The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF
MR D
ON (date redacted)
AGED [redacted]

[Published 27 November 2013]

Dates and names have been removed from this report, and redactions applied, solely to preserve the privacy of the deceased, their family and others who contributed to the investigation. All facts and analysis which are in the public interest have been retained.

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PREFACE

This investigation, including the preparation of the report, was conducted by my predecessor, Pauline McCabe, who met with Mr D's family after his death. On 4 July 2013 I shared the content of this report with them and responded to the questions and issues they raised. I offer my sincere condolences to Mr D's family for their loss.

A detailed account of the evidence examined during the investigation has been included in the main body of the report. This is particularly to assist Mr D's family, the South Eastern Health and Social Care Trust (SEHSCT), the Northern Ireland Prison Service and the Coroners Service for Northern Ireland. There is a comprehensive summary for readers who do not wish to consider all of the investigative detail.

It has been the practice of the Office of the Prisoner Ombudsman to identify matters of concern that require action to improve standards of prisoner care and help to prevent serious incidents or deaths in the future. In the case of Mr D, 14 matters of concern have been identified. In future reports I will be making specific recommendations for improvement.

I would like to thank everyone from the Northern Ireland Prison Service, the SEHSCT, Dr Peter Saul, who carried out a clinical review of Mr D's medical treatment whilst in prison and other agencies who assisted with this investigation.

Tom McGonigle.

Prisoner Ombudsman for Northern Ireland
27th November 2013

SUMMARY

Mr D was born on (date redacted). He was [redacted] years old when he died [redacted] in the early hours of (date redacted), after being released from Maghaberry Prison the previous evening. The post mortem found that Mr D died of pneumonia. In addition to this, a specialist toxicology analysis concluded that the combination of prescribed and non-prescribed medication, Mr D was taking *"can cause sedation and as such, when taken together, the possibility that their combined central nervous system depressant effects may have contributed to Mr D's death"* could not be *"ruled out"*.

Mr D's medical records show that, in (date redacted), he was involved in a road traffic collision in which he sustained extensive injuries. As a result of the accident, Mr D's mobility was severely impaired and he suffered from chronic leg and back pain for which he was treated with high doses of painkillers and had to use a wheelchair. Mr D's (name redacted) said that they noticed a marked deterioration in his quality of life after his accident.

From (date redacted), Mr D regularly displayed symptoms of anxiety, depression and Post Traumatic Stress Disorder (PTSD)[1] for which he received support from community psychiatric services. Mr D's community medical records note that his low mood was due to "*his inability to cope with his social and physical circumstances."* Over a nine year period, it is noted that he was addicted to alcohol, took several overdoses of his medication, had problems sleeping and informed the doctor of other self harm incidents. There is also evidence that he, at times, abused illicit drugs.

On (date redacted), Mr D was admitted to the Dorothy Gardner Unit[2] at Knockbracken Healthcare Park and transferred to Ards Hospital acute mental health unit. In (date redacted), he was placed on the Northern Ireland Drug Addicts Index[3] because he had become addicted to OxyContin tablets,

[1] Post Traumatic Stress Disorder is an anxiety disorder caused by very stressful, frightening or distressing events.
[2] Dorothy Gardner Unit is one of five hospital recovery mental health inpatient services at Knockbracken Healthcare Park.
[3] People are registered on the index if they are known to be, or if a medical practitioner considers them to be addicted to one or more controlled drugs.

prescribed for his chronic pain. He had regularly attended his GP surgery or hospital claiming to have "*run out of*" or "*lost*" his medication.

On (date redacted), Mr D was discharged from the Ulster Hospital after being admitted on (date redacted) for abdominal pain. The discharge and medication advice letter stated that Mr D is on a *"high dose OxyContin after RTA* (Road Traffic Accident). *On oxygen in A+E became drowsy and had a respiratory acidosis*[4] *with type 2 respiratory failure... needs investigated for obstructive sleep apnoea*[5]. *OxyContin reduced from 60mg to 40mg* (twice a day)." The doctor at the Ulster Hospital stopped Mr D's diazepam prescription and reduced his dose of OxyContin, because of his respiratory depression. He was, however, subsequently prescribed diazepam and his higher dose of OxyContin by his GP.

Mr D's last inpatient admission was to Belfast City Hospital on (date redacted), after he was found unconscious by a friend and noted to have medication boxes scattered around him. He was diagnosed with self-poisoning, alcohol intoxication, aspiration pneumonia[6] and rhabdomyolysis[7]. He was discharged from hospital on (date redacted).

Mr D was committed to Maghaberry Prison on (date redacted). Because he did not arrive at the prison until 21.06, a limited "Keepsafe"[8] healthcare assessment took place that night. The nurse who completed the assessment recorded that Mr D had "*deterioration in mobility"* since his last committal, that he *"now uses a wheelchair more or less permanently"* and that he could *"manage approx 20-30 yards walking on crutches".* The nurse also recorded that Mr D had been seen by *"FASA*[9] *for recent dsh* (deliberate self harm) *by deliberate overdose of prescription meds,"* four weeks prior to his committal. She noted that Mr D was in a ground floor cell in Lagan House but that he

[4] Respiratory acidosis is a condition in which a build up of carbon dioxide in the blood produces a shift in the body's pH balance and causes the body's system to become more acidic.
[5] Sleep apnoea is a condition where a persons breathing stops for short spells when they are asleep.
[6] Aspiration pneumonia is inflammation of the lungs and airways to the lungs from breathing in foreign material. It occurs when foreign materials (usually food, liquids, vomit or fluids from the mouth) are breathed into the lungs or airways leading to the lungs.
[7] Rhabdomyolysis is the rapid destruction of skeletal muscle resulting in leakage into the urine of the muscle protein myoglobin.
[8] A Keepsafe assessment is carried out when a prisoner is committed late in the evening. It is followed by a full healthcare assessment the following day.
[9] FASA is an organisation which provides specialist services in relation to substance misuse, suicide, and self harm.

would *"need a disabled cell and bottom bunk"*. She also noted that he would need to see a doctor in relation to his physical health and his medication, which was noted to be *"as per EMIS*[10] (date redacted)*"*.

On (date redacted) a more comprehensive healthcare assessment was completed. The nurse recorded that Mr D had "*long standing illness, disability or infirmity*", "*mobility issues"* and *"uses wheelchair majority of time and crutches in addition to mobilise short distances only"*. She noted also that Mr D had said that he had *"depression, mainly as a result of his impaired physical health post RTA,"* that he was *"on controlled drug meds – OxyContin 60mgs bd* (twice a day)*"* and that he had been admitted to Belfast City Hospital, four weeks prior to his committal, because *"he took his medication while intoxicated,"* but that this *"was accidental and not a suicidal attempt"*. The nurse also recorded that Mr D was a heavy drinker who admitted *"to drinking a bottle of gin or vodka most days"* but that there were *"no signs of withdrawal currently – will require GP review today or tomorrow"*. She noted that he would require a *"disabled cell and/or bed in healthcare"*.

The nurse recorded that Mr D had *"no thoughts of self harm currently. Mental state alert, cooperative and coherent. Behaviour assessment appropriate, no obvious causes for concern"* and that there was no *"immediate action required."* It was also recorded that Mr D's GP had been contacted to confirm his medication. His medical notes were not, however, requested.

A "First Night in Prison" committal interview with a member of prison staff did not, as required, take place and at 11.25 on (date redacted), Mr D was moved to a *"low mobility cell"*[11] in Braid House.

Mr D did not, as the nurse had stated he should, see a doctor on (date redacted) but a prison doctor did, without a consultation, prescribe Mr D with: citalopram hydrobromide[12] 20mg one to be taken each morning; co-codamol[13]

[10] EMIS (Egton Medical Information System): an electronic medical records system used by the healthcare department of the Northern Ireland Prison Service.
[11] A low mobility cell is one which has been adapted to be suitable to accommodate a disabled inmate.
[12] Citalopram Hydrobromide is a medicine which is used to treat a variety of mental health problems. It is thought that it increases the activity and levels of certain chemicals in the brain. This can improve symptoms such as depression and anxiety.
[13] Co-codamol contains codeine and paracetamol. It is a medicine which is used in relieving severe pain

30/500 two to be taken three times a day, oxycodone hydrochloride[14] (trade name: OxyContin[15]) 20mg 3 BD (twice a day); diazepam[16] 5mg one to be taken twice a day; omeprazole capsules[17] 20mg once daily; furosemide[18] 20mg once daily; baclofen[19] 10mg two three times a day and pregabalin[20] capsules 300mg one twice a day. It is not possible to confirm when Mr D was issued with his medication because Maghaberry's healthcare department could not locate his Kardex[21].

At 21.29 on (date redacted), a nurse saw Mr D because he was complaining of diarrhoea and vomiting. The nurse noted that Mr D was *"on large doses of morphine and codeine based meds, not had any since am* (date redacted) *in police custody....scoring 25[22] on COWS[23] d/w* (discussed with) (a prison doctor) (name redacted), *pr* (prisoner) *to have co-codamol 30/500 x 2 qid* (four times a day) *and ventolin inhaler, must be seen in am".*

At 10.30 the next morning, (date redacted), a nurse carried out a further withdrawal assessment and Mr D scored 13[24] on the Scale, indicating that withdrawal was "*moderate*". Mr D's recorded symptoms included: vomiting, diarrhoea, increased irritability / anxiousness, sweat on brow, nose running and severe diffuse aching of joints and muscles.

That day, Mr D was assessed by a prison doctor who recorded that he had *"accerbation asthma wheeze...no resp distress... increase steroid inhaler for 2 weeks then one puff bd* (twice a day), *review as needed, smoking advice given patches".* Mr D was also prescribed an antibiotic for a chest infection;

[14] Oxycodone Hydrochloride is an analgesic (pain killer) used to relieve moderate to severe pain.
[15] OxyContin is a trade name for the drug Oxycodone Hydrochloride. It is an opioid (narcotic) analgesic (pain reliever). OxyContin is a controlled release oral formulation of oxycodone hydrochloride. It is used to treat moderate to severe pain.
[16] Diazepam is a type of medicine called a benzodiazepine. It is used to relieve anxiety, muscle spasms and seizures and to control agitation caused by alcohol withdrawal.
[17] Omeprazole belongs to a class of medicines called proton-pump inhibitors. It is used to treat stomach ulcers and to relieve heartburn and indigestion. It works by reducing the amount of acid in the patient's stomach.
[18] Furosemide is a medicine which is used in oedema to reduce swelling and fluid retention.
[19] Baclofen is used to relieve muscle spasms which may result from some conditions which affect the nervous system. It is also used following long term injuries to the head or back.
[20] Pregabalin is a medicine which is used in neuropathic pain (pain from damaged nerves), anxiety disorder, partial epilepsy and secondarily generalised partial epilepsy.
[21] A Kardex is a medication administration card which records when and how much medication is administered by healthcare staff.
[22] 25 – 36 on the Clinical Opiate Withdrawal Scale indicates that withdrawal was moderately severe.
[23] COWS: Clinical Opiate Withdrawal Scale.
[24] 13 – 24 on the Clinical Opiate Withdrawal Scale indicates that withdrawal was moderate.

prednisolone[25] 5mg eight to be taken each morning for five days, nicotine patches,[26] a cream for a skin infection and beclometasone[27] 200mg two puffs twice a day. In addition to this, Mr D's citalopram hydrobromide was increased from 20mg to 40mg (in line with his community prescription), and his co-codamol 30/500 was increased from six to eight tablets a day.

On (date redacted), a nurse carried out a risk assessment to ascertain Mr D's suitability for holding and administering his own OxyContin. Despite the fact that Mr D had informed healthcare staff that he had taken an overdose four weeks prior to his committal the nurse determined that it was appropriate for him to hold OxyContin in his cell. It would also appear to be the case that, when confirming Mr D's medication prescription by phone, Healthcare was not made aware that Mr D was registered on the Drug Addicts Index in connection with his addiction to oxycodone.

As the Kardex in respect of all of Mr D's other medication is missing, it is not known what risk assessment was carried out or administration arrangements were put in place for administering these.

On (date redacted) a prison doctor prescribed diazepam 2mg two to be taken twice a day. This was a reduced dose from that currently prescribed to Mr D, consistent with the SEHSCT policy of trying to reduce the use of particular medications in prison. There is no record that Mr D was seen by a doctor or nurse on this date or of the Trust's policy in relation to reducing medication being explained to Mr D. It is, therefore, not clear how the appropriateness of applying the medicine reduction policy in this instance was assessed. There is also no evidence that suitable review arrangements were put in place. It is to note that, on (date redacted), a nurse recorded on EMIS that Mr D was *"requesting to see Dr regards insomnia and reduction of diazepam. Explained that it is standard procedure to reduce diazepam."*

[25] Prednisolone is a corticosteroid. It works by preventing or reducing inflammation. It is used to treat a number of conditions that are characterised by excessive inflammation such as asthma, rheumatoid arthritis and colitis.
[26] Nicotine transdermal patches are medication that belongs to a family of medications known as nicotine replacement therapies. It is used to help people to quit smoking. This medication helps reduce the symptoms of nicotine withdrawal by replacing some of the nicotine that the person no longer receives through cigarettes.
[27] Bedometasone is a preventer inhaler. It is a corticosteroid (steroid) inhaler. Steroids like Beclometasone work by reducing the inflammation in the patient's airways.

On (date redacted), after visiting (Mr D), Mr D's (name redacted) telephoned the prison and spoke to a healthcare officer in the healthcare department. (Name redacted) told the healthcare officer that (Mr D) was having to sleep in his wheelchair at night. During a meeting with Mr D's (name redacted), she informed the investigation that she told the healthcare officer that Mr D had a profiling pressure relieving mattress at home and couldn't get comfortable in his prison bed.

The healthcare officer asked a nurse to speak with Mr D about the matter. Mr D told her that he slept in his wheelchair because of pain in his hip and said that he *"finds it more comfortable to sit in* (his) *chair"*. He said also that he *"can't get comfortable in bed"* and that he has a mattress that can be adjusted into an upright position but that this does not help. The nurse concluded her assessment noting that Mr D was *"due to see the doctor tomorrow for assessment".*

On (date redacted), Mr D was assessed by a prison doctor who recorded that he had *"chronic intractable pain"* and that "*he had lower body pain since an RTA in 2002, on wheelchair, attending MH*[28] *Pain Clinic, gets intermittent injection in back, pain persistent, disturbing sleep, poor concentration*". The doctor prescribed Mr D zopiclone (sleeping tablets) 3.75mg one to be taken at night for five nights, and increased his daily dose of oxycodone hydrochloride (OxyContin) from 120mg to 160mg, to help his pain. No plan to review Mr D, following the increase of this controlled drug, was recorded and there was no further discussion about the suitability of his mattress.

Reported adverse effects of oxycodone include respiratory depression leading to coma and death[29] and it is to note that the British National Formulary[30] states that the contra-indications for zopiclone, which the doctor prescribed to assist Mr D with his sleeping difficulties, include neuromuscular respiratory weakness, respiratory failure and severe sleep apnoea syndrome.

[28] Mater Hospital.
[29] Toxicology Report of Cristina Isalberti, Forensic Scientist.
[30] The British National Formulary contains information for health professionals on prescribing, monitoring, supplying and administering medicines.

