The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INDEPENDENT INVESTIGATION REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF

Mr Paul McGonigle

AGED 63
AT MAGHABERRY PRISON
ON 1 FEBRUARY 2021

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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 the Northern Ireland Prison Service (NIPS), the South Eastern Health and Social Care Trust (the Trust) and others to ensure the safety and wellbeing of their loved one.

Mr Paul McGonigle, a remand prisoner was 63 years old. This was his first time in prison custody.

Mr McGonigle had a long and complex medical history and frequently attended a hospital emergency department in relation to his physical and mental health issues. On Monday 1 February 2021 at 05:30 Mr McGonigle was found unresponsive in his cell in the Moyola Unit at Maghaberry Prison. Despite attempts he could not be resuscitated and his life was recognised as extinct at 06:51.
A Clinical Reviewer was commissioned to consider the Healthcare in Prison (HiP) Mr McGonigle received. The Clinical Reviewer's report included areas of good practice around Mr McGonigle's prescribing, risk assessments and patient education.

The previous Ombudsman also met the McGonigle family in July 2021 and the family relayed their concerns regarding Mr McGonigle's healthcare. I am sorry for the delay in publishing this report and I appreciate the McGonigle family's patience and their contribution to this investigation.

I offer my sincere condolences to Mr McGonigle's family on their loss. I hope the information contained in this report will be helpful to them, allay their concerns as much as possible and explain the events leading up to Paul's death.

I also 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
December 2024

The role of the Prisoner Ombudsman

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

The Prisoner Ombudsman (Ombudsman) is an independent appointment made by the Minister of Justice and his Investigating Officers are completely independent of NIPS.

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; assist the Coroner's investigative obligations under Article 2 of the European Convention on Human Rights (ECHR) and make recommendations to 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 Terms of Reference for our investigations are available at www.niprisonerombudsman.com/index.php/publications.

Investigation objectives are set out in the Ombudsman's Terms of Reference and are tailored to each independent investigation into deaths in custody to:

- establish the circumstances and events surrounding the death, including the care provided by NIPS;
- examine any relevant HiP issues and assess the clinical care provided by the Trust;

- examine whether any changes in NIPS or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure the deceased's family has an opportunity to raise any concerns they may have, and take these into account in the investigation;
- identify commendable practice;
- highlight areas for improvement where applicable; and
- 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 and any relevant failing is exposed, any commendable practice is identified and any lessons from the death are learned.

Within the above objectives the Ombudsman will identify specific matters to be investigated in line with the circumstances of each case in order that learning from investigations is spread as widely as possible.

In the interests of openness and transparency investigation reports are published on the Ombudsman's website. Reports are also disseminated to those who independently monitor services in prisons and the care and treatment of prisoners and patients. These include:

- CJI;
- the Regulation and Quality Improvement Authority; and
- Independent Monitoring Boards (IMBs).

More information about published reports from these organisations can be found at Appendix 2.

SECTION 1: Investigation Objectives

The overall objectives for this investigation are to:

1.	establish the circumstances and events surrounding Mr McGonigle's death on 1 February 2021 including an overview and examination of immediate responses when he was found;
2.	examine how Mr McGonigle was cared for by NIPS and the Trust while in Maghaberry Prison;
3.	examine Covid-19 risk control measures and their application by NIPS and the Trust and any possible implications for Mr McGonigle;
4.	identify any relevant failing or commendable practice and highlight any lessons learned from the death of Mr McGonigle; and
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 and any relevant failing is exposed, any commendable practice is identified and any lessons from the death are learned.

SECTION 2: Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This comprises interviews with prison staff, prisoners, family and friends and an examination of all prison records in relation to the deceased's life while in custody are examined. This includes closed-circuit television footage, telephone calls and mail. This report is structured to detail the events and emergency response leading up to the death of Mr McGonigle on 1 February 2021. Notices of Investigation into Mr McGonigle's death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and IMB. This allows anyone with information to come forward and speak to the Ombudsman's Investigators.

All of the information gathered was carefully examined and the relevant matters that underpin this report's findings have been detailed.

2.1 Independent advice

After further consideration of the issues, I obtained independent professional advice from a Clinical Reviewer, who is a registered Adult Nurse with extensive experience in Primary Care, Secondary Care, and Health in Justice across both the National Health Service and private sector.

