The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR LIAM ADAMS
AGED 63
WHILE IN THE CARE OF MAGHABERRY PRISON ON 25th February 2019

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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

ECR	Emergency Control Room
EMIS	Egton Medical Information System
IMB	Independent Monitoring Board
PBNI	Probation Board Northern Ireland
PPANI	Public Protection Arrangements Northern Ireland
PSST	Prisoner and Safety Support Team
Prison Service	Northern Ireland Prison Service
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 Adams' family in mind. I offer my sincere condolences to them on their sad loss and hope this report provides information to address some of the questions they raised. It is critical that, as far as possible, we provide explanations and insight to bereaved relatives. I am grateful to Mr Adams' family for their contribution to this investigation and I assure them of the care I have taken in my approach. However, it is important that I acknowledge the disappointment they have articulated to me about my findings.

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
6th September 2021

Section 1: Summary

Mr Adams was aged 63 years when he died at a hospice on 25th February 2019. He had taken unwell at Maghaberry Prison during December 2018. He was initially treated at the prison and on 12th January 2019 he was transferred to hospital for further investigations and treatment.

On 24th January 2019, Mr Adams was diagnosed with non-curative intra-abdominal malignancy (cancer). He was subsequently moved to a hospice on 4th February 2019. He remained in prison custody at the time of his death although he was not escorted by prison officers.

There was extensive consultation between family members and prison management so as to provide an appropriate level of monitoring and supervision as Mr Adams approached the end of his life.

The post mortem finding was that death was caused by metastatic carcinoma of the pancreas and an inquest is pending.

The clinical reviewer concluded that Mr Adams received appropriate clinical care while he was in Maghaberry Prison and that appropriate investigations were conducted when he first reported feeling unwell. He found nothing to suggest that the cancer diagnosis had been missed or delayed.

I accept and endorse the findings of the independent clinical review and I make no recommendations.

Section 2: Background information – Maghaberry Prison

2.1 Maghaberry Prison

Maghaberry Prison is a high security prison, which holds male adult sentenced and remand prisoners. The population in the prison at the time of Mr Adams' death was around 800.

It has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners.

Since 2008, the Trust have provided prison healthcare services. There is a 24 hour primary healthcare service. The Mental Health Team was on site Monday to Friday between 08:00 and 17:00 and from 30th October 2020 this service is now seven days a week. Also from October 2020 all mental health committal screens triage is done face to face. There are no in-patient beds.

2.2 Criminal Justice Inspection

The most recent inspection of Maghaberry Prison by the Criminal Justice Inspectorate took place in April 2018 and the report was published in November 2018. Inspectors reported that the prison had settled considerably since the last full inspection in May 2015 and was now much safer.

Inspectors reported that they observed friendly, respectful interactions and some very good care for men who needed more support on the Moyola and Donard Landings.

2.3 Independent Monitoring Board (IMB)

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

The 2018-19 IMB annual report described continued improvement in the prison and attributed this to the introduction of a core day and a sustained focus on reducing the amount of drugs coming into the prison.

The IMB commented that the Moyola Landing continued to provide a more therapeutic environment for those living with complex health conditions and that provision of end-of-life care continued to pose challenges.

2.4 Previous incidents at Maghaberry Prison

Mr Adams' death was the third death from natural causes since January 2016. There are no significant similarities with these deaths.

Section 3: Framework for this investigation

Mr Adams died from a terminal illness while he remained 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 Adams' family.

3.1 Questions raised by Mr Adams' family

I met with family members on, 9th April 2019 who raised a number of questions relevant to my investigation and these are listed below:

- Was there any relationship between Mr Adams' illness in 2017 and the diagnosis of cancer in January 2019?
- What investigations were conducted when Mr Adams was first unwell in December 2018 and if these were appropriate?
- Were there opportunities to detect and diagnose Mr Adams' illness earlier than 24th January 2019?
- How responsive were both the Prison Service and the Trust to concerns raised by Mr Adams' family about his wellbeing during January 2019?
- What were the preparations for Mr Adams' transfer to hospital on 12th January 2019 and why did he not have a change of clothes or toiletries when he was first taken to hospital?

A family member raised concerns about aspects of care Mr Adams had received from the Trust during 2017 in relation to a complaint that had been raised at that time. These matters are not within the scope of my investigation other than to examine if there was any relationship between this and the subsequent cancer diagnosis in January 2019.

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 the health care provided to Mr Adams. This was conducted by Dr Andrew N. T. Davies MBBS, MSc, MD, FRCP. Dr Davies is a Clinical Director/Consultant in Palliative Medicine at Royal Surrey County Hospital (St. Luke's Cancer Centre).

