The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INDEPENDENT INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR V

AGED 76
AT CAUSEWAY HOSPITAL
ON 16 DECEMBER 2022

Date finalised: **23 April 2026**

Date published: **14 May 2026**

CONTENTS PAGE

Foreword from the Prisoner Ombudsman

Mr V, a 76 year old man, was a sentenced prisoner who had been in custody from 27 August 2021. This was Mr V's only time in a custodial setting. He died at hospital shortly after having been released from Magilligan Prison.

This report details the outcome of the treatment and care Mr V 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 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 V's family has had to wait for the completion of the investigative process and appreciate their patience.

This report provides a detailed account of Mr V'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 V 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 V, were to ensure the safety of prisoners and staff during the pandemic. The procedures put in place by NIPS to mitigate the limitations caused by the Covid-19 arrangements are documented in Appendix 1.

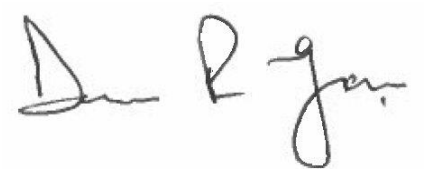
On 08 September 2021, after 10 days quarantine, Mr V was moved out of Foyle House and into the main prison. He was transferred from Maghaberry Prison to Magilligan Prison on 14 October 2021. On 28 November 2022 Mr V was transferred to Causeway hospital where he remained until his death on 16 December 2022.

Mr V entered the Prison with established additional medical requirements as well as undiagnosed health issues. Following assessment by Healthcare in Prison and appropriate referrals, a diagnosis of terminal cancer was communicated to Mr V in January 2022 following his attendance at various medical appointments while serving his sentence.

A Clinical Reviewer was commissioned to assist consideration of the healthcare aspects of Mr V's time in custody and the potential impacts on his wellbeing. The Clinical Reviewer's report included recommendations and areas of good practice about Mr V's healthcare in prison and the response to his needs as they arose.

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

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



Darrin Jones
Prisoner Ombudsman

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[1] 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 Trust was established on 1st April 2007 and is one of 5 Trusts in total within Northern Ireland. The South Eastern Health and Social Care 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.

The generic investigation objectives are set out in the Ombudsman's Terms of Reference and are available here.

[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."

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

The overall objectives for this investigation are to:

1.	Establish the circumstances and events surrounding Mr V's care by NIPS and HiP from committal up to his transfer to hospital on 28 November 2022
2.	Establish the circumstances and events leading up to and surrounding Mr V's death on 16 December 2022, looking at involvement from both NIPS and the Trust
3.	Examine whether the provision of healthcare services provided to Mr V were at least equivalent to those he might have received in the community
4.	Ensure Mr V's family has an opportunity to raise any concerns they may have and take these into account in the investigation
5.	Identify any relevant failing or good practice and highlight any lessons learned from the death of Mr V; and
6.	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 prison staff, HiP staff, prisoners, family and friends. All prison records in relation to the deceased's life while in custody are examined. This includes examination of evidence such as closed circuit television footage, telephone calls and mail. This report is structured to detail the circumstances and events leading up to Mr V's death on 16 December 2022.

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

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

2.1 Independent advice

Mr V entered the Prison with established medical requirements as well as undiagnosed health issues. A diagnosis of terminal cancer was communicated to Mr V in January 2022 following his attendance at various hospital appointments while serving his sentence.

After further consideration of the issues, independent professional advice from a Clinical Reviewer was obtained. The Clinical Reviewer is a registered Mental Health Nurse with over 20 years' experience, a fully accredited Advanced Nurse Practitioner and a registered Specialist Non-Medical Prescriber.

The Clinical Reviewer was previously employed as National Head of Nursing for the largest provider of prison healthcare services in England, overseeing Primary Care, Mental Health and Substance Misuse services in 48 English prisons encompassing prisoners in all categories.

The information and advice which informed the findings and conclusions are included at Section 6 of this report. The Ombudsman has discretion, based on the overall context of the case, whether the advice is included within the recommendations for this report.

2.2 Family Liaison

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

A meeting with Mr V's family was held on 07 February 2023 to consider their questions and concerns. These are listed below.

1.	Was Mr V treated differently/better as a result of his diagnosis?
2.	Why was Mr V not released earlier given the finality of the diagnosis?

SECTION 3: Summary of Mr V's case

Mr V was committed to Maghaberry Prison on 27 August 2021. He was aged 74 at the time of his committal. Mr V was sentenced to 17 years. Mr V was recorded as a smoker when committed to Maghaberry Prison.

On 07 October 2021 Mr V met with Doctor D. From Egton Medical Information System records (EMIS) Mr V was recorded as having had a cough for a period of one year and Doctor D made a referral for a chest x-ray. It was noted they would discuss this further once the results were returned.

On 12 October 2021 electronic healthcare records (EHR) evidence Mr V was examined and an x-ray of his chest was carried out. Physio A recorded Mr V felt he was *"under too much pressure at the moment to consider"* ceasing smoking.

EHR evidence Doctor A reviewed Mr V's chest x-ray result on 19 October 2021 and made a subsequent referral to have a computed tomography scan[2] (CT scan).

On 09 November 2021 Mr V's electronic records were updated by Doctor B. He added a *"red flag referral re recent CT chest result"*. He noted the results would be discussed with Mr V *"this week".*

On 11 November 2021 Doctor B recorded a face to face meeting on EHR with Mr V and discussed a possible diagnosis of lung cancer. Mr V's EHR evidenced a 4.5cm growth in Mr V's upper left lung.

On 11 April 2022 HiP Nurse A updated Mr V's EHR confirming he had attended Laurel House[3] for the first round of chemotherapy[4].
Mr V's electronic medical records confirmed he continued to smoke throughout his time in prison despite medical advice to cease smoking. He regularly met with medical

[2] A CT scan, also known as CAT scan, uses X-rays and computer algorithms to produce cross-sectional images of the body.
[3] Laurel House Chemotherapy Unit provides an outpatient service and a day unit for the delivery of chemotherapy, and other treatments for the care of patients with cancer or haematology conditions.
[4] Chemotherapy is a common cancer treatment that uses medicine to kill cancer cells.

professionals, both HiP and at hospitals, as a result of his healthcare requirements over the next number of months.

EHR evidenced HiP nurses assessed Mr V on 26 November 2022 in his cell and requested an emergency ambulance to be tasked to Magilligan Prison. HiP records stated Mr V had remained in bed for most of the day and had a level of reduced consciousness. They recorded Mr V as being difficult to rouse. High flow oxygen was given to Mr V and both Nurse A and Nurse B observed him until the Northern Ireland Ambulance Service arrived at the prison. Mr V was taken to Altnagelvin Hospital where he remained and was treated overnight. He returned to Magilligan Prison on 27 November 2022.

EHR stated on 28 November 2022 Nurse C attended Mr V's room to administer medication in the morning before returning in the afternoon to administer medication. An electronic healthcare record entry by Nurse C stated Mr V presented as confused and agitated. Nurse C referred Mr V to the hospital once again by emergency ambulance. Mr V was taken to the Causeway Hospital and he remained there under the care of the Northern Trust until his death on 16 December 2022.

