The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INDEPENDENT INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR WILLIAM (BILLY) PURDY

AGED 65
WHILE IN THE CARE OF
MAGHABERRY PRISON
ON 19 APRIL 2022

Date finalised: **30 May 2025**

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Foreword from the Prisoner Ombudsman

When a death occurs in prison it is particularly challenging for families who have limited interactions with their loved ones prior to their death.

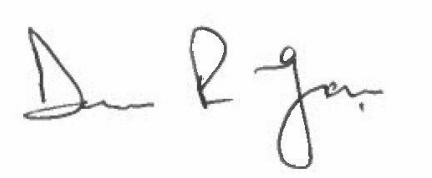
Mr William (Billy) Purdy was 65 years old and had been in custody since 20 August 2021 awaiting trial. On Friday 15 April 2022, Mr Purdy suffered a stroke in hospital and passed away on Tuesday 19 April 2022.

A Clinical Reviewer was commissioned to consider the healthcare Mr Purdy received while in custody. The Clinical Reviewer's report included areas of good practice and confirmed the provision of care to Mr Purdy was thorough and closely aligned with the standards he would have received outside of the custodial environment

The findings made in this report, together with good practice identified, will inform those who provide care to prisoners and I hope will bring some comfort and confidence to those who have family members in custody.

I have made no recommendations to the Northern Ireland Prison Service or the Trust.

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



Darrin Jones
Prisoner Ombudsman for Northern Ireland
30 May 2025

The role of the Prisoner Ombudsman

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

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

The purpose of the Ombudsman's investigation is to find out, as far as possible, what happened and why; establish whether there are any lessons to be learned; assist the Coroner's investigative obligations under Article 2 of the European Convention on Human Rights and make recommendations to NIPS and the South Eastern Health and Social Care Trust (the Trust) for improvement where appropriate.

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

Investigation objectives are set out in the Ombudsman's Terms of Reference on our website at www.niprisonerombudsman.com/index.php/publications and are further tailored to each independent investigation into deaths in custody to:

- establish the circumstances and events surrounding the death, including the care provided by NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the Trust;
- examine whether any changes in NIPS or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure the deceased's family has an opportunity to raise any concerns they may have and take these into account in the investigation;
- identify commendable practice;

- highlight areas for improvement where applicable; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible 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.

In the interests of transparency, investigation reports are published on the Ombudsman's website. Reports are also circulated to those who provide services in prisons. This includes:

- Criminal Justice Inspection Northern Ireland (CJI);and
- Independent Monitoring Board (IMB).

More information about published reports from these organisations can be found at Appendix 2.

SECTION 1: Investigation Objectives

Mr Purdy died while in prison custody and as a result the Office of the Ombudsman is required to investigate and report on the circumstances surrounding his death.

1.1 The overall objectives for this investigation are to:

1.	establish the circumstances and events surrounding Mr Purdy's death on 19 April 2022, including the care provided by NIPS;
2.	examine whether the provision of healthcare services provided to Mr Purdy, including risk assessments, was at least equivalent to those he might have received in the community;
3.	examine the adequacy of Mr Purdy's healthcare including the recording of his wound management;
4.	consider the rationale regarding Mr Purdy attending Craigavon Area Hospital on 17 February 2022, not being admitted and then being admitted to the Lagan Valley Hospital (LVH) the next day;
5.	consider whether the personal care Mr Purdy received was adequate to his needs;
6.	consider the level of social care support provided in prison and if it was appropriate;
7.	assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights by ensuring as far as possible 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; and
8.	identify any learning for improvement and instances of good practice.

SECTION 2: Investigation methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This comprises examinations of prison records in relation to the deceased's life while in custody. This report is structured to detail the events and emergency response leading up to the death of Mr Purdy on 19 April 2022. Notices of the investigation into Mr Purdy's death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and IMB. This asks anyone who may have information to come forward and speak to the Ombudsman's Investigators.

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

2.1 Independent advice

After further consideration of the issues, independent professional advice was obtained from a Clinical Reviewer who is a registered Adult Nurse with extensive experience in Primary Care, Secondary Care and Health in Justice across both the NHS and private sector.

The Clinical Reviewer also contributes their expertise in the development and implementation of primary care, mental health and substance use programs at local, regional and national levels and has responsibility for national clinical leadership in resuscitation management and safeguarding.

