The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR BERNARD LAW
AGED 44
AT MAGILLIGAN PRISON
ON 25TH MARCH 2017

Date finalised: 24th June 2019

Date published: 26th September 2019

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Glossary

AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
AED	Automated External Defibrillator
CCTV	Close Circuit Television
CPR	Cardiopulmonary Resuscitation
ECR	Electronic Care Record
ECR	Emergency Control Room
EMIS	Egton Medical Information System
GP	General Practitioner
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence (Order) NI
PECCS	Prisoner Escorting and Court Custody Service
PSNI	Police Service of Northern Ireland
PREPS	Progressive Regimes & Earned Privileges Scheme
PRISM	Prisoner Record and Inmate System Management
PTSD	Post-Traumatic Stress Disorder
SPAR	Supporting Prisoners At Risk (procedure)
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure
S/O	Senior Officer

Preface

Introduction

My office is responsible for investigating deaths in prison custody in Northern Ireland. We are completely independent of the Northern Ireland Prison Service (the Prison Service). The Terms of Reference for our investigations are available at: https://niprisonerombudsman.gov.uk/publications

We make recommendations for improvement where appropriate. Our investigation reports are published following consultation with the next of kin, in order that investigation findings and recommendations are widely disseminated, in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for Prisoner Ombudsman investigations of deaths in custody are to:

- establish the circumstances and events surrounding the death, including the care provided by the Prison Service;
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust (the Trust);
- examine whether any changes in the Prison Service or the Trust's operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation 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 practice is identified, and any lessons from the death are learned.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. Mr Law's next of kin was a paternal Aunt. At the initial meeting with her, Mr Law's father and the family's legal representative, a number of concerns were raised about how Mr Law's medical condition was managed in prison, particularly when he was in Magilligan prison. The legal representative provided a large bundle of clinical records to the investigation. We took account of these matters, where we could, during our investigation.

Although this report will inform several interested parties, it is written with Mr Law's family in mind. It is Mr Law's family who experience his loss most keenly and I am grateful for their contribution to this investigation. I offer my sincere condolences to them in their sad loss. I hope this report will provide information to help them understand the circumstances of Mr Law's death, although I acknowledge, given the scope of our investigations, that we were not able to satisfactorily address all of the concerns the family raised. The family continue to have concerns about the level of care provided to Mr Law while he was in Magilligan prison.

I am grateful to the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contributions to this investigation.

This report is structured to detail the events leading up to Mr Law's death on 25th March 2017 to help establish the circumstances and events surrounding his death, recommend change in operational methods, policy and practice and give those mourning Mr Law some insight into what happened.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
24th June 2019

Summary

Mr Law was 44 years old when he died in his room on House Block 2 (H2) A&B landing, Magilligan prison on 25th March 2017. The post mortem report found that he died from Cardiomegaly and Coronary Artery Atheroma. The pathologist noted that the coronary artery atheroma and the cardiomegaly were of such severity that Mr Law could have died suddenly from a heart attack at any time.

Mr Law was committed to Maghaberry prison on 4th September 2015 to serve a four year sentence and transferred to Magilligan prison later that month on 24th September 2015.

He was diagnosed with epilepsy in 2002 and the following year was diagnosed with pseudo seizures related to stress and anxiety. He had a history of low mood and depression and had previously been engaged with community mental health services following two self-harm attempts. Mr Law took a significant number of pseudo seizures during the time he was in custody and he was managed under the Prison Service Supporting Prisoners at Risk (SPAR) procedures on four occasions including shortly after his committal.

The clinical reviewer, Ms Walsh, was satisfied that the care which Mr Law received in prison was equivalent and at times, better than the care which he would have received in the community, when assessed against national guidelines and protocols. She noted that Mr Law was encouraged to become more physically active to address his weight and had numerous blood tests and physical observations taken. These did not show that he was suffering from high blood pressure, high cholesterol or diabetes, all of which she highlighted could indicate coronary heart disease.

The reviewer was satisfied with the decision not to resuscitate Mr Law after he was found.

She recognised three areas of good practice which are highlighted in this report.

This report makes three recommendations to the Prison Service for improvement though none of these matters directly contributed to Mr Law's death. The Prison Service accepted the three recommendations.

Recommendations

1. **Headcounts:** The Governor should ensure that the required headcounts are conducted (Page 25).

2. **Inter-prison transfers:** The Prison Service should ensure that all relevant information pertaining to a prisoner's continuity of care should be recorded on PRISM and made available to the receiving prison (Page 26).

3. **Debriefs:** The Governor should ensure that effective hot and cold debrief meetings are conducted following a death in custody (Page 27).

Methodology

The Investigating Officer issued notices to staff and prisoners at Magilligan prison informing them of the investigation and asking anyone with relevant information to contact him. No-one responded to those notices.