Noting that Mr D was also prescribed diazepam, Forensic Scientist Cristina Isalberti stated in Mr D's post mortem toxicology report that *"The presence of benzodiazepine* (diazepam) *drugs and zopiclone may enhance the central nervous system depressant effects of codeine, morphine and oxycodone* (OxyContin), *which may also interact, enhancing their own depressant effects… When different drugs with different effects are taken in combination, as in this case, the interactions are likely to be unpredictable. Nonetheless, it has to be noted that most of these drugs can cause sedation and as such, when taken together, the possibility that their combined central nervous system depressant effects may have contributed to Mr D's death cannot be completely ruled out."*

At interview, the doctor who saw Mr D on (date redacted) said that he was trying to address the breakthrough chronic intractable pain Mr D was experiencing and to try and improve his sleep. In the absence of Mr D's community medical notes, the doctor was unaware of Mr D's medical history and his addiction to oxycodone but felt that, on the basis of the medication that Mr D had been prescribed in the community, the decisions made were "*reasonable".*

On (date redacted), Mr D was again seen by a prison doctor in relation to an infected injection site. During this consultation Mr D raised his concern regarding his mattress and the doctor referred him to occupational therapy *"re bed and appropriate pressure relieving mattress and cushion".*

On (date redacted), Mr D was seen by a nurse who carried out an assessment in preparation for his referral to occupational therapy. The nurse noted that Mr D had the start of a pressure sore on his sacrum (bottom of spine) and that his *"ulcer* (was) *to be monitored and Duoderm dressings ordered for sacrum. To be R/V* (reviewed) *regularly."* The nurse also recorded that Mr D had "*no pressure relieving cusion (sic) and no appropriate mattress"* but had "*airflow at home".*

The nurse carried out a detailed assessment which included a review of Mr D's background and noted that during the consultation Mr D "*dosed off several times and had to be verbally roused".* He further noted that *"this is due to side effects of medications. Also had accidental scald whilst making tea 2 days ago,*

? related to medications. D/W (discussed with) *SO* (Senior Nurse Officer) (name redacted) *to be assessed by GP in emergency clinic tomorrow with regard to medication R/V* (review)."

It was the case that this helpful information was written down and scanned as an attachment to the nurse's record on EMIS. Healthcare staff reviewing Mr D's EMIS record would, therefore, only be aware of the information if they opened the attachment.

In the event, Mr D's name was not put down for the emergency clinic, which was scheduled to take place the following day, nor was his name on the list of those who attended the clinic on (date redacted) or (date redacted).

On (date redacted), Mr D was seen by a senior nurse who noted that he now had *"2 small ulcers on right buttock"*. The nurse recorded that the affected areas were to be redressed in five days and noted also that Mr D had damaged tendons in his feet *"which contributes to decreased mobility"*. She referred him for physiotherapy and noted that he "*states* (he) *has a pressure relieving mattress at home… will liaise with OT* (Occupational Therapy)".

Mr D's pressure sores were re-dressed eleven days later, when he saw a nurse who again referred him for physiotherapy. Mr D was not seen by a physiotherapist before he was released from prison.

On (date redacted), a prison doctor prescribed Mr D with diazepam tablets 2mg 56 tablets four daily and on (date redacted) and (date redacted), further prescriptions of oxycodone (OxyContin) were provided for Mr D, without a consultation with a doctor and without any medication review taking place. The doctor was not aware that Mr D was addicted to oxycodone and was not aware also of the nurse's note of (date redacted) recording that Mr D had been "*dozing off*" during a consultation "*due to side effect of medications*". The doctor confirmed that, if he had been aware of this information, he would have seen Mr D before issuing a repeat prescription for the higher dose of oxycodone, but pointed out that the prescription request for Mr D was "*put through as a medication renewal request, not a review patient request*".

At interview, the South Eastern Health and Social Care's Clinical Lead for Maghaberry Prison explained that a practice had evolved whereby, in the event that an inmate has run out of medication, a nurse would sometimes call the doctor and ask him to authorise a further prescription over the phone. The Clinical Lead said that new arrangements were now in place which meant that doctors would not *"continue acute prescriptions over the phone without first seeing the patient... This would be particularly useful when the drug being prescribed is a controlled drug or one with significant side effects."*

The clinical lead further said that: "*Mr D should not have received a further prescription for oxycodone hydrochloride on the* (date redacted), (date redacted) *or the* (date redacted) *without being seen by a doctor because the initial increased prescription for oxycodone hydrochloride on* (date redacted) *was an acute prescription. If an acute prescription is given it indicates that the doctor wants the patient to be seen at the end of the course of that acute prescription otherwise a repeat prescription would have been given by the doctor."*

On (date redacted) Mr D was assessed by an occupational therapist. The therapist recorded that *"[Mr D] reports he has a home help service twice a day, seven days a week in the community pre prison incarceration. The home help service provided assistance with personal care needs and he also received meals on wheels and he had considered hiring a cleaner for domestic activities of daily living. Within prison, he used a disabled cell. He presently sleeps on a prison issue mattress however reports he used a profiling pressure relieving bed and mattress in the community. Presently reports a pressure sore."* The occupational therapist considered *"a pressure relieving cushion"* for Mr D and recorded "*Plan: connect with staff involved with client*". Mr D was released before the recorded action was taken.

It is to note that Mr D's solicitor wrote to Maghaberry Prison on (date redacted) stating that Mr D was having *"serious difficulties sleeping"* and that *"he has had to sleep in his wheelchair"*. The solicitor also requested that Mr D be seen by an occupational therapist. The South Eastern Health and Social Care Trust (SEHSCT) replied on the (date redacted) saying that the concerns would be "*passed to the appropriate health care professional to deal with*".

During a consultation on (date redacted), a prison doctor recorded that *"the* (pressure) *sore is healing well but sleep still an issue".* Zopiclone 7.5mg was again prescribed and a repeat prescription for diazepam 2mg four daily.

On (date redacted), Mr D was found during a routine rub down search, to be in possession of medication not prescribed to him. The medication consisted of "*five white tablets*" and 10 codydramol[31]. It is to note that, following this medication find, Mr D was not put forward for a drugs test nor was he referred to Ad:Ept[32]. There is also no record in Mr D's EMIS records to suggest that healthcare staff were aware that he had been found with medication that was not prescribed to him. As a result no further in possession medication risk assessment, as required by the South Eastern Health and Social Care Trust's Standard Operating Procedures, took place.

The investigation found evidence from both staff and inmates who were located in Foyle House on the same landing as Mr D, that there was a significant problem with medication and illicit drug abuse on that landing at the time.

At interview, an officer who worked regularly in Foyle House and remembered Mr D said that he *"got the impression that there was a serious drugs issue going on with him* (Mr D)*, in that he was either taking drugs from other people or using his own to hand out... I just got the impression that he would use anything that he could get and at that time on that landing there was an awful lot of drugs, an awful lot."*

The officer said that there were *"periods when he came back from substitution therapy* (where Mr D's OxyContin was administered) *there would be prisoners constantly around his cell door, they were always moving and this was prisoners coming down from up the stairs, on* (the) *threes and fours. We were trying to get them all away from the grill because his cell was right beside the end of wing grill"* the staff were *"constantly shooing them off"* to get them to *"keep away from his cell".* He continued saying that staff would be

[31] Codydramol is a pain killing medicine used to relieve mild to moderate pain and fever. Codydramol tablets contain contain two active ingredients, paracetamol and dihydrocodeine.
[32] Ad:Ept (Alcohol and Drugs: Empowering People through Therapy): a comprehensive substance misuse service that provides a multi component model of delivery.

"constantly… trying to get people out of (his) *cell that shouldn't have been there"* and said that he thought that other inmates would have gathered round his cell for *"tobacco"* or *"drugs".*

The officer recalled that *"there was also boys… always tapping him for tobacco. That was just the normal ongoing thing all the time he was there."*

The officer suggested that Mr D, because of his disability, was vulnerable "*he was all alone in the fact that he was in a wheelchair… and whether he was giving the stuff willingly…"* the officer said that *"there's every chance"* that Mr D might have been put under pressure *"to hand stuff out…"* and *"we had a particularly bad element on those two landings."*

The officer said, at that time "*in terms of behaviour and drugs… there was fines men* (fine defaulters) *with lifers. It* (the two landings) *was just a complete zoo… it was just something* (we) *were trying to keep on top of all the time".*

Another officer who also worked in Foyle House said that Mr D *"had quite a lot of visitors in his cell"* and that *"it seemed like he had a lot of friends, in a sense, because they were in and out of his cell….whether they were scrounging off him or whatever, but he did seem to have quite a lot of people around him".*

The officer said that the people who hung around Mr D's cell would have been associated with drug use and that prisoners from the landing upstairs would have been calling for Mr D at the grill at the end of the landing and that he (the officer) would have told them to move on quite a few times "*if they were looking for him obviously to scrounge off him*".

The officer noticed that Mr D was sometimes drowsy and slurred his words but said that he put that down to his medication. The officer said that "*there's that much drug dealing on that landing, a lot of them are drowsy a lot of the time".*

The investigation spoke to a number of inmates who were housed in Foyle House during Mr D's period in custody. An inmate who associated with Mr D

said that Mr D *"was into his drugs in a big way....He loved his medication....OxyContin, Pregablin, it's what he done with them was dangerous."*

The inmate said that Mr D "*would put them in a bag and mix them all up with a powder, diazepam, OxyContin's, muscle tablets, he would mix them all together... and he would have sucked them into his lungs... he poured the powder into the wee hole* (of his inhaler) *and then sucked it through his lungs, he said that it would go to the veins in your lungs and would give you a better hit."* The inmate said that Mr D "*swallowed tablets too".*

When asked if he knew if Mr D was taking anything other than his prescription medication the inmate said *"he was taking his medication heavy, he was doing deals with people, so he would have been taking subutex*[33] *as well do you know what I mean, anything he could get his hands on".*

Another inmate said that *"He* (Mr D) *would come down into the association room and talked away to the boys and all then I think he started getting pissed off because people were torturing him for his medication, people hounding him about it like because he was on a lot of strong medication".* He said that Mr D *"stopped going down* (to the recreation room) *because people were annoying him for his medication".*

The inmate recalled that Mr D bragged about the strength of the medication he was on and would *"leave his* (medication) *box open on display"* on top of his desk in his cell. He said that he was drowsy all the time and that *"you knew when he was off his head* (because) *his eyes, or whatever, were down and he wasn't as chirpy, not as chirpy as normal when you knew he was off his head and he was talking about holidays and all that".* The inmate explained that it was obvious when Mr D had had *"his fix"* because his eyes would be *"drooping out of his head".*

The inmate said that it was the talk of the yards that *"your man in the wheelchair gets 300's* (pregabalin)*... people were torturing him about it. He*

[33] Subutex is a type of medicine called an opioid. Opioids are painkillers that work by mimicking the action of naturally occurring pain-reducing chemicals called endorphins.

sold his pregabalin and his morphine patches (actually nicotine patches) *in return for tobacco… they were smoking it, they were like taking that off and like rubbing it together and it came off out like a snooter and they were putting that on the foil and burning it."*

There is also evidence in telephone conversations that Mr D was taking medication over and above that prescribed for him and that other inmates were putting him under pressure for his medication. On (date redacted), during a telephone conversation, Mr D says that if he did not need to use the phone, he would not bother coming out of his cell as he gets *"tortured"* for his medication.

On (date redacted), Mr D calls someone different and talks to them about his temazepam (previously prescribed in the community to address sleeping problems) being stopped but says that he has been buying them in prison and that he will tell the doctor when he gets out *"what he has had to take as a replacement".* Mr D says that what he has been getting is *"even more effective than the temazepam,"* but that he can't say the name of the tablet on the phone because as far as he knows *"there's only one man in the jail that's on them"* and that he has *"been getting the odd one off him".* Mr D says that these tablets have *"given him the best night's sleep he's had in years".*

During his phone calls, Mr D's speech is slurred and he sounds very drowsy.

At 18.30 on (date redacted), Mr D was released from Maghaberry Prison. At 10.05, he was given his daily dose of OxyContin. Prior to his release at 18.20, he was then given a three day supply of OxyContin. It is not possible to say what quantity of his other medication Mr D was given prior to his release because, as stated, the Kardex detailing his other medication can not be found by healthcare staff.

One of the concerns raised by Mr D's family was why he appeared to be drowsy, unsteady and looking so unwell when they collected him from Maghaberry.

At interview, a governor who discharged Mr D said that he was *"very upbeat,"* had *"a smile on his face"* and mentioned that he was going to have a party and a drink when he got out. The governor said that Mr D did not seem unwell or look drowsy and there was nothing unusual about his appearance that caused him concern. The driver of the bus which transported Mr D from the main prison to the Quakers Centre to meet (name redacted) said that they chatted during the short journey. He said that Mr D appeared to be *"pleasant, friendly"* and *"alert and talking away".*

At interview, an inmate said that on the morning of the day that Mr D was released, *"he took something, OxyContin he got out of the hospital and something else, it was pregabalin, he took them before he got out. Now he did tell me there was medication outside for him, waiting for him, and as far as the rumours, the rumours went in prison after he died, was he took more OxyContin's outside and that's why he died, that's what I know of."*

Mr D's community GP records confirm that a week's supply of his medication was prescribed, in readiness for his release from prison. Medicines removed from Mr D's home after his death were not retained by the PSNI, so it is not possible to say whether any were used.

Mr D' family met him at the Quaker's Centre at 18.30 on (date redacted). His (name redacted) said that on the way home Mr D began to appear *"under the influence of drink"* and *"highly medicated"*. (Name redacted) recalled that Mr D said that his swollen legs were hanging out over his socks and that his head *"felt up to here,"* whilst making gestures with his hand above his head. They said his eyes were *"looking heavy"* and said also that he was falling asleep in the car on the way home.

(Name redacted) said that, when they arrived home, Mr D struggled to stay awake throughout dinner, "*could not hold himself up at the dinner table and at one point turned a grey colour*". She said that she therefore encouraged him to have a lie down on the couch, which he did. She said she placed a blanket over him and he fell asleep immediately.

(Name redacted) said he heard Mr D snoring at midnight and (name redacted) said he was snoring at 01.10, when she went downstairs to check him. (Name redacted) said that she went downstairs to check him again at 05.10 and she knew he was dead.

Mr D's (name redacted) contacted the police and ambulance service. He was subsequently pronounced dead at 07.00 on (date redacted).

An autopsy examination was carried out on (date redacted) and gave the cause of Mr D's death as pneumonia.

The report, detailed at Page 68 of this report, stated that *"Death was due to natural causes. Microscopic examination of tissue sections revealed evidence of an acute bacterial infection of one or both of the lungs. This can be a severe, life-threatening condition as it can impair the respiratory function of the lungs and infection may enter the bloodstream, spreading its effect around the body."*

Toxicological analysis of a sample of blood taken at autopsy revealed the presence of a number of drugs. The opiate analgesic (painkilling) drugs codeine, morphine and oxycodone (OxyContin) were detected at concentrations that lay within their respective therapeutic ranges. The concentrations of the drugs in the stomach contents suggested that Mr D had taken codeine and a relatively high dose of oxycodone in the hours prior to his death. The antidepressant drug citalopram, the sleeping pill zopiclone, the sedative drug diazepam (Valium) and a breakdown product of a related drug, clonazepam, were also detected in the blood sample.