The information and advice which informed the findings and conclusions are included within the body of this report. It must be noted the Clinical Reviewer provides advice only. It is then down to the discretion of the Prisoner Ombudsman, based on the overall context of the case, whether to include this advice or any recommendations.

SECTION 3: Summary

Mr Purdy was aged 65 years when he died at the Lagan Valley Hospital (LVH) on 19 April 2022. Mr Purdy had complex co-morbidities including type 2 Diabetes, Chronic Obstructive Pulmonary Disorder, Obesity, reduced mobility and was a smoker.

Mr Purdy was transferred to the LVH from Maghaberry Prison on 18 February 2022. This was due to his increased care needs and the lack of a dedicated care package being available to meet his needs while in custody. Mr Purdy remained in prison custody at the time of his death although he was not under the supervision of Prison Officers whilst in hospital.

The post mortem cause of death was Pneumonia due to Cerebral Infarction.

The clinical reviewer concluded, "*Mr Purdy received appropriate clinical care while he was in Maghaberry Prison and that a pro-active approach to his healthcare needs was taken*".

SECTION 4: Description of Key Events Surrounding Mr Purdy's Death

4.1 Maghaberry Prison

Maghaberry Prison is a high security prison that holds adult male sentenced and remand prisoners. From the NIPS's Operations report, the prison population at the time of Mr Purdy's transfer to LVH on 18 February 2022 was 963 and on his death was 954.

NIPS has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners.

Since 2008 the Trust has seen a diversification of professions and the range of services provided to prisoners. HiP is planned and delivered in line with primary care services in the community.

There is access to 24-hour primary healthcare emergency service in Maghaberry Prison.

4.2 Background information

Mr Purdy was committed to Maghaberry Prison on 20 August 2021 and was awaiting trial. He had three previous custodial periods during 2020 and 2021.

During Mr Purdy's last period in custody, he was in Maghaberry Prison for 65 days, with the remaining 177 days spent at various times as an inpatient in hospital.

- 29/08/21 – 30/09/21 Admitted to Craigavon Area Hospital;
- 30/09/21 – 23/12/21 Transferred to Lurgan Hospital;
- 23/12/21 – 17/02/22 In custody at Maghaberry Prison;
- 17/02/22 – Attended Craigavon Area Hospital but not admitted; and
- 18/02/22 – 19/04/22 Admitted to LVH.

During his time within both prison and hospital Mr Purdy's behaviour was complex to manage. He frequently self-neglected and refused to allow carers or healthcare workers to attend to his personal hygiene or clinical needs. There were instances when his behaviour of both verbal and physical aggression to carers and healthcare workers affected the ability of HiP staff to administer prescribed medication.

Despite these challenges, HiP and NIPS staff demonstrated perseverance in attempting to provide care within the constraints imposed by Mr Purdy's resistance. The barriers created by his refusal to participate in his care, coupled with his aggressive behaviour, undoubtedly limited the team's ability to maintain or improve his health. HiP staff endeavoured to create a safe environment for Mr Purdy, this included moving his bed to a safe position and placing crashmats at either side of his bed.

SECTION 5: Chronology of events Leading Up to Mr Purdy's Death

16/02/22	Concern raised by HiP nursing staff regarding level of care required to give to Mr Purdy as it was felt by HiP they are unable to manage his medical needs.
17/02/22	Mr Purdy was transferred to Craigavon Area Hospital, as Maghaberry Prison could not meet his medical needs. Medical professionals at Craigavon Area Hospital deemed there was no need for admission. Mr Purdy was returned to Maghaberry Prison.
18/02/22	Following a discussion with Dr A (LVH) Mr Purdy was transferred from Maghaberry Prison for admission to LVH while awaiting a care package.
20/02/22	Update provided by LVH: Mr Purdy remains difficult to provide for and is not eating at times or taking his prescribed medication. To remain in Medical Assessment Unit (MAU).
21/02/22	Call with Nurse from LVH informed Maghaberry Prison Mr Purdy is medically fit for discharge; however, Maghaberry Prison informed his needs could not be met in Maghaberry Prison without a care package so he remained in LVH.
06/03/22	Mr Purdy remains medically fit for discharge, settled, eating and drinking well. Awaiting care package to be able to be discharged from LVH.

