The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF MR MARK CHARLES MAGINNIS (AGED 40) WHILST IN THE CUSTODY OF MAGHABERRY PRISON ON 25 OCTOBER 2010

[29 February 2012]

[Published, 21 March 2012]

Please note that where applicable, names have been removed to anonymise the following report

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PREFACE

Mr Mark Charles Maginnis was born on 6 August 1970. He was 40 years old when he died of features consistent with septicaemia due to infection of foot ulcers on Monday 25 October 2010, whilst in the custody of Maghaberry Prison.

I offer my sincere condolences to Mr Maginnis' family for their sad loss. I met with Mr Maginnis' mother following his death and met with her again to share the content of this report.

The report contains this preface, a summary followed by issues of concern, an introduction and the investigation findings. The findings are in five sections:

- Section 1: Review of Background History
- Section 2: Events Leading up to Mr Maginnis' Death on 25 October 2010
- Section 3: Mr Maginnis' Mental Healthcare
- Section 4: Other Issues
- Section 5: Autopsy Report

As part of the investigation into Mr Maginnis' death, Dr Michael Flynn, Consultant Physician at the Chaucer Hospital, Canterbury was commissioned to carry out a clinical review of his healthcare needs and medical treatment whilst in prison. I am grateful to Dr Flynn for his assistance.

I am also grateful to Dr Seena Fazel, Forensic Consultant Psychiatrist at Warneford Hospital, who was commissioned to provide a mental health report.

In the event that anything else comes to light in connection with the circumstances of the death of Mr Maginnis, I shall record this in an addendum to this report and notify all concerned.

It has been my practice to include in my reports, recommendations for action that would lead to improved standards of inmate care and may help to prevent serious incidents or deaths in the future.

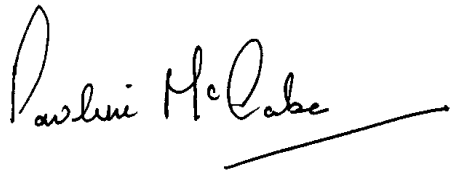
In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that *"An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become a barrier rather than a stimulus to progress, with a plethora of action plans at local and central level, and a focus on servicing the plans rather than acting on them This has led to inspection and monitoring being defined as a problem within the service, rather than a solution and a driver for change."*

The Prison Service and South Eastern Health and Social Care Trust (SEHSCT) are currently engaged in two programmes of work with the aim of achieving significant change in Northern Ireland prisons. These are the Strategic Efficiency and Effectiveness (SEE) Programme and the SEHSCT's Service Improvement Boards.

In light of Dame Owers' comments and in order to support the development of a more strategic and joined up approach to service development, I took a decision in June 2011 not to, for the time being, make recommendations following death in custody investigations. I decided that I would instead detail issues of concern that I would expect the Prison Service and SEHSCT to fully address in the context of their programmes for change, with appropriate urgency. I shall keep this approach under review and revert to making recommendations if I am not satisfied that the response of the Prison Service and / or Trust is adequate.

In the case of Mr Maginnis I identify six matters of concern.

I would like to thank all those from the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and other agencies who assisted with this investigation.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
29 February 2012

SUMMARY

Mr Mark Charles Maginnis was 40 years old when he died of features consistent with septicaemia due to infection of foot ulcers on 25 October 2010, whilst in the custody of Maghaberry Prison. Mr Maginnis was diagnosed as an insulin dependant Type 1 diabetic at the age of nine years and, over the years before his committal on 1 May 1991, his medical records note that his blood glucose *"tended to be a little high."*

As diabetes was a contributory factor in Mr Maginnis' death, one of the questions asked by his mother was whether his healthcare in prison was adequate.

Mr Maginnis' prison healthcare records going back to 1991, indicate that close attention was paid to his diabetic status. There are numerous recordings of his blood sugar level and administration of his insulin therapy. There is also documented evidence that, throughout his time in prison, Mr Maginnis was attending secondary services such as diabetic clinics, specialist dieticians, podiatrists and eye services at the Royal Victoria and Belfast City Hospitals. Mr Maginnis was also visited in prison by a Consultant Physician on a number of occasions, primarily to attend to his diabetes.

A person with diabetes must maintain a good control of their blood sugar levels in order to reduce the risk of having diabetic complications, and to do this it is essential to have the full and active co-operation of the patient. As early as 1991 and up to a month before Mr Maginnis died, there is evidence of his non-compliance with the dietary requirements of his condition. In Mr Maginnis' later years this included a high intake of sugar, which placed him at risk of developing a type of coma called diabetic ketoacidosis. There are also many recorded instances of Mr Maginnis refusing food, which can result in hypoglycaemia[1] and of him refusing his insulin. Failure to take the required insulin considerably increased the instability of Mr Maginnis' diabetes and the risk of him developing health complications.

[1] Hypoglycaemia is a condition that occurs when a persons blood sugar (glucose) is too low and can cause symptoms such as double or blurred vision, acting aggressive, headache, shaking/ trembling, sweating, tiredness/ weakness, have a seizure or go into a coma.

There is also recurring and frequent evidence of Mr Maginnis refusing hospital appointments and of him not attending appointments for clinics and some investigations. In his overall assessment of Mr Maginnis' healthcare in prison, the clinical reviewer, Dr Michael Flynn, concluded:

"It is my opinion that the management of an individual's diabetes requires the ongoing co-operation of the individual in the management plan. Mr Maginnis prior to his remand in prison attended diabetic clinic appointments. It is clear from the records that his compliance with all aspects of treatment was erratic and frequently was wilfully obstructive. There are an enormous number of documented episodes when he failed to comply in a major and significant way with his diet, insulin administration etc. His overall control of his diabetes was very poor."

Dr Flynn noted that Mr Maginnis was seen regularly by Consultant Physicians, either by request in outside hospitals or by regular review within the prison and that there was also evidence of the increasing application of structured diabetic care throughout his prison life. He said that *"this would parallel the developments of the delivery of diabetic care outside prison with increasing involvement of specially trained dieticians, nurses, podiatrists and a diabetes management plan. There is also evidence that his diet plan was discussed with him and meal plans were organised well in advance with his consent".*

Mr Maginnis died from features consistent with septicaemia due to infection of foot ulcers. As far back as 1998, Mr Maginnis first began to complain of burning and numbness in his feet, which are symptoms of diabetic neuropathy. Over the subsequent years, Mr Maginnis began to develop ulcers on both of his feet.

As appropriate, the prison medical service referred Mr Maginnis for external specialist opinion in relation to podiatry and for specialist surgical advice, but his failure to attend some of these appointments, along with his poor diabetic management, regrettably had a detrimental affect on the health of his feet and in particular his left foot.

In early 2007, an ulcer on Mr Maginnis' left foot appeared to be deteriorating despite antibiotics, regular dressings and referral to specialist podiatry clinics and

he was sent to the Accident and Emergency Department of Belfast City Hospital. As had happened in the past, Mr Maginnis refused to have blood samples taken or to be admitted for intravenous antibiotics and he was discharged back to Maghaberry with oral antibiotics. Two days later, with his foot still not settling, Mr Maginnis returned to hospital at his own request. He remained in hospital for ten days having had a debridement[2] and amputation of the little toe on his left foot. Mr Maginnis was offered an angioplasty[3] during this admission in order to improve his circulation, but he refused this procedure and discharged himself back to Maghaberry.

Mr Maginnis' mother was concerned that her son had not received appropriate medical treatment, or specialist footwear, following the amputation of his toe. Prison healthcare records indicate concern about the condition of Mr Maginnis' foot following amputation. The investigation found, however, that Mr Maginnis refused intravenous antibiotics and the opportunity to return to hospital on a number of occasions and appeared to ignore advice given to him about his persistent injection of very inadequate doses of insulin when he had obviously high glucose readings.

Over the following months, there are frequent entries in records to evidence Mr Maginnis' foot being redressed and periodically swabbed. There is also evidence of him experiencing different types of infections, for which he received oral antibiotics.

On 10 February 2008, Mr Maginnis was seen in Maghaberry by a visiting Consultant Orthopaedic Surgeon who arranged x-rays and swabs. The swab results showed an infection of Methicillin-resistant Staphylococcus aureus (MRSA) and streptococcus. Mr Maginnis was advised of this and agreed to attend outside hospital on 12 February 2008. Mr Maginnis remained in outside hospital for 16 days with a planned re-admission 10 days later for an MRI scan to exclude the possibility of osteomyelitis (bone infection). Following Mr Maginnis' return to Maghaberry, wound swabs taken showed no evidence of MRSA and his MRI scan showed no evidence of osteomyelitis but did show the possibility of osteoarthropathy (progressive degeneration of a weight bearing joint.) Advice was

[2] Debridement is the medical removal of a patient's dead, damaged or infected tissue to improve the healing potential of the remaining healthy tissue.

[3] Angioplasty – is a technique of widening a narrowed or obstructed blood vessel. An empty and collapsed balloon on a guide wire is passed into the narrow locations and then inflated to a fixed size. The balloon crushes any fatty deposits, opening up the blood vessel for improved flow, and the balloon is deflated and withdrawn.

received from a podiatrist but Mr Maginnis subsequently failed to attend follow up podiatry appointments. It is recorded that he said that he had "*lost confidence in the podiatrist.*"

In January 2009, there was a recurrence of infection in Mr Maginnis left foot and he was prescribed further antibiotics and treatment. It is recorded that he failed to attend for further MRI scans and, following a further deterioration in June, refused to attend a podiatry appointment at Belfast City Hospital, another appointment for an MRI scan and appointments with a prison doctor. He also refused, on a number of occasions, to have his wound dressed or to take his insulin.

Mr Maginnis was sent to outside hospital on three occasions between 23 September and 6 October 2009, but refused to accept intravenous antibiotics and continued to take oral antibiotics. His wound continued to be reviewed and dressed and was at times necrotic[4]. His non-compliance with diet and insulin management was also recorded.

On 26 March 2010, swab results showed that Mr Maginnis had a further infection of MRSA and he was given a course of oral antibiotics and a referral for an opinion from a vascular surgeon was made, which Mr Maginnis later refused to attend. Further swabs of his wound, taken on 16 April 2010, showed that Mr Maginnis no longer had MRSA.

Mr Maginnis' mother was concerned that her son did not receive appropriate treatment for his MRSA and that proper infection control measures were not implemented. It was, however, the view of the clinical reviewer that this was not the case.

After 16 April 2010, there was still no improvement in Mr Maginnis' surgery site wound and an x-ray was taken to check for osteomyelitis (bone infection). This confirmed that there was no evidence of infection.

On the 27 May 2010, it was noted that Mr Maginnis had received specially fitted shoes, from the Appliance Office at Belfast City Hospital. He refused to attend a

[4] Necrotic tissue in this instance refers to skin that has died.

further appointment at the Appliance Office to organise a second pair of shoes saying that he "*could not cope with people on the outside."*

Commenting on Mr Maginnis' treatment following his toe amputation, Dr Flynn said that:

"The prison medical service referred him appropriately for external specialist opinion in relation to his diabetes for podiatry and for specialist surgical advice. His failure to attend undoubtedly had a detrimental effect on his care as his management was fragmented. In any chronic condition such as diabetes or a diabetic foot ulcer an individual is likely to require frequent and regular review by specialists to monitor his progress and to apply specialist treatments. There is clear evidence that Mr Maginnis declined important aspects of his treatments such as angioplasty, and specialist podiatric debridement of his foot ulcer……."

Dr Flynn also noted that it was clear that Mr Maginnis *'was referred for specialist bespoke footwear and a pair of shoes was issued. Although not explicit in the notes it appears he defaulted several appointments for the fitting of such shoes and was eventually discharged. The driving point of this referral would probably be persistence of swelling due to ongoing infection meaning that conventional footwear was unsuitable."*

Mr Maginnis continued to be seen regularly by members of Maghaberry's healthcare team. On 14 October 2010, it is recorded that he kicked his cell door with both feet when he was angry and caused them to bleed. He refused to make a statement about the matter, and it is not clear what made him angry. It is to note, however, that on 10 October and the morning of 14 October 2010, Mr Maginnis had requested to see a member of the mental health team. It is recorded that this was because *"he states he needs support"* and that he had current issues which he was *"reluctant to discuss"* with the nurse officer and that he *"feels let down by the system."* Foot swelling was noted with possible haematoma[5] and both feet were closely observed over the next few days.

