The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INDEPENDENT INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR THOMAS DAVIDSON

AGED 53
AT MAGHABERRY PRISON
ON 28 AUGUST 2021

Date finalised **16 June 2025**

Date published **22 August 2025**

Foreword from the Prisoner Ombudsman

Thomas Davidson was 53 years old. He was remanded into custody in Maghaberry Prison on 15th July 2021. This was his first time in a custodial setting. He died in prison on 28th August 2021.

This report aims to outline the treatment and care Mr Davidson received prior to his death and the circumstances leading up to it. The responsibility for the care and wellbeing of prisoners lies with the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust.

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

It is crucial any opportunities for learning are addressed and good practice is acknowledged and shared across the custodial environment. It is only through this process prisoners and their families can be assured of confidence in the prison system, the standard of medical care, the investigation itself and the operational independence of the Office of the Prisoner Ombudsman.

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

This report provides as much detail as possible about Mr Davidson's time in custody and the circumstances surrounding his death. I hope this information will be helpful to his family as they piece together the last days of his life.

Mr Davidson was a new committal detained during the Covid 19 pandemic (pandemic). The process for new committals was to complete a period of 14 days in quarantine in Foyle House Maghaberry Prison prior to being admitted into the wider prison establishment. The new measures adopted during the reception process, which applied to Mr Davidson, were to ensure the safety of prisoners and staff during the pandemic. On 29 July 2021 on completion of his 14 days in quarantine, Mr Davidson was moved to a single cell in Bann House. Given the extraordinary circumstances both

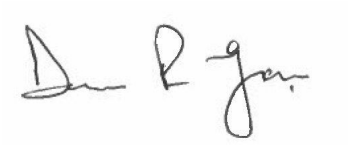
in general society and prison, it is important to acknowledge Mr Davidson faced isolation due to these measures which may have influenced his wellbeing. This issue prompted questions from his family which are addressed later in this report. The procedures put in place by NIPS to mitigate the limitations caused by the Covid-19 arrangements are documented in Appendix 3.

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

On Saturday 28 August 2021 at 10:15 Mr Davidson was found unresponsive in his cell. Despite attempts, he could not be resuscitated and his life was recognised as extinct by a paramedic at 11:35.

I offer my condolences to Mr Davidson's family on their loss. I hope this report provides information to address questions they raised and explains events leading up to Thomas' death. I hope the learning and recommendations will also bring some comfort to those who have family members in custody.

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



Darrin Jones
Prisoner Ombudsman for Northern Ireland

The role of the Prisoner Ombudsman

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

The Prisoner Ombudsman (Ombudsman) is an independent appointment made by the Minister of Justice.

The purpose of the Ombudsman's investigation is to find out, as far as possible, what happened and why; establish whether there are any lessons to be learned; assist the Coroner's investigative obligations under Article 2 of the European Convention on Human Rights (ECHR)[1] and make recommendations to NIPS and the Trust for improvement where appropriate.

By highlighting learning to the Northen Ireland Prison Service (NIPS), the South Eastern Health and Social Care Trust (the Trust) and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

The Terms of Reference for our investigations are available at www.niprisonerombudsman.com/index.php/publications.

[1] "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
(c) in action lawfully taken for the purpose of quelling a riot or insurrection."

Investigation objectives are set out in the Ombudsman's Terms of Reference and are 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 Mr Davidsons 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 openness and transparency investigation reports are published on the Ombudsman's website. Reports are also disseminated to those who independently monitor services in prisons and the care and treatment of prisoners these include:

- Criminal Justice Inspection Northern Ireland (CJI);
- the Regulation and Quality Improvement Authority (RQIA); and
- Independent Monitoring Boards (IMBs).

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

SECTION 1: Investigation objectives

The objectives of this investigation included questions raised by Mr Davidson's family. They are to:

1.	provide a timeline of events surrounding the death of Mr Davidson, including a detailed timeline of his movements during the last week of his life;
2.	examine the healthcare provided to Mr Davidson by the Trust. Examine the care provided by NIPS and whether any of his human rights in relation to standards of accommodation, access to legal representation and family contact were impacted. Consider whether any changes would help prevent a similar death in the future. This will include taking account of measures in place due to the pandemic and to Mr Davidson's care generally;
3.	examine the adequacy of the induction process and how Mr Davidson was cared for using cell progression and consider whether any changes would help prevent a similar death in the future;
4.	examine the relationships around, and with, Mr Davidson and his family and consider whether improvements could be made to provide support in the future;
5.	examine the mental health assessments and support provided to Mr Davidson, including Supporting People At Risk Evolution (SPAR Evo)[2] given his experience of being quarantined due to the pandemic and being mindful this was his first time in custody;
6.	identify any relevant failings or learning and good practice for the future and highlight any lessons learned from the death of Mr Davidson; and
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

[2] Supporting People at Risk Evolution (SPAR Evo) was jointly developed by NIPS/SEHSCT in 2018 and, following a proof of concept between April and July 2018, went through several iterations until it was finally signed off by both organisations in April 2019. The approach is person-centred and aims to support people through a period of crisis or distress in a way that meets their needs.

brought to light and any relevant failing is exposed, any commendable practice is identified and any lessons from the death are learned.