Relevant information from the following sources was examined by the Investigating Officer:

- A meeting with Mr Law's family and their legal representative on 24th April 2017 at which a number of questions and concerns in relation to his care were discussed.
- Copies of relevant prison records and Mr Law's prison healthcare records obtained by the Investigating Officer. A copy of the Trust's local incident review was not available at the time of writing this report.
- A bundle of materials, primarily reports generated during the course of his trial, provided by the family's legal representative.
- Copies of witness statements taken by PSNI on behalf of the Coroner.
- The regular Senior Officer on the landing and the prisoner who found Mr Law interviewed in the course of the investigation.
- CCTV for the 24 hour period leading up to when Mr Law was found and the radio transmissions generated after the alarm was raised were reviewed.
- An investigator also listened to telephone calls made by Mr Law for 90 days prior to his death.
- The post mortem report (25th September 2017).

The investigation has addressed the main issues involved in Mr Law's care including:

- if the medical records provided by Mr Law's legal representative at court informed his care in Maghaberry and Magilligan prisons;
- the level of care and treatment he generally received while in prison, and;
- if it was appropriate that Mr Law was accommodated in a single cell at the time of his death.

An independent review of the medical care provided to the prisoner was conducted by Ms Laura Walsh. Ms Walsh is currently a senior manager responsible for the operational delivery of Mental Health Services in North Lancashire. Formerly a service manager for 7 prisons in the North West of England and with a clinical nursing background, Ms Walsh has more than 12 years' experience within offender health.

Background information

Magilligan prison

Magilligan is a medium security prison which holds male adult sentenced prisoners mainly transferred there from Maghaberry prison. The average daily population[1] of Magilligan prison during 2016/17 was 453.

Mr Law lived on the H2 A&B landing at the time of his death. This landing predominantly accommodates older prisoners, as well as those who may be vulnerable due to the nature of their offences and/or who have complex care needs.

Since 2008 prison healthcare services have been provided by the South Eastern Health and Social Care Trust (the Trust). There is a 24 hour primary health care service and the Mental Health Team is on site Monday to Friday between 08:00 and 17:00. There are no in-patient beds.

Criminal Justice Inspection

The most recent inspection of Magilligan prison was conducted in June 2017 and the report published in December 2017. Inspectors found that outcomes for prisoners were good against the healthy prison tests for resettlement and respect and reasonably good for safety and purposeful activity. Inspectors noted there had been some innovative work to develop provision for disabled and older men in House Block 2. They reported that some residential areas had been adapted to provide more suitable accommodation and there was a range of activities to encourage mental and physical stimulation.

Inspectors also found that health services had improved and mental health provision was particularly good for those known to the service.

Independent Monitoring Board

Magilligan has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners.

The IMB 2017-18 annual report highlighted the provision made for older prisoners in House Block 2 but recommended that the NIPS and Trust plan to adequately resource the social care needs of a growing number of aging prisoners.

[1] Source: Analytical Services Group, The Northern Ireland Prison Population 2016 and 2016/17. Research and Statistical Bulletin 27/2017, September 2017.

Previous deaths at Magilligan prison

Mr Law's death was the first death in custody in Magilligan prison since March 2015.

Key events

Committal and early days in custody

Mr Law received a four year sentence and was committed to Maghaberry prison on 4th September 2015. Throughout his trial Mr Law's family expressed concerns about how he might cope in prison given his personal background, medical and mental health. The court heard that Mr Law had learning difficulties and he had been diagnosed with epilepsy which was being treated effectively. Prior to the court case being brought against him, he had also suffered from mild depressive symptoms which had escalated to moderate depressive disorder symptoms following disclosure and during the court proceedings. A consultant psychiatrist gave evidence that he would present a significant risk of self-harm in prison and should he be incarcerated, his mental health and associated risk should be conveyed to the prison authority.

In his closing remarks the sentencing Judge suggested to the defence team that a full bundle of the defendant's psychiatric and medical reports were made available to the prison authorities. These were passed to the prison escorting staff by Mr Law's legal representative. It was evident in these records that Mr Law received significant support from his family, particularly his Aunt, when he lived in the community.

A SPAR was opened shortly after Mr Law arrived at Maghaberry by the Reception Senior Officer. The SPAR assessment and initial healthcare assessment interviews both referenced information provided by the police FMO and referred to reports giving details of Mr Law's medical history. A repeat prescription was issued by a prison doctor and included anti-depressant, anxiety and anti-seizure medications. Mr Law was accommodated on the Moyola landing.

The Operational Nurse Manager took part in monitoring Mr Law's SPAR on the evening of 4th September 2015. She noted the contents of the consultant psychiatrist's report provided by Mr Law's solicitor and recorded that this and accompanying information would be placed in the medical record office for Mr Law's file.

On 7th September 2015, a mental health screen was conducted and contact was made with Mr Law's social worker and it was established that Mr Law had been under the care of a consultant psychiatrist in the community and had a diagnosis of anxiety and personality traits.