3.4 Scope and remit of the investigation

The specific objectives of this investigation were to:

1. Establish whether or not Mr Adams' particular needs were identified, assessed and appropriately managed by prison and healthcare staff in relation to his most recent illness.
2. Establish if there was any relationship between the illness in 2017 and the diagnosis of cancer in January 2019.
3. Establish what investigations were conducted when Mr Adams was first unwell in December 2018 and if these were appropriate.
4. Establish if there were opportunities to detect and diagnose Mr Adams earlier than 24th January 2019.
5. Establish the responsiveness of both the Prison Service and the Trust to concerns raised by family members about Mr Adams' wellbeing during January 2019.
6. Establish the preparations for Mr Adams' transfer to hospital on 12th January 2019 and why he did not have a change of clothes or toiletries when he was first taken to hospital.
7. Identify any areas of good practice and learning opportunities arising from this case.

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

Section 4: Description of key events

4.1 Background

Mr Adams was committed to Maghaberry Prison on 1st October 2013. He was later sentenced and his earliest date of release was June 2021. Due to the nature of his offences he was subject to Public Protection Arrangements Northern Ireland (PPANI) and had been assessed at PPANI Category 1[1].

From 23rd September 2014, Mr Adams was accommodated in Moyola House, a small unit located beside healthcare which predominantly accommodates older prisoners and people with disabilities. Mr Adams' last location in Moyola House was cell 15, which was larger than an average cell to enable him to receive optimal health care. He had a cell alarm bell and a medical alarm located on the wall beside his bed. He also had an alarm pendant to wear around his neck.

Mr Adams had previously been treated for a number of serious health conditions. In April 2014, he collapsed, was resuscitated by staff and taken to hospital where he received treatment for a heart condition and in 2016 he again received treatment for chest pain. During 2017 he had surgery to remove a tumour from his lung.

Mr Adams passed a number of drug tests throughout his custody, maintained an enhanced regime, was adjudication free and engaged well with staff and other inmates. He was involved in reading, writing, literacy, numeracy and horticulture activities and had regular contact with family members.

4.2 Most recent illness

Entries made in the Egton Medical Information System (EMIS) by healthcare staff following consultations with Mr Adams indicated that he first reported feeling unwell on 18th December 2018 and that his condition was regularly monitored until a decision was made to transfer him to hospital on 12th January 2019.

The following table sets out the chronology of events leading up to 11th January 2019, the day before Mr Adams was admitted to hospital.

18/12/2018	Reviewed by a nurse (Nurse A) with a two day history of diarrhoea. Provided with medication and advised about maintaining hydration. Told to inform healthcare staff about ongoing diarrhoea.

[1] Definition of PPANI Category 1: 'Where previous offending and/or current behaviour and/or current circumstances present little evidence that the offender could cause serious harm.'

21/12/2018	Reviewed by a nurse (Nurse A) with moderate pain "down both of his sides", pain in the right arm / right shoulder, and pain in the back. Mr Adams reported to the nurse that this pain was keeping him awake at night and that he was concerned that his cancer may have returned. Plan was for doctor to review.
27/12/2018	Reviewed by a nurse (Nurse A) who spoke to a prison GP and asked him to see Mr Adams at his afternoon clinic. Reviewed by a prison GP (Doctor A) and a detailed examination was conducted. Plan was for a doctor to review as needed.
29/12/2018	Reviewed by a nurse (Nurse B) as he continued to feel unwell and reported poor appetite. Mr Adams was advised to inform healthcare staff about ongoing symptoms.
30/12/2018	Reviewed by a nurse (Nurse C) with nausea and vomiting. Plan was to conduct a urine sample test.
31/12/2018	Reviewed by a senior nurse (Senior Nurse A) with ongoing symptoms. Plan was for a doctor to review urinalysis and substantial weight loss. Urinalysis reviewed by prison GP (Doctor B).
01/01/2019	Reviewed by a nurse (Nurse A) as he continued to feel unwell. Mr Adams was encouraged to shower and contact his family.
02/01/2019	Reviewed by a nurse (Nurse A) when he stated he felt a bit better.
06/01/2019	Reviewed by a senior nurse (Senior Nurse A) and stated that he was tolerating small amounts of food but that he continued to feel weak and unwell. Plan was for a doctor to review.
08/01/2019	Reviewed by a nurse (Nurse D) and reported that he continued to feel unwell. Advised to contact healthcare as required.
09/01/2019	Case discussed at Prison Safety and Support weekly meeting.
10/01/2019	Reviewed by a nurse (Nurse E) and a prison GP (Doctor B) and reported a fever and an ongoing feeling of being weak and lethargic. Plan was for blood sample testing. Commenced Ciproxin (an antibiotic).