SECTION 2: Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This comprises interviews with prison staff, prisoners, family and friends and examination of all prison records in relation to the deceased's life while in custody including (CCTV) footage, telephone calls and mail. This report is structured to detail the events and emergency response leading up to the death of Mr Davidson on 28 August 2021. Notices of the Ombudsman's investigation into Mr Davidson's death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and the Independent Monitoring Board (IMB). This allows anyone with information to come forward and speak to the Ombudsman's Investigators.

All of the information gathered was carefully examined and the relevant matters underpinning this report's findings have been detailed. This includes the sharing of reports concerning Mr Davidson's care from Healthcare in Prison (HiP).

2.1 Independent advice

After further consideration of the issues, independent professional advice from a Clinical Reviewer was obtained. The Clinical Reviewer is a registered Mental Health Nurse with over 20 years' experience, a fully accredited Advanced Nurse Practitioner and a registered Specialist Non-Medical Prescriber.

The Clinical Reviewer was previously employed as National Head of Nursing for the largest provider of prison healthcare services in England, overseeing Primary Care, Mental Health and Substance Misuse services in 48 English prisons encompassing prisoners in all categories.

The information and advice which informed the findings and conclusions are included at Section 8 of this report. It must be noted the Clinical Reviewer provides advice only. It is then down to my discretion, based on the overall context of the case, whether I include the advice within the recommendations for this report.

For each Death in Custody, the Trust declares a Serious Adverse Incident and carries out their own independent investigation.

2.2 Family Liaison

Liaison with the deceased's family is a very important aspect of the Ombudsman's role when investigating a death in custody. A meeting with Mr Davidson's family was held on 11 February 2022 to listen to their questions and concerns. These questions and concerns covered:-

- timeline of events and general care;
- committal;
- clothing and other personal items;
- family contact;
- relationships on the landing;
- treatment by Prison Officers;
- accommodation;
- access to legal support and court; and
- healthcare, wellbeing and management of the SPAR Evo.

Section 3: Summary of Mr Davidson's case

On 15 July 2021 Mr Davidson was remanded into the custody of Maghaberry Prison. This was Mr Davidson's first time in prison custody. On arrival at Maghaberry Prison Reception, NIPS staff interviewed Mr Davidson. He was medically assessed by Healthcare in Prison (HiP) Primary Care Nurse (PCN) A, the assessment concluded Mr Davidson to be 'at risk' due to suicidal thoughts. For his own safety Mr Davidson's needs were addressed under the SPAR Evo approach, placed in a safer cell with camera observation and given anti ligature clothing. This SPAR Evo care plan was regularly reviewed, with appropriate and proportionate mitigation in place until its closure on 10 August 2021.

On entering Maghaberry Prison Mr Davidson was initially placed in quarantine due to Covid-19 pandemic arrangements in Foyle House Landing 1 Cell 1. On 29 July 2021, after his period of quarantine was completed, he was relocated to Bann House Landing 2 Cell 12.

At approximately 10:15 on Saturday 28 August 2021 Prison Officer A found Mr Davidson unresponsive in his cell in Bann House. On entry Mr Davison was found with a ligature around his neck. Mr Davidson was lowered to the floor and Prison Officer B immediately commenced cardiopulmonary resuscitation (CPR). Mr Davidson could not be saved and recognition of life extinct was recorded at 11:35 by a paramedic.

At the time of his death Mr Davidson had been in custody for 44 days.

The cause of Mr Davidson's death stated in the Post Mortem report was Hanging.

SECTION 4: Background Information

4.1 Maghaberry Prison

Maghaberry Prison is a high security prison for both sentenced and on remand male adults and has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners in custody who are at risk of suicide or self-harm.

There is also a 24-hour primary healthcare service in Maghaberry Prison. The Mental Health Team (MHT) was on site Monday to Friday between 08:00 and 17:00 at the time of Mr Davidson's death.

Both the Trust and NIPS have undertaken a review of the SPAR Evo process to improve risk management.

From October 2020 all mental health committal screen triaging is completed face to face by a mental health practitioner. There are no in-patient beds. HiP is commissioned on a basis equivalent to a community service, and as such those prisoners who require transfer to an acute hospital or acute psychiatric facility are facilitated.

4.2 Previous incidents at Maghaberry Prison

Mr Davidson's death was one of two unrelated deaths in custody at Maghaberry Prison in 2021.

Section 5: The impact of the Covid 19 pandemic

The Ombudsman acknowledges the Covid management procedures NIPS introduced at the time of Mr Davidson's death at Appendix 3

5.1 Mr Davidson's committal during the pandemic 2021

Upon his committal to Maghaberry Prison on 15 July 2021 Mr Davidson was accommodated in Foyle House Quarantine Unit.