In his first six days in prison, records indicated that Mr Law suffered from at least 18 seizures or episodes. He was attended to by nursing staff and his condition closely observed. His case was discussed at daily huddle[2] meetings.

On 10th September 2015, following a discussion with Mr Law, a Governor issued a record of the discussion to prison healthcare staff, the prison's day manager, security manager, safer custody governor and residential staff in Moyola advising of the outcome of the discussion and actions arising. He also gave instructions to prison staff on how to respond to Mr Law's seizures to minimise his stress. Prison staff were advised not to activate the discipline alarm unless they had specific concerns over and above how Mr Law had presented at that time; Mr Law was to be observed and prisoners were to be moved when Mr Law was taking a seizure so as to preserve his dignity; healthcare were to be contacted by telephone and would be asked to confirm that Mr Law had not inflicted any lasting damage on himself; and prison staff were to address the episodes with minimum disruption so that Mr Law's stress levels were not elevated.

In the course of the discussion with the Governor, Mr Law requested a transfer to Magilligan and the Governor asked healthcare if there was any reason why this would not be possible.

Following the Governor's meeting with Mr Law, the Operational Nurse Manager undertook to fast track a mental health assessment to facilitate a transfer to Magilligan, if found suitable.

An initial Mental Health assessment was conducted by a Mental Health nurse on 15th September 2015. She concluded that Mr Law was well settled and felt that he would benefit from being transferred to Magilligan where he would be closer to his family. She contacted her counterpart in Magilligan to make them aware of Mr Law's transfer and highlighted that Mr Law required some mental health support until he settled in Magilligan.

On 21st September Mr Law's SPAR was closed. It was noted that the number of documented seizures had reduced significantly and that Mr Law was looking forward to being transferred to Magilligan. The post closure reviewed took place two days later and on the 24th September he was transferred to Magilligan prison.

[2] A daily huddle is a short multi-disciplinary meeting held daily on weekdays to highlight issues and patients of concern and agree actions to be taken.

Significant events while Mr Law was in Magilligan prison

Mr Law was accommodated on H2 A&B landing when he first arrived in Magilligan prison. On committal he was reviewed by healthcare and saw a prison doctor on 5th October 2015 for joint pain and when bloods were taken. The test results were discussed with Mr Law on 19th October 2015. During this consultation the doctor noted that Mr Law was overweight.

A mental health review was conducted by a mental health nurse on 20th October 2015 and it was agreed that Mr Law would require ongoing support from the mental health team and would be added to their caseload. The nurse also recorded that he spoke with the Senior Officer in H2 A&B and advised that Mr Law should not be moved to any other location in the prison without the mental health team being consulted.

In the days following this review Mr Law had a number of seizures and a further meeting with the mental health nurse due to reports that he was concerned about having to share a cell. The mental health nurse explained to Mr Law that sharing may be necessary because of ongoing refurbishment work but also because of his seizures as he was located on a low supervision landing.

Mr Law was extremely anxious about having to share a cell but at a case conference on 28th October 2015, and following discussion with a prison doctor, it was agreed that he should move to a larger cell in Halward House and be doubled up for his own safety, due to the increase in the number of seizures he was experiencing. After a period when his seizures reduced, Mr Law was again returned to H2 A&B on 3rd November 2015. He continued to be seen by nursing staff and by a mental health nurse.

On 22nd November 2015 a SPAR was opened as Mr Law reported to a prison officer that he was very depressed and had nothing to live for. He stated that if he had access to his medication, he would take it all. He was moved to an observation cell in Halward House and monitored. The following day at the initial case review, the SPAR was closed and he was returned to H2 A&B. Mr Law reported that he missed his Aunt and was finding it difficult to cope. It was noted that Mr Law's Aunt visited him every week and had regular telephone contact with him.

Over the Christmas period Mr Law again reported he was feeling lonely and had thoughts of self-harm but had not acted on them. On 31st December Mr Law asked

to speak to a Listener[3]. He told a nurse the following day that he had fallen out with two other men on the landing.

On 5th January 2016, a nurse responded to a Code Blue message. Mr Law had taken a seizure but was conscious when she arrived in the cell. Mr Law's observations were taken. He was reviewed by nurses daily and was treated for an abrasion/burn to his head. A nurse spoke to the prison doctor because of the recent seizure activity and arranged an emergency GP appointment on 8th January 2016. The prison doctor reviewed Mr Law and advised that he needed to be doubled up. He also made a referral to a neurologist at Altnagelvin Hospital.

In response to the concern that Mr Law should not be in a single cell, he was moved to a different residential location at Sperrin House. Mr Law was unhappy about being located in Sperrin and he experienced several more seizures. As before he was closely monitored and continued to engage with a mental health nurse. At one consultation he requested to be moved back to Maghaberry and the mental health nurse e mailed a Governor about this request. The nurse reiterated to Mr Law that if transferred healthcare advice would remain that he should share a cell for his own safety.

