REPORT BY THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

MARTIN JAMES HARPER

AGED 47

WHO COLLAPSED IN MAGHABERRY PRISON

ON 30 JANUARY 2009 AND LATER DIED

IN LAGAN VALLEY HOSPITAL

29 MARCH 2010

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

22nd Floor, Windsor House, Bedford Street, Belfast BT2 7FT
T 028 9044 3982 F 028 9044 3993 www.niprisonerombudsman.gov.uk

PREFACE

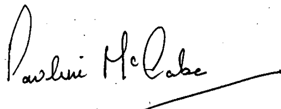
This is my report into the circumstances surrounding the death of Mr Martin James Harper who was 47 years old when he died on 30 January 2009. Mr Harper had collapsed in Bush House, Maghaberry Prison at approximately 08.35 that day and later died in Lagan Valley Hospital as a result of a brain haemorrhage.

I offer my condolences to Martin's family for their sad loss. I have met with them to share the content of this report.

My overall findings would suggest that Mr Harper was well cared for at Maghaberry and that staff were very responsive when Mr Harper collapsed.

My report is, therefore, a shorter version of my normal report and I have not found it necessary to make any recommendations to the Northern Ireland Prison Service as a result of my investigation into Mr Harper's death.

Before completing my investigation I submitted a draft of this report to the Director of the Northern Ireland Prison Service for a factual accuracy check. The Prison Service responded with some comments for consideration. I have now fully considered these comments and made amendments to my report, where appropriate.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
29 March 2010

RESPONSIBILITY OF THE PRISONER OMBUDSMAN

1. As Prisoner Ombudsman[1] for Northern Ireland, I have responsibility for investigating the death of Mr Martin Harper who collapsed in Maghaberry Prison on 30 January 2009 and later died in outside hospital. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Annex 1.

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

3. I am independent of the Prison Service, as are my investigators.

Objectives

4. The objectives for the investigation into Martin's death are:

    - to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;
    - to examine any relevant healthcare issues and assess clinical care afforded by the Prison Service;
    - to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;

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

- to ensure that Martin’s family have the opportunity to raise any concerns that they may have and that these are taken into account in my investigation; and

- to assist the Coroner’s inquest.

INVESTIGATION REPORT

Mr Martin James Harper was a long serving prisoner in Maghaberry Prison housed in Bush House, where he collapsed on the morning of 30 January 2009.

Following Mr Harper's death, I conducted a review of all the information and material held on him by the Prison Service.

My review included an analysis of Mr Harper's healthcare records, personal file, recent telephone calls made by Mr Harper and the CCTV of his last hours in Bush House, Maghaberry Prison.

All Prison Service policies and procedures, relevant to this investigation were reviewed and it was found that they had all been complied with.

I also made contact with Mr Harper's aunt, who was his recorded next of kin and noted that Mr Harper's family had no concerns about his treatment in Maghaberry Prison or the circumstances of his death. Mr Harper's family were notified by a Governor of his death as quickly as possible.

As Mr Harper's death was from natural causes and because he had minimal recent contact with prison healthcare, prior to his death, apart from ongoing treatment for a painful right arm and shoulder which he fractured in 1998, I decided that an independent clinical review was not required.

On the night of 29 January 2009, Mr Harper had been playing table tennis in the recreation room with another inmate who said, at interview, that, at one point in their game, the table tennis ball ended

up on the floor. The inmate recalls that, as Mr Harper lifted the ball, his head hit the pillar and Mr Harper immediately said *"that was sore".*

The inmate said that Mr Harper had *"rubbed it off and then they just started playing on again for about another 20 minutes."* He said he had asked Mr Harper when he was going to his cell for lockup at about 20.00 *"are you alright".* He said that Mr Harper said to him that his "*head was busting".*

There is no record of Mr Harper reporting this incident to landing or healthcare staff that evening or early the next morning.

On the morning of 30 January 2009, it is reported by staff and inmates that Mr Harper woke up at approximately 08.00 and got dressed as usual in his kitchen whites, in preparation for his work in the prison kitchens.

Mr Harper then went to the kitchen area to have his breakfast. After breakfast he returned to the staff work station on the landing to get lighter fluid for his cigarette lighter. Staff said at interview, that this was Mr Harper's usual morning routine and that on this morning, Mr Harper *"gave absolutely no indication that he felt unwell".*

There was nothing to indicate, prior to Mr Harper collapsing on 30 January 2009 at 08.35, that he was unwell.