A forensic scientist, Christina Isalberti, was commissioned, as part of the post mortem investigation, to provide a detailed analysis of blood and stomach contents samples of Mr D. Over and above the conclusions referred to in the autopsy report, Ms Isalberti concluded that *"codeinem morphone and oxycodone* (OxyContin) *may interact, enhancing their own central nervous depressant effect. Their depressant effects may have been further enhanced by the presence of benzodiazepines, zopiclone and citalopram. The possibility that the combined central nervous system depressant effects of all these drugs may have contributed to Mr D's death cannot be completely ruled out."*

In his clinical review, Dr Saul, said that he would agree with Ms Isalberti's conclusions but he noted that each medication was being prescribed for specific clinical reasons to alleviate distress and manage medical conditions. Dr Saul said that it would not have been possible to offer this medical support without incurring a risk of adverse effects. Dr Saul also highlighted that there was evidence of use of non prescribed drugs which have had a sedative effect and may have further contributed to the risks of Mr D developing pneumonia.

Dr Saul noted also that the fact that Mr D experienced increased pain and a pressure sore due to the fact that suitable bedding was not been provided. He commented that the consequences of this were that the dose of opiates was increased and he became more drowsy with increased risks of respiratory complications. A full summary of Dr Saul's findings is at Section 8.

The Prisoner Ombudsman has raised issues in relation to the availability and management of drugs in Northern Ireland prisons time and again in previous reports into Death in Custody investigations. The need for a comprehensive and consistently applied strategy for addressing issues related to both the supply of and demand for illicit substances and non-prescribed medication has been emphasised. It is to note that several areas of concern identified in previous Death in Custody reports were, once again, evidenced during the course of this investigation. These are included as Issues of Concern in the following section.

ISSUES OF CONCERN REQUIRING ACTION

As explained in the preface, the following issues of concern, requiring action by the Northern Ireland Prison Service (NIPS) and South Eastern Health and Social Care Trust (SEHSCT), were identified during the investigation into the death of Mr D. I have asked the Director General of NIPS and Chief Executive of the SEHSCT to confirm to me that these issues will be addressed, where relevant service wide.

1. Mr D received a further prescription for OxyContin on the (date redacted), (date redacted) and the (date redacted) without being seen by a doctor.

2. Mr D was not provided with an appropriate mattress and bed in prison which resulted in him suffering unnecessary discomfort and pain, sleeping in his wheelchair and requiring additional pain control medication.

3. When Mr D was referred to physiotherapy on (date redacted), the referral was not received.

4. The Healthcare Department were not advised that Mr D had been found in-possession of non-prescribed medicines.

5. Mr D's community medical records were not requested.

6. Mr D's Kardex detailing the medication issued to him could not be provided to the investigation.

7. No consideration was given to referring Mr D to Ad:Ept even though it was known that he was being seen by FASA in the community.

8. No consideration was given by prison staff to referring Mr D to Ad:Ept when he was found to have taken non-prescribed medication.

9. The Healthcare Department did not find out that Mr D was on the Northern Ireland Drug Addicts Index when they spoke to his GP.

10. There is no access to EMIS in the Substitution Therapy Clinic where risk assessments for controlled drugs are carried out.

11. During his period in police custody and following his committal, Mr D was recorded to have been without all of his medication for more than two days.

12. When his diazepam prescription was reduced, Trust policy was not explained to Mr D and a suitable care and support plan was not put in place.

13. Mr D's pressure sore was not re-dressed for 11 days.

14. The investigation found evidence of the following issues related to the management of illicit drugs and non-prescribed medication, all of which have been highlighted in previous death in custody and complaint investigation reports:

- An acceptance by staff of the inevitability of the prevalence of drugs in prison.

- The ease with which medicines and illicit drugs can be sourced and traded in prison.

- A failure on the part of both prison and healthcare staff to take action where somebody is displaying clear indications of drowsiness and slurred speech as a result of medicine/drug abuse.

- Inadequate intelligence led cell searching.

- A failure to listen to and act on evidence from phone calls where there is reason to suspect drug / medicine abuse.

- A failure to refer inmates with obvious addiction problems to therapeutic support services.

- An inadequate response to vulnerability issues that are known to staff.

- No clear communication strategy between prison and healthcare staff that can be implemented in the event that an inmate is found with medication which has not been prescribed to them.

- No written policy in relation to what course of action an officer should take having found an inmate to be in possession of medication which has not been prescribed to him.

- No automatic drug testing in response to incidents where an inmate is found to be in possession of medication which has not been prescribed to him.

- Inadequate cell searching arrangements when it is known that drugs / medication are being abused on a landing.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[34] for Northern Ireland, I have responsibility for investigating the death of Mr D. My Terms of Reference for investigating deaths occurring in prison custody, or (in certain circumstances) shortly after leaving prison are attached at Appendix 1 to this report.

2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the State's 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 Mr D's death were:

- 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 and South Eastern Health and Social Care Trust.

- To examine whether any change in Prison Service or South Eastern Health and Social Care Trust operational methods, policy, practice or management arrangements could help prevent a similar death in the future.

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

- To ensure that Mr D's family have an opportunity to raise any concerns that they may have and that these are taken into account in the investigation.

- To 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.

Family Liaison

5. An important aspect of the role of the Prisoner Ombudsman dealing with any death in custody is to liaise with the family.

6. When an inmate dies in prison custody, or shortly after leaving prison, it is important to listen to any questions or concerns family members may have.

7. My predecessor, Pauline McCabe, first met with Mr D's family on (date redacted) and my investigators were grateful for the opportunity to provide them with progress updates throughout the investigation. In July 2013, I met with Mr D's family to explain and discuss the findings and issues of concerns within this report.

8. It was important for the investigation to learn more about Mr D's background, history and personal circumstances before he died. I would like to thank his family for giving us the opportunity to talk with them about this.

9. Although the report will inform many interested parties, it is written primarily with Mr D's family in mind. It is also written in the trust that it will inform Prison Service and SEHSCT policy or practice, in a way that may help to prevent a similar death in the future.

10. The following questions were raised by Mr D's family:

- Why was Mr D so drowsy, unsteady and looking so unwell when he was released from Maghaberry Prison and why did he continue to be this way for the rest of his last evening?
- Why were Mr D's legs so swollen at the time of his release?
- What medication was Mr D taking whilst in Maghaberry Prison?
- Was the medication/dosage Mr D was prescribed in prison appropriate for his medical needs?
- Were Mr D's mobility issues properly addressed in prison?
- What medication was Mr D given on the day of his discharge?

FINDINGS

SECTION 1: BACKGROUND

Mr D

Mr D was born on (date redacted). He was (age redacted) when he died at [redacted] on (date redacted).

The investigation examined Mr D's community medical records, prison records and prison medical records and noted the following background information.

Mr D was committed to Maghaberry Prison on (date redacted) and released on the evening of (date redacted). Prior to Mr D's last committal, he had six previous committals between 1999 and 2010. These ranged from three days to seven weeks and were for a range of motoring and fine default offences.

In (date redacted), Mr D was involved in a road traffic collision in which his friend died and he sustained extensive injuries. As a result of the accident, his mobility was severely impaired and he suffered from chronic leg and back pain for which he was treated with high doses of painkillers and had to use a wheelchair. (Name redacted) said that they noticed a marked deterioration in his quality of life after his accident.

Mr D had a [redacted] with whom he had [redacted] and, after the collision, (name redacted) was his full time carer. The relationship ended (date redacted) prior to Mr D's death.

From (date redacted), Mr D regularly displayed symptoms of anxiety, depression and Post Traumatic Stress Disorder (PTSD)[35] for which he received support from community psychiatric services. Mr D's community medical records note that his low mood was due to "*his inability to cope with his social and physical circumstances*". Mr D was noted to have spoken of his

[35] Post Traumatic Stress Disorder is an anxiety disorder caused by very stressful, frightening or distressing events.

[redacted] problems, his poor physical health and a threat from [redacted] he was under.

On (date redacted), Mr D was admitted to the Dorothy Gardner Unit[36] at Knockbracken Healthcare Park and was then transferred to Ards Hospital acute mental health unit. When Mr D was discharged on (date redacted), the doctor noted that "*there was no evidence of a depressive illness and that his distress prior to admission was the result of situational difficulties".*

From (date redacted) to Mr D's final committal to Maghaberry, it is recorded that he was dependent on alcohol. It is also recorded that he took several overdoses of his medication and told his doctor of other self harm incidents, including one in (date redacted) when he drove into a wall and one in (date redacted) when he walked in front of a bus after writing "*goodbye letters"* to [redacted]. Following this incident, he was taken to hospital.

In (date redacted) was placed on the Northern Ireland Drug Addicts Index[37]. It is recorded that this was because he had become addicted to OxyContin[38] tablets. Over the years Mr D regularly attended his GP surgery and hospital outpatient departments looking for pain relief medication, stating that he had *"run out of"* or *"lost"* his prescribed medication. There is also evidence that Mr D, at times, abused illicit drugs[39].

In (date redacted), it is recorded that Mr D had problems sleeping and had said that his *"sleep pattern usually involved no sleep for 72—96 hours followed by 12 hours sleep".* Mr D was also recorded to have reported *"having problems with flashbacks and nightmares* (from the road traffic collision) *and this is the reason why he keeps himself awake*".

In (date redacted), it is recorded that Mr D reported to the Mental Heath Outpatients Centre that he had asked *"his* [redacted] *to manage his medications*

[36] Dorothy Gardner Unit is one of five hospital recovery mental health inpatient services based at Knockbracken Healthcare Park.
[37] People are registered on the index if they are known to be, or if a medical practitioner considers them to be, addicted to one or more controlled drugs.
[38] OxyContin is a trade name for the drug oxycodone hydrochloride. It is an opioid (narcotic) analgesic (pain reliever). OxyContin is a controlled release oral formulation of oxycodone hydrochloride. It is used to treat moderate to severe pain.
[39] Heroin, Cannabis, Cocaine and Ecstasy.

for him as he had previous problems with missed dosing and overdosing, particularly on his pm medications".

On (date redacted), a consultant in Anaesthesia and Pain Management recorded that Mr D's *"speech was quite slurred and slow which may be related to his 600mgs pregabalin[40]. He still continues to take 120mgs OxyContin and whether that is contributing to his other aches and pains by causing opioid induced hyperalgesia[41] or whether he has become tolerant of it, it is hard to know."*

On (date redacted), Mr D was discharged from the Ulster Hospital after being admitted on (date redacted) for abdominal pain. The discharge and medication advice letter stated that Mr D is on a *"high dose* (of) *OxyContin after RTA* (Road Traffic Accident). *On oxygen in A+E became drowsy and had a respiratory acidosis[42] with type 2 respiratory failure....needs investigated for sleep apnoea[43]. OxyContin reduced from 60mg to 40mg* (twice a day)." It is to note that the doctor at the Ulster Hospital stopped Mr D's diazepam prescription and reduced his dose of OxyContin, because of his respiratory depression.

Back in the community, Mr D continued to be prescribed diazepam and his higher dose of OxyContin, 120mg per day.

A psychiatric assessment on (date redacted) notes that, since the breakdown of his relationship with (name redacted), Mr D's (name redacted) was keeping *"his eye on his medications"*.

Mr D's last inpatient admission was to Belfast City Hospital on (date redacted) and occurred after he was found unconscious by a friend and noted to have medication boxes scattered around him. He was diagnosed with self-

[40] Pregabalin is a medicine which is used in neuropathic pain (pain from damaged nerves), anxiety disorder, partial epilepsy and secondarily generalised partial epilepsy.
[41] Opioid Induced Hyperalgesia (OIH) is caused by exposure to opioids. The condition is characterized by a paradoxical response whereby a patient receiving opioids for the treatment of pain could actually become more sensitive to certain painful stimuli. OIH is a paradoxical response whereby instead of a pain killing effect occurring, there is an increase in pain perception.
[42] Respiratory acidosis is a condition in which a build up of carbon dioxide in the blood produces a shift in the body's pH balance and causes the body's system to become more acidic.
[43] Sleep apnoea is a condition where a persons breathing stops for short spells when they are asleep.

poisoning, alcohol intoxication, aspiration pneumonia[44] and rhabdomyolysis[45] and was discharged on (date redacted).

Mr D's prison medical records note that, in the community, he was receiving a home help service twice a day, seven days a week, to assist him with his personal care needs.

[44] Aspiration pneumonia is inflammation of the lungs and airways to the lungs from breathing in foreign material. It occurs when foreign materials (usually food, liquids, vomit or fluids from the mouth) are breathed into the lungs or airways leading to the lungs.
[45] Rhabdomyolysis is the rapid destruction of skeletal muscle resulting in leakage into the urine of the muscle protein myoglobin.

SECTION 2: MR D'S COMMITTAL TO MAGHABERRY PRISON ON (date redacted)

Arrival at Prison (date redacted)

Mr D's Temporary Inmate Record[46] shows that he arrived at Maghaberry at 21.06 on (date redacted), having been convicted of a number of driving offences and a breach of a suspended sentence.

Due to the lateness of Mr D's arrival, an initial 'Keepsafe[47]' healthcare assessment took place. The nurse who completed the assessment recorded that Mr D had "*deterioration in mobility*" since his last committal, that he *"now uses a wheelchair more or less permanently"* and that he could *"manage approx 20-30 yards walking on crutches".* The nurse also recorded that Mr D had been seen by *"FASA[48] for recent dsh* (deliberate self harm) *by deliberate overdose of prescription meds"* four weeks prior to his committal. She noted that Mr D was in a ground floor cell in Lagan House but that he would *"need a disabled cell and bottom bunk".* She also noted that he would need to see a doctor in relation to his physical health and medication and that his medication was *"as per EMIS[49]* (date redacted)*."*

It is to note that despite Mr D's history of alcohol and drug (prescription and illicit) abuse and the fact that he was being seen by FASA in the community, no consideration was given to refer Mr D to Ad:Ept[50] services in prison.

At interview the nurse said that "*a Keepsafe assessment can last on average between 10 and 20 minutes. Its purpose is to keep the inmate safe overnight and to ensure that there is nothing pressing that needs to be done that night to keep the inmate safe.... I was aware of [Mr D's] history and asked him, as part of the Keepsafe assessment, if he had any thoughts of self harm, he answered*

[46] This is a record which is created as soon as an inmate is checked into the prison via the main gate. Until Reception processes the inmate by generating an inmate ID, the inmate remains has a temporary inmate record.
[47] A Keepsafe assessment is carried out when a prisoner is committed late in the evening. It is followed by a full healthcare assessment the following day.
[48] FASA is an organisation which provides specialist services in relation to substance misuse, suicide, and self harm.
[49] EMIS (Egton Medical Information System): an electronic medical records system used by the healthcare department of the Northern Ireland Prison Service.
[50] Ad:Ept (Alcohol and Drugs: Empowering People through Therapy): a comprehensive substance misuse service that provides a multi component model of delivery.

that he had none at present. When asked, the nurse said *"I was aware that [Mr D] was a registered addict and that he abused alcohol, however, a Keepsafe assessment is not the time for a referral to be made to Ad:Ept or any other specialist support services or specific mental health services. I knew that [Mr D] would have a full healthcare assessment the next day and it is at that assessment that any necessary referral should be made."*

Committal Healthcare Assessment

On (date redacted), as required by Prison Service policy, a more comprehensive healthcare assessment was completed. The nurse who completed this assessment recorded, at 09.13, that Mr D had "*long standing illness, disability or infirmity*", "*mobility issues"* and *"uses wheelchair majority of time and crutches in addition to mobilise short distances only. This man was placed in landing one Lagan House last night as Bann* (House)[51] *was overcrowded."* The nurse also recorded that Mr D denied being able to use the stairs but *"would have had to complete stairs in order to get to where he is now located".* She noted that Mr D had said: that he had *"depression, mainly as a result of his impaired physical health post RTA";* that he was *"on controlled drug meds – OxyContin 60mgs bd* (twice a day)*"* and that he had been admitted to Belfast City Hospital, four weeks prior to his committal, because *"he took his medication while intoxicated,"* but that this *"was accidental and not a suicidal attempt".* The nurse also recorded that Mr D was a heavy drinker who admitted *"to drinking a bottle of gin or vodka most days"* but that there were *"no signs of withdrawal currently – will require GP review today or tomorrow".* She noted that he would require a *"disabled cell and/or bed in healthcare".*

The nurse recorded that Mr D had *"no thoughts of self harm currently. Mental state alert, cooperative and coherent. Behaviour assessment appropriate, no obvious causes for concern"* and that there was no *"immediate action required".* It was also recorded that Mr D's GP had been contacted to confirm his medication.