On 26th January Mr Law saw a prison doctor again and stated that he did not want to stay in Sperrin. During this discussion Mr Law acknowledged that when he had been at home, his Aunt had stayed with him during the night. Mr Law asked to see another prison doctor to get a second opinion.

On 28th January Mr Law reported that he had taken 12 paracetamol. A nurse sought advice from Causeway Hospital and Mr Law was transferred to hospital for assessment. All blood paracetamol levels were found to be normal and Mr Law was transferred back to Magilligan prison (Sperrin House) the following day and referred to the mental health team.

Additionally a mental health nurse, a prison doctor and a house nurse met on 29 January 2016 and discussed Mr Law's case. Given the reported paracetamol overdose, an assault on another prisoner (earlier that day) and seizure history, they concluded that Sperrin was not an appropriate location for him and that a move back to H2 A&B wing should be explored with prison management.

In the interim Mr Law was accommodated in the prison's Care and Supervision Unit (CSU) from 29th January 2016 to 15th February 2016 after he was adjudicated for assaulting another prisoner. While there he was seen by nurses on a daily basis. On

[3] Listeners are prisoners who have undertaken training with the Samaritans to provide peer support to those experiencing crisis. Arrangements for Listeners or other suitable peer support scheme is set out in Standards 14 and 15 of the NIPS Suicide and Self Harm Prevention Policy.

5th February 2016 he saw a different prison doctor following on from the appointment at the end of January when he had asked for a second opinion on his care. In the course of this discussion Mr Law reported increased seizures because he was in the CSU and said that he was feeling low. The prison doctor expressed concern about how genuine Mr Law's seizures were given his presentation. He also advised Mr Law that he would liaise with a doctor at the Royal Victoria Hospital concerning his prescription for pregabalin.

On completion of cellular confinement Mr Law transferred back to Sperrin.

On 29th February 2016 Mr Law was charged under prison rules for exiting Sperrin House through a fire door. He was described as being in a confused state and at the time was wearing little clothing. He was immediately transferred to Halward House for observation and the subsequent adjudication was withdrawn on medical grounds.

On 2nd March 2016 while in Halward House Mr Law was charged with assaulting a prisoner. On the same date Mr Law was himself assaulted when a prisoner poured rice pudding over him. Mr Law was charged under prison rules for assaulting another inmate and at adjudication he pleaded guilty and subsequently spent another period in the CSU. On the same day Mr Law's Aunt spoke to healthcare and was reassured that he was being seen on a daily basis and after each turn he took.

While in the CSU a SPAR was opened as he felt down after a visit with his next of kin. At the time he reported he was determined to harm himself and at one stage was placed in anti-ligature clothing. This SPAR was closed on 11th March 2016 and on the same day he was moved to House Block 3 (H3). A post closure review meeting was conducted on 18th March 2017 and he was recorded as being in a much better place.

During this period Mr Law's legal representative contacted Magilligan prison and again forwarded the bundle of medical notes initially submitted to Maghaberry when Mr Law was committed to custody. This was during the period Mr Law was accommodated in CSU. It appears this resulted from Mr Law's solicitor raising concerns about Mr Law's care and treatment after he had been assaulted.

It's not clear from the available records how these notes were used although a copy was available in the prison healthcare records.

Thereafter he continued to be supported by nurses and the mental health team and his seizures appeared to lessen. A psychiatry liaison meeting was held on 22nd March 2016 when Mr Law's case was discussed and it was agreed that he remain under psychiatry review, that his community mental health notes should be ordered and

vulnerable adult status checked with Probation. Notes from a community Resource Centre were later provided and shared with a prison psychiatrist.

Mr Law saw a prison doctor on 5th April 2016 due to swelling of his leg. Blood tests were requested and the results were noted to be normal with no follow up action required.

On 13th April 2016 Mr Law again requested a move back to Maghaberry when he learned he was to be moved out of the large cell in H3 to facilitate the needs of another prisoner. Although being placed in the larger cell he was not doubled up at this time. The move out of the larger cell did not transpire.

Mr Law's case was reviewed at a safer custody caseload meeting on 24th April 2016 it was agreed that he would be monitored closely. At a mental health multi-disciplinary meeting on 27th April 2016 Mr Law's case was discussed and his mental state was recorded as being stable.

On 29th April 2016 Mr Law attended a neurology appointment at Antrim Area Hospital.

Contact was made with the Learning Disability Service in the Northern Trust on 11th May 2016 who advised that Mr Law was not known to them. Prison healthcare received Mr Law's consent to make such a referral in advance of his release from custody.

On 11th May 2016 Mr Law was assaulted when an inmate poured lighter fluid round him when he was using the phone on the landing. This matter was reported to police.

