



The
**Prisoner
Ombudsman**
for Northern Ireland

OFFICIAL - SENSITIVE

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

ORHAN KIBAR

**AGED 47
AT MAGHABERRY PRISON
ON 30 MAY 2023**

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Foreword from the Prisoner Ombudsman

Mr Orhan Kibar was a 47 year-old sentenced prisoner who had been in custody for four years from 05 April 2019. He died in Maghaberry prison on 30 May 2023.

This report aims to outline the treatment and care Mr Kibar received while in custody 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.

Both organisations have cooperated fully in this investigation and have had the opportunity to review the report for factual accuracy.

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.

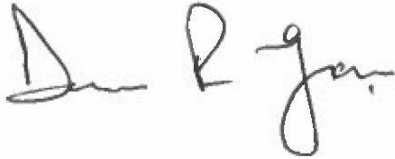
I am conscious of the length of time Mr Kibar's family have had to wait for the completion of this investigative process and appreciate their patience.

This report provides as much detail as possible about Mr Kibar'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.

To assist consideration of the healthcare aspects of Mr Kibar's time in custody and the potential impacts on his wellbeing a Clinical Reviewer was commissioned. The Clinical Reviewer's report included recommendations and areas of good practice about Mr Kibar's healthcare in prison and the response when he was found.

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

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

A handwritten signature in black ink, appearing to read 'Darrin Jones'.

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) and make recommendations to Northern Ireland Prison Service (NIPS) and the South Eastern Health and Social Care Trust (the Trust) for improvement where appropriate.

By highlighting learning to NIPS, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

The Trust was established on 01 April 2007 and is one of five 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](#).

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 specific objectives for this investigation are to:

1.	Establish the circumstances and events surrounding Mr Kibar's death on 30 May 2023, including the care provided by NIPS.
2.	Examine the provision of healthcare services provided to Mr Kibar. In particular, whether his needs were appropriately managed and if the care provided was at least equivalent to what he would have received in the community.
3.	Examine the mental health assessments, support and care planning provided to Mr Kibar during his time in custody.
4.	Ensure Mr Kibar'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 Kibar.
6.	Examine the adequacy of committal processes provided by HiP; and
7.	Assist the Coroner's investigative obligation under Article 2 of the ECHR.

SECTION 2: Investigation Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This comprises interviews and meetings with prison staff, HiP staff, prisoners and family. 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. The report is structured to detail the events and emergency response leading up to Mr Kibar's death on 30 May 2023.

Notices of the investigation into Mr Kibar's death were issued to relevant parties, including prisoners, NIPS, the Trust and the Independent Monitoring Board (IMB). This encourages anyone with information to come forward and speak to the Ombudsman's Investigators.

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

2.1 Independent Advice

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 within the body of this report. It should be noted the Clinical Reviewer provides advice and recommendations. It is then down to the discretion of the Ombudsman, based on the overall context of the case, whether the advice or recommendations are included within the final recommendations for this report.

2.2 Family Liaison

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

A meeting with Mr Kibar's family was held on 02 August 2023 to listen to their questions and concerns. These questions and concerns covered: -

1.	Why Mr Kibar was late to in-person visits. Did he need additional assistance and did staff act on concerns raised during a family visit.
2.	Medication – what Mr Kibar was prescribed and how this was administered/consumed. Was he giving his medication away.
3.	Did Mr Kibar receive the same level of care as in the community.
4.	Were there any indications of Mr Kibar being unwell in the lead up to his death.
5.	Mr Kibar's personal belongings – was he giving them away.
6.	Was Mr Kibar treated properly from a cultural/religious perspective – was he getting access to an Imam and Halal food.
7.	Physical health – whether there was evidence of Mr Kibar being abused.
8.	Mental health care – was Mr Kibar being treated properly for his mental health and did he understand everything he was being told.

SECTION 3: Summary of Orhan Kibar's case

Mr Kibar was 47 years old at the time of his death in custody, having served four years of a 16 year sentence. He had a brief prior period on remand between November 2017 and January 2018.

He was originally of Turkish nationality and naturalised as a British citizen in 2012.

Mr Kibar had a complex medical history, including bipolar affective disorder with multiple psychiatric admissions in Turkey and the UK.

His physical health conditions included Type 2 diabetes¹, hypertension², hypercholesterolaemia³, atrial fibrillation⁴, and a history of alcohol use.

On 30th May 2023, Mr Kibar was found unresponsive by his cellmate upon unlock at 08:40 in his cell at Shimna House at Maghaberry Prison.