The Clinical Reviewer also contributes their expertise in the development and implementation of primary care, mental health and substance misuse programs at local, regional and national levels. The Clinical Reviewer also holds responsibility for national clinical leadership in resuscitation management and safeguarding.

The information and advice which informed the findings and conclusions are included within the body of this report. It must be noted that the Clinical Reviewer provides advice only. It is then down to my discretion, based on the overall context of the case, whether I base my recommendations on this advice.

2.2 Family liaison

Liaison with the deceased's family is a very important aspect of the Ombudsman's role when investigating a death in custody. On 7 July 2021 Mr McGonigle's family met with the then Ombudsman and asked the following areas to be included in the Ombudsman's investigation:

1. continuity of healthcare between the community and custody;
2. medication review and assessments for compliance;
3. medical appointment review; and
4. personal care.

SECTION 3: Summary

On 23 November 2019 Mr McGonigle was remanded in custody to Maghaberry Prison. This was Mr McGonigle's first time in prison custody. On arrival at Maghaberry Prison Reception, NIPS staff interviewed Mr McGonigle. He was medically examined by HiP staff and was assessed to be at risk due to suicidal thoughts. For his own safety Mr McGonigle was placed on a Supporting People At Risk (SPAR Evo)[1] procedure for the first five days he was in custody.

Prior to his committal Mr McGonigle had a complex medical history which included self-harming. Mr McGonigle was moved to Moyola Unit[2], Maghaberry Prison on 27 November 2019 due to his serious physical health issues; these included Chronic Obstructive Pulmonary Disease (COPD) and a collapsed lung. Mr McGonigle had mobility issues and required the use of a walking aid. Examination of his medical records showed he also had very poor hearing and limited vision.

During his detention Mr McGonigle was treated for breathing issues and was encouraged to try to stop smoking. HiP provided Mr McGonigle with a hospital bed, hearing aids, glasses and a Zimmer frame.

During his time in the Moyola Unit he was seen regularly by HiP practitioners and appeared to be in good spirits.

Mr McGonigle was being treated for depression at the time of his death and was recovering from cancer. On 1 February 2021, Mr McGonigle was found unresponsive in his cell. He was 63 years old when he died

The cause of Mr McGonigle's death stated in the Post Mortem report was:

(1) Coronary Atheroma and (2) Emphysema.

[1] Supporting People at Risk Evolution (SPAR Evo) was jointly developed by NIPS/the Trust in 2018 and, following a proof of concept between April and July 2018, went through several iterations until it was finally signed off by both organisations in April 2019. The approach is person-centred and aims to support people through a period of crisis or distress in a way that meets their needs.

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

SECTION 4 – Background Information

4.1 Maghaberry Prison

Maghaberry Prison is a high security prison that holds adult male sentenced and remand prisoners. The population at the time of Mr McGonigle's death was 878.

Maghaberry Prison has a Prisoner Safety and Support Team whose responsibilities include supporting vulnerable prisoners.

Since 2008 the Trust has increased the number of HiP staff and the range of services provided to prisoners. HiP is planned and delivered in line with primary care services in the community. There is a 24-hour primary healthcare service in Maghaberry Prison. The Mental Health Team (MHT) was on site Monday to Friday between 08:00 and 17:00 at the time of Mr McGonigle's death. From October 2020 all mental health committal screening triaging is completed face to face. There are no in-patient beds.

4.2 Measures to contain the spread of the COVID-19 virus during the pandemic

The global impact of the pandemic included the protection of clinically vulnerable groups of people including those in prisons. As noted by the World Health Organisation[3]:

> *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. 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.*

Prisons standards remained critical at a time when there was also a 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

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

are foundational to preventing the ill-treatment of those in custody. From the information available, Investigators and the previous Ombudsman considered how those in prisons were treated by those caring for them, the facilities provided to them were to standard and measures were applied humanely[4]. Pressure on HiP services was a theme across the United Kingdom and the prison population was 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 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 NIPS followed a similar incremental pathway to 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 and moved to virtual arrangements;
- 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 HiP workers; and
- quarantine for 14 days for those coming into custody.

[4] 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

SECTION 5: Description of key events surrounding Mr McGonigle's death

5.1 Care in Custody

On 2 December 2019 Mr McGonigle was to attend a respiratory clinic at Maghaberry Prison; however, it is documented that he refused to attend this clinic.