5 - A haematoma consists of a swelling caused by accumulation of clotted blood in tissues

Further to this incident Mr Maginnis was found to have evidence of an infection tracking from the area surrounding the wound on his foot. This eventually led to him being sent to Lagan Valley Hospital on 22 October, where it was decided he should be transferred to Belfast City Hospital for treatment. It is recorded that Mr Maginnis refused to travel to Belfast City Hospital and refused to have intravenous antibiotics and was, therefore, returned to Maghaberry. The clinical reviewer, Dr Flynn expressed concern that Mr Maginnis returned to prison. He noted that Mr Maginnis *"was reviewed promptly and appropriately by a prison doctor and sent appropriately to outside hospital. There is not doubt that at this point admission to an NHS hospital was extremely important to deliver a standard of care and observation which would have been difficult to administer in the prison."*

On 23 October 2010, Mr Maginnis was reviewed by healthcare staff on three occasions. Following receipt of his morning medication the nurse officer recorded that Mr Maginnis was *"in good form"* and that she *"again stated very clearly the implications for his foot as a result of continual refusal to attend hospital."* She recorded that he understood this. At interview, the nurse officer said that *"Mr Maginnis came down on the Saturday morning for his normal insulin. He was in very good form, he was very chatty. I hadn't seen him for a while, for any length of time, and he had been out at the hospital the night before, at the Lagan Valley, and had refused to go on to the City for treatment. He did tell me that he had bad memories of being at the hospital. We talked about why he didn't go on for treatment, we talked about the implications for his foot and the risk of further amputation etc. without IV antibiotics and he understood. I mean he said he just... he understood that and accepted that but he wasn't prepared to go."*

Later that day, Mr Maginnis' wound was again dressed by the same nurse officer and it is recorded that its condition was deteriorating. At interview, the nurse officer said, *"I felt that it didn't look good and I felt that it was mostly likely deteriorating and... it didn't smell good, naturally it wasn't going to smell good without the proper treatment. So because of the infection I issued Mr Maginnis with keto sticks to check his urine for ketones, because there was always a risk of diabetic ketoacidosis which is a condition where there is very, very high sugars and it can result in further complications which are very life threatening."*

Later on that evening, landing staff contacted healthcare to state that Mr Maginnis was feeling unwell and felt shaky. A nurse officer advised staff that she would be with him shortly but in the meantime Mr Maginnis was to check his blood sugar levels and, if they were low, to eat some bread, drink some milk and take some glucose tablets. It is recorded that shortly afterwards the nurse officer assessed Mr Maginnis, administered his medication and advised him to drink plenty of fluids.

The following morning Mr Maginnis reported to a nurse officer that he had been sick five times during the night and had been unable to pass urine since the previous morning. The nurse officer informed a senior nurse officer and requested that Mr Maginnis be seen by the doctor.

CCTV shows that during the morning, Mr Maginnis walked down the landing to get hot water and that he later emptied his rubbish bag and replenished his cell with toilet rolls and a fresh bin liner. Then at 11.27, he activated his cell alarm and three officers went to his cell. Three minutes later, the nurse officer who had seen him earlier arrived at Mr Maginnis' cell and found that his condition had deteriorated. The nurse officer contacted the prison doctor who advised a routine ambulance be requested to take him to outside hospital.

At 12.04, a routine ambulance was requested. However, at 12.50, because of her concern that Mr Maginnis' blood pressure had changed, that he felt faint/unsteady on his feet and that he would be locked up over lunchtime, the nurse requested an emergency ambulance instead.

Two officers accompanied Mr Maginnis to hospital. It is recorded that at 17.35, 21.05 and 23.15, Mr Maginnis wanted to sign himself out of hospital in order to return to Maghaberry Prison. He was persuaded by medical and prison staff to remain in hospital and arrangements were made for him to be moved to a side ward.

At 06.00 on 25 October 2010, Mr Maginnis asked for a glass of water which one of the prison officers provided to him. Mr Maginnis spilt some of the water on his bed and then got out of bed. The officer said that he *"advised Mr Maginnis to stay in bed, (but) he said he wanted to go back to Maghaberry and then slumped onto the floor. We tried to lift him up. He tried to assist us. He started complaining about his*

breathing. My colleague and I lifted him onto the bed and I went to the nurses' station and called the nurse. The nurse came straight away." An alarm was then raised and several staff attended to Mr Maginnis.

At 06.20, contact was made with Maghaberry Prison, at the request of nursing staff in order for Mr Maginnis' next of kin to be contacted. At 06.40, contact was made with Mrs Maginnis and she was told to immediately go to the hospital. At 06.50, officers were informed by medical staff that Mr Maginnis had passed away.

One of the concerns raised by Mr Maginnis' mother was in relation to why the Prison Service did not notify her that her son had been admitted to hospital on 24 October 2010, or as soon as Mr Maginnis had become critically ill.

The policy at the time was that officers in attendance at a hospital would provide feedback to the prison on a prisoner's condition and whether this was improving or deteriorating. Based on the information provided, prison management would then make a decision as to whether or not next of kin needed to be contacted. When Mr Maginnis was admitted to hospital on 24 October, staff who dealt with him and who were interviewed as part of this investigation, did not think that Mr Maginnis' medical condition was seriously life threatening. It was the case, therefore, that it was not considered to be necessary to contact his mother that day.

It would appear that Mr Maginnis' condition deteriorated very rapidly on the morning of 25 October and his death, occurring as it did, was not expected. It is regrettable that this meant his mother did not see him before he died.

It is to note that due to Mr Maginnis' medical problems, he had difficulties providing urine samples when required for drug testing purposes and his privilege regime was adversely affected by this. The problem, on occasions, led him to self harm. The investigation raised concerns about the way that both Mr Maginnis' difficulties with testing and his access to privileges was managed and these are described in sub sections 12 and 16 and listed as Issues of Concern Requiring Action in the section that follows.

Mr Maginnis' mother was very concerned that he frequently missed hospital appointments and wanted to know why. In light of the substantial evidence of Mr Maginnis' non-compliance with the management of his diabetes, the investigation considered possible reasons for this and whether Mr Maginnis' mental healthcare and support were adequate.

There are no records of diagnosed mental health problems before Mr Maginnis' custodial sentence. Whilst there are numerous mental health entries in Mr Maginnis' prison records, there is again, no formal diagnosis of mental illness.

In a report dated 3 May 2001 by a Consultant Clinical Psychologist, it is recorded that Mr Maginnis showed no signs of having a major mental illness or personality disorder but it is noted that Mr Maginnis had certain personality traits associated with an increased risk of violence. A Principal Psychologist at Maghaberry also concluded that Mr Maginnis had no evidence of major mental illness or clinical personality disorder and conducted a psychometric personality scale assessment, the results of where were consistent with no diagnosis of personality disorder. It is, however, recorded that Mr Maginnis displayed elevated scores on several parts of this scale including those measuring anxiety, dysthymia[6], depression and avoidant symptoms. A structured assessment of psychopathy found no evidence of meeting the threshold for a psychopathic disorder.

A report dated 19 July 2005 by a Consultant Forensic Psychiatrist concluded that there was no evidence that Mr Maginnis had an affective disorder, such as clinical depression, but the psychiatrist thought that he had an adjustment disorder with traits consistent with '*personality deficits.*' A further psychiatric assessment in January 2008, by a different Forensic Consultant Psychiatrist, similarly concluded that Mr Maginnis did not have a psychiatric diagnosis.

Mr Maginnis was first referred to prison mental health services in 1992 and, throughout his time in prison, had several other referrals to mental health services. He had a number of self harm episodes and 'Supporting Prisoners at Risk' (SPAR)[7] booklets were opened on several occasions. In 2001, Mr Maginnis started to see a

[6] Dysthymia is a chronic type of depression in which a person's moods are regularly low. However, symptoms are not as severe as with major depression.

[7] SPAR booklets are opened when prisoners have become vulnerable and require increased supervision and support.

clinical psychologist and community psychiatric nurse on a regular basis and started to see a psychotherapist in February 2007 on a weekly basis. He continued to have regular consultations with the psychotherapist until his death in October 2010.

Mr Maginnis was prescribed two medications in connection with mental health difficulties. These were Chlorpromazine (a tranquiliser) and Promethazine (for insomnia).

Commenting on whether Mr Maginnis' mental health treatment was appropriate, the clinical reviewer, Dr Fazel concluded that:

"Mr Maginnis does not appear to have had a diagnosable mental illness and therefore clinical guidelines are not necessarily applicable. However, a number of clinicians identified occasional symptoms of low mood and anxiety, and problems in his personality organization. The latter led him to act impulsively at times, have problems controlling his anger, and caused his mood to be changeable (but not to the extent of having a clinical depressive illness).

In relation to treatment for his personality problems, Mr Maginnis received regular clinical psychology from 2001 to 2004, and then weekly psychotherapy from 2007 onwards. The latter appears to have enabled him to start psychological work on his offence, which would have likely reduced his risks of serious repeat offending. In addition, he received an oral major tranquilizer, Chlorpromazine, (which is also used as an antipsychotic) that is occasionally used in individuals with personality disorders and related personality problems for particular symptom clusters including anxiety and anger. Taken together, these are not inappropriate treatments for Mr Maginnis."

Noting that Mr Maginnis received weekly psychotherapy from February 2007 until his death in October 2010, Dr Fazel said that *"this is likely to have been longer in duration than he would have received in the NHS if he was a person living in the community. I think that such psychotherapy was beneficial to Mr Maginnis and improved his mental health. However, I note that the evidence for longer term psychotherapies is limited, and it is my view that any interventions of this level of*

intensity that extend beyond six months needs to demonstrate their ongoing efficacy and value. This is even more relevant in prison settings where access to such therapies is very limited."

Dr Fazel also observed that it was generally believed that Mr Maginnis had the capacity to refuse medical treatment. He noted that this was the view of a Consultant Psychiatrist who saw Mr Maginnis in 2007. Dr Fazel did, however, say that he believed that a clearly documented capacity assessment would be preferable in such circumstances.

In the absence of a major mental illness such as depression or schizophrenia, which would have been the most obvious psychiatric factor that could have impacted on Mr Maginnis' management of his diabetes, it is not clear why he was often unwilling to co-operate with his care. A number of possibilities were, however, identified.

Mr Maginnis had been in prison since 1991 and at interview, his psychotherapist said that he "*was overwhelmed at how the outside world had changed so much"* when he attended outside appointments, and was *"amazed at the number of cars he could see on the roads".* Officers who accompanied Mr Maginnis to outside hospital appointments said at interview that he would have panic attacks and request to be returned to the prison. It also appeared to be the case that Mr Maginnis had explained that he was frightened of being identified and didn't like being handcuffed at outside appointments.

On 17 June 2010, it is recorded in Mr Maginnis' safer custody records that it was felt that Mr Maginnis was *"concerned about being released,"* and an officer in attendance stated that he *"felt that perhaps this is why Mr Maginnis is being frustrating in case a release date may arise.... He is going to have to live on his own somewhere and is frightened".*

Another possible factor considered by the clinical reviewer Dr Fazel was that Mr Maginnis' actions were part of "*a concerted and chronic plan to harm himself*" and hasten his death from diabetic complications. Dr Fazel felt that there was mixed evidence for this. On 16 December 2009, Mr Maginnis wrote a letter in the third

person talking about "Mark." He wrote that *"Despite all that the diabetes team taught Mark about the preventability of diabetic tissue damage, his childhood impressions were so strong that he always equated diabetes with inevitable blindness, amputation, and being overweight. He decided if this was the future he would rather not know. He would have a short life, and a merry one."* The letter, however, ends with the statement, *"This person needs to wake up, get some help, before he kills himself."*

There is, however, also evidence in prison records that, towards the end of his sentence, Mr Maginnis did have hopes and plans for the future.

The clinical reviewer also noted that there was evidence from Mr Maginnis' mental health records that, as a result of his experiences before coming into prison, he had a big issue with control, which caused strong and conflicting emotions for him. He suggested that Mr Maginnis' diabetes was something that he could control. He, therefore, appeared to react against others telling him what to do in relation to his diabetic care.

There was also evidence that Mr Maginnis thought that by refusing to do certain things, the way that the prison related to him would change. He disliked, for example, the fact that for reasons of security, prisoners are not notified of hospital appointments until the morning of the appointment. It would appear that Mr Maginnis thought that if he refused to attend enough times, prison staff would inform him the previous day.

Notwithstanding the reasons for Mr Maginnis' not cooperating, at times, with the management of his illness, the clinical reviewer Dr Flynn concluded that "*prison staff on numerous occasions in a humane fashion tried to reason with Mr Maginnis about the importance of compliance with his treatment regime and that it was difficult to identify any way in which Mr Maginnis' diabetic care could have been improved."*

ISSUES OF CONCERN REQUIRING ACTION

As explained in the preface, the following issues of concern, requiring action by the Northern Ireland Prison Service and South Eastern Health and Social Care Trust [SEHSCT], were identified during the investigation into the death of Mr Mark Maginnis. I have asked the Director General of the Prison Service and Chief Executive of the SEHSCT to confirm to me that these issues will be addressed.

1. Despite written medical confirmation that Mr Maginnis was exempt from providing voluntary drug tests, he was still subjected to regime demotions when he refused to provide a sample, which made him feel down and, on occasions, led him to self harm.

2. Whilst it was subsequently agreed that he should not be demoted to Basic regime, Mr Maginnis was prohibited from progressing to Enhanced regime. This was not appropriate. It was also the case that Mr Maginnis was subsequently demoted to Basic regime.