CPR was initiated by HiP and NIPS staff and continued until paramedics from the Northern Ireland Ambulance Service arrived, life was pronounced extinct at 09:16.

The cause of Mr Kibar's death as stated in the Post Mortem Report was Intracerebral Haemorrhage and Hypertension. An intracerebral haemorrhage is a common form of stroke. It is frequently associated with prolonged raised blood pressure, which is a condition Mr Kibar was known to have suffered from. Mr Kibar's death is recorded as being from natural causes.

During the course of this investigation there were serious concerns raised regarding the level of checks which were noted as carried out on prisoners throughout the night.

¹ Type 2 diabetes happens when the body cannot use insulin correctly and sugar builds up in the blood.

² Hypertension is abnormally high blood pressure.

³ Hypercholesterolaemia is a lipid disorder in which your low-density lipoprotein (LDL), or bad cholesterol, is too high. This makes fat collect in your arteries (atherosclerosis), which puts you at a higher risk of heart attack and stroke.

⁴ Atrial fibrillation (AFib) is an irregular and often very rapid heart rhythm.

Whilst this is not seen as directly linked to Mr Kibars death, it is a grave concern which has been raised with NIPS. NIPS have advised they are conducting an investigation into this.

SECTION 4: Chronology of events leading up to Orhan Kibar's death

4.1 Maghaberry Prison 2019 – 2023

Mr Kibar was committed to Maghaberry on 05 April 2019. He underwent required assessments in relation to his health and mental health.

There were instances of concerns raised by Mr Kibar's family regarding his mental health. These were followed up appropriately by HiP and NIPS staff.

Records show Mr Kibar was seen on numerous occasions during his time in custody by HiP which included the Mental Health Team (MHT), Physiotherapist, General Practitioner (GP) and Dietician.

It is recorded throughout notes the use of translation services were appropriately identified and used where required.

Mr Kibar raised concerns with NIPS during the early part of his period in custody about being bullied and his medication possibly being stolen. These were investigated and nothing untoward was found. No other concerns were raised by Mr Kibar.

4.2 Maghaberry Prison 29 May 2023

At 16:35 the landing is locked for the night. Mr Kibar is in his cell with his cellmate. They watched television until around 21:40 after which Mr Kibar retired to bed on the top bunk. At around 22:45 Mr Kibar descended from his bunk and went to the bathroom within the cell. He was heard to be dry retching. When he exited the toilet Mr Kibar's cellmate noted he was unsteady on his feet. Mr Kibar's cellmate asked if he was ok and Mr Kibar grunted at him. Mr Kibar got back into his bunk and appeared to fall asleep.

Mr Kibar's cellmate was awoken at either 01.40 or 02.40 (he was unable to see the clock clearly so exact time is unknown) by Mr Kibar coming loudly down from his bunk and going into the bathroom. Mr Kibar put the light on and used the toilet. Mr Kibar's

cellmate noticed he was still unsteady on his feet but not as noticeable as earlier. Mr Kibar sat on the chair for a few minutes dry retching into the sink then went back to bed and quickly began snoring. Mr Kibar's cellmate woke again at around 05:00 and noted he could not hear any snoring however this was not unusual and he went back to sleep.

Official NIPS records show that there were three checks of Mr Kibar's cell carried out between 02.55 and 06.45 but on checking CCTV, investigators noted that these checks were not in fact carried out.

4.3 Maghaberry Prison 30 May 2023

08:40 – Landing was unlocked by NIPS staff Prison Officer A and Prison Officer B.

08:42 – Senior Nurse A was called to the landing due to Mr Kibar being found unresponsive by his cell mate.

08:44 - CPR commenced by Senior Nurse A with Prison Officer A and Prison Officer B while Mr Kibar was still on the top bunk. It was noted Mr Kibar's arms were mottled, and stiff and no carotid pulse was found. Also, Mr Kibar's pupils were fixed and dilated. Senior Nurse A was unable to get an i-gel⁵ adjunct inserted due to the stiffness of Mr Kibar's neck and jaw.

08:51 - Discipline Alarm was raised. Senior Officer A and other NIPS staff arrived and helped move Mr Kibar onto the landing to allow more room for resuscitation efforts to continue.

08:54 - Ambulance tasked by Emergency Control Room.

08:56 – Defibrillator to landing. No shock was advised once the defibrillator was attached and throughout the resuscitation efforts.

09:13 – Ambulance and first response arrive at Shimna House who placed their own defibrillator onto Mr Kibar. It showed the heart rhythm as being asystole⁶.

