The Prisoner Ombudsman for Northern Ireland

OFFICIAL – SENSITIVE

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF

MR SAMUEL FREDERICK PINKERTON
AGED 62 YEARS
AT MAGILLIGAN PRISON
ON 23 AUGUST 2019

Date finalised: **13 June 2022**

Date published: **20 July 2022**

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.

Table of contents

Glossary

CCTV	Close Circuit Television
CPR	Cardiopulmonary Resuscitation
CT	Computed Tomography
ECHO	Echocardiogram
ECR	Electronic Care Record
ECR	Emergency Control Room
EMIS	Egton Medical Information System
GP	General Practitioner
ICU	Intensive Care Unit
IHD	Ischemic Heart Disease
NIPS	Northern Ireland Prison Service
NHS	National Health Service
PRISM	Prisoner Record and Inmate System Management
PTSD	Post-Traumatic Stress Disorder
RGN	Registered General Nurse
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure

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, in Healthcare providers, 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. I highlight good practice by both the Prison Service and the Trust so it can be repeated.

Mr Pinkerton had served multiple sentences over a twenty year period and was a resident of Magilligan Prison at the time of his death. He had a history of physical and mental health problems which had a significant impact on his wellbeing. Mr Pinkerton frequently declined to attend scheduled healthcare appointments which was particularly challenging for healthcare staff. Given the severity of his condition staff continued to work with him to deliver the care he needed. His leg ulcers in particular were an issue in the months prior to his death and he often refused both medication and attention to the dressings. There were times when he did not attend at the allotted time but did seek attention in his own time. Healthcare staff made every effort to support him through what was a difficult time for him.

On the morning of 22 August 2019 Mr Pinkerton was seen by a nurse in his cell. His blood pressure and oxygen level were very low and his heart rate and breathing rate were high. Mr Pinkerton refused to travel to hospital by ambulance so was transferred instead in a prison van. My report will discuss the method of his transfer in Section 4 and 5. On arrival at the hospital Mr Pinkerton received treatment for sepsis and pneumonia and despite medical advice he refused a blood transfusion. On the evening of 22 August 2019 Mr Pinkerton was taken to have a line inserted under anesthetic. He had a cardiac arrest and in response received Cardiopulmonary Resuscitation (CPR) before being moved into the Intensive Care Unit (ICU). Sadly Mr Pinkerton had a further cardiac arrest and continued to deteriorate so a decision was made to withdraw treatment, and he died peacefully at 01:55 in the early hours of 23 August 2019. He was 62 years old.

The clinical reviewer, Kate Varley RGN, concluded that that standard of clinical care Mr Pinkerton received by the Trust at Magilligan Prison was of mixed equivalence to that which he would have received in the community. Equivalence with that provided in the community must take the custodial environment into account, including the lack of normal, regular family contact as would be the case in the community.

I accept and endorse the findings of the independent clinical review and I make two recommendations to the Trust.

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

This report is written primarily with Mr Pinkerton's family in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I offer my sincere condolences to Mr Pinkerton's family on their sad loss and hope this report provides information that will be helpful to them.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
22 June 2022

Section 1: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

Recommendation 1

The Trust should consider implementing the Sepsis risk stratification tool (for adults out of hospital) outlined in NICE Guidance 51 Sepsis: Recognition, diagnosis and early management.

Recommendation 2

As recommended in NICE Guidance 57, Physical Health of People in Prison, The Trust should review the current system of the management of long term conditions, to ensure a system and process is in place in accordance with NICE chronic condition guidelines endorsed within Northern Ireland.

The Trust have implemented both recommendations as a result of a practice change. These changes were introduced prior to publication of this report.

Section 2: Background information

2.1 Magilligan Prison

Magilligan Prison is a medium security prison which holds male adult sentenced prisoners mainly transferred from Maghaberry Prison.

Since 2008 prison healthcare services have been provided by the Trust. There is a 24 hour primary healthcare 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 February 2022. Inspectors recognised the progress made at Magilligan Prison since their previous inspection and noted six areas of innovative work that had resulted in particularly good outcomes for prisoners. These included:

- A culture of care driven by the Prisoner Safety and Support Team;
- The development and recent increased use of a therapeutic garden in the Care and Supervision Unit;
- The work of the Family Support Officers and partners to sustain and promote family contact;
- The introduction of a video technology scheme where a small number of prisoners were able to support their children virtually in completion of their homework;
- Integrated social care packages for prisoners with severe needs; and
- Excellent rehabilitative opportunity for prisoners to serve out the final period of their sentence while living and working in the community.

