The Prisoner Ombudsman for Northern Ireland

OFFICIAL SENSITIVE

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

JASON WEIR

AGED 33 AT MAGILLIGAN PRISON ON 9 FEBRUARY 2021

Date finalised: 28 November 2024

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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 (NIPS) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate. By highlighting learning to NIPS, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

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. Independence is critical and while the Ombudsman will co-operate and when appropriate collaborate with other parties, such as the Police Service of Northern Ireland (PSNI), the investigation's process is safeguarded to ensure independence.

The remit for Ombudsman investigations is set out in the Terms of Reference included at Appendix 1. Each death in custody draws on this remit to decide objectives that define the scope of the investigation into that particular death. These objectives identify specific matters for investigation, the circumstances of the individual case and include queries and concerns raised by the family of the deceased. In this case, the objectives for the investigation can be found in Section 3.

To spread learning from investigations as widely as possible, and in the interests of transparency, investigation reports are published on the Ombudsman's website following consultation with the Coroner.

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Glossary

AED	Automated Electronic Device
CCTV	Closed-Circuit Television
CJI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
DNA	Deoxyribonucleic acid
DoJ	Department of Justice
ECHR	European Convention on Human Rights
ED	Emergency Department
EEG	Electroencephalograph
EMIS	Egton Medical Information System
GP	General Practitioner
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
IP	In-Possession
MSST	Magilligan Safety and Support Team
MRI	Magnetic Resonance Imaging
MHT	Mental Health Team
MDT	Mandatory Drug Test
NIPS	Northern Ireland Prison Service
NPM	National Preventive Mechanism
PCNI	Parole Commissioner for Northern
PDU	Ireland Prisoner Development Unit
PHA	Public Health Agency
PSNI	Police Service of Northern Ireland

RISE	Regime Indexed Supervision Easement
RQIA	Regulation and Quality Improvement Authority
SPAR Evo	Supporting People At Risk Evolution (procedure)
The Trust	South Eastern Health and Social Care Trust
UTR	Unaccompanied Temporary Release
VGKC	Voltage-Gated Potassium Channel

Foreword from the Prisoner Ombudsman

The death of a loved one is always difficult. When their death occurs in prison it is particularly challenging given the loss families experience when their family member is taken into custody and their reliance on NIPS, the Trust and others to ensure the safety and wellbeing of their loved one.

All those in custody should have their Convention Rights protected and experience care and treatment in compliance with the Mandela Rules. I believe families need to have confidence their loved one is safe, being treated in a dignified way and having their health care needs met while in custody.

The findings made in this report, together with learning identified, will address and inform those who provide care for prisoners. Where appropriate, I have made recommendations directly to NIPS and the Trust. Both organisations provide the Prisoner Ombudsman's Office with a response indicating if they accept my recommendations and what steps they are going to take, or have taken, to address them.

The Trust has advised me they do not accept Recommendation 1 and believe the care Mr Weir received was at least equivalent to that which he would have received in the community. I have commented on the care Mr Weir received by the Trust, however, I remain of the view, that as a vulnerable person in detention with the health issues he had, it was not unreasonable to expect that his referral to a neurology consultant was followed up sooner notwithstanding the well-known pressures on waiting lists for access to secondary care.

I am sorry for the delay in publishing this report and I appreciate the Weir family's patience and their contribution to this investigation.

I have provided as much detail as possible and hope the comprehensive information contained in this report will be helpful to the family as they piece together the events in Mr Weir's life. The previous substantive Ombudsman commissioned a Clinical Reviewer to consider the healthcare Mr Weir received. The outcome of that Clinical Review is contained within the body of this report and makes three recommendations focused on learning to improve the care of all prisoners in light of what happened to Mr Weir.

Mr Weir was 33 years old and a life sentenced prisoner, he had been in custody for nine years. His life tariff[1] expired on 18 January 2020. His brother who was also a sentenced prisoner (unfortunately now also deceased), had been released four months before Jason died.

[1] Life tariff is when someone is given a life sentence, they will be subject to that sentence for the rest of their life. When a judge passes a life sentence, they must specify the minimum term a prisoner must spend in prison before becoming eligible to apply for parole (sometimes called the tariff).

Mr Weir and his brother spent their time in prison largely together. For a period they were accommodated together segregated from the main Maghaberry Prison population due to concerns for their personal safety. Mr Weir had regular contact with his family while in custody. After a hiatus between 2013 and 2019 Mr Weir re-established a relationship with his father and had regular visits.

Mr Weir maintained telephone contact with his mother and brother while he was in prison. During telephone calls Mr Weir appeared pre-occupied and would often talk in detail about his perceived reality.

Mr Weir was moved from Magilligan Prison to the Moyola Unit[2], Maghaberry Prison in August 2019 due to his poor mental health. He was awaiting a Transfer Direction Order to Shannon Clinic Knockbracken Health Care. Mr Weir was seen regularly by Psychiatrist, Doctor A and appeared to improve with a strict supervised medication regime. Mr Weir was transferred to Magilligan Prison in January 2020 and was discharged from Healthcare in Prison (HiP) Mental Health Team (MHT) on 22 October 2020.

On 30 October 2020 Mr Weir submitted a request to NIPS in which he referred to himself as the son of God. As a consequence Mr Weir was assessed by a psychiatrist and recommenced medication. The MHT including the psychiatrist continued to see him during his custodial detention.

Mr Weir's custodial drug tests all came back clear and he was on a waiting list to see a neurologist due to a suspected organic cause of his psychosis. On 4 February 2021 Mr Weir was informed by NIPS that a close relative had died. NIPS provided him with additional support in the form of the MHT and Prisoner Safety and Support Team (PSST). He appeared not to be very upset by this news but was observed during a virtual visit talking as if the family member was still alive.

Mr Weir worked full time while in custody, however in the months prior to his death he was noted to be somewhat withdrawn and was advised not to operate prison machinery due to the medication he was taking. From enquiries Mr Weir appears to have a good working relationship with the NIPS Trades Instructor.

Mr Weir was referred for a hospital neurologist consultation in December 2019. Despite a request in November 2020 to expedite the referral and a letter of response from a Consultant Neurologist in December 2020 stating the referral would be treated as urgent, Mr Weir was not seen by a neurologist before his death.

[2] The Moyola Unit predominately accommodates older prisoners and those with complex health care needs.

Mr. Weir was involved in proceedings with the Parole Commissioners for Northern Ireland (PCNI). On 24 November 2020, the PCNI issued a Direction[3] requiring a full psychiatric assessment of Mr Weir. Subsequently, an additional Direction was issued and a further hearing postponed. On 26 January 2021, with the agreement of his legal representatives, the previous two Directions were amended, setting a new deadline of 9 March 2021 for the completion of the required assessment.

Prison Records and Information System Management records show that an Officer checked in with Mr Weir on 4 February 2021 after learning that a close family member had passed away. The records note Mr Weir said he felt fine and had no thoughts of suicide or self-harm at present. The records further note a member of the MHT spoke to Mr Weir that day and she had no concerns about him at that time.

On Tuesday 9 February 2021 at 07:22 Mr Weir was found unresponsive on H1 A Wing at Magilligan Prison. Despite attempts, he could not be resuscitated and his life was recognised as extinct at 08:15.

I offer my sincere condolences to Mr Weir's family on their sad and painful loss. I hope this report provides information to address some of the questions they raised and explains the events leading up to Jason's death. I hope the learning and recommendations in this report will bring some comfort and confidence to those who have family members in custody.

DARRIN JONES
Prisoner Ombudsman for Northern Ireland
25 November 2024

[3] A Direction from Parole Commissioners is the final decision made by the Commissioners regarding a prisoner's release. It is issued if the risk of harm the prisoner would pose if released is minimal.

Section 1: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

Recommendation 1: Early psychiatric and neurology referral and follow-up

In complex cases involving physical and mental health issues and possible organic causes for psychosis, the Trust should consider the early involvement of a Consultant Psychiatrist and early referral to neurology with prompt follow-up**.**

Recommendation 2: Risk assessment

The Trust should ensure there is clarity between psychiatry and primary health care teams about patient risk assessments and 'in possession' and observed medication administration; and consider amending the HiP medication self-administration risk form to include the option of direct administration of medication where a clinician has serious concerns about the patients' mental health. If a patient is non-compliant or possibly misusing medication, a risk assessment should be completed with consideration of observed medication administration.

Recommendation 3: Parole Commissioners Directions for assessment

The Department of Justice, NIPS and HiP should work together to ensure assessments directed by PCNI are expedited as soon as possible or if clarification is required this is actioned promptly in the best interests of the prisoner.

1.2 NIPS Review of Supporting People At Risk Evolution (SPAR Evo)

NIPS and the Trust jointly commissioned an external review of the SPAR Evo procedure and its report contains a number of recommendations that should enable better information sharing between the NIPS and the Trust.

I look forward to the outworking of those recommendations.

Section 2: Background information

2.1: Magilligan Prison

Magilligan Prison is a medium security prison that houses prisoners who have been sentenced and transferred from either Maghaberry Prison or Hydebank Wood Secure College. The population of Magilligan Prison at the time of Mr Weir's death was 374.

