The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR FRED McCLENAGHAN
AGED 57
WHILE IN THE CUSTODY OF MAGILLIGAN PRISON
ON 21st OCTOBER 2018

Date finalised: 10th June 2021

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The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation of deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

The purpose of the Prisoner Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

By highlighting learning to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

Investigation objectives are set out in the Ombudsman's terms of reference and are to:

- establish the circumstances and events surrounding the death, including the care provided by the Prison Service;
- examine any relevant healthcare issues and assess the clinical care provided by the Trust;
- examine whether any changes in Prison Service or Trust 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.

Within the above objectives, the Ombudsman will identify specific matters to be investigated in line with the circumstances of an individual case.

In order that learning from investigations is spread as widely as possible, and in the interests of transparency, investigation reports are published on the Prisoner Ombudsman's website following consultation with the next of kin. Reports are also disseminated to those who provide services in prisons.

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Glossary

CCTV	Closed Circuit Television
ECR	Emergency Control Room
FAST	Face Arms Speech Test
GP	General Practitioner
IMB	Independent Monitoring Board
NICE	National Institute of Clinical Excellence
NMC	Nursing Midwifery Code
Prison Service	Northern Ireland Prison Service
SPAR	Supporting Prisoners at Risk
TIA	Transient Ischaemic Attack
Trust	South Eastern Health and Social Care Trust

Foreword from the Ombudsman

The death of a loved one is always difficult. The fact that a death occurs in custody, or shortly after someone is released from prison, has particular difficulties given the loss families experience when a loved one is taken into custody and the trust they must place in the Prison Service, the Trust, and others to ensure the safety and wellbeing of their loved one.

All those in custody should expect to be treated decently and with respect, receiving the best care possible for their wellbeing and rehabilitation.

This report will address and inform several interested parties, all of whom will learn from the findings. Where appropriate, recommendations will be made directly to the Prison Service and the Trust. Both organisations will then provide my office with a response indicating if they accept my recommendations and what steps they are going to take, or have taken, to address them.

While interested parties are important this report is written primarily with Mr McClenaghan's family in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am grateful to them for their contribution to this investigation and I appreciate their patience. Questions raised by Mr McClenaghan's family are noted at Section 3: 1 and responses to those questions can be found in Section 5: 1, 2, & 3.

I offer my sincere condolences to Mr McClenaghan's family on their sad loss and in the knowledge that the experience of loss can be long-lasting. I hope this report provides information to address some of the questions they raised and explains events leading up to Mr McClenaghan's death.

I am grateful to the Prison Service, the Trust and the clinical reviewer for their contributions to this investigation. Others have helped in the information gathering process and to them I also extend my gratitude.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
10th June 2021

Section 1: Summary

Mr McClenaghan had been in prison for over seven years at the time of his death. He had transferred from Maghaberry Prison to Magilligan on 28th September 2017 where he remained until the time of his death. Mr McClenaghan had a number of underlying health conditions for which he received treatment and which I will consider in this report. He was treated as a vulnerable prisoner and was managed under the Prison Service Supporting Prisoners at Risk (SPAR) arrangement on three occasions during this period in custody.

Mr McClenaghan engaged well in the H2 landing regime and with his peers. One of his peers was particularly attentive to him and to his needs on the last evening he spent in Magilligan and is to be commended for the care and attention he provided. Mr McClenaghan also had regular contact with family members. His sister had visited him several weeks before his death. She was concerned about his low mood on that visit and reported her concerns to the Visits Senior Officer (Senior Officer A). Following this report concerns were reported to the Mental Health Team and Mr McClenaghan saw a nurse 11 days before his death and doctor six days before his death.

Mr McClenaghan collapsed twice on the landing on 16th October 2018. His first collapse was just before midnight on 16th October 2018 and he collapsed again a short time later. He received medical attention on both occasions and was transferred to hospital after his second collapse. An emergency ambulance was called and transferred him to hospital for further treatment. I will consider whether or not this referral could have been made after his first collapse. Nevertheless, I hope it is of some comfort to Mr McClenaghan's family to know that he was seen by the nurse on both occasions and cared for by a friend on the landing until he was transferred to hospital that evening. Mr McClenaghan died in hospital on 21st October 2018. He was 57 years old.

