



The
**Prisoner
Ombudsman**
for Northern Ireland

OFFICIAL - SENSITIVE

**INDEPENDENT INVESTIGATION REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF**

**MR CONOR CURRAN
AGED 35
AT MAGHABERRY PRISON
ON 28 DECEMBER 2022**

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Foreword from the Prisoner Ombudsman

Conor Curran, a 35 year-old Irish national, was a remanded prisoner who had been in custody from 17 July 2021 awaiting trial. This was Mr Curran's only time in a custodial setting in Northern Ireland. Mr Curran had previous custodial periods in the Republic of Ireland. He died in Maghaberry Prison on 28 December 2022.

This report details the outcome of the investigation into the treatment and care Mr Curran received prior to his death and the circumstances leading up to it.

The responsibility for the care and wellbeing of prisoners lies with the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust and both organisations have cooperated fully in this investigation.

It is crucial any opportunities for learning are addressed and good practice is acknowledged and shared across the custodial environment. It is only through this process prisoners and their families can be assured of confidence in the prison system, the standard of medical care, the investigation itself and the operational independence of the Office of the Prisoner Ombudsman.

I am conscious of the length of time Mr Curran's family has had to wait for the completion of the investigative process and appreciate their patience.

This report provides as much detail as possible about Mr Curran's time in custody and the circumstances surrounding his death. I hope this information will be helpful to his family as they piece together the last days of his life.

Mr Curran was a new committal detained during the Covid-19 pandemic (pandemic). The process for new committals was to complete a period of 14 days in quarantine in Foyle House Maghaberry Prison prior to being admitted into the wider prison establishment. The new measures adopted during the reception process, which applied to Mr Curran, were to ensure the safety of prisoners and staff during the pandemic. Given the extraordinary circumstances both in general society and prison,

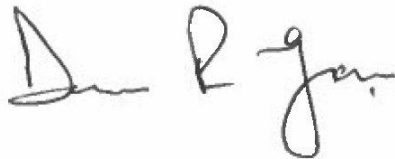
it is important to acknowledge Mr Curran faced isolation due to these measures which may have influenced his wellbeing.

Mr Curran was moved out of the committal house upon completion of his quarantine and re-housed among general population where he remained throughout his custodial period.

Following a medical emergency on 28 December 2022 Mr Curran's life was recognised as extinct.

I would like to thank all those who contributed to the preparation of this report including the Northern Ireland Prison Service and the South Eastern Health & Social Care Trust's Healthcare in Prison team.

I offer my condolences to Mr Curran's family on their loss.

A handwritten signature in black ink, appearing to read 'Darrin Jones', written in a cursive style.

Darrin Jones
Prisoner Ombudsman for Northern Ireland

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 independent of the Northern Ireland Prison Service (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)¹ and make recommendations to Northern Ireland Prison Service 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 Trust was established on 1st April 2007 and is one of five Trusts in total within Northern Ireland. The South Eastern Trust has responsibility for providing healthcare to all prisoners in Northern Ireland. This is delivered on a day to day basis by the Healthcare in Prison (HiP) team. While they are based in the Establishments, they are not part of NIPS.

¹ "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

- (a) in defence of any person from unlawful violence;
- (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

The generic investigation objectives are set out in the Ombudsman's Terms of Reference and are available [here](#).

In the interests of 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:

- Criminal Justice Inspection Northern Ireland (CJINI);
- the Regulation and Quality Improvement Authority (RQIA); and
- Independent Monitoring Board (IMB).

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

SECTION 1: Investigation Objectives

Mr Curran took part in a football match with other prisoners on the morning of 28 December 2022. When the match concluded he left the pitch and entered the gym reception area along with the other prisoners who had taken part. Mr Curran is seen on closed circuit television (CCTV). He is seated on a bench and is approached by another prisoner. Mr Curran leans back against the wall and places his hand on his chest. Shortly after Mr Curran walks to get a drink of water. He returns to his seat for a short while then walks off camera. Mr Curran appears shortly after beside the grille to leave the gym area. Mr Curran collapses to the ground, falling forward, onto his front. Two Physical Education Instructor's (PEI) respond to Mr Curran immediately. Despite the efforts of NIPS and HiP staff, and Northern Ireland Ambulance Service (NIAS) staff, Mr Curran passed away.

