The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INDEPENDENT INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MS PAULINE FERRIN

AGED 27
POST-RELEASE FROM HYDEBANK WOOD COLLEGE AND WOMEN'S PRISON
ON 25 NOVEMBER 2025

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Foreword from the Prisoner Ombudsman

Ms Pauline Ferrin was a 27-year-old prisoner committed on remand to Hydebank Wood College and Women's Prison on 27 October 2025. She was released from prison on 24 November 2025. She died one day after release.

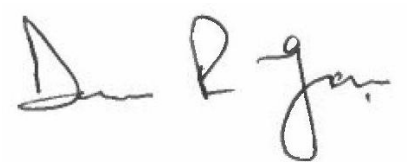
This report details the outcome of the investigation into the treatment and care Ms Ferrin received prior to her death and the circumstances leading up to it.

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 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.

This report provides as much detail as possible about Ms Ferrin's time in custody and the circumstances surrounding her death.

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

I offer my condolences to Ms Ferrin's family on their loss.



Darrin Jones

Prisoner Ombudsman for Northern Ireland

The Role of the Prisoner Ombudsman

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

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

The purpose of the Ombudsman's investigation is to find out, as far as possible, what happened and why; establish whether there are any lessons to be learned; assist the Coroner's investigative obligations under Article 2 of the European Convention on Human Rights (ECHR)[1] and make recommendations to 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 five Trusts in total within Northern Ireland. The Trust has responsibility for providing healthcare to all prisoners in Northern Ireland. This is delivered on a day to day basis by the

[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.
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.

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 1**.

SECTION 1 - Investigation Objectives

The overall objectives for this investigation are to:

1.	**Establish the circumstances of this Post Release Death (PRD);**
2.	**Examine the care provided by NIPS;**
3.	**Examine the healthcare provided by the Trust;**
4.	**Ensure Ms Ferrin'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 commendable practice, and highlight any lessons learned from the death of Ms Ferrin;**
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 may comprise of interviews with NIPS staff, HIP staff, prisoners and a meeting held with family. All prison records in relation to Ms Ferrin's life while in custody are examined. This includes examination of evidence such as Closed-Circuit Television (CCTV) footage, telephone calls and mail.

Notices of investigation into Ms Ferrin's death were issued to relevant parties within Hydebank Wood College and Women's Prison (HBW), including prisoners, NIPS, HiP and the IMB. This encourages anyone with information to come forward and speak to the Ombudsman's Investigators.

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

2.2 - Family Liaison

A telephone conversation took place with Ms Ferrin's next of kin on 10 September 2026. The next of kin confirmed that he had no concerns to raise and was content for the report to be published.

SECTION 3 - Summary of Ms Ferrin's Case

Between 2016 and the time of her death, Ms Ferrin had been in HBW on 20 occasions. Prior to this, Ms Ferrin had spent time in Woodlands Juvenile Justice Centre[2].

On 27 October 2025, Ms Ferrin was remanded to HBW. A reception risk assessment was completed on admission; it determined she was not considered to be at risk of suicide or serious self-harm and did not require any special care arrangements. Records from the Safer Custody Profile report[3] state:

> *"Pauline is quiet, wanting a smoke. States she cut a few weeks ago but is ok being here. No current thoughts. Very skinny and carrying infection in injections sites. Pauline seemed quite withdrawn and said she felt quite low but said she has no current thoughts of self-harm or suicide but says she has done in the past but can keep herself safe. She was happy to answer questions, and her main concern was getting to Hydebank so she could get a smoke and she needed money left in. Pauline is on meds for psychosis, depression, HIV and Hep C but she has not been given any medication while in police custody and states she is feeling the impact of that. Pauline is involved with addiction services and is also engaging with her Dr for her mental health".*

On 27 October 2025, Ms Ferrin also met with HiP staff for an initial healthcare triage as part of the committal process. Records from the *Egton Medical Information System (EMIS)* state:

> *"Pauline reports deliberate self-harm last month/and reports she stole makeup so that she could come into custody and assures she can keep herself safe."*

[2] Youth Justice Agency provides custodial facilities for children and young people referred to it by the court system in Northern Ireland.