Prison records confirmed Mr V was issued with an Article 20[5] compassionate release, via the Criminal Justice (NI) Order 2008, by NIPS on 15 December 2022.
The coroner Service states Mr V's death was attributed to:

1a) Community Acquired Pneumonia
1b) Lung Cancer, Cellulitis, UTI
2) Asthma

A post-mortem was not required.

[5] Article 20 of the Criminal Justice Order (NI) 2008 directs the Department Of Justice may permit the release of a prisoner on compassionate grounds following specific criteria having been met.

SECTION 4 – Description of Key Events Surrounding Mr V's Death

4.1 Key Events at Maghaberry Prison

27 August 2021

On arrival at Maghaberry Prison Reception NIPS staff interviewed Mr V. Prison Service recorded Mr V was *"presenting well, talking clearly and maintaining good eye contact".*

Mr V was medically assessed by HiP Nurse D. Mr V disclosed he was concerned about his safety in prison due to the nature of his charges but assured NIPS and HiP staff he could keep himself safe and confirmed no history of self-harm. The assessments concluded Mr V was no apparent risk of suicide or serious self-harm.

30 August 2021

Nurse E recorded Mr V as a cigarette smoker. It was recorded on EHR that Mr V smoked 20 a day.

8 September 2021

Doctor C prescribed Mr V Omeprazole[6] capsules. Mr V was also prescribed Atorvastatin[7] tablets, Montelukast sodium[8] tablets, Uniphyllin continus[9] tablets, Pregabalin[10] capsules, Salbutamol CFC-free inhaler[11] and DuoResp Spiromax Dry Powder inhaler[12].

[6] Omeprazole is used to treat conditions like gastroesophageal reflux diseases (GERD) and stomach ulcers.
[7] Atorvastatin belongs to a group of medicines called statins. It is used to lower cholesterol if diagnosed with high blood cholesterol and prevent heart disease, including heart attacks and strokes.
[8] Montelukast sodium is a medication used to prevent and treat asthma symptoms and to relieve symptoms of seasonal allergies. It works by decreasing inflammation in the airways, making it easier to breathe. Montelukast is effective for long-term asthma management but should not be used for sudden asthma attacks.
[9] It is used in lung-related problems such as asthma and chronic obstructive pulmonary disease (COPD) and sometimes used to treat heart failure.
[10] Pregabalin is used to treat epilepsy and anxiety. It is also taken to treat nerve pain.
[11] Salbutamol is used to relieve symptoms of asthma and chronic obstructive pulmonary disease (COPD) such as coughing, wheezing and feeling breathless. It is known as a bronchodilator which works by relaxing the muscles of the airways into the lungs, which makes it easier to breathe.
[12] DuoResp Spiromax is indicated in adults, aged 18 years and older for the symptomatic treatment of patients with COPD.

Note, Mr V was regularly prescribed these throughout his time in the care of NIPS and HiP.

7 October 2021

Mr V was seen by Doctor D in relation to knee pain he had been experiencing. An entry from Doctor D on electronic healthcare system recorded Mr V had disclosed he had a cough which had been present for a year. It was noted Mr V *"still smokes, has asthma, using SABA (Short-acting beta-agonists)*[13] *more often".* Doctor D referred Mr V for an x-ray of his chest. Doctor D recorded Mr V was given the recommendation to stop smoking.

12 October 2021

Mr V was seen by Physio A. EHR confirm this to be *"Respiratory disease monitoring (First)"* appointment. Mr V indicated he had noticed more occasions of shortness of breath on exertion over recent years. Records from this appointment detail he had an obstruction in his airway but would require additional testing to understand further. Physio A also discussed stopping smoking with Mr V but he is recorded as stating he *"feels under too much pressure at the moment to consider this".*

An electronic healthcare record entered by Admin A confirmed Mr V received an x-ray on his chest.

4.2 Key Events at Magilligan Prison

19 October 2021

EHR confirmed Mr V was referred to have a CT scan by Doctor A.

[13] Used to treat asthma symptoms quickly. Primarily inhaled via a rescue inhaler or a nebulizer. Works by relaxing the muscles around the airways, making it easier to breathe during an asthma attack.

9 November 2021

Mr V's medical records were updated by Doctor B. He added a *"red flag referral re recent CT chest result".* Notes on the electronic healthcare system recorded to *"discuss with patient this week".*

11 November 2021

EHR evidenced Doctor B met face to face with Mr V and confirmed a *"4.5cm growth upper left lung"* had been recorded. It was described in EHR as cancerous growth. EHR state a new lung cancer diagnosis plan was commenced. Doctor B recorded Mr V was advised to speak to HiP if he felt unwell.

EHR state Nurse A met with Mr V on the same day to discuss his diagnosis. Nurse A stated Mr V was shocked but denied thoughts of self harm or life not worth living.

15 November 2021

Mr V was seen by Physio A. Medical records confirm this to be *"Respiratory disease monitoring (Review)"* appointment. Mr V's CT scan showed signs of extensive emphysema[14]. Mr V was confirmed to have chronic obstructive pulmonary disease (COPD)[15]. It is noted Mr V continued to smoke.

[14] Emphysema is a long-term lung condition that causes shortness of breath. Over time, the condition damages the thin walls of the air sacs in the lungs called alveoli.
[15] Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. It includes emphysema and chronic bronchitis. COPD is a common condition that mainly affects middle-aged or older adults who smoke.

1 March 2022

EHR confirmed Doctor B met face to face with Mr V. It was noted he was waiting on an oncology appointment. Mr V complained of some pain issues mainly in his right hip. Medical records show Mr V was using co-codamol and ibuprofen regularly and had requested more. Doctor B made changes to his medication based on this face to face appointment.

11 March 2022

NIPS documents evidence Mr V "*is in significant pain which can quite clearly be seen when he is moving about the wing"*. This entry stated;

> *"We are managing Mr V on the wing as best we can providing support where we can but really there is little for us as officers to offer him other than someone to listen to".*

16 March 2022

EHR confirmed Mr V had a phone call with MacMillan Lung Cancer Nurse A. An appointment with the Oncology Department was made for 28 March 2022.

20 March 2022

NIPS records evidence an entry relating to a phone call with MacMillan nurses.
The record states Mr V had missed an appointment at Antrim Area Hospital. The record confirms Mr V was unaware of this appointment and was upset as this had been missed. It has not been possible to determine why the appointment was missed.

22 March 2022

NIPS documents evidence Mr V spoke with Prisoner Development Unit (PDU) Officer A. An entry by PDU Task Management noted Mr V had *"visibly failed since our last meeting due to his condition".*

NIPS records stated Mr V was aware of the finality of his diagnosis and he was *"looking for some quality of life".*

The entry to NIPS computer system recorded Mr V had lodged a complaint to HiP with regards to the missed appointment at Antrim Area Hospital. No record of a complaint ever having been lodged was recorded by HiP.