[51] Bann House is a House where all committal prisoners are located for the first 3 to 5 days of their custody. During this time they undertake a set induction course.

It is to note that despite the information Mr D had provided during this interview and during the Keepsafe assessment the previous evening, there was still no referral made to Ad:Ept. When asked about their policy in relation to referral to Ad:Ept, a Healthcare manager said: *"Ad:Ept is a self referral service however they will take referrals from healthcare staff, it can be done in committals, this would be where a person presents with an alcohol problem and wishes to take advice or address same. Healthcare shall advise upon Ad:Ept service and if the client is not best able to refer self the nurse shall do on his behalf. There is no policy upon referral to Ad:Ept and I understand Ad:Ept shall take referral at any point."*

It is to note that an inmate can be referred to Ad:Ept by healthcare staff, prison staff, chaplaincy staff or by a fellow inmate as well as through self referral. Enquiries made with Ad:Ept confirmed that Mr D did not make any self referral during his time in custody.

Processing Interview

On (date redacted) Mr D was processed through prison reception by a reception officer. The officer recorded that there was no evidence or indicators of self harm and that Mr D had no thoughts of self harm.

"First Night in Prison" Committal Interview

Prison Service policy states that, as part of the committal process, prisoners should receive a "First Night in Prison" committal interview with a member of prison staff. This interview is intended to cover subjects such as a prisoner's history, personal details in relation to dependants and next of kin and whether or not he feels at risk in custody. Mr D did not have his "First Night in Prison" committal interview either on (date redacted) or (date redacted).

At interview, the officer who had processed Mr D through reception said that, at the time of Mr D's committal in (date redacted), reception officers did not carry out committal interviews. He said that there was a committal officer who carried out these interviews, either in reception or on the committal landing in Bann House. He said that if the committal interview did not take

place in reception then it would be assumed that it would be carried out on the committal landing. As stated previously, Mr D did not go to Bann House due to overcrowding.

The senior officer said that the process has since changed and that now *"the reception officer does all the committal interviews, which slows the process down, but it covers the point that all of the paperwork is now completed".*

Transfer to Low Mobility Cell

It is recorded in the Class Officer's Journal that at 11.25 on (date redacted), Mr D was moved to Braid House. The investigation has established that Mr D was moved to a *"low mobility cell"*[52].

Non Urgent Call-Out

Although the nurse who carried out Mr D's Keepsafe assessment on (date redacted) recorded that he should see a prison doctor the next day, Mr D did not see a doctor on (date redacted). At 21.29 on the (date redacted), it is recorded in Mr D's medical records that he was seen by a nurse in Braid House because he was complaining of diarrhoea and vomiting. She noted that Mr D was *"on large doses of morphine and codeine based meds, not had any since am* (date redacted) *in police custody....scoreing (sic) 25*[53] *on COWS*[54] *d/w* (discussed with) (a prison doctor) *, pr* (prisoner) *to have co-codamol*[55] *30/500 x 2 qid* (four times a day) *and ventolin*[56] *inhaler, must be seen in am".*

At interview the nurse said *"On the night of the* (date redacted) *I was called out to see [Mr D]. He was displaying signs of withdrawal and a chest infection. I spoke to* (a prison doctor) *on the telephone and discussed [Mr D]'s condition with him. He gave a prescription over the phone of two co-codamol four times a day and a ventolin inhaler. This was to treat the withdrawal from opiates and to aid his breathing. I recorded that [Mr D] would need to be seen the next*

[52] A low mobility cell is one which has been adapted to be suitable to accommodate a disabled inmate.
[53] 25 – 36 on the Clinical Opiate Withdrawal Scale indicates that withdrawal was moderately severe.
[54] COWS: Clinical Opiate Withdrawal Scale.
[55] Co-codamol contains codeine and paracetamol. It is a medicine which is used in relieving severe pain
[56] Ventolin is a medicine which is used to treat asthma and bronchospasm. It relaxes muscles in the air passages of the lungs and helps to keep the airways open making it easier to breathe. It contains salbutamol.

morning. I would have recorded that in the House handover sheet which I would have brought to healthcare at the end of my shift the next morning for the information of the nurse who was coming on duty in that house."

It is to note that the Kardex[57] in respect of all of Mr D's medication, except his OxyContin, is missing and cannot be located by healthcare staff. It was not, therefore, possible for the investigation to review what medication Mr D received or what arrangements were put in place for the administration of this medication.

At 10.30 the next morning, a nurse carried out a further Clinical Opiate Withdrawal Scale assessment. At this assessment, Mr D scored 13[58] on the scale. A result of between 13–24 on the Clinical Opiate Withdrawal Scale indicates that withdrawal is moderate. The following noted symptoms were ticked on the assessment sheet: vomiting, diarrhoea, increased irritability or anxiousness, sweat on brow or face, nose running or tearing and severe diffuse aching of joints and muscles.

[57] A Kardex is a medication administration card which records when and how much medication is administered by healthcare staff to the patient.
[58] 13 – 24 on the Clinical Opiate Withdrawal Scale indicates that withdrawal was moderate.

SECTION 3: MR D'S MEDICATION MANAGEMENT

Community Medication

Prior to his committal, Mr D was being prescribed the following medication by his GP in the community:

- Temazepam 10mg, one at night – used to address sleeping problems
- Loperamide 2mg, as needed – used for stomach problems
- Citalopram 40mg, once daily – used for depression
- Furosemide 20mg, once daily – used to reduce swelling and fluid retention
- Movelat gel, to be applied three times daily – used to treat muscular aches and pains
- OxyContin 20mg, three in the morning and three at night - an opioid painkiller to treat moderate to severe pain
- Co-codamol 30mg+500mg, two tablets up to four times a day - a pain killer
- Omeprazole 20mg, once daily – used to treat stomach problems
- Baclofen 10mg, two three times a day – used to relieve muscle spasms
- Diazepam 5mg, one twice a day – used to relieve anxiety
- Pregabalin 300mg, one twice a day – used to treat nerve damage
- Beclometasone 100mg, inhale two doses twice daily – reduces inflammation in the airway
- Salbutamol 100mg, inhale two doses as needed – used to treat asthma

(Date redacted)

On (date redacted) a prison doctor prescribed Mr D with the following medication: citalopram hydrobromide 20mg one to be taken each morning; co-codamol 30/500 two to be taken three times a day, oxycodone hydrochloride (trade name: OxyContin) 20mg 3 BD (twice a day)[59]; diazepam 5mg one to be taken twice a day; omeprazole capsules 20mg once daily; furosemide 20mg once daily; baclofen 10mg two three times a day and pregabalin capsules

300mg one twice a day. The doctor did not have a face to face consultation with Mr D before prescribing this medication, despite, as stated earlier, the nurse's referral to do so.

Assessment by Prison Doctor - (date redacted)

On (date redacted), Mr D was assessed by a prison doctor. The doctor recorded in Mr D's prison medical records that he had *"accerbation asthma wheeze…no resp distress…increase steroid inhaler for 2 weeks then one puff bd* (twice a day)*, review as needed, smoking advice given patches".*

Mr D was also prescribed co-amoxiclav (an antibiotic) 500/125 one three times a day for a chest infection; prednisolone[60] 5mg eight to be taken each morning for five days, nicotine transdermal patches[61] 21mg, fusidic acid cream[62] 2% and beclometasone 200mg two puffs twice a day. In addition to this, Mr D's citalopram hydrobromide was increased from 20mg to 40mg, (in line with his community prescription) and his co-codamol 30/500 was increased from six to eight tablets a day.

In Possession Risk Assessment – (date redacted)

On (date redacted), a nurse carried out a risk assessment to ascertain Mr D's suitability for holding and administering his own OxyContin (a controlled drug). As the Kardex detailing all of Mr D's other medication is missing, it is not known what arrangements were put in place for administering these medicines and whether a separate "In Possession Risk Assessment" was completed. Evidence from interviews would, however, suggest that Mr D was permitted to manage his own medication.

A question asked during the risk assessment for OxyContin was *"Has the prisoner overdosed on prescribed medication in the last three months?"* Despite the information recorded at the time of Mr D's Keepsafe and committal

[60] Prednisolone is a corticosteroid. It works by preventing or reducing inflammation. It is used to treat a number of conditions that are characterised by excessive inflammation such as asthma, rheumatoid arthritis and colitis.
[61] Nicotine transdermal patches are medication that belongs to a family of medications known as nicotine replacement therapies. It is used to help people to quit smoking. This medication helps reduce the symptoms of nicotine withdrawal by replacing some of the nicotine that the person no longer receives through cigarettes.
[62] Fusidic Acid Cream is an antibacterial cream which is used to treat skin infections.

healthcare assessments that he had overdosed on his prescription medication four weeks prior to committal, the nurse recorded *"no"* as the answer to this question.

At interview the nurse said "*I do not have any memory of carrying out this risk assessment…there is no EMIS access in the substitution therapy clinic*[63] *where I would have carried out the risk assessment and I can not recall if I saw on EMIS that* [Mr D] *had taken an unintentional overdose four weeks prior to committal. However, even if I had been aware of the unintentional overdose the fact that he* (Mr D) *said it was an accidental overdose while he was intoxicated and that it was not a suicidal attempt would have been a significant factor that I would have taken into consideration in my assessment that he was suitable for in possession medication."*

Another question asked during the risk assessment was *"Did the prisoner look after their own medications at home?"* In answer to this, the nurse recorded *"yes"*. As stated previously, Mr D's community medical records note that (name redacted), in fact, managed his medication prior to the breakdown of their relationship and (name redacted) then "*kept an eye on his medication*". It was, however, the case that Mr D's community medical records were never requested by healthcare staff.

At interview, the nurse said "*The answers to the questions I asked during the risk assessment would have been provided to me by [Mr D]. [Mr D] had told me that he had looked after his own medication at home and therefore I would have wanted to maintain that independence which he had in the community by assessing that he was suitable for in-possession medication. I would not have been aware that (name redacted) had managed his medication and then (name redacted) kept an eye on his medication in the community."*

The nurse also explained that *"I do not have any access to an inmate's medical history, his GP community records and therefore I would have been unaware of [Mr D]'s problems with medication in the community."*

[63] Mr D attended the substitution therapy clinic because he was receiving OxyContin which is a controlled drug and is only administered in this clinic.

The nurse assessed Mr D as suitable for in-possession medication for the controlled drug oxycodone (trade name OxyContin). Mr D was required to see the nurse each morning to have his oxycodone administered and supervised. He was given a further dose to administer himself in the evening, 12 hours after his first dose.

When asked about Mr D's missing Kardex, Healthcare staff said that the Kardex had been searched for and said that it was possible that it had been misfiled and that it may turn up at a later date. At the time of publishing this report, Mr D's Kardex had still not been found.

(Date redacted)

On (date redacted) a prison doctor prescribed diazepam 2mg two to be taken twice a day for Mr D. This was a reduced dose from that prescribed by Mr D's GP, consistent with the South Eastern Health and Social Care Trust policy of trying to reduce the use of particular medications in prison. There is no record that Mr D was seen by the doctor on this date. There is also no record of Mr D seeing the nurse on this date or of the Trust policy in relation to reducing medication being explained to Mr D. It is, therefore, not clear how the appropriateness of applying the medicine reduction policy in this instance was assessed. There is also no evidence that suitable review arrangements were put in place. However, on (date redacted), a nurse did record on EMIS that Mr D was *"requesting to see Dr regards insomnia and reduction of diazepam. Explained that it is standard procedure to reduce diazepam".*

The South Eastern Health and Social Care Trust's (SEHSCT) Clinical Lead for Maghaberry Prison told the investigation why it was the policy of the SEHSCT to reduce a patient's diazepam during their time in custody. He said that: *"It* (diazepam) *is addictive. It has a license for short term use only, in extreme anxiety, as stated in the British National Formulary and support by such institutions as the National Institute for Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). It is usually for two weeks use and in exceptional circumstances four. When someone comes to us they are usually on it for a lot longer than this. It also has a high currency value in prison."*

It is to note that the Prisoner Ombudsman supports the approach of the SEHSCT to gradually reduce the use of particular medicines in prison, **provided** the necessary and appropriate regime and support arrangements are in place and that the policy and care plan is explained to any inmate whose medication is to be reduced.

Telephone Call from (name redacted) – (date redacted)

On (date redacted), after visiting him in prison, (name redacted) telephoned the prison and spoke to a healthcare officer in the healthcare department. It is recorded on EMIS that (name redacted) called to tell the prison that Mr D was having to sleep in his wheelchair in prison. At interview, (name redacted) said that she informed the healthcare officer that Mr D had a profiling pressure relieving mattress at home and that he couldn't get comfortable in his prison bed.

It is recorded in Mr D's prison medical records that the healthcare officer asked a nurse to speak with Mr D about the matter. The nurse recorded that when she spoke to Mr D, he told her that he slept in his wheelchair because of pain he had in his hip and that he *"finds it more comfortable to sit in* (his) *chair"*. The nurse also recorded that Mr D told her that he *"can't get comfortable in bed"* and that he had a mattress that could be adjusted into an upright position, but that this does not help him. The nurse concluded her assessment noting that Mr D was *"due to see the doctor tomorrow for assessment".*

At interview, the nurse said that she could not remember this conversation with Mr D, but said that he must have told her that his mattress at the time folded because the consultation would have been in the treatment room and she would not, therefore, have seen for herself what type of bed he was sleeping on.

It is to note that there are only two types of beds available to a prisoner: a standard prison issue bed or an adjustable hospital bed. The healthcare centre does not keep a record of who is issued with an adjustable bed.

Mr D was seen by the doctor the following day where he was prescribed sleeping tablets and his oxycodone (OxyContin) medication was increased to 160mg per day. There is no evidence that any consideration was given to the suitability of Mr D's bed.

