The observation log, where staff recorded their observations and conversations with Mr H, was comprehensive and showed that NIPS officers were appropriately concerned about Mr H and encouraged him to eat and drink and accept medical help. Observations of his eating and drinking were also recorded, as were conversations officers had with his family and

Healthcare staff. There were also well-documented handovers between day and night staff.

SPAR Reviews were held in accordance with Prison Service policy. Summaries of the reviews identified Mr H's health concerns and that he had no self-harm or suicidal ideation. It was however, not clear whether SPAR observation logs were considered as part of the review.

Despite the attendance of a nurse at Mr H's reviews, his Care Plans did not include any healthcare interventions to assist his dehydration and malnutrition, such as rehydration solutions and nutritional supplement drinks. This basic assistance was actually what he needed most.

SECTION 3: CONCERNS RAISED BY MR H'S FAMILY

A number of healthcare related concerns which were raised by Mr H's family have been addressed by the clinical reviewer, Dr Hall.

When did the tumour start to grow and could an earlier diagnosis have been made which could have increased life expectancy?

Dr Hall stated that it would be impossible to determine when the tumour started to grow. Mr H's brain tumour had been graded as a Grade 2 astrocytoma (cancer of the brain). This classification indicates that it grew slowly. Dr Hall believes the tumour was present when Mr H returned to prison on 28th April 2014.

Dr Hall's review of Mr H's prison medical records identified two reported seizures – the first on 16th September 2010 whilst he was in Magilligan Prison; and the second on 27th March 2013 whilst he was in Maghaberry Prison. Neither of these seizures were investigated by Healthcare staff and prison staff were not alerted to instigate the protocol for prisoners with epilepsy or possible epilepsy. If the 2013 seizure had been investigated, Dr Hall said it would be reasonable to question whether the results would have identified the tumour in its early stages.

First Missed Opportunity

Dr Hall stated that the first missed opportunity to investigate Mr H urgently was on 4th June 2014 when a squint had developed in his eye. Dr Hall stated that such a finding would be unusual in an adult and should have led to thorough investigations during the consultation – such as checking eye movement, pupils, visual fields, reading ability, and assessment of the optic nerve using an ophthalmoscope (an instrument used to look at the back of the eye). An assessment of the optic nerve may have revealed pressure on Mr H's brain. There are no such examination notes in Mr H's medical records. Whilst a general referral was made to an ophthalmologist, a thorough assessment by the doctor may have led this to being an urgent referral.

Second Missed Opportunity

Mr H saw the same doctor on 12th June 2014 whom he had met on 4th June and presented with two new symptoms – dizziness and nystagmus when looking left. Dr Hall said the records of this consultation were poor and showed no evidence of any examinations that were conducted. Mr H was prescribed medication for his dizziness only and no further action was taken. Dr Hall said *"alarm bells"* should have been ringing for the doctor at this stage.

Third Missed Opportunity

On 5th July 2014 Mr H was seen by a nurse who noted that residential staff and the senior officer raised concerns about his deteriorating mood and behaviour over the previous three to four weeks. She noted the state of his cell, his loss of appetite, poor fluid intake and that he had difficulty engaging in conversations.

The only action arising from this was to discuss her observations with the senior nurse and refer him to the mental health team. A mental health referral form was completed the following day, but there is no evidence that a conversation took place with the senior nurse and there was no consideration of creating a nursing care plan, contacting the doctor on call (given that it was the weekend) or placing him on the next doctors clinic.

Fourth Missed Opportunity

On 11th July 2014 Mr H refused to attend A&E for further investigations. Dr Hall stated that this should have triggered a multi-disciplinary team meeting that included a doctor. Following this meeting and in view of his deteriorating condition a plan of action should have been developed to include Mr H being seen by a doctor to explain the risks of not being assessed at outside hospital, having a mental capacity assessment undertaken, a detailed nursing care plan created and regular reviews by a doctor.

Dr Hall said that a major finding of his review was that no doctor was involved with Mr H for six days after a nurse tried to admit him to A&E on 11th July 2014.

Meanwhile residential staff, PSST, chaplaincy and nurses could see that there was something seriously wrong with Mr H, but Dr Hall said there was no leadership or drawing together of all the available intelligence about his health. Dr Hall said there was no one who said *"something must be done – now"* and this resulted in Mr H's symptoms being left uncontrolled.

Urgent Doctor's Appointments

On 14th July 2014 a nurse who saw Mr H as part of a SPAR review noted again his lack of appetite and constant feeling of nausea. The nurse noted that he was scheduled to attend a doctor's appointment on 17th July, but given his recent history and continuing concerns, the nurse should have considered contacting the duty doctor for an urgent appointment.

A duty doctor is available between Monday and Friday, 9am to 5pm. As there are no clinics scheduled for the duty doctor they can provide urgent appointments and in cell visits when required.

The current Standard Operating Procedure (SOP) for nursing triage and onward referrals for a doctor's appointment does not, however, advise nurses of the circumstances in which

an urgent doctor's appointment should be arranged, how to book one and the fact that an appointment can be conducted in a prisoners cell.

Life Expectancy

Dr Hall stated that Mr H's brain tumour was always going to be life-threatening. Whilst acknowledging that he is not an oncologist, Dr Hall said that an urgent referral on 4th or 12th June might have allowed Mr H more opportunity for palliative treatment such as radiotherapy.

Were Mr H's healthcare needs fully addressed in accordance with best practice?