The PDU entry stated;

> *"I informed Mr V that we have no input or influence with regards to healthcare but NIPS staff would assist him in whatever way we could. Mr V said that all the staff in his residential location have been really good with him and that he was appreciative of their efforts and concerns"*

The record stated Mr V was *"happy to liaise with residential staff"* if there were issues in Prison.

8 April 2022

NIPS records stated Mr V was offered a move within the Prison to a room which was larger on a different landing. Records state Mr V declined this move. The record evidenced NIPS offering to accommodate the same move *"if at any time he feels it would be of benefit to him".*

EHR evidence Mr V had a zoom call with Laurel House Deputy Manager A during which they discussed Mr V's upcoming chemotherapy treatment and side effects of same.

11 April 2022

EHR state Mr V attended Laurel House for his first round of chemotherapy treatment. Nurse A recorded the medications Mr V returned to Magilligan Prison with. A second appointment was placed in Mr V's diary for 09 May 2022.

21 April 2022

An entry from PDU evidenced Mr V was also aware he would be moving room in the near future. It states NIPS and HiP were working together to make the *"convalescence room"* appropriate for Mr V to move to. Records stated this would *"be better for him offering him more comfort and privacy than he has at the moment."* It was noted Mr V accepted this view also.

26 April 2022

EHR state;

> *"Telephone call received from SO (Senior Officer) A today to advise that there is a positive case of Covid in H2 and NIPS are keen to move Mr V into the palliative care suite as a precaution."*

Occupational Therapist (OT) A recorded there were no issues noted with the palliative care suite and Mr V was moved into this new room.

1 June 2022

OT B recorded on EHR that she met with Mr V and issued him with a HydroFlex Level 3 Chair. Mr V was shown how the chair worked and confirmed he was happy to use this without assistance.

2 June 2022

NIPS documentation stated Mr V was in *"great form".* It was stated he had received a medical chair on 01 June 2022.

14 June 2022

EHR from Physio A state Mr V did not attend the respiratory clinic in HiP. Physio A recorded Mr V did *"not feel well enough".* Records state *"he is on maximum therapy treatment for COPD, he does not wish to quit smoking at this stage. Discharge from respiratory at present".*

An entry on EHR from Nurse C states Mr V had discussed recent feelings of anxiousness and agitation in regard to his diagnosis of cancer. Mr V confirmed he had no thoughts of self harm but required some help with those emotions. Nurse C referred this to Doctor B and Mr V was prescribed medication to address.

25 June 2022

EHR state Mr V had a fall. Nurse C examined Mr V and noted;

> *"Abrasion to left side of face. Complaining of painful left hip. Mr V is able to weight bear and has a full range of movement. Small skin tear to left elbow the size of a 10 pence"*

Nurse C completed a body chart and tended to Mr V as required.

26 June 2022

NIPS documentation stated Mr V had a fall (on 25 June 2022). As a result Mr V had grazed his face and elbow. The entry to the NIPS computer system stated Mr V was initially able to walk with the use of his crutch but as the day progressed he required a

wheelchair to move. It is recorded Nurse C met with Mr V on 25 June 2022 and would return on 26 June 2022 to assess.

Nurse C met with Mr V to administer medication on 26 June 2022 and it was noted by NIPS Mr V could not put weight on his legs and could not step forward. Mr V was referred by Nurse C to the *"Accident and Emergency Department"* at Altnagelvin Hospital.

EHR state Nurse C met with Mr V who was recorded as being able *"to stand but unable to put his full weight on his left leg".* Nurse C records state *"due to his diagnosis I feel he would need further assessment at A+E".*

EHR entered by Nurse F state Mr V was discharged from Altnagelvin hospital with a fracture to his hip. Mr V was issued with a walking frame and referred to physio and fracture clinic.

Note, Mr V was due to travel to Laurel House on 27 June 2022 for his planned chemotherapy treatment and was unable to attend as a result. HiP contacted Laurel House and spoke to Staff Nurse A. It states Staff Nurse A advised not to attend until contacted by Laurel House.

27 June 2022

EHR evidence Nurse G spoke to Deputy Sister A in Laurel House. Mr V's appointment there was rescheduled for another date and he was informed of same.

4 August 2022

NIPS Officer A met with Mr V. It was noted by NIPS Mr V was not receiving chemotherapy due to surgery he received on his hip and the wound needing to heal.

22 August 2022

NIPS documents evidence Mr V spoke with PDU Officer A. An entry by PDU Task Management stated Mr V had *"visibly deteriorated".* The record stated Mr V had not received chemotherapy for *"some time"* due to the fracture of his hip. It was not clear when this would recommence.

Mr V stated he had a chest infection but when asked if he had informed HiP he confirmed he had not, *"despite seeing them twice a day".*

The PDU record stated Mr V *"did mention that the landing staff have been very good with him".*

20 September 2022

NIPS documents evidence Mr V spoke with PDU Officer A. An entry by PDU Task Management stated Mr V was feeling much better having felt unwell for a number of days.

It was noted Mr V was awaiting a scan of his hip to understand if his chemotherapy could recommence.

27 September 2022

An electronic healthcare record entered by Physio A states Mr V was feeling very well at present. It was noted he was *"still smoking and not planning on stopping".*

24 October 2022

Prison documentation recorded Mr V stated he woke at 03.45 and was looking for NIPS staff as he thought it was *"the middle of the day".* It was recorded Mr V complained about being *"unsteady on his feet and feeling embarrassed using his*

walking aid". It is stated NIPS encouraged Mr V to use the aids when walking and discussed there was no need to feel embarrassed.

Records state Mr V was *"encouraged"* to use the phone to contact family. He was told his son had made a phone call into the Prison due to being worried about him.

28 October 2022

Prison Service documentation recorded Mr V appeared *"disorientated about the time and day"* and he slept later in the day.

30 October 2022

Prison documentation states;

> *"Cell alarm activated at 0545. When we entered the cell Mr V was on the floor, he wanted us to help lift him up onto the bed as he didn't have the strength to do it himself. We got him up onto the bed and asked did he need any medical attention, he refused and said he was OK. Incident was reported to the ECR.*[16]*"*

A follow up entry to Mr V's fall stated Mr V reported he had been on the floor of the room for approximately one hour and didn't have the strength to pull the alarm. Mr V was assisted back to his bed. Prison documentation stated;

> *"0730* Nurse A *came to check on Mr V and the initial assessment was that he should be seen by OSH* (outside hospital)*,* Nurse F *believed this to be unnecessary and that they would check on him later in the day.*

A third entry that day recorded Mr V did not eat much that day. With reference to Mr V's fall it was stated HiP staff checked him and monitored him throughout the day as well as NIPS staff.

[16] Emergency Control Room

EHR from Nurse A also refer to Mr V's fall. They attended Mr V's room at 07:45 to assess.

Nurse A record states Mr V *"fell last night as he was walking unaided to the bench in his room"*. Mr V was assessed by Nurse A and they recommended Mr V be assessed by and transferred to hospital but Mr V refused.