11/01/2019	Reviewed by a senior nurse (Senior Nurse A) and a prison GP (Doctor B) with ongoing feeling of being unwell, nausea, abdominal pain and earache. Plan was to continue with antibiotics and if no improvement refer to hospital the following day.

On 12th January 2019, Mr Adams was reviewed by a healthcare assistant. As there was no improvement in his condition, a Staff Nurse was informed and arrangements were made to transfer him to hospital in accordance with the prison GP's instructions.

Mr Adams presented at hospital with abdominal pain, vomiting and deranged liver function tests. An ultrasound performed on 13th January indicated multiple lesions through the liver in keeping with metastatic liver disease and further investigations on 15th January reported features suggestive of advanced pancreatic malignancy. A liver biopsy was conducted on 22nd January and confirmed a likely pancreatic adenocarcinoma. Following an oncology review on 24th January 2019, a consultant medical oncologist concluded that the toxicity of anti-cancer treatment/palliative chemotherapy would outweigh the benefit of it.

Mr Adams was subsequently transferred to the Northern Ireland Hospice on 4th February 2019 for symptom control and end of life care. Following admission to the hospice, his clinical condition continued to deteriorate with worsening liver function and cancer related symptoms. The Prison Service invoked Rule 27[2] on 21st February 2019 and withdrew prison officers from the hospice at 19:00. He remained in custody and died on 25th February 2019. The time of death was 07:00.

The Prison Service made extensive efforts to respect Mr Adams' privacy and dignity during the period he was in hospital and the hospice.

[2] A prisoner can be temporarily released under Rule 27 for any special purpose or to enable them to have health care – this can be withdrawn at any time.

Section 5: Findings

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

Given the nature of Mr Adams' death, I invited the clinical reviewer to comment on objectives relating to clinical care i.e. 5.1-5.4 below.

5.1 Establish whether or not Mr Adams' particular needs were identified, assessed and appropriately managed by prison and healthcare staff in relation to his most recent illness.

The clinical reviewer stated that Mr Adams appeared to have received appropriate care for the symptoms/problems arising during his final illness. Dr Davies found that Mr Adams was regularly reviewed and was given appropriate medication and advice.

5.2 Establish if there was any relationship between the illness in 2017 and the diagnosis of cancer in January 2019.

Dr Davies said that the cancer of the pancreas (diagnosed in 2019) was unrelated to the lung cancer (diagnosed/treated in 2017). The post mortem report also indicated this was the case.

5.3 Establish what investigations were conducted when Mr Adams was first unwell in December 2018 and if these were appropriate.

Dr Davies reported that appropriate investigations were done on 30th December 2018 and 10th January 2019. Dr Davies stated "As he did not have any "red flag" symptoms, there was no indication for further investigations during this period."

5.4 Establish if there were opportunities to detect and diagnose Mr Adams earlier than 24th January 2019.

Dr Davies advised that there was nothing in the records to suggest that Mr Adams' care was mismanaged, or to suggest that the diagnosis of pancreatic cancer had been 'missed' or 'delayed' by the healthcare team at Maghaberry Prison. He highlighted that the hospital's surgical team had initially made a provisional clinical diagnosis of "cholecystitis" (inflammation of the gallbladder), or "choledocholithiasis" (gallstone in the common bile duct), and the diagnosis was only amended after a series of specialist investigations.

5.5 Establish the responsiveness of both the Prison Service and the Trust to concerns raised by Mr Adams' family about his wellbeing during January 2019.

A family member said their worry about Mr Adams' condition increased following a visit with him in early January 2019. The family member said that both they and another family member made numerous calls to Maghaberry Prison to request that the cause of Mr Adams' illness be investigated and that he see a doctor. At that time the family member was advised by the Trust that Mr Adams was suffering from gastroenteritis. In another call with prison healthcare staff the family member was told that a doctor was not available over the Christmas period. In addition to speaking to the Trust the family member also spoke with two different family support officers and a prison chaplain. However, it wasn't until they spoke to a representative of the IMB that they felt their concerns were being listened to.

An examination of the prison healthcare records showed that a family member had telephoned the prison on 29 December 2018 because they were concerned about Mr Adams' symptoms/condition. The records also showed that another family member also telephoned the prison on 1 January 2019 because they too were concerned that Mr Adams had not telephoned them for two days. A nurse (Nurse A) provided reassurance that Mr Adams was being monitored and it was recorded that the family member was thankful for this. The nurse further recorded that she had encouraged Mr Adams to telephone his family, which he did later that same day.

