



The
**Prisoner
Ombudsman**
for Northern Ireland

OFFICIAL - SENSITIVE

**INDEPENDENT INVESTIGATION REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF**

MR THOMAS SLOAN

**AGED 66
AT MAGHABERRY PRISON
ON 5 APRIL 2024**

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Foreword from the Prisoner Ombudsman

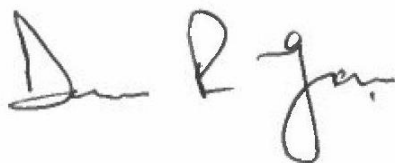
Mr Thomas Sloan was a 66 year-old remand prisoner who had been in custody from 30 January 2024. This was not his first time in a custodial setting. He died in prison custody on 5 April 2024.

This report details the outcome of the investigation into the treatment and care Mr Sloan 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 and both organisations have cooperated fully in this investigation.

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

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



Darrin Jones
Prisoner Ombudsman for Northern Ireland

The Role of the Prisoner Ombudsman

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

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

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

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

The Trust was established on 1st April 2007 and is one of 5 Trusts in total within Northern Ireland. The South Eastern Trust has responsibility for providing healthcare to all prisoners in Northern Ireland. This is delivered on a day to day basis by the Healthcare in Prison (HiP) team. While they are based in the establishments, they are not part of NIPS.

The generic investigation objectives are set out in the Ombudsman's Terms of Reference and are available [here](#).

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."

In the interests of transparency, investigation reports are published on the Ombudsman's website. Reports are also disseminated to those who independently monitor services in prisons and the care and treatment of prisoners and patients. These include:

- Criminal Justice Inspection Northern Ireland (CJINI);
- the Regulation and Quality Improvement Authority (RQIA); and
- Independent Monitoring Board (IMB).

More information about published reports from these organisations can be found at Appendix 1.

SECTION 1: Investigation Objectives

The specific objectives for this investigation are to:

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|----|--|
| 1. | Establish the circumstances which led to Mr Sloan dying in custody at Craigavon Area Hospital (CAH) on 5 April 2024, including the care provided by NIPS, the Trust and any other relevant contributory factors; |
| 2. | Examine any relevant health and clinical issues; |
| 3. | Highlight good practice; |
| 4. | Examine whether any operational methods, policy, practice or management arrangements require improvement. |

SECTION 2: Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This comprises interviews and meetings with prison staff, HiP staff, prisoners, family and friends. All prison records in relation to the deceased's life while in custody are examined. This includes examination of evidence such as Closed-Circuit Television (CCTV) footage, telephone calls and mail. The report is structured to detail the events leading up to Mr Sloan's death on 5 April 2024.

Notices of the investigation into Mr Sloan's death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and the IMB. This encourages anyone with information to come forward and speak to the Ombudsman's Investigators.

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

2.1 Family Liaison

Liaison with Mr Sloan's family is a very important aspect of the Ombudsman's role when investigating a death in custody. A meeting with Mr Sloan's family was held in August 2024.

SECTION 3: Summary of Mr Sloan's Case

Custody at Maghaberry Prison from January to March 2024

Mr Sloan was received into Maghaberry Prison on Tuesday 30 January 2024 through the standard committal process.

Mr Sloan's short 7-week stay in Maghaberry Prison was uneventful – he was not considered at risk of suicide or serious self-harm by the Prison Service nor in need of any special care arrangements.

A HiP nurse took Mr Sloan through a Comprehensive Health Assessment on the morning of 31 January 2024 and completed his Medication Reconciliation. NIPS records captured his "*stomach issues*" with "*too much acid*" for which he took daily medication.

A summary of Active Problems & Medications from Mr Sloan's Community GP was received by HiP on 5 February 2024.

On 26 February 2024, Mr Sloan was seen by a HiP nurse for his Mental Health Triage where he reported no issues and the nurse recorded "*no indication for keyworking/mental health assessment at this time*".

On 18 March 2024 Mr Sloan was seen by HiP Nurse A reporting a "*sore stomach and vomiting due to heartburn*". In response, the nurse requested Lansoprazole which was prescribed the following day.

On the morning of 20 March 2024 at around 6am, Mr Sloan was seen by HiP Paramedic B reporting nausea, vomiting, heartburn and lower back pain which he described as spasmodic. He was given pain relief but vomited shortly after consuming it.