The inspectors noted two areas of concern. These included:

- The effectiveness of the prison's drug and alcohol strategy; and
- The standards of cleanliness in some parts of the prison.

2.3 Independent Monitoring Board (IMB)

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

The 2020-21 IMB annual report noted that the Primary Care Services in Magilligan Prison are consistently under staffed and the IMB recognised that following a

recruitment campaign in July- August 2020, all nursing vacancies had been filled. Throughout the Covid pandemic, and to date, nursing staff continue to provide a full although stretched service.

2.4 Previous incidents at Magilligan Prison

Mr Pinkerton's death was the only death from natural causes in 2019 in Magilligan Prison.

Section 3: Framework for this investigation

Mr Pinkerton died in hospital while 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 in Section 3.4.

3.1 Questions raised by Mr Pinkerton's family

No questions raised.

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;
- CCTV;
- Trust records;
- Hospital records;
- Post mortem records;
- Interviews with Prison Officers; and
- Interviews with Trust staff.

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

When appropriate, I commission an independent clinical review of specific aspects of healthcare. A clinical reviewer is commissioned from an agreed list, usually to provide peer review of healthcare provision, and they provide a report with recommendations. My office provides relevant documentation and reviewers receive a terms of reference specific to each case. They provide an independent, expert opinion about care provided. A clinical reviewer may, for example, assess delivery of care in relation to current clinically approved guidelines, local and national. They will keep in mind whether or not care has equivalency with that provided in the community and any learning to improve care in the future.

In Mr Pinkerton's case I invited the clinical reviewer to examine:

- the provision of primary healthcare, treatment and medication management in relation to that which would have been provided in the community;
- any shortcomings in care or service provision;
- any comments in respect of the policies and procedures under which Mr Pinkerton was managed and;
- any learning opportunities and recommendations for future practice.

I commissioned Kate Varley, a Registered General Nurse with over 21 years' experience in healthcare as a Senior Nurse, to complete the review. She is a National Health Service (NHS) Senior Head of Patient Safety and National Patient Safety Lead and has completed over ninety death in custody reviews to date.

3.4 Scope and remit of the investigation

The specific objectives of this investigation were to:

1. Establish a timeline of events from the night before Mr Pinkerton was taken to hospital until he passed away;
2. Determine the adequacy of action taken by staff in their interactions with Mr Pinkerton during the night of 21 August 2019 and the morning of 22 August 2019;
3. The adequacy of provision of primary and secondary healthcare services provided to Mr Pinkerton and whether those services were at least equivalent to those he might have received in the community;
4. The provision of care given to Mr Pinkerton by the Prison Service;
5. The adequacy of the decision to escort Mr Pinkerton to hospital in a Prison Service van;
6. Any learnings which may help prevent similar deaths in the future;
7. Any areas of good practice arising from this case.

A description of the key events leading up to Mr Pinkerton's 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 Pinkerton had thirteen previous periods in custody, dating back to 1992. On 23 July 2018 he was committed to Maghaberry Prison for sexual offences. On 6 September 2018 he transferred to Magilligan Prison.

Mr Pinkerton's Prison Service records note the following medical markers: smoker, history of heart problems, diabetes (non-insulin dependent) and severe mental illness (Bi Polar). His Trust records noted on the Egton Medical Information System (EMIS) show that Mr Pinkerton had a history of Diabetes, Chronic Kidney Disease Stage 3, Angina, Ischaemic Heart Disease and leg ulcers.

Mr Pinkerton had a long history of noncompliance in relation to the treatment for his leg ulcers, as he would regularly remove the dressings and pick at the sores on his legs. The problem was first referenced in his EMIS records as chronic varicose eczema on 5 August 2014, and leg ulcers on 13 February 2015. In the six months prior to his death Mr Pinkerton's leg ulcers were cleaned and redressed by staff more than 30 times.

EMIS records show that Mr Pinkerton frequently attended the medical room at a time convenient for him and was unhappy when the nurse was unable to see him. He also regularly refused to attend the medical room when called to attend by a nurse.