On 3 December 2019 Mr McGonigle was assessed by Nurse A. She reported his condition was normal given his COPD; however, she believed his health could be improved if Mr McGonigle was to leave his cell. NIPS staff were informed by HiP they should continue to encourage Mr McGonigle to leave his cell in order to improve his health.

On 14 January 2020 Mr McGonigle's Prisoner Development Unit Co-ordinator Officer A expressed concerns regarding Mr McGonigle's appearance.

On 14 January 2020 Mr McGonigle expressed concerns to staff about his hearing aids. On 4 February 2020 HiP provided Mr McGonigle with new batteries for his hearing aids and this issue was resolved.

The Moyola Unit staff were asked to encourage Mr McGonigle to make use of the ablutions and Prison Orderlies were asked to ensure his bedding and cell were clean and tidy. On 16 February 2020 Prison Officer A noted Mr McGonigle appeared in much better form and he was clean and tidy.

On 9 April 2020, Mr McGonigle presented as upset and confused regarding his weekly medication. The MHT was contacted by Prison Officer B and informed of Mr McGonigle's presentation. Additionally, Nurse B attended the Moyola Unit and explained his medication to Mr McGonigle. On 16 April 2020 Mr McGonigle was seen by Nurse C for a medication check.

Later that day Mr McGonigle was seen by Nurse A for a second medication check. A decision was made to issue Mr McGonigle's medication daily to save him any confusion.

Maghaberry Prison MHT continued to engage with Mr McGonigle throughout April 2020 and increased their engagement in May 2020.

From June to August 2020 Doctors A and B prescribed Mr McGonigle medications for his mood.

On 15 September 2020 Nurse D, a respiratory nurse, saw Mr McGonigle. Nurse D expressed concerns regarding his COPD and stated she would speak with HiP staff regarding his medication and the use of his inhalers.

On 22 September 2020 Nurse D saw Mr McGonigle and was happy with his progress. A hospital bed was provided by NIPS to aid Mr McGonigle's COPD and breathing.

On 25 September 2020 Mr McGonigle was seen by Occupational Therapist A and encouraged to engage in exercise outside of his cell.

On 1 October 2020 Mr McGonigle presented as breathless and was seen by Respiratory Physiotherapist A who instructed him on the correct use of his inhaler.

During October 2020 both HiP and NIPS Officers were concerned regarding to his breathing and closely observed Mr McGonigle.

On 30 October 2020 Mr McGonigle started using a nicotine inhaler in an attempt to stop smoking.

5.2 Social Interaction

Mr McGonigle did not receive any visits and did not make any telephone calls while in custody.

In late December 2020 Mr McGonigle, with encouragement from NIPS staff, began to visit the association room in the Moyola Unit and interacted with other prisoners. Throughout January 2021 Mr McGonigle continued to interact well with other prisoners in the Moyola Unit.

Observations recorded Mr McGonigle was often emotional during interactions with both NIPS Officers and HiP staff. Mr McGonigle never expressed any thoughts of self-harm or suicide. NIPS documentation shows prison staff were concerned and spoke with Mr McGonigle regularly about both his medical and mental health issues.

5.3 Events leading up to Mr McGonigle's Death

The Investigating Officers have ascertained there were no significant events on the days leading up to Mr McGonigle's death.

On 31 January 2021 cells were unlocked at 08:30 and Mr McGonigle received his medication at 08:55. Prisoners were returned to their cells at 12:00 and lunch offered at 12:10. The wing was then locked at 12:25.

Mr McGonigle received his medication at 13:55. Prisoners were unlocked for association at 14:35 and returned to their cells at 16:15. Dinner was offered at 16:20 and the wing was locked at 16:35.

The 17:30 NIPS handover notes stated Mr McGonigle is hard of hearing and it may be difficult to get a response from him. At 17:40 Mr McGonigle received his medication.

The 19:20 the NIPS handover notes state Mr McGonigle is hard of hearing and it may be difficult to get a response from him.

On 31 January 2021, hourly checks were carried out on Mr McGonigle from 20:30 until 05:30 on 1 February 2021 as required by NIPS policy.

