The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR T

AGED 64
WHILE IN THE CUSTODY OF MAGILLIGAN PRISON ON
30 NOVEMBER 2018

Date finalised: 15 October 2024

Date published: 21 October 2024

The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland (the Ombudsman) 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 custody and incidents of serious self-harm.

The purpose of the 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 people in custody.

The Ombudsman's investigation has an important role in the Coroner's inquest at which cause of death is established. Together with other independent investigations, the Ombudsman's investigation provides information to assist the Coroner to reach a conclusion regarding the cause of death. It is not for the Ombudsman to draw a conclusion as to cause of death but rather to consider what happened and identify any administrative shortcomings, errors and good practice. Standards applied to all investigations safeguard the Ombudsman's independent investigations. At times, the Ombudsman will co-operate with other parties where such co-operation will inform an investigation.

The remit for Ombudsman investigations is set out in the Terms of Reference included at Appendix 1. From these Terms of Reference each death in custody investigation sets out objectives that define the scope of the investigation into that particular death. These objectives will include queries and concerns raised by the family of the deceased. Section 3.4 sets out the objectives for this investigation.

Reports are published on the Prisoner Ombudsman's website, following consultation with the Coroner, so that learning from investigations is shared as widely as possible and in the interests of transparency.

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Glossary

A&E	Accident and Emergency
BP	Blood pressure
CCTV	Closed Circuit Television
CJI	Criminal Justice Inspection Northern Ireland
CRP	C-Reactive Protein
ECG	Electrocardiogram
ECR	Electronic Care Record
EMIS	Egton Medical Information System
GTN	Glyceryl Trinitrate Spray
HDL	High-density lipoprotein
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
Prison Service	Northern Ireland Prison Service
RACP	Rapid Access Chest Pain
SPAR	Supporting People at Risk
Trust	South Eastern Health and Social Care Trust
UTR	Unaccompanied Temporary Release

Foreword from the Interim Prisoner Ombudsman

Introduction

This report was at an advanced stage before the former Prisoner Ombudsman, Dr Lesley Carroll, left office in February 2024.

The death of a loved one is always difficult. When that happens in prison, it is particularly challenging for families who rely on 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.

The findings in this report, together with the learning identified, will address and inform those who provide care for people in custody. Where appropriate, I have made recommendations to the Prison Service and the Trust and both organisations have accepted them.

While improvements in the provision of care for people in custody is important to ensure confidence, this report is written with Mr T's family primarily in mind. It is critical that, as far as it can, this report provides explanations and insight to bereaved relatives.

I am very conscious of the length of time it has taken to complete the investigation and this report. I appreciate the patience and continued engagement of Mr T's family and am grateful to them for their contribution to this investigation.

I am also mindful that long delays are not helpful to the Prison Service or Trust in considering the lessons learned and timely opportunities to implement accepted recommendations.

I have aimed to establish the circumstances surrounding Mr T's death and included as much detail as possible. I hope the information provided will be helpful to the family as they piece together the last events in Mr T's life. I have made three recommendations focused on learning to improve the care of all those in custody in light of what happened to Mr T.

Mr T was committed to Maghaberry Prison 2 October 2013. He transferred to Magilligan Prison on 4 May 2016. On 23 July 2016, he was accommodated in H2 Landings A and B where he remained until he was transferred to the Altnagelvin Hospital on Friday 30 November 2018 where he sadly died later that same day.

Mr T was the subject of a Supporting People at Risk (SPAR) policy from 2 to 11 October 2013. This was the only time he received support in this way. Prison Service

records note Mr T was a smoker and had a history of mental illness and self-harm.

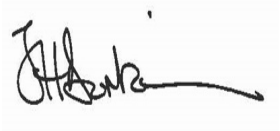
Mr T engaged with the Magilligan Prison regime, participated in educational programmes and was employed as an Orderly. He benefitted from enhanced privileges, as set out in the Progressive Regimes and Earned Privileges Scheme, and he enjoyed painting and decorating.

Mr T spoke to Prisoner Ombudsman's Office Investigators on Wednesday 24 October 2018 in relation to the death of another individual in custody whom he considered a good friend. Mr T spoke fondly about his friend and warmly described their friendship and the painting and decorating they worked on together. In memory of his friend, Mr T wanted to complete the painting work he had started with him.

Mr T's healthcare records confirm that on 23 November 2018, a week before his death, Mr T had chest pains and shortness of breath. This was the first reported instance of a heart complaint. These records also detail the Healthcare in Prison (HiP) response to how Mr T was presenting at that time. Nurses reviewed Mr T on 30 November 2018 after which they referred him to the Accident and Emergency (A&E) Department of Altnagelvin Hospital for assessment. Before he was transferred to A&E his health suddenly deteriorated and an emergency ambulance called to take him to hospital. He was medically examined on arrival at A&E at 12:34 and was taken straight to surgery. Staff in A&E worked with Mr T however, he unfortunately died shortly after surgery at 13:46 on Friday 30 November 2018.

I have no recommendations to make to the Prison Service regarding Mr T's care while in Magilligan Prison. Following a review of Mr T's clinical records, I have made three recommendations to the Trust to improve care in the future.

I offer my sincere condolences to Mr T's family on their sad loss. I hope this report provides the T family with information and explains the events leading up to his death. I also hope the learning, expressed in recommendations, will bring some comfort and confidence to those who have family members in custody.



JACQUI DURKIN
INTERIM PRISONER OMBUDSMAN

Section 1: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

In considering investigation findings, recommendations made by Doctors Rees and Dymond, Clinical Reviewers, and discussions at factual accuracy check stage, I have made the following recommendations to the Trust:

Recommendation 1: Pathways for managing chest pain

The Trust (HiP Service Managers) should develop pathways for the management of patient's chest pain that includes the potential prescription of anti-ischaemic medication and antiplatelet drugs by doctors.