The overall objectives for this investigation are to:

1.	Establish the circumstances and events leading up to and surrounding Mr Curran's death on 28 December 2022, considering the involvement of both NIPS and the Trust.
2.	Examine whether the provision of healthcare services provided to Mr Curran were at least equivalent to those he might have received in the community.
3	Ensure Mr Curran's family has an opportunity to raise any concerns they may have and take these into account in the investigation
4.	Identify any relevant failing or commendable practice, and highlight any lessons learned from the death of Mr Curran;
5.	Assist the Coroner's investigative obligation under Article 2 of the ECHR.

SECTION 2: Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This comprises interviews with NIPS staff, HiP staff, prisoners and family and friends. All prison records in relation to Mr Curran's life while in custody are examined. This includes examination of evidence such as CCTV footage, telephone calls and mail. This report is structured to detail the circumstances and events leading up to Mr Curran's death on 28 December 2022.

Notices of investigation into Mr Curran's death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and the IMB. This encourages anyone with information to come forward and speak to the Ombudsman's Investigators.

All the information gathered was carefully examined with the relevant matters that underpin this report's findings detailed in this report.

2.1 Independent Advice

Mr Curran entered the Prison with established additional requirements including an addiction to alcohol. HiP records evidenced Mr Curran was taking a number of medications for pain relief and to address anxiety. Records evidence Mr Curran disclosed he was a "recreational cocaine user".

After further consideration of the issues and evidence from NIPS and the Trust, and particularly the Coroner Service independent professional advice from a Clinical Reviewer was not deemed necessary on this occasion

2.2 Family Liaison

Liaison with the Mr Curran's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody.

A meeting was held with Mr Curran's family on 08 February 2023 to consider their questions and concerns. These are listed below.

1.	Had Mr Curran been seen by healthcare professionals while in Maghaberry Prison?
2.	Had Mr Curran ever presented with or complained of chest pains while in Maghaberry Prison?
3.	Had Mr Curran ever presented with or contracted Covid-19 while in Maghaberry Prison?
4.	Was Mr Curran offered immediate medical assistance when he collapsed in the gym reception on 28 December 2022?

SECTION 3: Summary of Mr Curran's Case

On 17 July 2021 Mr Curran was remanded to Maghaberry Prison while he was awaiting trial. This was Mr Curran's first time in custody in Northern Ireland. From the Safer Custody Report², on arrival at Maghaberry Prison, Mr Curran was deemed "No Apparent Risk" of deliberate self harm (DSH) or suicide. He denied any history of DSH or suicide to NIPS.

On 17 July 2021 Mr Curran also met with HiP for an initial committal assessment as part of the committal process. From Egton Medical Information System (EMIS/Electronic Healthcare Records) records Mr Curran did disclose a history of addictions, deliberate self harm and a previous suicide attempt from several years ago.

On 18 July 2021 Mr Curran met with HiP for a face to face "*Mental Health Triage*" (MHT) as part of the committal process. Mr Curran consented to be referred to "*Alcohol and Drugs: Empowering People Through Therapy*" (AD:EPT)³ for help with alcohol addiction.

In October 2021 Mr Curran was served with an extradition order for charges against him in the Republic of Ireland.

Throughout his time in custody Mr Curran engaged with HiP regarding his mental health, sleep and a previous neck injury.

Mr Curran had an unremarkable history with NIPS and HiP from committal to 27 December 2022.

² A Safer Custody Report is a document used by NIPS to provide an overview of a prisoner. It includes a summary of the prisoners' initial interview and presentation when committed to Prison.

³ AD:EPT is Northern Ireland's largest drug and alcohol treatment service for adults based in the three prisons. They provide a range of services to people in custody who have problems with drug and alcohol use.

On 28 December 2022 Mr Curran attended a football match after which he collapsed in the Gym reception. PEI and HiP Staff commenced cardiopulmonary resuscitation (CPR) and used the automated external defibrillator (AED)⁴ until an ambulance arrived.

Mr Curran was then transferred to the ambulance, however before he could be taken to Royal Victoria Hospital paramedics pronounced life extinct in the ambulance at 12:05. The ambulance was still on Prison establishment grounds.

Mr Curran's death was attributed to:

1a) Coronary Artery Atheroma and Thrombosis

A post mortem was carried out on Mr Curran.