Doctor's Assessment – (date redacted)

On (date redacted), Mr D was assessed by a prison doctor. The doctor recorded in Mr D's medical notes that Mr D had *"chronic intractable pain"* and that "*he had lower body pain since an RTA in 2002, on wheelchair, attending MH*[64] *Pain Clinic, gets intermittent injection in back, pain persistent, disturbing sleep, poor concentration*". The doctor prescribed Mr D zopiclone (sleeping tablets) 3.75mg one to be taken at night for five nights and increased his daily dose of oxycodone hydrochloride from 120mg to 160mg, to help his pain. No plan to review Mr D, following the increase of this controlled drug, was recorded. In his clinical review report, Dr Saul stated that it would have been consistent with *"best practice"* for Mr D to be medically reviewed one week later.

Oxycodone (OxyContin) is an opiate analgesic drug, related to morphine and codeine. Reported adverse effects of opiate drugs such as codeine and morphine include nausea, vomiting, drowsiness and confusion, with higher doses causing respiratory depression leading to coma and death[65].

It is also to note that the British National Formulary[66] states that the contraindications for zopiclone include neuromuscular respiratory weakness including respiratory failure and severe sleep apnoea syndrome.

Forensic Scientist, Cristina Isalberti, from LGC Forensics, who was commissioned to carry out an analysis of samples of Mr D's blood and stomach contents as part of Mr D's post mortem investigation said that *"The presence of benzodiazepine drugs* (which Mr D was also taking) *and zopiclone may enhance the central nervous system depressant effects of codeine,*

[64] Mater Hospital.
[65] Toxicology Report of Cristina Isalberti, Forensic Scientist
[66] The British National Formulary contains information for health professionals on prescribing, monitoring, supplying and administering medicines.

morphine and oxycodone (OxyContin), *which may also interact, enhancing their own depressant effects… When different drugs with different effects are taken in combination, as in this case, the interactions are likely to be unpredictable. Nonetheless, it has to be noted that most of these drugs can cause sedation and as such, when taken together, the possibility that their combined central nervous system depressant effects may have contributed to Mr D's death cannot be completely ruled out."*

At interview the prison doctor who saw Mr D on (date redacted), said that he would access a copy of a prisoner's full medical history in *"extraordinary circumstances only"* and that he would usually obtain a prisoner's medical history by speaking to the prisoner. The doctor said that it would be *"very rare"* to get a *"full set of medical notes"* as healthcare *"don't have that contact, access to the full records".* It was the case, therefore, that the doctor was unaware of Mr D's addiction to oxycodone and his other health problems during the consultation.

The doctor said that "*He* (Mr D) *described having chronic intractable lower body pain since a traffic collision …ten years before. He was in a wheelchair and had been attending the Mater Chronic Pain Clinic. He had been given injections in his back and was on long term opiate medications to control his pain. He was getting breakthrough pain and at that time… I increased his dose of the oxycodone* (OxyContin) *medication from 60mg twice a day to 80mg twice a day and added a small dose of a sedative to try and improve his sleep."*

The investigation found that the Prison Healthcare Service was not told by Mr D's GP that he was a registered addict and the doctor and other medical staff were, therefore, unaware of this. Whilst one nurse said, when asked at interview, that she did know that Mr D was a registered addict, there is no evidence of this on EMIS. The doctor did, however, say "*Clearly he* (Mr D) *was dependent on it* (OxyContin) *but he appeared to be in a situation where he was in chronic intractable pain which is …. by definition a pain without an organic cause, well a current organic cause and there is dependence there. It appeared from the history and the information I had from the GP that it was reasonable to continue the opiate he had been given, the 60mg* (twice a day) *of oxycodone* (OxyContin), *plus a significant dose of codeine for quite some time."*

When asked whether any alternatives to increasing Mr D's prescription of oxycodone, such as a profiling pressure relieving bed and mattress were considered, the doctor said "*I don't' know, sometimes we would ask the OT* (occupational therapists) *to consider it, but we don't get involved directly as physicians… I suppose in time if… it had become a regular complaint. He didn't mention it during any consultation we had with him. If he had asked about it I probably would have…Whether it would be considered as an alternative or as an adjunct… obtaining something like that is again something that is going to take weeks."*

Individual Support Plan – (date redacted)

An Individual Support Plan is designed to help support prisoners with disabilities who are finding it difficult to cope with the normal prison regime. The Equality and Diversity Principal Officer visited Mr D on his landing on (date redacted) to commence the development of an Individual Support Plan for him and to ascertain whether there was anything additional he needed as a result of his disability. The following actions were agreed with Mr D: "*Occupational Therapy to assess, additional mattress to be supplied, cell to be cleaned by orderly, orderly to carry meals, to be facilitated with normal house gym sessions, orderly to push to gym if necessary."* The review date for all of these agreed actions was (date redacted). Mr D had been released from prison and had passed away by this date.

Referral to Occupational Therapy

On (date redacted), Mr D was seen by a prison doctor in relation to an infected injection site (likely to be injection site of injections Mr D was receiving in the community for pain). During this consultation Mr D raised his concern about his mattress and the doctor referred him to occupational therapy *"re bed and appropriate pressure relieving mattress and cushion".*

Nurse Assessment and Request for Medication Review

On (date redacted), Mr D was seen by a nurse who carried out a detailed assessment in preparation for his referral to occupational therapy. The nurse

reviewed Mr D's background, wheelchair use, activities, medication, home aids and pressure sores. The nurse noted that, during the consultation, Mr D "*dosed off several times and had to be verbally roused*". He further noted that *"this is due to side effects of medications. Also had accidental scald whilst making tea 2 days ago, ? related to medications. D/W* (discussed with) *SO* (Senior Nurse) (name redacted) *to be assessed by GP in emergency clinic tomorrow with regard to medication R/V* (review)*."*

It was the case that this helpful information was written down and scanned as an attachment to the nurse's entry on EMIS. The EMIS entry, however, said only *"Referred to OT* (occupational therapy) *re* (doctor's) (name redacted) *referral. Poor cognition noted whilst using wheelchair. No pressure relieving cushion and no appropriate mattress. Had airflow* (mattress) *at home. Has the start of a pressure on sacrum* (bottom of spine)*... Placed on vulnerable prisoners register in Foyle. Ulcer to be monitored and Duoderm dressings ordered for sacrum. To be reviewed regularly."* Healthcare staff reviewing Mr D's EMIS record would, therefore, only be aware of the additional information relating to Mr D dosing off during his consultation as a result of his medication and the request for him to be seen at the emergency clinic the next day, if they opened the attachment.

The investigation established that Mr D's name was not put down for the emergency clinic, nor was his name on the lists of prisoners who attended the emergency clinic on (date redacted), (date redacted) or (date redacted).

At interview, the senior nurse whom the nurse who assessed Mr D had spoken with, said that she had no recollection of this conversation. The senior nurse also said that *"it would have been the responsibility of* (the nurse) (name redacted) *to put [Mr D] on the emergency clinic list for the next day."*

The investigation attempted to source a copy of the "vulnerable prisoners register" in Foyle house, referred to by the nurse in his notes, but found that there is no such register. It is not, therefore, clear to what the nurse is referring in his notes but it would seem that he was recognising that Mr D's demeanour, and the fact that he scalded himself, showed him to be vulnerable and that landing staff should made aware of this. Shortly afterwards the

nurse left the Trust and neither the Healthcare Department in Maghaberry Prison nor the SEHSCT headquarters hold any contact details for him.

Request in relation to Mr D's Wheelchair

On (date redacted), Mr D submitted a request which stated *"I had spoken to the medical staff two weeks ago about faults developing in my wheelchair since coming in. It has now broken. There are a number of faults which are so bad, I have fallen straight out of it on to my hands because it locks up completely going down the ramps. One foot rest won't stay up and the other broke off completely today. I am in chronic pain from my back and leg, which I made worse today by scalding my leg with boiling water. I rely on it to get over to the hospital everyday for medication as well as getting about the landing. Could someone from the workshops please at least make it useable."*

It is recorded on EMIS that this request was actioned by a healthcare officer on (date redacted). The EMIS entry states *"Ref: wheelchair repair / service. Spoke to staff at NRS Lisburn*[67] *and have arranged with* (an) *Officer* (name redacted) *to take his wheelchair to NRS for repair on Monday* (date redacted). (Name redacted) (The officer) *will pick up the wheelchair from the unloading bay early on Monday morning."*

On (date redacted) a nurse recorded on EMIS *"advised [Mr D] of pending repair on Monday of wheelchair and that nurse on Sun will bring a healthcare wheelchair to him. Advised his own wheelchair will need left at loading bay."*

On (date redacted) a nurse triaged Mr D in the treatment room. The nurse recorded on EMIS, *"Attended treatment room in wheelchair. Requesting to see Dr regards insomnia and reduction of diazepam. Explained that it is standard procedure to reduce diazepam. Placed on next available GP clinic for discussion re insomnia. Requesting possible referral to OT* (occupational therapy). *Also regular wheelchair away for servicing. States wheels on replacement's flat. On inspection tyres feel well inflated and firm."*

[67] Nottingham Rehab Supplies – Manufacturers and suppliers of disability equipment.

On (date redacted), a nurse recorded on EMIS *"*(Mr D came) *to treatment room states that the wheelchair has not been fixed correctly and that it has been damaged. Left safety strap appeared to have been overheated/melted, spoke x 1 broken and 1 bent on left wheel also covered in black substance. He feels the wheel is buckled also left front small wheel not tightened which was his original complaint. Both foot guards were repaired. Advised to complete prison complaint form. SNO* (Senior Nurse Officer) (name redacted) *informed."*

It is to note that, when asked at the time of his release if he had any complaints, Mr D referred to the problems with his wheelchair.

Referral to Physiotherapy and Ulcer Management

On (date redacted), Mr D was seen by senior nurse who noted in his medical records that he now had *"2 small ulcers on right buttock".* The nurse recorded that both areas were dressed and that if the dressings stayed on, they were to be redressed in five days. The nurse recorded that she would "*re assess w/c* (week commencing) (date redacted)*".* In addition to the treatment given for Mr D's ulcers, the nurse recorded that Mr D had damaged tendons in his feet *"which contributes to decreased mobility. Cannot hold weight on elbows with crutches. Referred to physio. Would use rowing machine at home and feels his mobility and strength has decreased with not being able to use. Will contact senior nurse in Foyle to request further use."* The nurse also recorded that she provided Mr D with advice about pressure relieving movements which he agreed to carry out at least every two hours. She noted that Mr D *"states* (he) *has a pressure relieving mattress at home"* and that she *"will liaise with OT* (Occupational Therapy)".

At interview the senior nurse said *"I confirm that I carried out an assessment of [Mr D]'s ulcers. I have some recollection of this consultation. I recommended that the wounds should be redressed in five days. It would be the responsibility of the House nurse to redress the wound as I would have handed her the care plan for the ulcers after I carried out the assessment. It would have been the House nurses responsibility to put future appointments for the wound to be redressed every five days. Will contact senior nurse in Foyle*

should read: Will contact senior officer in Foyle. I sent the senior officer an email requesting that [Mr D] be allowed to use the rowing machine. I have no idea whether this happened or not but I did ask the SO (senior officer) *to facilitate [Mr D]'s use of the rowing machine. I have recorded that I liaised with OT; however, I have no recollection of my conversation with OT. I would not have recommended that [Mr D] needed a pressure relieving mattress as his risk was low on the Braden Scale[68]. I have recorded that I would reassess the wounds week commencing* (date redacted). *There is no record of this taking place on EMIS or on [Mr D]'s wound care plan and I can offer no explanation as to why this review did not take place."*

There are no further entries in Mr D's medical records regarding the treatment of his pressure sores until (date redacted), when he saw a nurse. The entry notes *"dressing of pressure sore – states was redressed ytd* (yesterday) *– will place in diary for r/v* (review) – (date redacted) – *Will also refer to o.t* (occupational therapy) *ref mattress."* The nurse also referred Mr D for physiotherapy on (date redacted).

Notwithstanding the fact that it is recorded on EMIS the nurse said at interview that it is likely that she did not know that Mr D had already been referred to occupational therapy on (date redacted) and for physiotherapy on (date redacted). The nurse explained that the diary she referred to was the house healthcare diary that would have been kept in the medical room. It is to note that there is no record of Mr D's pressure sore being redressed from the (date redacted) to (date redacted) despite the fact that it is recorded by the senior nurse on EMIS on (date redacted) that it should have been redressed in five days.

A review of the medical room diary indicates that Mr D was called to the medical room to have his ulcers redressed on (date redacted), (date redacted) and (date redacted). It is recorded on EMIS that he refused to let the nurse redress his wound on the (date redacted) and (date redacted) because he said that his wound was *"doing better"* and *"it feels more comfortable without the dressing on."*

[68] The Braden Scale determines how likely it is that the patient will develop further pressure ulcers or sores.

Mr D was not seen by a physiotherapist before he was released from prison. It is recorded on EMIS that Mr D was referred to physiotherapy on (date redacted). The Physiotherapist Department did not receive this referral. The investigation established that the referral to physiotherapy made on (date redacted) was received by the physiotherapist on (date redacted) and that an appointment was made for Mr D for (date redacted). The investigation confirmed that the target waiting time for an inmate to be seen by the Physiotherapy Department is nine weeks.

Repeat Prescription of Diazepam – (date redacted)

On (date redacted), a prison doctor prescribed diazepam tablets 2mg 56 tablets four daily for Mr D.

At interview the doctor said *"I authorised a prescription for diazepam 2mg for [Mr D] on* (date redacted)*. I did not see [Mr D] on this date. If an inmate has run out of medication the nurse sometimes calls the doctor and asks him to authorise a further prescription over the phone. When I am writing a prescription I do not have any access to an inmate's community medical records and I would in practice not have time to check the inmate's current EMIS notes, it would not be realistically practical as I would on average be signing 50 prescriptions in prison a day. Generally speaking, an inmate's medication is reviewed six months after committal as it is assumed that his GP has been prescribing him the correct and appropriate medication when we receive the list of an inmate's medication from their GP at committal. If I had been aware that Mr D had fallen asleep during a consultation with a nurse I would still have prescribed his diazepam because it is very dangerous to stop it suddenly but I would have carried out a review of his medications."*

On (date redacted), (date redacted) and (date redacted), further prescriptions of OxyContin were provided for Mr D, without him being seen by a doctor and without any medication review taking place.

At interview a doctor who authorised one of the repeat prescriptions said that he would be willing to issue a repeat prescription for a higher dose of OxyContin without seeing the patient, or without reviewing the increased

dose, providing there were no *"reports of any adverse side effects which* (related to) *sedation."* The doctor said that *"after two weeks any adverse side effects would have been picked up* (by) *that point and* (if there was no sign of any side effects then) *you would be safe to continue on the repeated dose".*

At interview, the doctor was informed of the nurse's note of (date redacted) stating that Mr D kept "*dozing off*" during a consultation. Asked whether, if he had been aware of this information, he would have seen Mr D before issuing a repeat prescription for the higher dose of OxyContin, the doctor said, *"yes, absolutely. If there are signs that he's having side effects from medication of course you'd want to review before continuing increases."* The doctor did, however, point out that the prescription request for Mr D on (date redacted) was "*put through as a medication renewal request, not a review patient request."*

The doctor also said that he did not have access to Mr D's community medical records and was not aware that he was registered as being addicted to oxycodone (OxyContin). When made aware of Mr D's medical history and asked whether his decision making process would have been influenced by this information had it been available, the doctor said, *"Yes of course, that information is quite clear cut. We didn't have access to it… information is everything, the more information we have, yes, in this case if we had the notes it would have made a difference in terms of what prescriptions were offered."*

The doctor also said that he would have reviewed Mr D to check if he had *"pinpoint pupils"* and to check if *"his respiration* (was) *affected"* in order to ascertain whether Mr D was just *"tired"* or whether his drowsiness was *"a side effect of the medication."*

The doctor said that, when issuing "*countless"* repeat prescriptions, a prison doctor goes to the notes and checks highlights but "*It's an imperfect system of doing things. On the other hand we don't have the luxury of having the ten minute consultation for every prescription that needs to be issued as well. With that particular type of medication obviously you'd be more careful, but he (*Mr D*) had been on it for a long time… He had been given an increase of his previous stable dose, but he had been taking that for two weeks without significant*

event. Obviously there are some notes of being sleepy but that doesn't necessarily mean he was overdosed - but obviously (there is) *the history of abuse which we weren't aware of."*

At interview, the South Eastern Health and Social Care's Clinical Lead for Maghaberry Prison explained that a practice has evolved whereby, in the event that an inmate has run out of medication, a nurse would sometimes call the doctor and ask him to authorise a further prescription over the phone.