3. When Mr Maginnis took an overdose in March 2007, no 'Prisoner at Risk' (PAR) booklet was opened and the incident was not discussed at the next safer custody meeting.

4. On 30 November 2009, whilst Mr Maginnis was on a Supporting Prisoner's at Risk' booklet (formally known as PAR), he was notified that he had been demoted to Basic regime following a refusal to provide a drug test and his television was removed. Three hours later Mr Maginnis self harmed saying that he had been *"pushed too far."* No consideration, as required by Prison service policy, was given to the appropriateness of removing Mr Maginnis' television at the time.

5. There was no formal 'Capacity Assessment' carried out and recorded when Mr Maginnis refused important medical intervention.

6. There is no clear supervisory/ review process for the long term use of therapies.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[8] for Northern Ireland, I have responsibility for investigating the death of Mr Mark Charles Maginnis, who died in the Belfast City Hospital on 25 October 2010, whilst in the custody of Maghaberry Prison. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Appendix 1.

2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. I am independent of the Prison Service as are my investigators. As required by law, the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives

4. The objectives for my investigation into Mr Maginnis' death are:

- to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;

- to examine any relevant healthcare issues and assess the clinical care afforded by the Prison Service;

- to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;

[8] The Prisoner Ombudsman took over the investigation of deaths in prison custody in Northern Ireland from 1 September 2005.

- to ensure that Mr Maginnis' family have the opportunity to raise any concerns that they may have and that these are taken into account in my investigation; and

- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

Family Liaison

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the family.

6. It is important for the investigation to learn more about a prisoner who dies in prison custody from family members and to listen to any questions or concerns they may have.

7. I first met with Mr Maginnis' mother on 24 November 2010, and my investigators were grateful for the opportunity to keep in contact with her in order to provide an update on the progress of the investigation. I met with Mr Maginnis' mother again to explain and discuss the findings and recommendations within this report. I would like to thank Mrs Maginnis for giving me the opportunity to talk with her on these occasions.

8. Although my report will inform many interested parties, I write it primarily with Mr Maginnis' family in mind. I also write it in the trust that it will inform policy or practice which may make a contribution to the prevention of a similar death in future within the Northern Ireland Prison Service.

9. Mr Maginnis' mother asked the following questions:

    - Did Mr Maginnis receive adequate healthcare in prison?

- Was Mr Maginnis' diagnosis of MRSA delayed and did he receive the appropriate treatment for it?

- Why did Mr Maginnis not receive the appropriate medical treatment following the amputation of a toe on his left foot in April 2007?

- Why did Mr Maginnis not receive the appropriate medical treatment when he thought he had broken his left foot in May 2010?

- Why did Mr Maginnis miss medical appointments and not attend some hospital appointments?

- Why was Mr Maginnis not provided with specialist footwear in a timely manner following the amputation of his toe?

- Why was Mr Maginnis treated poorly by some prison staff?

- Why was Mr Maginnis prevented from buying certain items from the tuck shop when others with diabetes were not restricted in this way?

- Why was Mr Maginnis' computer, which he used to complete work for the Braille Unit, removed from his cell into a classroom on the landing, contributing to a deterioration in his condition?

- Why did the Prison Service not notify Mrs Maginnis that her son had been admitted to hospital on 24 October 2010, or as soon as Mr Maginnis had become critically ill?

INVESTIGATION METHODOLOGY

Notification

10. In the early hours of Monday 25 October 2010, the Prisoner Ombudsman's office was notified by the Prison Service about Mr Maginnis' death.

11. A member of the Ombudsman's investigation team attended Maghaberry Prison at 25 October 2010 to be briefed about the series of events leading up to Mr Maginnis' death.

12. On 26 October 2010, Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison, inviting anyone with information relevant to Mr Maginnis' death to contact the investigation team. No responses were received.

Prison Records and Interviews

13. All prison records relating to Mr Maginnis' period of custody were obtained.

14. Interviews were carried out with prison management, staff and prisoners in order to obtain information about Mr Maginnis and the circumstances surrounding his death.

Telephone Calls

15. Between 14 August 2010 and 25 October 2010, Mr Maginnis made 26 telephone calls. All 26 telephone calls were obtained and listened to.

CCTV Footage

16. CCTV from Mr Maginnis' landing on 24 October 2010 was obtained and reviewed.

Maghaberry Prison

17. Background information on Maghaberry Prison is attached at Appendix 2.

Autopsy Report

18. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy report.

Clinical Review

19. As part of the investigation into Mr Maginnis' death, Dr Michael Flynn, Consultant Physician at the Chaucer Hospital, Canterbury was commissioned to carry out a clinical review of Mr Maginnis' healthcare needs and medical treatment whilst in prison. I am grateful to Dr Flynn for his assistance.

20. I am also grateful to Dr Seena Fazel, Forensic Consultant Psychiatrist at Warneford Hospital, who was commissioned to provide a report on whether Mr Maginnis suffered from any mental health problems, and if so, whether these were adequately addressed in prison.

21. Dr Flynn's and Dr Fazel's clinical review reports were forwarded to the South Eastern Health and Social Care Trust (SEHSCT) for comment. The Trust responded and I have included the comments made at the appropriate places in this report.

Criminal Justice Inspectorate/Other Reports

22. Previous recommendations made to the Northern Ireland Prison Service by the Prisoner Ombudsman and the Criminal Justice Inspectorate which are relevant to the circumstances surrounding Mr Maginnis' death have been considered as part of this investigation.

Factual Accuracy Check

25. I submitted my draft report to the Director of the Northern Ireland Prison Service and the Chief Executive of the SEHSCT for a factual accuracy check.

26. The Prison Service and SEHSCT responded with comments for my consideration. I have fully considered these comments and made amendments where appropriate.

FINDINGS

SECTION 1: REVIEW OF BACKGROUND HISTORY

1. Mr Mark Charles Maginnis

On 1 May 1991, when Mr Mark Charles Maginnis was 20 years old, he was remanded into the custody of Belfast Prison. Healthcare records indicate that Mr Maginnis had been diagnosed as an insulin dependent Type 1 diabetic[9] at the age of 9 years. Over the years before his committal, Mr Maginnis' medical records noted that his blood glucose *"tended to be a little high."*

On 24 February 1992, Mr Maginnis was sentenced and given a 17 year tariff and on 11 March 1992, he was transferred to Maghaberry Prison. He remained in Maghaberry until 25 October 2010 when, at the age of 40 years, he died in Belfast City Hospital.

The Autopsy Report records Mr Maginnis' death as:

I (a) Features consistent with septicaemia due to
(b) Infection of foot ulcers

II Coronary Artery Atheroma
Myocardial Fibrosis
Pneumonia
Diabetes Mellitus

[9] Type 1 diabetes develops when the body's immune system attacks and destroys the cells that produce insulin. As a result the body is unable to produce insulin and this leads to increased blood glucose levels, which in turn can cause serious damage to all organ systems in the body. People with diabetes often need additional treatments such as medication to control their diabetes, blood pressure and blood fats.

2. Management of Mr Maginnis' Diabetes - Overview

Mr Maginnis' diabetes was a contributory factor in his death and one of the questions raised by his mother was whether Mr Maginnis' healthcare in prison was adequate.

Mr Maginnis' prison healthcare records extend to several hundred pages. Records going back to 1991, his first year in prison, indicate that close attention was paid to his diabetic status. There are numerous recordings of his blood sugar level and administration of his insulin therapy. There is also documented evidence that, following committal to prison, Mr Maginnis was continuing to attend secondary services at the Royal Victoria Hospital in Belfast. There is also evidence of ongoing interaction, over the years, between the prison medical service and various secondary care NHS diabetic clinics, including specialist dieticians, podiatrists and eye services. Mr Maginnis was also visited in prison by a Consultant Physician on a number of occasions, primarily to attend to his diabetes.

It is important for those suffering from diabetes, to maintain a good level of diabetic control in order to prevent or diminish the risk of developing complications of diabetes such as, retinopathy[10] that affects the eyes and neuropathy[11], which could lead to nerve damage particularly in the lower limb and foot and renders the foot prone to a complication known as neuropathic ulceration[12]. Diabetes can also affect blood vessels, restricting the circulation to the lower limbs, which can exacerbate formation of ulcers and also increase the risk of heart disease. In order to achieve a good level of control, it is essential to have the full and active co-operation of the patient.

[10] Retinopathy – is damage to the retina which can eventually lead to blindness.
[11] Neuropathy – is the term for damage to the nerves of the peripheral nervous system and may be associated with varying combinations of weakness, autonomic changes, and sensory changes.
[12] Neuropathic Ulceration – is where the foot can be injured by direct trauma or from ill fitting shoes. Tissue breakdown takes place and the healing process can be impaired due to diabetes itself. Ulceration can lead to loss of tissue, amputation or toes or limb and because of the risk of infection it can be life threatening.

As early as 1991 and up to a month before Mr Maginnis died, there is evidence of his non-compliance with the dietary requirements of his condition. In Mr Maginnis' later years, this included a high intake of sugar which placed him at risk of developing a type of coma called diabetic ketoacidosis. There are, also many recorded instances of Mr Maginnis refusing food, which can result in hypoglycaemia[13] and of him refusing his insulin. Failure to take the required insulin considerably increased the instability of Mr Maginnis' diabetes and the risk of him developing health complications.

There is also recurring and frequent evidence of Mr Maginnis refusing hospital appointments and of him not attending appointments for clinics and some investigations.

In his overall assessment of Mr Maginnis' healthcare in prison, the Clinical Reviewer Dr Michael Flynn, concluded:

"It is my opinion that the management of an individual's diabetes requires the ongoing co-operation of the individual in the management plan. Mr Maginnis prior to his remand in prison attended diabetic clinic appointments. It is clear from the records that his compliance with all aspects of treatment was erratic and frequently was wilfully obstructive. There are an enormous number of documented episodes when he failed to comply in a major and significant way with his diet, insulin administration etc. His overall control of his diabetes was very poor."

Dr Flynn said that there was evidence in Mr Maginnis' records that prison staff on numerous occasions in a humane fashion, tried to reason with him about the importance of compliance with his treatment regime. He said that it was difficult to identify any way in which Mr Maginnis' diabetic care could have been improved. Dr Flynn noted that Mr Maginnis was seen regularly by Consultant Physicians, either by request in outside hospitals or by regular review within the prison and that there was also evidence of the

[13] Hypoglycaemia is a condition that occurs when your blood sugar (glucose) is too low and can cause symptoms such as double or blurred vision, acting aggressive, headache, shaking/ trembling, sweating, tiredness/ weakness, have a seizure or go into a coma.

increasing application of structured diabetic care throughout his prison life. He said that "*this would parallel the developments of the delivery of diabetic care outside prison with increasing involvement of specially trained dieticians, nurses, podiatrists and a diabetes management plan. There is also evidence that his diet plan was discussed with him and meal plans were organised well in advance with his consent".*

Dr Flynn concluded that *"I, therefore, do not think that there is anything further that could have been done in a humane and normal fashion to assist in the management of his illnesses."*

Possible explanations for Mr Maginnis' non co-operation with the management of his diabetes and the clinical review of his mental healthcare are fully considered in Section Three of this Report.

3. Mr Maginnis' Management of his Diet

Diabetes is a common, life-long condition where the amount of glucose in the blood is too high and cannot be reduced properly by the body.

Although balancing carbohydrate and insulin is the most important task in managing diabetes, eating a healthy balanced diet plays a vital role in benefiting a person's health by keeping their weight, blood fats and blood pressure under control.

At interview, a nurse officer said that for a number of years a senior diabetic dietician from Belfast City Hospital regularly visited Maghaberry to review the dietary needs of prisoners with diabetes. The nurse officer said that, in line with normal practice, Mr Maginnis would not have been placed on a special diet *"and the dietician wouldn't have recommended"* one either. She said that the dietician looked at the menus available and felt that there were appropriate options which would give Mr Maginnis a balanced, healthy diet.

In addition to the general daily menu, the kitchen manager advised the investigation that, when asked, the catering department provided Mr Maginnis with digestive biscuits, additional milk and extra portions of fruit.

Mr Maginnis' Tuck Shop Purchases

Once a week, prisoners have the opportunity to purchase items such as sweets, crisps, soft drinks, noodles, coffee, tea and sugar from the prison tuck shop.

Mr Maginnis' mother was concerned that Mr Maginnis had been prevented from buying certain items from the tuck shop, when other prisoners with diabetes had not had the same limitations applied to them.

A review of Mr Maginnis' prison records and information gathered at interviews with prison staff shows that despite the advice that he was given Mr Maginnis, throughout his custodial period, bought and consumed large

amounts of sugar - at times *"up to 40, 50 spoonfuls a day maybe 60, (in) several litres of coffee"*.