This is within the normal range for providing effective care to prisoners. The focus of care and support at Magilligan Prison is on providing the opportunity to reduce the risk of reoffending and prepare prisoners for release.

Since 2008 the Trust has provided Healthcare in Prison. There is a 24 hour primary healthcare service and the MHT is 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)

CJI is a United Kingdom National Preventive Mechanism (NPM) member body that independently monitors places of detention to prevent the ill treatment of detained prisoners.

The most recent inspection report of Magilligan Prison was published in February 2022 and made two key recommendations and 30 other recommendations as well as noting six areas of innovative work. An Independent Review of Progress against the two key and 12 other recommendations was published in February 2024. Prison inspections in Northern Ireland are carried out in partnership by CJI, His Majesty's Inspectorate of Prisons, the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate.

Magilligan Prison inspection report - February 2022

Magilligan Prison independent review of progress - February 2024

2.3: Independent Monitoring Board (IMB)

Magilligan Prison has an IMB whose role is to satisfy themselves regarding the treatment of prisoners, facilities available to them for purposeful activity and the cleanliness and adequacy of prison premises. The IMB is also a United Kingdom NPM member body.

In their 2020/21 Annual Report, the IMB noted the beginning of the Covid-19 pandemic (the pandemic). The IMB stated there had been a robust operation put in place to reduce the spread of infection and they found measures reasonable and proportionate. Communication with prisoners was good, they understood the

reasons for measures to contain the transmission of the coronavirus and they worked together with staff to enhance infection control.

As a result of pandemic measures there was still a reduced regime by the end of March 2022. Work was completed to ensure those who normally went out to work had other activities to occupy them, for example, additional Orderly roles were created although some were more meaningful than others. The IMB noted prisoners had access to activity packs, showers and could exercise outside throughout the pandemic. The IMB stated there was a 'calmness' amongst the prison population.

In relation to healthcare, the IMB was satisfied patient needs continued to be met despite the difficulties and complexities healthcare staff dealt with during the pandemic.

2.4: The Regulation and Quality Improvement Authority (RQIA)

The RQIA is an independent body and United Kingdom NPM member body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services, including in prisons and other places of detention in Northern Ireland. The RQIA identify best practice, highlight gaps or shortfalls in services and identify where improvement is required. All their inspections and reviews are aimed at protecting the public interest.

Following a report of an incident of serious self-harm from the Prisoner Ombudsman's Office in 2016 and the number of recorded suicides in prisons, a review was commissioned jointly by the Departments of Health and Justice to consider provision for particularly vulnerable prisoners. The RQIA Review, published in October 2021, goes some way to addressing concerns. Recommendations made by the RQIA specifically address mental healthcare. The Ombudsman continues to work with the RQIA, and with others, to raise matters of concern and improve delivery of support to those in custody.

RQIA review - October 2021

2.5: Measures to contain the spread of the COVID-19 pandemic

The global impact of the pandemic included the protection of particularly vulnerable groups of people including those in prisons. As noted by the World Health Organisation[4]:

People deprived of their liberty, such as people in prisons and other places of detention, are more vulnerable to the coronavirus disease (Covid-19) outbreak.

[4] https://www.who.int/europe/activities/ensuring-prevention-and-control-of-covid-19-in-prisons-and-other-places-of-detention

People in prison live in settings in close proximity and thus may act as a source of infection, amplification and spread of infectious diseases within and beyond prisons.

For prisons, standards remained critical at a time when they also had to fulfil the positive duty to protect life. These standards are set out in the *United Nations Standard Minimum Rules for the Treatment of Prisoners*, also known as the *Nelson Mandela Rules*, and are foundational to preventing the ill-treatment of prisoners. The Ombudsman's Office received a number of complaints relating to measures in place during the pandemic and its impact continues to feature in current investigations. From the information available, the previous Ombudsman considered how prisoners were treated by those caring for them, that the facilities provided to them were to standard and that measures were applied humanely[5]. Pressure on healthcare services is a theme across the United Kingdom and the prison population is no different. The ongoing impacts of the pandemic are important particularly in the area of mental health.

From the beginning of the pandemic, NIPS worked in collaboration with HiP, the Trust and the Public Health Agency (PHA) to contain the spread of the Covid–19 virus. They had a responsibility, a positive Article 2 of the European Convention on Human Rights (ECHR/Convention) duty, to keep those residing and working in prisons safe. At the same time, they had to balance prevention and containment with maintaining standards for the care and rehabilitation of those in custody.

The Minister of Justice and the Prison Service followed a similar incremental pathway as Great Britain with regard to prisons: suspending visits on 20 March 2020, gradually closing the prison estate to all but essential workers, limiting movement within prisons and ensuring safety measures were in place within each prison.

In March 2020, Governors received instructions to focus on infection control and minimise the risk of transmission. Between 20 and 25 March 2020, they took significant action to minimise risk, including the:

- suspension of all domestic and legal in-person visits to prisons;
- suspension of accompanied and unaccompanied temporary release, including all release under the home leave scheme;
- access to prisons was restricted for all but essential prison staff and healthcare workers; and
- quarantine for 14 days for those coming into custody.

Testing, contact tracing and infection control measures kept pace with wider society. From March 2020, all new committals were placed in isolation for 14 days on arrival, in line with PHA advice. From April 2020, NIPS met weekly with the Trust, the PHA

[5] Measures taken amid a health crisis should not undermine the fundamental rights of detained people, including their rights to adequate food and water. Safeguards against ill-treatment of people in custody, including access to a lawyer and doctor, should also be fully respected, https://www.ohchr.org/en/statements/2020/03/urgent-action-needed-prevent-covid-19-rampaging-through-places-detention

and the Health and Social Care Board to oversee what was happening in prisons and share knowledge and learning. In the early stages of the pandemic, everyone was learning and developing an understanding of how Covid-19 affected health.

The PHA published *Guidance for Prisons and Places of Detention in NI* on 20 April 2020, and NIPS formalised its *Pandemic Plan and Procedures* in June 2020, which set out infection control measures for staff testing and remained in place until 1 July 2022. These measures aimed to prevent the presence and spread of Covid-19 in prisons.

There is no doubt that those held in isolation for 14 days experienced challenges. The 14 days was reduced to 10 days from 14 December 2020, in line with guidance at that time. Thankfully, there were no deaths in custody due to Covid-19. This is in stark contrast to the situation in England and Wales where 185 prisoners died in custody due to Covid-19 infection.

2.6: Previous incidents at Magilligan Prison

Mr Weir died at Magilligan Prison on Tuesday 9 February 2021. His death was one of two deaths in Magilligan Prison that year. There does not appear to be any connection or similarity between these two deaths.

PART A: INVESTIGATION AND FINDINGS

Section 3: Framework and scope for investigation

Mr Weir was found unresponsive in his cell, on H1 A Wing Magilligan Prison on Tuesday 9 February 2021.

As he was in prison custody at the time of his death, a Prisoner Ombudsman is required to investigate the circumstances surrounding his death. This report with findings is a matter of public accountability and informs the Coroner's inquest. The former substantive Ombudsman met with Mr Weir's family members on 30 April 2021 to hear directly from them and to listen to their questions and concerns which have assisted in informing the objectives for this investigation.

3.1 Questions raised by Mr Weir's family

Issues raised and agreed for consideration in this independent investigation were:

1. **HEALTHCARE**

- "Was the provision of healthcare provided to Jason at least equivalent to what he would have received in the community?
- How long is the average wait for a prisoner to see a mental health professional whilst in custody?
- Did Jason have a diagnosis in relation to his mental health?
- What informed the decision to put him on anti-psychotic medication?
- Could decisions about Jason's medication be made appropriately if Jason didn't have a diagnosis?
- Was Jason considered for in-patient care?
- What were the series of events that informed Jason's move to Maghaberry Prison, Moyola Unit?
- Why Jason was moved back from Moyola Unit in Maghaberry Prison to Magilligan Prison general population, and was this decision appropriate?
- Was Jason appropriately risk assessed in relation to his medication and was he on 'supervised swallow' at the time of his death?
- Did Jason always have capacity to make decisions in relation to family contact?
- What is the process for those prisoners who, like Jason, experienced severe mental illness, in relation to involving the prisoner's family in their care? Is this process appropriate?
- What role, if any, does the Family Officer have in this process?
- Jason's family believe that he was deemed 'unfit' for release due to his mental illness. Was this the case and what were the Prison Service and the Trust

doing to work with Jason to improve his mental health and help him become 'fit' for release?

2. MULTI-DISCIPLINARY CARE

- Is there a traffic light system for SPAR Evo and prisoners in crisis?
- Was Jason ever on a SPAR and if so why was he taken off it? Did Jason have a SPAR Evo in the period of time immediately before his death and was this appropriate?
- Do Prison Officers receive any training in relation to dealing with prisoners with mental illness and is this training adequate?
- Do prisoners with mental illness have a key worker from the Prison Service?
- How is information, in relation to prisoners with mental illness, shared between the Trust and the Prison Service and is this process adequate?
- What process is in place in prison for a prisoner who lacks any insight into their illness and is this process adequate?
- Family members would like to know the support available for prison staff dealing with a death in custody.