An electronic healthcare entry from Nurse B recorded Mr V's blood pressure remained low later that morning. He was asked if he had been taking regular fluids and Mr V pointed towards a cup of orange. Nurse B recorded Mr V had not taken much and he was encouraged to increase his fluid intake.

Nurse A made an entry to EHR. They recorded blood pressure to have improved slightly but fluid intake remained poor. Mr V was encouraged to increase intake of fluids. They stated they *"feel that in recent weeks Mr V has deteriorated physically"*.

16 November 2022

Nurse H made an entry on electronic healthcare system in regards to Mr Vs medication. They stated;

> *"when issuing weekly supply of Pregabalin note Mr V has surplus stock – 23 extra 100mg tablets and 12 extra 50mg tablets."*

It was noted Mr V declined a "*supervised swallow"*[17] (HiP no longer use this term which has since been renamed *"direct administration"*) but Nurse H requested a Pill Pac[18].

[17] Administration to the patient will be undertaken directly by a Registered Nurse or Medicines Management Technician at the prescribed time.
[18] A pill pack (Pill Pac) is a pre-sorted and organized package of medications designed to simplify the process of taking daily prescriptions.

23 November 2022

Prison documentation recorded Mr V was unable to get out of his bed. It was documented his legs were swollen and Mr V described feeling *"as though he had been given a good kicking".*

NIPS staff checked on him several times during the morning, by lunchtime he still hadn't eaten anything and complained that he had vomited. The entry to NIPS computer system stated staff were concerned about Mr V's presentation and requested HiP to attend his room. Records evidence this request was completed and HiP saw Mr V that day.

24 November 2022

Prison records state Mr V was *"rather confused today*". HiP requested Mr V to see them but initially he refused to, stating he *"hadn't the energy to go over to healthcare".* NIPS arranged transport for him and he was taken to HiP.

25 November 2022

Prison documentation states Mr V was seen by OT B as part of her assessment. NIPS recorded;

> *"she was surprised how much he has deteriorated since she last saw him in June. She was concerned about his confusion and also his mobility and will speak to healthcare about this."*

Prison documentation also recorded Nurse H saw Mr V and it was evident he had not been taking his medication as required. Nurse H took Mr Vs medication and Mr V was now to be issued them by direct administration.

EHR state OT B met with Mr V and noted his speech was slow and exaggerated. They stated Mr V presented as weak, frail and has been observed to have physically deteriorated since his last review.

OT B continued to note they observed Mr V to be *"muddled and knocked off cognitively"*. Their record stated NIPS staff had shared similar concerns as well as additional observations about Mr V's presentation.

OT B made Senior Nurse A aware of her concerns.

Nurse H observed Mr V's management of his medication. It is stated they advised Mr V HiP may need to manage his medication in future. Nurse H states *"he reluctantly allowed me to remove his medications."*

26 November 2022

EHR stated an *"Emergency Call Out"* was required for Mr V. He was taken to Altnagelvin Hospital after Nurse A observed Mr V presenting as *"very confused with a reduced level of consciousness".* Mr V was recorded as appearing dishevelled and unkempt *"which is unusual"* for him.

Prison documentation stated Mr V *"is becoming more confused as time goes on".* Records evidence HiP visited Mr V in the afternoon and after completing observations instructed NIPS to request an emergency ambulance.

Prison documentation states;

> *"Ambulance staff arrived on the scene at approx. 15.43pm and were briefed by the duty healthcare staff on Mr V's condition. Mr V left the wing at approx. 15.49pm and was taken to outside hospital via ambulance".*

27 November 2022

EHR confirmed Mr V was assessed by Altnagelvin Accident and Emergency department. He was recorded as having a lower respiratory tract infection and received intravenous[19] fluids and antibiotics. Prison documentation evidenced Mr V returned from hospital. The entry states Mr V appeared comfortable and had been seen by HiP.

EHR documented Mr V was discharged and returned to Magilligan Prison and was prescribed with a course of antibiotics. It is stated Mr V will be supervised in future with medication.

28 November 2022

Prison documentation stated Mr V was to be discussed at an upcoming Prisoner Safety and Support Team (PSST) meeting *"to ensure all areas are aware about his ongoing care"*

Prison records state Mr V had *"visibly deteriorated".* Records evidence Mr V had caused concern earlier in the day as he presented confused and incoherent. NIPS documentation stated;

> *"Given all of these factors consideration should maybe be given to professional healthcare providers to be used for Mr V as our staff are not in any way trained*

[19] Administering medication or liquids via intravenous means is a medical technique that administers fluids, medications and nutrients directly into a person's vein.

for caring for people with a terminal diagnosis. I offered this opinion to residential management and will do the same with PSST."

Another entry that day recorded Mr V *"was very confused".* It stated;

"I notice how rapid Mr V has deteriorated over the past few days and phoned across to Healthcare to see if they would have a look at him."

EHR from Nurse C stated they had seen a marked deterioration in Mr V in the last week. Mr V appeared weak and frail. He was encouraged to drink more fluids.

Nurse C returned to Mr V in the afternoon when Mr V was observed to have been "confused and agitated".

At 16:20 on 28 November 2022 Mr V was transferred to Causeway hospital by ambulance.

4.3 Key Events at Causeway Hospital (Bedwatch)

Mr V was admitted to a Causeway hospital and remained under bedwatch by NIPS. Records kept by NIPS of this time are short in detail and many of the notes are repetitive in nature.

EHR created by HiP throughout Mr V's period at Causeway hospital summarized communications between HiP and Northern Trust staff. They were repetitive in nature but gave brief summaries of Mr V's current condition.

Given these records were updates on Mr V's condition while in the care of the Northern Trust that is to be expected.

On 14 December 2022 Prison documentation evidences Governor A confirmed Mr V's family were contacted and he was permitted to have family visits at Causeway Hospital. Documentation from Healthcare records and Multi-disciplinary Support and

Strategy Team (MSS) conferences also reference Mr V had a *"syringe driver"*[20] in place from this date.

Mr V was visited by family from 14 December 2022.

Mr V remained at Causeway hospital, under bed watch by NIPS, until 15 December 2022 when Governor B issued an Article 20 in respect of Mr V. The Article 20 was signed for on Mr V's behalf and NIPS withdrew from the hospital immediately.

Mr V passed away on 16 December 2022.

4.4 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 all parties directly involved in the death an opportunity to discuss the action taken, identify good practices and highlight any difficulties, identifying opportunities to make changes, if applicable.

The Hot debrief takes place, usually, immediately following a death in custody. The Cold debrief must take place within 2 weeks of a death in custody.

Mr V was transferred to Causeway Hospital on 28 November 2022 and remained under NIPS custody, via "*Bedwatch",* until shortly before his death when he was issued with an Article 20 and released from NIPS custody.

[20] Syringe drivers (or syringe pumps) deliver a continuous flow of medication just under the skin. They can be used to help manage symptoms at any stage of treatment.

As a result there was no action taken by NIPS to complete a Hot or Cold debrief as staff were not directly involved in his final moments and these debriefs were deemed not to be required.

SECTION 5: Family Liaison

5.1 Contact with Mr V's Next of Kin

NIPS documentation evidence Mr V's next of kin was his son.