The Clinical Lead said *"this is a practice that we at the Trust are trying to put a stop to. In an effort to achieve consistency we have recruited a number of new doctors that will be Trust employees. From 22 April 2013, there will be a consistent policy in relation to the prescription of medication which will be implemented consistently by the newly recruited doctors. These doctors will be asked not to continue acute prescriptions over the phone without first seeing the patient. Inmates should be seen by the doctor at the end of an acute prescription before another prescription is authorised. This would be particularly useful when the drug being prescribed is a controlled drug or one with significant side effects. Mr D should not have received a further prescription for oxycodone hydrochloride* (OxyContin) *on the* (date redacted), (date redacted) *or the* (date redacted) *without being seen by a doctor because the initial increased prescription for oxycodone hydrochloride on* (date redacted) *was an acute prescription. If an acute prescription is given it indicates that the doctor wants the patient to be seen at the end of the course of that acute prescription otherwise a repeat prescription would have been given by the doctor".*

Occupational Therapy (OT) Assessment – (date redacted)

On (date redacted) Mr D was assessed by an occupational therapist. The therapist recorded that a "*functional assessment*" was completed and that *"[Mr D] reports he has a home help service twice a day, seven days a week in the community pre prison incarceration. The home help service provided assistance with personal care needs and he also received meals on wheels and he had considered hiring a cleaner for domestic activities of daily living. Within prison, he used a disabled cell. He presently sleeps on a prison issue mattress*

however reports he used a profiling pressure relieving bed and mattress in the community. Presently reports a pressure sore." The occupational therapist considered *"a pressure relieving cushion"* for Mr D and recorded "*Plan: connect with staff involved with client*". The occupational therapist explained that she would not have acted on the referral made on the (date redacted) because the reason for the referral was in relation to an appropriate mattress and bed which, she said, is not an occupational therapy issue. She said that this is a matter which should be dealt with by nursing staff, and she would have informed them of this.

At interview the occupational therapist said *"I can remember meeting him* (Mr D) *with a colleague of mine and the reasons why we had met him as well for an OT functional assessment and I remember going over to the landing that he was in, where he was situated, and meeting him within his cell and then doing the assessment".*

It was explained to the occupational therapist that a nurse had recorded that Mr D had told her that he had an adjustable bed. In response to this, the occupational therapist said: *"I have not seen that in my time here. When I write down a prison issue mattress, I mean a prison issue mattress... and bed... if I had seen something that was different from prison issue mattress I would have documented it."* The occupational therapist confirmed that she was not just relying on what Mr D told her, because she had carried out the assessment in Mr D's cell.

The occupational therapist said that following the assessment, *"the plan in my notes was to connect with the staff involved with the client which I did do. I went away on annual leave and on returning I had seen from my notes that I tried to, I was looking up his case, reviewing it again and I had seen that he had went back out to the community and I was going to connect with Community Services then, which is part and parcel of what we would do."* The occupational therapist said that she then learned of Mr D's death and did not, therefore, make contact with community services.

In his clinical review, Dr Saul made the following points in relation to this matter: *"Pressure sores have a number of causes, three factors may be*

important, immobility, poor circulation and other pathology, in [Mr D]'s case the factors were his damaged circulation due to previous injury, previous chronic infections and the fact that he found movement of the leg difficult and painful. These risks should have been apparent to nursing staff. A lack of access to a pressure relieving mattress which was used at home was an avoidable factor leading to his pressure sore. Availability may have prevented the development of this condition. It may also have obviated the need to increase his painkillers, an increase which almost certainly resulted in increased daytime sleepiness and which would have made the development of respiratory infections more likely."

"Concerns were noted on (date redacted) *that he was not able to get comfortable in bed. Staff were aware that at home [Mr D] had the use of a profiling pressure relieving bed and mattress. There is mention that in prison he had a folding mattress.* (Note: The investigation established this was not the case). *A day later he was reviewed by the doctor and in view of his pain the OxyContin was increased from 120mg per day to 160mg. On the* (date redacted) *staff noticed a painful area on his bottom. This became worse and, given the description, can be considered a pressure ulcer. Appropriate action was taken in terms of advice to [Mr D], dressings and there is mention of the need to obtain a pressure relieving mattress. This seems to have been directed via Occupational Therapy services. OT staff did not however visit until* (date redacted) *and there was no mention regarding any arrangements to obtain a mattress."*

It is to note that Mr D's solicitor wrote to Maghaberry Prison on (date redacted) stating that Mr D was having *"serious difficulties sleeping"* and that *"he has had to sleep in his wheelchair".* In this letter Mr D's solicitor also requested that he be seen by an occupational therapist. The SEHSCT replied on the (date redacted) saying that the concerns "*would be passed to the appropriate health care professional to deal with".*

During a consultation on (date redacted) to discuss Mr D's sleep problems, he was assessed by a prison doctor in relation to his pressure sore. The doctor recorded in Mr D's medical notes that *"the sore is healing well but sleep still an issue, give zopiclone for 2 weeks".* The doctor prescribed zopiclone 7.5mg one

to be taken at night and wrote a repeat prescription for diazepam 2mg four daily.

At interview, the doctor said that he would have been aware of Mr D's prescription for OxyContin. When asked whether he had any concerns about prescribing zopiclone for Mr D, bearing in mind the contraindications for its use, as stated in the British National Formulary (described earlier), the doctor said that he didn't, because the prescription was for a *"standard"* dose. The doctor said that he *"didn't recall"* whether he was aware of Mr D's asthma condition or previous chest infection and said that *"it would be difficult to say"* whether or not his decision to prescribe zopiclone would have changed if he knew this. The doctor said, *"my only recollection of the consultation now was that he* (Mr D) *was in a wheelchair and he had great difficulty with comfort at night and restlessness and my interest was in giving him some respite... for the two weeks before he was released."*

It is to note that Mr D's community medical records, which had not been requested by Maghaberry's healthcare team, indicated that investigations were ongoing in the community to establish whether he suffered from sleep apnoea. The doctor said that even if he had been aware of this he couldn't confirm whether or not it would have changed his decision to prescribe zopiclone because he said, *"it's a very, very common sleeping medication that's used a lot in the community, in hospital and in the prison... At the time when I saw him, I felt that it was a reasonable prescription and in particular to get him some respite before he was released".*

One of the questions asked by Mr D's family was whether the medication he was prescribed in prison was appropriate for his medical needs. Commenting on this matter, in his clinical review report, Dr Saul said:

"At the final committal in (date redacted) (Mr D) *had a comprehensive medical assessment. Appropriate measures were taken...* (and) *staff recognised that his medical condition had deteriorated. Initially, medications were continued substantially unaltered with the exception of a reduction in his sleeping tablets and in his diazepam.*

There is evidence that Mr D was suffering considerable daytime drowsiness. Part of this may have been due to his sleep apnoea syndrome but the increase in oxycodone (OxyContin) *is likely to have exacerbated this. This situation does not appear to have been recognised by the medical staff. Given that his medications had been increased because of specific problems relating to his prison stay it would have been best practice to review these within a week of the change and certainly before release. Having said that, the doctor was in a difficult position needing to balance symptom relief (because of the absent pressure mattress) against the increased daytime somnolence. It is probable that* (if he had been reviewed prior to his release) *he* (the doctor) *would have left the dose unchanged and advised [Mr D] to see his own GP for further advice as soon as convenient.*

The diagnosis of sleep apnoea does not seem to have been considered by healthcare staff. Unless mentioned by [Mr D] this may not have been obvious. He was awaiting referral for investigation by NHS services. Doses of sedative drugs (such as oxycodone/OxyContin) can make sleep apnoea worse. However, even if this diagnosis had been considered, the condition can only be addressed by specialist equipment available from hospital clinics after a full assessment (which [Mr D] had previously been referred for) so this would not have been an option for healthcare staff. Faced with a patient in discomfort I take the view that increasing the oxycodone was a reasonable action. However concerns raised by nursing staff in early (date redacted) *about excessive drowsiness do not appear to have been addressed."*

SECTION 4: EVIDENCE OF MEDICATION MISUSE

Adverse Report – (date redacted)

On (date redacted) the prison dedicated search team carried out a routine, supervised check of the recreation room in Foyle House. A number of prisoners were searched including Mr D. Mr D was given a rub down search and was found to be in possession of medication that was not prescribed for him. The medication comprised of five white tablets and 10 codydramol[69]. An officer issued Mr D with an adverse report which stated: *"I am giving you an adverse report for having medication not prescribed to you when you were searched on the* (date redacted) *in Foyle Recreation Room by the search team."*

When asked, the officer said that he could not remember the search in question. He did, however, explain that in the event that medication is found on an inmate during a search, the healthcare department would be contacted to verify whether that medication had been prescribed to the prisoner. The officer said that this verification process also serves to inform healthcare about the find. The officer further explained that the decision to charge a prisoner or give them an adverse report *"is at the discretion of the officer"* and *"there is no obligation on the officer to carry out any follow-up action as a result of a search/find."* It is to note that it is in fact the case that, as a minimum, an officer finding evidence of misuse of drugs must submit a Security Information Report[70] detailing the relevant incident.

It is to note that at no point was Mr D referred to Ad:Ept for support in addressing his medication addiction /abuse problems.

Asked why Mr D was not subsequently required to take a drugs test, the officer stated that "*it would not have served any purpose as all it would show was that Mr D had prescribed medication in his system which he was already legitimately prescribed."* He said that he would be more inclined to require a drugs test if an inmate is found with illegal drugs in his possession.

[69] Codydramol is a pain killing medicine used to relieve mild to moderate pain and fever. Codydramol tablets contain two active ingredients, paracetamol and dihydrocodeine.
[70] Security Information Report contains information in relation to an incident which would be of interest to the Security Department.

It was, nevertheless, the case that Mr D had been found with prescription medication which he had not been prescribed. A drugs test might have provided important evidence to show what Mr D was taking, over and above his prescribed medication.

There is no information in Mr D's EMIS records indicating that healthcare staff had been informed that he had been found with medication in his possession that was not prescribed to him. It was, therefore, clearly the case that the verification information request (described above) was not treated as notification of an abuse of medication. It was also the case that, as required by the SEHSCT's Standard Operating Procedures, no further in-possession medication risk assessment took place in respect of the administration of Mr D's OxyContin, following the find.

Clarification was sought by the investigation as to whether there is a written policy in relation to what action should be taken when an inmate is found to be in possession of medication which has not been prescribed to him. The Security Department at Maghaberry advised that *"any incident, where a prisoner is deemed to be in possession of an unauthorised article, may be dealt with in a number of ways, dependent on the particular circumstances. These may include, referring the matter to the PSNI, placing the prisoner on report or issuing an adverse report. Prison Rules 33 and 34 relate to unauthorised and prohibited articles."*

Illicit Drug Seeking Behaviour - Officer's Accounts

At interview, an officer who worked regularly in Foyle House and remembered Mr D said that he *"got the impression that there was a serious drugs issue going on with him, in that he was either taking drugs from other people or using his own to hand out... I just got the impression that he would use anything that he could get and at that time on that landing there was an awful lot of drugs, an awful lot."*

The officer said that there were *"periods when he came back from substitution therapy* (where Mr D's OxyContin was administered), *there would be prisoners constantly around his cell door, they were always moving and this was*

prisoners coming down from up the stairs, on (the) *threes and fours. We were trying to get them all away from the grill because his cell was right beside the end of wing grill"* the staff were *"constantly shooing them off"* to get them to *"keep away from his cell".* The officer said that staff would be *"constantly... trying to get people out of* (his) *cell that shouldn't have been there"* and said also that he thought that other inmates would have gathered round his cell for *"tobacco"* or *"drugs".*

The officer recalled that *"there was also boys... always tapping him for tobacco. That was just the normal ongoing thing all the time he was there."*

The officer said that *"there were times he would come back from substitution therapy and he would have been fine. There were other times he would come back and an hour later he'd be out of it."*

The officer thought that Mr D was taking something over and above his medication. The officer said on *"one particular occasion I came in, in the morning to do a head count and his* (cell) *would have been the first cell that we checked...and he was sleeping in the wheelchair... I just got, you know, the feeling that he must have taken something to be that way...it's just the fact that he slept all night in the wheelchair... that didn't seem normal to me... he would constantly be... asleep in the chair."*

In relation to the substitution therapy clinic, the officer said that *"from what I'm led to believe,... there was a sort of dealing and horse-trading went on over there... this was just a constant problem. I think, we certainly had at least two people on substitution on the landing at the time, possibly three."*

The officer suggested that Mr D, because of his disability, was vulnerable "*he was all alone in the fact that he was in a wheelchair... and whether he was giving the stuff willingly...".* The officer said he thought that *"there's every chance"* that Mr D might have been put under pressure *"to hand stuff out".*

The officer said that they *"had a particularly bad element on those two landings"* at that time in terms of "*behaviour and drugs... There was finer men*

(fine defaulters) *with lifers. It was just a complete zoo… It was just something* (we) *were trying to keep on top of all the time."*

The officer said that the "*type of prisoners who were hanging around his* (Mr D's) *cell*" were known drug users. He said that *"it was the type of these guys. They were… predators… they basically used that house as a clearing ground… I got the impression that they were just throwing prisoners in there they had problems placing anywhere else, so we ended up with a particularly bad mix of prisoners, particularly at that period, that's* (date redacted)*."*

The officer said that during lock up periods, prisoners would hover around Mr D's cell saying that he was going to give them tobacco. When asked why he thought that the inmates were getting more than tobacco, the officer said "*the prisoners we had down there were, there was, it was a bad crowd and there was a serious drugs issue in Foyle 1, serious drugs issues and this was what you were dealing with. You know, these guys were constantly needing tobacco, needing drugs, it might have been the subs, whatever… The type of prisoners we had down there, you know, we had some serious drugs users down those two landings. It was bad… a big problem and I just knew like, these guys were at that for other purposes, you know. The guy is getting substitution therapy and he's in a wheelchair, he's vulnerable, so why are they constantly down there?* (We had to) *move them on… It was ongoing all the time with them… it seemed to be an area that no one wanted to know about, Foyle 1 and 2, …* (there) *didn't seem to be any concern about the drugs. Nobody wanted to deal with the problems there… just wanted a lid kept on the situation."*

The officer also said that *"this was a daily thing… people down there being under the influence, whether they got it from him or somebody else, you know. It was impossible to tell. There was that much of it… Constantly prisoners down there were just off their face all the time."*

Another officer who also worked in Foyle House said that Mr D *"had quite a lot of visitors in his cell"* and that *"it seemed like he had a lot of friends, in a sense, because they were in and out of his cell. …Whether they were scrounging off him or whatever, but he did seem to have quite a lot of people around him."*

When asked what they would have been scrounging off Mr D, the officer said that "*he always seemed to get a big tuck shop. So, it would've been tuck shop and it could have been drugs, to be honest with you, you know.*" The officer said that Mr D "*was on a lot of medication*" and that it could well have been this that they were *"scrounging off him".*

The officer said that Mr D had a good relationship with the other inmates "*because they were looking something off him probably, you know what I mean... Unfortunately that's the nature of it, you know.*"

The officer noticed that Mr D was sometimes drowsy and slurred his words but said that he put that down to his medication. The officer said, however, that "*there's that much drug dealing on that landing, a lot of them are drowsy a lot of the time.*"

In relation to Mr D being vulnerable the officer said *"you probably did keep an eye on him because he was vulnerable, as in wheelchair bound, you know what I mean."*

The officer said that "*the amount of drug taking in the jail is sky high. So you don't know what people are taking most of the time... Unless you catch somebody red-handed, you're not going to catch them.*" He said that Foyle House in general would have been known for a lot of illegal drug use.