3. ISOLATION

- Was Jason held for an extended period in isolation and then moved back into mainstream population?
- Why was Jason put in isolation? instead of the other party?
- Was the impact of extended isolation on Jason risk assessed appropriately?
- Was the impact of being moved back into general population risk assessed appropriately?

4. MAGILLIGAN ACCOMMODATION

- The reason Jason was housed on a mainstream landing with minimal supervision and was this appropriate accommodation for Jason?
- What were the night checks on Jason's landing on the 8 February 2021 and were these appropriate for someone like Jason?
- Was there a handover between day staff and night staff on 8 February 2021 and night staff and day staff on 9 February 2021?

5. UNACCOMPANIED TEMPORARY RELEASE (UTR)

- When Jason was out on his last Unaccompanied Temporary Release (UTR) he contacted the prison by telephone to explain that he was being put under pressure by other prisoners to bring drugs into the prison, which he did not

want to do. He also told prison staff that he was being put under pressure to move drugs when he was going to and from work. How did the Prison Service process this information and was it handled appropriately in relation to Jason? Why did Jason not get another UTR after this incident?

- How are the Prison Service tackling coercive control in relation to UTRs and drug smuggling and what support is available to those that seek help"?

The former substantive Ombudsman met with Mr Weir's father on 10 June 2021 and in addition to the above it was agreed to consider the following as part of this investigation:

- The response to the request made by Mr Weir's father to speak to Mental Health Nurse B in the Trust's MHT on 5 February 2021 and if this response was appropriate.

- Jason's move to Magilligan Prison and if this was appropriate.

- Jason's "bleed on the brain," and how information in relation to this was shared with the family and if this was appropriate.

- The allegations of Jason being "spiked" whilst in Magilligan Prison.

3.2 Objectives for this investigation

The objectives for this investigation take account of the questions raised by Mr Weir's family. This investigation must meet the standards set out in the 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 Reviewer inform the objectives of this investigation which are to:

1.	establish the circumstances and events surrounding Mr Weir's death on 9 February 2021, including an overview and examination of immediate responses when he was found;
2.	examine how Mr Weir was cared for by NIPS and the Trust while in Prison, particularly the standard of his mental health care given the circumstances of his detention;

3.	examine Covid-19 risk control measures and their application by the NIPS and Trust and any possible implications for Mr Weir;
4.	provide information to Mr Weir's family in response to the issues they have raised;
5.	assist the Coroner's investigative obligations under Article 2 of the ECHR, 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; and
6.	identify any learning for improvement and instances of good practice.

3.3 Investigation methodology

The Prisoner Ombudsman's investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. The Prisoner Ombudsman's Office issued notices of investigation to relevant parties on 10 February 2021. This included to prisoners, NIPS and IMB. This allowed anyone with information to come forward and speak to investigators. Individuals were also identified for interview by the Investigating Officer.

The following information was gathered and analysed during this investigation:

- NIPS records including relevant Closed-Circuit Television (CCTV footage and radio transmissions;
- interviews with NIPS 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.

3.4: Independent clinical advice

A Clinical Reviewer is commissioned from an agreed list, usually to deliver a peer review of HiP provision. They supply the Ombudsman with a report and any recommendations. The Lead Investigator provides the Clinical Reviewer with documentation and a Terms of Reference specific to each case to enable them to

provide an independent, expert opinion about a prisoner'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 that 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.

Professor Jenny Shaw was commissioned as Clinical Reviewer, she is a Consultant Forensic Psychiatrist at Greater Manchester Mental Health Foundation Trust and Professor of Forensic Psychiatry at the University of Manchester. She provided an independent Clinical Review of the healthcare provided to Mr Weir. As a Forensic Psychiatrist she has particular experience of assessing and treating patients involved in the judicial process and in the preparation of psychiatric reports.

In Mr Weir's case, Terms of Reference for the Clinical Review were agreed (see Appendix 2) and Professor Shaw considered the following specific areas:

- provision of clinical care and treatment including risk assessment and medication management;
- any secondary care provided, in this case mental health, psychiatric care and neurology including any comments on the care received during his 2019/20 presentation in comparison to Mr Weir's 2020/2021 presentation, adequacy of decision making, timeliness of referrals, in this case neurology and psychiatry;
- any care or service delivery failings that may have contributed to his death;
- the specific concerns raised by the family;
- any relevant policy and practice;
- any recommendations and learning opportunities;
- examples of good practice; and
- any other observations relevant to Mr Weir's care.

Professor Shaw provided a report setting out her opinion on the matters she was asked to consider.

Section 4: Chronology and events surrounding Mr Weir's death.

4.1 Committal to Maghaberry Prison 2012 – 2017

On 17 January 2012 Mr Weir was committed to Maghaberry Prison.

Mr Weir's committal assessment notes on the Egton Medical Information System (EMIS)[6] recorded he had previously been in custody in the Young Offenders Centre, now known as Hydebank Wood Secure College, a prison for 18-24year old men. It was noted he had a history of self-harm and depression including attempting suicide. He had a history of alcohol misuse and had dependence on Diazepam, which he obtained illicitly within the custodial environment.

For his personal safety Mr Weir was accommodated in protective custody segregated from the general population for approximately three years with his brother. He had access to healthcare, a telephone, visits and education. He was an enhanced prisoner and was employed as a Prison Orderly.

4.2 Magilligan Prison 2017

On 11 May 2017 Mr Weir was transferred from Maghaberry Prison to Magilligan Prison.

On 17 July 2017 Mr Weir was seen by Mental Health Occupational Therapist A. Before he was transferred to Magilligan Prison Mr Weir had been in protective custody and segregated from the general prison population in Maghaberry Prison for approximately three years. In Magilligan Prison he was started on a programme for anxiety management. Mr Weir's engagement with the Mental Health Occupational Therapist assisted him in managing his anxiety.

On 21 September 2017 Mr Weir worked as a welder in the Industries Department of Magilligan Prison. He built a reputation as a trusted prisoner who worked hard and was a talented welder. As a result of this Mr Weir was often sent to various locations around the prison estate to work alone.

On 20 November 2017 Mr Weir was moved to a single cell on the Regime Indexed Supervision Easement (RISE)[5] landing.

4 Emis is the Trust's electronic clinical record keeping system.
5 RISE Wing (A-Wing) Criteria, Enhanced Regime Fully engaged with sentence plan.

4.3 Magilligan Prison 2018

Mr Weir made good progress regarding his engagement with Mental Health Occupational Therapy. However, on 5 May 2018 Mr Weir felt his anxiety was increasing, leading to paranoid thinking. He discussed this with Mental Health Occupational Therapist A and advice was given to him in relation to his anxiety management.

On 29 June 2018 Mr Weir had a review with Mental Health Occupational Therapy and with Mental Health Occupational Therapist A. Mr Weir with the agreement of the General Practitioner (GP), stopped his Mirtazapine medication. Mr Weir felt he was not getting any benefit from the medication. Mental Health Occupational Therapist A planned to review Mr Weir in four weeks' time with a view to discharging him.

Mr Weir was engaged with his Prisoner Development Unit (PDU) Co-ordinator from the Probation Board for Northern Ireland.

On 16 August 2018 Mr Weir left Magilligan Prison for his first one day UTR as part of his pre-release testing. Four further one-day UTRs followed throughout 2018.

On 17 August 2018 Mental Health Occupational Therapist A saw Mr Weir. It was noted Mr Weir was feeling brighter in his mood and was managing well. It was agreed Mr Weir would be discharged from mental health. Mr Weir was encouraged to maintain a good routine and reminded he could be referred again to mental health if he required further support.

4.4 Decline in Mr Weir's Mental Health 2019

On 24 April 2019 Mr Weir saw GP A regarding ankle pain. At this appointment he requested a referral to the MHT for anxiety. GP A found no evidence of low mood or psychotic features at this consultation.

On 9 May 2019 Mr Weir's mental health referral was screened by the Mental Health Nurse A and Mental Health Occupational Therapist A. As a result Mr Weir was put on the waiting list for anxiety interventions, such as STRESSPAC[7] and relaxation therapy.

On 24 June 2019 Mr Weir left Magilligan Prison on a UTR as part of his pre-release testing.

On 26 June 2019 Mr Weir telephoned Magilligan Prison in a reportedly distressed state to report he was being "tortured" to traffic drugs back into the jail. On his arrival

[7] STRESSPAC A seven week skills training group for people with anxiety.

back into Magilligan Prison later that day he agreed to, and was accommodated in, the Care and Supervision Unit (CSU) under Prison Rule 32[8] where he remained until 17 July 2019.

On 30 June 2019 Mr Weir failed a mandatory drug test (MDT).

On 18 July 2019 at the request of a Prison Officer Nurse A saw Mr Weir. Mr Weir was presenting with bizarre behaviour and had all his belongings packed thinking he was going home. Nurse A noted Mr Weir had lost a significant amount of weight since she had last seen him. Mr Weir informed her he was under a lot of pressure to bring drugs back into the prison from his UTR. Mr Weir stated he had taken 'fourteen buds' and flushed the rest down the toilet two weeks ago. He provided a urine sample for drug testing. Nurse A recorded she spoke with Mental Health Occupational Therapist A who would contact Psychiatrist, Doctor A for advice. Later that day GP A recorded speaking with Psychiatrist, Doctor A. It was agreed that given the acute nature of the event and his unexplained weight loss he should attend a hospital Emergency Department (ED) to exclude an organic cause. The Mental Health Occupational Therapist A recorded a detailed entry on EMIS regarding Mr Weir's presentation. It stated Mr Weir was happy, pain free and believed he was being released that day. Mental Health Occupational Therapist A reported Mr Weir was orientated to time, place and was aware he had a life sentence. She discussed the need for a SPAR Evo[9] however NIPS staff had moved Mr Weir to an observation cell under a 'keep safe' document, to ensure his continuing safety for a 24-hour period.

