Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **[REDACTED], Governor, Morton Hall Immigration Removal Centre, Swinderby, Lincoln LN6 9HX**
2. **Dr [REDACTED], Chief Executive, Nottingham Healthcare – NHS Foundation Trust, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA**

1 CORONER

I am Timothy BRENNAND, HM Senior Coroner for the area of Lincolnshire

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On 9th November 2017 my predecessor Mr Stuart Fisher commenced an investigation following the report of the death of Carlington Maurice SPENCER aged 38. The investigation concluded following an inquest before me as the Coroner sitting with a jury, with a number of specific conclusions and determinations returned on the 7th and 9th November 2019 following a 5 week inquest.

The medical cause of death was:

I a Right Middle cerebral Artery Territory Cerebral Infarction

I b

I c

II

The Box 4 conclusion of the jury on the Record of Inquest was a "narrative conclusion", namely:

"Carlington Maurice Spencer died as a consequence of a stroke. Possible contributing factors were inadequate management of his Type 1 Diabetes, numerous missed opportunities by discipline staff to sufficiently monitor Mr Spencer and medical staff to identify symptoms of stroke and take appropriate actions in a timely manner. It is possible that a further CT scan on arrival at Queen's Medical Centre may have identified the potential deterioration in Mr Spencer's condition, prompting an earlier craniectomy which might have prevented his death"

The jury also answered 14 questions within a jury questionnaire document including a determination that there had been inadequate management of the deceased's pre-existing co-morbidities, in particular they described healthcare staff as having "adopted a complacent attitude" in the blood testing and follow up appointments that ought to have

been pursued in circumstances where insufficient priority was given to the deceased given findings of elevated blood glucose and his susceptibility to develop a thrombus".

The jury also made specific findings of fact concerning the treatment of the deceased by healthcare staff that concluded:

- Failure to review the illicit substance misuse log;
- Failure to make an in depth clinical judgment;
- Failure to follow up welfare check;
- Confirmatory bias regarding alleged illicit drug use;
- Failure to complete medical assessments adequately regarding administration of medications (insulin) to avoid doubt;
- Consultations being too short to make correct clinical assessments and limited documentation;
- Poor communication between (Discipline) Officers, Healthcare staff and detainees;
- No "FAST" test carried out;
- Substance Misuse Log closed by Healthcare staff after only a verbal discussion with non-medically qualified Discipline Officer and without a healthcare review;
- Incomplete observations;
- The standing down of a "Code 2" emergency call before a full assessment completed by a nurse;
- Failure to follow emergency procedures as in calling the correct code and request for a non-urgent ambulance;
- Sub-optimal treatment and care that created delays;
- Failures to appreciate "red flag" signs that would be suggestive of a clinical deterioration;
- Failure to document observations and poor documentation on the "System 1" health records;
- Failure to assess a situation correctly resulting in confirmatory bias and resulting absence of any differential diagnosis;
- Failure to adequately train Healthcare staff in Morton Hall IRC procedures, provide refresher training and monitor new members of staff;
- Failure to utilise facilities such as the isolation room;
- Inadequate staffing overnight;
- Reliance on non-medical staff to perform observations;
- Guidelines for "new psychoactive substances" toolkit not applied;

The jury also made a number of findings of fact concerning the management and observation of the deceased by Security/Discipline staff that concluded:

- Inadequate management and observation of the deceased on the 28th and 29th September 2017;
- Inaccurate and non-contemporaneous note taking upon the Illicit Substance Misuse Document;
- Failure to report or act upon concerns raised by other detainees;
- Failure to retain CCTV footage;

- Failure to follow correct emergency procedures (especially the Code 1 and 2 system that ought to have been the Code Red and Blue system);
- Lack of communication between Healthcare staff and detainees;
- Inadequate training and monitoring of new members of staff;
- Failure to escalate concerns to higher management;
- Failure to carry out appropriate searches for each alleged "Spice" attack;
- The need for staff to refer to an implement guidance within the "NPS Toolkit";

4 CIRCUMSTANCES OF THE DEATH

The circumstances of the death were as follows:

Mr Spencer was a lawful detainee at Morton Hall IRC between 21st May 2017 and the 29th September 2017.

He had a known medical history of insulin-controlled Type 1 Diabetes, Statin controlled Hypercholesterolemia and Hypertension.

He had a known history of alcohol misuse and recreational drug misuse.

At approximately 15.40hrs on the 28th September 2017 a "Code 2" call was made in respect of Mr Spencer. Between 15.40hrs and 12.45hrs on 29th September 2017 Mr Spencer was seen by Morton Hall Discipline Officers, Healthcare staff and residents.

At approximately 12.45hrs on the 29th September 2017 a resident went to the Healthcare office at Morton Hall IRC to seek support for Mr Spencer. Healthcare staff subsequently attended to assess Mr Spencer in his room, accompanied by Officers.

An ambulance was called at 13.09hrs. The East Midlands Ambulance Service confirmed that although the call was correctly coded as a "Category 2", which requires an 18 minute mean time response and a 40 minute 90th percentile response time, there was a delay in sending an ambulance to Mr Spencer. The ambulance arrived at Morton Hall IRC at 14.16hrs. Ambulance staff arrived with Mr Spencer at 14.25hrs.

Mr Spencer was transported to Lincoln County Hospital in an ambulance which departed from Morton Hall IRC at 15.00hrs. The ambulance arrived at Lincoln County Hospital at 15.33hrs and Mr Spencer was handed over to staff in the rapid Assessment Triage Room.

A CT scan reported at 16.41hrs showed Mr Spencer had right middle cerebral artery infarction with a 2mm midline shift to the left.

