The Prisoner Ombudsman for Northern Ireland

INVESTIGATION INTO THE DEATH OF MR O WHO DIED ON 16TH JANUARY 2018, ELEVEN DAYS AFTER HIS RELEASE FROM HYDEBANK WOOD SECURE COLLEGE

When notified that a person has died within fourteen days of their release from prison, the Prisoner Ombudsman has discretion to investigate, to the extent appropriate, matters relating to the care they received in prison.

Mr O was released from Hydebank Wood on 5th January 2018 after perfecting bail on a number of charges. He died eleven days later, aged 19.

During the afternoon of 16th January 2018 Mr O was discovered unresponsive in a friend's flat and the emergency services were called. The ambulance crew found no signs of life and he was formally pronounced dead by a doctor at 18:05.

A post mortem was conducted on 18th January 2018 and the cause of death was recorded as being due to the toxic effects of 3, 4-Methyldioxymethylamphetamine (Ecstasy) and Chloroethcathinone (a stimulant drug). The pathologist stated that it seemed likely that it was the combined effects of these two drugs which precipitated a fatal disturbance in the rhythm of Mr O's heart leading to his death. Other drugs were also detected in his system but the levels of these were not considered to be particularly high and they were unlikely to have made a significant contribution to Mr O's death.

Mr O was committed to Hydebank Wood Secure College on 9th December 2017. He had been in Hydebank Wood on four previous occasions and had been released from the College around a month prior to his arrest on new offences.

As Mr O had only been in custody for four weeks before he was released on bail, there was relatively little opportunity to engage with him in any meaningful way. He was flagged on the prison system for addictions, severe mental health and behavioural problems.

While in police custody he was examined by two police forensic medical officers (FMOs) and his medical history was recorded and he was issued with medication. It was noted that he was not currently attending psychiatry services but had previously attended a child and adolescent in-patient facility in Belfast. He was initially monitored every 15 minutes when first in police custody and after a period the observation intervals were reduced to 30 minutes. When he was taken to Hydebank Wood Mr O was seen by a Nurse who reviewed the police documentation and took his medical history. She established that Mr O had been engaged with social services and had previously engaged with psychiatry services in the community. Mr O reported he had learning difficulties, had ADHD and suffered from anxiety and paranoia. He also stated that he believed he was schizophrenic. The Nurse made a referral to a doctor, the College's drug and alcohol support service and to the mental health

team. She also accessed the electronic care record to check Mr O's medication history and noted that he was not currently on any regular medications. She also noted an injury to his wrist and that he had previously attempted self harm but that he had no current thoughts of deliberate self harm (DSH) or of life not worth living (LNWL). Based on the information she gathered during the initial committal process the Nurse spoke with a prison officer to request that committal observations were increased to every 30 minutes. A follow up committal assessment was completed the following day and a mental health screen took place on 11th December 2017. Mr O was referred to the mental health team for a pre-assessment interview.

Mr O was accommodated in Beech House. He was not identified as needing to be managed under the College's Supporting Prisoner At Risk (SPAR) procedures but he had been subject to SPARs twice before. As noted above the committal nurse had asked for Mr O to be monitored more frequently than the normal committal observations. He was not drug tested during this period of custody and had no guilty adjudications. He had though been given three adverse reports for failing to engage in activities and refusing to end a telephone call when asked by a member of staff.

During the last period of custody he had no contact with the College's drug and alcohol service although he had engaged with this service previously when he had been adamant he would leave his old life behind. He had been allocated a job working in the prison grounds but he refused to attend employment from 2nd – 4th January 2018.

Mr O had no visits while in custody but he kept in touch with friends and family by telephone. At various times in telephone calls he expressed a wish to address his problems so that he could eventually have access to his young son. His family were clearly very supportive and urged him to give up drugs. However in other calls to friends it appeared he intended to revert to his previous lifestyle. He anticipated being sentenced on the most recent set of offences and indicated that he planned to revoke his bail after a short period so that he could serve most of any sentence imposed on remand. He wanted to be out of custody to attend a hearing in relation to access to his son which was scheduled to take place in January.

He attended a mental health pre-assessment interview on 2nd January 2018 at which Mr O reported that his main concern at present was anxiety. He provided further detail about his previous engagement with community Adolescent mental health services and medication history. The Nurse concluded that Mr O would be discussed at a forthcoming multi-disciplinary case conference and would be reviewed again by the mental health team. The case conference was held on 12th January 2018 at which time Mr O had already been released.

He attended an appointment with Housing Rights on the day of his release to discuss a tenancy agreement although this was not his bail address.

It was noted in the prison healthcare records on 8th January 2018 that Mr O had been released on bail on 5th January 2018 and a discharge letter was issued to his GP the following day on 9th January 2018. The correspondence indicated that Mr O had not been prescribed medication while in Hydebank Wood and provided a summary of his pre assessment interview with the mental health nurse several days before his release and that he was released before being reviewed again.

Sadly this case along with others highlights the difficulties when people are committed to short periods of custody as it provides little opportunity for support agencies either within custody or the community to engage with individual's to address their chaotic lifestyles and problems in an effective way.

On the basis of these findings I conclude there are no matters relating to Mr O's management and care by the NI Prison Service or South Eastern Health and Social Care Trust that require further investigation.

I offer my sincere condolences to Mr O's family for their sad loss.

Dr Lesley Carroll
Prisoner Ombudsman for Northern Ireland
7th March 2019