On 19 July 2019 it is recorded Mr Weir returned to the observation cell on his return from ED having had a Magnetic Resonance Imaging scan (MRI) and blood tests. It was noted these tests were clear. Prison Officers reported Mr Weir had been unsettled and disorientated all night while in hospital. Later that day Mental Health Occupational Therapist A and the MHT Lead, Nurse A reviewed Mr Weir. He stated a family member was a disciple from Jesus and he reported he had slept all night. However Prison Officers reported Mr Weir had only slept for one hour. Mr Weir was found sobbing uncontrollably in his cell later by Prison Officers. Nurse B attended and found him staring blankly, he appeared to be in a catatonic state. For his own safety Mr Weir was placed on a SPAR Evo Care Plan.

[8] *Restriction of association*
Prison Rule 32. –(1) Where it is necessary for the maintenance of good order or discipline, or to ensure the safety of officers, prisoners or any other person or in his own interests that the association permitted to a prisoner should be restricted, either generally or for particular purposes, the governor may arrange for the restriction of his association.

[9] The Supporting People At Risk Evolution (SPAR Evo) process is contained within the NIPS Suicide and Self-Harm Risk Management guidance 2011 (updated 2013) and Joint Suicide and Self-Harm Risk Management Strategy. It was produced to help staff and others to raise a concern, assess an individual's risk of suicide or self-harm and to meet the needs of those in distress and/or crisis.

The hospital discharge summary letter described Mr Weir's presentation as a 'psychotic episode today + weight loss', no organic cause was found and the working diagnosis was delirium (acute confusion).

On 21 July 2019 Nurse C attended Mr Weir in his cell as he had vomited and was jerking. Mr Weir's clinical observations were normal but Nurse A noted bizarre behaviour and he was not 'making much sense'.

On 22 July 2019 GP B saw Mr Weir who recorded his blood tests and Computed Tomography scan (CT) were normal. GP B also noted Mr Weir was delusional with no obvious organic cause, queried drug-induced psychosis and emailed Psychiatrist, Doctor A to see him urgently.

On 24 July 2019 Mr Weir's blood test, carried out by the Trust, indicated abuse of Pregabalin and Codeine.

On 25 July 2019 Psychiatrist, Doctor A undertook a comprehensive assessment of Mr Weir because of an urgent referral from the Primary Healthcare Team and MHT. Mr Weir said he saw a light in his room and he believed it was from God. His diagnosis was unclear. Psychiatrist, Doctor A did not feel Mr Weir was at risk to himself or others but felt he should continue to be monitored via the SPAR Evo process due to recent changes in his clinical presentation. She requested further monitoring by the MHT (at least twice a week). Mr Weir did not want to take psychotropic medications at this time and Psychiatrist, Doctor A agreed to monitor this.

On 6 August 2019 Mr Weir pleaded guilty at adjudication for his failed MDT and was awarded three days cellular confinement which was suspended for six months.

On 8 August 2019 a further review was carried out by the Psychiatrist, Doctor A who stated Mr Weir's recent bizarre behaviour, thought content and elevated moods, may have been due to illicit substance misuse. Mr Weir stated his psychosis may be due to recent discontinuation of long term substance misuse. There was no clinical indication to prescribe psychotropic medication. Psychiatrist, Doctor A deemed him not to be at risk of harm to himself or others. She noted Mr Weir's overall presentation had improved, however, he would have an extended period of mental health assessments in order to establish a clinical presentation.

On 13 August 2019 Mental Health Nurse A and Mental Health Occupational Therapist A saw Mr Weir. Mr Weir made some suggestive remarks about being in a relationship with Mental Health Occupational Therapist A. As a result of this a decision was made that Mental Health Nurse A would now be Mr Weir's key worker.

It was also recommended Mental Health Occupational Therapist A should not see Mr Weir alone. It was recorded Mr Weir was continuing to present bizarrely.

On the night of 14 – 15 August 2019 Prison Officers reported Mr Weir was howling through the night and was acting bizarrely. After a review by the MHT it was agreed Mr Weir should be transferred to the Moyola Unit, Maghaberry Prison for further treatment.

On 15 August 2019 Mr Weir was transferred from Magilligan Prison to the Moyola Unit in Maghaberry Prison.

On 16 August 2019 Psychiatrist, Doctor A and Mental Health Nurse B reviewed Mr Weir in his cell as he refused to leave it. Psychiatrist, Doctor A noted Mr Weir presented with a recent acute change in his mental state. She stated that illicit substance misuse could not be ruled out and his current presentation may be reflective of hypomania/mania given his recent history of low mood. Psychiatrist, Doctor A wanted to request an electro-encephalography (EEG) to rule out seizure activity. Mr Weir was prescribed antipsychotic drugs and given his current mental state an urgent referral was made to the Shannon Clinic[10].

On 20 August 2019 Psychiatrist, Doctor A reviewed Mr Weir in the Moyola Unit Maghaberry Prison and increased his anti-psychotic medication. In her opinion, it was unclear if his presentation was because of "underlying functional mental illness, and organic mental state secondary to underlying seizure activity, or illicit substance misuse" and noted novel psychoactive substance misuse may not show on routine drug screening.

On 21 August 2019 Mr Weir refused to attend his hospital EEG appointment.

On 22 August 2019 Mr Weir was seen by Forensic Consultant Psychiatrist, Doctor A from the Shannon Clinic. Mr Weir co-operated for three-four minutes of the assessment. The Forensic Consultant Psychiatrist advised Mr Weir should attend the ED at hospital for blood tests. This was because of Mr Weir's new onset psychosis with 'motor ticks and twitches' and he was concerned about autoimmune encephalitis. Mr Weir refused to attend hospital.

On 23 August 2019 Psychiatrist, Doctor A reviewed Mr Weir again. She was concerned about his mental health capacity as he was unable to retain and fully understand information given to him. She advised Mr Weir should be taken to hospital 'against his wishes in the least restrictive and distressing manner should no other option be available.' Mr Weir agreed to attend hospital. There was no twitching

[10] Shannon Clinic is a 34 bed medium secure unit providing in-patient services for people with mental illnesses who also require intensive psychiatric treatment and rehabilitation.

noted at the hospital and his neurological examination was normal. The doctor deemed Mr Weir to have capacity. Mr Weir refused to stay for further observation and returned to Moyola House in Maghaberry Prison.

On 27 August 2019 Psychiatrist, Doctor A followed up with Mr Weir. She was concerned Mr Weir was not fully aware of the consequences of his decision not to remain in hospital. He was noted to be compliant with his medication. Mr Weir was assessed by nursing staff from the Shannon Clinic the same day, where he agreed his 'short term mental health needs would be best met in an outside mental health facility in the community rather than within custody.'

On 30 August 2019 Mr Weir was seen by Psychiatrist, Doctor A. She noted some improvement in Mr Weir's presentation and without evidence of side effects, increased his Olanzapine to 10mg.

On 12 September 2019 a letter was received from Forensic Consultant Psychiatrist, Doctor A requesting completion of the neurological tests previously requested to rule out encephalitis. Psychiatrist, Doctor A reviewed Mr Weir and obtained verbal consent from him to attend hospital for another EEG. An EEG was re-requested as Mr Weir had declined to go on two previous occasions. He stated he believed his mental health issues were related to situational difficulties and illicit drug misuse. He still believed he was in a relationship with Mental Health Occupational Therapist A.

On 26 September 2019 Mr Weir was reviewed by Psychiatrist, Doctor A. She had recently consulted with NIPS staff regarding his presentation. It was reported there had been deterioration in his clinical presentation. Psychiatrist, Doctor A recorded Mr Weir was referring again to Mental Health Occupational Therapist A as his wife. Psychiatrist, Doctor A discussed medication and with Mr Weir's agreement, she increased his Olanzapine medication to 15mg.

On 2 October 2019 Mr Weir was referred for a MRI scan which had been previously agreed between Psychiatrist, Doctor A and GP C. He also attended hospital for an EEG later that day.

On 11 October 2019 a letter was received from Forensic Consultant Psychiatrist, Doctor A at the Shannon Clinic to indicate an in-reach (multidisciplinary) service would be provided for Mr Weir. It stated he was on the waiting list for Shannon Clinic in case in-reach was not successful.

On 17 October 2019 Psychiatrist, Doctor A reviewed Mr Weir and noted he had visits from his mother and father (this was the first time Mr Weir had seen his father in six years). It was recorded he appeared more settled and acknowledged he was not in a relationship with any staff. He was informed his EEG was within normal limits. The

Forensic Consultant Psychiatrist, Doctor A was informed of the outcome of Mr Weir's review.