Mr Spencer was reviewed at 18.05hrs by a Stroke Consultant. Steps were taken to transfer Mr Spencer into the care of the Neurosurgeons at the Queen's Medical Centre in Nottingham.

At approximately 20.38hrs Mr Spencer left Lincoln County Hospital and was physically transferred to the Queen's Medical Centre for on-going care and management.

Mr Spencer was reviewed at 22.45hrs following his arrival at the Queen's Medical Centre, with a plan to undertake neurological observations and monitor for deterioration.

On the 30th September 2017 at approximately 20.00hrs a second CT scan was carried out which showed further brain swelling had occurred since the first scan, and that there was now a 13mm midline shift to the left.

At approximately 23.00hrs the deceased underwent a surgical craniectomy that was carried out without event. Following the surgery, he was admitted to adult intensive care for on-going management. His craniectomy site was lax over the next 24 hours.

On the 2nd October 2017 Mr Spencer's craniectomy site became tense and swollen. A third CT scan was carried out which showed the area of the stroke had extended and there was further swelling involving both the left and right sides of his brain.

Mr Spencer underwent brain stem testing on the 3rd October 2017 which suggested brain stem death. He was subsequently confirmed deceased at 15.35hrs on the 3rd October 2017.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

1. The case demonstrated the failures of existing systems, management and working practices within the Discipline staff employed by Morton Hall IRC namely:
    a. The existence of "confirmation bias" or "confirmatory bias" when dealing with detainees with a known history of recreational use of drugs in such a way that when a detainee presents in a manner that is interpreted as being presumed and/or assumed to be under the influence of drugs, this presumption and/or assumption is not challenged or tested or verified (as an example, by meaningful searches of the detainee or his room; review of CCTV evidence or escalation for advice from healthcare personnel);
    b. Concerns of co-detainees are not appreciated or noted or actively sought;
    c. Record keeping and purported observations of detainees who are incapacitated by reason of presumed self-induced intoxication are inaccurate, irregular and unavailable for inspection by health care personnel;
    d. Discipline staff have no meaningful training on the categories of self-induced intoxication and in particular "new psychoactive substances" such as the synthetic cannabinoid known as "Spice";
    e. There is no adequate communication or working protocols as between Discipline staff and healthcare staff for clear escalation pathways when dealing with a presumed "Spice" related incident;
    f. There is no adequate communication or working protocols as between Discipline staff and healthcare staff for clear escalation pathways when dealing with an incident that may have commenced as a drug related incident but develops into a potential medical emergency;
    g. Access, review, storage and retrieval of CCTV footage is inadequate and

unsatisfactory;

2. The case demonstrated the failures of existing systems, management and working practices within the healthcare provision for detainees at Morton Hall IRC namely:
    a. The existence of "confirmation bias" or "confirmatory bias" when dealing with a detainee with a known history of recreational drug use in such a way that when a detainee presents in a manner that is interpreted as being presumed or assumed to be attributable to recent self-induced intoxication, this assumption or presumption is not clinically evaluated by reference to a verification of evidence supporting of recent drug consumption (such evidence being available either from the patient, from Discipline staff, from other detainees, physical evidence in the room);
    b. In cases where a diagnosis of recent self-induced intoxication has been reasonably made, a differential diagnosis is not considered to evaluate the potential exacerbations of the patients pre-existing co-morbidities;
    c. No appreciation exists of the importance of establishing when the detainee had last consumed drugs and in what quantity and at what potency;
    d. Failure to consult information contained on the Illicit Substance Misuse Programme;
    e. An absence of protocols or clear instructions/expectations from healthcare staff to Discipline staff that in the event a conservative pathway of treatment is considered appropriate (the detainee being allowed to "sleep off" the effects of the drugs) how long this should be permitted in a case of presumed "Spice" consumption;
    f. An absence of protocols or clear escalation pathways or working practices between healthcare staff and Discipline staff that recognises the primacy of the role of healthcare staff in any case involving ongoing care for a detainee, in particular in a scenario of a detainee with relevant co-morbidities who is recovering from a presumed "Spice" incident;
    g. Inadequacy of knowledge and training on the diagnosis, treatment and care in cases of self-induced intoxication by reason of "new psychoactive substances";

3. In this case, a "general alarm" was called and in evidence from both Discipline and Healthcare staff, there exists on-going confusion and uncertainty as to the calling of a general alarm or a "Code 1" or "Code 2" alarm or "Code Red" or "Code Blue" (the replacement codification) confirming the need for training or re-training on this issue.

4. Training is needed to enable staff to appreciate the potential for their decision making to be affected by "confirmation bias" in addition to the need for diversity awareness training when dealing with detainees of Afro-Caribbean heritage;

5. Record keeping, both for Discipline and healthcare staff was established in this case to be partial, incomplete and undertaken in circumstances where the provenance of such records is unverifiable;

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 22 October 2020. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following

Birnberg Peirce Ltd, 14 inverness Street, London, NW1 7HJ who will also pass on to the Next of Kin

The Rt. Hon Priti Patel MP, Secretary of State for the Home Office, House of Commons, London, SW1A 0AA

[REDACTED], Chief Constable, Lincolnshire Police, Deepdale Lane, Nettleham, LN2 2LT

[REDACTED], Chief Executive, East Midllands Ambulance Service NHS Trust, 1 Horizon Place, Mellors Way, Nottingham, NG8 6PY

[REDACTED], Head of Service for Neurology, Queens Medical Centre, Derby Road Nottingham NG7 2UH

[REDACTED] Chief Executive, Legal Aid Agency, 13th Floor, 102 Petty France, London SW1H 9AJ

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

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Timothy BRENNAND
HM Senior Coroner for Lincolnshire
Dated: 28 August 2020