4.2 March – June 2019

On 21 March 2019 Doctor A requested blood tests for Mr Pinkerton following abnormalities in his liver function test. This was booked for 25 March 2019 however Mr Pinkerton refused to attend. He agreed to a blood test on 27 March 2019.

On 09 April 2019 a further blood test was requested. The appointment was made for 11 April 2019 however Mr Pinkerton refused to attend.

Between 09 April 2019 and 08 May 2019 Mr Pinkerton attended the medical room for treatment to his leg ulcers 11 times. He was prescribed antibiotics on 8 May 2019 following reports that his leg ulcers were presenting as cellulitis and Mr Pinkerton had a temperature.

Between 08 May 2019 and 28 June 2019 Mr Pinkerton was seen a further 18 times for treatment to his legs.

Mr Pinkerton refused his medication and antibiotics (to treat cellulitis) unless he was admitted to hospital, consequently on 28 June 2019 he attended hospital and received treatment (with variable compliance) for infection in his legs and swelling (oedema). He refused to have an ultrasound of his heart (an ECHO) to check the flow of blood around the heart, and he also refused blood tests. The hospital deemed he had full capacity to refuse the recommended tests and he was discharged back to Magilligan Prison on 01 July 2019.

4.3 July 2019

On return to prison, Mr Pinkerton was placed on supervised swallow[1] for his antibiotics.

On 03 July 2019 Mr Pinkerton refused to attend an appointment with healthcare. Later that day he requested a return to hospital citing palpitations, worsening legs and feeling shivery. EMIS notes record Mr Pinkerton stated that he would continue to refuse treatment in Magilligan Prison unless transferred to hospital.

Mr Pinkerton was transferred to hospital on 04 July 2019. An ECHO on Mr Pinkerton showed pulmonary hypertension and mitral valve regurgitation and he was treated for bilateral pitting oedema. During a telephone call on 04 July 2019 between the hospital staff and Trust staff Mr Pinkerton was reported to be non-compliant with his hospital treatment.

On 08 July 2019 Mr Pinkerton self-discharged from hospital against medical advice. His intravenous antibiotics were changed to accommodate this and the discharge summary described changes to Mr Pinkerton's medication, an appointment to outpatient cardiology in eight weeks and a required blood test in 1 week. The basis for this course of action was detailed on a discharge letter from Mr Pinkerton's Consultant Cardiologist, dated 03 September 2019. There was concern that Mr Pinkerton may had developed post-operative constrictive pericarditis and would benefit from a cardiac MRI. He had requested an outpatient CT because there was a concern that Mr Pinkerton would not tolerate an MRI. This letter was received after Mr Pinkerton passed away, therefore these appointments were pending.

On 09 July 2019 Mr Pinkerton was moved to supervised swallow for all medication due to noncompliance.

On 16 July 2019 Mr Pinkerton refused treatment to his legs on two occasions before later going voluntarily to the medical room for treatment. Mr Pinkerton reported

[1] A patient on 'Supervised Swallow' is given each dose of their medication under supervision to ensure compliance.

feeling unwell and healthcare arranged for a blood test. This was discussed with Doctor A on 17 July 2019 and it was recorded that there was no concern about Mr Pinkerton's presentation at that time but if any acute concerns were raised then Mr Pinkerton should attend the hospital given his recent history.

Mr Pinkerton refused a blood test on the following dates:

- 19 July 2019 (will have them taken on 22 July)
- 22 July 2019 (legs bleeding – lost too much blood already)
- 23 July 2019 (doesn't want them done)
- 25 July 2019 (unhappy with healthcare provision in Magilligan Prison)

On the morning of 17 July 2019 Mr Pinkerton attended the medical room without an appointment and became "irate" when the nurse explained that she was unable to deal with his leg dressing at that time. He was called to attend at 14:00 but Mr Pinkerton refused. At 15:00 Mr Pinkerton again went to the medical room but the nurse was leaving to attend another block and Mr Pinkerton is reported in the EMIS records to have "walked off extremely unhappy."

On 18 July 2019 Mr Pinkerton initially refused his morning medications before later complying.

On 24 July 2019 Mr Pinkerton refused to have his legs dressed.