On 14 December 2022, records evidence Mr V's next of kin was contacted by NIPS and advised of his current health concerns. NIPS permitted family visits to Mr V as of this date. Mr V had been in Causeway Hospital for 16 days at this point.

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.*

As part of the investigation into the circumstances surrounding Mr V's death NIPS were asked about this period of time in more detail. Governor B stated attempts were made to contact Mr V's next of kin prior to 14 December but was unable to give an exact date. At interview Governor B stated;

> *"there was maybe one, certainly one, phone call made but I think there could have been three…..He gave me, maybe not the first time, but he gave me the name of a young lady…..She would take control or take charge or be the person for me to contact"*

Governor B also stated initial contact with the next of kin was made *"3 or 4 days after Mr V possibly went into hospital."*

The next of kin and the additional party were contacted as part of the investigation. Their recollection of this period was that no contact was made prior to 14 December 2022.

It should be noted NIPS were unable to provide any recorded evidence of any attempts to contact Mr V's next of kin during the period of 28 November 2022 to 14 December 2022 other than the account of Governor B.

This period of time, coupled with Mr V's condition, is unjustifiably long and a recommendation has been made to the NIPS in this report.

On 15 December 2022 Governor B issued Mr V with an Article 20, releasing Mr V under licensed conditions, and NIPS care was withdrawn. Mr V remained in the care of the Causeway Hospital/Trust.

While it is normal practice for NIPS to contact the next of kin in the event of a death within NIPS establishments, NIPS made no contact with the next of kin following Mr V's death upon the understanding the family were aware of the circumstances.

At interview Governor B stated he became aware of Mr V's death as a result of the additional party, acting as next of kin, contacting NIPS to advise of the same.

Governor B also arranged to meet the additional party to return Mr V's personal belongings to the family.

SECTION 6 - FINDINGS

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

6.1 The provision of healthcare services provided by HiP to Mr V including risk assessments, and if those services were at least equivalent to those he might have received in the community.

There were many aspects to Mr V's care while in the custody of NIPS. They have been separated below and addressed.

Asthma/COPD

Clinical guidelines[21] and recognised best practice help determine when referral to secondary care respiratory services may be appropriate for managing chronic respiratory conditions. The Clinical Reviewer stated;

> *"There is no evidence that at this time, Mr V required referral into secondary care respiratory services and was appropriately managed within the prison. Mr V attended chronic disease monitoring where his respiratory history was recorded, his medication regimen confirmed, and the active cycle breathing technique (ACBT) taught."*

EHR evidence a follow-up was scheduled for 3 months. The Clinical reviewer stated this *"was shorter than a routine community interval for stable COPD; however this was appropriate to Mr V's needs at this time.*"

Mr V was also prescribed with a nebuliser via the General Practitioner (GP). The Clinical Reviewer confirmed *"a structured respiratory assessment tool, aligned with best practice, was utilised throughout."*

[21] NICE guidelines. Chronic obstructive pulmonary disease in over 16s: diagnosis and management (2018). NICE guideline [NG115] (last updated: 2019).

Risk Assessment Tools

EHR evidenced Mr V was formally assessed using recognised instruments used to support risk assessment during his time in custody. The Clinical Reviewer highlighted staff "used their clinical judgement" to respond to emerging risks".

The Clinical reviewer stated;

> *"All actions taken were appropriate and reflected a proactive, judgement-based extension of standard assessment protocols"*

Fall Management

On 25 June 2022 Mr V was recorded on EHR as having had a fall whilst in his cell. This resulted in a fracture to Mr V's hip. Mr V was referred to hospital as a result of this. Upon Mr V's return to Magilligan Prison HiP completed *"a thorough mobility assessment, provided safety advice, and managed his daily mobilisation and pain needs effectively, including appropriate use of breakthrough analgesia."*

On 30 October 2022 Mr V fell while *"walking unaided"* in his cell. NIPS staff raised an alarm when he was discovered and entered the cell to help him back to his bed. HiP recommended a hospital referral having assessed Mr V however Mr V refused this. HiP made a number of visits to Mr V for updates and recorded these on EHR.

Pain Management

EHR evidence Mr V was regularly prescribed pain medication. HiP staff advised Mr V on breakthrough pain relief and the frequency of which this could be accessed. An entry on Prison Service records evidenced Mr V did not always advise HiP of the level of pain. The Clinical Reviewer did state;

> *"When Mr V raised concerns about pain or the effects of his medication, healthcare staff responded promptly, including making timely adjustments such*

as altering his evening doses. After further increases to his analgesia, with engagement from Macmillan and the oncologist, his pain management appeared to be more effective, and less breakthrough analgesia was required. Pain management in palliative and custodial settings can be complex. In this case, it was reasonable and aligned with specialist hospital guidance, with adjustments made in response to Mr V's reported discomfort."

Dietic Care

Mr V reported weight loss and was reviewed by HiP. His dietary intake was reviewed in detail and an agreed approach of "small, frequent meals" was made in an attempt to stabilise Mr V's weight. Follow ups were scheduled at regular intervals during Mr V's custodial period.

Physiotherapy and Occupational Therapy

Mr V was assessed by HiP Physio staff regularly throughout his time in custody. Equipment was reviewed and the height of his walking aids adjusted to optimise posture and gait. He was assessed at being able to mobilise short distances independently and no further immediate physiotherapy intervention was indicated.

The Clinical Reviewer stated;

A plan was made on 7th December 2022 for a further mobility assessment, following his anticipated discharge from hospital. The input by the physiotherapist was consistent and detailed in nature and demonstrated a good level of support for Mr V and his identified needs.

HiP also provided multiple occupational therapy assessments to Mr V, particularly during his time in Magilligan Prison. These focused on transfers[22], the use of aids and Mr V's mobility.

[22] Transfer – moving from one place to another

Mr V was issued with a medical chair to assist with his transfers following one of the Occupational Therapy assessments.

The Clinical Reviewer stated that the Occupational Therapist noted *"Mr V appeared weak, frail, unkempt and fatigued, reporting reduced food and fluid intake despite dietic supplements."*

OT B also identified a fault with Mr V's medical chair later in the year. The Clinical Reviewer noted the HiP staff *"actively followed up with the supplier".*

The Clinical Reviewer confirmed concerns from the Occupational Therapist were escalated to NIPS and HiP teams appropriately.

Mental Health

HiP completed a mental health triage with Mr V following his committal which identified no current or historical involvement with community mental health services and no immediate risk of self-harm or suicide. Mr V was informed he could re-refer if needed. The Clinical Reviewer stated triage was completed *"in line with best-practice timeframes."*

Mr V's case was discussed at MSS meetings. The MSS meetings included mental health and documented ongoing collaboration between healthcare and custodial teams, and planned joint reviews of hospital recommendations, ensuring continuity and integrated care.

Clinically Unwell Presentations

Mr V presented as unwell on two occasions late in November of 2022.