On 1st January 2019, a member of the IMB raised concerns with the Prison Service and the Prisoner and Safety Support Team (PSST) about Mr Adams' health. A PSST Officer (Officer A) went to see Mr Adams and liaised with IMB, residential prison officers, the Trust and the family office in relation to this visit. The officer (PSST Officer A) was advised that Mr Adams' medical issues were being addressed.

PSST records showed that Mr Adams' progress continued to be reviewed and that PSST staff liaised with a number of different partners, including Probation Board Northern Ireland (PBNI) and Chaplaincy until 6th February 2019.

On 13th January 2019, a family member submitted a complaint in respect of Mr Adams' care to the Trust. It was their view that had Mr Adams been in the community, an earlier diagnosis would have been made and, although this would not have prevented his death, the family may have had more time with him. As set out above, the clinical reviewer did not believe this to be the case.

Both the family member and their legal representative spoke highly of any engagement they had with one of the prison Governors, (Governor A) who coordinated arrangements for Mr Adams' supervision while he was at hospital and the hospice. Detailed records were kept of correspondence between the prison, the

legal representative and other agencies on options considered for the monitoring and supervision of Mr Adams during the latter stages of his illness. Bar a number of instances of uncertainty around visiting arrangements and a potential return to custody, which did not materialise, no matters for investigation about how the Prison Service managed Mr Adams following his transfer to hospital were raised by family members.

5.6 Establish what preparations were made for Mr Adams' transfer to hospital on 12th January 2019 and why he did not have a change of clothes or toiletries when he was first taken to hospital.

The prison doctor (Doctor B), who reviewed Mr Adams, on 11th January 2019 left instructions that if Mr Adams' health did not improve by the following day, he was to be taken to hospital. Mr Adams was reviewed again on 12th January 2019 and, as his condition had not improved, arrangements were made to transfer him to hospital.

Mr Adams left Maghaberry Prison at 11:14 on 12th January 2019 and arrived at hospital at 11.42. Prison staff at the hospital were informed by a doctor at 14:00 that Mr Adams may be admitted overnight. His admission was subsequently confirmed and this was notified to Maghaberry Prison Emergency Control Room (ECR) at 14.25.

It is unclear from the Prison Service and the Trust records whether Mr Adams had a change of clothes or toiletries with him when he went to hospital. It's possible that it was uncertain what the outcome of the hospital's assessment would be and if he would be admitted.

There is a record in the healthcare notes that a family member spoke to a nurse in healthcare on 13th January 2019 to ask for further details of which hospital Mr Adams had been taken to as they wanted to bring him clean pyjamas. The family member was advised by the nurse to speak to the prison to request further information.

Prison records indicated that the Prison Service facilitated a visit for the family member with Mr Adams on 13th January 2019.

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

In summary the clinical reviewer said that Mr Adams had several chronic health problems, which appeared to be well monitored/managed over the years by the prison healthcare services (in conjunction with non-prison healthcare services). He found that care needs were outlined in care plans, and Mr Adams had adequate access to medications and other interventions (e.g. occupational therapy, physiotherapy). Dr Davies stated that Mr Adams was probably reviewed more

regularly by healthcare professionals than most people living in the community with similar symptoms / problems.

I commend the Prison Service for the time invested in liaising with family members and a range of other agencies in making arrangements for Mr Adams' monitoring and supervision during the latter stages of his illness. In a recently published report, where the family experience was very different, I asked the Prison Service to ensure that there is effective and ongoing communication with families of prisoners diagnosed with a terminal illness. This case provides a model of good practice going forward.

Section 6: Conclusions

With regard to my responsibilities to investigate Mr Adams' 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 Adams' death on 25th February 2019. I am satisfied that, overall, the Prison Service provided appropriate care and made reasonable adjustments to address Mr Adams' needs, whilst in prison custody.

ii. I accept the opinion of the clinical reviewer that Mr Adams received appropriate care from the Trust when he became unwell during December 2018 and that appropriate investigations were undertaken at that time and, furthermore, that his diagnosis was not missed or delayed.

iii. I am satisfied that my investigation into Mr Adams' death did not highlight any need for changes to be made in Prison Service or Trust operational methods, policy, practice or management arrangements which could help prevent a similar death in future.

iv. I do not make any recommendations in this case.

v. I have addressed as far as possible the matters raised by family members and while it does not address their loss, I am satisfied that Mr Adams' was well cared for while he was in custody and that care was taken in the latter stages of his illness to sensitively balance the needs of the family with monitoring and supervision requirements. The family remain disappointed. I sincerely hope that the information provided here will assist the inquest and the family.

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.