The post mortem finding was that death was caused by a subarachnoid haemorrhage and intra cerebral haemorrhage due to a ruptured berry aneurysm of the anterior communicating artery. An inquest is pending.

Given Mr McClenaghan's underlying health challenges and the nature of his death I commissioned an independent clinical review of his healthcare while in custody. I also sought the opinion of a Consultant Neurosurgeon and his opinion was that after Mr McClenaghan's initial collapse he should have been transferred to hospital immediately. Sadly, even if he had been transferred after his first collapse it is the opinion of the Consultant Neurosurgeon that it is most likely the outcome would not have been different given the nature of his condition. These reviews are discussed in Sections 4 & 5.

I accept and endorse the findings of the independent clinical review.

Section 2: Background information – Magilligan Prison

2.1 Magilligan Prison

Magilligan is a medium security prison which holds male adult sentenced prisoners mainly transferred from Maghaberry prison. The population of Magilligan prison on the night of this incident was 406.

Since 2008 prison health care services have been provided by the South Eastern Health and Social Care Trust (the Trust). There is a 24 hour primary health care service and the Mental Health Team is on site Monday to Friday between 08:00 and 17:00. There are no in-patient beds.

2.2 Criminal Justice Inspection

The most recent inspection report of Magilligan Prison was published in December 2017. Inspectors recognised the progress made at Magilligan since their previous inspection. They welcomed the innovative work to improve provision for disabled and older prisoners and improvements in relation to healthcare.

2.3 Independent Monitoring Board (IMB)

Magilligan has an IMB whose role is to satisfy themselves regarding the treatment of prisoners.

The 2018-19 IMB annual report noted the regime and facilities in House Block 2 (H2) A&B as a model of good practice for older prisoners and those who required assistance. The report also outlined the healthcare provision and noted that the impact of regional shortages of nurses was impacting on the prison but that attempts had been made to enhance recruitment.

2.4 Previous incidents at Magilligan Prison

Mr McClenaghan's death was one of two deaths at Magilligan during 2018. Both deaths appear to have been from natural causes. There are no significant similarities with these deaths.

Section 3: Framework for this investigation

Mr McClenaghan died while he was in prison custody. As a result I am required to investigate and report on the circumstances surrounding his death.

This investigation was conducted in line with the objectives set out on page 2, which include providing explanations, where possible, to Mr McClenaghan's family.

3.1 Questions raised by Mr McClenaghan's family

My predecessor met with Mr McClengahan's family on 15th November 2018 and they raised two particular questions in respect of his care:

- What investigations were conducted into Fred's recurring headaches and whether the care and treatment provided to him in prison was at least comparable with that which might have been provided in the community?
- What observations were conducted when Fred first collapsed on the landing and could he have been transferred to hospital sooner?

3.2 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. The following information was gathered and analysed by the Investigating Officer:

- Prison Service records;
- Prison healthcare records;
- Hospital records; and
- Post mortem records.

All of this information was carefully examined and I have detailed the relevant matters, which underpin my findings, in this report.

3.3 Independent advice

I commissioned an independent clinical review of Mr McClenaghan's nursing care from Hilary Pinfold, a Registered Mental Health Nurse (RMN) with extensive experience of conducting Death in Custody Reviews on behalf of Health Inspectorate Wales (HIW). An opinion was also sought from Mr Ashraf Abouharb, Consultant Neurosurgeon, Belfast Health and Social Care Trust (BHSCT).

3.4 Scope and remit of the investigation

The specific objectives of this investigation were to:

1. Establish whether the care Mr McClenaghan received was equitable to that he could have expected to receive in the community.
2. Examine if there was evidence in the records that Mr McClenaghan had been suffering from recurring headaches and whether appropriate investigations were conducted.
3. Establish if there was an opportunity to transfer Mr McClenaghan to hospital at an earlier stage and whether the ultimate outcome would have been different.
4. Examine the standard of recordkeeping and determine if this was in keeping with Nursing Midwifery guidelines.
5. Identify any areas of good practice and learning opportunities arising from this case.

A description of the key events leading up to Mr McClenaghan's death is set out in Section 4 and my findings are set out in Section 5.