Recommendation 2: Electrocardiograms (ECGs)

The Trust (HiP Service Managers) should ensure that staff carrying out electrocardiograms (ECGs) have access to timely interpretation from trained staff such as a doctor who is on or off site or an appropriately trained nurse.

Recommendation 3: Screening for Individuals in Custody at risk of heart disease.

The Trust (HiP Service Managers) should consider measures to encourage men in custody to regularly avail of well men checks including blood pressure measurement, smoking and diet advice and fasting lipid tests.

Section 2: Background information

2.1 Magilligan Prison

Magilligan Prison is a medium security prison. It is not a committal prison but rather houses individuals in custody who have been sentenced and transferred from either Maghaberry Prison or Hydebank Wood Secure College. The population of Magilligan Prison on the day of Mr T's death was 430. This is within the normal range for providing effective care to those in custody. The focus of care and support at Magilligan Prison is on providing the opportunity to reduce the risk of reoffending and prepare people in custody for release.

The Trust has provided Prison health care services since 2008. There is a 24-hour primary health care service and Mental Health Team on site Monday to Friday between 08:00 and 17:00. There are no in-patient beds.

2.2 Criminal Justice Inspection Northern Ireland (CJI)

The most recent inspection report of Magilligan Prison was published in February 2022 and an Independent Review of Progress against recommendations was published in February 2024. 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 individuals in custody. 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 to sustain and promote family contact;
- the introduction of a video technology scheme that allows a small number of individuals in custody to use a virtual platform to support their children with their homework;
- integrated social care packages for individuals in custody who have severe needs; and
- excellent rehabilitative opportunities for individuals to serve the final period of their sentence while living and working in the community.

The Chief Inspectors noted two key areas of concern:

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

and made a further 30 recommendations for improvement.

2.3 Independent Monitoring Board (IMB)

Magilligan Prison has an IMB whose role is to monitor the care and treatment of individuals in custody, facilities available to them for purposeful activity and the cleanliness and adequacy of prison premises.

In their 2020/21 Annual Report the IMB was satisfied patient health care needs continued to be met despite the difficulties and complexities healthcare staff dealt with during the COVID-19 pandemic (pandemic).

2.4 Previous incidents at Magilligan Prison

Mr T's death was one of two deaths at Magilligan Prison during 2018. Both deaths appear to have been from natural causes. There are no significant similarities between these deaths.

PART A: INVESTIGATION AND FINDINGS

Section 3: Framework and scope for investigation

As Mr T died in hospital while in the custody of Magilligan Prison, I am required to investigate and report on the circumstances surrounding his death.

Investigators conducted this investigation in line with Terms of Reference for the Prisoner Ombudsman's investigation of deaths in custody, Appendix 1.

3.1 Contact with Mr T's family

Mr T's family have not raised any specific questions with me concerning his death. They believe the death of Mr T's friend, who was also in custody, had a significant impact on him. Mr T's family were unaware of any history of heart problems. However, they were aware he had attended hospital for medical treatment.

3.2 Investigation methodology

Prisoner Ombudsman investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. Notices of Investigation into Mr T's death were issued by the Prisoner Ombudsman's Office to relevant parties, including those in custody, the Prison Service and the IMB. The following information was gathered and analysed by the Investigating Officer:

- Prison Service records including relevant Closed-Circuit Television (CCTV) footage and radio transmissions;
- interviews with Prison Service and HiP staff; and
- HiP records.

Investigators have carefully examined all of this information and I have detailed the relevant matters underpinning my findings, in this report.

3.3 Independent Clinical Review

When appropriate, I commission an Independent Clinical Review of specific aspects of healthcare. I commission a Clinical Reviewer from an agreed list, usually to deliver a peer review of healthcare provision, and they supply a report to me with recommendations. My Office provides the Clinical Reviewer with relevant documentation and a Terms of Reference specific to each case to enable them to provide an independent, expert opinion about an individual's care in custody. A Clinical Reviewer may, for example, assess delivery of care in relation to current clinically approved guidelines, local and national and/or consider policy and practice within the relevant prison. 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. By equivalency, I do not mean care should be the same as that provided in a community setting but rather the care should be at least equivalent and take the constraints of the custodial environment into account.

Three Clinical Reviewers were engaged for the purposes of this investigation.

The former Ombudsman commissioned an Independent Clinical Review from Hilary Pinfold RMN, a registered mental health nurse since 1998 with experience of working in Mental Health Care settings including within the prison environment (Clinical Reviewer 1).

The former Ombudsman also commissioned an Independent Clinical Review from Doctor Janes Rees MB, BS, MRCGP, MA, RCGP, a registered medical practitioner who has over forty years' experience in primary care including, working in prisons since 2004 (Clinical Reviewer 2).

Additional expert opinion was sought from Doctor Duncan S Dymond, MD, FRCP, FACC, FESC, a consultant cardiologist since 1987, who has been producing medico-legal reports for 12 years (Clinical Reviewer 3).

The Clinical Reviewers each provided a report setting out their opinion on the matters they were asked to consider. I have included their opinion on relevant matters in my investigation report.

The Terms of Reference for each Clinical Review can be found at Appendix 2.

The draft report was also shared with the Northern Health and Social Care Trust given Mr T's attendance at the Causeway Hospital Emergency Department a few days before his death and the references in it to the Causeway Hospital.

3.4 Scope and remit of this investigation

The scope and remit of my investigation must meet the standards set out in Terms of Reference for Prisoner Ombudsman Northern Ireland Investigations of Deaths in Custody. These are broad objectives for every investigation and are found at Appendix 1 of this report. These overarching Terms of Reference, together with observations from the family and the views of the Clinical Reviewers inform the objectives of this investigation which are to:

1.	Establish the circumstances and events surrounding Mr T's death, including the care provided by the Prison Service.
2.	Examine any relevant healthcare issues and assess the clinical care provided by the Trust in relation to Mr T to establish if it was appropriate, timely and equivalent to the care Mr T would have expected to receive in the community, bearing in mind he was in a custodial setting.
3.	Establish if there was an opportunity to transfer Mr T to hospital at an earlier stage and, if so, whether the ultimate outcome would have been different.
4.	Establish if there were issues around communication between Trust and Prison Service staff.
5.	Assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring, as far as possible, the full facts are brought to light, any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.
6.	Identify any learning for improvement and instances of good practice.