At 4:30 Prison Officer C observed Mr McGonigle in bed but noted there was movement. At 05:30 Prison Officer C checked Mr McGonigle's cell and saw that the light was on and that he could not observe Mr McGonigle through the spy glass. Prison Officer C then checked the spy glass which would have given a view of the bathroom and could not see Mr McGonigle. Prisoner Officer C then adjusted the angle he was looking through the spy glass and observed Mr McGonigle lying on his bathroom floor. The Emergency Control Room (ECR) was informed and Prison Officer C entered Mr McGonigle's cell with the onsite Paramedic A at 05:36. The ECR also tasked an ambulance from the Northern Ireland Ambulance Service (NIAS).

5.4 Events after Mr McGonigle was found unresponsive

On arrival at Mr McGonigle's cell he was found lying face down on the floor. Mr McGonigle was turned over onto his back. It was noted Mr McGonigle had a small laceration in the middle of his forehead and bruising to his right eye. Paramedic A noted mild hypostasis; however, Mr McGonigle was still warm to the touch and had no signs of rigor mortis. Prison Officer C commenced cardiopulmonary resuscitation.

At 05:38 Nurse F attended and at 05:39 an Emergency Ambulance was tasked by Maghaberry Prison ECR.

Prior to the arrival of the Emergency Ambulance HiP staff administered two doses of Adrenaline. Paramedic A cannulated Mr McGonigle to allow emergency medication to be administered. An Automated External Defibrillator was deployed on two occasions but did not get a response to shock.

The Emergency Ambulance arrived at 05:58 and NIAS paramedics arrived at Mr McGonigle's cell at 06:06. On arrival paramedics attempted to shock Mr McGonigle. A further four doses of Adrenaline and one dose of Amiodarone were administered

to him. A further three shocks were administered unfortunately all were unsuccessful in restarting Mr McGonigle's heart.

CPR continued for approximately 1 hour and 15 minutes and Mr McGonigle remained unresponsive. At 06:51 on 1 February 2021 NIAS paramedics declared recognition of life extinct.

5.5 Hot and cold debrief meetings

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

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

The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning

On 1 February 2021 the hot debrief took place at 07:45 for those who had responded immediately to Mr McGonigle. The events surrounding the incident were recorded and all staff involved were asked after their welfare and signposted to support services. Contact details for the Duty Governor were also supplied to all those present.

The cold brief took place on 18 February 2021; however, both HiP and IMB declined the invitation and sent their apologies. No staff involved in the incident had sought support during the previous 17 days but were again advised of the support services available to them.

5.6 Contact with Mr McGonigle's next of kin

Initial efforts to contact Mr McGonigle's next of kin were unsuccessful. Mr McGonigle's friend was listed as his next of kin but had not been in contact with him for approximately 14 months. The telephone number listed in his prison documentation was no longer serviceable. NIPS contacted Mr McGonigle's solicitor but they were unable to supply any next of kin contact information. NIPS was eventually able to reach one of Mr McGonigle's children that day.

SECTION 6 - Findings

This section outlines the findings of this report in relation to its objectives.

6.1 The circumstances and events surrounding Mr McGonigle's death on 1 February 2021, including an overview and examination of immediate responses when he was found?

There were no significant incidents or events immediately leading up to Mr McGonigle's death. When his cell was unlocked Mr McGonigle was found to be warm to the touch and was not showing signs of rigor mortis.

Given Mr McGonigle's complex healthcare needs a Clinical Reviewer was asked to assess the appropriateness of the decision to commence CPR and if the resuscitation effort was conducted in line with national guidelines. The Clinical Reviewer found the decision to commence CPR for Mr McGonigle and the subsequent resuscitation efforts were conducted in accordance with best practices and national guidelines and in line with healthcare staff training and competency. The Clinical Reviewer also stated actions taken were appropriate given the clinical situation and were supported by the continuity of care provided by both NIPS and HiP staff and the NIAS crew.

6.2 Was the continuation of care adequate coming into Maghaberry Prison from the community?

The Clinical Reviewer found the continuation of Mr McGonigle's care was *'adequate based on the available documentation.*' The first assessment which took place upon Mr McGonigle's committal '*effectively captured his medical history, including multiple co-morbidities and his frequent interactions with healthcare in the months prior'* and ensured both his physical and mental health were considered from the outset of his care within Maghaberry Prison.

