The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

Mr M
AGED 34

AT MAGHABERRY PRISON

ON 30TH NOVEMBER 2016

Date finalised: 28th August 2018

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Names have been removed from this report and redactions applied.
All facts and analysis remain the same.

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PRISONER OMBUDSMAN INVESTIGATION REPORT

Mr M

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GLOSSARY

AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
AED	Automated External Defibrillator
CCTV	Close Circuit Television
ECR	Electronic Care Record
EMIS	Egton Medical Information System
GP	General Practitioner
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence (Order) NI
PECCS	Prisoner Escorting and Court Custody Service
PSNI	Police Service of Northern Ireland
PREPS	Progressive Regimes & Earned Privileges Scheme
PRISM	Prisoner Record and Inmate System Management
PTSD	Post-Traumatic Stress Disorder
SPAR	Supporting Prisoners At Risk (procedure)
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure

PREFACE

The previous Prisoner Ombudsman, Tom McGonigle, retired from post on 31 August 2017. His successor will be announced following the appointment of a Justice Minister. In the interim, the important work of the Ombudsman's office must continue. Given the commonality of purpose between that office and the Criminal Justice Inspection Northern Ireland, the Department of Justice has asked me to oversee the Ombudsman's office until a successor to Mr McGonigle can be appointed. It is in that capacity that I publish this report.

The investigators of the Office of the Prisoner Ombudsman for Northern Ireland and I are completely independent of the Northern Ireland Prison Service (NIPS). The Terms of Reference for our investigations are available at www.niprisonerombudsman.com/index.php/publications.

I make recommendations for improvement where appropriate; and our investigation reports are published subject to consent of the next of kin in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for Prisoner Ombudsman investigations of deaths in custody are to:

- establish the circumstances and events surrounding the death, including the care provided by the Northern Ireland Prison Service (NIPS);
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust (SEHSCT);
- examine whether any changes in NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation 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 practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. The clinical review in this case was conducted by Dr Jane Rees who has over 40 years' experience in Primary Care in England, including 11 years working in prisons there.

This report is structured to detail the events leading up to, and the emergency response to Mr M's death on 30th November 2016.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. In this communication with the family was via a solicitor for his nominated next of kin in Cork.

Although this report will inform several interested parties, it is written primarily with Mr M's family in mind.

I am grateful to the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contribution to this investigation.

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

BRENDAN MCGUIGAN
Office of the Prisoner Ombudsman for Northern Ireland/Chief Inspector, Criminal Justice Inspection Northern Ireland
28th August 2018

PRISONER OMBUDSMAN INVESTIGATION REPORT

Mr M

SUMMARY

Mr M was 34 years old when he died in his cell in Quoile House, Maghaberry Prison, on 30th November 2016. Despite extensive efforts, the post mortem investigation failed to determine a cause of death.

Mr M's death was the third in Maghaberry Prison in November 2016 and followed an earlier death in August. The four men who died were located in different residential units and the circumstances of their deaths do not appear to have been related.

Little is known about Mr M's background. He had not previously been in prison in Northern Ireland. He was remanded from Londonderry Magistrates' Court to Maghaberry prison on 21st October 2016 for a number offences against his partner. While in police custody Mr M reported that he had had some recent thoughts of self harm and reported receiving treatment for depression and anxiety. He had medication for depression and schizophrenia in his possession when he arrived at Maghaberry.

After completing the prison induction programme in Bann House, Mr M was moved to Quoile House where he remained until the time of his death. On 11th November 2016 he requested to be moved into a single cell, stating that he was a diagnosed paranoid schizophrenic. The House Senior Officer consulted with the prison Healthcare Department and the request was later granted pending further assessment of Mr M's mental health.

Throughout his six weeks in custody Mr M was unhappy about his prescribed medication. In particular, he complained that he had not been given the same format of the antipsychotic medication he had received in the community. On 7th November Mr M attended a GP appointment and complained of appetite loss. The doctor requested a series of tests and administered a depression screening questionnaire. This indicated that Mr M was severely depressed but the doctor did not prescribe antidepressant medication or make a referral to the mental health team. Mr M also received treatment for an infected toe while in prison custody.