On 25 July 2019 Mr Pinkerton initially refused his morning medications before later complying. He refused to have his legs dressed. Mr Pinkerton later reported falling in his cell (11:34) and hurting his right arm and right leg but he refused paracetamol. He attended the treatment room and complied with his leg dressings following the alleged fall.

An EMIS entry on 25 July 2019 recorded that Mr Pinkerton was seen in the medical room at the request of Prison Service staff who reported that he was a 'bad colour.' Mr Pinkerton reported needing to attend hospital for his legs to which the nurse replied that she had seen his legs earlier that day and they did not require hospital treatment. Mr Pinkerton was advised to go out and get some fresh air.

On 25 July 2019 Mr Pinkerton refused his night medications despite reporting that he was in pain.

On 29 July 2019 Mr Pinkerton refused to have his leg ulcers dressed by the nurse.

4.4 August 2019

On 07 August 2019 Doctor B saw Mr Pinkerton and recorded that he appeared to be refusing medications, had not had blood taken in four months and appeared to be suffering from incontinence.

On 08 August 2019 Mr Pinkerton refused a blood test.

Mr Pinkerton had his leg ulcers attended to on 08 August 2019, 12 August 2019 and 19 August 2019. EMIS notes for 19 August 2019 recorded that Mr Pinkerton had removed the dressings from his legs and appeared to have been scratching them.

CCTV confirms that Mr Pinkerton was seen in his cell by Nurse A at 23:56 on 21 August 2019.

CCTV confirms that Mr Pinkerton was seen in the treatment room by Nurse A at 02:10 on 22 August 2019. This was a non-urgent call out in response to Mr Pinkerton complaining of back pain and feeling unwell. Nurse A recorded on EMIS that Mr Pinkerton looked pale, had a temperature of 38.5C, was given paracetamol and a specimen bottle but refused to attend outside hospital.

On 22 August 2019 Mr Pinkerton can be seen on CCTV walking slowly up the landing to the grille and then back down again to his cell. He did this at 08:33 and again at 08:49. A nurse attended Mr Pinkerton's cell with a trolley of medical equipment at 08:54. She left at 09:03 and Nurse B attended Mr Pinkerton's cell at 09:07.

Nurse B recorded an urgent call to see Mr Pinkerton in his cell on EMIS. He recorded that Mr Pinkerton has a temperature of 37.3C with paracetamol, was able to complete sentences in full but was slightly short of breath. He had stabbing pain in the right side of his chest and blood was noted on the tissues in the cell bin. The EMIS records goes on to record that, "due to having no access to a GP today and Sam's current presentation with change in clinical observations I have arranged transfer for Sam to go to A&E for assessment."

At 10:25 on 22 August 2019 Prison Service staff used a wheelchair to transfer Mr Pinkerton from his cell to a Prison Service van. It is not clear why the decision was taken to transport Mr Pinkerton in a Prison Service van and not in an ambulance, although we do know that Mr Pinkerton had refused to attend hospital when seen during the night by Nurse A. I address this point further in Section 5. Mr Pinkerton was driven to Causeway Hospital and Prison Service staff used a wheelchair to transport him from the van and into the hospital building.

Later that day, a telephone encounter between Nurse B and the hospital reported that Mr Pinkerton required a blood transfusion. Mr Pinkerton refused this. At 18:07 the hospital reported that Mr Pinkerton was going to be admitted; he was not stable and he needed treatment for a serious infection. Mr Pinkerton was recorded as not fully compliant with hospital staff.

During the evening of 22 August 2019, Mr Pinkerton had a cardiac arrest and was taken to theatre. Following a further cardiac arrest while in recovery, Mr Pinkerton died at 01:55 on 23 August 2019. The primary cause of death was recorded as Sepsis.

Section 5: Findings

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

Given the nature of Mr Pinkerton's death, I invited the clinical reviewer, Kate Varley RGN, to comment on objectives relating to clinical care i.e. 5.2-5.3 and 5.5-5.7 below.

5.1 Establish a timeline of events from the night before Mr Pinkerton was taken to hospital until he passed away;

This is detailed in Section 4.