On 31st May 2016 Mr Law did not respond when called to attend a physiotherapy appointment in the prison's healthcare department. Mr Law was moved back to his landing by prison staff under Control and Restraint. He was examined by a nurse and red cuff marks to both wrists were noted. Subsequently Mr Law reported this incident to the police and requested an investigation.

A consultant neurologist wrote to a prison doctor on 1st June and stated that his plan at future reviews was to gradually withdraw most of Mr Law's medication as the clinical diagnosis was more likely one of dissociative attacks.

Clobazam (an anticonvulsant) was prescribed by a prison doctor on 10th June 2016 but on 12th June a nurse spoke to the out of hours GP service to report that Mr Law had not received this medication for two days, that he had taken a seizure that morning and a further pseudo seizure at 14:00. The out of hours doctor advised that observations be done on Mr Law every two hours and arrangements were made to

source the medication locally. A first dose was administered that afternoon and a second dose later in the evening.

A fourth SPAR was opened on 7th July 2016 when Mr Law reported that he wanted to end it all. Although he wanted to remain in a single cell, he was doubled up at this time. The SPAR was closed on 9th July 2016. There is no record of a post closure review meeting being conducted.

A prison doctor discussed reducing and stopping the prescription of anticonvulsants sometime in the future given that his diagnosis was of non-epileptic seizures. This consultation took place on 7th July 2016. The prison doctor noted that Mr Law was to be reviewed by a consultant and when he tried to explain the withdrawal of medications to Mr Law he was adamant that he had epilepsy and it was getting worse.

On 21st July 2016 a prison psychiatrist recorded an update on Mr Law's diagnosis and plan on EMIS.

Mr Law was moved to a different residential unit – Alpha- on 22nd July 2016 on the instructions of a Governor. Mr Law continued to take seizures while in Alpha and shortly after he arrived on the landing he disclosed to a nurse that he had been bullied for his medication. The nurse spoke to a Senior Officer about the appropriateness of this particular residential unit as it appeared he was not able to manage his medication independently. He was reverted to supervised swallow.

He then took a number of further seizures before being relocated to H2 A&B wing on 22nd August 2016. Three days later Mr Law had another seizure which resulted in him sustaining a large bump to his forehead and lip. It transpired he had slipped out of bed because he had placed one mattress on top of the other on his bed rather than placing one mattress[4] on the floor to reduce any injury incurred by taking a seizure. There was further discussion about the advice given by healthcare to double Mr Law up with another prisoner.

Mr Law remained in H2 A&B from this point onwards. He had frequent contact with healthcare in relation to a number of ailments. He remained under the care of the mental health team and he was reviewed at multi-disciplinary case conferences until discharged from psychiatric review on 8th November 2016. A Consultant Psychiatrist

[4] The proposal to provide an additional mattress was first raised by a nurse on 28th October 2015 when Mr law expressed extreme anxiety at the suggestion that he be doubled up for his own safety. At that stage he was doubled in Halward House and when the seizures settled he was moved back to H2 A&B. Healthcare later requested an additional mattress for him on 10th January 2016 after an incident when he burned his head on a radiator after taking a seizure.

noted that there was insufficient evidence at that time to warrant a referral to community mental health services and that Mr Law would be discharged to the care of his community GP unless his presentation changed.

From August 2016 until his death on 25th March 2017 Mr Law reported a further eleven seizures. These took the form of him being in a trance like state or slapping himself. He last stated he had a seizure during the night of 20th March 2016 but did not report this to prison staff.

During this period he seemed to be reasonably well settled in H2 A&B and took part in a range of activities and classes.

He was treated by healthcare on a number of occasions for problems including:

- a skin complaint;
- a sore foot;
- shoulder pain; and
- a stomach upset.

On 16th January 2017 he presented to the House nurse complaining of a lump in his stomach. He was seen by a prison doctor the following day who examined Mr Law and found that he had a small hernia. Given the relatively short time Mr Law had left to serve in prison the doctor recorded that if there was not an emergency a hernia operation could be done on his release.

On 2nd February 2017 Mr Law attended a further review appointment with the Consultant Neurologist. In a letter to the prison doctor the consultant indicated that he preferred to delay the withdrawal of medication prescribed for seizures until Mr Law was released from custody. A further review was planned for October 2017.

Mr Law's case was again reviewed at a safer custody caseload meeting on 22nd February 2017. No new action points were identified.

Mr Law again presented with abdominal pain in February and saw a prison doctor on 28th February 2017. The doctor examined him and noted a small hernia which was easily, reducible. He requested blood tests including a troponin test which can help diagnose a heart attack. The doctor recorded that there was no history of cardiac problems but that he would do the bloods to confirm/exclude this. The bloods were taken after the appointment with the doctor and the results reviewed by him on 13th March 2017. The troponin test result was in the normal range. The doctor requested that the liver function test be repeated the following month.