Our Clinical Reviewer, Dr Jane Rees, concluded that Mr M was a vulnerable man with a history of anxiety, depression and panic attacks. Although not directly related to his death, Dr Rees said in failing to carry out a mental health assessment and prescribing an antidepressant, despite evidence of severe depression, the care Mr M received in Maghaberry was not equivalent to that he would have received in the community. The Clinical Reviewer also raised issues about other aspects of Mr M's medication regime, the provision of mental health support and record-keeping by prison doctors.

Dr Rees commended the rapid provision of podiatry services.

Shortly prior to his death Mr M appeared anxious about his financial affairs and had spoken to a number of prison officers and a prison chaplain about transferring money into his

prison bank account. He seemed to be concerned that someone in the community would access his money online.

Mr M was found by night guard officers during a routine check at 04:32 on 30th November 2016. He was lying on the floor and was unresponsive. The officers raised the alarm and entered the cell. Two nurses responded and an emergency ambulance was tasked. CPR was commenced and continued until the arrival of paramedics. He was pronounced dead by paramedics at 05.27.

The clinical reviewer concluded the resuscitation attempt was conducted as efficiently as possible given the location of Quoile House.

The SEHSCT conducted a Level 1 review of the circumstances of Mr M's death but it was not available at the time of writing this report. Ideally this internal review would be made available to the clinical reviewer at the time of writing their report so that all relevant issues are addressed. The Trust advised that steps have been taken to provide these reports on a timely basis.

This report makes three recommendations for improvement to the Trust. All have been accepted by the SEHSCT.

RECOMMENDATIONS

SEHSCT:

1. **Detoxification**: The SEHSCT should ensure that prison GPs are aware of the NICE guidelines on diazepam reduction regimes and the prescribing of antipsychotic medication (Page 13).

2. **Record-keeping:** The SEHSCT should ensure that prison's GPs make comprehensive entries of their consultations in the EMIS medical records (Page 14).

3. **Prescribing:** The SEHSCT should ensure that all prescribers are made aware of potential drug-drug interactions with Quetiapine and prescribe accordingly (Page 15).

MAGHABERRY PRISON

Maghaberry is a high security prison which holds male adult sentenced and remand prisoners. It opened in 1987.

It has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners. Mr M was not known to PSST.

Delivery of healthcare at Maghaberry transferred from the NIPS to the SEHSCT in 2008. Following a period of transition all Healthcare staff had become Trust employees by April 2012. The Trust subsequently increased the numbers of staff and the range of services provided. Healthcare is planned and delivered in line with primary care services in the community.

The Trust introduced a Primary Care Pathway with a dedicated committals team, providing comprehensive health screening within 72 hours of admission to the prison. It subsequently introduced a Mental Health Pathway, and an Addictions Team was created in 2014.

An inspection report on the safety of prisoners in Northern Ireland was jointly published by the Criminal Justice Inspectorate and the Regulation & Quality Improvement Authority in October 2014. While inspectors saw evidence of good work in dealing with vulnerable prisoners, they also said joint NIPS/SEHSCT strategies were urgently needed to revise the Suicide & Self Harm policy and the Substance Misuse policy. Joint strategies were completed in August 2017 and work to develop implementation plans has recently commenced.

A further inspection report, published in August 2017, found improvements, but there were still shortcomings in the care and support provided to the most vulnerable prisoners; and the Chief Inspector highlighted concern that, despite the critical reports into deaths in custody and serious self-harm, some important lessons had not been learned.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Their 2016-17 annual report highlighted a number of concerns relating to healthcare within Maghaberry.

FINDINGS

SECTION 1: BACKGROUND

Mr M was remanded to Maghaberry on 21th October 2016 having been charged with a number of offences against his partner. He had been in prison about six weeks before his death on 30th November 2016, aged 34.