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

"Pauline last use of Heroin was 25/10/25"

"Pauline reports last use of cocaine was Saturday 25th October 2025"

"Inappropriate use of over the counter/prescription medications - Street Pregabalin"

On 27 and 28 October 2025, Ms Ferrin had withdrawal observations carried out by HiP staff using the Clinical Benzodiazepine Withdrawal Scale (CBWS)[4] and Clinical Opiate Withdrawal Scale (COWS)[5].

On 28 October 2025, EMIS records also state:

"Pauline declined assessment of infected groin site, but was advised to seek medication attention if condition deteriorates".

There is no record to indicate that Ms Ferrin sought any further medical assistance or support in relation to this issue.

On 29 October 2025, Ms Ferrin declined withdrawal observations via CBWS and COWS.

On 30 October 2025, EMIS notes state:

"Pauline scoring less than 10[6] on both withdrawal assessments, observations discontinued"

[4] The Clinical Institute Withdrawal Assessment – Benzodiazepines is a standardized instrument used to assess and monitor benzodiazepine withdrawal severity.

[5] The Clinical Opiate Withdrawal Scale is a method used by registered practitioners to measure the severity of a patient's opioid withdrawal symptoms.

[6] Score of less than 10 generally indicates mild withdrawal or no significant withdrawal.

Ms Ferrin was referred to AD:EPT[7] and Start360[8] during her period in custody. She attended four of five scheduled appointments with AD:EPT and two appointments with Start360. In addition, Ms Ferrin engaged with Flourish NI[9] on three occasions.

On 05 November 2025, Ms Ferrin underwent a mental health triage. Records from EMIS notes state:

> *"At present no clinical indication for mental health assessment as per Care pathways, aware of all support in custody and how to access same. If any changes she can be referred via correct pathways.*
> *No other concerns at time of note".*

Following this consultation, there is no further record of any contact between Ms Ferrin and HiP staff prior to her release on 24 November 2025.

CCTV footage from the day of Ms Ferrin's release shows her presenting in good spirits, engaging in conversation and sharing hugs with other inmates.

Prior to Ms Ferrin's release from HBW, NIPS Prisoner Development Unit (PDU) contacted Glenview Women's Shelter who confirmed there would be a safe place for Ms Ferrin to sleep. Staff arranged for a taxi to drive Ms Ferrin to Glenview Women's Shelter as Complex Lives and Beyond the Gate were unable to facilitate collection from HBW on this occasion. Ms Ferrin was released from HBW, at around 16:20 hours on 24 November 2025, however, did not present herself at Glenview Women's Shelter

[7] Alcohol and Drugs: Empowering People Through Therapy. It is a substance misuse treatment and support service that operates in Northern Ireland prisons and is delivered by the charity Start360.

[8] Start360 is a Northern Ireland charity that works with people involved in the justice system, including those in prison to help people address issues such as substance misuse, mental health, offending behaviour, education, employability, and reintegration into the community.

[9] Flourish NI, a registered charity that provides support to individuals affected by human trafficking in Northern Ireland.

until 01:30 hours on 25 November 2025. Her movements between release and presentation remain unknown. She was last seen alive at 18:58 hours on this date and was declared deceased at 21:02 hours.

The Autopsy took place the next day, the following is an excerpt from the report:

> *"Ms Ferrin was released from Hydebank Wood on 24 November 2025, at around 16:20 hours. She then went to stay at room 401 in a women's shelter at the Glenview Building in Belfast. It was a private room. She was last seen alive in person on 25 November 2025, at around 18:58 hours when an agency worker checked on her room. At this time, she seemed in good spirits, however there was no documentation of her communicating with the agency worker.*
>
> *At around 20:15 hours on 25 November 2025, Miss Ferrin was found during a room check at the property, within her room, lying on the floor, unresponsive. There was no vomit around her mouth. The emergency services were contacted, and CPR was commenced, however this was unsuccessful, and her life was pronounced extinct at 21:02 hours, on 25 November 2025, by a paramedic.*
>
> *Within the room, the following drugs were identified: a stericup containing a brown resin-like substance, a white oval tablet, a partial blister pack of solifenacin[10] and a partial blister pack of quetiapine[11]. No alcohol was present within the room".*
>
> *Cause of death - Heroin and Cocaine Intoxication".*

[10] Solifenacin is a prescription medicine used to treat symptoms of an overactive bladder. It works by relaxing the bladder muscle, which helps reduce sudden urges to urinate and urinary leakage.
[11] Quetiapine is a second-generation (atypical) antipsychotic used to treat mental health problems.