15/04/22	MAU confirmed Mr Purdy had been refusing all medication for some time. There was a deterioration in his level of consciousness. CT scan with no formal report. NEWS[1] score 11. Mr Purdy's notes stated 'do not resuscitate'. Attempts were made to contact family members. Maghaberry Prison Governor informed of change.
15/04/22	NIPS staff withdraw, no longer required as per instructions from Governor B.
16/04/22	LVH update: no change to Mr Purdy's condition he remains unresponsive. Mr Purdy's family called by LVH and visited him the previous evening.
18/04/22	LVH update: Mr Purdy is terminally ill and in receipt of end-of-life care. Medical care is via IV access through which he is receiving fluids and antibiotics. Mr Purdy is not on syringe driver at this time and he remains comfortable with no change.
19/04/22 09:07 hours	LVH update: Mr Purdy is on end-of-life care receiving 15L oxygen therapy. His cannula remains intact and he is still receiving IV fluids and antibiotics. The Palliative Nurse is due on Wednesday 20 April to consider syringe driver.
19/04/22 19:28 hours	A telephone call was received by NIPS from the LVH to inform Mr Purdy had passed away in the LVH MAU where life had been pronounced extinct at 18:30.

[1] MEWS – Modified Early Warning Score is a system for scoring the physiological measurements that are routinely recorded at a patient's bedside with the purpose of identifying acutely ill patients.

SECTION 6. Hot and Cold Debrief Meetings.

Standard 25 of NIPS 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 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.

As Mr Purdy died in the hospital environment these debriefs were not required.

Healthcare in Prison staff were offered support by Senior Healthcare in Prison staff including psychological services.

SECTION 7: Findings

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

Given the nature of Mr Purdy's death, the Clinical Reviewer was invited to comment on objectives relating to his clinical care.

7.1 Examine whether the provision of healthcare services provided to Mr Purdy, including risk assessments, and consider if those services were at least equivalent to those he might have received in the community.

The Clinical Reviewer stated the healthcare services provided to Mr Purdy while in custody *"appeared to be at least equivalent to those he may have received in the community and in certain aspects far exceeded that which would be received within the community. Upon each of his committals, Mr Purdy underwent comprehensive screenings where his past medical history, mobility and medications were recorded. Medicine risk assessments were also completed..."*

"Care plans were detailed with clear objectives, indicating the provision of care was thorough and closely aligned with the standards he would have received outside of the custodial environment."

7.2 Examine the adequacy of Mr Purdy's healthcare including the recording of his wounds.

The Clinical Reviewer reported *"the adequacy of Mr Purdy's healthcare, including the recording of his wounds, appeared to have been generally appropriate though there were challenges due to his non-compliance. The BRADEN[2] scale was used to assess Mr Purdy's pressure ulcer risk and skin assessments were documented. The nurses demonstrated a solid knowledge*

[2] The Braden scale is a scale that measures the risk of developing pressure ulcers. The scale consists of six subscales that reflect determinants of pressure (sensory perception, activity and mobility) and factors influencing tissue tolerance (moisture, nutrition and friction and shear).

base in making these assessments and maintaining records. They also highlighted within their record keeping the risks they identified such as incontinence and lack of re-positioning appropriately.

Inconsistencies in reassessing Mr Purdy's pressure ulcers were noted, primarily due to his refusal to co-operate during these checks. Despite this HiP staff made every effort to offer assistance with repositioning Mr Purdy though these offers were often declined. They also attempted to educate Mr Purdy on the risks of damage from immobility. Other areas of pressure management were also addressed, such as a cushion to relieve pressure between his knees.

The categorisation of Mr Purdy's pressure ulcers and wound sizes were recorded to monitor any changes over time.

Additionally, Analgesia[3] was prescribed to help manage pain during wound care appointments; however, Mr Purdy often declined this. Overall, while there were some limitations due to Mr Purdy's refusal of care, HiP staff made consistent efforts to manage and record his wounds appropriately".

7.3 Consider the rationale regarding Mr Purdy attending Craigavon Area Hospital on 17 February 2022 and not being admitted and then being admitted to LVH the next day.