Section 4: Chronology of events

4.1 The circumstances and events surrounding Mr T's death

This section will set out information regarding Mr T's committal into custody, the decisions taken regarding where he would live while in custody and in particular the operational decisions taken by the Prison Service when he became unwell and was transferred to hospital.

4.2 Background

Mr T was committed to Maghaberry Prison on 2 October 2013. He transferred to Magilligan Prison on 4 May 2016. On 23 July 2016, Mr T was accommodated in H2 A and B landings. He remained there until he was transferred to Altnagelvin Hospital on Friday 30 November 2018. Mr T sadly died later that day after emergency surgery.

The Investigator obtained Mr T's healthcare records from the Prison Service and the Trust. These records confirmed Mr T first reported chest pain on 23 November 2018.

4.3 Events on Friday 23 November 2018

At 09.24 on Friday 23 November 2018 Mr T attended the treatment room. He explained to Nurse A that he was experiencing episodes of shortness of breath when he exerted himself. Mr T explained this had occurred on and off in the previous few weeks and it settled down when he rested so he was still able to perform his Orderly duties and painting. Healthcare records show Mr T's general health observations were normal; he looked well and was not distressed. Mr T was advised to rest and if his symptoms persisted he was to alert HiP staff.

Later that day, at 15:40, healthcare records show Mr T arrived at the treatment room distressed and clutching his chest. He explained he had severe tightness in his chest and a shortness of breath. Nurse A completed general observations and these showed that his blood pressure (BP) was higher than recorded earlier in the morning. Nurse A was concerned by Mr T's symptoms, and spoke with the duty Doctor, Dr A. Dr A decided Mr T required an ECG[1] and he should rest until this could be performed.

[1] Electrocardiography is the process of producing an electrocardiogram (ECG), a recording of the heart's electrical activity through repeated cardiac cycles.

Dr A saw Mr T at 18:26 for his ECG. By that time, Mr T reported he was not having chest pain and he experienced tightness, not true pain, during periods of exertion. He also explained he had never collapsed and his shortness of breath was transient. Mr T advised that symptoms quickly resolved when he rested. He was adamant he never had any symptoms while he was resting or during low-level exertion, and the tightness did not stop him from performing his work. Dr A prescribed Mr T with a Glyceryl Trinitrate (GTN)[2] spray to have in his possession for when the tightness in his chest occurred. Dr A explained how to use the spray and what to do should Mr T's symptoms worsen. Mr T was advised to rest and do no further work over the weekend or until he had been seen at the clinic. Dr A reiterated the importance of not ignoring tightness in the chest that does not resolve immediately along with associated features and symptoms to look out for while he was at rest.

A healthcare record entry made at 18:47 by Nurse A records a discussion with Dr A regarding Mr T, the outcome of which was that he was to be monitored closely during the night and over the weekend. If further episodes occurred, Mr T was to attend A&E. Nurse A notes Mr T was reviewed at 16:45 and again at 18:30 when he appeared well and settled. Mr T was advised not to do any work over the weekend and to rest in bed. He was further advised if he had any further symptoms he should alert staff immediately. Mr T gave an assurance he would.

The HiP handover sheet for 23 November 2018 for Mr T stated, "Please observe tonight and over the weekend. Chest Tightness on examination Angina".

[2] Glyceryl trinitrate, or GTN, is a type of medicine called a nitrate. It is used to treat angina (chest pain). It can help stop chest pain if an angina attack has already started. It can also help to prevent them from starting.

4.4 Events on Sunday 25 November 2018

On Sunday 25 November 2018 at 21:10, Nurse B recorded Mr T had asked for paracetamol and appeared chesty and hoarse and his colour was good. Nurse B advised Mr T to alert staff immediately using his cell alarm bell if he suffered any episodes of chest tightness or pain overnight. Nurse B also advised Mr T to sleep in an upright position and to refrain from working as the paint might aggravate his chest. Nurse B scheduled Mr T for further review the following morning.

4.5 Events on Monday 26 November 2018

At 07:05 on Monday 26 November 2018, Nurse B recorded Mr T had not requested any further medical assistance overnight and he was going to be reviewed later that morning.

A healthcare record entry timed 08:55 made by Nurse A records Mr T stated he had been having chest pains on exertion over the weekend, but had relieved this by using the GTN spray. Nurse A took bloods from Mr T and recorded all his clinical observations as normal. The blood tests requested by Nurse A included Troponin[3] which indicates possible heart damage or heart attack and C-reactive protein (CRP)[4] to confirm any inflammation. Mr T said he was due for an Unaccompanied Temporary Release (UTR) on 28 November 2018 and asked what he should do. Nurse A advised Mr T to await the doctor's advice having arranged for him to see the doctor later that afternoon. Nurse A recalled at interview that unfortunately they had not been able to speak to the doctor about Mr T until the next day.

Healthcare records, entry time 09:15, confirm observations carried out by Nurse A as complete, this included checking Mr T's blood pressure, pulse rate and respiration rate. An entry timed 13:40 by Nurse C confirms blood test results were reviewed by Doctor A on the Electronic Care Record system (ECR) and advice regarding Mr T's chest pain was to be sought from the doctor.

[3] A troponin test is a blood test that can help assess heart damage. It is used along with other diagnostic tests to help evaluate the likelihood of a heart attack.

[4] C-reactive protein (CRP) is an annular (ring-shaped) pentameric protein found in blood plasma, whose circulating concentrations rise in response to inflammation. It is an acute-phase protein of hepatic origin that increases following interleukin-6 secretion by macrophages and T cells.