On 26 November HiP Nurses A and Nurse B completed *"a comprehensive assessment, documenting a full set of observations and calculating a NEWS2*[23] *(National Early Warning Score) score".* An ambulance was called early in the assessment and HiP nurses continued to monitor Mr V until he was in the care of Northern Ireland Ambulance Service paramedics and taken to Causeway hospital.

On 28 November 2022, Nurse C recorded a marked deterioration in Mr V on EHR. Nurse C recorded dry lips and eyes, dishevelled appearance and episodes of agitation.

The Clinical Reviewer stated;

> *"Although physiological observations were taken and fell outside normal ranges, equating to a NEWS2 of at least 8 (had all parameters, including temperature, been recorded), neither NEWS2 nor a structured sepsis tool were completed, both of which should have been triggered."*

On the absence of recognised tools being used in this instance the Clinical Reviewer stated;

> *"Best practice would have been to calculate NEWS2 at that point to provide an objective baseline and to support consideration of sepsis, particularly given his history of cancer, COPD and recent hospital discharge."*

National Institute for Health and Care Excellence (NICE) guidance for Northern Ireland endorses the use of such tools in primary, secondary and tertiary care, especially for

[23] The partial or complete suppression of the immune response of an individual, either naturally as a result of disease or another condition or artificially induced to help the survival of an organ after a transplant operation

patients with known vulnerabilities such as immunosuppression[24] or chronic respiratory disease, both of which were applicable for Mr V.

The Clinical Reviewer did confirm while the tools were not used on this occasion the decision to refer Mr V to hospital was appropriate and ensured prompt acute care.

Medicine Management

Mr V was deemed suitable to be *"in possession"* of his prescribed medicines when he was first committed to Maghaberry Prison and he self managed these. The form was fully completed and confirmed he was independent with activities of daily living. No concerns were raised about his capacity to adhere to his prescribed regimen at this time.

On 16 November 2022 HiP visited Mr V in his cell and became aware Mr V had surplus medication. Nurse H recorded on electronic health care records;

> *"when issuing weekly supply of Pregabalin note Mr V has surplus stock – 23 extra 100mg tablets and 12 extra 50mg tablets."*

HiP recommended Mr V was supervised when taking his medication but Mr V refused this and HiP arranged for a Pill Pac.

On 25 November 2022 HiP made the decision to implement the direct administration process as it became evident again Mr V had not been taking his medication as required.

[24] The partial or complete suppression of the immune response of an individual, either naturally as a result of disease or another condition or artificially induced to help the survival of an organ after a transplant operation

6.2 Whether or not Mr V's particular healthcare needs were identified, assessed and appropriately managed by Healthcare in Prison staff?

There were many aspects to Mr V's care while in the custody of NIPS. They have been separated below and addressed.

When Mr V was committed to the care of NIPS his medical history was recorded. It was noted Mr V felt *"at risk and unsafe"* in custody due to the nature of his charges.

The Clinical Reviewer stated;

> *"These concerns informed a tailored induction and ongoing welfare monitoring. It was noted in his 'inmate notes' that within a short period he was observed to have settled into the prison regime"*

On 07 October 2021 Mr V attended a HiP appointment with a GP. The GP identified a 12-month history of cough. A prompt referral for chest x-ray, followed by CT imaging, led to a diagnosis of lung cancer. Concurrently, respiratory physiotherapy input began immediately. Mr V was taught breathing techniques, reviewed regularly and prescribed nebulisers as required.

Mr V received consistent assessments from occupational therapy, physiotherapy and dietetics as well as HiP Primary care and Mental Health Team. The Clinical reviewer stated;

> *"It is reasonable to consider the breadth and consistency of allied healthcare involvement, and the logistical challenges facing community services during the COVID-19 pandemic, it is likely that the coordinated support Mr V received in custody provided a level of multidisciplinary input that may not have been as readily accessible to him in the community at that time."*

It was evident the HiP teams maintained liaison with hospitals when Mr V was taken there at various points. The Clinical Reviewer stated by doing this it would *"ensure*

there would be a joined up approach for planning. This proactive approach ensured continuity and safety on return to Magilligan Prison"

NIPS documentation evidenced Mr V's care was continuously reviewed through MSS meetings. Different NIPS departments alongside HiP were able to share the most current information and Mr V also contributed to these meetings. There was clear documentation and evidence of actions to be taken to any areas that required additional input from one of the members present.

The Clinical Reviewer stated;

> *"This approach in prison, is best practice and appeared to ensure integrated, patient-centred management throughout his sentence."*

6.3 To what extent did the Covid-19 pandemic impact on Mr V's primary and mental health care during his time in custody?

The COVID-19 pandemic significantly affected service and care delivery globally, including within prison services and healthcare systems. Although it is not possible to comprehensively measure the pandemic's impact on Mr V's primary and mental health care during his periods of custody, several key observations can be made.

Isolation measures were carefully managed throughout his custody. Mr V attended Antrim Area Hospital on 25 January 2022 and spent the night in hospital following a chest drain. After his discharge on 26 January 2022, healthcare staff advocated that the *"Care and Supervision Unit"* was not a suitable location given his health status at the time and recent diagnosis. In response, effective communication between NIPS staff and healthcare providers ensured that a more appropriate isolation environment was identified.

Mr V's COVID-19 vaccine booster was administered while in custody of NIPS. The Clinical Reviewer stated this ensured *"he had access to necessary immunisation*

measures, notably important due to his immunocompromised status because of chemotherapy".

Mr V was accommodated *"in a designated side room"* during periods of outbreak of Covid-19 in the prison. This was a decision which was supported by the multidisciplinary team and helped to minimise exposure risks.

The Clinical Reviewer identified Mr V as a *"self isolator"* upon arrival in custody. This was due to personal concerns about his safety due to offences. The Clinical Reviewer stated this was *"a decision that may have limited his interactions."*

In regards to the impact Covid-19 had upon his care the Clinical Reviewer concluded there was *"no evidence from this clinical review to suggest that the Covid-19 pandemic negatively impacted his care delivery"*

6.4 Was the sharing of information between the Trust and NIPS adequate?

The Clinical Reviewer stated;

> *"The review of available records indicates that information sharing between the Trust and NIPS was adequate and adhered to healthcare confidentiality standards. Medical notes and detailed entries from Multi-Disciplinary Support and Strategy (MSS) meetings demonstrated consistent and appropriate communication across both parties."*

Mr V's condition, including his cancer treatment status and subsequent changes following his fall, was clearly documented and communicated. Updates from hospital oncology reviews such as the pause in chemotherapy and later confirmation of cancer progression were reflected accurately within NIPS and HiP records.

The Clinical Reviewer found that information discussed at MSS meetings captured broader aspects of Mr V's care. This included peer support, access to allied health professionals, and their associated recommendations. The Clinical Reviewer stated;

> *"These meetings ensured that both the Trust and NIPS were informed of Mr V's health, and that his residential and wider needs were addressed as they evolved."*

The Clinical Reviewer recorded Mr V's own disclosures to NIPS or HiP staff "*further supported shared understanding, with consistency noted in how this was recorded by both parties."*

6.5 Whether or not the decision to cease chemotherapy following Mr V's fall on 25 June 2022 was the appropriate decision and was this monitored and managed effectively at intervals with a view to recommencing treatment?