The Clinical Reviewer reported *"Mr Purdy was initially sent to Craigavon Area Hospital from Maghaberry Prison due to several escalating concerns around his health and well-being. He had been consistently refusing to take his prescribed medications, raising significant worries about the management of his chronic conditions.*

Mr Purdy required a high level of nursing care; however, there was no longer any dedicated provision for a care package in place to meet these needs. The previous care package ceased on 14 January 2022 as a result of Mr Purdy's

[3] Analgesia - medication that acts to relieve pain

verbal and physical behaviour, there were also difficulties sourcing a new package of care due to regional shortages of domiciliary care. Mr Purdy had also been placing himself on a mattress on the floor, further complicating his care. His skin had broken down and he persistently refused regular monitoring and dressing changes which hindered the proper care management of his wounds. These factors combined to create a situation where HiP staff at Maghaberry Prison felt a hospital intervention was required".

Upon investigation HiP documentation showed staff had provided crash mattresses either side of the bed, moved Mr Purdy's bed to a safer location and lowered the bed height to lessen injury that may be experienced.

The Clinical Reviewer went on to say: *"Following transfer to Craigavon Area Hospital and a clinical assessment by healthcare professionals, no medical reason for hospital admission was identified. Mr Purdy was then returned to Maghaberry Prison. The decision not to admit Mr Purdy was based on healthcare staff identifying no acute issues that required clinical treatment within a hospital setting. From an acute perspective, this decision was reasoned within medical records; however, this did not resolve the demand on nursing resources required to adequately provide Mr Purdy's care in the prison setting. This review identified HiP nursing staff concerns relating to the standard and quality of care Mr Purdy should have received. This could no longer be met in the prison setting without a dedicated care package being in place. This care package should be equivalent to that in a community setting. Unfortunately as previously stated this was ceased by the care provider with immediate effect due to Mr Purdy's verbal and physical behaviours.*

Following further discussion by the HiP team, Mr Purdy was referred to the LVH the following day. The concerns and risks relating to his lack of nutritional intake and management of pressure damage continued to be a clinical risk the HiP team felt they could not manage within the custodial setting. This appears to be a reasonable decision based on the available evidence".

For the Clinical Reviewer one of the main areas that continued to influence decision-making was the higher demand for personal care and Mr Purdy's lack of engagement. NIPS and HiP were experiencing significant challenges in trying to meet Mr Purdy's needs. An acute hospital setting would have been equally challenged.

7.4 Consider whether the personal care Mr Purdy received was adequate for his needs.

The Clinical Reviewer found: *"Mr Purdy's personal care needs were identified and HiP staff understood both his capabilities and his unwillingness to participate in his own personal care. Care plans were in place to encourage and support Mr Purdy with his daily living activities and assessments conducted post-discharge for carers to follow.*
HiP staff were responsive to Mr Purdy's engagement, offering opportunities for him to shower instead of washing in bed and attended to his hygiene needs when he was incontinent. Despite frequent efforts by staff to keep him clean, change his clothes and freshen his bed, Mr Purdy often resisted, sometimes becoming verbally and physically aggressive. Nevertheless, the care offered appeared suitable to meet Mr Purdy's personal care needs and was equitable to a community setting".

7.5 Consider the level of social care support provided in prison and if it was appropriate.

The Clinical Reviewer stated "The level of social care support arranged by the Trust of Origin for Mr Purdy in prison and delivered by the independent care providers was initially appropriate, as it mirrored the higher level of community care typically provided prior to a full-time nursing or care home placement. Upon discharge from hospital in December 2021, an assessment took place and Mr Purdy was given a care package of four visits per day for approximately two weeks. Following the cessation of services by the outside care providers in mid-January 2022 no further dedicated care package was provided due to a combination of behavioural issues along with regional shortages in domiciliary care.

Without a dedicated social care package, the strain on the healthcare system in the prison became apparent. Mr Purdy's medical records show that he could receive over five visits per day from HiP staff for issues such as falls, personal hygiene and general healthcare checks. These visits were in addition to regular clinical care, such as medication administration, wound assessments and interactions with NIPS staff.

Overall, while the initial social care support was appropriate, the sudden withdrawal of services and difficulties in securing a further package of care left a gap in Mr Purdy's care that placed significant pressure on HiP resources".

Although Mr Purdy's additional care package had been withdrawn, HiP filled the care gap notwithstanding the impact on HiP Resources.

SECTION 8: Conclusions

With regard to my responsibilities to investigate Mr Purdy's death and specifically considering the objectives of the investigation, I have drawn the following conclusions:

The investigation established the circumstances and events leading up to Mr Purdy's death on 19 April 2022. I am satisfied that overall NIPS provided appropriate care to Mr Purdy.