09:15 – Helicopter Emergency Medical Service (HEMS) Doctor arrives at Shimna House.

09:16 – Life pronounced as extinct by HEMS Doctor.

⁵ A device used to provide ventilation to a patient with respiratory arrest.

⁶ the heart has completely stopped electrical and mechanical activity, resulting in no heartbeat or blood flow, and is a severe form of cardiac arrest

4.4 Hot and Cold Debrief Meetings.

In all cases involving a serious incident of self-harm or death in custody, hot de-briefing will take place and will involve all the staff (where possible) who were closely involved with the incident.

The hot de-brief is held by the Duty Governor or the most senior NIPS manager at the time and will take place as soon as possible once the incident has been brought under control. During the hot de-brief staff should have the opportunity to express their views in relation to how the situation was discovered, managed and any additional support or learning that could have assisted. In addition, the hot de-brief is an opportunity to identify if staff themselves require specific support.

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.

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

The hot and cold debrief took place on 30 May 2023 and 12 June 2023 respectively with no issues raised.

SECTION 5 - Findings

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

	Investigation Objectives
1.	Establish the circumstances and events surrounding Mr Kibar’s death on 30 May 2023, including the care provided by NIPS;
	<p>The circumstances and chronology of Mr Kibar’s death have been established by this investigation and recorded in Section 3 by way of summary, with a more detailed timeline in Section 4.</p>
2.	Examine the provision of healthcare services healthcare provided to Mr Kibar. In particular, whether his needs were appropriately managed and if the care provided was at least equivalent to what he would have received in the community;
	<p>The Clinical Reviewer noted:</p> <p><i>“Between 2019 and 2021, Mr Kibar accessed a range of primary care services while in custody.</i></p> <p><i>Mr Kibar had a known diagnosis of type 2 diabetes, with diabetic care plans in place to support self-management. These plans were appropriate and reflected best practice in custodial settings.</i></p> <p><i>Overall, Mr Kibar’s diabetes appeared well-managed during his time in custody, with appropriate monitoring, multidisciplinary input, and no indication of deterioration in his condition.</i></p> <p><i>The management of Mr Kibar’s medication during his time in custody reflected appropriate practice. While community records had previously noted concerns regarding his compliance with prescribed mental health treatments, custodial healthcare documentation demonstrated structured oversight.</i></p>

	<p><i>IPRA in-possession risk assessments and SARA⁷ documentation were present and repeated as required. Mr Kibar was issued PillPac^{®8}, which he reported to be beneficial; ad hoc checks confirmed that his medicines regimen was being achieved. Following one such check, he was reviewed by the psychiatrist and noted to be stable. Where dose adjustments were required, the presence of PillPac[®] was acknowledged and plans made to align future supply accordingly. Prescriptions were arranged regularly on repeat, with no indication of gaps in access or administration.</i></p> <p><i>Preventative healthcare interventions were appropriately delivered. Mr Kibar received both the COVID-19 booster and seasonal influenza vaccination on 28th October 2022, in line with expectations for individuals living with long-term conditions. BBV screening bloods were also completed in January 2022, supporting routine health surveillance and early identification of communicable disease risk”.</i></p>
3.	<p>Examine the mental health assessments, support and care planning provided to Mr Kibar during his time in custody;</p>
	<p>The Clinical Reviewer stated:</p> <p><i>“Mr Kibar was managed under the care of the mental health team throughout his time in custody, with input from both a designated keyworker and the psychiatrist. Records indicate that his care was delivered through a multidisciplinary approach, with regular reviews, medication oversight, and personalised planning in place to support his mental health needs”.</i></p>
4.	<p>Ensure Mr Kibar’s family has an opportunity to raise any concerns they may have and take these into account in the investigation;</p>
	<p>Concerns raised by the family of Mr Kibar are detailed in Section 2.2.</p>
5.	<p>Identify any relevant failing or good practice and highlight any areas for improvement from the death of Mr Kibar;</p>

⁷ Self-administration risk assessment – to assess whether the patient should be administered medications directly.

⁸ This packs each day’s medicines into individual tear-off sachets, clearly labelled with the patient’s name, the medicines inside, and the time they should be taken. It helps people manage their treatment safely and independently.