A healthcare record entry timed 16:23, made by Nurse D, records that they checked in with Mr T and that he appeared bright, was well and all clinical observations were normal. Mr T said he was beginning to feel better and had no shortness of breath, no chest pain or tightness in his chest. Nurse D reminded Mr T that if he did experience any of these symptoms he was to alert healthcare staff immediately.

A healthcare record entry, timed 23:25, made by Nurse E, records that during the medication round Mr T stated he had chest pain and had taken the GTN spray to relieve this pain. General observations were completed and Nurse D reminded Mr T to alert healthcare staff if there were any further episodes.

4.6 Events on Tuesday 27 November 2018

A healthcare record entry, timed 12:36, made by Nurse A, records that Mr T had been unwell the previous night with chest tightness on exertion and this settled with a GTN spray and rest. Mr T attended the Causeway Hospital after a discussion between Nurse A and Dr A.

Causeway Hospital records state Mr T attended the A&E department at 14:05 on 27 November 2018. An A&E doctor assessed and later discharged Mr T from hospital with a note to return promptly if his condition deteriorated. Mr T was referred to the Rapid Access Chest Pain (RACP) clinic.

4.7 Events on Wednesday 28 November 2018

A healthcare record entry, timed at 09:10, made by Nurse A, recorded that after attending A&E the previous day, Mr T was concerned that he was still having ongoing chest pain on exertion. He stated the hospital doctor had referred him to the RACP clinic in two weeks' time. Mr T stated that he would not go on his UTR planned for that day as he was not well enough. Nurse A requested transport to take Mr T from reception back to his accommodation in H2.

Separate healthcare record entries, timed 09:08 and 09:10, made by Nurse B record Mr T attended for his weekly medication at which he appeared flushed; however, on examination his temperature was normal. Nurse B's entry also records that Mr T was due to go out on his UTR and that he had said he was not well enough to go, as he would be on his own. Mr T had arranged to see his wife but did not want to worry her. Nurse B advised him to speak to the Senior Officer to rearrange his UTR and Mr T said he would think about it. He also advised Nurse B that he had attended the Causeway Hospital where he had an ECG test, a chest X-ray and had his bloods taken. Mr T said he had to return in two weeks' time to complete a treadmill test.

A healthcare record entry timed 11:06, made by Nurse A, records Mr T was experiencing chest pain at rest whilst in bed and that he had taken the GTN spray to relieve the pain. Mr T walked to the treatment room and notes record that he had no shortness of breath and was not perspiring at that time. Mr T was very worried about himself and mentioned this to healthcare staff. Nurse A completed clinical observations, noted them as normal, and advised Mr T that as he was now experiencing pain at rest, he should attend A&E. Mr T was not keen to attend A&E so Nurse A explained the consequences of what could happen if he refused to attend hospital. Nurse A spoke to Prison Service staff who agreed to monitor Mr T. He was to be medically reviewed again that afternoon.

A healthcare record entry, timed 12:14 made by Nurse A, records a discussion with Lead Nurse A during which they agreed a decision to repeat an ECG. The ECG result was the same as before and recorded no change. In the absence of any change and, because Mr T's pain had now resolved itself, they decided to wait and monitor him. HiP staff advised Mr T to rest, take his GTN spray as necessary and to alert staff if the pain returned.

A healthcare record entry, timed 13:20, made by Lead Nurse A, records that Mr T's ECG result was reviewed as he was still experiencing pain at rest, although GTN spray did relieve this pain. The entry further records that the ECG result was 'unremarkable', Mr T refused to attend the A&E department. Lead Nurse A had experience in cardiology and ECGs having previously worked in coronary care for 10 years. This would not be the case for most HiP nurses.

A healthcare record entry, timed 17:38, made by Nurse B, records that HiP staff reviewed Mr T and advised he was fine and was having no further episodes of chest pain and that he was aware that he needed to alert staff should this happen. Nurse B informed Mr T that he could call a nurse at any time, day or night. Mr T thanked Nurse B and gave an assurance that he would alert HiP staff if needed.

4.8 Timeline of events on the day of Mr T's death Friday 30 November 2018

Having reviewed CCTV, Prison Service documents, HiP records, Causeway and Altnagelvin Hospital records the following is a timeline of events:

Time Stamp	Notes
09:16	Nurse arrives on the landing and at 09:17 goes straight to Mr T who is sitting on a chair.
09:20	Mr T gets up from the chair and walks to the telephone.
09:21	Mr T walks from the telephone box back up the landing towards his room. The nurse leaves the landing.
09:29	Mr T comes out of his room chatting to another individual in custody. He goes through the security grille and out of sight at 09:30.
09:34	Mr T walks back onto the landing and goes back into his room.
09:38	An entry states that Nurse F was called to the landing to see Mr T as he was experiencing central chest pain. On arrival, Nurse F noted that Mr T was very pale and sweaty and was sitting on a chair. He had taken one spray of GTN, which had not relieved his pain. HiP staff advised Mr T to take another dose. His BP was down but this could have been due to the GTN spray. ECG requested whilst Mr T was experiencing chest pain. Mr T asked to make a phone call and to have a 'buddy' with him.
09:47	Mr T comes out of his room and walks down the landing with assistance. He walks through the security grille at 09:48 rubbing/holding his chest before going out of sight.
09:56	Mr T comes back onto the landing walking through the security grille and to the telephone box.
10:01	Mr T comes out of the telephone box and other individuals in custody assist in putting him into a chair.
10:02	Three nurses arrive on the landing. At 10:04, other individuals in custody help Mr T into a wheelchair and wheel him down the landing at 10:08.
10:08	An entry by Nurse F records that a hospital referral was sent.