I accept the opinion of the Clinical Reviewer that Mr Purdy received appropriate care from the Trust. This is especially admirable taking into account the difficulties surrounding the care of Mr Purdy due to his limitations of poor compliance and refusal of care at times. The Clinical Reviewer noted several examples of good practice.

It is to be noted where assistance with activities of daily living may be required for a patient in prison, HiP clinical staff (including nursing, Occupational Therapy, Physiotherapy and Speech and Language Therapy) undertake appropriate assessments. These assessments are provided to the "trust of origin" care manager who ascertain the level of package of care that is required and liaise with an independent community care provider to arrange the appropriate package of care. The "trust of origin" will also have responsibility for the payment, oversight and governance of these packages, as they would within the community. As the model of commissioning of these services by the Department of Health is unclear and given the challenges of delivering social care in a secure environment, there are often delays in these being arranged. I intend to raise this issue with the Minister of Health and the Minister of Justice.

SECTION 9: Good Practices

Several examples of good practice were identified during the provision of care to Mr Purdy.

Joined-Up Responses: There was clear collaboration between NIPS and HiP staff, particularly in managing Mr Purdy's fall risk and encouraging his engagement with daily living activities. This integrated approach helped in understanding Mr Purdy's needs and plans were effectively identified to address these.

Access and collaborative working: The NIPS Governor acted swiftly to ensure that when a care package was identified, timely access would be granted for any carer's who needed to attend Maghaberry Prison.

Occupational Therapy Engagement: The Occupational Therapy team made commendable efforts to engage with Mr Purdy recognising that building a therapeutic relationship was crucial before setting meaningful goals. Their multi-disciplinary approach, conducting joint assessments with other professionals like physiotherapists, was a further example of patient-centred care.

Medicines Reconciliation: Following Mr Purdy's discharges, the HiP team ensured a medicines reconciliation process was followed, confirming the correct prescriptions were in place. This practice ensured continuity of care and staff had access to the medications needed for administration.

Tissue Viability Nursing (TVN) Services: Engagement with TVN services for the management of Mr Purdy's grade/category 1 and 2 wounds reflected the team's commitment to timely accessing specialist expertise and providing responsive wound care.

Appendix 1

GLOSSARY

CJI	Criminal Justice Inspection Northern Ireland
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
IV	Intravenous
LVH	Lagan Valley Hospital
MAU	Medical Assessment Unit
MEWS	Modified Early Warning Score
NIPS	Northern Ireland Prison Service
SEHSCT/Trust	South Eastern Health and Social Care Trust

Appendix 2

Criminal Justice Inspection Northern Ireland (CJI)

At the time of Mr Purdy's death, the most recent inspection of Maghaberry Prison by the CJI had taken place in April 2018 and the report published in November 2018. They noted health care provision was much improved and was now reasonably good. Partnership working between the SEHSCT and the prison had improved and included some joint training. A current health needs assessment and a recent mental health and substance use assessment were informing service development. Chronic disease management had improved. Work was under way to improve data capture to support chronic disease management. A diabetic clinic pilot project was providing successful outcomes for patients.

Prisoners said that there were no difficulties accessing secondary care. There were good network links with a range of SEHSCT and other Trusts' specialist teams who provided care to patients and advice and training to staff, for example in palliative care, diabetes, dermatology, genitor-urinary medicine, hematology, podiatry, ophthalmology and infection prevention control.

The report is available at CJINI - Criminal Justice Inspection Northern Ireland - Maghaberry Prison.

to addressing concerns. Recommendations made by the RQIA specifically address mental healthcare. The Ombudsman works with the RQIA and others to raise matters of concern and improve the delivery of support to prisoners.

Independent Monitoring Board

Maghaberry Prison has an IMB of volunteers whose role is to independently monitor the care and treatment of prisoners. From the 2021-2022 Maghaberry Prison LVH annual report the IMB state the South Eastern Health and Social Care Trust continues to provide a very professional and dedicated service within Maghaberry. At the heart of their provision of healthcare, there is an aim to ensure equality of care to everyone in the prison and to provide a comparable level of service with that provided in the

community. They observed that waiting times and medical intervention seemed to be equivalent to what is occurring within the community.

IMB Annual Reports can be viewed at Independent Monitoring Board (imb-ni.org.uk)