	These are detailed in section 7
6.	Examine the adequacy of committal processes provided by HiP; and
	<p>The Clinical Reviewer noted:</p> <p><i>“Mr Kibar’s healthcare needs during the committal period were addressed in a timely and appropriate manner. Both primary and follow-up assessments were completed within the expected timeframes, with clear documentation of his individual health requirements. These assessments included condition-specific considerations, such as the management of his diabetes, and reflected a responsive approach to identifying and recording relevant risks”.</i></p>
7.	Assist the Coroner’s investigative obligation under Article 2 of the ECHR.
	A copy of this report and underlying materials will be provided to the Coroner as part of the usual process.

The Kibar family raised several questions during their meeting with the then Ombudsman. These are detailed in section 2.2 and findings recorded below:

	Family Concerns
1.	Why Mr Kibar was late to in person visits. Did he need additional assistance and did staff act on concerns raised during a family visit?
	It is noted throughout his time in custody that Mr Kibar was tardy and slow which led him to receiving adverse reports on a few occasions. There are no records to indicate Mr Kibar was late for visits.

Records show when concerns were raised by the family directly to NIPS or through the Office of the Prisoner Ombudsman these were relayed to the relevant staff and were followed up on promptly.

The Clinical Reviewer noted:

“From a healthcare perspective, there’s nothing in the records to suggest that Mr Kibar needed extra help to attend visits. He was able to communicate clearly and manage his own care, and there were no concerns raised about his ability to access visits or understand arrangements in general”.

2.

Medication – what Mr Kibar was prescribed and how this was administered/consumed. Was he giving his medication away?

Mr Kibar was prescribed the following medications:

Amisulpride – Used to treat mental health conditions, such as schizophrenia.

Apixaban – A blood thinner used to prevent blood clots.

Atorvastatin – A statin used to lower cholesterol.

Bisoprolol Fumarate – A beta-blocker that slows the heart rate and lowers blood pressure.

Metformin – A medicine for type 2 diabetes.

Paracetamol – A common painkiller.

Promethazine – An antihistamine that can help with sleep problems.

Sertraline – An antidepressant.

Valproic Acid – Used to treat bipolar disorder.

The Clinical Reviewer noted:

“Mr Kibar received his medication through a system called PillPac®. This packs each day’s medicines into individual tear-off sachets, clearly labelled with the patient’s

name, the medicines inside, and the time they should be taken. It helps people manage their treatment safely and independently.

Mr Kibar told pharmacy staff that he liked using PillPac®. It allowed him to keep track of his medicines easily and take them as prescribed”.

There had been some concerns raised earlier in Mr Kibar’s sentence to medication and bullying however, there was no evidence of this, and nothing further was raised by Mr Kibar.

3. Did Mr Kibar receive the same level of care as in the community?

The Clinical Reviewer stated

“Mr Kibar received the same level of care he would have in the community, recognising that custodial environments are inherently different. During his period of poor mental health, it would be reasonable to comment that he likely had a higher level of support and monitoring than he would have received if living at home in the community”.

4. Were there any indications of Mr Kibar being unwell in the lead up to his death?

The Clinical Reviewer stated:

“the management plan for Mr Kibar’s care and treatment appeared suitable and proportionate to his needs. There was no indication within the records of any clinical presentation or deterioration that would have reasonably prompted escalation or intervention beyond what was provided”.

Mr Kibar had seen the GP on 25 April 2023. Blood samples were taken on 26 April 2023 and reviewed promptly. The GP requested repeat tests which were completed on 05 May 2023 and were noted to be satisfactory when reviewed by the GP. Mr Kibar had not seen HiP or reported any immediate concerns in the days prior to his death.

5. Mr Kibar's personal belongings – was he giving them away?

Records indicate Mr Kibar was giving away items from his tuckshop including tobacco. From reviewing records, it does appear that NIPS staff tried to help Mr Kibar and were concerned other people could take advantage of him. They spoke to him on more than one occasion and explained he was not to do this as these were his items.

It is also noted in June 2021 Mr Kibar requested for his clothing card to be updated as he informed NIPS staff, he had been throwing clothes away or giving them to other people. NIPS staff carried out this request promptly.

6. Was Mr Kibar treated properly from a cultural/religious perspective – was he getting access to an Imam and Halal food.

There is no evidence to suggest Mr Kibar was not treated properly from a religious/cultural perspective. It is recorded on 15 April 2019 that Mr Kibar required Muslim meals. In January 2020, it is noted the Chaplain had previously visited Mr Kibar with the Imam however, Mr Kibar had asked for him not to bring the Imam back. In March 2022 staff met with Mr Kibar to discuss Ramadan. Mr Kibar stated he would not be celebrating it due to medical issues. Mr Kibar had not made any complaints regarding not being treated properly and there is no mention of it throughout his records.