5.2 Determine the adequacy of action taken by Trust staff in their interactions with Mr Pinkerton during the night of 21 August 2019 and the morning of 22 August 2019;

Mr Pinkerton was known to Trust staff and regularly attended to have the ulcers on his legs dressed. Nurse A, who assessed Mr Pinkerton on the night of 21 August 2019 and the morning of 22 August 2019 knew Mr Pinkerton well and was aware of his history of noncompliance in relation to his healthcare. She suspected a urine infection and as Mr Pinkerton refused to attend hospital, handed over to the day staff that a further nursing review would be required. A further review took place in Mr Pinkerton's cell at 09.14 on 22 August 2019, after which Mr Pinkerton was transferred to hospital.

NEWS is a clinical decision making tool used alongside clinical judgement to monitor a person's condition and help decide whether care should be escalated and the frequency of monitoring vital signs required. The vital signs required to accurately calculate the score are heart rate, blood pressure, and temperature, breathing rate, peripheral oxygen levels and level of consciousness. Only three of the vital signs were taken during the review at 02:10rs on the 22 August 2019. These were blood pressure, slightly high at 150/90 mmHg, temperature high at 38.5, heart rate slightly high at 98 beats per minute. Four vital signs were taken at the review at 09:14 on 22 August 2019.

Kate Varley RGN made the following recommendation in her report –

The Head of Healthcare should consider the use of the National Early Warning Score (NEWS) system to standardise the approach to the monitoring/escalation of unwell prisoners and aid the handover of care to secondary care services. Escalation guidance should include the use of disclaimers and escalation to a Senior Nurse and Oscar One / Oscar Two (the most senior officer) if a prisoner refuses to travel when an emergency ambulance is clinically indicated.

A Trust wide practice change, known as NEWS2, has since been implemented. The revised Early Warning Score (EWS) system for clinical observations includes a clear escalation process. This tool standardises the taking, frequency and monitoring and escalation of vital signs abnormal to that person. I commend the Trust for this addition to their processes.

Mr Pinkerton refused to attend hospital and had the capacity to do so. In addition, at interview Nurse A stated that in her clinical judgement and knowledge of Mr Pinkerton, an emergency ambulance was not required at that time. It is important to note that clinical decision-making tools are used alongside clinical judgement.

Mr Pinkerton went on to develop a serious infection in hospital. It is accepted that earlier treatment leads to improved outcomes for patients with Sepsis. Kate Varley RGN recommended in her report the implementation of a Sepsis risk stratification tool in addition to the NEWS system. These additions would be for the purpose of standardising care, monitoring care and recording the care received and would not, in the opinion of Kate Varley RGN, have changed the outcome for Mr Pinkerton.

I make the following recommendation: -

Recommendation 1: Implementation of a Sepsis risk Stratification Tool
The Trust should consider implementing the Sepsis risk stratification tool (for adults out of hospital) outlined in NICE Guidance 51 Sepsis: Recognition, diagnosis and early management.

It should be noted that at the time of report publication a Sepsis risk stratification tool has been implemented by the Trust's Healthcare in Prison team as part of the EWS system. I acknowledge this positive addition and standardisation in health care in prison.

5.3 The adequacy of provision of primary and secondary healthcare services provided to Mr Pinkerton and whether those services were at least equivalent to those he might have received in the community;

Kate Varley RGN commented in her report that equivalence does not mean that care provision in secure environments should be 'the same as that provided in the community, it should however be of at 'least equivalent' and consider the constraints of a custodial environment.

Having reviewed the clinical care extended to Mr Pinkerton, she considers that the care received by the Trust to be of mixed equivalence.

There were no concerns regarding the mental healthcare Mr Pinkerton received, the team made numerous attempts to support and assess him, all of which he declined.

Trust staff worked very hard to engage Mr Pinkerton in his primary healthcare. In line with good practice his capacity to consent was considered on several occasions. He was considered capacious; therefore the healthcare team managed his ulcers and recurrent cellulitis as best they could, given the restrictions self-imposed by Mr Pinkerton. His refusal to take antibiotics for cellulitis meant the infection did not clear as quickly as it could have. The team went beyond what would be expected in primary care by recalling him for appointments more than the required two times. This is above equivalence.

The management of Mr Pinkerton's numerous long term conditions was not in line with applicable NICE guidance, whilst there is evidence of attempts to take blood to monitor his numerous long term conditions, there is no evidence of structured reviews are in place as per NICE guidance.