⁴ An Automated External Defibrillator or AED is a lightweight, battery-operated, portable device used to help people having sudden cardiac arrest (SCA). The AED checks the heart's rhythm and, if needed, sends a shock to restore a normal rhythm.

SECTION 4: Description of Key Events Surrounding Mr Curran's Death

4.1 Key Events Within Gym Reception.

28 December 2022

09:10

Mr Curran enters the gym reception area. He makes his way to get changed into appropriate attire for the football match.

09:19

Mr Curran reappears on CCTV. He is dressed in a blue long sleeved top and grey trousers with blue football socks over the top of the trousers. Mr Curran stands and takes several drinks of water from a sports bottle. He then walks off camera.

09:22

Mr Curran is seen on camera in the gym reception at the turnstile along with several others in his team. Mr Curran appears content and can be seen laughing and talking with his team members.

09:25

Mr Curran and all other team members walk off camera.

09:27

Mr Curran and all other team members appear on camera in the gym reception. Mr Curran jogs into frame and collects the ball. The gate at the gym reception is opened and the prisoners exit and head directly to the pitch for the match to commence.

Witness statements taken from other prisoners playing that day and NIPS staff noted nothing remarkable about the match itself.

Prisoners playing with Mr Curran described him as “*normal*” and being “*in good form*” prior to the match. Mr Curran’s performance during the match was described as “*all good*” and “*nothing unusual during the match*”.

10:05

Mr Curran and the other prisoners involved in the match exit the pitch and enter the Gym Reception. All players enter via the gate in the gym. The prisoners walk off camera into the changing rooms.

10:10

Mr Curran appears on the camera in the gym reception and immediately takes a seat on a bench. He approaches a table and collects a can of juice and crisps. He returns to the bench and sits again. Mr Curran rests his elbows on his legs and leans forward, looking at the ground, and appears to cough.

Another prisoner approaches Mr Curran. While seated Mr Curran sits upright and leans back against the wall. He places his left hand on his chest for a very brief moment.

Mr Curran sets the crisps and juice on the bench and leans forward again and puts his left hand to his forehead. Mr Curran stands up from the bench and walks past the gate to a water fountain which is in the corner of the gym reception.

10:12

Mr Curran walks off camera for a few seconds before reappearing again with several other prisoners at the turnstile in gym reception.

10:13

While seemingly waiting to exit the turnstile and gym reception area Mr Curran, on the periphery of the camera, collapses to the floor and falls face down at the feet of another prisoner.

PEI A and PEI B immediately approach Mr Curran.

10:15

Mr Curran is rotated to his left hand side by the PEI officers present.

An entry at 10:15 to the Emergency Control Room (ECR) log stated *“Nurse required in gym, prisoner has collapsed having some sort of seizure – He is breathing”*.

It also confirmed *“Nurse on scene is asking for assistance from another nurse – tasked”*

10:18

Nurse A arrives at Gym Reception and she enters via the gate. She has with her a large green bag and a smaller black bag containing medical apparatus. An oxygen canister is taken from the green bag and the Nurse sets up the apparatus.

10:20

The other prisoners playing football that morning with Mr Curran leave the gym reception via the gate, leaving only NIPS staff and HiP staff with Mr Curran. Nurse A places the canister at Mr Curran’s head and walks around Mr Curran to face him.

10:21

Mr Curran is rolled from his left hand side onto his back by the PEI A and Nurse A. Electronic healthcare records entered by Nurse A stated

“Conor was lying in recovery position on the floor at gym and was vomiting before I arrived. Noted patient had difficulties breathing and face purple in colour. I have placed him on the back and green guedel⁵ inserted into mouth”

⁵ A Guedel is a rigid plastic tube which sits along top of mouth and ends at base of tongue (an adjunct to help keep airway open). An oxygen mask or bag mask ventilation can be applied over the top if needed.

10:22

Nurse A applied defibrillator pads. Nurse A recorded on electronic healthcare records that a shock was advised. The AED completed this and Nurse A commenced chest compressions.

10:23

An electronic healthcare record entered by Nurse A stated *“emergency ambulance tasked at 10:23”*. Chest compressions were continued by PEI A and Nurse A.