Mr Law was scheduled to attend a mental health review appointment on the 14th March 2017 but he did not attend. No reason was provided to the mental health team. A note was made to follow up on this appointment the following week.

On 21st March 2017 a nurse recorded that Mr Law reported that he had taken a seizure in his cell during the night but did not report it to anyone. This was the last reported seizure before Mr Law's death and the first he had reported since 17th February 2017.

CCTV footage viewed for the 24 hour period prior to Mr Law being found shows normal activity on the 24th March 2017. The last sighting of Mr Law is when he left his cell at shortly after 03:00 (03:07) to go to the ablutions. He returned to his cell several minutes later.

On 24th March Mr Law had several conversations with his next of kin (whom he phoned most days) and one with his father. These calls were general in nature and during these he did not refer to any concerns about feeling unwell. The last call was made at 20:17.

After Mr Law's death, a prisoner reported that at around 04:00 he heard a loud bang followed by 'moaning and groaning' coming from Mr Law's cell. He said that this behaviour was normal for Mr Law so it did not unduly concern him.

Events after Mr Law was found

On the morning of Saturday 25th March 2017, a prisoner left his cell at approximately 08:45. When he passed Mr Law's cell he noticed that his milk carton was still above his door which he thought was unusual. He lifted the flap and saw Mr Law was not in his bed. He then saw Mr Law lying on the floor of his cell. He assumed Mr Law had taken another seizure and went to the grille to alert prison staff. The prisoner spoke to the Senior Officer and told him that Mr Law was lying on the floor of his cell and was unresponsive. The Senior Officer immediately requested the assistance of healthcare and drew keys to access Mr Law's cell.

Two officers initially went to Mr Law's cell where they found him lying face down on the floor. One officer checked Mr Law to see if he could find a pulse but he could not. He noted that Mr Law was cold to the touch. The officers secured the cell and awaited the arrival of healthcare staff. At 08:56 two nurses entered Mr Law's cell. The nurses examined Mr Law and found no breath or heart sounds. CPR was not attempted as their clinical observations indicated he had been dead for some time.

Paramedics arrived at approximately 09:30 and confirmed the nurses' assessment and resuscitation was not attempted.

Contact with Mr Law's family

Mr Law's next of kin was informed of his death by the police at 10:16 on 25th March 2017.

The then Prisoner Ombudsman met with Mr Law's family and their legal representative on 24th April 2017. A significant bundle of papers were provided to the investigation which gave an insight into Mr Law's medical conditions and included assessments conducted by experts during his court case. The family expressed concern about particular aspects of Mr Law's management during the period from January to May 2016 and a number of key questions emerged from the meeting. These included if the medical records provided at court had transferred from Maghaberry to Magilligan prisons, the nature of the care and treatment Mr Law received in Magilligan prison, why he was in a single cell at the time of his death and other matters relating to a temporary release application and an incident which took place in healthcare during which he was restrained and removed from the area by prison staff.

In the days following Mr Law's death a Senior Officer maintained contact with the next of kin and facilitated a visit to the House Block for them. The family appreciated the support offered by this officer and spoke highly of her.

Support for prisoners and staff

A hot debrief was conducted at 14:30 on 25th March 2017 and was chaired by the Duty Governor. The meeting was attended by those who had first responded to Mr Law being found unresponsive including one of the nurses and those who had been involved thereafter. Apart from difficulty in contacting the Ombudsman Duty Officer to notify them of the death, no issues were identified in terms of the management of the incident and the support provided to prisoners and staff is documented.

The cold debrief took place on 19 April 2017 and was chaired by the same Governor who chaired the hot debrief. On this occasion there were only three attendees (including the Chair). No further issues other than those identified at the cold debrief were identified.

Post mortem report

A post mortem examination was conducted on 27th March 2017 and a report of the autopsy was shared with the Prisoner Ombudsman in September 2017. The pathologist found that the cause of death was Cardiomegaly and Coronary Artery Atheroma. Significant enlargement and dilatation of the heart was found. The pathologist reported that such was the severity of the coronary artery atheroma and cardiomegaly that Mr Law's sudden death from a heart attack could have occurred at any time.

Given Mr Law's diagnosis of non-epileptic seizures, a detailed examination was conducted of the brain by a neuropathologist. No significant neuropathological finding which could account for Mr Law's apparent seizures or his death was found.

No alcohol was detected in Mr Law's blood. Medications consistent with therapeutic use were detected.

Findings

Clinical care

In line with Root Cause Analysis processes, the Clinical Reviewer considered the National Patient Safety Agency Classification Framework with regards to causal and influencing factors relating to the cause of death. She concluded: 'Mr Law was an overweight man who was encouraged by both the Healthcare and Prison team to increase his physical activity. Despite this encouragement, Mr. Law chose not to attend exercise and the gym. Throughout his stay in Prison he had numerous blood tests and physical observations, which were all, recorded as within normal limitations and did not indicate that he was suffering with high blood pressure, high cholesterol or diabetes all of which could indicate coronary heart disease.