Mr M was found lying face down on the floor of his cell during a routine night guard check at 04:32 on the morning of 30th November 2016. He was pronounced dead by paramedics a short time later.

The post mortem report records that a large quantity of vomit was on and beside the bed. Mr M had a makeshift tourniquet on his left arm and although a clear plastic bag containing a small amount of powder was located in his cell, no other drug paraphernalia was found. The medical staff did not apply the makeshift tourniquet. Toxicology analysis found there was no alcohol in Mr M's system. Drugs at a level consistent with therapeutic use were found in his blood. The white powder was analysed for a wide range of substances but could not be identified. The post mortem report concluded: "*The possibility of a toxicological cause cannot be entirely excluded and in the absence of any natural cause it would seem best for registration purposes to conclude the cause of death could not be determined*."

Mr M had not been in prison previously in Northern Ireland. He self-reported that he had been in Portlaoise prison but no further details are contained within the available records. Given the nature of Mr M's offences he had been flagged as being subject to the multi-agency Public Protection Arrangements for Northern Ireland (PPANI) and was allocated a Personal Development Plan (PDP) coordinator on his committal to prison. He later refused to engage in a needs assessment.

Mr M was on standard regime and was not engaged in any prison activities at the time of his death. No drug tests had been undertaken. He had attempted to make three telephone calls to a number believed to belong to his common law wife. He had no visits other than professional visits with his solicitor. He had a number of meetings with a prison chaplain.

Several letters written to friends were found in his cell. These indicated Mr M anticipated a lengthy period in custody but otherwise did not reveal anything of personal significance. Although the letters and in one telephone call Mr M made reference to having two children, he did not disclose this to prison staff at committal.

SECTION 2: EVENTS LEADING UP TO MR M'S DEATH

Mr M was remanded to Maghaberry Prison on 21st October 2016 from Londonderry Magistrates' Court. The following documentation was given to the Reception Officer on his arrival in the prison Reception:

- PECCS New Committal Form;
- PACE 15 Detained person's medical form; and
- PACE 16 Prisoner Escort Record and custodial record relating to Mr M's detention in police custody.

The PECCS committal form recorded that Mr M had medication in his possession and a small quantity of cash. There was no reference to any potential vulnerability on this form. The PACE 16 indicated that he may have suicidal/self-harm tendencies and 'physical illness/mental disturbance' was flagged. The custodial record noted warning flags on the police computer that Mr M was suicidal and suffered from depression and anxiety. The PSNI documentation also recorded that Mr M had recent thoughts of self harm but he had refused to elaborate about this.

Mr M was interviewed by a Reception Officer (Officer A) shortly after arriving in Maghaberry. He reviewed the committal documentation and completed the committal screens on PRISM. He recorded that he explored the comments in the police documentation relating to recent thoughts of suicide and Mr M's response was that the records were inaccurate.

The Reception Officer printed the healthcare cover sheet which extracts aspects of the NIPS committal interview including responses to questions about vulnerability and drug and alcohol misuse. This document recorded that Mr M had misused drugs prior to coming into custody but that he was not suffering withdrawal symptoms. Involvement with mental health services was noted but the record shows that Mr M did not require immediate support.

The prison committal documentation was completed and a landing file created. It contained a cell compact form[1], and documents relating to PREPS, television hire and communications.

Healthcare committal

The healthcare committal process comprises an initial screen, undertaken within four hours of committal, followed by a comprehensive health screen within 72 hours. The purpose of this screen is to gather information to keep a prisoner safe during the early stages of their

[1] A cell compact form is signed by a prisoner to acknowledge the integrity of the physical structure of the cell and to record if a key to a medication box has been issued.

time in custody. The assessment focusses particularly on medication, alcohol and drugs misuse, immediate mental health issues (including risk of suicide and self-harm) and any conditions that fall under the critical medications list.

