The Prisoner Ombudsman for Northern Ireland

INVESTIGATION INTO THE DEATH OF MR P WHO DIED ON 13th SEPTEMBER 2017, FIVE DAYS AFTER HIS RELEASE FROM MAGHABERRY PRISON

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 P was released from Maghaberry prison on 8th September 2017. He was not required to adhere to any supervised licence conditions.

Mr P was 25 years old when he died. In the early hours of 13th September 2017 a 999 call was made alerting the Emergency Services that the resident of a flat had suffered a cardiac arrest. An ambulance was dispatched and paramedics found Mr P unresponsive. He was pronounced dead at 1:51am.

A post mortem was conducted on 13th September 2017. The cause of death was recorded as probable heroin toxicity combined with pregabalin, diazepam, venlafaxine and mirtazapine. Mr P had been issued with a small supply of venlafaxine (an antidepressant) when discharged from custody but not the other drugs found in his system.

Mr P's father was his nominated next of kin. Mr P's father did not raise any concerns about his son's care whilst in custody but asked my Office to examine how well his son was managing his addiction issues in prison.

Mr P was committed to Maghaberry prison on 6th May 2017. He had been in custody before but this was his first time in an adult prison.

When he arrived in Maghaberry prison, Mr P told the Committal Nurse that he was a heroin user with a history of self-harm and suicidal ideation. The Nurse recorded that Mr P had been diagnosed five years earlier with personality disorder, depression and anxiety. She noted that he had no recent involvement with psychiatry but attended his own General Practitioner (GP). A clinical opiate withdrawal assessment was completed and medication was issued. A comprehensive health assessment was completed the following day by the same Nurse when his withdrawal score was again recorded. At this appointment Mr P declined to have an infected injection site dressed and an antibiotic was given.

On 8th May 2017 the Committal Nurse was advised by the Reception Senior Officer that Mr P was to see a doctor in Maghaberry by Order of the Judge. The Nurse enrolled Mr P to see a GP and informed the Mental Health Team. A Mental Health Screening took place on the same day and the Mental Health Nurse noted that Mr P had previously been seen by

the Mental Health Team in 2013. Due to his recent chaotic behaviour he was offered an urgent pre-assessment appointment.

On 16th May 2017 Mr P requested to see the Clinical Addiction Team (CAT) as he had been clean since arriving in custody and stated he would like help to stay that way. He reported that he had overdosed five times and was an intravenous heroin user. There is no record of this referral being made.

A mental health assessment took place on 22nd May 2017 when a detailed history was taken. The Mental Health Nurse recorded that Mr P had experienced significant trauma in his life and had numerous self-harming behaviours. She believed that Mr P would benefit from structured activity in the prison and planned to refer him to a number of activities. She also advised Mr P that the Mental Health Team did not have the skills to address his trauma and that he should refer himself for specialist support when he was released. The Nurse offered advice on good building blocks of mental health and recorded that she had no plans to routinely follow up with Mr P.

The prison's drug and alcohol service -Alcohol and Drugs: Empowering People through Therapy (AD:EPT) - received a self-referral from Mr P on 22nd May 2017 and he subsequently attended four pre-release support sessions prior to his release.

Mr P was managed under the prison's Supporting Prisoners at Risk (SPAR) process on seven occasions while he was in Maghaberry. SPARs were opened in response to incidents of self-harm or thoughts of suicide. A referral was made to Mental Health after one incident and following a discussion with the House Nurse, the Mental Health Nurse noted there was no indication that the earlier pre-assessment contact needed to be escalated to urgent.

Mr P failed a drug test for cannabis use on 19th June 2017 and was charged under prison rules on 10th July 2017 when he refused to provide a sample for a further drug test. He completed a failed drug test review with AD:EPT on 18th July 2017.

On the 29th August 2017 Mr P attended an appointment with the House Nurse. He said that although he had not used heroin for 4 months, he had every intention of taking it when he was released. She advised of the danger of doing this and made a referral to the CAT. The referral was reviewed that day. Mr P did not meet the criteria as the CAT was only accepting referrals for individuals already established on opiate substitution therapy. T

The CAT advised the Nurse to liaise with AD:EPT with a view to Mr P completing Naloxone[1] training.

[1] Naloxone is an Opiate Blocker and is issued to people at risk of overdose.

Mr P took part in the Naloxone training on 1st September 2017. However, when released, he did not take the Naloxone kit with him.

An AD:EPT support worker completed a comprehensive release plan with Mr P on 6th September 2017. The meeting focussed on his substance misuse problems, tolerance levels, an ongoing medical condition and the impact of substance use on it. He advised he was being met by "Beyond the Gate" on release, a through care service provided by De Paul.

Prior to his release, prison Healthcare wrote to Mr P's GP and provided details of his current medication regime, highlighted ongoing referrals and alerted the GP that, though he had been allocated a routine mental health assessment, this had not been conducted due to his pending release and may require community follow up. He was issued with a short supply of his current medication.

Mr P was met by a support worker from the De Paul throughcare service and was brought to his flat. De Paul had a number of further contacts with him before his death and reported that, though he was initially very positive about his release, it was evident that he had been drinking heavily and misusing drugs.

In most telephone calls made from prison shortly before his release Mr P appeared to be looking forward to starting a catering course and talked positively about staying drug free. He was encouraged by family members not to return to taking heroin again.

Mr P had clearly suffered significant trauma and struggled with addiction issues and self harm behaviours from a young age. Although at times he requested help with addiction issues in particular, he was not able to remain drug free.

The Trust conducted a Local Significant Incident Review (LSIR) (December 2017) which concluded that practitioners involved in Mr P's care were sensitive to his needs and acted in an informed and professional manner despite Mr P's chaotic behaviour. The Reviewer observed that an individual with frequent short-term committals would appear to be at higher risk of 'slipping through the net' in relation to addiction services and he made four proposals for service improvement.

The majority of cases notified to my Office where someone has died shortly after their release from custody are drug related deaths and similar issues have been reflected in other cases. I welcome and endorse the findings of the Trust's review and the potential for learning from it.

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

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

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
31st May 2019