On 7 January 2010, during a safer custody case conference, the option of stopping Mr Maginnis from purchasing sugar and sugary items from the tuck shop was discussed. It is recorded that an officer from Mr Maginnis' landing stated that this had already been tried on the landing but that staff had been told that they could not stop Mr Maginnis purchasing these types of items. It is recorded that the Governing Governor stated that he would be *"content to stop Mr Maginnis from buying products which are potentially injurious to his health. If he wishes to refuse medical treatment that is entirely a matter for him and that is his right. We cannot force him to accept medical treatment."*

On 12 January 2010, an instruction was sent to the tuck shop not to permit Mr Maginnis to buy any sugar or sugary products. As an alternative, Mr Maginnis was provided, at no cost, with digestive biscuits as a source of carbohydrate and sweetener as a replacement for the sugar he had been buying. Sugar free and "no added sugar" goods were also available for Mr Maginnis to buy from the tuck shop.

On 18 January 2010, Mr Maginnis initiated an internal complaint in connection with the ban on him buying sugar and sugary items stating that the rule should apply to all prisoners with diabetes and that it was an abuse of his human rights.

On 28 January 2010, the Governing Governor met with Mr Maginnis and it is recorded that the meeting was *"a happy exchange"* and that Mr Maginnis understood that the Governing Governor had a duty of care.

A review of Mr Maginnis' tuck shop purchases shows that this arrangement remained in place throughout the remainder of Mr Maginnis' custodial period. It is to note, however, that sugar is supplied to each landing by the prison kitchen and, on 11 August, 26 September, 7 October, and 9 October

2010 healthcare and safer custody records indicate that Mr Maginnis was still using sugar.

4. Healthcare 1997 to 2006

The following is a summary of significant points relating to the management of Mr Maginnis' diabetes between 1997 and 2006.

In 1997, Mr Maginnis had blurred vision and was noted to have severe bilateral proliferative retinopathy[14]. He was offered inpatient admission for urgent laser treatment. There are a number of documented follow up appointments which he refused to attend. He was re-referred to Opthamology to have surgery to his eyes to prevent further vision loss and restore his vision.

In 1998, Mr Maginnis first began to complain of burning and numbness in his feet, which can be a manifestation of diabetic neuropathy. He was referred to a consultant physician for further investigations.

In 2001, Mr Maginnis was admitted to hospital twice with diabetic ketoacidosis due to his refusal to eat. He also failed to attend a hospital diabetic clinic that year and a further episode of diabetic ketoacidosis was noted.

In 2004, Mr Maginnis again failed to attend an ophthalmology appointment and his diabetes remained problematic with episodes of hypoglycaemia. There is documented evidence of a specific diabetic care plan and there is also evidence of input from a podiatrist, diabetic specialist nurse and a referral for assessment by a mobile retinopathy screening team.

In 2005, Mr Maginnis was noted to be refusing chiropody and, a few days later, was noted to have an ulcer on the third and fourth toes on his right foot. He was subsequently reviewed in the prison by a Consultant Physician who documented typical neuropathic changes in his foot and significant neuropathy and a blister on his right toe, which was not infected. The problems with recurrent hypoglycaemia were noted.

[14] Retinopathy is damage to the retina and is a complication that can affect anyone who has diabetes.

Records also suggest that Mr Maginnis may have taken more than his prescribed insulin on some occasions, which would explain the hypoglycaemia. On other occasions his blood sugars were recorded as high and it is noted that he was unwilling to take the amount of insulin advised by staff or that he refused insulin.

In 2006, a particular challenge to Mr Maginnis' diabetes was that he refused to eat which resulted in frequent hypoglycaemic episodes. At this stage Mr Maginnis had an agreed three weekly menu plan drawn up in consultation with him and the prison kitchen. It was recorded that despite this, Mr Maginnis continued to take multiple cups of coffee with large amounts of sugar and chocolate.

5. Toe Amputation and Subsequent Treatment

Mr Maginnis declined a chiropody appointment in November 2006 and in early 2007, it was noted that he had ulcers on the left side of his foot. He was referred to the diabetic podiatry clinic at Belfast City Hospital and follow up contacts were made by the prison medical service.

Mr Maginnis' foot ulcer appeared to be deteriorating with increasing fluid leakage and the development of cellulites[15], despite antibiotics and regular dressings. The nurses at Maghaberry contacted a diabetic specialist podiatrist and a foot assessment took place at the Accident and Emergency department of the Belfast City Hospital. It is recorded that Mr Maginnis refused to provide blood samples or to be admitted for intravenous antibiotics and was discharged back to Maghaberry with oral antibiotics.

Two days following Mr Maginnis' discharge from Belfast City Hospital, it is recorded that his foot was still not settling. At Mr Maginnis' request, he was sent to hospital where he remained for ten days having had a debridement[16] and amputation of the little toe on his left foot.

Mr Maginnis was offered an angioplasty[17] during this admission in order to improve his circulation but he refused this procedure and discharged himself back to Maghaberry.

Following the amputation of his toe, Mr Maginnis' mother was concerned that he had not received appropriate medical treatment or specialist footwear.

Prison healthcare records indicate concern about the condition of Mr Maginnis' foot, following the amputation, despite healthcare staff dressing his wound on an almost daily basis and administering oral antibiotics. Mr

[15] Cellulites - is inflammation of the skin caused by a bacterial infection.
[16] Debridement - is the medical removal of a patient's dead, damaged or infected tissue to improve the healing potential of the remaining healthy tissue.
[17] Angioplasty – is a technique of widening a narrowed or obstructed blood vessel. An empty and collapsed balloon on a guide wire is passed into the narrow locations and then inflated to a fixed size. The balloon crushes any fatty deposits, opening up the blood vessel for improved flow, and the balloon is deflated and withdrawn.

Maginnis, however, refused intravenous antibiotics or to return to hospital. On 26 May 2007, it is recorded that advice was given to him about his persistent injection of very inadequate doses of insulin when he had obviously high glucose readings.

Over the following months, there are frequent records of Mr Maginnis' foot being redressed and periodically swabbed. There was evidence of a bacterial growth of staphylococcus aureus and streptococcus during the three months following surgery and advice was sought by the prison healthcare team from the specialist podiatry clinic at the Royal Victoria Hospital. The clinic advised that this was a common contaminant and not necessarily indicative of systemic infection. Mr Maginnis was treated with oral antibiotics and also seen in the vascular clinic for further advice on the types of dressing to be used to improve the rate of healing. Five months after surgery, the general impression was that Mr Maginnis' wound was gradually healing and the previous infections had cleared up.

Six weeks later on 8 November, a further swab showed that Mr Maginnis again had a growth of staphylococcus aureus and additional swabs at other sites showed evidence of Methicillin-resistant Staphylococcus aureus (MRSA). Mr Maginnis was treated with antibiotics but his wound began to discharge more and his leg and foot became swollen. Mr Maginnis refused to attend a podiatrist appointment, refused insulin therapy and refused to eat.

On 6 December 2007, a month after MRSA was detected, a further wound swab returned showing staphylococcus and pseudomonas (a different bacteria). Mr Maginnis' antibiotics were changed to match the sensitivities of the organisms detected and on 7 December his leg was thought to be less swollen. However, due to the continuing discharge from the wound, Mr Maginnis was referred to the Accident and Emergency Department at the Belfast City Hospital on 12 December 2007. He was noted to have evidence of groin lymphadenopathy[18] with an x-ray showing possible osteomyelitis

[18] Swollen lymph glands are referred to as lymphadenopathy. Swelling of the lymph glands is typically a result of local or widespread inflammation.

(bone infection) of his foot. Mr Maginnis left before treatment, discharging himself back to Maghaberry.

A week later, Mr Maginnis was re-referred to hospital. It is recorded that there was physical evidence of the infection spreading but, despite this, Mr Maginnis refused to stay in hospital. The reason recorded was that he *"got fed up waiting."* On Mr Maginnis' return to prison he was seen by a nurse officer who recorded *"Have spoken to Mr Maginnis about the seriousness of his clinical situation. He refuses point blank to consider hospital until after Christmas…….He knows he could become seriously ill suddenly and could, therefore, lose control of his destiny somewhat. This stance may mollify with time so I suggest continuation with current dressings, awaiting swab sensitivities and daily monitoring of his general condition."*

A couple of weeks after Christmas 2007, with no improvement to Mr Maginnis' wound, a nurse officer asked Mr Maginnis again if he would consider attending outside hospital. It is recorded that Mr Maginnis was *"advised this wound will probably not heal without secondary care intervention. Mr Maginnis explained that he does not want to be sent to A&E….wishes to wait and see if the Senior Medical Officer can sort something out."*

Dressings were continued and Mr Maginnis was seen by a prison doctor weekly.

On 10 February 2008, Mr Maginnis was seen in Maghaberry by a visiting Consultant Orthopaedic Surgeon who arranged x-rays and swabs. The swab results showed a re-infection of MRSA and streptococcus. Mr Maginnis was advised of this and agreed to attend outside hospital on 12 February 2008. Mr Maginnis remained in outside hospital for 16 days with a planned re-admission 10 days later for an MRI scan to exclude the possibility of osteomyelitis (bone infection). Following Mr Maginnis' return to Maghaberry, a wound swab taken showed no evidence of MRSA.

Mr Maginnis' subsequent MRI scan showed no evidence of osteomyelitis, but did show the possibility of charcot osteoarthropathy (progressive degeneration of a weight bearing joint). Advice was received from a podiatrist but Mr Maginnis subsequently failed to attend podiatry appointments in May and June.

As there was a clear build up of thickened skin over his wound, Mr Maginnis was again advised to see a podiatrist but it is recorded in November that he said he had "*lost confidence in the podiatrist.*"

In January 2009, there was a recurrence of infection in Mr Maginnis' left foot. Further antibiotics were prescribed and it was noted that he failed to attend further MRI scans. Wound swabs at this time were satisfactory. In March Mr Maginnis was advised to have an ulcer debrided at the diabetic clinic which he had previously refused. He was referred back on 10 March and re-commenced antibiotics. On 18 March, he requested an appointment with the prison podiatrist, but failed to attend an appointment made for 23 March.

The condition of Mr Maginnis' foot deteriorated again in June. An appointment at Belfast City Hospital's podiatry department was arranged, but Mr Maginnis refused to attend. He also refused to attend an MRI scan and a number of appointments with a prison doctor and, on a number of occasions around this time, refused to have his wound redressed or to take his insulin.

Due to the number of appointments that Mr Maginnis had refused to attend, Maghaberry's healthcare team received a call from Belfast City Hospital's podiatry department on 16 September 2009, to say that Mr Maginnis had been taken off their list. It was agreed that if Mr Maginnis attended the prison podiatrist and there was a requirement to be referred to Belfast City Hospital, then they would see him. It is recorded that Mr Maginnis was informed of this decision and allowed the prison podiatrist to assess his foot and treat his nails on 21 September. The podiatrist recorded that Mr Maginnis' *"wound is beyond a podiatrist and I feel that it would be beneficial*

if it was seen by a doctor." Mr Maginnis saw the doctor the next day and was sent to outside hospital on 23 September, returning to Maghaberry with a new course of antibiotics.

On 2 October, Mr Maginnis' condition deteriorated and he was sent to the Accident and Emergency department of Belfast City Hospital. He returned to Maghaberry with a "cellulites pack" (a pack containing medication and advice on skin infection) and advice for intravenous antibiotics. Over the following days, Mr Maginnis refused intravenous antibiotics and was returned to Belfast City Hospital on 6 October 2009, where he was advised to continue on oral antibiotics.

Mr Maginnis' foot continued to be regularly reviewed and dressed on almost a daily basis and was at times necrotic. His non-compliance with diet and insulin management was recorded.

On 26 March 2010, swab results showed that Mr Maginnis' left foot showed evidence of MRSA. Mr Maginnis was given a course of antibiotics and a referral for an opinion from a vascular surgeon was made, which Mr Maginnis later refused to attend. Further swabs of Mr Maginnis' left foot, taken on 16 April 2010, showed that Mr Maginnis no longer had MRSA.

There was still no improvement in Mr Maginnis' surgery site wound and a prison doctor requested an x-ray to determine whether or not Mr Maginnis had osteomyelitis. Having twice refused to attend for an x-ray, Mr Maginnis' foot was eventually x-rayed on 5 May 2010.

Arrangements for Specialist Footwear

Arrangements for Mr Maginnis to have specialist footwear were made through Podiatry and the Appliance Office at Belfast City Hospital at the start of 2010. On 27 May 2010 it was noted that Mr Maginnis had received specially fitted shoes.

On 15 October 2010, Mr Maginnis refused to attend a further appointment at the Appliance Office in order for him to have a second pair of specially fitted shoes made. It is recorded that the reason he did not attend was because *"he could not cope with communicating with people on the outside, encouraged to attend appointment this AM but adamantly refused."* He was not offered a further appointment as he had refused to attend on several previous occasions.