On 23 October 2019 Mental Health Nurse B reviewed Mr Weir and found him more settled. There was no evidence of delusional ideation or thought disorder. He was compliant with his medication.

On 7 November 2019 Mr Weir was reviewed by Psychiatrist, Doctor A. Mr Weir said he had visits with his mother and another family member and they were good. Mr Weir stated he had requested another visit from his father. He said he was no longer taking drugs and seemed embarrassed by his previous behaviour and thoughts. The Psychiatrist's opinion was Mr Weir had experienced drug induced psychosis. She felt there was a notable improvement in his clinical presentation due to his treatment plan and the fact he had stopped taking illicit substances.

On 14 November 2019 it was reported Mr Weir refused to attend his hospital MRI appointment. Psychiatrist, Doctor A went to the landing and met with Mr Weir emphasising the reasons why he should attend. After this meeting Mr Weir agreed to attend this appointment.

On 26 November 2019 Psychiatrist, Doctor A reviewed Mr Weir and recorded he was currently presenting with stable mental health. Mr Weir reported abstinence from drugs and stated he intended to continue doing so going forward. Psychiatrist, Doctor A felt Mr Weir could be discharged from the waiting list for the Shannon Clinic and wrote to Forensic Consultant Psychiatrist, Doctor A in respect of this.

On 28 November 2019 Psychiatrist, Doctor A recorded Mr Weir's immunology blood test results as elevated. She stated the clinical significance was unclear but on the whole was positive. Psychiatrist, Doctor A recommended Mr Weir's ongoing management should be discussed at the daily huddle. Mr Weir was also seen by GP B later that day. He documented Mr Weir appeared very well and there was no clinical indication of meningitis. Mr Weir's main issue at this time was back pain and GP B changed Mr Weir's non-steroidal anti-inflammatory medication with a view to referring him for physiotherapy if the pain did not settle.

On 4 December 2019 Nurse D spoke to Mr Weir about refusing his Olanzapine medication. He was advised against this until he spoke to his keyworker or Psychiatrist. Nurse D recorded she would inform his keyworker and Psychiatrist, Doctor A.

On 5 December 2019 GP B referred Mr Weir to a hospital neurologist.

On 16 December 2019 Mr Weir was seen by his keyworker, Mental Health Nurse B who recorded Mr Weir was not showing signs of psychosis and was planning for the future.

On 31 December 2019 a letter was received from the Forensic Consultant Psychiatrist, Doctor A at the Shannon Clinic. The letter stated due to Mr Weir's current clinical presentation he did not require transfer to the Shannon Clinic. Mr Weir was therefore removed from the Shannon Clinic waiting list.

4.5 Magilligan Prison 2020

On 10 January 2020 in Maghaberry Prison Mr Weir was seen by his keyworker, Mental Health Nurse B for a mental health review. It was recorded Mr Weir was bright and alert with no symptoms of psychosis observed or reported.

On 15 January 2020 Mr Weir's MRI scan showed no significant abnormalities.

On 16 January 2020 Mr Weir was transferred back to Magilligan Prison. He remained under the care of the MHT and Psychiatry.

On 27 February 2020 Psychiatrist, Doctor A reviewed Mr Weir. Mr Weir reported he was well settled and had no concerns or issues. Psychiatrist, Doctor A did not observe any evidence of psychosis. Mr Weir acknowledged his thoughts about Mental Health Occupational Therapist A were not correct and she was *"nothing more than a mental health nurse*". He stated he was not taking illicit substances. Mr Weir said he had side effects because of the Olanzapine medication, such as increased appetite along with weight gain. Psychiatrist, Doctor A reduced his Olanzapine medication to 5mg and warned Mr Weir about the potential deterioration of his mental health. Mr Weir was advised to inform staff if he experienced any deterioration in his mental health. It was explained to Mr Weir about some possible underlying conditions in relation to his Voltage-Gated Potassium Channel (VGKC) levels and was advised to seek a medical review if he became aware of any new symptoms or changes.

On 10 March 2020 and 7 April 2020 Mr Weir was reviewed by Mental Health Nurse A from the MHT. Mr Weir reported no concerns or issues. Mental Health Nurse A did not observe any mental health issues and did not identify any risks.

On 8 May 2020 Mr Weir declined his mental health review and staff reported no concerns in relation to Mr Weir when asked by Mental Health Nurse A.

On 19 May 2020 Mr Weir's case was referred to the PCNI.

On 19 June 2020 Mr Weir was reviewed by Mental Health Nurse A from the MHT. He did not report any current mental health issues. Mr Weir was uncomfortable when talking about when he had previously been unwell with his mental health.

On 30 June 2020 GP D recorded staff should encourage Mr Weir to self-manage his pain and only use Co-codamol when needed as opposed to regular usage.

On 1 July 2020 Mr Weir passed his MDT.

On 16 July 2020 Psychiatrist, Doctor A reviewed Mr Weir. Mr Weir stated he had no physical or mental health issues and he was not taking illicit drugs. Psychiatrist's Doctor A's opinion was Mr Weir was clinically stable. There were no signs of psychosis and his Olanzapine was reduced to 2.5mg for four weeks with a view to it being stopped.

On 28 July 2020 GP D urged staff that Mr Weir should be encouraged to use Co-codamol on a requirement basis and focus on self-management of pain. He stated the patient should complete a medical triage form if the pain continued to ensure appropriate management.

On 31 July 2020 Mr Weir was reviewed by Mental Health Nurse A from the MHT. Mr Weir did not want to see Mental Health Nurse A because he thought he was discharged from the psychiatrist. Mental Health Nurse A explained Mr Weir was still officially on the case load and would continue to be reviewed. Mental Health Nurse A agreed there are no current mental health issues and it was hoped Mr Weir would be discharged soon.

On 12 August 2020 Mr Weir's Olanzapine medication ended as planned.

On 8 October 2020 Psychiatrist, Doctor A was due to review Mr Weir. However due to the pandemic infection control measures in place within the healthcare setting Psychiatrist, Doctor A decided she would re-arrange the appointment. She had taken into consideration Mr Weir having been reported as mentally unwell on 31 July 2020 by the MHT.

On 12 October 2020 Mr Weir passed his MDT.

On 16 October 2020 Mr Weir was reviewed by Mental Health Nurse A from the MHT and Mr Weir requested to be discharged from the psychiatrists caseload. Mr Weir was informed he could not do this without Psychiatrist, Doctor A's agreement.

On 22 October 2020 Mr Weir was discharged from Psychiatry and Mental Health Services at his request. Records state at this time Mr Weir was not medicated for his

mental health and presented as clinically well with no evidence of mood or psychotic symptoms. Mr Weir was provided with guidance on managing his prospective wellbeing and future appointments.

Mr Weir's brother who was housed on the RISE landing Magilligan Prison and worked with him in the industries department, was released from prison custody on 26 October 2020. Interviews with NIPS staff and prisoners from Mr Weir's landing viewed this event as significant for Mr Weir.

On 29 October 2020 the PCNI requested a mental health assessment for Mr Weir.

On 30 October 2020 Mr Weir was urgently re-referred to the MHT by NIPS due to a deterioration in his mental state and evidence of bizarre behaviour. Mr Weir submitted a request to NIPS staff which read, *"Request to speak to someone about my program when I was down at Maghaberry from August til January last year as I am the son of god spritly and want to no when I get my sprit stuff back namely frair lady bill board man and my god off angils thanks J Weir*"

Mr Weir was assessed by the MHT, Mental Health Nurse A and Mental Health Occupational Therapist A. Mr Weir was informed his presentation was very similar to his last period of mental ill health, however he did not agree. Mr Weir denied taking illicit substances and consented to give blood and urine samples for tests.

On 2 November 2020 Mr Weir was reviewed by the Mental Health Nurse A. There was ongoing evidence of bizarre thoughts and views. Mr Weir's drug screen results were negative.

On 3 November 2020 Mr Weir was assessed by GP D. There was no evidence of physical health symptoms and a request was sent to expedite Mr Weir's neurology referral (he was first referred to neurology on 5 December 2019). Mr Weir was also urgently referred to Psychiatrist, Doctor A at the Psychiatric Clinic for assessment.

On 5 November 2020 Mr Weir was assessed by Psychiatrist, Doctor A. Records state Mr Weir presented with a one week history of deterioration in his mental state with "evidence of elation of mood and bizarre thought content." The Psychiatrist stated previous and current elevated VGKC levels had not been established and can be associated with limbic encephalitis[11]. The Psychiatrist was uncertain of the reason for the change in Mr Weir's mental state. Psychiatrist, Doctor A prescribed Olanzapine 10mg for Mr Weir as he had previously improved with this medication. The Psychiatrist, Doctor A further advised Mr Weir should receive this medication under supervision to ensure compliance.

[11] A disease characterised by inflammation of the brain.

On 8 November 2020 a medication in-possession (IP) risk assessment form was completed for Mr Weir. He was found not suitable to be in possession of 'high risk medications.' The risk assessment form also records, "due to current presentation to be strictly supervised for issue of medication. History of noncompliance with antipsychotic regime." It further noted to consult the MHT or Psychiatry if considering in-possession.

On 10 November 2020 the Magilligan Safety and Support Team (MSST) recorded a check in with Mr Weir, stating he seemed, "reluctant to engage in conversation. He did say that he was doing fine and had no issues."