Police Service of Northern Ireland (PSNI):

An investigation was commenced by PSNI on behalf of the Coroner as this was a drugs death involving the supply of controlled/illegal drugs to Ms Ferrin which ultimately resulted in her death.

SECTION 4 - Findings

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

Investigation Objectives	
1.	**Establish the circumstances of this Post Release Death (PRD);**
	The circumstances and chronology have been established by this investigation and recorded in Section 3 by way of summary.
2.	**Examine the care provided by NIPS;**
	This investigation found the care of Ms Ferrin at HBW by NIPS staff was in line with relevant procedures and met the professional standards expected.
3.	**Examine the healthcare provided by the Trust;**
	Consideration of appropriateness in the level of care provided by HiP during Ms Ferrin's period in custody can also be found in Section 3. I am satisfied Ms Ferrin received healthcare at least equivalent to that within the community.
4.	**Ensure Ms Ferrin's family has an opportunity to raise any concerns they may have and take these into account in the investigation.**
	A telephone conversation took place with Ms Ferrin's next of kin on 10 September 2026. The next of kin confirmed that he had no concerns to raise and was content for the report to be published.

5.	**Identify any relevant failing or commendable practice, and highlight any lessons learned from the death of Ms Ferrin.**
	No relevant failings or learnings were identified in respect of the care Ms Ferrin received while in NIPS custody. Areas of good practice are included in Section 5.
6.	**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.

SECTION 5 - Good Practices

While HBW has no statutory obligation to secure accommodation or provide transport by taxi for individuals upon release, staff determined that, in this case, a taxi was the safest and most appropriate means of transport for Ms Ferrin directly from HBW to Glenview Women's Shelter. This approach demonstrates HBW's commitment to good practice and its willingness to take reasonable steps beyond statutory requirements to support individuals leaving custody.

SECTION 6 - Learning and Recommendations

As a result of this investigation, I have identified no areas of learning for either NIPS or the Trust and have no concerns to raise.

The investigation did not identify any issues requiring further action, and therefore, I make no recommendations.

SECTION 7 - Conclusion

Following a comprehensive review of all evidence relating to Ms Ferrin's brief period in custody, this investigation found no action or omission by either NIPS or the Trust that directly contributed to her death. There were no concerns identified regarding Ms Ferrin's time in custody, and no evidence was found to suggest any link between her time in custody and her death.

Ms Ferrin had a longstanding history of polysubstance misuse, including the use of legal highs, cocaine, and heroin. She had also engaged with mental health services and had recently been affected by a family bereavement.

I would like to express my thanks to all those who contributed to the preparation of this report.

Appendix 1 - Reports

Criminal Justice Inspection Northern Ireland (CJINI)

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.

CJI reports relating to Maghaberry Prison are available at Maghaberry Prison Archives - CJI NI.

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

The Ombudsman works with the RQIA and others to raise matters of concern and improve the delivery of support to prisoners.

The last review commissioned by the Prisoner Ombudsman NI and the Departments of Justice and Health to consider particularly vulnerable prisoners within Prisons was published by RQIA in 2021 is available here.

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)

Appendix 2 - Prison Establishments

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 aged 18-24, and women prisoners aged 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.

Appendix 3 - Glossary

CBWS	Clinical Benzodiazepine Withdrawal Scale
CCTV	Closed-Circuit Television
COWS	Clinical Opiate Withdrawal Scale
CJI	Criminal Justice Inspection Northern Ireland
ECHR	European Convention on Human Rights
EMIS	Egton Medical Information System
HiP	Healthcare in Prison
HBW	Hydebank Wood College and Women's Prison
IMB	Independent Monitoring Board
NIPS	Northern Ireland Prison Service
PDU	Prisoner Development Unit
PRD	Post Released Death
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
the Trust	South Eastern Health and Social Care Trust