The Reviewer was satisfied that the care which Mr Law received in prison was equivalent and, at times, better than the care which he would have received in the community when assessed against national guidelines and protocols.

Resuscitation

The Clinical Reviewer was satisfied that the decision not to commence CPR was appropriate as there were signs of irreversible death.

Good practice

Ms Walsh identified a number of areas of good practice in the care provided to Mr Law while in Maghaberry and Magilligan prisons. She highlighted the following:

- The committal healthcare assessment (Maghaberry);
- The information sharing between prison and healthcare (in Maghaberry prison) after Mr Law's committal and a subsequent e mail sent by a Governor assisted staff to manage a complicated presentation and provide continuity of care;
- Access to mental health services was timely and consistent and she particularly highlighted the work of a mental health nurse at Magilligan prison who provided ongoing support and assessment of Mr Law.

Questions raised by Mr Law's family

Mr Law's family raised a number of concerns following his death. A number of matters were also raised with the Prison Service by his legal representative during the time Mr Law was in prison.

Transfer of medical records

The Clinical Reviewer found references made by both the Healthcare team within the medical records and the Prison Service within the SPAR process that the health records, which were sent to the Prison by Mr Law's legal team, were in fact received. There was further evidence that the information was shared again on the 7th March 2016 when Mr Law's legal team provided a fax copy of all of the medical reports, which were presented at court 6 months previously. Ms Walsh stated that at an appropriate point a reconciliation of the records provided to the prison should have been undertaken in order to obtain as much relevant information about his needs as possible.

Care and treatment Mr Law received in Magilligan prison and Incident in prison healthcare

The Clinical Reviewer was satisfied with the healthcare and treatment provided to Mr Law. His family queried whether Mr Law's seizures were regarded as genuine by those who cared for him. Mr Law also raised a number of complaints himself about staff (prison and nursing) and harassment from other prisoners but these were all closed at Stage 1 following discussion with him. The records indicate that prison staff were aware of his seizures and nursing staff responded to each incident. The clinical reviewer identified one isolated query in the prison healthcare records querying if his seizures were genuine but she was satisfied this was not reflected at any other time in the records. The Reviewer highlighted that the management of Mr Law's seizures was '*clearly challenging*' given their unusual presentation and difficulty in determining the nature of them.

The Clinical Reviewer reviewed the records available of the control and restraint incident on 31st May 2016. She concluded there was no clear rationale for the reason to remove Mr Law under Control and Restraint given his history which, by that time, was known to staff. She felt this action was excessive but appeared to be an isolated incident.

Single cell

At the time of Mr Law's death he was located in a single cell on H2 A&B. The Clinical Reviewer said the review of Mr Law's health records revealed a conflict between the healthcare team's assessment of safety and his individual requests to be located in a single cell. Mr Law had a clear preference to be accommodated in a single cell on H2 A&B landing. Although the Prison Service is responsible for cell moves, their decisions were informed by advice received from healthcare staff about the risks associated with Mr Law being accommodated in a single cell. On numerous occasions healthcare provided advice to prison managers about the risks pertaining to Mr Law being accommodated in a single cell and there was evidence in the healthcare records of this rationale being discussed with Mr Law. An examination of the cell location history indicated a mix of reasons for the cell moves (24) during the time he was in Magilligan. These included risks of self-harm, seizures and bullying, as well as, Mr Law's unsuitability for the particular regime in certain locations. Prison managers attempted to settle Mr Law in a number of locations and with different cell mates but these moves broke down for a variety of reasons.

Based on the papers she reviewed the Clinical Reviewer's opinion was that the allocation of Mr Law to a single cell was a balanced and appropriate decision.

Temporary release application

Mr Law's family were concerned that he was stressed over a home leave application in the days before his death. His home leave eligibility date was 18th March 2017 and he submitted an application which was considered at a Home Leave Board on 6th February 2017. His application was deferred pending an Understanding the Needs of Children in Northern Ireland (UNOCINI) application being completed. The status of Mr Law's application had been explained to him on several occasions but he was concerned that he would not be found suitable.

Other observations

When the alarm was raised that Mr Law was unresponsive in his cell, 14 hours had elapsed since he was last checked by prison staff. A headcount was conducted by day staff at 18:45 on 24th March 2017 before they went off duty. No night guard checks are routinely completed on H2 A&B given the designation of this location as a low supervision wing but two night guard officers are on duty in the House and were available to respond to any unusual activity including medical emergencies. A further headcount had not taken place on the morning of 25th March 2017 prior to Mr Law being found shortly before 09:00. As it appears Mr Law had been dead for

some time an earlier check would have resulted in him being found earlier but would not have altered the outcome in this case.