On 11 November 2020 Mr Weir passed a MDT. NIPS records state Mr Weir seems settled, keeps himself and his surroundings clean and tidy and continues to work in the prison furniture shop.

On 12 November 2020 Mr Weir was seen by the Mental Health Nurse A. He reported no issues and was content with his current medication. Mr Weir stated he still had the same thoughts he reported to Psychiatrist, Doctor A the previous week.

On 18 November 2020 Mr Weir was reviewed by Mental Health Nurse A from the MHT. Mr Weir reported no issues but again admitted to having the same thoughts over the last couple of weeks. It was planned for the MHT to continue monitoring Mr Weir and for him to see psychiatry as required.

Also on 18 November 2020 Mr Weir spoke to his mother on the telephone. Mr Weir sounded agitated throughout the telephone call and talked about himself and his brother being in the army and his dishonourable discharge. He asked his mother who is in her head talking to her and that he has people in his head talking to him. He explained to his mother psychiatry told him he had a psychotic episode but he knows it was real. The telephone call lasts for approximately eight minutes, most of which was Mr Weir talking about his perceived 'reality.'

On 19 November 2020 Mr Weir was seen by Psychiatrist, Doctor A. Mr Weir demonstrated evidence of grandiosity referring to himself as the son of God and stating he had telepathic powers. Mr Weir's medication was increased to 20mg of Olanzapine. It was recorded Mr Weir would require transfer to community care mental health services should he be released post the PCNI's hearing on 24 November 2020. Later that day Mr Weir had a virtual visit by video-link with his father. NIPS staff voiced concerns that Mr Weir had made strange comments. Mr Weir was reviewed again by Mental Health Nurse A who recorded no change in Mr Weir's recent presentation.

On 23 November 2020 NIPS records report Mr Weir was receiving additional support from non-residential staff and will continue to be monitored “as it is clear that since his brother got out this has impacted on him.”

On 24 November 2020 Mr Weir attended the PCNI hearing remotely and a full psychiatric assessment of his mental health was requested. This included recommendations in relation to his future treatment as well as an assessment of his competency to give instruction to his legal representative and participating in a parole hearing. Further details of the PCNI’s further consideration of Mr Weir’s case is contained on page 37 of this report.

On 24 November 2020 Mr Weir’s NIPS Instructor reported Mr Weir “has to be 'pushed' constantly to work. He feels he does have the ability but no motivation and there has been a gradual decline in his behaviour since his brother left (time served).”

On 26, 27 and 28 November 2020 Mr Weir spoke to his mother and brother on the telephone and can be heard displaying bizarre thoughts, discussing a complex reality and denying he is on any medication.

On 27 November 2020 Mr Weir was assessed by Mental Health Nurse C in his workplace after concerns were raised about his suitability to operate prison machinery. No psychotic features were observed at the time and Mr Weir appeared to be concentrating well. It is not known if any recommendations were made in relation to Mr Weir’s work. He continued to attend and his Instructor, who knew Mr Weir well, recounted in interview Mr Weir was much slower than usual. His work was not of the same standard and he felt having Mr Weir in work was giving him a focus which he believed was beneficial.

On 2 December 2020 a letter was received, dated 19 November 2020, from the Consultant Neurologist, Doctor A acknowledging receipt of the referral dated 3 November 2020. Consultant Neurologist, Doctor A stated she had graded the referral as urgent. She regarded the significance of the VGKC result as uncertain and suggested an EEG in the interim.

Also on 2 December 2020 Mr Weir made five telephone calls to his mother. He sounded agitated and pre occupied about getting in contact with the Church of England to ask them about stuff that had gone missing. He talked about his reality and history, referring to himself as a soldier from World War I and World War II. He said his father was a Nazi who had Mr Weir’s brain cut out. Mr Weir referred to himself as the son of God and asked why his mother was pretending not to know what he was talking about.

On 3 December 2020, GP D referred Mr Weir for an EEG as recommended by Consultant Neurologist, Doctor A. Mr Weir was also reviewed by Psychiatrist, Doctor A. Mr Weir expressed his frustration with the parole process as he could not meet some of the conditions due to the pandemic. Psychiatrist Doctor A noted he presented with possible mood and psychotic symptoms but appeared settled clinically. It was noted further test results were awaited and Mr Weir was to continue with his anti-psychotic medication.

Also on 3 December 2020 Mr Weir made two telephone calls to his mother's telephone and speaks to both his mother and his brother. He again discussed his reality and made reference to the Church of England.

On 4 December 2020 Mr Weir was discussed at the MSST meeting. On-going safety concerns about the use of heavy machinery by Mr Weir were discussed. Mental Health Nurse C stated it would not be advisable for Mr Weir to operate a forklift truck due to the medication he was taking.

On 8 December 2020 Mr Weir's Medical Administration Record shows he moved from receiving his Olanzapine medication supervised, to being in-possession of the medication himself. He was issued a seven day supply (x14 10mg tablets) to hold in his cell. It is not clear why this change occurred – Mr Weir's medical records show a review of his in-possession medication. However there does not appear to be a risk assessment for same.

Also on 8 December 2020 Mr Weir made an 11 minute telephone call to his mother's phone and conversed with his brother. He told him they are not their father's sons and a DNA test will prove it. He talked for a prolonged period about them being soldiers in World War II, that there is photographic evidence of this and their father was involved in Nazi organisations. Mr Weir then made a telephone call to his mother where he discussed his parole and money situation and asked about family members. Mr Weir asked about the Criminal Investigation Department Christian boys and he could not get their telephone numbers. Mr Weir telephoned a close family member and asked her to telephone Newtownards police station and speak to the two Christian boys in CID murder squad and arrange a visit.

On 9 December 2020 Mr Weir made a five minute telephone call to his mother and brother where they discuss money, tuck and Christmas.

On 14 December 2020 Mr Weir's blood results were received and were a little out of range.

On 15 December 2020 Mr Weir was reviewed by Mental Health Nurse C at his workplace. Mr Weirt was unable to complete a full review due to the time of day and

the fact he had to return to his accommodation in H1. Some risks were identified such as smoking near combustible materials and lack of concentration, however it remained beneficial for Mr Weir to attend work.

On 19 December 2020 Mr Weir made a 12 minute telephone call to his mother and brother discussing money and his release.

On 21 December 2020 Mr Weir had a spot check carried out on medication held in his possession for self-administration. HiP EMIS records Mr Weir had two unaccounted for Olanzapine, four unaccounted for Co-codamol and seven additional Omeprazole tablets. He reported that Olanzapine medication was causing him to have headaches. He was advised to inform the MHT using a request form. Additionally, Nurse E who carried out the spot check informed Mr Weir's Mental Health Nurse C who was unaware that Mr Weir was in possession of his Olanzapine medication and requested Mr Weir be supervised.

Later that day Nurse E discussed Mr Weir's medication with Nursing Sister A and Lead Nurse A. Nurse E was advised to complete another risk assessment to determine if medication should be supervised or self-administered. A Contingency IP Risk Assessment was completed for Mr Weir. These contingency arrangements were in place due to reduced staffing levels over the Christmas period. When this occurs a lower threshold for self-administration of medication is implemented with limited amounts of medication dispensed to patients risk assessed as suitable for same. Mr Weir was deemed suitable to self-administer his Olanzapine medication. Nurse E recorded she advised Mr Weir to continue taking his medication as prescribed after he asked if he could reduce it to one tablet at night instead of two due to his headaches.

Later on 21 December 2020, Mr Weir attended a mental health review with Mental Health Nurse C. Mr Weir explained he threw out his remaining Olanzapine by mistake 'thinking the box was empty'. Mr Weir said he was taking his medication as prescribed. Mr Weir reported he started getting headaches when his dose of Olanzapine was increased to 20mg. Mr Weir informed Mental Health Nurse C he had no issues with his mental health. Mental Health Nurse C provided a rationale why Mr Weir should be supervised taking anti-psychotic medication, which was due to a risk of relapse in his mental health and previous non-compliance.

On 27 December 2020 Mr Weir made a telephone call to his mother however this call went to voicemail. Mr Weir made a further telephone call to his brother, they discussed Christmas and Mr Weir asked after their mother. Mr Weir attempted to call his mother again approximately 90 minutes later and again the call went to voicemail.

On 31 December 2020 Mr Weir was reviewed by Psychiatrist, Doctor A. Mr Weir reported no mental health issues or concerns. Mr Weir however, continued to express bizarre thoughts. He informed Psychiatrist, Doctor A he had not been taking his Olanzapine medication as prescribed and denied taking illicit substances. Psychiatrist, Doctor A's opinion was Mr Weir continued 'to present with evidence of mood and psychotic symptoms'. Psychiatrist, Doctor A strongly recommended Mr Weir should be supervised when taking his Olanzapine medication and planned to discuss this with the Primary Healthcare Team. It is not clear if this discussion took place between HiP staff and Mr Weir remained in-possession of his medication.

Also on 31 December 2020 Mr Weir attempted to call his mother however the call was again unsuccessful and went to voicemail.