Time Stamp	Notes
10:13	Another individual in custody pushes Mr T in a wheelchair back onto the landing to the ablutions.
10:15	An entry by Lead Nurse A records that HiP staff carried out an ECG test on Mr T whilst he was experiencing chest pain and that the result showed minimal change. Staff referred Mr T to A&E for assessment as a result.
10:49	Senior Officer A goes into the ablutions and comes out at 10:50.
10.51	Senior Officer A comes back onto the landing and into the ablutions.
10:53	A nurse goes into the ablutions and leaves at 10:54.
10:54	Emergency Ambulance requested.
10:55	Another nurse comes out of the ablutions.
10:57	Senior Officer A comes out of ablutions.
10:58	A nurse enters ablutions.
10:59	A nurse exits ablutions; Mr T is pushed in his wheelchair from ablutions through the security grille.
11:24	An entry by Nurse F records that Mr T's chest pain had worsened and that an emergency ambulance was called due to the sudden deterioration in his health. Ambulance arrives at 11:27.
12:38	Mr T arrives at A&E – Altnagelvin Hospital.
13:34	Resuscitation procedures commenced.
13:46	Life pronounced extinct by doctor.

4.9 Clinical Reviews Commissioned

The former Ombudsman commissioned three Independent Clinical Reviews regarding the level of care Mr T received.

Clinical Reviewer 1, a registered mental health nurse, completed the initial Clinical Review. Clinical Reviewer 1 expressed the view that an earlier request for an ambulance would have been better. However, she could not reach a definitive opinion on this or whether doing so would have changed the outcome for Mr T. She considered it would have been both comforting and safe for all involved had a member of HiP staff remained with Mr T. Clinical Reviewer 1 confirmed the care Mr T received was of equitable standard to that he would have received had he remained in the community. She also stated Mr T received a full range of primary care interventions, which were both timely and appropriate. However, Clinical Reviewer 1 highlighted the disappointing standard of communication between HiP and Prison Service staff.

As Clinical Reviewer 1 was unable to give a definitive opinion on whether an earlier request for the ambulance would have changed the outcome, the former Ombudsman commissioned a second opinion from independent Clinical Reviewer 2 who is a registered medical practitioner. She asked Clinical Reviewer 2 to address this issue and to comment generally on the standard of care Mr T received.

In Clinical Reviewer 2's opinion an ambulance should have been called at 0900/0930 on 30 November 2018 when Mr T was observed having chest pain. Clinical Reviewer 2 was unable to comment if this delay contributed to Mr T's death. In her opinion, it would have been preferable for Mr T to attend hospital on 28 November 2018 when advised to do so. Although there was no indication Mr T was suffering from a heart attack on that particular day. Clinical Reviewer 2 believes that had he attended hospital on 28 November 2018 Mr T could have received a coronary angiograph[5], which may have helped to prevent his heart attack on the 30 November 2018.

Clinical Reviewer 2 also states in her report that blood tests completed on 26 November 2018 showed that Mr T had moderately raised cholesterol. This test showed an abnormal ratio of cholesterol to HDL cholesterol[6]. Mr T was a long-term smoker and as such, his risk of heart attack or stroke was raised. There is

[5] Coronary angiogram. An angiogram (also known as a cardiac catheterisation) is a special type of x-ray, which uses contrast dye to allow your doctor to look at your coronary arteries (the blood vessels that supply your heart). The dye lets your doctor see how well the blood is flowing and shows up any narrowing

[6] HDL (high-density lipoprotein), or "good" cholesterol, absorbs cholesterol and carries it back to the liver. The liver then flushes it from the body. High levels of HDL cholesterol can lower your risk for heart disease and stroke

nothing in his records to show that a Q-risk assessment[7], which would have shown the percentage risk of him having a heart attack, was completed.

Based on Clinical Reviewer 2's comments the former Ombudsman decided that a Consultant Cardiologist's opinion was required and commissioned an independent Consultant Cardiologist, Clinical Reviewer 3. He reviewed the clinical care and medical records in this case. Clinical Reviewer 3 provided expert cardiological opinion in relation to Mr T's treatment. This also included commenting on the delay in requesting an ambulance.

In Clinical Reviewer 3's opinion, the medical entries made on 23 November 2018 are all consistent with a classical history of angina and of effort relieved by rest. Both staff and Dr A were quick to make this diagnosis. Mr T received a GTN spray, which was correct. Clinical Reviewer 3 considers that Mr T should have additionally been given some anti-platelet medication in the form of Aspirin, if he could tolerate it, and if not, Clopidogrel as well as some form of Beta-Blocker.

Clinical Reviewer 3 made the following recommendation, which I endorse:

Recommendation 1: Pathways for managing chest pain

The Trust (HiP Service Managers) should develop pathways for the management of patient's chest pain that includes the potential prescription of anti-ischaemic medication and antiplatelet drugs by doctors.

Clinical Reviewer 3 also notes that on 23 November 2018 Mr T's ECG was normal. Between the 23 and 27 November 2018, Mr T's symptoms changed from "chest tightness during heavy periods of exertion" to "chest tightness on any exertion". Clinical Reviewer 3 agrees that Clinical Reviewer 2 was quite right in her opinion that at the time a rapid change in the symptoms from heavy exertion to any exertion is one of the definitions of unstable angina or crescendo angina. At this stage it was quite correct to send Mr T to A&E on 27 November 2018. Clinical Reviewer 3 agreed it was perfectly appropriate to transport Mr T to an A&E Department however, it would have been up to the A&E Department (not the Ambulance Service) to direct Mr T's healthcare from that point onwards.

On 27 November 2018, Mr T was treated in the A&E Department of Causeway Hospital and returned to Magilligan Prison. Clinical Reviewer 3 raised concerns on the standard of care Mr T received at the Causeway Hospital in relation to there not being a prescription made for any anti-ischaemic medication, no record of

[7] A Q-Risk assessment is a prediction algorithm for cardiovascular disease

any ECG and no referral to a cardiologist. Clinical Reviewer 3 believes that had the hospital followed proper procedures, Mr T could have received an angiograph before 30 November 2018. It was inappropriate for the Causeway Hospital to recommend a RACP Clinic follow up given the change in Mr T's symptoms. In Clinical Reviewer 3's opinion, Mr T should have remained in hospital. He considers that the Causeway Hospital doctors missed an early opportunity to prevent Mr T's death.