In particular, the Clinical Reviewer noted Mr McGonigle's previous prescriptions were '*promptly re-prescribed and issued within a suitable period'* after his committal.

6.3 Was the provision of primary and secondary healthcare services provided to Mr McGonigle at least equivalent to those he might have received in the community, balanced against the fact that he was in a custodial environment and not in the community?

Prior to entering custody Mr McGonigle's healthcare needs were managed by his General Practitioner (GP), though he did frequently attend a hospital emergency department in relation to his physical and mental health.

Although Mr McGonigle had been diagnosed with Asthma and COPD prior to his committal the Clinical Reviewer found '*his adherence to inhaler therapy appears to have been poor within a community setting.'*

During his time in custody Mr McGonigle's Asthma and COPD were managed through the Respiratory Disease and Monitoring Clinic. The Clinical Reviewer found 'he *was assessed in a timely manner…with a review of his inhaler therapy and technique addressed as part of his management plan.'* The Clinical Reviewer concluded *'the management of his Asthma and COPD was at least equivalent to what he would have received in the community.'*

Prior to entering custody Mr McGonigle had presented to his GP and at the hospital Emergency Department in relation to anxiety and depression on a number of occasions.

Upon committal Mr McGonigle was assessed as part of the SPAR Evo process and monitored accordingly. He was referred to the MHT and was prescribed anti-depressant therapy.

Of special note during his time in custody Mr McGonigle received assessment and monitoring from specialists. The Clinical Reviewer described his mental health care

as exceeding '*the kind of support and intervention that he would have been able to access within a community setting.'*

6.4 Were Mr McGonigle's physical and mental healthcare needs adequately and appropriately met within Maghaberry Prison's healthcare environment based on all the information known about Mr McGonigle and was this information available and considered within the prison healthcare environment?

Also of special note due to Mr McGonigle's complex healthcare needs, he was placed in the Moyola Unit where more frequent access to and engagement with HiP staff could take place.

The Clinical Reviewer stated '*Mr McGonigle's health, social and well-being needs were systematically identified, recorded and addressed through planned interventions with respective healthcare teams. These needs were closely monitored and managed within the prison's healthcare environment.'*
The Clinical Reviewer further stated *'the healthcare environment within Maghaberry Prison appears well-suited to meet his physical and mental healthcare needs. The information available was effectively used by the healthcare and prison services, ensuring Mr McGonigle received appropriate care throughout his time in custody.'*

6.5 Was there adequate sharing of information between the Trust and NIPS to ensure Mr McGonigle's individual needs could be managed appropriately and adequately within a custodial setting?

This investigation found NIPS actively raised concerns with HiP when issues with Mr McGonigle's health arose. This is reflected in the Clinical Review which states '*Prison staff demonstrated responsiveness by communicating with healthcare professionals whenever there were concerns about welfare… These actions reflect a proactive approach in ensuring the necessary care and attention when needed*.'

The Clinical Reviewer stated *'The sharing of information between the South Eastern Health and Social Care Trust (SEHSCT) and the Prison Service regarding Mr*

McGonigle's individual needs appears to have been adequate to ensure that his health and well-being could be managed appropriately within the custodial setting.'

6.6 Covid-19 risk control measures and their application by NIPS and the Trust and any possible implications for Mr McGonigle.

Covid-19 control measures were appropriate and Covid -19 did not unduly impact upon Mr McGonigle's care and treatment.

The Clinical Reviewer was asked to comment and reported on the impact of Covid-19 on Mr McGonigle's primary care while in custody and stated it was minimal. While Mr McGonigle's choice to self-isolate may have limited his interactions there was no evidence to indicate the pandemic negatively affected his primary care delivery during this period.

The only noted impact reported related to Mr McGonigle's secondary care, in that there were delays to his audiology assessment. The Clinical Reviewer concluded, while this referral was crucial for addressing Mr McGonigle's issues with hearing aids, it was not the direct consequences of healthcare provision in prisons but the broader limitations of accessing external healthcare services during the pandemic.