4.6 Magilligan Prison 2021

Throughout January 2021 Mr Weir was in regular telephone contact with his mother and brother. During these telephone calls they discussed his parole and other matters in relation to his psychiatric assessment. He also asked after family and for money to be put into his Inmates Personal Cash account.

On 4 January 2021 Mr Weir had a drug screening test, which was positive for opioids, however, at that time Mr Weir was prescribed Co-codamol.

Mr Weir also attended a check in with his PDU Co-ordinator, Prison Officer A and is recorded as stating, "all good; keeping the head down." PDU Co-ordinator records Mr Weir as being in "good form."

On 12 January 2021 Mr Weir attended a mental health review with Mental Health Nurse A. It was recorded Mr Weir had the same previous bizarre thoughts and beliefs. Primary Healthcare issued 14 x Olanzapine 10mg tablets to Mr Weir.

On 20 January 2021 the PCNI again requested a full psychiatric assessment of Mr Weir.

On 21 January 2021 during a telephone call with his mother, Mr Weir asked why a report has to be completed on his mental health because there isn't anything wrong with it. He went on to talk about the programme he was put through in Maghaberry Prison and how people there were just posing as mental health and were really just "doing science" on him.

Also on 21 January 2021 Forensic Consultant Psychiatrist, Doctor A had a discussion with the Assistant Director of HiP who was going to write to the PCNI and

request an adjournment to “tomorrow’s hearing” explaining this is a “complex case requiring further neurological/neuropsychological/psychiatric assessment.”

On 22 January 2021 NIPS records note Mr Weir did not attend a scheduled parole hearing because it had been adjourned. Prison Officer B who served the paperwork on Mr Weir recorded “there is outstanding paperwork which the commissioners want completed at the earliest opportunity.” No new hearing date was given.

On 23 January 2021 Prison Officer C recorded a residential note. Mr Weir described things as going well at the minute and that he remained in contact with his family.

On 25 January 2021 Mr Weir submitted a request to have the Church of England’s telephone number added to his telephone list.

On 26 January 2021 a Risk Assessment for IP Medication was completed which suggested Mr Weir was unsuitable to be IP of ‘High Risk’ medications. A note on the form reads, ‘contingency IP went well, has been on IP since 21 December 2020, agreed to keep going with IP with regular updates’. There is no record of Psychiatrist, Doctor A or the MHT being consulted about this decision, as requested on the IP Risk Assessment Form dated 8 November 2020. Mr Weir was given 14 Olanzapine 10mg tablets. However, the Trust have now reviewed this practice. Now only seven Olanzapine tablets are now given to patients in custody assessed as suitable for IP.

Also on 26 January 2021 the PCNI gave agreement for Mr Weir’s legal representative to obtain a full psychiatric assessment for Mr Weir.

On 2 February 2021 Mr Weir was due to be issued 14 x Olanzapine 10mg tablets. His Medical Administration Record does not indicate these were dispensed. It does however, record he was dispensed 28 8/500 Co-codamol tablets.

On 3 February 2021 Mr Weir submitted a request to have a video link visit with his father and the visit was booked for 5 February 2021. Mr Weir made two telephone calls to his mother where he discussed his reality and delusional beliefs. He asked her if his grandfather was dead or alive. Mr Weir reported he was due in front of the Parole Commissioners on 23 February 2021. He asked for more money, telling her he owed out what he had. Mr Weir’s final telephone call at 15:47 lasted seven minutes and ended with Mr Weir reassuring his mother he would call her the next day.

On 4 February 2021 a scheduled appointment at the Psychiatry Clinic was cancelled due to unforeseen circumstances. Mr Weir was instead seen by the Mental Health and Addictions Team Leader, Nurse A. Mr Weir had been informed that morning by

NIPS staff a close family member had passed away. Mr Weir did not appear upset and said to the Mental Health and Addictions Team Leader, Nurse A that it was a friend, not a relative. He did not report any mental health issues or concerns but again presented delusional thoughts and beliefs. Mental Health and Addictions Team Leader, Nurse A recorded a plan of speaking with the Multi-Disciplinary Team and updating them on Mr Weir's presentation. There is no record of a Multi-Disciplinary Team meeting or an update being given on Mr Weir's presentation prior to his death.

Also on 4 February 2021 Mr Weir was seen by Prison Officer C in relation to a family member's death, they recorded he "said he felt fine about the news at present." A note on NIPS records from the H1 Senior Officer A recorded Mr Weir did not appear upset by the news. Both Prison Officers made Mr Weir aware of support services available to him should they be required.

On 5 February 2021 a video link visit was booked for Mr Weir. NIPS records state Mr Weir did not attend.

PCNI Hearings and Directions

Mr Weir was engaged with the PCNI and on 24 November 2020 a full psychiatric assessment of him was directed by the Panel of Commissioners to be submitted for the next hearing on 22 January 2021. However, the HiP report submitted to the PCNI in advance of the January hearing did not address the PCNI's Direction and on the 20 January 2021 the hearing was adjourned and a further Direction to the Department of Justice (DoJ) was issued.

On 25 January 2021 the DoJ submitted a response to the PCNI's Direction stating that the DoJ could not compel a Trust employee to respond to the Direction and that Mr Weir's human rights were engaged, making it inappropriate for the DoJ to commission Mr Weir's psychiatric assessment. The DoJ requested a variation to the Direction so that Mr Weir's legal representative obtained the medical report and Mr Weir's solicitor submitted an e mail that same day noting the DoJ's position and requesting the PCNI issued a Direction requiring them to obtain a medical report.

On 26 January 2021 the PCNI issued a Direction noting the DoJ's submission was not accepted but, in light of Mr Weir's solicitors' request and without prejudice, amended the two previous Directions. Mr Weir's legal representatives were required to submit a full psychiatric assessment by 9 March 2021 and the Panel hearing was rescheduled for 23 March 2021.

It is regrettable that it took two months from the PCNI's Direction, which is akin to a Court Order, for issues to be raised regarding who should obtain Mr Weir's full

psychiatric assessment and that he had died before it was scheduled to be submitted to the PCNI.

4.7 Magilligan Prison 8 February 2021

On Monday 8 February 2021 NIPS records indicate Mr Weir was due to see his Probation Board for Northern Ireland PDU Co-ordinator, however due to the ongoing pandemic footfall on the landing was restricted and the meeting did not take place. From NIPS CCTV footage on 8 February 2021 at 08:40 Mr Weir was seen leaving H1 A Wing to attend his work. He returned at 11:17 and is seen entering his cell. At 15:55 Mr Weir can be seen in the doorway of his cell in H1 A Wing for a stand fast headcount. At 16:20 Mr Weir can be seen on CCTV walking alone along the landing periodically before the evening meal is served. Mr Weir is seen collecting his evening meal from the servery and takes it back to his cell. At 20:20 Mr Weir engages in a four minute interaction with another prisoner in the servery area of H1 A Wing. At 23:35 Mr Weir walks alone from his cell to the servery and appears to use the toaster to light a cigarette before returning to his cell. This is the last time he is seen alive on CCTV.

4.8 Post Incident

On Tuesday 9 February 2021 at 07:18 Prison Officer D entered H1 A Wing to take a headcount. At 07:22 Prison Officer D discovered Mr Weir suspended from the window of his cell by a ligature and immediately raised the alarm. Prison Officer D was assisted by Prison Officer E and a Hoffman knife was used to cut the ligature from Mr Weir. Mr Weir's body was lowered to the floor of the cell. Officers recalled Mr Weir's body was cold to the touch. However cardiopulmonary resuscitation (CPR) was immediately started on Mr Weir. At 07:25 HiP staff immediately responded attending the scene having collected emergency equipment from the treatment room on their way to the cell. They found Mr Weir lying in a supine position on the floor with his feet facing the door. NIPS staff were performing CPR and an Automated Electronic Device (AED) was attached to his chest. HiP staff were informed Mr Weir had been suspended by a ligature and had been cut down. An ambulance was requested. Additional HiP and ambulance staff arrived to assist, unfortunately Mr Weir could not be saved. At 08:15 recognition of life extinct was noted by ambulance paramedics. At 09:25 Mr Weir's family were informed by a Prison Governor that he had sadly died. At 11:50 that day a Hot Debrief took place in House Block 1 Magilligan Prison. Prison Officers D and E were present. There were two members from IMB however there was no HiP representative present as they were not invited due to an oversight. Staff Welfare details were provided to all those in attendance.

On 10 February 2021 a Safety and Support Weekly Review Meeting was chaired by Governor B. Mental Health and Addictions Team Leader, Nurse A suggested a Coffee Morning. This could be held in H1 as a time of reflection and to encourage help and support for anyone who was affected by Mr Weir's death. Extra Safety and Support staff were to be made available over the next few days to offer support in residential locations, particularly H1AB. It was stated Safety and Support staff would be available for both prisoners and staff. Inmates had requested a sympathy card to be ordered for them to sign and issue to Mr Weir's family. Additional support was offered to inmates of H1AB including CRUSE bereavement support counselling. It was confirmed all staff involved in response to the incident were given leaflets and information in relation to support services. Mental Health and Addictions Team Leader, Nurse A stated the MHT would be available to provide support for any staff that may require it. The MHT Lead at Magilligan Prison, Nurse A, provided reflective supportive sessions for HiP and NIPS staff and for other people in custody who may have been affected by Mr Weir's death on all three prison sites. I have been advised these sessions had excellent feedback. Governor B said future checks on Trust and NIPS should be done to ensure everyone was supported.