Recommendation 1
Headcounts: The Governor should ensure that the required headcounts are conducted.

The NIPS advised that a Governor's Order was issued in December 2018 which addressed this recommendation.

It seems most likely that Mr Law was taken unwell around 04:00 but he was not found until just under five hours later. In Mr Law's case, although his risk of seizures was well known, there was no diagnosis of a cardiac problem or imminent health risk. The prison would have preferred for him to share a cell which potentially would have allowed for the alarm to be raised sooner but it was his clear preference to be in a single cell and, he had been issued with an additional mattress to mitigate the risk of injury if he fell during a seizure. He did not alert other prisoners or staff to feeling unwell before he collapsed. A number of staff in H2A&B documented concern about Mr Law being accommodated on a low supervision unit and this appears mainly to relate to his demands on staff time rather than his medical needs.

There is potentially a broader issue, given the complex needs of some of those accommodated on H2 A&B, of a delay in someone receiving appropriate treatment if they took unwell on this landing. There is clearly a delicate balance to ensure that obtrusive checks at night are kept to a minimum with the need to provide assurance that the risks posed by those in the care of the prison are appropriately managed. A range of additional safeguarding mechanisms are in place during periods of lock up to reflect the type of prisoners living on H2 A&B. These include: the selection of prisoners for the landing, an assessment of their suitability for the H2A&B community and compliance with the compact; availability of designated peer carers and fire assists; adoption of additional means of raising the alarm in a medical emergency. Personal wrist alarms which alert someone nearby are routinely issued on the landing, and more recently eight cells have been fitted with emergency touch strips which connect to the landing's control room (pod). The advanced care room is fitted with an emergency pull cord. The latter two measures are specifically designed for those who would have difficulty reaching the normal cell alarm point.

The current Governor is satisfied that he has reasonable and proportionate measures in place to mitigate the risk of delay in someone receiving timely medical attention on H2A&B during the night period. It is important that given the needs of the population on this landing that the Governor keeps this matter under review.

A review of Mr Law's prison records indicated that he had difficulty adjusting to prison life and at times presented challenges to prison managers in terms of how and where best to accommodate his specific needs - particularly during the early period of his transfer to Magilligan prison. It is not clear from the records whether the advice to staff provided by a Governor in Maghaberry as to how best to manage Mr Law was shared with Magilligan nor whether any similar formulation for his management was developed while he was in Magilligan. This was an example of good practice developed to assist staff in Maghaberry and would have been beneficial to share with Magilligan in order to provide continuity of approach and care.

Recommendation 2
Inter-prison transfers: The Prison Service should ensure that all relevant information pertaining to the continuity of care of a prisoner should be recorded on PRISM and made available to the receiving prison.

As noted in the clinical review a mental health nurse played a pivotal role in coordinating the care provided to Mr Law.

Support for prisoners and staff

Standard 25 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody.

The hot debrief should take place as soon after the incident as possible and involve all the staff (where possible) who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

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

The cold debrief meeting in this case was poorly attended despite already having been rescheduled due to the unavailability of key staff. The record of this meeting does not provide a sufficiently detailed insight into the issues covered. The hot debrief meeting was better attended and documented the post incident support provided to both inmates and staff.

Recommendations relating to various aspects of these debrief meetings have been made to and accepted by the Prison Service in previous investigation reports and the Prison Service reported that considerable progress has been made in this area in the two years since Mr Law's death.

Debrief meetings are an important mechanism to review the circumstances surrounding a serious incident and present an opportunity to reflect on opportunities for potential learning. Despite the actions taken by the Prison Service in response to previous recommendations, the records provided in this instance do not provide sufficient assurance that the opportunity for learning from this case was optimised in accordance with the Prison Service policy intention.

Recommendation 3
Debriefs: The Governor should ensure that effective hot and cold debrief meetings are conducted following a death in custody.

CONCLUSIONS

1. The circumstances and events leading up to Mr Law's death on 25th March 2017 were established during the course of this investigation. This included an examination of the care provided by both the Prison Service and the Trust. The latter was informed by the independent clinical review commissioned in this case.

2. No changes to operational methods or policy by either the Prison Service or the Trust were identified that may prevent a similar death in future.

3. The concerns raised by Mr Law's family mainly related to issues not connected with the cause of his death. Although outside the scope of our investigation, we attempted, where possible, to provide explanations to Mr Law's family on these matters in the course of this investigation.

4. Three areas of good practice were identified by the clinical reviewer and endorsed by the Prisoner Ombudsman.

5. Three learning points for service improvement were identified for the Prison Service in relation to headcounts, post incident learning and continuity of care when a prisoner transfers from Maghaberry to Magilligan.

As Mr Law appears to have died from coronary problems, I am satisfied none of these matters directly contributed to Mr Law's death.