Clinical Reviewer's Comments

Commenting on Mr Maginnis' treatment following his toe amputation and whether he received appropriate specialist footwear, Dr Flynn stated that:

"The prison medical service referred him appropriately for external specialist opinion in relation to his diabetes for podiatry and for specialist surgical advice. His failure to attend undoubtedly had a detrimental effect on his care as his management was fragmented. In any chronic condition such as diabetes or a diabetic foot ulcer an individual is likely to require frequent and regular review by specialists to monitor his progress and to apply specialist treatments. There is clear evidence that Mr Maginnis declined important aspects of his treatments such as angioplasty, specialist podiatric debridement of his foot ulcer……..He was under the specialist care of a vascular surgeon but took premature discharge from hospital. He was followed sporadically by a specialist podiatrist and also by the prison podiatrist. A podiatrist would be able to give specific advice about footwear and any modification of any normal footwear with insoles and other appliances. It is clear that he was referred for specialist bespoke footwear and a pair of shoes issued. Although not explicit in the notes it appears he defaulted several appointments for the fitting of such shoes and was eventually discharged. The driving point of this referral would probably be persistence of swelling due to ongoing infection resulting in conventional footwear being unsuitable. I note that early on he was issued with a pair of work boots and in general these have additional space for the foot and are less likely to result in any ulceration from shoe trauma."

6. Suspected Broken Left Foot – May 2010

In May 2010 Mr Maginnis injured his foot. Mr Maginnis' mother was concerned about whether or not he received the appropriate treatment for his injury.

On 7 May 2010, Mr Maginnis complained of ankle pain and reported to a nurse officer that he had been walking on the landing and felt something snap in his left ankle. The nurse officer assessed Mr Maginnis' foot and recorded that he had the full range of movement and that it was difficult to assess whether there was any swelling, due to the swelling already present from the ongoing problems with his foot. The nurse issued Mr Maginnis with a cold compress and advised him to rest his foot. The following day Mr Maginnis was seen by a prison doctor and it is recorded that Mr Maginnis said that his ankle had been painful with a burning sensation, but that he was able to weight-bear. The doctor recorded that *"there was no evidence of boney injury or achilles tendon rupture. Had x-ray several days ago for pre existing pain in foot/ ankle and results not available as yet. Await report of same next few days. No specific action in interim."*

On 10 May 2010, the x-ray results showed degenerative changes in Mr Maginnis' tarsometatarsal joint (the bones across the bridge of the foot) with the possibility of neuropathic arthropathy (degeneration of a weight bearing joint.) There was no evidence of osteomyelitis.

On 19 May 2010, it is recorded that *"Mr Maginnis requested the use of a crutch for his visit today due to his sore foot."*

Despite Mr Maginnis seeing a nurse officer either every day or every two to three days regarding his diabetes, there is no further reference in his medical records to his injured ankle until 27 July 2010. On 27 July, Mr Maginnis saw a prison doctor and it is recorded that Mr Maginnis was complaining of a swollen left heel from a fall that he said had occurred three months previously. An x-ray was carried out on 11 August and the results,

received by the prison on 25 August, showed an acute fracture of the calcaneus (heel bone).

Mr Maginnis was reviewed by a prison doctor on 31 August and referred to the fracture clinic. It is recorded that Mr Maginnis' ankle *"remains painful to walk and is still swollen.....On further enquiry re injury in April – states did not fall but stepped over a wire and heard crack in foot."*

On 21 September 2010, Mr Maginnis attended the Royal Victoria Hospital fracture clinic and the discharge letter states *"He (Mr Maginnis) says there is minimal pain in this area and only causes him trouble when he is walking for long periods of time."* No specific treatment was suggested other than for Mr Maginnis to be reviewed at a specialist foot clinic with repeat x-rays on arrival.

Clinical Reviewer's Comment

Commenting on whether or not Mr Maginnis received appropriate medical treatment when he suspected he had broken his foot, the clinical reviewer, Dr Flynn stated *"I am not a specialist Orthopaedic surgeon. As a specialist Diabetologist I am aware that a diabetic with neuropathy may be much more at risk than a normal individual of a fracture of the foot bone. The history that something snapped in his ankle would be suggestive of a boney fracture. He was however examined by a medical practitioner who had seen him before and felt had been no change in the swelling of the foot. He was particularly concerned about the achilles tendon and examination showed that there was no evidence that this had ruptured. Mr Maginnis had had an x-ray a few days earlier and the decision to wait for the report of that x-ray was probably reasonable.....It is my opinion as a non-specialist, that this had no significant impact on his problem of foot ulceration and probably had very little effect on his mobility. Had he presented to an orthopaedic surgeon at the time of his fracture, the management would have been complex. Any immobilization or casting of his foot would render the management of his foot ulcer more difficult and run the risk of ulceration around the lower edge of the cast. I think it is*

likely that he would merely be advised not to weight bear on his foot by the use of crutches."

Notwithstanding the above, it was the case that the first time Mr Maginnis' foot was x-rayed, following him reporting an injury on 7 May, was on 11 August 2011.

7. Methicillin-resistant Staphylococcus aureus [MRSA] – September 2010

On 3 September 2010, it is recorded that Mr Maginnis showed a nurse officer a discoloured spot on his left foot which he was concerned about. The following day, Mr Maginnis was seen by a prison doctor who reviewed the condition of his foot. It is recorded that Mr Maginnis had blistering around the site of the surgery he had undergone in April 2007. Mr Maginnis was placed on a broad spectrum antibiotic whilst awaiting the results of swabs that had been taken from a boil under his right armpit on 31 August 2010.

On 6 September 2010, a nurse officer contacted the Royal Victoria Hospital to obtain Mr Maginnis' swab test result, but was advised that the hospital had not received the swab that was taken on 31 August. The following day a further swab was taken. The result dated 10 September, but not date stamped to show when it was received in Maghaberry, showed that there was a re-isolate of MRSA in Mr Maginnis' left foot.

Mr Maginnis' mother was concerned that, following the receipt of this result, Mr Maginnis had not received appropriate treatment or that proper infection control measures had not been implemented.

On 15 September, it is recorded that instructions about infection control measures were issued to landing staff to ensure that Mr Maginnis had appropriate infection control bags for his laundry and that he showered last in the morning. It was established that the showers were then cleaned after Mr Maginnis had used them. It is also recorded that advice was given to Mr Maginnis regarding good personal and hand hygiene and that the hand wash Cutan hand sanitizer, and a wall chart of hand washing techniques, was issued to staff on Mr Maginnis' landing. There is evidence also that healthcare staff sought advice from a nurse with specialist knowledge of wound management.

On 19 September, a nurse officer recorded that Mr Maginnis' left foot wound appeared more reddened and that he was generally feeling unwell. A prison doctor was contacted and it is recorded that he advised that Mr Maginnis

should be sent to outside hospital. Mr Maginnis was taken to outside hospital for a few hours but returned to prison having refused treatment. His antibiotics were changed.

Mr Maginnis continued to receive oral antibiotics and his wound was re-dressed regularly.

A further swab was taken on 23 September. The result showed that Mr Maginnis no longer had MRSA in the wound on his left foot but did have an infection of streptococcus group B. Oral antibiotic therapy continued.

Clinical Reviewer's Comments

Referring to the swab result of 15 September, Dr Flynn stated that the result *"indicated that this was a re-isolated staph aureus (MRSA). This may indicate that the microbiology lab had at this stage located the previous result."* Dr Flynn further states *"It is quite clear that this had not been communicated to the prison despite their multiple attempts to obtain the result."*

Commenting on how the healthcare department managed the occurrence of MRSA, Dr Flynn said the following:

"Mr Maginnis had regular swabs of his foot ulcer and at various times these showed evidence of MRSA. Foot ulcer swabs are rarely of clinical significance and are more likely to merely indicate surface contamination of a wound. The presence of MRSA is likely in an individual who has had repeated courses of antibiotics and who has also had a number of admissions to healthcare establishments. The presence of MRSA in a wound swab is merely likely to represent superficial colonisation. At no stage was there any suggestion that he had a significant MRSA infection. There is no evidence that MRSA was a contributing factor to his death. Advice was requested on more than one occasion as to the management of his infection either from specialist teams or from microbiologists. It is my opinion that the prison staff took appropriate swabs and made appropriate efforts to obtain results and when the results were available on repeat swabs, appropriate action was taken."

SECTION 2: EVENTS LEADING UP TO MR MAGINNIS' DEATH ON 25 OCTOBER 2010

8. Referral to Lagan Valley Hospital

It is recorded on 14 October 2010 that Mr Maginnis kicked his cell door with both feet when he was angry and caused them to bleed. Foot swelling was also noted with possible haematoma[19] and both feet were closely observed over the next few days. Mr Maginnis was also referred to the prison mental health team.

On 19 October, Mr Maginnis was seen by a prison doctor and it is recorded that his left foot *"had settled slightly"*.

On 21 October, Mr Maginnis was again seen by a prison doctor and it is recorded that there was evidence of infection tracking from the area surrounding the wound on his left foot, associated with some erythema[20] and a high temperature. It is recorded that swabs were taken and that Mr Maginnis was started on a course of antibiotics.

On 22 October 2010, Mr Maginnis was seen by a prison doctor and it is recorded that his left foot had deteriorated further and was more swollen, red and painful. It is recorded that Mr Maginnis' blood sugars were erratic and that he felt shivery, as a result, he was sent to outside hospital.

At 17.09 on 22 October, Mr Maginnis arrived at the Accident and Emergency Department of Lagan Valley Hospital. He was assessed at 18.30 and the hospital records note that Mr Maginnis' wound had been swabbed a week before and that he had stated that the results showed no evidence of MRSA. Mr Maginnis' case was discussed with surgeons at Belfast City Hospital and it was agreed that he should be transferred there for treatment.
It is recorded that Mr Maginnis refused to travel to Belfast City Hospital and refused to have intravenous antibiotics. He was, therefore, returned to

[19] A haematoma consists of a swelling caused by accumulation of clotted blood in tissues.
[20] Erythema – Redness of the skin which can be associated with injury, infection or inflammation.

Maghaberry. It is further recorded that if Mr Maginnis wished to reconsider his actions, the hospital would be happy to review him again.

Clinical Reviewer's Comments

Commenting on the decision to send Mr Maginnis to hospital, Dr Flynn said:

"It was recognised that after kicking a chair with his foot there was evidence of a tracking infection in the area surrounding the wound. He was reviewed promptly and appropriately by a prison doctor and sent appropriately to an outside hospital.

There is no doubt that at this point admission to an NHS hospital was extremely important to deliver a standard of care and observation which would have been difficult to administer in the prison."

Given the above, Dr Flynn was of the opinion that it was extremely unsatisfactory that Mr Maginnis returned to prison.

9. 23 October 2010 - Key Events

On 23 October 2010, Mr Maginnis was seen for his morning medication by a nurse officer. His blood pressure was recorded to be 110/70, his pulse was 112 and his temperature was 37.9. Mr Maginnis' blood glucose was elevated to 21.4. This is a satisfactory pulse reading and whilst the temperature was slightly elevated, this was consistent with his temperature on the last two days and the presence of a known infection. Mr Maginnis was advised to take adequate fluids and it is recorded that he was *"in good form."* It is also recorded that the nurse officer *"again stated very clearly the implications for his foot as a result of continual refusal to attend hospital, and he understands this."*

At interview, the nurse officer said that *"Mr Maginnis came down on the Saturday morning for his normal insulin. He was in very good form, he was very chatty. I hadn't seen him for a while, for any length of time, and he had been out at the hospital the night before, at the Lagan Valley, and had refused to go on to the City for treatment. He did tell me that he had bad memories of being at the hospital. We talked about why he didn't go on for treatment, we talked about the implications for his foot and the risk of further amputation etc. without IV antibiotics and he understood. I mean he said he just... he understood that and accepted that but he wasn't prepared to go."*

Later that day, Mr Maginnis' wound was dressed again by the same nurse officer and it is recorded that its condition was deteriorating. At interview, the nurse officer said, *"I felt that it didn't look good and I felt that it was mostly likely deteriorating and... it didn't smell good, naturally it wasn't going to smell good without the proper treatment. So because of the infection I issued Mr Maginnis with keto sticks to check his urine for ketones, because there was always a risk of diabetic ketoacidosis which is a condition where there is very, very high sugars and it can result in further complications which are very life threatening. "*

Later on that evening, landing staff contacted healthcare to state that Mr Maginnis was feeling unwell and shaky. A nurse officer advised staff that

she would be with him shortly but in the meantime Mr Maginnis was to check his blood sugar levels and, if they were low, to eat some bread, drink some milk and take some glucose tablets. It is recorded that shortly afterwards the nurse officer assessed Mr Maginnis and found that his blood sugar level was 8.3 which is within the normal range and that his temperature was normal. Mr Maginnis' medication was administered and he was advised to drink plenty of fluids.