The officer explained that the requirement is that staff carry out a search on two cells on each landing each day and he said *"other than that, you try your best to get things, searching and all but they're ingenious where they put stuff... there's a big, big problem with drugs in this jail and we all know it... but we don't have the tools to deal with it."* The officer said that there should be "*more regular searching... more searching the cells, proper searches*" and that visits needed to be *"controlled far better".*

Illicit Drug Use - Inmate's Accounts

The investigation spoke to a number of inmates who were housed in Foyle House during Mr D's period in custody. An inmate who associated with Mr D said that he *"was into his drugs in a big way. …He loved his medication. …OxyContin, pregabalin, it's what he done with them that was dangerous."*

The inmate said that Mr D "*would put them in a bag and mix them all up with a powder, diazepam, OxyContin's, muscle tablets, he would mix them all together… and he would have sucked them into his lungs… he poured the powder into the wee hole* (of his inhaler) *and then sucked it through his lungs, he said that it would go to the veins in your lungs and would give you a better hit."* The inmate added that Mr D "*swallowed tablets too".*

When asked if he knew if Mr D was taking anything other than his prescription medication the inmate said *"he was taking his medication heavy, he was doing deals with people, so he would have been taking subutex*[71] *as well do you know what I mean, anything he could get his hands on".*

In relation to Mr D "*doing deals*" with other inmates, the inmate said "*he would have done deals, wee deals with other people for tobacco and maybe, maybe his own medication and done swops and things like that, that's sort of how it works… I have maybe been walking down the wing and he would be doing deals through the grill and I would maybe see a bit of hand exchange, but I never asked him what he done, do you know what I mean?"*

Another inmate said that *"He* (Mr D) *would have come down into the association room and talked away to the boys and all, then I think he started getting pissed off because people were torturing him for his medication, people hounding him about it like because he was on a lot of strong medication."* He said that Mr D *"stopped going down* (to the recreation room) *because people were annoying him for his medication".*

[71] Subutex is a type of medicine called an opioid. Opioids are painkillers that work by mimicking the action of naturally occurring pain-reducing chemicals called endorphins.

When asked did Mr D have a good relationship with other inmates, the inmate said *"I wouldn't say good but I would just say he had people sitting in his cell with him smoking".*

The inmate said that other inmates would say to Mr D *"ah [Mr D] you said last week you'd sort me out"* and then they would try to pick a row with him over it. The inmate also spoke about how the other inmates were *"torturing him about his morphine patch".* It is to note that Mr D was provided with nicotine patches.

The inmate said that he recalled that Mr D bragged about the strength of the medication he was on and would *"leave his* (medication) *box open on display"* on top of his desk in his cell.

The inmate said also that Mr D was drowsy all the time and that *"you knew when he was off his head* (because) *his eyes or whatever were down and he wasn't as chirpy, not as chirpy as normal when you knew he was off his head and he was talking about holidays and all that".* The inmate explained that it was obvious when Mr D had had *"his fix"* because his eyes would be *"drooping out of his head".*

The inmate said that it was the talk of the yards that *"your man in the wheelchair gets 300's* (pregabalin)*... people were torturing him about it. He sold his pregabalin and his morphine patches in return for tobacco... they were smoking it, they were like taking that off and like rubbing it together and it came off out like a snooter and they were putting that on the foil and burning it".* As stated earlier, Mr D was not provided with morphine patches.

The inmate said that he was sure that Mr D regretted making it public that he had so much medication.

Evidence of Illicit Drug Use - Telephone Calls

On (date redacted), during a telephone conversation, a person called by Mr D can be heard to ask him *"what all are you getting [Mr D] you told me you were selling some to get?"* Mr D then talks over the person and talks about how he

can't do "*things like that*" because he could end up losing his medication. Mr D tells the person called that no other prisoner is on the same pain killers as he is. He says that if he did not need to use the phone, he would not bother coming out of his cell as he gets *"tortured"* for his medication. (It is to note that Mr D again talks about the problem with other prisoners wanting his medication, in a subsequent phone call.)

During the telephone conversation on (date redacted), Mr D talks about *"juggling his tablets about,"* before he came into prison. He talks also about how some days he is *"sorer than others"* and took the medication that he needed and, other days, would not have needed as much and would *"just take the bare minimum I could".* He says that he would take extra pain killers if he had the kids coming or, if he was going out for the day, he would take 12 tablets in order to manage the pain and then later on in the week he would be "*short and he would have to stretch them out".*

On (date redacted), Mr D calls someone different and talks to them about his temazepam being stopped but says also that he has been buying them in prison and that he will tell the doctor when he gets out *"what he has had to take as a replacement".* Mr D says that what he has been getting is *"even more effective than the temazepam,"* but that he can't say the name of the tablet on the phone because as far as he knows *"there's only one man in the jail that's on them"* and that he has *"been getting the odd one off him".* Mr D says that these tablets have *"given him the best night's sleep he's had in years".*

It is to note that Mr D was prescribed temazepam in the community up until his committal on (date redacted). The South Eastern Health and Social Care Trust (SEHSCT) Clinical Lead for Maghaberry Prison confirmed that it is the policy of the SEHSCT not to prescribe temazepam to any patients in prison. The reason for this is because it is very addictive and has a very high currency in prison.

During his phone calls, Mr D's speech is slurred and he sounds very drowsy.

It is to note that the Prisoner Ombudsman has raised issues in relation to the availability and management of drugs in Northern Ireland prisons time and again in previous reports into Death in Custody investigations. The Prisoner Ombudsman has emphasised the need for a comprehensive and consistently applied strategy for addressing issues related to both the supply of and demand for illicit substances and non-prescribed medication.

In the investigation, evidence was found of the following, all of which have been highlighted in previous death in custody and complaint investigation reports:

- An acceptance by staff of the inevitability of the prevalence of drugs in prison.
- The ease with which drugs can be sourced and traded in prison.
- A failure on the part of both prison and healthcare staff to take action where somebody is displaying clear indications of drowsiness and slurred speech as a result of medicine / drug abuse.
- Inadequate intelligence led cell searching.
- A failure to listen to and act on evidence from phone calls where there is reason to suspect drug / medicine abuse.
- A failure to refer inmates with obvious addiction problems to therapeutic support services.
- An inadequate response to vulnerability issues that have been identified by staff.
- No clear communication strategy between prison and healthcare staff that can be implemented in the event that an inmate is found with medication which has not been prescribed to him.
- No written policy in relation to what course of action an officer should take having found an inmate to be in possession of medication which has not been prescribed to him.
- No automatic drug testing in response to incidents where an inmate is found to be in possession of medication which has not been prescribed to him.

Furthermore, it was previously recommended that the prison service review the policy and guidelines defining all of the action that should be taken where staff believes that prisoner's behaviour suggests that they may have used non prescribed medicines or illicit substances. The recommendation stated that this should include a review of the role and expectation of healthcare staff and said that the outcome of the review should be communicated to all staff, and included in staff induction and training programmes.

This recommendation was accepted.

SECTION 5: MR D'S RELEASE ON (date redacted)

At 18.30 on (date redacted), Mr D was released from Maghaberry Prison. At 10.05, he was given his daily dose of OxyContin. Prior to his release at 18.20, he was then given a three day supply of OxyContin. It is not possible to say what quantity of his other medication Mr D was given that day because, as explained earlier, the Kardex detailing his other medication can not be located by healthcare staff.

One of the concerns raised by Mr D's family was why he "*appeared to be drowsy, unsteady and looking so unwell when they collected him from Maghaberry".*

At interview, a governor who was on duty on the day of Mr D's release explained Mr D's discharge process.

The governor said that when he met with Mr D he confirmed his identity as the person due to be released and verified that the prison had the authority to lawfully release him. He also said that he conducted a "*very brief*" interview with Mr D at the main reception desk. He said that the purpose of this interview was to carry out a final identification check to ensure that Mr D was the person whom the Court Order referred to and to ask him if he had any requests or complaints before being released from custody. No requests were made or complaints raised. Mr D was collected by a prison transport department bus and taken to the Quakers Visitors Centre at the entrance to Maghaberry Prison.

When asked how Mr D presented during the discharge process the governor said that he was *"very upbeat,"* had *"a smile on his face"* and mentioned that he was going to have a party and a drink when he got out. The governor said that Mr D did not seem unwell or look drowsy and there was nothing unusual about his appearance that caused him concern.

At interview, the driver of the bus which collected Mr D from the main prison said that he recalled that it was late in the evening and that Mr D was the

only passenger on the bus. He said that he helped Mr D with his things when he was getting into and out of the bus and that they chatted during the short journey to the Quakers Centre. He said that Mr D appeared to be *"pleasant, friendly"* and in *"decent form"*. He said also that Mr D was *"alert and talking away"* and that there was nothing unusual to note about him.

At interview, an inmate said that on the morning of the day that Mr D was released, *"he took something, OxyContin he got out of the hospital, and something else, it was pregabalin, he took them before he got out. Now he did tell me about there was medication outside for him, waiting for him, and as far as the rumours, the rumours went in prison, after he died was he took more OxyContin's outside and that's why he died, that's what I know of."*

It is to note that, in a phone call on (date redacted), Mr D, asked the person called to get a prescription for four weeks of his medication, so that it would be there for him on his release. In another call, on (date redacted), Mr D is told by the same person that he has got Mr D a week's supply of tablets but "*slipped up"* because he told the GP that Mr D's temazepam had been stopped in prison.

Mr D's community GP records confirm that a week's supply of his medication was prescribed, in readiness for his release from prison. It is to note that Mr D was not referred to the Healthcare Discharge Liaison Team and therefore healthcare had no contact with his community GP either prior to or at the time of his release.

SECTION 6: MR D'S DEATH ON (date redacted)

Mr D's family met him at the Quaker's Centre at Maghaberry Prison at 18.30 on (date redacted). His (name redacted) said that on the way home Mr D began to appear *"under the influence of drink"* and *"highly medicated"*. (Name redacted) recalled that Mr D said that his swollen legs were hanging out over his socks and that his head *"felt up to here,"* whilst making gestures with his hand above his head. They said his eyes were *"looking heavy"* and said also that he was falling asleep in the car on the way home.

(Name redacted) said that, when they arrived home, she made dinner. (Name redacted) said that Mr D then struggled to stay awake throughout the meal and that his head was falling forward into his dinner. (Name redacted) said Mr D "*could not hold himself up at the dinner table and at one point turned a grey colour".* She said that she, therefore, encouraged him to have a lie down on the couch, which he did. She said she placed a blanket over him and he fell asleep immediately. Mr D's (name redacted) confirmed that Mr D did not consume any alcohol with his dinner. (Name redacted) said that he did not give Mr D any of the medication that had been prescribed for him from the doctor, in preparation for his release.

(Name redacted) said he heard Mr D snoring at midnight and (name redacted) said he was snoring at 01.10 when she went downstairs to check him. (Name redacted) said that she went downstairs to check Mr D again at 05.10 and saw that his colour was changing. She said that, when she held his face, he was still warm but that he wasn't breathing and she knew he was dead.

(Name redacted) contacted the police and ambulance service. Mr D was subsequently pronounced dead at 07.00 on (date redacted).

Enquiries made with the Police Service for Northern Ireland have established that Mr D's medication had been seized after his death but, when asked for as part of this investigation, the PSNI said that they were unable to verify the type and quantity of medication seized, as this had not been recorded and had

been disposed of once they were no longer required as part of the police enquiries.

SECTION 7: AUTOPSY AND TOXICOLOGY REPORT

Autopsy Findings

An autopsy examination was carried out on (date redacted) and gave the cause of Mr D's death as:

I Pneumonia

II Left Ventricular Hypertrophy

The report states:

"Death was due to natural causes.

Microscopic examination of tissue sections revealed evidence of an acute bacterial infection of one or both of the lungs. This can be a severe, life-threatening condition as it can impair the respiratory function of the lungs and infection may enter the bloodstream, spreading its effect around the body.

Autopsy revealed that the heart was somewhat enlarged due to increased muscle bulk of the left main pumping chamber (left ventricular hypertrophy). This on its own can cause death as the enlarged heart is prone to outstrip it's blood supply and is susceptible to sudden fatal disturbances of rhythm.

Toxicological analysis of a sample of blood taken at autopsy revealed the presence of a number of drugs. The opiate analgesic (painkilling) drugs codeine, morphine and oxycodone (OxyContin) *were detected at concentrations that lay within their respective therapeutic ranges. It is quite likely that the morphine has been derived as a breakdown product of codeine within the body, however the possibility that it came from another source cannot be completely excluded. The concentrations of the drugs in the stomach contents suggested that he had taken codeine and a relatively high dose of oxycodone* (OxyContin) *in the hours prior to his death. Opiate analgesic drugs have an opiate effect on many of the important functions of the brain and, in this instance, the presence of three*

opiate analgesic drugs would have had an additive effect. However, this is unlikely to have had a lethal effect at the concentrations detected, especially in an individual who is likely to have built up a degree of tolerance to these drugs.

The commonly prescribed antidepressant drug citalopram was also detected in the blood sample at a relatively high concentration, but well below the range of values associated with fatal toxicity due to this drug alone.

The commonly prescribed sedative drug diazepam (Valium) and a breakdown product of a related drug, clonazepam, were also detected in the blood sample. The concentrations of these two benzodiazepine drugs in the blood and stomach contents suggested non-recent therapeutic use of diazepam and clonazepam.

The commonly prescribed 'sleeping pill' zopiclone was present in the blood sample. The concentrations in the blood and stomach contents were consistent with therapeutic doses of zopiclone having been taken in the hours prior to his death.

Analysis of the blood sample revealed an insignificant concentration of alcohol, quite possibly produced in the post-mortem interval by the actions of micro-organisms. No alcohol was present in the urine sample.

There was nothing to suggest that the deceased had been the victim of an assault."