SECTION 7 - Conclusions

1.	**Establish the circumstances and events surrounding Mr McGonigle's death on 1 February 2021, including an overview and examination of immediate responses when he was found;**
	The circumstances of Mr McGonigle's death are outlined in sections 5.3 and 5.4. Consideration of appropriateness of the response can be found in Section 6.1.
2.	**Examine how Mr McGonigle was cared for by NIPS and the Trust while at Maghaberry Prison;**
	The Ombudsman is satisfied the care provided by NIPS and the Trust was appropriate.
3.	**Examine Covid-19 risk control measures and their application by NIPS and the Trust and any possible implications for Mr McGonigle;**
	The Ombudsman is satisfied COVID-19 control measures do not appear to have negatively affected Mr McGonigle while in custody.
4.	**Identify any areas for improvement or commendable practice, and highlight any lessons learned from the death of Mr McGonigle;**
	Areas of commendable practice are highlighted in section 8; there were no lessons to be learned from the death of Mr McGonigle.
5.	**To 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.**
	This report will be provided to the Coroner along with full disclosure of investigative materials and inform the inquest.

SECTION 8: Commendable Practice and Recommendations

8.1 Commendable Practice.

Mr McGonigle arrived into custody with complex health needs which were assessed and managed appropriately and efficiently.

This investigation showed clear examples of effective communication between NIPS and the Trust in relation to Mr McGonigle's care. In particular, NIPS staff promptly reported concerns to HiP as well as encouraging and supporting Mr McGonigle to engage with others in custody.

The Clinical Reviewer highlighted the patient's healthcare which was emphasised as part of Mr McGonigle's inhaler therapy and recognised this as '*consistent with best practices for improving self-management in patients with long-term conditions.'*

The Clinical Reviewer also highlighted the management and risk assessing of Mr McGonigle's medication noting a medication spot check was effectively used to inform a decision to move Mr McGonigle to supervised administration.

NIPS staff appeared to be actively engaged in encouraging Mr McGonigle to address both his physical and mental health needs. They reported relevant issues to HiP when necessary and encouraged Mr McGonigle to engage with his peers.

Prescribing and Risk Assessments:

The management of Mr McGonigle's prescribing, including the completion of associated risk assessments, was handled effectively. During a spot check of his medicines, a concern was identified regarding the remaining quantity, leading to the decision for witnessed consumption to improve compliance.

Patient Education:

Patient education was emphasised as part of managing Mr McGonigle's inhaler therapy. Given his likely poor compliance with inhalers in the community, evidenced by the absence of repeat prescriptions and

frequent COPD exacerbations. Patient education and re-education were consistent with best practices for improving self-management in patients with long-term conditions.

Rapid Assessment and Planning:

Following the first screening, a comprehensive and timely assessment and plan were undertaken regarding aids and equipment needed. This prompt response reflects good practice in addressing his needs efficiently.

In summary, while Mr McGonigle's care was predominately consistent with best practices, future improvements could include deeper exploration of medication non-compliance, thorough assessment of sensory impairments and enhanced interdisciplinary communication. These steps will contribute to more comprehensive and effective patient care in the future.

8.2 Recommendations

The Ombudsman makes no recommendations for the NIPS or HiP in respect of this investigation.

The Ombudsman acknowledges the Clinical Reviewers advice and notes the management of his Asthma and COPD was at least equivalent to what he would have received in the community and aligned with best practice.

Appendix 1

GLOSSARY

CJI	Criminal Justice Inspection Northern Ireland
COPD	Chronic obstructive pulmonary disease
GP	General Practitioner
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
MHT	Mental Health Team
NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
SPAR Evo	Supporting People at Risk (procedure)
SEHSCT/theTrust	South Eastern Health and Social Care Trust

Appendix 2

Criminal Justice Inspection Northern Ireland (CJI)

At the time of Mr McGonigle's death, the most recent inspection of Maghaberry Prison by the CJI had taken place in April 2018 and the report published in November 2018. The report is available at CJINI - Criminal Justice Inspection Northern Ireland - Maghaberry Prison.

Of particular relevance to this investigation the report noted Inspectors had observed friendly, respectful interactions and some very good care for men who needed more support on the Moyola and Donard Units.

Independent Monitoring Board

Maghaberry Prison has an Independent Monitoring Board (IMB) of volunteers whose role is to independently monitor the care and treatment of individuals in custody.

The 2018-19 IMB annual report commented the Moyola Unit continued to provide a more therapeutic environment for those living with complex health conditions and provision of end-of-life care continued to pose challenges. IMB reports for 2019-2021 can be viewed at Independent Monitoring Board (imb-ni.org.uk) .