An entry at 10:23 to the ECR log stated *“Ambulance required – CPR being used on prisoner – Ambulance tasked – all relevant parties informed”*

10:25

The AED delivers a second shock to Mr Curran and CPR is recommenced by PEI A.

10:26

Nurse B arrives at the Gym reception and is accompanied by Nurse C. Nurse B removes the non-rebreathe mask and started ventilation using a bag valve mask. The AED delivered another shock to Mr Curran and chest compressions recommenced. Due to individuals positioning themselves between the CCTV camera and Mr Curran it was not possible to comment on further shocks.

10:28

Governor A arrived at the Gym reception.

10:29

PEI B delivers additional medical bags. Nurse A, Nurse B and PEI A continue to tend to Mr Curran. Chest compressions are rotated between Nurse A and PEI A. PEI B was not required directly when he returned but he adopts an observant role. In interview PEI B confirmed he offered support to others as required.

An entry to the ECR log stated *“Nurses requesting more oxygen”*.

10:31

Nurse C arrived back with additional oxygen cannisters and medical bags. He is accompanied by an additional HiP Nurse (unidentified). An additional (unidentified) HiP nurse also arrives on scene, closely followed by a NIPS Prison Officer (unidentified) with additional oxygen cannisters.

10:34

Additional HiP nurses (unidentified) arrive at the Gym reception. This was as a result of a request by those actively involved with Mr Curran for additional assistance.

10:36

CPR is stopped to allow some treatment to be given to Mr Curran. Appears that CPR is no longer required. An electronic healthcare record by Nurse A evidenced Mr Curran was administered Naloxone⁶ at this time.

An electronic healthcare record entered by Nurse C stated

“CPR continued until AED machine advised otherwise and cardiac output was evident at carotid and radial pulse. Patient at this time was breathing independently but restless and disorientated”.

An electronic healthcare record entered by Nurse B stated

“Radial, carotid and femoral pulses were felt and patient was showing signs of life by breathing, incomprehensible sounds and movement, ROSC” (return of spontaneous circulation)

An electronic healthcare record entered by Nurse D stated

“after a short time patient showed signs of attempting to breath himself, he was still tolerating the guedel airway, he was switched to the non rebreather mask,

⁶ Naloxone hydrochloride is a drug used to reverse opioid overdose and withdrawal. It is available in different forms and doses for various indications and routes of administration.

there was an established spontaneous return of circulation with pulses palpable at the radius and carotid areas. He began to commit and was repositioned onto his side and suction applied”.

10:40

Mr Curran is rolled onto his right hand side by Nurse B and Nurse C to clear some fluid before being positioned on his back again.

An entry to the ECR log stated *“First response arrives”*.

10:41

Mr Curran is rolled onto his back more by Nurse B.

10:42

An entry to the ECR log stated *“Ambulance arrives”*.

10:44

Two paramedics from the *Air Ambulance Northern Ireland (AANI)* arrive at the Gym reception.

10:45

Two paramedics from NIAS arrive at the Gym reception.

A handover is completed from HiP to AANI and NIAS staff. Mr Curran’s medical requirements are managed by NIAS and AANI, however Nurse B and Nurse C remain in the gym reception to assist further. Mr Curran was observed on CCTV to be conscious and showing signs of life but also appearing to be uncomfortable and disorientated. Mr Curran made a number of attempts to sit up and get off the floor however NIAS professionals can be seen encouraging Mr Curran to remain where he was for the meantime.

10:47

Handover to NIAS appears to have been completed.

Nurse B and Nurse C remained on scene and can be seen assisting the NIAS staff throughout.

10:48

An entry to the ECR log stated *“prisoner is breathing and has a pulse – Ambulance crews are dealing with him now”*.

11:07

NIAS and AANI paramedics transfer Mr Curran onto a stretcher. Mr Curran is then transferred from the floor onto a stretcher bed. Mr Curran suddenly becomes non responsive again and NIAS staff apply an AED to Mr Curran.

Nurse B entry to EMIS states

“....was lifted using a scoop stretcher on the trolley where he arrested again with CPR commenced by NIAS. Further shocks were administered and patient had ROSC again. Prior to leaving gym CPR was commenced by NIAS and patient was taken out to ambulance”.

11:09

CPR is commenced by NIAS paramedics and the AED administers shocks. An entry to the NIPS ECR log evidenced *“paramedics performing CPR again”*.