Prison Officers managed the cleaning and infection control within Foyle House. Prisoners were responsible for the cleanliness of their cell and while landing staff manage the deep cleaning of the cells between prisoners with the support of one [3]Orderly. This responsibility was in addition to running the House, including offering telephone calls and showers, responding to requests from prisoners, providing their meals to them in their cells, answering emergencies and all that goes with running prison landings. Responsibility for cleaning individual cells was that of the occupant and cleaning products were provided for this purpose.

5.2 Foyle House Maghaberry Prison during the Pandemic

In order to prevent widespread infection and outbreaks in prisons NIPS took an early decision to quarantine new committals. The purpose of quarantine was to act in keeping with the Article 2 Human Rights duty to protect life by reducing the risk of exposure. As a result, normal regime was suspended and longer period's in-cell were experienced across the general prison estate. In Foyle House, it meant that everyone was in their cells unless they were using the phone or the shower. Mr Davidson experienced this restricted regime in July 2021.

It was of the utmost importance to keep prisoners and staff safe during the pandemic and restrictions were only removed when it was safe to do so.

The 'Samaritans Phone' was available to those in Foyle House as on other landings and both NIPS and HiP staff were available for support. Distraction packs assisted with the longer days and nights alone in-cell and the opportunity to shower and use

[3] An Orderly is a trusted prisoner who assists other prisoners requiring additional assistance with tasks such as, fetching meals, and washing their clothes.

the telephone helped to break up the day. Time outside could not be facilitated in Foyle House largely due to the geography of Maghaberry Prison. There is no outside space easily accessible from Foyle House where prisoners held there could move to without considerable management and staff attention. In the interests of providing a balanced regime across the prison, moving anyone a distance within the prison establishment was not permitted. These factors resulted in the decision that there would be no provision of outside exercise. Most cells in Foyle House had a radio or TV, some cells did not and these were used for the first few days only when a prisoner arrived into custody.

Throughout the pandemic, and at the time of Mr Davidson's death, NIPS worked in collaboration with the Trust and the Public Health Agency (PHA) to contain the spread of the Covid-19 virus. They had a responsibility, a positive ECHR Article 2 duty, to keep those residing and working in prisons safe. At the same time, they had to balance prevention and containment with maintaining standards for the care and rehabilitation of prisoners.

Quarantine periods limited opportunities for time out of cell and a reduction in meaningful human contact was very difficult for some prisoners including those with mental health, alcohol dependency and substance use issues.

Section 6: Chronology of events leading up to Mr Davidson's death.

6.1 Committal Maghaberry Prison Thursday 15 July 2021

The Police Custody Medical Form attached to Mr Davidson's records at committal stated he had wounds and dressings and at this time he stated he had no suicidal ideation or Thoughts of Life Not Worth Living (TLNWL). A Western Health and Social Care Trust letter attached to his records stated he attended the Emergency Department on 12 July 2021 with a stab wound to his chest and both wrists sutured. His wounds were assessed on 13 July 2021 and the sutures removed on 19 July 2021 whilst in prison.

Mr Davidson was remanded and committed to Maghaberry Prison for the first time on 15 July 2021. PCN A saw him for his initial nursing assessment. Records show Mr Davidson had recently self-harmed. He stated he could not keep himself safe with on-going thoughts of self-harm. PCN A recommended a safer cell with camera observation for Mr Davidson and for him to wear anti-ligature clothing. Before entering custody Mr Davidson had no contact with community mental health services; however, he had seen his General Practitioner (GP) in respect of stress. Mr Davidson denied any alcohol or drug issues. He also had a diagnosis of arthritis and eczema.

All appropriate committal welfare checks were carried out as per NIPS policy.

Upon committal Mr Davidson was located in Foyle House Maghaberry Prison, Following his committal medical triage assessment which recorded "Thoughts of deliberate self-harm, states he cannot keep himself safe, is very tearful and emotional on committal….. I have advised a safe cell under camera observations, in anti ligature clothing". Mr Davidson was moved to the Care and Supervision Unit where he stayed until the next day.

Maghaberry Prison Friday 16 July – 28 August 2021

On the afternoon of 16 July Mr Davidson briefly moved back to Foyle House. Mental Health Nurse (MHN) A saw Mr Davidson for a face-to-face mental health triage on 16 July. Mr Davidson "presented as physically tired and exhausted" and it was recommended Mr Davidson remain in a safer cell "until such times that he adjusts to being in custody and gives staff monitoring him via the SPAR process assurances regarding his ability to remain safe within custody". Mr Davidson stated he had been prescribed citalopram[4] previously for anxiety/low mood; however, he was not compliant with this medication, as he did not think it worked. Mr Davidson received advice on how to access support if he was not coping. Documentation notes the MHT via the SPAR-Evo care plan would support him. MHN A recorded Mr Davidson would receive a routine mental health assessment and this could be upgraded to urgent if his risk behavior escalated.

Primary Care Deputy Charge Nurse PCN B carried out a comprehensive nursing assessment for Mr Davidson on the afternoon of the 16 July . Records show Mr Davidson engaged well with this assessment. Later that day Mr Davidson attended a SPAR-Evo review with MHN B. He was described as being 'quite flat and blunt' and when asked about further self-harm/suicidal ideation Mr Davidson replied, "*I just don't know what to think*". It was agreed Mr Davidson's SPAR-Evo should remain in place.