Commenting on Mr D's cause of death, in his clinical review report, Dr Saul said:

"Pneumonia is not uncommon and can cause death rapidly with few symptoms. Thomas et al found that of 350 cases of sudden death in London due to 'natural causes' 22 were caused by pneumonia. (BMJ 1988;297:1453). [Mr D] had a number of risk factors. He had a smoking history, he had chronic chest problems by way of Asthma and/or COPD, he had had a previous episode of pneumonia, he was on drugs that depress the respiratory system, he almost certainly had sleep apnoea and there was a previous history of alcohol abuse.

He had been resident in an institution which will also predispose. In addition there was evidence that he had consumed non prescribed sedative drugs in the period prior to his death."

Toxicology Findings

A forensic scientist, Ms Christina Isalberti, from LGC Forensics was commissioned, as part of the post mortem investigation, to provide a detailed analysis of blood and stomach contents samples of Mr D for the presence of common drugs of abuse, and certain medications, including oxycodone (OxyContin), and, if present, to ascertain whether or not any of these substances may have been involved in his death.

The following substances were detected in Mr D's blood sample:

- Codeine
- Morphine
- Oxycodone (OxyContin)
- Citalopram
- Norcitalopram
- Diazepam
- Desmethyldiazepam
- Temazepam
- Oxazepam
- 7-aminoclonazepam
- Zopiclone

The following substances were detected in Mr D's stomach:

- Codeine
- Morphine
- Oxycodone (OxyContin)
- Citalopram
- Diazepam
- Desmethyldiazepam
- Zopiclone

Over and above the conclusions referred to in the autopsy report, Ms Isalberti concluded that *"codeinem morphone and oxycodone* (OxyContin) *may interact, enhancing their own central nervous depressant effect. Their depressant effects may have been further enhanced by the presence of benzodiazepines, zopiclone and citalopram. The possibility that the combined central nervous system*

depressant effects of all these drugs may have contributed to Mr D's death cannot be completely ruled out."

SECTION 8: CLINICAL REVIEWER FINDINGS

Review by Dr Peter Saul – Independent Medical Expert

Some of the findings of Dr Saul's clinical review have been included at appropriate places throughout this report. Below is a summary of key findings and provides answers to some of the family's healthcare related concerns:

1. *From the records [Mr D] appears to have been in prison on seven occasions, all for relatively short periods from* (date redacted) *until* (date redacted). *I have reviewed the provided records for all these periods:*

    - *On the first occasion in* (date redacted) *it appears that [Mr D] was generally fit and well, there were no health concerns raised by him or by the staff.*
    - *The period in* (date redacted) *was after the RTA, his stay was short and apart from being in a wheelchair no special concerns were identified.*
    - *In* (date redacted) *there was another period of imprisonment. The assessment on committal performed by staff was thorough and good. No particular problems arose.*
    - *Notes from the period in* (date redacted) *were patchy, medical problems were identified on admission but there was no reference to mobility or wheelchair. I assume that there were no problems and this was a short sentence.*
    - *The period in* (date redacted) *was not problematic, again there was no specific mention about mobility but appropriate medications were given and there were no records of problems.*
    - *In* (date redacted) *[Mr D] had a comprehensive assessment on entry. Mobility problems were identified and steps taken to mitigate these. These included an attempt to move him closer to healthcare. He was offered support to deal with alcohol problems. During the stay he had cellulitis affecting his leg and this was dealt with properly by the Healthcare staff. [Mr D]'s complaint that despite a request from clinical staff, pillows to support his inflamed left leg were not provided is*

supported by entries in the EMIS record. This was an avoidable cause of discomfort to [Mr D]. A complaint that evening medications were sometimes not delivered is also supported by the records; again this is likely to have led to avoidable discomfort. Concerns were raised that he was very sleepy at times and as a result had had a fall with a minor injury. There is an entry in the notes which advises that he be seen by a doctor for review but I can find no evidence that this was done.

- *During the period of imprisonment in* (date redacted) *[Mr D] did not initially have his wheelchair in prison. There was reference by healthcare staff that this should be brought in, but the notes are unclear if this was done. There is another entry in the notes which indicate that Healthcare wanted him to be housed close to their facility. This was not initially possible, the notes are not clear if and when this took place.*

2. *At the final committal in late* (date redacted) *he again had a comprehensive medical assessment. Appropriate measures were taken, a disabled cell with bottom bunk was requested. Staff recognised that his medical condition had deteriorated. Initially, medications were continued substantially unaltered with the exception of a reduction in his sleeping tablets and in his diazepam. It would appear that he had his own wheelchair to use in the prison from the start. Unfortunately it became broken by* (date redacted). *Arrangements were made to have it repaired, but unfortunately further damage took place when it was away. During the period it was away [Mr D] had the use of a Healthcare Wheelchair. Healthcare and prison staff seem to have taken prompt action to repair the wheelchair, unfortunately this led to further damage over which they had no control. Whilst things did not go as well as they could with respect to facilitating mobility, this does not appear to be due to errors or omissions of staff.*

3. *The main reason why [Mr D]'s left leg was swollen was as a result of the accident and subsequent chronic infection. There is reference to cellulitis in the past and this is often recurrent in patients with this condition. Matters would be exacerbated by his obesity (BMI 32.8) and by the fact that he was wheelchair bound with legs hanging down. As a result there is likely to have been dependent oedema in both legs due to gravitational collection and poor circulation. Sleeping in a wheelchair is an important exacerbating factor. Had*

there been a suitable mattress available [Mr D] would not have had to sleep in his chair to minimise discomfort. This is a very difficult condition to treat as diuretics (water tablets) have little effect. Mobilisation and elevation of the legs can help. Availability of cushions or pillows would have facilitated daytime elevation which may have relieved some of his symptoms of swelling and made him more comfortable.

I looked at the transcripts from his telephone calls home to see if I could detect any pattern of declining health prior to his release. Although he was frequently referred to as slurring his speech and seeming drowsy on the call on the day of his release there were no such pattern of comments. He was released to the care of his family so I would assume if they had any concerns that evening they would have contacted the Out of Hours GP Service for advice.

4. *The report by Dr Isalberti, forensic scientist, indicates that at death drugs within [Mr D]'s stomach corresponded to those being prescribed. Within Mr D's blood* (there were) *prescribed substances, or breakdown products found* (to be present). (In addition) *7–aminoclonazepam and oxazepam were detected. These are both benzodiazepines and like temazepam and diazepam have general sedative effects. 7-aminoclonazepam is prescribed as an anticonvulsant but a level of 0.010 mg per litre is a low therapeutic amount. The drug has a long half life (17 to 56 hours) so it may represent the decline of a large dose taken several days earlier. (P191, Antiepileptic Drugs, 5, René H. Levy, Lippincott Williams & Wilkins, 2002) Levels of oxazepam were described as "low", this drug is an anxiolytic and has a half life of between 6 and 25 hours (Acta Psychiatr Scand Suppl. 1978;(274):47-55. The pharmacokinetic profile of oxazepam. Alván G, Odar-Cederlöf I). Very low alcohol concentrations were found. She felt that all the drugs were within the expected levels found in normal therapeutic use. She commented that the opiates found together with zopiclone, citalopram and benzodiazepines may react to cause central nervous system depression and that these may have contributed to the death cannot be completely ruled out.*

5. *I would agree with these conclusions. However each medication was being prescribed for specific clinical reasons to alleviate distress or manage medical conditions. It would not have been possible to offer this medical support without*

incurring a risk of adverse effects. It is also clear that there was evidence of use of non prescribed drugs (clonazepam and oxazepam). Both of these drugs have potentially long half lives so low levels at the time of death may reflect much higher and potentially significant levels some hours earlier. It would seem that there is evidence that [Mr D] took non prescribed prescription drugs some time before his death. The nature of these drugs would have had a sedative effect on [Mr D] and depending on the dose taken, may have further contributed to the risks of developing pneumonia.

6. *The fact that [Mr D] could not use the provided bed and developed increased pain and a pressure sore is extremely unfortunate. This is due to the fact that suitable bedding had not been provided. Consequences were that the dose of opiates was increased and he became more drowsy with increased risks of respiratory complications, he would also have had a worsening of ankle and leg swelling. He also had developed a pressure sore as a consequence. In a community setting it can take some time to source a pressure relieving mattresses for patients so it would be unrealistic to expect the Prison Service to keep one in stock or to have one quickly at hand. In future cases the Service should attempt to bring in such specialist equipment from prisoner's homes.*

7. *[Mr D]'s dose of oxycodone* (OxyContin) *was increased in prison. He had complex medical needs and best practice would have been for him to have a medical review within a week and certainly prior to release. As well as considering the need to continue the higher dose both in prison and after release it would have served the purpose of allowing a check on his pressure areas and to flag any issues for his GP to follow. Having said this, even if he had had a formal medical review before release, it is unlikely that the outcome would have been different. Medical staff should be encouraged to formally review, before discharge, prisoners who have complex medical needs, have had significant treatment changes whilst in prison or developed new medical problems.*

Response from The South Eastern Health and Social Care Trust

The South Eastern Health and Social Care Trust provided a response to the clinical review produced by Dr Saul.

The response stated the following:

"The South Eastern Health and Social Care Trust (SEHSCT) are minded to point out the challenges faced in relation to caring for someone with complex mental health and/or physical needs in a custodial setting. Dr Saul, in his report mentions the length of time a patient in the community may wait for a pressure relieving mattress to be delivered to their own home. We absolutely concur with this statement and would like to highlight that patients in prison fall into the same category as those in the community. Having equipment transferred from a patient's home to a South Eastern Trust facility would not be accepted practice, one reason for this is the risk of cross infection. That said it is accepted that due to an ageing prison population and a growing trend of patients with complex physical needs, the South Eastern Trust (SET) in conjunction with the Northern Ireland Prison Service (NIPS) should explore alternative ways of meeting the needs of this population in a more timely and effective way.

Since [Mr D]'s death, healthcare staff now have access to community electronic care records. This has mitigated the risk of missing important information held by General Practitioners in the community. The whole process for managing medications has also changed in relation to prescribing, dispensing and assessing the suitability for in-possession medication. All of these systems changes are designed to deliver safe and effective care and will be subject to ongoing audit to monitor compliance with agreed standards. The SEHSCT was recently were awarded a GAIN audit award for 100% compliance with phoning Community General Practitioners to confirm prescribed medication as per policy. This demonstrates the organisation's commitment to quality and it will continue to carry out audits in all areas of care.

It is wholly accepted that SET and NIPS need to further explore the feasibility of sharing important information in relation to significant events such as certain phone calls or behaviours which give rise to concern so that risks can be mitigated as far as possible."

APPENDICES

APPENDIX 1

PRISONER OMBUDSMAN FOR NORTHERN IRELAND
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 the Minister of Justice (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 Prison 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 Minister of Justice. 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 Minister of Justice.

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

Annex 'A'

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 Prison 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 Prison 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 Minister of Justice (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 Minister of Justice.

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 Minister of Justice. 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.

APPENDIX 2

INVESTIGATION METHODOLOGY

Notification

1. On (date redacted), the Prisoner Ombudsman's office was notified by the Prison Service about Mr D's death.

2. On the same day, Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison, inviting anyone with information relevant to Mr D's death to contact the investigation team.

Prison Records and Interviews

3. All prison records relating to Mr D's period of custody were obtained.

4. Interviews were carried out with prison management, staff and prisoners in order to obtain information about Mr D and the circumstances surrounding his death.

Telephone Calls

5. All of Mr D's phone calls for his period of custody were obtained and listened to.

Maghaberry Prison

6. Background information on Maghaberry Prison is attached at Appendix 3.

Autopsy Report

7. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy report.

Clinical Review

8. As part of the investigation into Mr D's death, Dr Peter Saul, GP Associate Postgraduate Dean at Cardiff University, was commissioned to carry out a clinical review of Mr D's healthcare needs and medical treatment whilst in prison. I am grateful to Dr Peter Saul for his assistance.

9. Dr Peter Saul's clinical review forms an important part of my investigative report and it informed some of my findings and recommendations. The findings of his review report are included, as appropriate, at relevant points in the report.

Criminal Justice Inspectorate/Other Reports

10. Previous recommendations made to the Northern Ireland Prison Service by the Prisoner Ombudsman and the Criminal Justice Inspectorate which are relevant to the circumstances surrounding Mr D's death have been considered as part of this investigation.

Factual Accuracy Check

11. I submitted my draft report to the Director of the Northern Ireland Prison Service and the Chief Executive of the SEHSCT for a factual accuracy check.

APPENDIX 3

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[72] and integrated[73] conditions.

Maghaberry Prison is one of three Prison establishments managed by the Northern Ireland Prison Service, the others being Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. Four Square Houses - Bann, Erne, Foyle and Lagan, and the new purpose built accommodation of Quoile house, which has a landing used for housing poor coping prisoners who attend the Donard Unit[74]. There is also the purpose built separated accommodation houses of Roe and Bush, make up the present residential house accommodation.

There are three lower risk houses within the Mourne Complex of Maghaberry Prison, called Braid, Wilson and Martin Houses. These are usually used to house lifer prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU).

There is also a Landing within Maghaberry Prison called Glen House which is used to accommodate vulnerable prisoners.

There is also a Care and Supervision Unit[75] (CSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.

[72] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.
[73] Integrated – general residential accommodation houses accommodating all prisoners.
[74] The Donard Unit has been specifically designed to facilitate purposeful activity for poor coping prisoners.
[75] Care and Supervision Unit (CSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and resettlement of which addressing offending behaviour is an element.

Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[76] (PREPS).

The last reported inspection of Maghaberry Prison by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[77] in Northern Ireland was conducted in March 2012 and published on 17 December 2012.

[76] Progressive Regimes and Earned Privileges (PREPS) - There are three levels of regime. Basic - for those prisoners who, through their behaviour and attitude, demonstrate their refusal to comply with prison rules generally and/or co-operate with staff. Standard - for those prisoners whose behaviour is generally acceptable but who may have difficulty in adapting their attitude or who may not be actively participating in a sentence management plan. Enhanced - for those prisoners whose behaviour is continuously of a very high standard and who co-operate fully with staff and other professionals in managing their time in custody. Eligibility to this level also depends on full participation in Sentence Management Planning.

[77] Website link - http://inspectorates.homeoffice.gov.uk/hmiprisons/inspect_reports/547939/551446/maghaberry.pdf?view=Binary

APPENDIX 4

PRISON POLICIES AND PROCEDURES

The following is a summary of Prison Service policies and procedures relevant to my investigation. They are available from the Prisoner Ombudsman's Office on request.

Prison Rules

Rule 38(19) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – A prisoner shall be guilty of an offence against prison discipline if he, without consent consumes, sells or passes any intoxicating substance or drug.

Rule 85(2) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – In the absence of the medical officer, his duties shall be performed by a registered medical practitioner approved by the chief medical officer and the Secretary of State.

Rule 85(2A) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – In the absence of the medical officer a registered nurse may perform the duties of the medical officer set out In rules 21(1) and (2) (medical examination on reception), 41(2) (award cellular confinement), 47(5) (daily visit in cellular confinement), and 86(4) (prisoners who complain of illness).

Rule 85(2B) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – If a prisoner is examined, seen, considered or visited by a registered nurse under the rules set out in (2A) and the registered nurse is of the view that it is necessary for the prisoner to be examined, seen, considered or visited by the medical officer he shall make arrangements for that to occur as soon as reasonably practicable.