10. 24 October 2010 – The Day before Mr Maginnis' Death

At 09.02 on 24 October 2010, a nurse officer saw Mr Maginnis and recorded that he reported feeling sick and that he had been sick five times during the night. There is nothing noted in prison records to suggest that staff were aware that Mr Maginnis had been unwell during the night. The nurse carried out his clinical observations and recorded that he *"tells me that he has not passed urine since 9am yesterday…….He thinks that perhaps the antibiotics are making him sick ……ASNO (acting senior nurse officer) informed and Dr requested."*

CCTV shows that during the morning, Mr Maginnis walked down the landing to get hot water and that he later emptied his rubbish bag and replenished his cell with toilet rolls and a fresh bin liner.

At 11.27, CCTV shows that three officers went to Mr Maginnis' cell. One officer entered Mr Maginnis' cell whilst the other two remained outside. It is recorded in the class officer's journal that *"Prisoner Maginnis activated his cell alarm, house medic to landing."* Three minutes later, the nurse officer who had seen Mr Maginnis earlier returned to the landing and went to Mr Maginnis' cell. It is recorded that Mr Maginnis' condition was deteriorating and that the nurse had contacted a prison doctor to seek his advice.

The nurse officer recorded that she was advised by the prison doctor to request a routine ambulance that could take Mr Maginnis to outside hospital. It is recorded that a non-emergency ambulance was called at 12.04. At interview, the nurse officer said that a non-urgent ambulance can take up to a couple of hours to arrive.

At 12.50, it is recorded that an emergency ambulance was tasked for Mr Maginnis because his condition had deteriorated whilst being monitored. At interview, the nurse officer said that *"because of the changes in his blood pressure, because Mr Maginnis felt faint, he was unsteady and I felt if he was locked up over lunchtime for another hour, or maybe it may have been another two hours for an ambulance, I just didn't feel happy leaving him. So I stayed*

with him and ran back and forward and talked to the ambulance control, wrote a doctor's letter, that sort of thing. But he was still talking and he was still okay…….before the ambulance came in Mr Maginnis was able to get off his bed and rearrange some of his possessions."

It is recorded that at 13.05, the emergency ambulance arrived in the prison and at 13.09, CCTV shows that two paramedics entered Mr Maginnis' cell.

At 13.18, CCTV shows Mr Maginnis leaving Bush House in a wheelchair, to be taken to Belfast City Hospital.

Two prison officers accompanied Mr Maginnis in the ambulance and it is recorded in the bed watch journal that they arrived at Belfast City Hospital at 14.00. A bed watch journal is used by officers who accompany prisoners to outside hospital in order for them to log key events that take place. The following entries were made in the bed watch journal on 24 October 2010:

16.05	*Seen by Doctor.*
17.35	*Prisoner asked to sign himself out, decided to stay if he was allowed to stay in a side ward*
18.00	*Handed over to Night Guard.*
19.05	*Doctor in attendance.*
21.05	*Mr Maginnis wanted to sign himself out - Dr talked him into staying.*
22.40	*Doctor and nurse to see Mr Maginnis.*
23.15	*Nurse to see Mr Maginnis. He talked about signing himself out again.*

At interview, one of the prison officers who travelled with Mr Maginnis to hospital said that Mr Maginnis would only receive treatment or stay at the hospital overnight for observations if he was moved to a side ward. He said that this was agreed and Mr Maginnis was moved to a room on his own.

11. 25 October 2010 – Key Events

The following entries were made in the bed watch journal on 25 October 2010:

00.50 *Doctor and Nurse to see Mr Maginnis*

01.25 *Nurse to see Mr Maginnis*

02.50 *Nurse to see Mr Maginnis*

04.05 *Nurse to see Mr Maginnis*

05.30 *Nurse to see Mr Maginnis*

05.40 *Doctor to see Mr Maginnis*

06.00 *On post. Prisoner was standing beside the bed in an agitated mood was also unsteady on his feet. Prisoner slumped to the floor. Assisted by another officer we were able to get the prisoner into bed. The prisoner was also able to assist by getting his leg under him. The prisoner asked for oxygen and was given this. At this stage the nurse came round to do obs and while talking to her about the prisoner's care she noticed he was not breathing. Crash team was called and medical staff to ward F.*

In a statement provided to the police one of the officers, who had come on duty at the hospital at 06.00, said that when he arrived at the hospital and carried out his handover with the two night guard officers, there was a nurse with Mr Maginnis. He stated that the nurse left and a couple of minutes later he and his colleague checked in on Mr Maginnis. He stated that Mr Maginnis had asked him for some water which the officer provided for him. He stated that Mr Maginnis spilt some of the water on his bed and then got out of bed. It is recorded that the officer *"advised Mr Maginnis to stay in bed, (but) he said he wanted to go back to Maghaberry and then slumped onto the floor. We tried to lift him up. He tried to assist us. He started complaining about his breathing. My colleague and I lifted him onto the bed and I went to the nurse's station and called the nurse. The nurse came right away."*

It is noted that the nurse called Mr Maginnis' name two or three times, the alarm was raised and six or seven nurses then attended to him.

At interview, the other officer present at the hospital, said that after they had managed to get Mr Maginnis back into his bed he asked for the oxygen mask, which they assisted him with.

Once the medical team were with Mr Maginnis, the two officers left the room and waited outside.

It is recorded in the bed watch journal that at 06.20, contact was made with Maghaberry Prison, at the request of nursing staff in order for Mr Maginnis' next of kin to be contacted. At 06.50, it is recorded that the officers were informed by medical staff that Mr Maginnis had passed away.

Commenting on Mr Maginnis' death, Dr Flynn stated:

"His ultimate cause of death was infection from his foot ulcer. With any open wound this is a constant risk. When he was in the prison service he was continually observed and received regular dressings. I think that the ability to dress the wound on an almost daily basis was a factor <u>delaying</u> the onset of significant infection. Had he been outside the prison service he would have not received this level of care….The only factors which may have prevented Mr Maginnis' death would have been amputation of his foot. I do not believe that at any stage that this was clinically appropriate unless he had a life threatening infection, which was only present as a terminal event. The only other factors which would have prevented his death would have been his compliance with medical advice, in particular the willingness to accept intravenous antibiotics, intravenous fluids and also to permit appropriate blood investigations."

It is noted on the post mortem report that Mr Maginnis was hypotensive[21] and hypoxic[22] on arrival at hospital. He responded to fluid resuscitation and

[21] Hypotensive – to have abnormally low blood pressure.
[22] Hypoxia is when the body is deprived of adequate oxygen supply

oxygen supplementation. He was noted to be in acute renal impairment. He was treated with antibiotics but became increasingly unwell. It is reported that he refused intravenous access and blood sampling and suffered a cardiac arrest and wasn't able to be resuscitated.

Mr Maginnis' autopsy revealed that he had severe pre-existing heart disease in the form of marked narrowing of one of the main coronary arteries due to a severe degenerative process (coronary artery atheroma). This on its own is a common cause of heart attacks and a very common cause of sudden death. There was also evidence that Mr Maginnis had, in the past, suffered and survived a heart attack with the damaged heart muscle being replaced by fibrous scar tissue (myocardial fibrosis).

Commenting on the finding that Mr Maginnis had heart disease Dr Flynn noted:

"As a smoker he had evidence of vascular disease, but declined an angioplasty which would have helped to improve the blood flow to his leg and may have aided healing. The post mortem had evidence of coronary artery disease. This is frequently silent and thus does not come to clinical attention. I see from the records that at one point in time he was complaining of chest pain but was appropriately assessed with a number of ECG tracings, which showed no abnormalities. The chest pain was not persistent and management at that stage was appropriate."

SECTION 3: MR MAGINNIS' MENTAL HEALTHCARE

12. Background History

In light of the substantial evidence of Mr Maginnis' non-compliance with the management of his diabetes, the investigation considered whether Mr Maginnis' mental healthcare and support were adequate. A clinical reviewer Dr Seena Fazel was asked to review entries in Mr Maginnis' notes related to his mental healthcare.

There are no records of diagnosed mental health problems before Mr Maginnis' custodial sentence. Whilst there are numerous mental health entries in Mr Maginnis' prison records there is, again, no formal diagnosis of mental illness.

Mr Maginnis was first referred to prison mental health services in 1992 and twice in 1994 as he was complaining of low mood. In 1995 he was reported to be "uptight and tense" and was twice referred to psychiatry at his own request. In 2001, Mr Maginnis started to see a clinical psychologist and a community psychiatric nurse on a regular basis.

In 2003, Mr Maginnis was re-referred to mental health due to a reported increased risk of suicide. He was referred again in 2004 after taking an overdose. He continued to see a clinical psychologist throughout 2003 and 2004.

During his sentence, Mr Maginnis had ten 'Prisoner at Risk'[23] documents opened. These are dated 2003, 2004, 2005 (3 times), 2006, December 2007 2008, and 2009 (2 times). It is recorded that Mr Maginnis did not attend two mental health appointments in 2006 but his mental health was reported to be stable in September of that year.

[23] 'Prisoner at Risk' documents have since been replaced by 'Supporting Prisoners at Risk' booklets which are used when a prisoner becomes vulnerable and requires extra support and more frequent supervision.

Mr Maginnis started to see a psychotherapist in February 2007 on a weekly basis. He continued to see the psychotherapist on a regular basis until his death in 2010.

In a report dated 3 May 2001, by a Consultant Clinical Psychologist, it is recorded that Mr Maginnis showed no signs of having a major mental illness or personality disorder but it is noted that he did have certain personality traits associated with an increased risk of violence. A Principal Psychologist at Maghaberry also concluded that Mr Maginnis had no evidence of major mental illness and he conducted a psychometric personality scale assessment, the results of which were consistent with no diagnosis of personality disorder. However, it is recorded that Mr Maginnis displayed elevated scores on several parts of this scale including those measuring anxiety, dysthymia[24], depression, and avoidant symptoms. A structured assessment of psychopathy found no evidence of meeting the threshold for a psychopathic disorder.

In a report dated 19 July 2005, a Consultant Forensic Psychiatrist recorded that he found no evidence that Mr Maginnis had an affective disorder, such as clinical depression, but thought that he had an adjustment disorder with traits consistent with personality 'deficits'.

On 28 November 2005, following a mental health review it is recorded that Mr Maginnis had no evidence of depression or mental illness, and that his difficulties were *"reactive to social stresses".*

In March 2007, Mr Maginnis took an overdose. In a letter dated 12 April 2007, from Belfast City Hospital's Liaison Psychiatry Nurse, she noted that she had discussed Mr Maginnis' overdose with the Consultant Liaison Psychiatrist and that he felt that Mr Maginnis' overdose was *"impulsive."* It is also noted that the Consultant Liaison Psychiatrist "*accepts that the patient has the capacity to make decisions regarding medical help."* No 'Prisoner at

[24] Dysthymia is a chronic type of depression in which a person's moods are regularly low. However, symptoms are not as severe as with major depression.

Risk' booklet was opened when Mr Maginnis returned to prison and the overdose was not discussed at the next safer custody meeting.

In a further report produced in January 2008, a Consultant Forensic Psychiatrist does not conclude that Mr Maginnis has a psychiatric diagnosis.

November 2009 onwards

In November 2009, Mr Maginnis self harmed by *"consuming three handfuls of tablets"* and cutting his leg in a number of places. He was admitted to prison healthcare and placed on a SPAR.[25] Mr Maginnis remained on the SPAR until 18 December 2009 and was reviewed on a number of occasions by the mental health team. He was also reviewed by a psychiatrist on 1 December and 3 December 2009 and it is recorded that he was described as euthymic (normal) in mood with "*no biological features of depression*".

It was the case that Mr Maginnis sometimes had difficulty producing urine when requested for drugs tests (this is discussed in sub-section 16 of this report) and the psychiatrist recorded that Mr Maginnis gave the impression of "*deliberate self harm precipitated by situational difficulties including recent difficulties with urine drug testing which meant that he had lost some privileges."* It is also recorded that Mr Maginnis told the psychiatrist that he had previously self-harmed three weeks prior to this incident by pouring hot water on himself [which is confirmed in Mr Maginnis' SPAR booklet].

On 22 January 2010, it is recorded that at a review the psychiatrist found no ongoing concerns and that Mr Maginnis was *"bright and reactive"* and not suicidal. There was a similar review on 18 February 2010.

On 14 April 2010, Mr Maginnis was seen by a prison doctor after "*kicking furniture in anger."* He was referred back to the mental health team and assessed on 23 April 2010. It is recorded that the mental health nurse who assessed Mr Maginnis did not find him to be depressed, and that he denied any thoughts of self-harm. In another review by the same nurse on 3 May

[25] Supporting Prisoners at Risk (SPAR) booklets are used for vulnerable prisoners at risk of self harm or suicide.