On 17 July PCN C attended the Care and Supervision Unit (CSU) and administered Mr Davidson's medication. Records show Mr Davidson appeared to be flat in his mood but compliant with his medication; it further stated he conversed *to simple commands*. Mr Davidson was assessed and a SPAR-Evo took place later that day. Mental Health Occupational Therapist A (MHOT) attended. Mr Davidson was described as *engaging in minimal discussions and had long pauses before he answered questions.* Mr Davidson struggled to answer questions in respect to thoughts or plans to harm himself. He said he did not know if he wanted to be alive. It was agreed there should

[4] **Citalopram:** an antidepressant in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance. Citalopram is commonly used to treat depression.

be no change to his SPAR-Evo and the fifteen-minute observations and anti-ligature clothing would remain in place. Records show Mr Davidson was offered a committal telephone call several times and declined all offers.

On the 18 July Mr Davidsons SPAR-Evo review took place attended by MHN B. Mr Davidson got up from his bed when staff entered his cell. During interactions he was described as being 'flat, blunt and unreactive'. Mr Davidson said he did not know what to think and his head was "*all over the place*". When asked about thoughts/plans of self-harm or suicide Mr Davidson remained silent. NIPS encouraged Mr Davidson to engage with his family as they had been telephoning asking about his well-being which he agreed to do. Mr Davidson remained in anti-ligature clothing in a safer cell under fifteen-minute observations.

On the 19 July PCN D saw Mr Davidson and described him as having a low mood with minimal eye contact. They had no concerns in relation to his physical health. Later that day MHOT B attended Mr Davidson's SPAR-Evo review. When they entered Mr Davidson's cell he was lying on his bed and sat up to speak to staff. When asked how he was feeling Mr Davidson said, "*I just don't want to be here*". From the HiP notes when asked if he meant he did not want to live anymore records show he replied that, "He did not know"; however, Mr Davidson said he had no plans to end his life but could not guarantee his own safety. He was given encouragement by staff to engage with his family. Mr Davidsons SPAR-Evo care plan remained unchanged and he returned to Foyle House.

On the 20 July MHN D attended Mr Davidsons SPAR-Evo review. Records show Mr Davidson reported he was feeling okay and he had not yet been able to speak to his family. He denied any thoughts or plans or any intent to self-harm. The potential detrimental effects of being in a safer cell were discussed. Those in attendance agreed Mr Davidson could move from the safer cell and out of anti-ligature clothing; however, he would remain on thirty-minute observations.

Mr Davidson was due to attend a 30-minute virtual family visit on 22 July however, it is recorded he did not attend although no reason is given. On the 22 July MHN E attended Mr Davidson's SPAR-Evo review. Prison Staff reported Mr Davidson was more engaging and appeared to be a bit brighter. When he was spoken to Mr Davidson

was emotional and records show he stated, “he could not believe he was in prison”. He admitted to having fleeting TLNWL however denied any plans or thoughts of ending his life. Mr Davidson stated his family were his protective factors. He assured those present at the SPAR-Evo that he would seek help in a crisis and would use his cell bell if suicidal. It was agreed Mr Davidson’s SPAR-Evo would remain in place and his observations would change to hourly.

On 23 July Mental Health Peer Support Worker (PSW) 1 met with Mr Davidson in an attempt to alleviate any concerns he may have had regarding his custodial environment. They reported Mr Davidson was in shock and was emotional. PSW 1 answered questions Mr Davidson had concerning the prison. Mr Davidson also disclosed to PSW1 he had no motivation to do anything at that time. Records show Mr Davidson had been in contact with his family and he was concerned for them. He declined a referral to NIACRO[5].

Mr Davidson made a telephone call on 25 July.

On 26 July MHN B attended Mr Davidson’s SPAR-Evo review. They recorded Mr Davidson was more reactive and brighter than when they last reviewed him. They said he was settling into the prison environment. Mr Davidson had been in contact with his family and remained concerned for them. He denied any current thoughts or plans of self-harm or suicide. When asked about his future he stated, “*I don’t know*”. By agreement Mr Davidson’s SPAR-Evo remained unchanged.

Mr Davidson was due a 30-minute virtual family visit on 28 July which it is recorded he did not attend; however, the records show he had a telephone call.

On 29 July MHOT A attended Mr Davidson’s SPAR-Evo review. Mr Davidson engaged well during this review. He was keen to arrange a visit for a family member’s birthday. Mr Davidson denied any thoughts of self-harm or suicide. It was agreed he would be referred to the PSST. Mr Davidson’s SPAR-Evo was closed on his removal from Foyle House. A new SPAR Evo was opened following his resettlement to Bann House later the same day.

[5] NIACRO – (Northern Ireland Association for the Care and Resettlement of Offenders) is a voluntary agency and registered charity providing services and policy comment within the Criminal Justice System.