11:17

Mr Curran has a Lund University Cardiopulmonary Assist System (LUCAS) device⁷ fitted to his bed. Manual CPR is ceased and the LUCAS device takes over.

11:36

LUCAS device is stopped and preparations are made to transfer Mr Curran to ambulance.

⁷ LUCAS Device is mostly used in emergency medicine as an alternative to manual CPR because it provides consistent compressions at a fixed rate through difficult transport conditions and eliminates the physical strain on the person performing CPR

11:39

AANI and NIAS paramedics, assisted by HiP Nurse B and Nurse C gather medical equipment and transfer Mr Curran to the ambulance.

11:40

LUCAS device is restarted and AED administers shocks.

11:41

An entry to the ECR log stated *"Prisoner Curran is being loaded onto ambulance – He did have a heartbeat but it remains intermittent"*.

Records evidence Mr Curran required further medical attention while in the back of the ambulance but shortly after midday he was pronounced life extinct by NIAS paramedics.

4.2 Hot and Cold Debrief Meetings

Standard 25 of NIPS 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 de-brief will involve all staff (where possible) who were closely involved with the incident.

Hot and Cold debriefs are tools utilised by NIPS following a death in custody. They offer the opportunity for all parties directly involved in the death to discuss the action taken, identify good practices and highlight any difficulties, identifying opportunities for learning if applicable.

The Hot debrief took place immediately following Mr Curran's medical emergency and once NIAS had taken over from NIPS and HiP staff.

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 additional learnings. The Cold Debrief took place on 13 January 2023.

The hot and cold debriefs took place relatively as expected, noting the cold debrief was slightly longer than 14 days.

SECTION 5: Family Liaison

5.1 Contact with Mr Curran's Next of Kin

NIPS documentation evidence Mr Curran's next of kin was his ex-partner.

Rule 29 of "*The Prison and Young Offenders Centre Rules (Northern Ireland) 1995 (Prison Rules)*" states;

(1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital, the governor shall, if he knows the address, at once inform the prisoner's next-of-kin, and also any person the prisoner may reasonably have asked should be informed.

It would be normal practice for NIPS to contact next of kin in the event of a death within NIPS establishments.

While NIPS did not contact Mr Curran's next of kin directly this task was undertaken by Father A. NIPS confirmed the reason for this was due to initial difficulties in contacting the family. NIPS stated

"the family were living in the South of Ireland and there were difficulties contacting them by phone, a number of attempts were made. Fr A offered to make contact on NIPS behalf."

SECTION 6 - Findings

Having reviewed all evidence pertinent to Mr Curran’s case, including viewing CCTV of the gym reception area on 28 December 2022, it was clear NIPS and HiP staff present responded immediately and appropriately.

This section outlines the findings of this report in relation to its objectives and concerns raised by the family.

Investigation Objectives	
1.	<p>Establish the circumstances and events leading up to and surrounding Mr Curran’s death on 28 December 2022, looking at the involvement from both NIPS and the Trust.</p>
	<p>The circumstances of Mr Curran’s care while in NIPS custody are outlined in this report and can be found in Section 4. Consideration of appropriateness in the level of care provided by NIPS and HiP in the period immediately leading up to Mr Curran’s medical emergency can be found in Section 6.</p>
2.	<p>Examine whether the provision of healthcare services provided to Mr Curran were at least equivalent to those he might have received in the community.</p>
	<p>The healthcare services provided to Mr Curran while in NIPS custody are outlined in this report and can be found in Section 4.</p> <p>I am satisfied Mr Curran received healthcare at least equivalent to that within the community considering the sudden and dramatic nature of his death.</p>

3.	Ensure Mr Curran’s family has an opportunity to raise any concerns they may have and take these into account in the investigation
	Concerns raised by the family of Mr Curran and responses to these can be found in Section 6.
4.	Identify any relevant failing or commendable practice, and highlight any lessons learned from the death of Mr Curran;
	Areas of good practice and learning are included in Sections 7 and 8. No relevant failings were identified in the care of Mr Curran in the period immediately leading up and following to Mr Curran’s medical emergency or in his care prior to the incident.
5.	Assist the Coroner’s investigative obligation under Article 2 of the ECHR.
	A preliminary hearing into the death of Mr Curran by the Coroner’s Office was conducted on 14 October 2025.