7. Physical health – whether there was evidence of Mr Kibar being abused.

There were occasional interpersonal difficulties between Mr Kibar and cellmates which were typically resolved through cell reallocation and did not escalate further. There is no evidence within NIPS records, healthcare documentation, or verbal concerns raised by Mr Kibar to suggest that he had experienced any physical altercation involving others.

8.

Mental health care – was Mr Kibar being treated properly for his mental health and did he understand everything he was being told.

The Clinical Reviewer noted:

“Mr Kibar was looked after by the prison’s mental health team throughout his time in custody. He was on their caseload, meaning he was actively followed up and supported by both a named staff member and a psychiatrist. His care was regularly reviewed by a group of professionals, and he received medication, monitoring, and a plan tailored to his needs.

When he first arrived, staff noticed that Mr Kibar was struggling with his mental health. He showed signs of distress, including unusual behaviour and hearing voices. These concerns were taken seriously, and his treatment was adjusted to help him. Over time, his condition improved, and by 2022, the psychiatrist described him as mentally well, with no signs of confusion or distress.

There’s nothing in the records to suggest that Mr Kibar didn’t understand what was being said to him about his care. He was able to speak clearly with staff, take part in assessments, and talk about how he was feeling. He had a recovery plan in place and knew how to ask for extra help if he needed it.

Overall, the care he received seems to have been appropriate and in line with what’s expected for someone with long-term mental health needs”.

SECTION 6 - Conclusions

Mr Kibar was noted as being generally quiet, polite to both staff and other prisoners and of a good nature. It is clear from records he was encouraged by staff on many occasions to apply for education courses and engage in other activities. However, his lack of engaging in purposeful activities meant Mr Kibar spent the majority of his time in custody on standard regime.

Where there were concerns regarding Mr Kibar's understanding of English during the initial period of custody, records show the assistance of an interpreter was used appropriately. Information was offered to him in Turkish however, Mr Kibar stated he could read and understand English. There is no evidence to indicate language barriers affected any aspect of Mr Kibar's care or that staff failed to access translation support when required.

Mr Kibar received healthcare at least equivalent to that available within the community. The Clinical Reviewer stated:

“During his period of poor mental health, it would be reasonable to comment that he likely had a higher level of support and monitoring than he would have received if living at home in the community”.

I am satisfied that, in general, the level of care which Mr Kibar received by HiP was appropriate and in line with relevant policies with the exception of the decision to conduct CPR which I have addressed below in recommendations.

I am deeply concerned that the level of care provided by NIPS the night of Mr Kibar's death, failed to meet the required standards in respect of safety checks to be carried out during the night to ensure prisoner wellbeing. CCTV was reviewed and it is clear not all checks recorded were carried out, which is in contradiction to the physical records completed. This has been raised with the NIPS who have undertaken an internal investigation. NIPS have confirmed a fact-finding exercise has been carried out and has been sent for further investigation to NIPS Professional Standards Unit.

All night staff have undergone routine training with regard to conducting checks since the death of Mr Kibar.

SECTION 7: Good practice and areas of learning

Good practice:

NIPS:

It is noted in inmate records that Mr Kibar struggled with rationing his tobacco and records show both NIPS staff and other prisoners tried to help him with this. Even going to the extent of holding his tobacco and giving it to him at specified times throughout the day. While this would not be usual practice, it demonstrates the level of empathy and compassion shown towards Mr Kibar.

TRUST:

The Clinical Reviewer noted the following areas of good practice:

“Preventative healthcare measures were appropriately delivered, including vaccinations and routine screening, in line with best practice for individuals with long-term conditions.

The initial screening on committal was completed in alignment with best practice standards, with effective joint working between healthcare staff and NIPS.

Mr Kibar’s mental health care was consistently supported through proactive engagement by his key worker and the wider multidisciplinary team (MDT). Regular reviews, collaborative planning, and clear communication across the MDT ensured that his mental health needs were monitored and addressed.

Mr Kibar’s diabetes care was managed in line with best practice expectations, with appropriate access to specialist services, including diabetic foot care and diabetic retinopathy screening”.

Areas of learning:

While CPR had been commenced by NIPS staff, HiP staff on their arrival assessed Mr Kibar and noted his arms were mottled and stiff, no carotid pulse was present, his pupils were fixed and dilated, and his jaw and neck were so stiff they were unable to pass an i-gel adjunct. The HiP guide, which came into effect on 19 April 2023, regarding when not to perform CPR states:

“Resuscitation must be started on all patients who are found not breathing and/or pulseless UNLESS there is a DNACPR⁹ order in place or certain conditions exist which means that CPR has no chance of success and in terms of survival is pointless and may violate the right for dignity in death.