The Initial Health Screen was carried out by the Committal Nurse (Nurse A). She recorded that the PACE form highlighted a risk of self harm and that Mr M had disputed these comments, claiming the police had misunderstood him. The Committal Nurse recorded that Mr M reported suffering from anxiety, depression and panic attacks, and that he was known to the community mental health team in Dublin. She recorded the medication he said he was taking and his view that his mental health was stable.

The Committal Nurse accessed the Electronic Care Record (ECR) to confirm his medication and, as it was late, contacted the out of hour's doctor to request a prescription in line with the medications listed on the ECR. An In-Possession Risk assessment was conducted by Nurse J who concluded that Mr M was not suitable to hold his own medication. She referenced the comments in the PACE documentation under the additional comments section of the risk assessment form. Mr M was added to the GP committals list for 24th October 2016.

After the initial committal interviews were concluded, Mr M was escorted to Bann House where the newly committed prisoners are accommodated.

The following day, **22nd October 2016**, the comprehensive committal assessment was conducted by the same nurse who completed the initial health screen. In addition to recording Mr M's height weight and Body Mass Index, pulse and blood pressure, the Nurse recorded that Mr M had an ingrown toe nail on his left foot and that he had refused to remove the dressing to allow her to examine his foot. She gave him a dry dressing. Two routine referrals were submitted to podiatry: one on 22nd October and the second on 24th October.

As Mr M was committed on a Friday, medication was prescribed by the out of hours GP service on 21st October and 22nd October 2016 until he was reviewed by the prison doctor on **24th October**.

On this date Mr M attended an appointment with the prison doctor (Doctor A). The prison doctor recorded that Mr M wanted to get his medications prescribed and was advised that this had been done earlier in the morning.

The doctor had earlier issued prescriptions for a Salbutamol inhaler, Mirtazapine and Quetiapine without seeing Mr M. The doctor later revised the medication after reviewing a copy of the prescription generated by Mr M's Dublin GP which had been faxed to Maghaberry's Healthcare Department. As Mr M had not yet received medication that day, the doctor adjusted his earlier prescription, withdrawing the prescription for Mirtazapine as there had been a three week break in Mr M's treatment with this drug. He prescribed

Diazepam detoxification programme in line with what Mr M had been given in Dublin and a modified release form of Mr M's antipsychotic medication.

Dr Rees noted that a Diazepam detoxification programme did not start until three days after Mr M's committal; there was no record of the detoxification having been risk assessed or discussed with Mr M; nor did the records indicate how long he had been taking diazepam or of his level of dependence. She stated that he was not, therefore, put on a detoxification regime commonly used for prisoners who come into prison with a significant addiction to benzodiazepines.

The SEHSCT should ensure that prison GPs are aware of the NICE guidelines on diazepam detoxification guidelines and the prescribing of antipsychotic medication.

On 24th October Mr M had a committal interview with a prison chaplain. During this meeting he sought advice on how to close down his internet banking facility to ensure no electronic transactions could be made.

The mental health screen also took place on 24th October 2016 when a mental health nurse (Nurse B) reviewed the committal records. She recorded that no onward referral or allocation to a mental health key worker was required at that time.

Dr Rees commented that the mental health nurse did not record the reasons for her conclusion and that the screening tool was not included in the EMIS medical records.

On **25th October 2016** Mr M refused his Quetiapine medication as the format of this medication was not the same as he had been receiving in the community. However he reflected on the matter and, a short time later returned to the Nurse and asked for this medication.

On **27th October** Mr M asked to see a doctor and completed a request slip. He submitted a further request to see a Nurse on 30th October. This form records an appointment was scheduled with the prison doctor for 7th November.

Repeat prescriptions for Quetiapine and Diazepam were issued on **31st October 2016** and on **1st November** by the same doctor who he had seen Mr M shortly after his committal to Maghaberry.

On **7th November**, Mr M attended a second appointment with the doctor. He reported having put on weight and a loss of appetite. In the course of the consultation the doctor completed a patient health questionnaire (PH-Q)-9, which is a depression screening questionnaire. Mr M's score indicated he was severely depressed. The doctor requested a series of tests and indicated in the record of the consultation that he would review Mr M again when the test results were available.