The Northern Health and Social Care Trust have advised me that on 27 November 2018 a junior locum doctor would have been working independently managing Mr T's case. If Mr T presented now, middle grade doctors would be treating him who had access to a consultant. Also, a reminder has been issued to Emergency Department medical staff regarding the importance of clear documentation and that a history alone suggestive of unstable angina should warrant urgent investigation and admission.

On 28 November 2018 at approximately 11:00, Mr T experienced chest pain at rest. Clinical Reviewer 3 states that Nurse A quite correctly wanted to refer Mr T back to A&E. However, Mr T did not want to go in an ambulance. Clinical Reviewer 3 also observed that the ECG performed on Mr T and labelled as "unremarkable" showed subtle changes. Clinical Reviewer 3 stated that he was looking at this case from his perspective as a consultant cardiologist and acknowledged that this was from a different level of expertise than that of HiP staff. However, Clinical Reviewer 3 would have expected a doctor to compare the later trace with the ECG from 23 November 2018 and to notice the subtle changes present. It does not appear the ECG completed on 28 November 2018 had been looked at by the doctor. Had Mr T gone back to hospital at this stage he most likely would have undergone an angiograph on 28 or 29 November 2018.

Clinical Reviewer 3's report has informed the following recommendation:

Recommendation 2: Electrocardiograms (ECGs)

The Trust (HiP Service Managers) should ensure that staff carrying out ECGs have access to timely interpretation from trained staff such as a doctor who is on or off site or an appropriately trained nurse.

Clinical Reviewer 3 considers that it would have been better to call the ambulance when Mr T experienced chest pain on 30 November 2018 at approximately, 09:00/09:30. However, it was unlikely that calling the ambulance earlier, instead of at 11:00, would have made a significant difference because at that time Mr T was

already verging on cardiogenic shock[8]. Clinical Reviewer 3 was also of the opinion that is was a mistake to attribute Mr T's low blood pressure reading on 30 November 2018 to the GTN spray. His view was that the low blood pressure was due to destruction of the heart muscle.

Overall, Clinical Reviewer 3's opinion of the primary care Mr T received was good. Clinical Reviewer 3 is satisfied that this care would have been equivalent to that he would have received in the community taking into consideration that Mr T was in a custodial setting.

[8] Cardiogenic shock is a life-threatening condition in which your heart suddenly cannot pump enough blood to meet your body's needs. The condition is most often caused by a severe heart attack, but not everyone who has a heart attack has cardiogenic shock. Cardiogenic shock is rare.

PART B: LEARNING AND GOOD PRACTICE

Section 5: Learning for Improvement and Good Practice

One of the purposes of my investigation is ensuring learning from past experience improves practice in the future. During the course of an investigation, a considerable amount of information is collated from a variety of sources. This includes written documentation, CCTV, interviews, landing journals, inmate notes and healthcare records. It is also important that good practice is noted to ensure it continues into the future. Where practice has not been all that it could have been, improvements can be applied. A number of important learnings have been identified during the course of this investigation into Mr T's death. Such learning should enhance the care provided to those in custody.

I have made recommendations informed by the Clinical Review reports. From my investigations, I believe that improvement can be achieved in the area of care following episodes of unstable angina or episodes or recurring chest pain. I draw this conclusion from matters set out in Part A.

The following learning points have been identified during the course of my investigation into Mr T's death. The Trust should introduce a policy or expand existing policy and provide a pathway, following patients reporting chest pain. This should provide HiP staff with guidance on the processes to follow concerning chest pain and potential cardiac pain and any changes in the nature, frequency and precipitating factors for such pain. The Trust should also consider the provision of opportunistic screening to those at risk of heart disease in light of my findings. I therefore recommend:

Recommendation 3: Screening for Individuals in custody at risk of heart disease.

The Trust (HiP Service Managers) should consider measures to encourage men in custody to regularly avail of well men checks including blood pressure measurement, smoking and diet advice and fasting lipid tests.

Section 6: Conclusions

With regard to my responsibilities to investigate Mr T's death and specifically considering the objectives of my investigation, I draw the following conclusions:

1.	**Establish the circumstances and events surrounding Mr T's death, including the care provided by the Prison Service.**
	My investigation established the circumstances and events leading up to Mr T's death on 30 November 2018 as outlined in Section 4 of this report. I am satisfied that the Prison Service provided appropriate care to Mr T.
2.	**Examine any relevant healthcare issues and assess the clinical care provided by the Trust in relation to Mr T to establish if it was appropriate, timely and equivalent to the care Mr T would have expected to receive in the community, bearing in mind he was in a custodial setting.**
	I agree with the opinions of all three Clinical Reviewers regarding the standard of care Mr T received while in the custody of Magilligan Prison and that this was of equivalence to that he would have experienced in the community.

3.	**Establish if there was an opportunity to transfer Mr T to hospital at an earlier stage and, if so, whether the ultimate outcome would have been different.**
	It would appear that there was an earlier opportunity to transfer Mr T to hospital on 30 November 2018. However, I am content that Clinical Reviewer 3 has addressed this issue and I agree with his opinion that the delay in calling an ambulance would not have affected on the outcome.
4.	**Establish if there were issues around communication between Trust and Prison Service Staff.**
	Clinical Reviewer 1's overall opinion is that Mr T's case did show several examples of inadequate communication between HiP and Prison Service staff. This is an ongoing issue between the Trust and the Prison Service. It would be beneficial if more information was shared between both parties concerning the medical conditions of individuals in custody, as this knowledge would assist prison staff who are responsible for managing those individuals on a daily basis. I acknowledge that a solution to this will be difficult due to the legislative requirement that an Information Sharing Agreement must be in place. I welcome the finalisation of an Information Sharing Agreement and await its early implementation. I agree with the Clinical Reviewer's assessment and I will keep this recurring issue under review.