There are 7 conditions unequivocally associated with death and 2 were present in Mr Kibar, notably Hypostasis/Lividity (often referred to as ‘mottling’) and Rigor Mortis. The decision to continue with CPR goes against this policy and was inappropriate in this instance.

The Clinical Reviewer stated:

“It is acknowledged that such decisions can be extremely difficult in real-time, particularly when staff are motivated to help and act swiftly. While several experienced staff were present, it was unclear from documentation who was leading the resuscitation effort. This may have contributed to the continuation of CPR despite signs that it was not clinically appropriate”.

And noted the following area of learning:

1. The Trust may wish to consider ensuring that a named staff member is clearly assigned the role of designated Resuscitation Lead in future incidents. This designation should be explicitly recorded within incident documentation, and staff should be supported to undertake this responsibility with confidence.

⁹ **Do Not Attempt Cardiopulmonary Resuscitation.** It is a medical order indicating that if a person's heart or breathing stops, healthcare professionals should not attempt CPR to restart it.

Healthcare staff responsible for responding to emergencies should have the competence and clinical authority to assess whether CPR is clinically appropriate, in line with national guidance. The Trust should ensure that staff are adequately prepared through training and supervision to make such decisions based on clinical presentation and evidence-based practice.

SECTION 8: Recommendations

TRUST:

The Clinical Reviewer made the following recommendation:

1. The Trust should review any changes implemented since the death of Mr Kibar, relating to resuscitation protocols and decision-making. It is essential that staff responding to emergencies are clinically competent and confident in determining when CPR should not be commenced or when resuscitation efforts should be discontinued. These decisions must be underpinned by evidence-based, ethically sound, and clinically informed policies, with appropriate training and supervision in place to support staff in the real-time application.

GLOSSARY**Appendix 1**

CJINI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
GP	General Practitioner
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
MDT	Multi-Disciplinary Team
MHT	Mental Health Team
NIPS	Northern Ireland Prison Service
RQIA	Regulation and Quality Improvement Authority
The Trust	South Eastern Health and Social Care Trust

Appendix 2

Criminal Justice Inspection Northern Ireland (CJINI)

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

In February 2022 CJINI published a report of a Review into the Operation of Care and Supervision Units (CSUs) in Northern Ireland and published a Follow-Up Review of recommendation implementation on September 2023. Although focused on care and treatment in CSUs, the learning from the Review can be applied to prisoners who are segregated and held in quarantine for whatever reason. Recognising the importance of delivering meaningful human contact and recording access to time out of cell and purposeful activity will be important considerations in the event of a future pandemic or other reasons for prisoner quarantine for extended periods.

The most recent inspection report on Maghaberry Prison was published in June 2023 followed by an Independent Review of Progress (IRP) published in February 2024. Inspectors reported the prison had settled considerably since the last full inspection in May 2015 and was now a much safer place.

A priority concern in the 2023 report was when a prisoner died at Maghaberry Prison leaders waited for the Ombudsman's and Coroner's report to be delivered before they took action rather than conducting their own immediate investigation and putting

mitigating measures in place. The IRP report noted reasonable progress against this priority concern.

The overall picture of safety has progressed hugely and levels of violence and disorder had reduced; however, Inspectors remained concerned that work to support the most vulnerable men at Maghaberry Prison had not developed to the same level as other aspects of safety.

CJINI reports are available at [Maghaberry Prison inspection report June 2023](#) and [CJINI Independent Review Progress Report 2024](#).

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)

Maghaberry Prison has an IMB of volunteers whose role is to independently monitor the care and treatment of prisoners. From the 2021-2022 Maghaberry Prison IMB annual report the IMB state there has been clear evidence of prison staff intervention in relation to prisoners who may attempt suicide or inflict self-harm which has improved the safety and wellbeing of prisoners. The IMB would acknowledge the excellent work carried out by staff in this regard to ensure the safety of prisoners, especially those who have been identified as being vulnerable. The IMB did however, continue to have some concerns regarding the standard of accommodation within Foyle during this year particularly around lack of furniture and non-working showers, and the impacts on prisoners due to Covid-19 restrictions particularly 23-hour lock ups.

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

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 offences 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 modernised 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 emphasises 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 age 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.