Dr Hall stated that some of Mr H's care was very good, in particular the mental health assessments. However there were gaps which were not in accordance with best practice.

- Poor record keeping, especially by certain doctors;
- Lack of urgency when faced with new neurological symptoms on 4th June;
- Poor sharing of information with the doctors who saw Mr H by Healthcare staff who had attended SPAR and PSST reviews;
- Lack of a co-ordinated, urgent follow-up after Mr H refused to go to hospital on 11th June 2014;
- Lack of involvement by the doctors between 11th and 17th July 2014.

Whether Mr H had been suffering from headaches since December 2013 which were not investigated?

Longstanding headaches can be a symptom of a brain tumour. Mr H's cell mate from December 2013 for approximately three months stated that during that period, Mr H regularly complained to prison staff of severe headaches and only received ad hoc paracetamol. He said Mr H felt *"neglected"* and believed these headaches were a result of his pregabalin being stopped in March 2013[7].

Another prisoner who had known Mr H for a long time and shared a cell with him from 31st May until 6th June 2014 noticed a marked change in Mr H's demeanour following his return to Maghaberry. In particular he said his speech was slower and his eyes were clearly looking in different directions. Mr H told him that he had a pain in his head and saw a nurse every other day, but said that she would not give him anything for the pain. He said that Mr H had asked to have some of the prisoner's co-codamol, and had been buying painkillers from other prisoners. This was the period when Mr H's prescription of

[7] It is not uncommon for people to suffer with mild to moderate headaches for weeks or months following the cessation of pregabalin, particularly when it has been stopped abruptly and not tapered off. It would be uncommon for severe headaches to be caused by a withdrawal for 9-12 months as suggested by this prisoner.

paracetamol was changed to co-codamol due to the pain in his hands and legs and he was on a reducing rate of pregabalin.

A third prisoner who had known Mr H from previous periods in prison also noticed a significant change in his wellbeing. Contrary to other prisoners' accounts, this prisoner reported how both prison and Healthcare staff tried to encourage Mr H out of his cell, provided him with a single cell to see if his mood would lift and said nurses visited him in his cell for ten to fifteen minutes at a time. Records indicate Mr H had a cell on his own from 18th June until he left Maghaberry on 18th July 2014.

Between December 2013 and July 2014 there are 24 entries in his medical records to evidence that Mr H was seen by Healthcare professionals. Only one of these entries (6th April 2014) describes him having a headache, along with other 'flu like symptoms'. Mr H was also seen daily from 30th April to 18th June 2014 (50 occasions) to receive his reducing doses of pregabalin. Given these numerous opportunities to raise concerns about headaches, it is questionable whether he did in fact suffer from severe headaches on a daily basis.

It is also noteworthy that Mr H frequently informed medical staff of pains in his legs and hands. He used this mechanism to support requests for being restarted on pregabalin. These pains had been classified as neuropathic and although he had been offered other medication to ease his symptoms, he refused it.

There were however two occasions where discretionary administrations of paracetamol were given to Mr H by nurses due to headaches on 9th January 2014 and 27th May 2014.

Contrary to the SEHSCT's Standard Operating Procedure (SOP) for administering discretionary medicines, there are no corresponding entries in Mr H's medical records to detail the triage, diagnosis and treatment which led to him being provided with the paracetamol. It is also questionable whether the nurse who administered the discretionary paracetamol on 27th May 2014 checked which medicines Mr H was currently prescribed, because had they done so, they would have realised he was already on a prescription for paracetamol.

Mr H had not been prescribed paracetamol in his earlier custodial period. However he was prescribed paracetamol upon his return to Maghaberry on 28th April 2014 and the reason is unknown. This may have been a continuation of his community prescription, but the reason for continuation, or recognition of an existing prescription should have been recorded.

When Mr H visited his community GP on 10th April 2014 he made no complaints about a headache and only requested a new prescription of pregabalin, mirtazapine and paracetamol. The GP advised that no discharge letter was received from Maghaberry to inform him that they had stopped his pregabalin due to risk of abuse or seizure. The SEHSCT said this was as a result of the short notice in which Mr H was released, and the fact that they had not been informed.

Did Mr H receive appropriate medication?

Dr Hall said that Mr H was a challenge to doctors in relation to prescribing medication. He had decided which medication he wanted (pregabalin) and when this was denied to him he was not happy. Dr Hall suggested this may have dominated doctor's consultations to the extent that emergence of headaches and other symptoms related to his brain tumour were overlooked or never discussed during consultations.

However in June 2014 no effort was made to establish the cause of his dizziness and nausea and Mr H was simply given tablets instead of the cause being assessed.

Why, at times, was it difficult for the family to visit their terminally ill son/relative?

On 22nd July 2014 Mr H's father was refused a hospital visit with his son as he had not booked a visit via the usual process. Mr H's father explained that on this occasion the visits booking line was permanently engaged and he could not therefore book the visit prior to arriving at the hospital. Understandably he wanted to see his terminally ill son, but despite the circumstances the officer on duty denied him access and did not apply discretion or consult with superiors to consider the matter further.

Mr H's father also said that the same officer would only allow two people at a time in the room with his son, whereas other officers showed compassion and allowed up to eight visitors.

It is also noteworthy that bedwatch journal entries for 23rd and 24th July 2014 indicate that Mr H's family were not allowed to visit because he had already had his one allocated visit that week, which is the rule for a prisoner on the Standard PREPS Regime. A more flexible approach should be possible when a prisoner is diagnosed as terminally ill.