Family Concerns	
1.	Had Mr Curran been seen by healthcare professionals while in Maghaberry Prison?
	Electronic healthcare records evidence Mr Curran was seen by HiP teams throughout his time in custody at Maghaberry Prison for a variety of reasons and was treated appropriately.
2.	Had Mr Curran ever presented with or complained of chest pains while in Maghaberry Prison?
	There was no evidence to suggest Mr Curran had complained to HiP of chest pains.
3.	Had Mr Curran ever presented with or contracted Covid-19 while in Maghaberry Prison?
	As part of his committal process. Nurse D recorded Mr Curran had not received a Covid-19 vaccination to date. It was recorded Mr Curran would like to receive this while in custody. This was administered on 04 August 2021 to Mr Curran. There was no evidence of Mr Curran having contracted Covid throughout his electronic care records.
4.	Was Mr Curran offered immediate medical assistance when he collapsed in the gym reception on 28 December 2022?
	Mr Curran was observed falling to the floor and NIPS staff act appropriately and are by his side immediately. Shortly afterwards as a result of NIPS requesting medical assistance HiP staff arrive and tend to Mr Curran.

SECTION 7 – Good Practices

Pandemic restrictions significantly impacted daily activities throughout Mr Curran's custodial period and I am satisfied prisoner interaction, mitigating measures including meaningful contact opportunities were in place.

Action taken by NIPS staff and HiP staff was immediate and appropriate when Mr Curran's medical emergency began. All staff involved acted quickly in recognising cardiac arrest as early as possible and were able to provide the appropriate care.

It was evident NIPS and HiP staff worked well together and good teamwork was evident

SECTION 8 – Learning and Recommendations

Whilst a death has occurred in custody, on this occasion, there were no learnings or recommendations.

SECTION 9 – Conclusions

There was nothing to indicate that Mr Curran's death could have been predicted based on any of his interactions with NIPS or HiP staff. There were no occasions of Mr Curran ever having presented with any symptoms related to his chest or heart or having made any comments which would have alluded to such concerns.

On 29 December 2022 an autopsy was carried out on Mr Curran. The postmortem report from this concluded *“death was due to natural causes”*.

The postmortem report evidenced weaknesses with Mr Curran's heart. The postmortem stated an artery of Mr Curran's heart had been acutely blocked by a blood clot which resulted in reducing the flow of blood to an area of the heart. The report stated;

“As a consequence, the heart muscle would have been prone to injury and the heart susceptible to sudden fatal disturbance of rhythm (arrhythmias)⁸ and sudden death could have occurred at any time. This is a common form of heart attack”

I am satisfied Mr Curran received healthcare at least equivalent to that within the community considering the sudden and dramatic nature of his death.

⁸ An arrhythmia is an irregular heartbeat that occurs when electrical signals that control the hearts rhythm do not function properly. It can manifest as a heartbeat that is too fast, too slow or irregular.

Guidance during the Covid-19 pandemic

Appendix 1

NIPS worked with SEHSCT Infection control specialists from February 2020 in preparation for the pandemic and was informed by Public Health Authority (PHA) and the Health and Social Care Board (HSCB) from April 2020. NIPS and SEHSCT colleagues were also representatives on the 5 Nations Covid-19 Health and Justice group that proved a valuable forum in learning from other jurisdictions.

NIPS recognised that the general prisoner population did not present a risk; it was people coming into prison (staff and new committals) that posed a risk of transmission of the Covid-19 virus to general population. NIPS restricted staff access early on to essential staff (NIPS and SEHSCT) and introduced committal quarantine to protect the general prisoner population.

Committal quarantine was implemented for 14 days, based on PHA advice and quarantined prisoners were held in specific accommodation, with largely the same staff group in place. Committal quarantine was reduced to 10 days from 12 November 2021, subject to the individual agreeing to be tested for the virus (again, informed by PHA advice).

NIPS implemented its formal Pandemic Plan and procedures in June 2020 that included infection control measures, quarantine and isolation arrangements (for staff and prisoners) and virtual visits etc. The SEHSCT/NIPS Quarantine Arrangements for new committals during Covid-19 Pandemic was included at Appendix C and was informed by advice from Public Health England and our own Public Health Agency. The document was revised regularly in line with Chief Medical Officer and PHA advice, version 7.0 contained changes effective from 31/12/21 and 10/01/22, and version 8.0 was implemented 31/01/2022.