2010, it is recorded that Mr Maginnis stated that the review was *"stupid"* and requested no further mental health input. It is recorded that Mr Maginnis continued to see his psychotherapist weekly which, it is noted, Mr Maginnis thought was "*adequate."*

In August 2010, whilst Mr Maginnis' psychotherapist was on leave, arrangements were put in place to ensure that he was seen by a member of the mental health team on a weekly basis. The first review was on 7 August 2010, and it is recorded that Mr Maginnis was *"hopeful for the future and keen to make plans for his release"* and not suicidal. The second review, on 12 August 2010, was similar in nature and recorded that Mr Maginnis *"feels marked improvement in physical and mental state… he feels he has hope for the future."* His mood was reported to have *"dipped slightly"* on the next two reviews because he was concerned that he might lose his enhanced status for refusing a drug test and about the lack of progress with his move to Wilson House[26].

It is recorded that on 10 and 14 October 2010 Mr Maginnis requested a mental health review because *"he feels let down by the system and that he needs mental health support on top of his weekly sessions".*

On 14 October, it is recorded that Mr Maginnis kicked his cell door with both feet and stated that he did so out of *"anger"* and denied *"any further thoughts of self harm/suicide"*. It is recorded on the injury report form that Mr Maginnis refused to make a statement as to why he kicked the cell door.

Mr Maginnis was reviewed by a mental health nurse on 15 October. He recorded that Mr Maginnis' *"mood appears to have settled… that his work was currently giving him a positive focus and that he was enjoying teaching Braille skills to others… he also stated that he feels better as he is now physically improved and has been upgraded back to enhanced status"*.

[26] Wilson House is a lower risk house with a more relaxed regime to encourage a better sense of responsibility, which usually houses lifer prisoners nearing the end of their sentence as a stepping stone pre-release.

At interview, Mr Maginnis' psychotherapist said that his engagement with him "*was very good, better than expected in that he would never miss a session.*" He said that he was surprised to hear of Mr Maginnis' death because he was finally progressing in his psychological state, in that he did want to move to Wilson house. The psychotherapist said that a move to Wilson House would only have been granted if Mr Maginnis diabetic management had improved. The psychotherapist said that "*psychologically there was an improvement but physically there was deterioration.*"

Medication

Mr Maginnis was prescribed two medications for his mental health problems: Chlorpromazine (as a tranquiliser) and Promethazine (for insomnia.)

Clinical Reviewer's Opinion

Commenting on whether Mr Maginnis' mental health treatment whilst in prison custody was appropriate, Dr Fazel concluded that:

"Mr Maginnis does not appear to have had a diagnosable mental illness and therefore clinical guidelines are not necessarily applicable. However, a number of clinicians identified occasional symptoms of low mood and anxiety, and problems in his personality organisation. The latter led him to act impulsively at times, have problems controlling his anger, and caused his mood to be changeable (but not to the extent of having a clinical depressive illness).

In relation to treatment for his personality problems, Mr Maginnis received regular clinical psychology from 2001 to 2004, and then weekly psychotherapy from 2007 onwards. The latter appears to have enabled him to start psychological work on his offence, which would have likely reduced his risks of serious repeat offending. In addition, he received an oral major tranquilizer, Chlorpromazine, (which is also used as an antipsychotic) that is occasionally used in individuals with personality disorders and related personality problems for particular symptom clusters including anxiety and

anger. Taken together, these are not inappropriate treatments for Mr Maginnis."

Dr Fazel noted that the use of Mr Maginnis' medication appeared to be regularly reviewed and he said that he considered this *"good practice, and in line with recent NICE[27] guidance (for the treatment of Borderline and Antisocial Personality Disorders) that does not recommend medium and long term routine use of antipsychotic medication in personality disorder."*

Dr Fazel noted also that the *"NICE Guideline for the treatment of Borderline Personality Disorder also recommends that psychotherapy undertaken with individuals with such personality disorders should have clear provision for therapist supervision (Section 5.12). Although, Mr Maginnis did not have a diagnosed personality disorder, it is my view this would be appropriate for any long term psychotherapy with a prisoner with serious personality problems."*

Noting that Mr Maginnis received weekly psychotherapy from February 2007 until his death in October 2010, Dr Fazel said that *"this is likely to have been longer in duration than he would have received in the NHS if he was a person living in the community. I think that such psychotherapy was beneficial to Mr Maginnis and improved his mental health. However, I note that the evidence for longer term psychotherapies is limited, and it is my view that any interventions of this level of intensity that extend beyond six months needs to demonstrate their ongoing efficacy and value. This is even more relevant in prison settings where access to such therapies is very limited."*

Dr Fazel also examined evidence related to a number of Mr Maginnis' self-harm episodes and 'Supporting Prisoner at Risk' (SPAR) reviews. He said that "*I reviewed the last of these carefully (from December 2009), and I feel that it was appropriately undertaken with repeated mental health assessments, admission to the prison healthcare wing for further assessment, and mental health follow-up. Shortly before his death, however, there was one apparent episode of deliberate self harm (kicking the cell door), which did*

[27] NICE – National Institute for Clinical Excellence.

not attract a SPAR review. However, he was assessed as not having ongoing thoughts of self-harm and that the episode was thought to be secondary to 'anger'. In view of the fact that Mr Maginnis appears to have had such an episode in context of requests for additional mental health support (e.g. on 10/10/10 and 14/10/10), it may have been appropriate for a SPAR to have been opened or some indication be given, one way or the other, whether he would be reviewed regularly as per his requests on 10 and 14 October. However, in the circumstances, I am not of the view that if a SPAR had been opened, this would have prevented his death. I note on 15 October 2010 that it was reported that Mr Maginnis felt 'better', and that his mood appeared to have settled."

13. Possible Explanations for Mr Maginnis' Non Co-operation with the Management of his Diabetes

Mr Maginnis' mother was very concerned that he continually missed hospital appointments and the investigation considered why Mr Maginnis did so and why he mismanaged his diet and insulin intake, despite appearing to be fully aware of the associated health risks.

Mr Maginnis had been in prison since 1991 and at interview, his psychotherapist said that *"Mr Maginnis was overwhelmed at how the outside world had changed so much"* when he attended outside appointments, and was *"amazed at the number of cars he could see on the roads"*. Officers who accompanied Mr Maginnis to outside hospital appointments said at interview that he would have panic attacks and request to be returned to the prison.

On 17 June 2010, it is recorded in Mr Maginnis' safer custody records that it was felt that Mr Maginnis was *"concerned about being released,"* and an officer in attendance stated that he *"felt that perhaps this is why Mr Maginnis is being frustrating in case a release date may arise.... He is going to have to live on his own somewhere and is frightened"*.

A possible factor in Mr Maginnis' mismanagement considered by the clinical reviewer Dr Fazel was that it was part of a concerted and chronic plan to harm himself and hasten his death from diabetic complications. Dr Fazel felt that there was mixed evidence for this. On 16 December 2009, Mr Maginnis wrote a letter in the third person talking about "Mark." He wrote that *"Despite all that the diabetes team taught Mark about the preventability of diabetic tissue damage, his childhood impressions were so strong that he always equated diabetes with inevitable blindness, amputation, and being overweight. He decided if this was the future he would rather not know. He would have a short life, and a merry one."*

The letter, however, ends with the statement, *"This person needs to wake up, get some help, before he kills himself."*

There is, however, evidence in prison records that, towards the end of his sentence, Mr Maginnis had hopes and plans for the future. In a report dated 1 April 2008 by a clinical psychologist it is recorded that Mr Maginnis stated *"I'll be starting afresh, a flat, look for a job, doing computers, Braille….I'm coming thirty eight now, still years to go, I might get an artificial limb, I've a life to live, live in Belfast, get the train to see my Mum, I've a lot of things to look forward to, two or three years down the line, keep my nose clean, keep doing the work, get the help I need, ask if I've got any problems, don't sit and dwell on it".*

On 14 October 2010, it is also recorded in Mr Maginnis' safer custody records that, *"He will now talk about release whereas in the past he was adamant he did not want to be released".*

In the absence of a major mental illness such as depression or schizophrenia, which would have been the most obvious psychiatric factor that could have impacted on Mr Maginnis' management of his diabetes, the Clinical Reviewer, Dr Fazel also considered other possible reasons.

He said that there was evidence from Mr Maginnis' mental health records that, as a result of his experiences before coming into prison, he had a big issue with control, which caused strong and conflicting emotions for him. His diabetes was something he could control. He, therefore, appeared to react against others telling him what to do in relation to his diabetic care.

Dr Fazel said also that there was evidence that Mr Maginnis thought that by refusing to do certain things, the way that the prison related to him would change. He disliked, for example, the fact that for reasons of security, prisoners are not notified of hospital appointments until the morning of the appointment. It would appear that Mr Maginnis thought that if he refused to attend enough times, prison staff would inform him the previous day.

It was further the case, as noted earlier, that Mr Maginnis had explained that he was frightened of being identified and didn't like being handcuffed at outside appointments.

Dr Fazel observed that it was generally believed that Mr Maginnis had the capacity to refuse medical treatment. He noted that this was the view of a Consultant Psychiatrist who saw Mr Maginnis in hospital after an overdose in 2007. Dr Fazel did, however, say that he believed that *"a clearly documented capacity assessment would be preferable in such circumstances."* This would include a record of the fact that Mr Maginnis understood his illness and the treatments, was aware of the consequences of refusal and the alternatives and was making firm and consistent decisions about what he had decided to do.

SECTION 4: OTHER ISSUES

14. Family Notification of Mr Maginnis' Admission to Hospital

One of the concerns raised by Mr Maginnis' mother was that she had not been informed that Mr Maginnis had been admitted to hospital on 24 October 2010 or contacted sooner when he became critically ill on 25 October.

The policy at that time, in respect of notifying the next of kin when a prisoner was admitted to an outside hospital, was that it is the responsibility of the officers in attendance at the hospital to provide feedback to the prison as to whether a prisoner's condition was improving or deteriorating. Based on the information provided, prison management would then make a decision as to whether or not next of kin needed to be contacted.

The Prison Service's Suicide and Self Harm Prevention Policy February 2011, section 9.4 'Serious injury or death: Contacting the Family or Next of Kin', now emphasises that *"where a prisoner is seriously injured or hospitalised or has died, the Governor in charge or Duty Governor must inform, as a matter of urgency, the immediate family or next of kin or arrange for another appropriate person to do so."*

It is the case that when Mr Maginnis was admitted to Belfast City Hospital on 24 October 2010, prison staff did not think that his medical condition was seriously life threatening. CCTV shows that Mr Maginnis walked up and down the landing that morning in order to clean his cell and, on three occasions during that evening, staff recorded that Mr Maginnis tried to sign himself out of hospital.

Based on Mr Maginnis' condition at the time, it would appear, therefore, that it was not considered necessary to contact his mother on 24 October 2010.

At interview, one of the night custody officers said that during the night of 24 October and early hours of 25 October, *"nothing out of the ordinary happened."* The officer said that he did not know why Mr Maginnis was in hospital, due to patient confidentiality, but recalled one of Mr Maginnis' lower legs being swollen. He said that with regards to Mr Maginnis' general health, *"nothing sticks out of the ordinary that gave me cause for concern."* As previously stated, at around 06.00, after officers alerted hospital staff that Mr Maginnis was not well, emergency medical attention was provided to him. It is recorded that at 06.20, hospital staff requested that Mr Maginnis' next of kin be contacted and this was relayed to Maghaberry Prison by the officers in attendance.

It is further recorded that at 06.40, Mr Maginnis' mother was contacted. Information provided by the principal officer who contacted Mr Maginnis' mother states that the reason it took 20 minutes to make contact with Mr Maginnis' mother was because there was an old telephone number logged on the system, from a previous address. The principal officer said that staff managed to obtain the correct number through the internet. He said that when he spoke to Mr Maginnis' mother, he told her that Mr Maginnis was not very well and that she should go immediately to the hospital to see him. Ten minutes after this phone call, Maghaberry Prison was notified of Mr Maginnis' death.

It is regrettable that, because of Mr Maginnis' rapid deterioration and the manner of his death, his mother did not see him before he died.

15. Mr Maginnis' Work for the Braille Unit

The Braille Unit in Maghaberry has been running since the prison opened and produces a variety of Braille products from storybooks and GCSE papers to Government documents and even music. The Unit employs up to 12 prisoners and they each begin by doing a Braille Proficiency Examination, which can take six to nine months to complete. They have to learn the Braille language and all of the rules that go with it.

Mr Maginnis started to work for the Braille Unit soon after it opened and continued to do so, on an on and off basis, throughout his custodial period. Mr Maginnis did not engage in many purposeful activities and had told a senior officer and nurse officer, who were interviewed as part of this investigation, that the reason he wanted to learn Braille was because he knew that his diabetes would cause him to eventually lose his sight.

Most Braille employees would attend the Braille Unit, which is situated in the Mourne Complex[28] of Maghaberry Prison, but due to Mr Maginnis' particular medical needs, and the fact that he did not require supervision because of his high level of proficiency in the work, it was agreed that Mr Maginnis could have a computer in his cell to carry on working for the Braille Unit.

One of the concerns raised by Mr Maginnis' mother was that the computer had been moved from his cell into a classroom on the landing, which had contributed to a deterioration in his condition.