On 30 July Mr Davidson attended a 29-minute virtual family visit. A concern was raised by HiP. Mr Davidson had become tearful on talking to NIPS staff. A note by the Prisoner Development Unit stated '*staff have been very helpful and stated that he was upset as today is his child's first birthday'.* This comment was made to Senior Officer A. MHOT A attended Mr Davidson's SPAR Evo review. In order to support Mr Davidson he was on 60 minute observations. His next review was planned for 5 August.

PSW 1 met with Mr Davidson on 2 August to ascertain how he was coming to terms with being in custody. They found Mr Davidson to be quiet, 'flat and blunted'. They reported he continued to have no interest in anything and he did not turn on the television. PSW 1 noted Mr Davidson appeared to spend his day ruminating with intermittent sleeping. They recorded Mr Davidson did not wish to see the GP to consider having anti-depressants prescribed. Throughout his detention, Mr Davidson is deemed to have capacity. He stated he did not need a SPAR Evo plan and he was finding input from the Prison Family Officer supportive. He also cited his child and family as protective factors.

Mr Davidson attended a 59 minute virtual visit on 4 August with his legal representative.

MHOT A attended Mr Davidson's SPAR Evo review on 5 August. Mr Davidson expressed on-going feelings of low mood but denied thoughts of self-harm or plans to end his life. By agreement, there was no change to the current SPAR Evo care plan.

Mr Davidson attended a 29 minute virtual family visit on 7 August.

Mr Davidson was relocated to Bann 3 Cell 6 on 9 August. PSW 1 met with Mr Davidson. When asked if he found benefit in the visits he stated there was a lot to think about and get used to before he could fully engage. PSW 1 advised Mr Davidson he could be referred back to the Mental Health peer support service when he felt ready.

Mr Davidson was due a 30 minute virtual family visit on 10 August; however, he did not attend. MHOT B attended Mr Davidson's SPA Evo review. Mr Davidson reported being more settled denying any current TLNWL or self-harm. He spoke of family contact and said he was still experiencing anxiety due to being in prison and the

circumstances regarding same. He feels more able to manage and knows to inform staff if he requires assistance. Mr Davidson confirmed he could keep himself safe at present. It was agreed the SPAR Evo care plan could close; however, it could be re-opened if concerns returned.

Mr Davidson attended a 1-hour virtual visit with his legal representative on 11 August.

Mr Davidson attended a 29-minute virtual family visit on 13 August and attended a 1 hour face-to-face domestic visit on 18 August.

On 25 August Mr Davidson was relocated to Bann House Landing 6 Cell 7.

Mr Davidson attended a 29 minute virtual family visit on 27 August.

28 August 2021

Mr Davidson was last seen alive on 28 August at approximately 09:15 when Prison Officer A asked him if he wanted a flask of hot water.

At approximately 10:15 offers of telephone calls commenced on Bann House 6. The third cell door opened by NIPS staff was Mr Davidson's and he was found unresponsive, suspended by a ligature from the top bunk of the bed.

HiP staff were tasked, PCN E and PCN I immediately attended the scene and requested NIPS to summon help from other healthcare staff and to call an ambulance. This was the policy in place in 2021 however; a new standard operating procedure is to be agreed between HiP and NIPS regarding the tasking of an ambulance. One recommendation has been made to NIPS in respect of this matter.

PCN F, PCN G and PCN H attended. On arrival of HiP staff, NIPS staff were performing CPR, the Automated External Device was in situ indicating no pulse and

no shock advised. PCN H inserted an i[6]-gel airway and venous access for cannulation was attempted by PCN's I and F with no success.

At approximately 10:45 Naloxone[7] was administered by PCN G and followed up with a further dose by PCN F at approximately 10:50; with no effect.

The Northern Ireland Ambulance Service (NIAS) first responder arrived circa 11:05 and further NIAS staff arrived at 11:10. NIAS continued with CPR which proved unsuccessful and life extinct was recorded at 11:35

On 29 August 2021 PCN F recorded retrospectively that they observed a deep indentation around Mr Davidson's neck at the time of the emergency '*where the ligature had been*'.

6.2 Social Interactions

Due to pandemic restrictions Mr Davidson did not receive any in person visits during his fourteen days in quarantine (as was usual at that time). Mr Davidson attended four virtual family visits and one face to face visit during his time in custody. He did not avail of the opportunity to attend three virtual family visits that had been arranged for him.

Mr Davidson also attended two virtual visits with his legal representative

The table below shows the dates and times of Mr Davidson's visits.

Date	Time	Event
22.07.21	15:45	Virtual family visit non-attendance
28.07.21	11:00	Virtual family visit non-attendance

6 i-gel® is a second generation device for airway management in anaesthesia and resuscitation. It has a soft, gel-like, non-inflatable cuff that creates an anatomical seal without trauma.

7 Naloxone hydrochloride is a drug that can reverse the effects of opioids in overdose or withdrawal.

30.07.21	11:00 to 11:29	Virtual family visit Attended
04.08.21	14:30 to 15:29	Virtual Legal visit Attended
07.08.21	15:30 to 15:59	Virtual family visit Attended
10.08.21	15:30	Virtual family visit non-attendance
11.08.21	15:30 to 16:30	Virtual Legal visit Attended
13.0821	15:00 to 15:29	Virtual family visit Attended
18.08.21	14:00 to 15:00	Domestic visit Attended
27.08.21	11:00 to 11:29	Virtual family visit Attended

Mr Davidson spent the majority of his time in prison in his cell and as such social interactions with others within the prison was limited. Mr Davidson engaged well with NIPS and HiP staff.