Section 4: Description of key events surrounding Mr McClenaghan's death

4.1 Background

Mr McClenaghan had been in prison for over seven years at the time of his death. He had spent time in both Maghaberry and Magilligan prisons and most recently transferred to Magilligan on 28th September 2017 where he was accommodated on H2 A&B landing. Due to refurbishment the landing relocated to Alpha (another accommodation unit) on 31st July 2018 where the regime was largely the same.

H2 A&B landing predominantly accommodates older prisoners, as well as those who may be vulnerable due to the nature of their offences and/or who have complex care needs.

Mr McClenaghan had complex underlying health problems for which he received treatment while he was in custody. The clinical reviewer's report gives a chronology of the healthcare services provided to Mr McClenaghan from 2016.

He was managed under the Prison Service SPAR arrangements on three occasions during his most recent period of custody. Several weeks prior to his death Mr McClenaghan's sister reported to the Visits Senior Officer (Senior Officer A) that she was concerned because his mood had been low during a visit. The Visits S/O relayed this information to the H2 S/O (Senior Officer B) who explored this with Mr McClenaghan. She completed a concern form[1] and referred him to the mental health team following which he was seen by a nurse (10th October 2018) and a doctor (15th October 2018).

Mr McClenaghan engaged well in the H2 landing regime and with his peers. He had regular contact with family members.

4.2 Events on the evening of 16th October 2018 and early hours of 17th October 2018

At 23:37[2] on 16th October Mr McClenaghan collapsed on the landing and was helped to his feet by a friend (Prisoner A) who occupied the next room. He was attended to by other prisoners who also alerted the night guard officer (Officer A). Two minutes

[1] A concern form was introduced as part of new SPAR operating procedures – SPAR Evolution - at Magilligan prison on 30th April 2018. The form enables concerns about an individual to be documented and an assessment made of the potential risk of self-harm and appropriate referrals.

[2] Timings are taken from the Closed Circuit Television (CCTV) footage unless otherwise stated.

after he collapsed Mr McClenaghan was observed on CCTV walking unaided into the cell next to his own.

At 23:42 the Night Guard Manager (Senior Officer C) arrived on the landing accompanied by the night guard officer (Officer A). They were followed two minutes later by a nurse (Nurse A) who examined Mr McClenaghan. The Night Guard Manager recalled that Mr McClenaghan was lucid and that he told the nurse he had a slight sore head and as a result she had given him paracetamol. Prisoner A informed the Nurse that Mr McClenaghan had not been eating well for a couple of weeks and that he smoked heavily.

The Nurse performed her clinical observations and advised Mr McClenaghan to rest. She opened the window in Mr McClenaghan's cell and turned the radiator down as the room was very warm with limited ventilation. Mr McClenaghan walked slowly to his room unaided at 23:54. Shortly afterwards the officers and the Nurse left the landing.

Prisoner A explained when interviewed that he heard Mr McClenaghan groaning a short time later. He got up and checked on him and found that he had been sick on the floor of his room. He emptied the bin and got a mop to clean the floor. These movements were observed on CCTV. Prisoner A went to Mr McClenaghan's room at 23:55 and returned to his own room at 00:15. Prisoner A did not report that Mr McClenaghan had vomited at that time.

At 00:19 Mr McClenaghan left his room and walked up the landing towards the ablutions. On his way he appeared to stop at the door of a few rooms. He entered the ablutions area and then came back onto the landing when he spent about three minutes in another prisoner's room before returning to the ablutions at 00:25. A minute later a prisoner (Prisoner B) followed him into the ablutions after hearing a bang and a number of other prisoners started to come out of their rooms. The night guard officer (Officer A) was again alerted at 00:27. The Night Guard Manager and Nurse who had earlier attended the landing after Mr McClenaghan was first unwell, returned to the landing.

A second prisoner was also found collapsed in the ablutions but this incident was unrelated to Mr McClenaghan's collapse.

The Nurse examined Mr McClenaghan first as his condition appeared more serious. She immediately requested an ambulance. The prison's Emergency Control Room (ECR) occurrences/radio log indicated that the ambulance was tasked at 00:29 and arrived at the prison at 01:02. The Nurse continued to monitor Mr McClenaghan until the arrival of paramedics. The ambulance left the prison at 01:33 and took Mr McClenaghan to hospital.