An officer, who Mr Harper was standing chatting to at the work station, said that *"Marty suddenly collapsed just after 08.30"* and "*fell backwards like a tree on his back onto the ground."* The officer said that he immediately went to Mr Harper's assistance and noticed that he was still breathing. He called a nurse, who was starting her duty

in the medical room in Bush House, and placed Mr Harper in the recovery position.

The officer said that the nurse came running to assist within seconds. The nurse said at interview, that she immediately checked Mr Harper's breathing and airways, asked staff to call an ambulance and asked for another nurse who was working in a nearby house (Roe House) to attend.

She said that the other nurse arrived a few minutes later to assist and that Mr Harper was unconscious for a few minutes as they applied oxygen. She said that Mr Harper gained consciousness, but was visibly restless. He answered to his name and other questions, but was constantly holding the top of his head and was writhing about. Mr Harper's collapse and the response of staff are all recorded on CCTV.

Both nurses continued to check Mr Harper's vital signs until the ambulance paramedics arrived at 08.54. At 09.06, the paramedics then took Mr Harper by ambulance to Lagan Valley Hospital.

Once the alarm was raised, the staff response to Mr Harper collapsing on the landing in Bush House was prompt and efficient.

A letter, later written by a hospital doctor, records that, on arrival at the accident and emergency department of Lagan Valley Hospital, Mr Harper's Glasgow Coma Scale [2]was 4 out of 15. The hospital doctor recorded that a *"CT scan showed a large subarachnoid haemorrhage.*

[2] **The Glasgow Coma Scale** is a reliable, objective way of recording the conscious state of a person and is used by medical and nursing staff for initial and continuing assessment and it has value in predicting the ultimate outcome. The scale can range from 15 (fully awake and conscious) to 0 (comatose and unconscious).

Contact was made with the neurosurgeons, but no surgical intervention was thought appropriate. His family were made aware of the grave prognosis and later that day Mr Harper's death was confirmed."

A post mortem examination, carried out on 31 January 2009, reported the cause of Mr Harper's death as:

1 (a) Subarachnoid Haemorrhage
due to
(b) Rupture of Aneurysm of anterior communicating artery.

My overall findings would suggest that Mr Harper was well cared for at Maghaberry.

A medical opinion was sought in respect of whether or not Mr Harper's ruptured aneurysm was caused by the knock to his head. The advice given was that the aneurysm may have been a condition which Mr Harper had from birth, but the actual cause of this is unknown. It was further advised that the knock to Mr Harper's head would not have caused the aneurysm and, on the balance of probability, it would not be possible to say whether the knock on the head would have been a contributory factor of the haemorrhage.

Acknowledgement

I would like to commend the officer and nurses who attended to Mr Harper in a considerate and prompt manner once he collapsed and continued to care for him until the ambulance paramedics arrived.

INVESTIGATION METHODOLOGY

Prison Records and Interviews

1. My investigation team visited Maghaberry Prison on numerous occasions and met with prison management, staff and prisoners. My team retrieved all the prison records relating to Mr Harper's period in custody, including his medical records, and these were analysed as part of the investigation.

Telephone Calls

2. My team retrieved and listened to the last few days of telephone calls which Martin made in order to establish if any information in the calls were relevant to the circumstances of his death.

Clinical Review

3. As explained earlier, as part of any investigation into a prisoner's death, I have discretion whether to commission a clinical review of their healthcare needs and medical treatment whilst in custody.

4 For the reasons listed before, I decided that a clinical review was not appropriate.

5. A short investigation, which included an analysis of Mr Harper's healthcare records, personal file, and the CCTV of his last hours in Maghaberry Prison, supported this decision. My overall findings would suggest that Mr Harper was well cared for at Maghaberry.

Working together with interested parties

6. An integral part of any investigation is to work together with all interested parties involved. To that end my investigation team worked closely with the Coroner's Service for Northern Ireland. The PSNI were not involved in the investigation as Mr Harper died in outside hospital.

Post Mortem Report

7. My investigation team liaised with the Coroners Service for Northern Ireland to retrieve the post mortem/autopsy report in order to establish the exact cause of Mr Harper's death.

ANNEX 1

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

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

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

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

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

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

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

Clinical Issues

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

Other Investigations

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

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

Disclosure of Information

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

Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

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

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

Review of Reports

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

Publication of Reports

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

Follow-up of Recommendations

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

Annual, Other and Special Reports

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

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

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

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

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

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

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

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

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

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

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

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

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

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

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of

State for Northern Ireland. In that case, steps 8 to 11 may be modified.

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

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