6.3 Hot and Cold Debrief Meetings.

Standard 25 of the 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.

On 28 August 2021 the hot debrief took place at 11:30 for those who had responded immediately to the death of Mr Davidson. The events surrounding the incident were

recorded and all staff involved were asked how they were and signposted to support services. Contact details for the Duty Governor were also supplied to all those present.

The cold brief took place on 10 September 2021. No staff involved in the incident had sought support during the previous days but were again advised of the support services available to them.

SECTION 7: Findings

This section outlines the findings of this report in relation to its objectives. I am mindful of the health constraints that were in place during the pandemic and I am content that from CCTV and evidence gathered, Mr Davidson's interactions with Prison Officers and HiP were adequate and comparable to other prisoners in Bann House.

7.1 To review the standard of care and assessment of risk when Mr Davidson was committed into custody, in particular the committal assessments, including equivalency.

The Clinical Reviewer found:

> "*Mr Davidson's assessment process on committal was timely and appropriately focussed. All required elements of the assessment were conducted by suitably qualified healthcare professionals as per guidance*."

The Clinical Reviewer was also asked to comment on Mr Davidson's medication coming from the community into custody. The Clinical Reviewer stated:

> *"the medicines which Mr Davidson had been prescribed in the community were continued without delay and given consistently, with the exception of Citalopram which had been started by his GP on 25th June for stress. Mr Davidson was unable to recall the name of the medicine when he saw the police Forensic Medical Officer (FMO) and it was therefore omitted at that time."*

HiP medical staff reviewed this at the earliest opportunity and subsequently prescribed the medication. They further stated:

> *"Risk assessments relating to medicines being given [8]in-possession were completed at the correct time and were consistently applied as per policy. Medicines were not given to Mr Davidson in-possession due to his recent suicidal*

[8] In possession is the term used by Clinical Reviewer, however the term used by health care in Northern Ireland is self-administration

behaviour in accordance with the policy at the time. Medicines reconciliation was completed in a timely manner and consistent with policy. They further stated *care plans specific to the management of his long-term conditions were not created or implemented; though Mr Davidson's stay at Maghaberry prison was only 6 weeks in total, so this would not have been clinically significant*."

7.2 The Clinical Reviewer was asked to consider any impacts on Mr Davidson's mental health of his quarantine in the Foyle House for 14 days as a safety measure due to Covid-19, including the amount of time Mr Davidson spent in his cell, access to the telephone, virtual family visits, shower, diversionary materials, alleged verbal threats and bullying.

The Clinical Reviewer stated:

"*Mental Health Triage was conducted face to face in the safer cell as per best practice and took place within the recommended timescale."*

The Clinical Reviewer further *stated:*

"in the community, prior to committal, Mr Davidson had been prescribed an emollient to be used in bathwater to help control the discomfort caused by eczema. This was changed by the admitting medic to a shower gel preparation as a necessary alteration due to shower-only bathing facilities being available. It is possible this change may have caused some psychological upset and may also have affected the overall management of his eczema, leading to discomfort."

The Clinical Reviewer further stated:

"there are a number of influencing factors that would have affected Mr Davidson's mental state and growing sense of hopelessness during his brief time in custody, and possibly also the preceding events leading up to his arrest on 12 July. It is not possible to assert absolutely that any of these elements were directly causal, but it is reasonable to assume that in combination, they would all have contributed to Mr Davidson's ultimate suicidal thinking and actions.

Some of the factors to consider included:

- *The seriousness of the charges against him and the loss of his family.*
- *This was Mr Davidson's first time in a custodial environment.*
- *The entire environment would have been alien to him.*
- *Covid-19 restrictions were more stringent in custodial environments at this time than was common in the community.*
- *His domestic routine was entirely different.*
- *His personal hygiene routine was forced to change.*
- *His skin care routine for the management of his eczema was different. Different products can be less effective.*
- *He spent most of his time alone.*
- *He had time to reflect on the magnitude of the charges he was facing and what that would mean in terms of his own future in custody.*
- *The scarring from the wounds to his wrist and chest would have been a constant physical reminder of the events of 12th July and all that followed."*

Mr Davidson's family alleged he received verbal threats during his time in custody. Investigation of the alleged verbal threats and bullying found no incidents against Mr Davidson recorded by PSST from his committal to 28.08.21.

7.3 The Clinical Reviewer was asked to consider the application of the SPAR Evo process including: how concerns were raised and addressed and the application of the agreed care plans.