The decision to cease chemotherapy following Mr V's fall, which resulted in a fractured hip, was not made by the HiP team. It was made by a hospital oncology team led by a consultant. This was discussed at MSS meetings.

The Clinical Reviewer stated;

> *"This pause was justified due to the increased risks of delivering cytotoxic treatment to a patient with a recent fracture and limited weight-bearing capacity. It was intended to remain in place until Mr V could be reviewed by the fracture team and undergo a further oncology assessment in August"*

6.6 Whether or not ceasing chemotherapy following Mr V's fall on 25 June 2022 expedited Mr V's ill health and death?

The Clinical Reviewer stated;

> *"Chemotherapy was prescribed with palliative intent to manage symptoms, not to cure Mr V's illness, and it is not possible to determine whether its suspension expedited his death."*

6.7 Whether or not Mr V's periods of confusion should have been highlighted at an earlier opportunity and if failure to identify this expedited Mr V's ill health and death?

HiP staff saw Mr V frequently and documented each contact. No cognitive concerns were noted at his GP review on 24 November 2022.

On 25 November 2025 OT B recorded that Mr V appeared *"muddled and knocked off cognitively"* and that landing staff had observed similar behaviour over recent weeks. These informal reports had not been entered in medical records so it is unclear if HiP had been informed of these concerns. OT B escalated their concerns immediately to both NIPS and HiP teams.

The Clinical Reviewer stated;

> *"There is no clear record of any additional nursing assessment prompted by the OT's concern; best practice would have been a brief review with vital signs and mental-state observations, with further assessment conducted based on the clinical findings at the time."*

Healthcare professionals identified and documented confusion promptly once they observed it. There is no evidence of unaddressed periods of cognitive decline other than landing-staff anecdotes that were not formally reported.
The Clinical Reviewer stated;

"Given Mr V's advanced metastatic disease, acute infection and overall frailty, the onset of confusion was clinically plausible."

6.8 Whether or not Mr V's mismanagement of the self-administration of medicine should have been noticed prior to 16 November 2022 and if earlier intervention would have changed the outcome for Mr V?

Mr V was assessed by risk assessment at committal which determined he was permitted to be *"in possession"* of his medications. There were no concerns documented from committal until the 16 November 2022.

On 16 November 2022 HiP Nurse H recorded Mr V *"had surplus stock"* when they were issuing Mr V's weekly supply of pregabalin. Nurse H recorded an additional 35 tablets. It is unclear if these are a culmination of multiple missed tablets over a short period of time or an extended period of time.

Nurse H recorded a request made to provide Mr V with a *"Pill Pac"* after he declined a *"supervised swallow".*

The Clinical Reviewer recorded there were *"no interim measures (for example, pharmacist or GP review to check for potential overdose or adverse effects) were put in place prior to its arrival. A revised SARA (Self-Administration Risk Assessment) was not completed at that stage."*

On 25 November 2022 HiP Nurse attended Mr V's cell and again noted Mr V was not adhering to his prescribed medication on a regular basis.

The Clinical Reviewer stated;

> *"A SARA was then completed promptly, and although Mr V initially resisted, he agreed to this supervised regime, with a view to re-reviewing his self-administration capacity."*

When Mr V's *"in-possession medicines"* were removed and replaced with "*supervised swallow*" HiP correctly commenced an administration chart.

The Clinical Reviewer stated;

> *"The chart and accompanying medication records show that, over the <24-hour period before his hospital transfer on 26th November 2022, he received prescribed doses as required."*

Mr V's transfer from Magilligan Prison to hospital *"was precipitated by acute confusion and presumed chest infection, not by any failure to administer his medicines."* Following his brief discharge, the same supervised-swallow arrangement resumed until Mr V was admitted again on 28 November 2022.

6.9 Good practices and Areas for learning

HiP staff took time to explore Mr V's physical symptoms, emotional wellbeing and personal concerns. HiP developed a care plan and regularly revised plans based on Mr V's current needs. Such interactions reflected a thoughtful, patient-led approach that demonstrated high standards of holistic care.

The Clinical Reviewer stated;

> *"A multidisciplinary care plan detailed Mr V's comorbidity, current symptoms, professionals involved and immediate plus anticipatory actions. This ensured clarity of responsibility, continuity of care and proactive crisis management."*

EHR evidence timely input from physiotherapy, occupational therapy and dietitians which ensured Mr V's evolving needs were met promptly.

Public-health measures such as COVID-19 booster vaccination, lateral-flow testing, side-room isolation, and documented PPE usage allowed safe continuation of cancer treatment and routine care, *"reflecting strong adherence to national guidance"*

The Clinical Reviewer identified opportunities for HiP to improve processes in place when Mr V presented as unwell on 2 occasions in late November 2022. While a NEWS2 score was calculated for Mr V on the first occasion this same tool was not utilised on the second occasion. The Clinical Reviewer also found no evidence of a structured sepsis tool and stated *"both of which should have been triggered".*

The Clinical Reviewer stated HiP identified and documented confusion observed in Mr V promptly. In November 2022 EHR did not include any clear record of additional nursing assessments following identification. On this, the Clinical Reviewer stated;

> *"To strengthen future practice, healthcare teams should ensure that when concerns are raised, particularly regarding changes in cognitive function, timely follow-up assessments are clearly planned, documented and actioned, with escalation protocols in place where clinically indicated."*

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

	Investigation Objectives
1.	**Establish the circumstances and events surrounding Mr V's care by NIPS and HiP from committal up to his transfer to a hospital on 28 November 2022.**
	The circumstances of Mr V'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 V being transferred to Causeway hospital, where he remained until his death, can be found in Section 6.
2.	**Establish the circumstances and events leading up to and surrounding Mr V's death on 16 December 2022, looking at involvement from both NIPS and the Trust**
	The circumstances of Mr V'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 V being transferred to a Causeway hospital, where he remained until his death, can be found in Section 6.
3.	**Examine whether the provision of healthcare services provided to Mr V were at least equivalent to those he might have received in the community**
	Consideration of appropriateness in the level of care provided by NIPS and HiP in the period immediately leading up to Mr V being transferred to an

	Causeway hospital, where he remained until his death, can be found in Section 6.
4.	**Ensure Mr V'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 V and responses to these can be found in Section 6.
5.	**Identify any relevant failing or good practice and highlight any lessons learned from the death of Mr V; and**
	Areas of good practice and learning are included in Section 7.
6.	**Assist the Coroner's investigative obligation under Article 2 of the ECHR.**
	There is no inquest into the death of Mr V by the Coroner's Office given the circumstances of his death.