Recommendation 2: The Management of Long Term Conditions
As recommended in NICE Guidance 57, Physical Health of People in Prison, The Trust should review the current system of the management of long term conditions, to ensure a system and process is in place in accordance with NICE chronic condition guidelines endorsed within Northern Ireland.

By the time of publication the Trust had carried out a baseline assessment of compliance and now have a process in place to monitor compliance with NICE guidelines. Compliance is high and where standards are not met there is an established action plan in place. In addition to this it should be recognised that Mr Pinkerton was not compliant with healthcare and did not engage in the management of his conditions. Had he had been more compliant I am confident that his conditions would have been able to have been managed in line with applicable NICS guidance.

5.4 The provision of care given to Mr Pinkerton by the Prison Service;

My investigator found the care provided to Mr Pinkerton by the Prison Service to be of a good standard, with no areas of concern raised. I discuss this further in Section 5.5.

5.5 The adequacy of the decision to escort Mr Pinkerton to hospital in a van;

During the 09:14 assessment of Mr Pinkerton in his cell on 22 August 2019, the nurse noted blood on tissues in the bin in the cell. As there was no GP attending on site

that day and with Mr Pinkerton's presentation, the nurse arranged for his transfer to Causeway Hospital Emergency Department for assessment for haemoptysis, chest pain and deterioration in clinical observations. This was done via the Prison Service transport (escort van) rather than by NIAS.

Documentation records that Mr Pinkerton refused to travel to the hospital by ambulance on 22 August 2019. Details of the conversation with Mr Pinkerton about this are unknown due to the fact that the assessing nurse has been unavailable for interview for the duration of my investigation.

I am of the opinion that the decision to transport Mr Pinkerton via Prison Service transport escort van was made in his best interests to get him to the hospital and the treatment he needed. However, regardless of Mr Pinkerton's history of non-compliance, the decision to transport unstable clinically unwell prisoners in a prison van deviates from expected process and creates further risk of deterioration. It would not have allowed Mr Pinkerton or the accompanying Prison Service staff access to emergency lifesaving equipment or the skill of paramedics had he arrested. For these reasons an emergency ambulance should have been called, even if Mr Pinkerton refused this.

5.6 Any learnings which may help prevent similar deaths in the future;

It is encouraging that the Local Significant Incident Review conducted by the Trust identified similar learnings and that the EWS system and primary care record keeping tool have already been implemented.

While the implementation of these recommendations would not have changed the outcome for Mr Pinkerton their implementation is important in terms of providing an appropriate standard of care as well as monitoring and documenting that care. The standardised approach should also ensure that the handover of care of unwell prisoners to secondary care services will include the early identification of sepsis, using the risk stratification tool. It is important to ensure that prisoners with long term conditions benefit from regular, structured healthcare reviews.

5.7 Any areas of good practice arising from this case.

Trust staff worked very hard to engage Mr Pinkerton in his care, and there is evidence that care was both compassionate and responsive. His capacity to consent was considered on several occasions and Trust staff managed his ulcers and recurrent cellulitis as best they could, given the approach Mr Pinkerton took. For example, his refusal to take antibiotics for cellulitis meant the infection did not clear as quickly as it could have and Trust staff went beyond what would be expected in primary care by recalling him for appointments more often than was required.

Although recognised as an exceptional event, Prison Service Staff clearly acted in Mr Pinkerton's best interests by transporting him to hospital in a Prison Service van. Mr Pinkerton's history of refusal to attend hospital created a difficulty however by securing an alternative mode of transport, Prison Service staff ensured that Mr Pinkerton was able to receive the level of hospital care he required.

Section 6: Conclusions

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

1. My investigation established the circumstances and events leading up to Mr Pinkerton's death on 23 August 2019 and I am satisfied that, overall, the Prison Service provided appropriate care for Mr Pinkerton.

2. I accept the opinion of Kate Varley RGN, the clinical reviewer, that the standard of clinical care Mr Pinkerton received by the Trust at Magilligan Prison to be of mixed equivalence, whereby equivalence does not mean that care provision in secure environments should be 'the same as that provided in the community, but should be of at 'least equivalent' and consider the constraints of a custodial environment. I am content that his care was satisfactory to Mr Pinkerton's needs.

3. I make two recommendations as a result of the investigation into the circumstances surrounding the death of Mr Pinkerton. I commend the Trust for making progress with both recommendations in advance of the publication of this report.

4. 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.