The Clinical Reviewer highlighted:

> "*the SPAR Evo process appears to have been robust and timely. All reviews were attended by Mental Health professionals who were able to offer suitable input. The closure of the plan on 10th August noted that Mr Davidsons mental health presentation was both objectively and subjectively sufficiently improved as to merit the closure of the plan. There is nothing to suggest this was not the case at that time. Unfortunately, there are no clinical assessment tools which can accurately predict the likelihood of suicide. There are tools which can evaluate both static and dynamic risk, but patient presentation and disclosure are both essential elements of an assessment.* The Clinical Reviewer further stated *Mr Davidson was confirmed as disclosing no 'TLNWL' despite his previous impulsive suicide attempt on July 12th. It would not generally be considered appropriate to restrict an individual's right to privacy for longer than necessary by imposing high-level observations for longer than is deemed essential."*

7.4 The Clinical Reviewer was asked to consider the appropriateness of the decision to commence CPR and whether CPR was conducted in line with national guidelines.

The Clinical Reviewer stated:

> *"the decision to commence CPR was certainly appropriate at the time Mr Davidson was found. Instigating this potential life saving activity is always required except in very specific circumstances, none of which were present. These circumstances included Hypostasis; Rigor Mortis; Decapitation; Massive cranial and cerebral destruction……..* The Clinical Reviewer further stated *the fact that emergency technicians continued to attempt lifesaving CPR on arrival and administer a full drugs protocol via intraosseous access is further support that this was the correct initial decision."*

SECTION 8: Conclusions

The objectives of this report were to:

1.	provide a timeline of events surrounding the death of Mr Davidson, including a detailed timeline of his movements during the last week of his life.
	The timeline of events surrounding Mr Davidson's death are outlined in Section 6.
2.	Examine the healthcare care NIPS provided to Mr Davidson. In particular, whether any of his human rights in relation to standards of accommodation, access to legal representation and family contact were impacted. Consider whether any changes would help prevent a similar death in the future. This will include taking account of measures in place due to the pandemic and to Mr Davidson's care generally;
	Upon investigation I am satisfied the care provided by NIPS and HiP was appropriate. Mr Davidson's human rights in regard to the standard of his accommodation, access to legal representation and family contact were no more adversely affected than any other prisoner experiencing prison regime for the first time. Additional restrictions brought about by Covid-19 may have impacted but restrictions would have been in place in the community at this time so they would have been no more an aggravating factor either inside or outside the custodial environment.
3.	Examine the adequacy of the induction process and how Mr Davidson was cared for using cell progression and consider whether any changes would help prevent a similar death in the future.
	Upon investigation I am satisfied the care provided by NIPS induction process was appropriate and as per policy. Cell progression was inline with operational policy and is not considered to have had an impact on Mr Davidson.
4.	Examine the relationships around and with Mr Davidson and his family and consider whether improvements could be made to provide support in the future.

	Upon investigation I am satisfied that Mr Davidson received the same opportunities as other prisoners in respect of family contact during the pandemic, on occasion, he chose not to avail of the opportunities offered.
5.	Examine the mental health assessments and support provided to Mr Davidson, including through Supporting People At Risk Evolution (SPAR Evo) given his experience of being isolated due to the pandemic and as this was his first time in custody
	Upon investigation I am satisfied NIPS and HiP supplied the appropriate care to Mr Davidson during his 44 days detention and his mental health was continually assessed.
6.	Identify any relevant failings or learning and good practice for the future and highlight any lessons learned from the death of Mr Davidson.
	The investigation findings show there are no relevant failings or learning and no lessons learned. Areas of good practice are identified at section 9.1. One recommendation is outlined in Section 9.3.
7.	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.
	This report will be provided to the Coroner along with full disclosure of investigative materials and inform the inquest.

SECTION 9: Good practice and Recommendation

9.1 The Clinical Reviewer was asked to identify any examples of good practice.

The Clinical Reviewer highlighted the following good practice

- *Sound awareness demonstrated on a number of occasions regarding the increased risks associated with this being Mr Davidson's first contact with criminal justice services, his first time in custody, the charges relating to a close family member and the magnitude of the charges he was facing.*
- *Face to face mental health triage conducted in a safer cell.*
- *Consistent attendance of clinical mental health professionals at all the SPAR Evo meetings.*
- *Mr Davidson was asked regularly about his feelings, including suicidality at each encounter. There was good exploration of feelings within these encounters and follow-up about any comments made that may have suggested suicidal ideation. Healthcare notes reflect that conversations to identify 'TLNWL' were consistently broached and consistently denied by Mr Davidson.*

  HiP interventions provided to Mr Davidson were broadly in line with guidance and policy in terms of timeliness of interventions, supply of existing medicines and overall standard of care. Community equivalence is established in as much as it is possible due to the nature of the custodial environment.

9.2 The Clinical Reviewer was asked to identify any shortcomings.

The Clinical Reviewer identified the following:

- *It was identified by the FMO during initial reviews with Mr Davidson whilst still in police custody that he had recently been prescribed medication by his GP to help him manage stress, though Mr Davidson was unable at the time to recall the name of the medication.*

- *Due to the uncertainty, it does not appear to have been revisited once at Maghaberry Prison when the Electronic Care Record was available from Mr Davidsons GP.*

I note that on 16 July 2021 Mr Davidson stated during his face to face HiP meeting that he had been prescribed Citalopram previously for anxiety/low mood; however, he was not compliant with this medication, as he did not think it worked. Although the Clinical Reviewer believes this did not appear to have been revisited, I am satisfied from the evidence gathered that the appropriate checks were carried out in respect of Mr Davidson's medication by the HiP's pharmacist at Maghaberry Prison on committal.