At 03:16 prison staff escorting Mr McClenaghan notified the ECR that they had been told that Mr McClenaghan had suffered a large bleed on the brain and had been advised to inform his next of kin.

The Duty Governor (Governor A) was contacted and at 03.30 he informed Mr McClenaghan's family that he had been taken to hospital.

Mr McClenaghan was subsequently transferred to a hospital in Belfast at 05:35 on the morning of 17th October 2018.

A hot debrief meeting took place on 21st October 2018 and a cold debrief was conducted on 7th December 2018.

Section 5: Findings

This section sets out my findings under each specific investigation objective.

5.1 Establish whether the care Mr McClenaghan received was equitable to that he could have expected to receive in the community.

The clinical reviewer found that Mr McClenaghan received excellent primary care with regular dentistry and ophthalmic appointments. There was evidence of diabetic monitoring and podiatry. She also noted that Mr McClenaghan's request to see a prison General Practitioner (GP) were dealt with in a responsive and timely manner. She further noted the efforts of staff to get Mr McClenaghan food that he would enjoy when his appetite was poor.

5.2 Examine if there was evidence in the records that Mr McClenaghan had been suffering from recurring headaches and whether appropriate investigations were conducted.

The Egton Medical Information System consultation records were reviewed by the Investigating Officer for a 14 month period prior to Mr McClenaghan's death and there was no evidence that Mr McClenaghan had been complaining of recurring headaches. There is a reference to a hospital appointment in 2014 related to a tension headache.

Two prisoners (Prisoners A and B) said that Mr McClenaghan had complained to them about having headaches in the weeks before his death and they encouraged him to speak to the Nurse but they described him as being stubborn. Prisoner A said he eventually raised this with the House Senior Officer (Senior Officer B). The Senior Officer recalled Prisoner A raising concerns about Mr McClenaghan with her. She then spoke to Mr McClenaghan and it was following this discussion that she completed a concern form. At that time the only time a headache was mentioned to the Senior Officer was after Mr McClenaghan described a dark cloud hanging over him. In a telephone call to a family member on 1st October 2018 Mr McClenaghan stated that he had had a headache for weeks and weeks and that he could not get rid of it.

Mr McClenaghan saw a Nurse on 10th October and a Doctor on 15th October 2018 in relation to his low mood. He did not raise a complaint about headaches during those consultations.

As Mr McClenaghan did not raise a recurring headache with healthcare staff, no investigations relating to this could be conducted.

5.3 Establish if there was an opportunity to transfer Mr McClenaghan to hospital at an earlier stage and whether the ultimate outcome would have been different.

The Nurse who responded to Mr McClenaghan when he was first taken unwell stated at interview that she had no reason to call an ambulance at that time for a number of reasons, namely:

- his observations were normal;
- she felt that he probably wasn't hydrated properly and was aware that he may not have eaten well that day;
- it was very warm in his room; and
- he had been smoking in a very poorly ventilated room.

She had some prior knowledge of Mr McClenaghan's medical history but given the emergency call out, had not had an opportunity to check his notes before responding to the call.

While she was doing her observations the Nurse recalled that Mr McClenaghan reported that his head was sore. She explored if it was common for him to have headaches and he had told her that he had a headache a lot. She did not recall this being reported in any previous interactions with him. She administered paracetamol and reported that she advised Mr McClenaghan to rest, take plenty of fluids and that if he felt unwell again to contact staff and she would see him. She said that his speech remained clear throughout the time she was with him and that he was able to walk back to his own cell.

The second time the Nurse was called to see Mr McClenaghan, she conducted her assessment and although the observations came back within normal limits, she knew from her previous experience of working in neurology, that his condition was serious and that he needed to be transferred to hospital immediately. Her view at that time was that he was having a cerebrovascular accident.

Having considered the Nurse's records and the record of her interview, the clinical reviewer accepted that the Nurse did take Face Arms Speech Test (FAST)[3] principles into account during her first assessment although these were not fully reflected in her notes. The Nurse was unaware that Mr McClenaghan had vomited as this was not reported to her.

[3] The National Institute of Clinical Excellence (NICE) state in their guidance NG128 May 2019 (Prompt recognition of symptoms of stroke and transient ischaemic attack) that a validated tool such as FAST (FACE Arm Speech Test) should be used outside hospital to screen people with sudden onset of neurological symptoms for a diagnosis of stroke or transient ischaemic attack (TIA).