5.	**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, any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.**
	This report provides a detailed analysis of the circumstances surrounding Mr T's death and a copy of this investigation report, along with all supporting documentation, will be shared with the Coroner.
6.	**Identify any learning for improvement and instances of good practice.**
	Part B sets out learning for improvement found and several instances of good practice identified during my investigation.

My Office will fulfil this duty by making full disclosure of materials to the Coroner.

Appendix 1: Terms of Reference for Prisoner Ombudsman investigations into Deaths in Custody

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:
   - Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently.

     However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.
2. The Ombudsman will act on notification of a death from the Prison Service.
   - The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.
3. The aims of the Ombudsman's investigation will be to:
   - Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
   - Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
   - In conjunction with the (DHSS & PS) replaced with South Eastern Health and Social Care Trust as the healthcare provider in prisons, where appropriate, examine relevant health issues and assess clinical care.
   - Provide explanations and insight for the bereaved relatives.
   - Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising 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 action or practice is identified, and any lessons from the death are learned.

4. Within this framework, the Ombudsman will set Terms of Reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph one where a common factor is suggested.

Appendix 2: Terms of Reference for Clinical Reviewers regarding the healthcare in the case of Mr T

- Mental Health Nurse Hilary Pinfold. To review the medical and healthcare records of Mr T and produce a report giving your expert clinical opinion.
  In doing so, I would be grateful if you could advise on the following:

- In light of the ongoing chest pain that Mr T had been experiencing, his recent transfer to hospital and the advice given by the hospital that he should return promptly if his condition deteriorates, should Mr T have been transferred to hospital immediately on his first complaint of chest pain at 9.16am on the morning of the 30 November 2018? This was the first occasion that Mr T's GTN spray did not provide any relief to his chest pain.

- Mr T received assistance from healthcare staff and Prison Service staff on three occasions during the morning of the 30 November 2018: at 09.16, 10.01 and 10.53. It is apparent from analysis of the CCTV that in the interim periods between these three occasions, significant time elapsed during which Mr T did not have any contact with healthcare staff or Prison Service staff and therefore only had support from other prisoners. In the context of how Mr T presented on the morning of the 30 November 2018 and the fact that he had recently been experiencing ongoing chest pain. Do you think that it was acceptable Mr T was left alone without support or assistance from healthcare and Prison Service staff during these interim periods on the morning of 30 November 2018?

- Your view on the fact that it has come to our attention that EMIS records can be amended retrospectively by Super-Users. It is recorded under the 26 November in Mr T's EMIS records that patient is deceased. However, Mr T did not die until 30 November. It is therefore now apparent that not all entries can be relied upon as contemporaneous records of the treatment received by a patient.

- Doctor Jane Rees. To review the medical and healthcare records of Mr T and produce a report giving your expert clinical opinion.
  In doing so, I would be grateful if you could advise on the following:

- In light of the ongoing chest pain that Mr T had been experiencing, his recent transfer to hospital and the advice given by the hospital that he should return promptly if his condition deteriorates, should Mr T have been transferred to hospital immediately on his first complaint of chest pain at 9.16am on the morning of the 30 November 2018?

- If Mr T had been taken to hospital earlier, is it likely that the outcome could have been different?

- Doctor Duncan Dymond. To review the medical and healthcare records of Mr T and produce a report giving your expert clinical opinion.
  In doing so, I would be grateful if you could advise on the following:

- Does GTN spray lower blood pressure and based on how he presented at 09:16 would this alter the perception that he showed signs of a heart attack?

- In light of the ongoing chest pain that Mr T had been experiencing, his recent transfer to hospital and the advice given by the hospital that he should return promptly if his condition deteriorates, should Mr T have been transferred to hospital immediately on his first complaint of chest pain at 09:16 on the morning of the 30 November 2018?

- If Mr T had been taken to hospital earlier than he was on the morning of 30 November 2018, is it likely that the outcome could have been different?

Appendix 3: Timeline of Events

Friday 23 November 2018	
09:24	In the treatment room Mr T explained he had a shortness of breath when he exerted himself, this occurred on and off over the past few weeks. Mr T was advised to rest and if his symptoms persisted, he was to alert staff.
15:40	Mr T attended the treatment room clutching his chest; he had severe tightness in his chest and had a shortness of breath. Nurse A was concerned and spoke with the duty Doctor, Dr A. Dr A decided Mr T required an ECG and he should rest until this could be performed.
18:26	Mr T was seen by Dr A for his ECG he advised he had no true pain, had not collapsed and his shortness of breath was very transient. Mr T was adamant that he never had any symptoms at rest or during low-level exertion, and the tightness is not stopping him from performing his work. Mr T was given a GTN [9]spray. He was advised to rest and do no further work over the weekend. Dr A reiterated the importance of not ignoring tightness in the chest and symptoms to look out for at rest.
18:47	Nurse A records a discussion with Dr A regarding Mr T. Mr T was to be monitored closely during the night and over the weekend. If Mr T had any further episodes, he was to attend A&E. Nurse A notes Mr T was reviewed at 16:45 and again at 18:30.
20:00	The Trust handover sheet for 23 November 2018 stated, "Please observe tonight and over the weekend. Chest Tightness on examination Angina".

[9] Glyceryl trinitrate, or GTN, is a type of medicine called a nitrate. It is used to treat angina (chest pain). It can help stop chest pain if an angina attack has already started. It can also help to prevent them from starting.