9.3 Recommendation

I have one recommendation to make to NIPS and no recommendations to the Trust in this case.

Recommendation: Tasking an Emergency Ambulance

The Northern Ireland Prison Service should review policy in relation to tasking an emergency ambulance immediately when they find an unresponsive prisoner in their cell and not wait for Healthcare in Prison personnel to make their assessment.

Appendix 1

GLOSSARY

CCTV	Closed-Circuit Television
COVID 19	The pandemic
CPR	Cardiopulmonary Resuscitation
FMO	Forensic Medical Officer (police doctor)
GP	General Practitioner
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
MHN	Mental Health Nurse
NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
PCN	Primary Care Nurse
PHA	Public Health Agency
PSST	Prisoner Safety and Support Team
SPAR Evo	Supporting People At Risk Evolution (procedure)
The Trust	The South Eastern Health and Social Care Trust
TLNWL	Thoughts of Life Not Worth Living

Appendix 2

Criminal Justice Inspection Northern Ireland (CJI)

CJI is a United Kingdom National Preventive Mechanism (NPM) member body that independently monitors places of detention to prevent the ill treatment of prisoners. CJI inspects Northern Ireland prisons in partnership with His Majesty's Inspectorate of Prisons (HMIP), the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate. HMIP and the RQIA are also NPM members.

In November 2019 CJI and RQIA reported on the Safety of Prisoners held by NIPS and made two strategic and ten operational recommendations for improvement including better joint-working between NIPS and the Trust to increase the safety of prisoners.

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

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

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

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

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

CJI reports are available at Maghaberry Prison inspection report June 2023, CJINI Independent Review Progress Report 2024 and CJINI Full Inspection May 2015

RQIA Review of Services for Vulnerable Persons detained in Northern Ireland Prisons

Following a report of an accident of serious self-harm from the Prisoner Ombudsman's Office in 2016 and the number of recorded suicides in prisons, the Departments of Health and Justice jointly commissioned a review to consider provision for particularly vulnerable prisoners. The RQIA Review, published in October 2021, goes some way to addressing concerns. Recommendations made by the RQIA specifically address mental healthcare. The Ombudsman works with the RQIA and others to raise matters of concern and improve the delivery of support to prisoners.

The RQIA report is available here.

Independent Monitoring Board

Maghaberry Prison has an Independent Management Board (IMB) of volunteers whose role is to independently monitor the care and treatment of prisoners. From the 2021-2022 Maghaberry Prison IMB annual report the IMB state there has been clear evidence of prison staff intervention in relation to prisoners who may attempt suicide or inflict self-harm which has improved the safety and wellbeing of prisoners. The IMB would acknowledge the excellent work carried out by staff in this regard to ensure the safety of prisoners, especially those who have been identified as being vulnerable.

The IMB did however, continue to have some concerns regarding the standard of accommodation within Foyle during this year particularly around lack of furniture and non-working showers, and the impacts on prisoners due to Covid restrictions particularly 23 hour lock ups.

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

Appendix 3

Guidance during the Covid-19 pandemic

NIPS worked with SEHSCT Infection control specialists from February 2020 in preparation for the pandemic and was informed by PHA and the HSCB from April 2020. NIPS and SEHSCT colleagues were also representatives on the 5 Nations COVID-19 Health and Justice group that proved a valuable forum in learning from other jurisdictions.

NIPS recognised that the general prisoner population did not present a risk; it was people coming into prison (staff and new committals) that posed a risk of transmission of the COVID-19 virus to general population. NIPS restricted staff access early on to essential staff (NIPS and SEHSCT) and introduced committal quarantine to protect the general prisoner population.

Committal quarantine was implemented for 14 days, based on PHA advice and quarantined prisoners were held in specific accommodation, with largely the same staff group in place. Committal quarantine was reduced to 10 days from 12 November 2021, subject to the individual agreeing to be tested for the virus (again, informed by PHA advice).

NIPS implemented its formal Pandemic Plan and procedures in June 2020 that included infection control measures, quarantine and isolation arrangements (for staff and prisoners) and virtual visits etc. The SET/NIPS Quarantine Arrangements for new committals during COVID-19 Pandemic was included at Appendix C and was informed by advice from Public Health England and our own PHA. The document was revised regularly in line with Chief Medical Officer and PHA advice, version 7.0 contained changes effective from 31/12/21 and 10/01/22, and version 8.0 was implemented 31/01/2022.

Prisoners held in Foyle House quarantine landings had a TV in their cell, distraction packs and access to in-cell exercise equipment (procedure through funding provided by HSCN). All prisoners were facilitated to have regular showers and phone calls and, apart from check-ins with NIPS staff, quarantined prisoners were seen by Healthcare

in Prison staff daily. In addition, the HiP Prisoner Engagement staff also visited with each prisoner.