In the clinical reviewer's opinion, immediate support and advice from expert clinicians in a hospital setting should be sought in the event of any sudden collapse. This did not occur after Mr McClenaghan was first taken unwell for the reasons stated above.

In terms of whether earlier transfer to hospital might have altered the outcome a view was sought from the Consultant Neurosurgeon who treated Mr McClenaghan at Belfast Trust as this was outside the expertise of the clinical reviewer.

In Mr Ashraf Abouharb's opinion Mr McClenaghan should have been transferred immediately to hospital after the initial collapse. However he stated, "*In the most probabilities, given the significance of the subarachnoid haemorrhage and the bleed, the most likely outcome might not be different*."

Mr Abouharb also stated that in his view it was most likely that Mr McClenaghan's aneurysm bled more than once. He said that it was quite common that after the initial rupture an aneurysm could bleed again and that usually the first hours and days are the critical period.

As has been established Mr McClenaghan did not complain to healthcare staff about headaches so no earlier intervention was possible, nor can it be said that an earlier intervention would had altered the outcome.

In light of the comments by the clinical reviewer and consultant neurosurgeon, I make a recommendation to the Assistant Director of Healthcare in Prison to introduce a policy or expand existing policy to provide guidance on the processes to be followed in the event of a sudden collapse.

Recommendation 1:
The Assistant Director of Healthcare in Prison should introduce a policy or expand existing policy to provide guidance on the processes to be followed in the event of a sudden collapse.

This recommendation was accepted and a joint Trust and Prison Service procedure for responding to a collapsed adult / patient requiring cardiopulmonary resuscitation in prisons was finalised in May 2020.

It is the hope of Mr McClenaghan's family that this procedure could include staff staying with a patient, after a sudden collapse when the patient is still conscious and does not require cardiopulmonary resuscitation, for significantly longer than they did in this case. They feel that this could avoid someone in similar circumstances to Mr McClenaghan being left alone so soon after collapsing.

I appreciate that from the family's point of view that, it would have been of comfort to them to know that Mr McClenaghan was not left alone, however it is acknowledged that in this situation, staff made appropriate decisions in terms of policy and practice.

5.4 Examine the standard of recordkeeping and determine if this was in keeping with Nursing Midwifery guidelines.

The Nursing Midwifery Code (NMC) contains the professional standards that registered nurses must uphold. Part 10 of the Code refers to the requirement for nurses to keep clear and accurate records relevant to their practice.

The clinical reviewer identified a number of matters relating mainly to the initial entry made by Nurse A on 16th October 2018. She said this entry was brief and contained inadequate information relating to:

- Exploration of the circumstances leading to Mr McClenaghan taking unwell;
- The absence of a record of future plan of care;
- No record was made that Mr McClenaghan had complained of a sore head and of exploration of this;
- The timings of interventions and the actual results of ongoing observations were not recorded;
- There was no evidence in the record that the Nurse had taken account of the FAST principles.

Overall she found there were omissions in the records and the two records in question did not meet the requirements of the NMC. She noted that nursing staff at the prison presented as highly skilled and dedicated to their profession but was told that nursing staff at that time were under significant pressure due to staffing issues. She accepted that recruitment and retention of nurses is an issue that is impacting across prisons.

She made a recommendation that the Assistant Director of Healthcare in Prison should ensure that nursing records comply with NMC standards, entries are accurate and audit arrangements are put in place to monitor compliance.

In a death in custody investigation report published last year a recommendation was made to and accepted by the Trust that arrangements to audit health care records and monitor compliance with national and local standards should be made.

The Trust explained that an arrangement is in place to audit clinical records annually and that an audit had then recently been completed of GP records.

I note the finding of the clinical reviewer and I am satisfied that an arrangement is in place to audit clinical records.

5.5 Identify any areas of good practice and learning opportunities arising from this case.

During a conference call between the clinical reviewer and the Trust it was established that there had been difficulties in being able to conduct regular staff supervision. It is the clinical reviewer's opinion that "Clinical supervision underpins the very essence of good care, and without it clinicians cannot develop their knowledge, skills and ability." It is suggested that clinical supervision is beneficial for both the organisation and the Nursing staff.