Sunday 25 November 2018	
21:10	Mr T asked for paracetamol, as he appeared chesty and hoarse. His colour was good, but he was advised that if he had any episodes of chest tightness or pain overnight to alert staff immediately. Mr T was advised to sleep in an upright position and to refrain from working.
Monday 26 November 2018	
07:05	Nurse B records no further call outs in respect of Mr T and he was to be reviewed again that morning.
08:55	Nurse A records Mr T had chest pains over the weekend, but had relieved this by using the GTN spray. All his clinical observations were recorded as normal. Further tests were requested to include Troponin[10] CRP[11]. He was to see the doctor later that afternoon. However, Nurse A recalled at interview they had not been able to speak to the doctor but did talk to a doctor the next day.
13:40	Nurse A recorded Mr T's blood pressure, pulse rate and respiration rate. Healthcare entries recorded blood test results, reviewed by a Dr A. A further healthcare entry timed 13:40 by Nurse C records the results of the blood tests having been reviewed via the ECR. Doctor to be asked for advice regarding Mr T's chest pain.
16:23	Nurse D records a check in with Mr T he appeared bright and well and all clinical observations were normal. Mr T said he was beginning to feel better and had no shortness of breath, no chest pain, or tightness in his chest. Mr T was reminded that if he did experience any of these symptoms he was to alert staff immediately.
23:25	Nurse E records that during the medication round Mr T stated he had chest pain and had taken the GTN spray to relieve the pain. General observations were completed and Mr T was advised to alert staff if there were any further episodes.

[10] A troponin test is a blood test that can help assess heart damage. It is used along with other diagnostic tests to help evaluate the likelihood of a heart attack.
[11] C-reactive protein (CRP) is an annular (ring-shaped) pentameric protein found in blood plasma, whose circulating concentrations rise in response to inflammation. It is an acute-phase protein of hepatic origin that increases following interleukin-6 secretion by macrophages and T cells.

Tuesday 27 November 2018	
12:36	Nurse A records that Mr T had been unwell the previous night with chest tightness on any exertion, this settled with a GTN spray and rest. Nurse A discussed this with Dr A and Mr T attended the Causeway Hospital.
14:05	Mr T attended the A&E department at the Causeway Hospital on 27 November 2018 at 14:05, having been referred by HiP. He was discharged with a note to return promptly if his condition deteriorated. It was noted that Mr T had been referred to the RACP clinic
Wednesday 28 November 2018	
09:10	Nurse A recorded that after attending A&E, the previous day, Mr T was concerned that he was still having ongoing chest pain on exertion. Mr T agreed that he would not go on his UTR planned for that day as he was not well enough and transport was requested to take Mr T from reception back to his accommodation in H2.
09:10	Nurse B recorded Mr T appeared flushed, however, on examination his temperature was recorded as normal. He said he was not well enough to go on his UTR, as he would be on his own. Mr T said he had arranged to see his wife and he did not want to worry her. He told Nurse B that he had attended the Causeway Hospital and had an ECG test, a chest X-ray, had his bloods taken and that he had to return in two weeks to complete a treadmill test.
11:06	Mr T was experiencing chest pain at rest while in bed and GTN spray taken. Mr T walked to the treatment room he had no shortness of breath and was not perspiring. However, it was noted that Mr T was very worried about himself. Mr T advised that as he was now experiencing pain at rest, he should attend A&E. However, Mr T was not keen. The consequences were explained to Mr T of what could happen if he refused to attend hospital. Nurse A spoke to Prison Staff who agreed to monitor Mr T. He was to be reviewed again in the afternoon.
12:14	Nurse A records a discussion with Lead Nurse A in which they made a decision to repeat an ECG. The ECG result was the same as before and recorded no change. Because the ECG did not show any change and as his pain had now resolved itself, HiP staff.

	monitored Mr T instead. Mr T was to rest and take his GTN spray and to alert staff if the pain returned.
13:20	Lead Nurse A records ECG reviewed as Mr T was experiencing pain at rest but the GTN spray relieved this. The ECG result as 'unremarkable' and Mr T refused to attend the A&E Department.
17:38	Nurse B records Mr T advised he was fine and was having no further episodes of chest pain. Mr T was aware that he needed to alert staff if he experienced any further pain. Nurse B informed Mr T that he could call a nurse at any time day or night. Mr T assured them he would alert staff if needed.
Friday 30 November 2018	
09:16	Nurse arrives on the landing and at 09:17 goes straight to Mr T who is sitting on a chair.
09:20	Mr T gets up from the chair and walks to the telephone.
09:21	Mr T walks from the telephone box back up the landing towards his room. The nurse leaves the landing.
09:29	Mr T comes out of his room chatting to another individual in custody. He goes through the security grille and out of sight at 09:30.
09:34	Mr T walks back onto the landing and goes back into his room.
09:38	Healthcare records show Nurse F went to the landing to see Mr T as he was experiencing central chest pain. On arrival, Nurse F noted that Mr T was very pale and sweaty and was sitting on a chair. He had taken one spray of GTN, which did not relieved the pain and advised by the nurse to take another. ECG requested whilst Mr T was experiencing chest pain.
09:47	Mr T comes out of his room and walks down the landing with assistance. He walks through the security grille at 09:48 rubbing/holding his chest before going out of sight.
09:56	Mr T comes back onto the landing walking through the security grille and to the telephone box.
10:01	Mr T comes out of the telephone box and other individuals in custody assist in putting him into a chair.

10:02	Three nurses arrive on the landing. At 10:04, other individuals in custody help Mr T into a wheelchair after which they wheel him down the landing at 10:08.
10:08	An entry by Nurse F records that a Hospital referral was sent.
10:13	Another individual in custody pushes Mr T in a wheelchair back onto the landing to the ablutions.
10:15	An entry by Lead Nurse A records that HiP staff carried out an ECG test on Mr T whilst he was experiencing chest pain and that the result showed minimal change. Staff referred Mr T to A&E for assessment as a result.
10:49	Senior Officer A goes into the ablutions and comes out at 10:50.
10.51	Senior Officer A comes back onto the landing and into the ablutions.
10:53	A nurse goes into the ablutions and leaves at 10:54.
10:54	Emergency Ambulance requested.
10:59	A nurse exits ablutions, Mr T is pushed in his wheelchair from ablutions through the security grille.
11:24	Nurse F records that chest pain had worsened and emergency ambulance called due to sudden deterioration. Ambulance arrived at 11:27.
12:38	Mr T arrives at A&E – Altnagelvin Hospital.
13:34	Resuscitation procedures commenced.
13:46	Life pronounced extinct by a doctor.