Prisoners held in Foyle House quarantine landings had a TV in their cell, distraction packs and access to in-cell exercise equipment (procedure through funding provided by HSCB). All prisoners were facilitated to have regular showers and phone calls and, apart from check-ins with NIPS staff, quarantined prisoners were seen by Healthcare

in Prison staff daily. In addition, the HiP Prisoner Engagement staff also visited with each prisoner.

Criminal Justice Inspection Northern Ireland (CJINI)**Appendix 2**

CJI is a United Kingdom National Preventive Mechanism (NPM) member body that independently monitors places of detention to prevent the ill treatment of prisoners. CJI inspects Northern Ireland prisons in partnership with His Majesty's Inspectorate of Prisons (HMIP), the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate. HMIP and the RQIA are also NPM members.

In November 2019 CJI and RQIA reported on the Safety of Prisoners held by NIPS and made two strategic and ten operational recommendations for improvement including better joint-working between NIPS and the Trust to increase the safety of prisoners.

CJI reports relating to Prisons are available at <https://www.cjini.org/report-category/prisons/>

Regulation and Quality Improvement Authority (RQIA) Review of Services for Vulnerable Persons detained in Northern Ireland Prisons

Following a report of an accident of serious self-harm from the Prisoner Ombudsman's Office in 2016 and the number of recorded suicides in prisons, the Departments of Health and Justice jointly commissioned a review 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 works with the RQIA and others to raise matters of concern and improve the delivery of support to prisoners.

Independent Monitoring Board (IMB)

Prison establishments have an IMB of volunteers whose role is to independently monitor the care and treatment of prisoners.

IMB Annual Reports can be viewed at [Independent Monitoring Board \(imb-ni.org.uk\)](http://imb-ni.org.uk)

Prison Establishments

Appendix 3

Maghaberry Prison

Maghaberry Prison was established in 1986 and serves as a high-security prison in Northern Ireland. It was designed to replace the aging Long Kesh/Maze Prison and provides a secure environment for the detention and rehabilitation of individuals involved in serious criminal activities.

Maghaberry Prison is classified as a high-security prison. It houses individuals who have been convicted of serious offenses and pose a significant risk to public safety. The prison employs stringent security measures to ensure the safety of staff, visitors, and the wider community.

Magilligan Prison

Magilligan Prison, established in 1972, is a medium-security prison for male inmates. Located in Limavady, County Londonderry, it primarily accommodates offenders serving shorter sentences. Over the years, it has evolved to include various rehabilitation programs aimed at reducing reoffending rates.

The prison's infrastructure includes modernized facilities that support educational and vocational training, ensuring that inmates have opportunities to improve their skills and reintegrate into society post-release. The prison also emphasizes mental health support and substance abuse programs, crucial for the well-being and rehabilitation of its inmates.

Hydebank Wood College and Women's Prison

The campus of Hydebank Wood College and Ash House Women's Prison, (HBW) situated on the outskirts of Belfast, is a prison, which houses young male students from age 18-24, and women prisoners from 18 upwards. There is a combination of those who are sentenced and those who are on remand. HBW is the only location for

adult women prisoners in Northern Ireland and although they are housed separately, it is a shared campus with the young men.

Glossary**Appendix 4**

AANI	Air Ambulance Northern Ireland
AD:EPT	Alcohol and Drugs: Empowering People Through Therapy
AED	Automated External Defibrillator
CCTV	Closed-Circuit Television
CJI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
DSH	Deliberate Self Harm
ECHR	European Convention on Human Rights
ECR	Emergency Control Room
EMIS	Egton Medical Information System
HIP	Healthcare In Prison
HSCB	Health and Social Care Board
IMB	Independent Monitoring Board
LUCAS	Lund University Cardiopulmonary Assist System
MHT	Mental Health Triage
NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
PEI	Physical Education Instructor
PHA	Public Health Authority
ROSC	Return Of Spontaneous Circulation
RQIA	Regulation and Quality Improvement Authority
SEHSCT/Trust	South Eastern Health and Social Care Trust