Mr Sloan was reviewed face-to-face by HiP staff on three further occasions that day and through the night into 21 March 2024. Observations were taken and blood and other tests were sent for analysis. Mr Sloan reported finding blood in his vomit that evening.

By the morning of 22 March 2024, laboratory results were returned with an instruction from the doctor advising "*to be assessed today and if still unwell with abnormal clinical obs then to refer to hospital*". Mr Sloan was reviewed again at lunchtime and, while he felt some improvement following sickness medication, HiP staff suspected sepsis and

triggered arrangements for Mr Sloan to be taken to hospital for further investigation (to which he agreed). Mr Sloan was escorted to CAH at 16:30 that afternoon.

Events at Hospital – March/ April 2024

The medical care provided by the Southern Health and Social Care Trust at CAH is outside the remit of investigations by the Prisoner Ombudsman and a summary of the events occurring during Mr Sloan's stay are included here only to complete this account of the circumstances of his death.

Mr Sloan remained in the custody of NIPS officers at the hospital throughout this period and his condition was reported to Governors while he remained there. Similarly, HiP maintained regular checks on his clinical condition via medical and nursing staff at CAH.

On arrival at hospital on 22 March 2024, Mr Sloan was scanned, and this showed a colonic tumour and a liver lesion. Surgery was undertaken the next day to remove the tumour and part of his bowel. Following his operation, Mr Sloan was admitted into the hospital's ICU. Mr Sloan initially improved and was discharged to a surgical ward on 26 March 2024.

Mr Sloan's health declined on 30 March 2024 with high temperature and low blood pressure and medical staff had concerns there may have been a leak following surgery. No source of a leak was located during a further surgery on 31 March 2024. Mr Sloan was re-admitted to ICU where, on 3 April 2024, his condition deteriorated and he experienced multiple organ failure.

Mr Sloan's life was pronounced extinct at 11:47 on 5 April 2024 by the doctor responsible for his care in ICU. She confirmed to Police Service of Northern Ireland detectives there was nothing suspicious about Mr Sloan's death.

No Post Mortem was carried out on Mr Sloan.

Conclusion

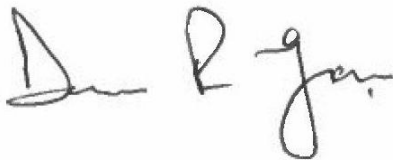
Having thoroughly examined the circumstances of this death in custody, this investigation did not find any action, or lack of action, by NIPS or the Trust which directly contributed to a negative outcome for Mr Sloan.

This investigation did not identify any issues of concern and I make no recommendations.

Mr Sloan died of natural causes (aggressive cancer) and his death was confirmed as non-suspicious by the medical team treating him at CAH.

I would like to thank those NIPS and HiP staff involved in the professional care afforded to Mr Sloan at Maghaberry Prison. Once Mr Sloan was at hospital, NIPS staff continued to support him via bed watch and HiP staff demonstrated their commitment to continuity of care through contacting their clinical counterparts regularly.

I would like to thank all those who contributed to the preparation of this report.



Darrin Jones
Prisoner Ombudsman for Northern Ireland

Appendix 1**Criminal Justice Inspection Northern Ireland (CJINI)**

CJINI 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 CJINI 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 quarantine for extended periods.

The most recent inspection report on Maghaberry Prison was published in June 2023 followed by an Independent Review of Progress 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 <https://www.cjini.org/report-category/prisons/>

Regulation and Quality Improvement Authority (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 reports are available [here](#).

Independent Monitoring Board (IMB)

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 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-19 restrictions particularly 23-hour lock ups.

IMB Annual Reports can be viewed at [Independent Monitoring Board \(imb-ni.org.uk\)](https://www.imb-ni.org.uk)

Appendix 2

Glossary

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| CAH | Craigavon Area Hospital |
| CCTV | Closed-Circuit Television |
| CJI | Criminal Justice Inspection Northern Ireland |
| CSU | Care and Supervision Unit |
| ECHR | European Convention on Human Rights |
| HIP | Healthcare in Prison |
| HMP | His Majesty's Prison |
| IMB | Independent Monitoring Board |
| NIPS | Northern Ireland Prison Service |
| NPM | National Preventative Mechanism |
| RQIA | Regulation and Quality Improvement Authority |
| Trust | South Eastern Health and Social Care Trust |