Dr Rees was critical of the lack of action taken by the prison doctor following the administration of the depression screening tool on 7th November. In her view an urgent mental health appointment for a more detailed assessment of Mr M's mood should have been made or his depression treated with medication.

She felt that an explanation should have been sought from the patient about the short period when he might not have had this medication or a risk assessment undertaken. She said that if the doctor felt that Mirtazapine was an inappropriate treatment for Mr M this should have been discussed at a face to face consultation and an alternative treatment for depression offered.

Dr Rees said the medical records relating to this consultation were brief to the point of being inadequate for a consultation on a mental health problem.

Dr Rees noted that PHQ-9 questionnaire is no longer used in the prison as its validity in a secure setting is not proven.

The SEHSCT should ensure that prison's GPs make comprehensive entries of their consultations in the EMIS medical records.

After several cell moves in Bann House Mr M moved to Quoile House on **8th November 2016**.

On the same day the doctor reviewed the results of a thyroid function test and Serum C reactive protein level and requested these to be repeated in two weeks and one month respectively.

On **9th November** a repeat prescription was issued for an inhaler by a Pharmacy Technician (Technician A).

On **10th November** Mr M made three telephone calls to a mobile number registered on prison records as that of a Ms M. One call went directly to voice mail and the second was very briefly answered. The third call lasted less than a minute. During this call the recipient said Mr M needed to explain a lot to her. Another person then joined the conversation and a voice in the background threatened to beat Mr M.

On the **11th November** Mr M submitted a request to be placed in a single cell due to a reported diagnosis of paranoid schizophrenia. On the request form he said he had asked to see a prison psychiatrist. However, this was not the case. The House SO (Senior Officer A) consulted with the House Nurse and they agreed to move Mr M into a single cell until a more in-depth review of his mental health could be conducted. There is no record of this discussion in the medical records.

On the same date a Nurse (Nurse C) made a routine referral for Mr M to see a prison doctor by adding him to the Quoile GP clinic list.

Medical records indicate that on **14th November** Mr M did not attend an appointment with the GP in Bann House because he had moved to Quoile House. It is not clear from the records if this appointment had been scheduled when Mr M had been in Bann in order to review his test results.

Mr M was moved into a single cell on 14th November 2016.

On **15th November** Mr M presented at the pharmacy room in Quoile requesting Mirtazapine (an antidepressant medication) and the same format of Quetiapine that he had received in the community. Mr M was advised by the Pharmacy Technician (Technician B) that he should speak to the GP about his medication and it was noted that a GP appointment was scheduled for 30th November.

Two days later, on **17th November**, an urgent referral form was submitted to podiatry by Nurse D. The next day Mr M was seen by Nurse E when he complained of pain in his left big toe. The Nurse examined his foot and requested that a doctor prescribe an antibiotic.

Later that day when the prescription was being processed by the prison pharmacy, a pharmacist (Pharmacist A), on noting the interaction between the prescribed antibiotic and Quetiapine, spoke to the prison doctor (Doctor A). He advised that he was happy to proceed with the antibiotic as the patient was only taking a total daily dose of 100mg of Quetiapine.

Dr Rees said that the prescription for Erythromycin in this situation was hard to understand from the information recorded in Mr M's EMIS records. He was not noted to be allergic to penicillin and had denied any allergies when asked in his reception assessment. However, the nurse who requested that Doctor A prescribe an antibiotic for Mr M's nail infection made a slot note that the patient was allergic to penicillin and this appears to be the reason for the Erythromycin prescription although the reason for the decision is not recorded in the EMIS records.

The SEHSCT should ensure that all prescribers are made aware of potential drug-drug interactions with quetiapine and prescribe accordingly.

On **22 November 2016**, Mr M attended a podiatry appointment when a treatment plan was agreed.