	Family Concerns
1.	**Was Mr V treated differently/better as a result of his diagnosis?**
	On 13 April 2022 an MSS conference took place in which Mr V's case was discussed. Residential matters were discussed and NIPS documentation evidenced Mr V did not like "that people are now treating him different due to his illness, and he just wants to be treated the same" There was no evidence to support that Mr V was treated any differently from another prisoner either before or after his diagnosis. Mr V was treated as he should have been by both NIPS and HiP. Mr V's needs were considered on its own merits.
2.	**Why was Mr V not released earlier given the finality of the diagnosis?**
	Article 20 of the Criminal Justice (Northern Ireland) Order 2008 provides the Department of Justice with the power to release a prisoner if it is satisfied that exceptional circumstances exist which justify the prisoner's release on compassionate grounds. Each case is considered on its own individual merits and all such releases are approved by the Minister of Justice. The qualification bar is set at a high level. Such releases are considered only in exceptional circumstances where a prisoner is nearing death or where their health has deteriorated to such an extent that they require a level of round-the-clock intensive care that is impossible to deliver in a prison environment. On the afternoon of 14 December 2022 the Clinical Director of HiP for the Trust informed NIPS that Mr V's health had deteriorated, that he was receiving palliative care via a syringe driver and that he appeared to be in the final stages of his terminal illness. On receipt of this information NIPS took the appropriate

action to secure Mr V's release under Article 20. He was released on 15 December 2022.

SECTION 7: Good practices

Pandemic restrictions significantly impacted daily activities. Procedures to manage prisoner interaction, mitigating measures including meaningful contact opportunities were in place.

This report recognises the collaborative efforts of NIPS and HiP in ensuring prisoner welfare despite the pandemic constraints.

While this report has identified areas for learning and recommendations, the overall standard of care provided to Mr V during his time in Magilligan Prison was appropriate. The Clinical Reviewer stated the level of care was *"good"*. It was evident that both HiP and NIPS staff engaged with him regularly, took time to listen to his concerns, and responded promptly and compassionately to his needs.

HiP staff took time to explore Mr V's physical symptoms, emotional wellbeing and personal concerns. HiP developed a care plan and regularly revised plans based on Mr V's current needs. Such interactions reflected a thoughtful, patient-led approach that demonstrated high standards of holistic care.

The Clinical Reviewer stated;

> *"A multidisciplinary care plan detailed Mr V's comorbidity, current symptoms, professionals involved and immediate plus anticipatory actions. This ensured clarity of responsibility, continuity of care and proactive crisis management."*

EHR evidence timely input from physiotherapy, occupational therapy and dietitians which ensured Mr V's evolving needs were met promptly.

Public-health measures such as COVID-19 booster vaccination, lateral-flow testing, side-room isolation, and documented PPE usage allowed safe continuation of cancer treatment and routine care, *"reflecting strong adherence to national guidance".*

SECTION 8: Learnings and Recommendations

The Clinical Reviewer identified opportunities for HiP to improve processes in place. When Mr V presented as unwell on two occasions in late November 2022. While a NEWS2 score was calculated for Mr V on the first occasion this same tool was not utilised on the second occasion. The Clinical Reviewer also found no evidence of a structured sepsis tool stating *"both of which should have been triggered".*

The Clinical Reviewer stated HiP identified and documented confusion observed in Mr V promptly. In November 2022 EHR did not include any clear record of additional nursing assessments following identification. On this, the Clinical Reviewer stated;

> *"To strengthen future practice, healthcare teams should ensure that when concerns are raised, particularly regarding changes in cognitive function, timely follow-up assessments are clearly planned, documented and actioned, with escalation protocols in place where clinically indicated."*

I have identified one Learning for NIPS and one Learning for the Trust. I have made one Recommendation to the Trust.

Learning 1

Mr V was taken to Causeway Hospital on 28 November 2022. There are claims and counter claims in regard to family contact. However, the evidence gathered and NIPS records suggest that there was no contact with the family until 14 December 2022. Mr V had been in hospital for 16 days at that stage and his condition had deteriorated so much, he had been set up with a syringe driver.

It should be noted NIPS were unable to provide any recorded evidence of any attempts to contact Mr V's next of kin during the period of 28 November 2022 to 14 December 2022 other than the account of Governor B.

This period of time, coupled with Mr V's condition, is unjustifiably long and raised concerns.

I originally recommended NIPS should amend the rule and policy currently in place. However changing *Prison Rules* is a lengthy legislative process and the rules are created at a high level, leaving the space for policies and procedures to implement the rules.

NIPS evidenced that they have reviewed their procedures, particularly concerning contact with family, and they have implemented significant improvements to their record keeping. Having reviewed updated guidance, I am satisfied this meets my original proposal

Learning 2

On 28 November 2022, HiP Nurse C recorded a marked deterioration in Mr V on EHR.

The Clinical Reviewer stated despite physiological observations being taken "*neither NEWS2 nor a structured sepsis tool were completed, both of which should have been triggered.*"

NICE guidance for Northern Ireland endorses the use of such tools in primary, secondary and tertiary care, especially for patients with known vulnerabilities such as immunosuppression or chronic respiratory disease, both of which were applicable for Mr V.

The Trust responded to this learning to advise a Sepsis Risk stratification tool is included in a revised NEWS2 chart. The Trust also confirmed the introduction of new systems to HiP *"will improve documentation, reporting and escalation processes as the NEWS is moving completely electronic which prompts escalation and consideration of sepsis."*

Recommendation 1

Mr V was noted on several occasions to have been displaying signs of confusion. Healthcare professionals identified and documented confusion promptly once they observed it. However, there was no clear record of additional nursing assessments carried out as a result of these observations. The Clinical Reviewer commented that best practice would have been a brief review of vital signs and mental-state observations, with further assessment conducted based on the clinical findings at the time.

HiP teams must ensure that when concerns are raised, particularly regarding changes in cognitive function, timely follow-up assessments are planned, documented and actioned, with escalation protocols in place where clinically indicated.

SECTION 9 – Conclusions

There was nothing to indicate that Mr V's death could have been prevented based on any of his interactions with NIPS or HiP staff. There was nothing which can be attributable to NIPS or HiP when considering the reasons for Mr V's death. Mr V became increasingly unwell as a result of his illness and when medical intervention was required HiP did so appropriately.

I am satisfied Mr V received healthcare at least equivalent to that within the community considering his illness while in custody.

I am further satisfied Mr V was treated appropriately by NIPS throughout his custodial period and staff were attentive to his needs as his condition deteriorated, with the exception of family contact while in hospital.

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 HSCN). 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 Magilligan Prison are available at Magilligan Prison Archives - CJI NI

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)

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

CJINI	Criminal Justice Inspection Northern Ireland
COPD	Chronic Obstructive Pulmonary Disease
CT Scan	Computed Tomography Scan
EHR	Electronic Healthcare Records
EMIS	Egton Medical Information System
GP	General Practitioner
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
MSS	Multi Disciplinary Support and Strategy
NEWS	National Early Warning Score
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
Ombudsman	Prisoner Ombudsman
OT	Occupational Therapist
Pandemic	Covid-19 Pandemic
PDU	Prisoner Development Unit
PSST	Prisoner Safety and Support Team
RQIA	Regulation and Quality Improvement Authority
SARA	Self Administration Risk Assessment
SEHSCT/theTrust	South Eastern Health and Social Care Trust