At interview, a governor said that he was aware that *"at some point,"* Mr Maginnis' computer had been moved from his cell onto the landing but that he could not recall when this was. He said that by having Mr Maginnis working on the landing, the work he was doing could be better managed and that this was also "*to try and encourage Mr Maginnis to come out of his cell. We had asked Mr Maginnis at one time to go over (to the Braille Unit*

[28] The Mourne Complex is separate to the main prison and enclosed by its own perimeter wall. The Mourne Complex houses three lower risk houses called Braid , Wilson and Martin House and also some educational / workshop units.

workshops)….. over lunchtime outside of his actual residential area, but Mr Maginnis declined. I was trying to encourage him to engage with more people, but unfortunately he didn't."

The first reference that Mr Maginnis had re-started working for the Braille unit after a break was on 3 December 2009 when a principal officer provided an e-mail update to the safer custody co-ordinator regarding Mr Maginnis' progress that week. In the e-mail, the principal officer wrote *"doing Braille unsupervised in classroom in Bush 3."*

The investigation was unable to establish precisely when Mr Maginnis' computer was removed from his cell, however, on 24 September 2009 it was recorded in safer custody minutes that *"until last year, Mr Maginnis worked on a computer for Braille, but then all such PC's were removed."* It is possible that it was around this time that Mr Maginnis' computer was removed.

A note in the Safer Custody minutes of 7 October 2010 confirms that Mr Maginnis was, at that time, carrying out Braille work in his cell. On 15 October 2010, during a mental health assessment, a nurse officer recorded on EMIS[29] that *"Mr Maginnis stated he was enjoying Braille – teaching it to others"* which would suggest he was working on Braille in a classroom environment and was content with this.

[29] EMIS – Egton Medical Information System which is a database for patient records.

16. Progressive Regimes and Earned Privileges Scheme (PREPS)[30] and the Management of Mr Maginnis' Drug Testing

A review of Mr Maginnis' prison records shows inconsistencies in the way in which Mr Maginnis' voluntary drug testing was managed. This resulted in Mr Maginnis being demoted in regime.

The Progressive Regimes and Earned Privileges Scheme (PREPS)

PREPS works towards its stated objectives by allocating privileges and incentives according to three different regime levels – Basic, Standard, and Enhanced.

Prisoners on all three regime levels are subject to voluntary drugs testing, for regime level progression. If a prisoner refuses or fails a drug test, consideration of a reduction in regime level will take place. The first failure to pass or provide a drugs test at Standard level should normally result in a referral to a drugs advisor and not an automatic demotion.

Where demotion to Basic regime level has been recommended, the following reduction of privileges will be applied:

1. Removal of in-cell television
2. Reduction in weekly wage from £11 to £4
3. Reduction in weekly visit time from one hour to a half hourly visit. (In practice this provision is not generally applied.)
4. Reduction in weekly phone credit purchases from £20 to £10.
5. Reduction in weekly gymnasium sessions from three times per week to once a week.
6. Reduction in weekly permitted allowance for cash brought in from £50 to £40.

[30] **PREPS** – **P**rogressive **R**egimes & **E**arned **P**rivileges **S**cheme which encourages and rewards prisoners for their commitment to complete their Sentence Plan and Compact agreement. It also encourages pro-social behaviour within the prison and to contribute to a better controlled, safer and healthier environment for prisoners and staff based on mutual respect and it is also rewarding for prisoners who display self motivation and commitment to developing improved citizenship qualities and self worth.

7. Reduction in weekly tuck shop spend from £30 to £20

Prisoners on the Basic privilege level are allowed to have a radio.

Mr Maginnis' Regime Promotions and Demotions

The Prison Services database PRISM, which was introduced in Maghaberry in June 2006, shows that between 3 June 2006 and 25 October 2010 Mr Maginnis was subject to the following demotions and promotions:

3 June 2006	On Basic regime level
9 July 2006	Promoted to Standard
28 February 2007	Promoted to Enhanced
1 March 2007	Demoted to Standard
4 December 2007	Demoted to Basic
20 December 2007	Promoted to Standard
24 January 2008	Demoted to Basic
10 April 2008	Promoted to Standard
30 November 2009	Demoted to Basic
5 December 2009	Promoted to Standard
(NB on 10.12.09 Mr Maginnis passed a drug test)	
4 August 2010	Promoted to Enhanced
23 September 2010	Demoted to Standard
7 October 2010	Promoted to Enhanced

Whilst regime demotions can occur due to a prisoner's poor behaviour or lack of engagement with their sentence plan, the above five demotions were all as a result of Mr Maginnis' refusal to provide a drugs test on the grounds that his medical condition prevented him from passing urine, within the allocated time slot of four hours.

On 22 January 2008, following Mr Maginnis' refusal to provide a specimen of urine for the drug test, he was offered a mouth swab, which was being piloted at the time. Mr Maginnis also refused the swab test and this resulted in his demotion to Basic on 24 January 2008.

Maghaberry's Management of Mr Maginnis' Drug Testing and Regime Level

On 20 December 2007, minutes from a safer custody case conference held to discuss Mr Maginnis note the fact that he was on Basic regime and state that:

"Mr Maginnis had been placed on Basic regime following his inability to provide a urine sample for a drug test. Mr Maginnis produced letters from a governor, dating back to the early part of this year, sent to Mr Maginnis acknowledging that Mr Maginnis had difficulty producing a sample on demand. There is also a letter on his file stating he has nerve damage to his bladder which could be the cause of his difficulty……it was agreed that Mr Maginnis should be given the opportunity to appeal his lowering of regime and he would be reinstated to Standard but would be unable to progress to Enhanced."

Given that there was evidence on Mr Maginnis' file of medical confirmation of his difficulties in producing a urine sample on demand, it is unclear why Mr Maginnis had been demoted to Basic on 4 December 2007. It is also unclear why he should be prevented from progressing to Enhanced regime if his difficulty was accepted to be genuine and, in all other respects, his cooperation with his sentence plan and his behaviour were to the standard required.

On 14 February 2008, safer custody minutes also recorded the following:

"Safer Custody had arranged through a governor that because of Mr Maginnis' difficulties in providing a urine sample he would be placed on standard regime and would not have to undergo drug testing — this would prevent him from progressing to Enhanced but would at least keep him on standard."

It is not known why Mr Maginnis refused a mouth swab test on 22 January 2008 but notwithstanding this, he was demoted on two further occasions on 30 November 2009 and 23 September 2010, for not producing a urine sample. On 10 December 2009, Mr Maginnis was able to produce a sample

and passed his drugs test and it would appear that it was for this reason that he was permitted to progress to Enhanced regime.

Because Mr Maginnis had reportedly overdosed on his medication, a SPAR booklet was opened on 9 November 2009. On 30 November, three hours after Mr Maginnis was told that a decision had been taken at a case conference to reduce his regime to Basic and remove his television, he self harmed by cutting his legs multiple times. This resulted in him being admitted to outside hospital. When Mr Maginnis was asked why he had cut his legs, it is recorded that he said *"I was pushed too far."*

The Prison Service PREPS Policy June 2009 states that *"All prisoners considered at risk from self-harm or suicide may be considered for in-cell television irrespective of privilege level on a case-by-case basis. Prisoners who are subject to the PAR1 (SPAR) process will not be denied a television, if agreed by the Suicide Prevention Co-ordinator or at the case conference."*

There is no record in the SPAR case conference of 30 November suggesting that consideration was given to whether or not it would be appropriate to remove Mr Maginnis' television. It would appear to be the case that following notification of demotion, landing staff automatically removed Mr Maginnis' television.

Mr Maginnis was assessed by a psychiatrist on 1 December 2009 and 3 December 2009. She concluded that it was her impression that Mr Maginnis' deliberate self harm was precipitated by situational difficulties "*including recent difficulties with urine testing."* The psychiatrist wrote to the governor about the urination issue.

At interview, the psychotherapist who regularly saw Mr Maginnis said that some of the governors "*were good at working with Mr Maginnis on his problems with producing urine on demand and others were not so helpful in that they didn't believe that Mr Maginnis couldn't provide a urine sample."*

In his Clinical review, Dr Fazel noted that "*Mr Maginnis had problems producing urine as he said that his medication limited his ability to urinate at will. It may be that the Prison Service considers guidelines for mandatory drug testing that accommodate individuals with serious medical problems where medical opinion deems it reasonable that urination will be affected.*"

The investigation found, however, that the Prison Service's 'Information to Prisoners on Mandatory Drug Testing' which was introduced on 15 September 2010, does already state that *"If there is a legitimate medical reason, which has been verified by the prison medical officer, for your inability to provide a sample, this will be given full consideration."*

SECTION 5: AUTOPSY REPORT

17. Findings of the Autopsy Report

An autopsy examination was carried out on 26 October 2010 and gave the cause of Mr Maginnis' death as:

I(a) Features consistent with Septicaemia
due to
(b) Infection of foot ulcers

II Coronary Artery Atheroma
Myocardial Fibrosis
Pneumonia
Diabetes Mellitus

The report states:

"Mark Maginnis had developed ulcers on one of his feet, and these ulcers subsequently became infected by bacteria.....It was not possible to confirm the nature of this infection on bacteriological investigation, however this is not unusual as post-mortem investigations are fraught with problems.

On clinical grounds it appeared that the infection had entered his bloodstream, spreading its affects around the body and this is known as septicaemia, which is a severe life-threatening condition.

....Autopsy also revealed severe pre-existing heart disease in the form of marked narrowing of one of the main coronary arteries due to a severe degenerative process (coronary artery atheroma). This on its own is a common cause of heart attacks and a very common cause of sudden death. Indeed, there was evidence that in the past he had suffered and survived a heart attack with the damaged heart muscle being replaced by fibrous scar tissue (myocardial fibrosis). This on its own can also cause sudden death as it

impairs pumping ability of the heart and also renders it susceptible to disturbances of rhythm (arrhythmias).

It is unclear to what extent heart disease may have played a role in his death, in view of other findings at autopsy, however it is undoubtedly warrants inclusion as a probable contributing factor not least as it would rendered him less able to survive the other life-threatening conditions.

….Diabetes mellitus warrants inclusion as a contributing factor in death as it could have rendered him more prone to ulcers of his feet, infections and coronary atheroma. Furthermore, analysis of a sample of eye fluid taken at autopsy revealed a high concentration of glucose, which correlates with very high ante mortem blood sugar level, indicating that at time of his death the condition was not optimally controlled.

Toxicological analysis of a sample of blood taken at autopsy revealed the presence of the analgesic drug tramadol, the antidepressant drug Amitriptyline, the antiemetic drug cyclizine and the allergy drug promethazine all at concentrations that lay within their respective therapeutic ranges. Further analysis of samples of blood and urine excluded the presence of alcohol."

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

   - **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights,

by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the

Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Secretary of State for Northern Ireland (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

16. Annex ‘A’ contains a more detailed description of the usual reporting procedure.

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

3. The Service responds within 28 days. The response:
   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman

may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

APPENDIX 2

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[31] and integrated[32] conditions.

Maghaberry Prison was built to accommodate 682 prisoners, however, there were 806 prisoners in Maghaberry on the day Mr Maginnis died.

Maghaberry Prison is one of three Prison establishments managed by the Northern Ireland Prison Service, the others being Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. Four Square Houses - Bann, Erne, Foyle and Lagan, along with purpose built separated accommodation houses of Roe and Bush, make up the present residential house accommodation.

There are three lower risk houses within the Mourne Complex of Maghaberry Prison, called Braid, Wilson and Martin Houses. These are usually used to house lifer prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU) located at Crumlin Road, Belfast.

There is also a Landing within Maghaberry Prison called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Foyle House, which is used for housing poor coping prisoners who attend the Donard Unit[33].

[31] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.
[32] Integrated – general residential accommodation houses accommodating all prisoners.
[33] The Donard Unit has been specifically designed to facilitate purposeful activity for poor coping prisoners.

There is also a Care and Supervision Unit[34] (CSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.

The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and resettlement of which addressing offending behaviour is an element.

Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[35] (PREPS).

Maghaberry Prison was last inspected by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[36] in Northern Ireland in July 2009.

[34] Care and Supervision Unit (CSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

[35] Progressive Regimes and Earned Privileges (PREPS) - There are three levels of regime. Basic - for those prisoners who, through their behaviour and attitude, demonstrate their refusal to comply with prison rules generally and/or co-operate with staff. Standard - for those prisoners whose behaviour is generally acceptable but who may have difficulty in adapting their attitude or who may not be actively participating in a sentence management plan. Enhanced - for those prisoners whose behaviour is continuously of a very high standard and who co-operate fully with staff and other professionals in managing their time in custody. Eligibility to this level also depends on full participation in Sentence Management Planning.

[36] Website link - http://inspectorates.homeoffice.gov.uk/hmiprisons/inspect_reports/547939/551446/maghaberry.pdf?view=Binary