On 23 February 2021 a Cold Debrief took place. Prison Officers D and E were not present this time however, there were now Trust staff present. There was an apology made to Trust staff as they had not been invited to the Hot Debrief due to a misunderstanding. Governor C listed various support mechanisms offered. It was acknowledged a NIPS Standard Operating Procedure for Deaths in Custody would be beneficial for Staff. It was agreed a Standard Operating Procedure in relation to deaths in custody could be shared between NIPS and the Trust.

Section 5: Events following Mr Weir's death

5.1 Support for Prison Officers, HiP staff and Prisoners

Following a serious incident such as this, support for staff involved is critical for their wellbeing, to enable them to continue to carry out their duties to a high standard. Support is initially offered during the Hot Debrief which takes place within hours of any event and again at a Cold Debrief some weeks later. In addition to offering support, these debriefs ensure important information is shared quickly and follow-up actions taken when required.

The Hot Debrief took place at 11:50 on 9 February 2021 in House Block 1 Magilligan Prison. Some procedural norms were not observed:

- not everyone involved in the incident attended, although this can often be the case due to other calls on their time. On this occasion Trust staff had not been invited to the Hot Debrief due to a misunderstanding

The Cold Debrief took place on 23 February 2021 at 12:45 within the stipulated timeframe. It took place in the same location as the Cold Debrief and as with the Hot Debrief I note procedural shortcomings:

- not everyone who attended the Hot Debrief on the morning of 9 February 2021 was present;

- no one from NIPS Headquarters attended.

I am satisfied the Hot and Cold Debriefs took place within procedural timeframes. It is important these debriefs take place. It is also important, both for an individual's wellbeing and for learning and improvement, NIPS and HiP staff attend together. I therefore reiterate recommendations the former substantive Ombudsman made previously about how Hot and Cold Debriefs are carried out and I again remind both NIPS and the Trust they should be implemented.

Given the significant society-wide concerns about mental health and wellbeing I am recommending Debrief procedures for both NIPS and HiP staff are reviewed for effectiveness and improvement. NIPS has put new measures in place for Prison Officers. This includes a peer support programme which is likely to be invaluable given the insights from shared experience. The Trust has also put new measures in place to support HiP staff when they have been involved in serious incidents. This includes a written process for managers about how to support staff following a critical incident. Also the offer of psychological support to an individual or group. Some HiP staff have also been trained in the Community Resiliency Model and some Prison Officers have participated in this training.

It is important those involved in serious events such as this are supported. It is equally important prisoners are offered support as they share in events from behind their cell door, sometimes losing friends. The Samaritans telephone was available to anyone on the Landing who needed it and the MHT was also available to any who needed additional support.

5.2 HiP's Significant Event Audit Report

The HiP completed a Significant Event Audit Report in June 2021. This report was shared with the Weir family who raised a number of issues with the Ombudsman's Office. The issues in the HiP's Significant Event Audit Report are of a medical nature and are therefore for the HiP and Trust to address.

5.3 Learning and Good Practice

One of the purposes of my investigations is to ensure learning is identified to improve practice in the future, including identifying existing good practice to ensure it continues. Such learning should enhance process, procedure and the experience of those involved with a death in custody.

I concur with the Clinical Reviewer, Professor Shaw's, very favourable comments on the high quality of the notes recorded by Psychiatrist, Doctor A.

Section 6: Conclusions

6:1 Conclusions

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

I concur with the opinion of the Clinical Reviewer, Professor Shaw, regarding the standard of care Mr Weir received while in the custody of Magilligan Prison. This care was of equivalence to what he would have experienced had he been in the community. However, the Clinical Reviewer's opinion was the exploration of possible organic causes for Mr Weir's illness was not equivalent to care in the community, as Mr Weir was referred for a neurology consultation in December 2019, which he had not received at the time of his death. A Consultant Neurologist also noted this referral as urgent in December 2020.

I believe the lapsed time between the PCNI's first Direction to obtain a full psychiatric assessment of Mr Weir, the subsequent issues raised about who should obtain it and a revised Direction issued is regrettable.

Mr Weir was on a SPAR Evo Care Plan when he died and was checked on 4 February 2021 when records state he had no thoughts of self-harm or suicide. NIPS and the Trust jointly commissioned an External Review of SPAR Evo and received the final report in May 2024.

In order to assist the Coroner's investigative obligations under Article 2 of ECHR this report will be provided along with full disclosure of investigative materials to inform the inquest.

Evidence of good practice is noted and confirmed by the Clinical Reviewer Professor Shaw's report. Mr Weir was seen regularly by the MHT who explored his symptoms and wrote detailed entries in their records. The Clinical Reviewers comments the entries by Psychiatrist, Doctor A were particularly well written and detailed.

I have made three recommendations.

Section 7: Recommendations

7.1 Recommendations

Recommendation 1

Early psychiatric and neurology referral and follow-up

In complex cases involving physical and mental health issues and possible organic causes for psychosis, the Trust should consider the early involvement of a Consultant Psychiatrist and early referral to neurology with prompt follow-up.

Recommendation 2

Risk assessment

The Trust should ensure there is clarity between psychiatry and primary health care teams about patient risk assessments and in possession and observed medication administration; and consider amending the HiP medication self-administration risk form to include the option of direct administration of medication where a clinician has serious concerns about the patients mental health. If a patient is non-compliant or possibly misusing medication, a risk assessment should be completed with consideration of observed medication administration.

Recommendation 3

Parole Commissioners Directions for assessment

The Department of Justice, NIPS and HiP should work together to ensure assessments directed by the PCNI are expedited as soon as possible or if clarification is required this is actioned promptly in the best interests of the prisoner.

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 (Department of Health and NIPS) 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 1 where a common factor is suggested.

Appendix 2: Terms of Reference for Clinical Reviewer regarding the healthcare in the case of Mr Jason Weir

To review the medical, healthcare and other records provided in relation to Mr Weir and produce a report giving your expert clinical opinion. The review should include comment on:

- the provision of clinical care and treatment, including both risk assessment and medication management;
- any secondary care provided (in this case mental health, psychiatric care and neurology) including any comments on the care received during Mr Weir's 2019/20 presentation in comparison to Mr Weir's 2020/21 presentation and the adequacy of decision making and timeliness of referrals (in this case neurology and psychiatry);
- any care or service delivery failings that may have contributed to Mr Weir's death;
- the specific concerns raised by the family in this case;
- any relevant policy and practice;
- any learning opportunities for future practice;
- any recommendations for future practice;
- identify any examples of good practice; and
- any other observations relevant to Mr Weir's care.

Appendix 3: Timeline of events

8 February 2021	
08:40	Mr Weir can be seen leaving H1 A Wing. Prison records indicate he was attending work that morning.
11:17	Mr Weir returns to H1 A Wing and goes into his cell.
12:10	Mr Weir enters the servery for his lunch meal and returns to eat alone in his cell.
12:23	Mr Weir can be seen entering the ablutions with a towel before returning to his cell. Prison records indicate that he did not attend work that afternoon.
15:55	Mr Weir can be seen in the doorway of his cell for a stand fast headcount.
16:20	Mr Weir can be seen on CCTV walking alone along the landing periodically before the evening meal is served. He collects his meal from the servery and takes it back to his cell.
18:30	H1 A Wing is locked for the night. This meant that the wing grille was locked, however prisoners on this wing are free to associate until 22:30 when they are expected to return to their cells. In keeping with usual practice there are no checks carried out on H1 A Wing by the Night Custody Officer.
19:15	Mr Weir enters the ablutions with a towel where he remains for approximately 15 minutes.
20:20	Mr Weir engages in a four minute interaction with another prisoner in the servery.
23:35	Mr Weir walks alone from his cell to the servery and appears to use the toaster to light a cigarette before returning to his cell.

9 February 2021- Incident response	
07:18	Prison Officer D entered H1 A Wing to commence headcount.
07:22.	Prison Officer D discovered Mr Weir suspended from the window of his cell by a ligature and immediately raised the alarm. Code Red was recorded at this stage. Prison Officer D was assisted by Prison Officer E, a Hoffman knife was used to cut the ligature and Mr Weir's body was lowered to the floor of the cell. At interview the Prison Officers recalled Mr Weir being cold to the touch and that his body was rigid. Despite this they immediately commenced CPR.
07:25	Trust staff attend the scene having collected the emergency equipment from the treatment room on their way to the cell where they found Mr Weir lying in a supine position on the floor with his feet facing the door. NIP staff had already commenced CPR and an AED was attached to his chest. They were informed Mr Weir had been suspended by a ligature and cut down. An ambulance was requested.
07:27	Code Blue correction recorded.
07:35-07:37	Two more HiP staff arrived and assisted with CPR.
07:46	Ambulance paramedics arrive at the scene.
07:52	Second ambulance paramedics arrive at the scene.
08:15	Recognition of life extinct noted by ambulance paramedics.
09:25	Governor A informed Mr Weir's mother.
10:45	PSNI arrive on the Landing.
15:52	Undertakers remove Mr Weir's body.