The Trust were able to inform us during the conference call that staff at the appropriate grade had been recruited and provided with the required training to be able to conduct clinical supervision. I would encourage the Assistant Director of Healthcare in Prison to ensure that clinical supervision is being conducted.

The clinical reviewer noted that Mr McClenaghan stated during a mental health review on 7th March 2017 that he did not have insight into his physical health conditions. The clinical reviewer understands that this was dated and was likely to be an isolated incident. However it is important that the Assistant Director of Healthcare in Prison should make sure all prisoners are offered information in relation to their health by the most appropriate method.

The clinical reviewer concluded that the general care offered to Mr McClenaghan within Magilligan prison was generally of an acceptable quality with him receiving a full range of primary care interventions which were both timely and appropriate.

Senior Officer B kept in regular contact with Mr McClenaghan's family over his time in hospital and indeed over his untimely death. Senior Officer B and another colleague met with the family to give them Mr McClenaghan's belongings and talked with them at length about his time in prison. The family seemed to have taken some comfort with the fact that Mr McClenaghan was respected by both his peers and staff. The family were grateful for all that the staff had done for him.

5.6 Other observations

The incident response was reviewed at the hot and cold debrief meetings.

Standard 25 of the NIPS Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody.

The hot debrief should take place as soon after the incident as possible and involve all the staff, where possible, who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning. This also provides a further opportunity to check in with staff involved in an incident.

Neither the hot or cold debrief were attended by the night guard staff involved directly in the incident but the Duty Governor was recorded as speaking directly with the staff concerned. Details of the incident were reviewed at both meetings. No actions were identified at the hot debrief but concern for the H2 Senior Officer, her staff and prisoners on the landing was raised at the cold debrief meeting. As a result the Governor and Deputy Governor attended the landing to speak to staff and prisoners impacted by Mr McClenaghan's sudden death. One of the prisoners who had been particularly close to Mr McClenaghan was offered bereavement support after his death but declined to avail of this support.

When interviewed the prison staff were aware of the staff support systems and acknowledged that line managers had offered support. The Nurse said she was not offered support but was aware of Carecall (now Inspire) and had been contacted by the Senior Officer to see if she was okay. She felt she could have been better supported.

The clinical reviewer said that the Assistant Director of Healthcare in Prison should ensure that all staff receive support following a significant incident.

In a separate death in custody investigation published in March 2020, the Trust advised that they continue to expand their staff care programme to include a trauma informed approach. I will keep this development under review and will request a formal update from the Trust following this report.

Section 6: Conclusions

With regard to my responsibilities to investigate Mr McClenaghan's death and specifically considering the objectives of my investigation, I draw the following conclusions:

i. My investigation established the circumstances and events leading up to Mr McClenaghan's death on 21st October 2018. I am satisfied that the Prison Service provided appropriate care to Mr McClenaghan.

ii. I accept the opinion of the clinical reviewer that Mr McClenaghan received good primary care.

iii. I note the comments of the Consultant Neurosurgeon that, in his view, Mr McClenaghan should have been transferred to hospital when he initially took unwell but that given the extent of the subarachnoid haemorrhage and the bleed, the most likely outcome might not be different.

iv. I make one recommendation to the Assistant Director of Healthcare in Prison to introduce a policy or expand existing policy to provide guidance on the processes to be followed in the event of a sudden collapse. This recommendation was accepted and a joint Trust and Prison Service procedure for responding to a collapsed adult / patient requiring cardiopulmonary resuscitation in prisons sudden collapse was finalised in May 2020. I would like to assure the family of Mr McClenaghan that I will raise their issue of staff staying with patients after a collapse with the Trust and Prison Service.

v. I have addressed as far as possible the matters raised by Mr McClenaghan's family and I apologise for the delay in providing them with a copy of my report.

vi. In order to assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, I will provide the Coroner with the materials underlying my investigation.

Section 7: Recommendations

Recommendation 1:

The Assistant Director of Healthcare in Prison should introduce a policy or expand existing policy to provide guidance on the processes to be followed in the event of a sudden collapse.

This recommendation was accepted and I am pleased that a joint Trust and Prison Service procedure for responding to a collapsed adult / patient requiring cardiopulmonary resuscitation in prisons sudden collapse was finalised in May 2020.