Shortly after this appointment Mr M attended the treatment room to collect his weekly medication. The Pharmacy Technician (Technician B) recorded that he continued to complain about the format of Quetiapine he was prescribed in prison. When she again explained that he should discuss the matter with the GP at his 30th November appointment, he said: "*It will be a waste of f****** time, I will get angry and end up doing something, its*

*p****** me off*." The Pharmacy Technician recorded that Mr M stormed off and that she would inform the House Nurse of this incident. However there is no further reference in the records to this matter.

Later on the same date a repeat prescription for Quetiapine (50mg to be taken twice per day) was printed by a Pharmacy Technician (Technician A) in line with the policy at that time. The prescription was signed by an authorising GP before being dispensed. Mr M was not seen by the GP prior to this repeat prescription being generated.

Throughout his period in custody Mr M had expressed dissatisfaction with the type of antipsychotic medication – Quetiapine – which had been prescribed.

Dr Rees commented Mr M was prescribed this antipsychotic medication by both his Belfast GP and his Dublin GP in the short-acting preparation. The prescription was changed to the long-acting version upon his entry to prison. Mr M did not like being given the 50mg long-acting version of Quetiapine in the prison as he felt it did not work as well as the short-acting drug. Short-acting Quetiapine is normally prescribed for the treatment of severe mental illness, often in high doses. There is no evidence in his EMIS records that Mr M suffered from a mental illness such as schizophrenia or bipolar disorder and he was not under the care of a community mental health team of a psychiatrist.

It is usual to prescribe the long-acting versions of antipsychotics in a secure setting as they are less likely to be abused. Doctor A ordered some blood tests, some of which would be relevant to the physical side effects of Quetiapine, but he failed to note that Mr M would be required to have an ECG. Quetiapine can cause potentially fatal heart rhythm problems, which would not be detectable at a post-mortem. Although NICE guidance on the prescribing of antipsychotics recommends a physical health check for all patients taking medications such as Quetiapine and an ECG where 'clinically indicated,' the Maudsley Prescribing Guidelines state that 'ECG monitoring is essential for all patients prescribed antipsychotics.' The Quetiapine was not initiated in the prison, but prescribers in any location have the responsibility to ensure that their prescribing is safe.

On **28th November**, a Nurse (Nurse F) completed a mental health referral form and submitted it to the Mental Health Team. The reason for the referral was anxiety, depression and panic attacks. The form recorded previous contact with the Mental Health Team although Mr M had not had contact with the prison Mental Health Team. It is not clear from the records what prompted a referral at this time. The referral was received by the Mental Health Team on the day of Mr M's death.

In addition to stating that there should have been more information included on this referral to enable the mental health team to assess the level of urgency, Dr Rees expressed wider concerns about Mr M's mental health management.

She was concerned that Mr M did not see a mental health nurse when in prison despite the prescription for antipsychotic medication. In her view there should have been a mental health assessment of whether Quetiapine was an appropriate medication in this case, especially in the absence of having been prescribed an antidepressant.

As stated earlier (page 14) in relation to the prescribing of Mirtazapine Dr Rees highlighted that, for reasons that are not recorded the doctor (Doctor A) failed to treat Mr M's depression with medication or to seek an urgent mental health appointment for a more detailed assessment of his mood.

29th November 2016

Further blood tests were taken and the results were reviewed by Doctor A. Later in the afternoon, Mr M saw the House Nurse (Nurse G) for foot pain and she issued him a pack of paracetamol.

Mr M had a meeting with a prison chaplain (Chaplain). As a result of this meeting the chaplain withdrew £230 from Mr M's bank account and it was lodged in his prison cash account. They also discussed a number of other issues related to Mr M's finances. The chaplain described Mr M as being in good form and later when he was returning to reception from Quoile House at 11:30am he saw him in a deep conversation with another prisoner. The chaplain also saw him briefly again around 15:00 in the afternoon.

Mr M also had several interactions with prison staff on the morning of 29th November to query how much money he could have in his prison account and attendance at a healthcare appointment that morning. One officer reported that he had attended this appointment while another said he did not plan to attend as he had already taken a number of tests when he was in a Dublin prison and he did not want to go through all that again.

SECTION 3: EVENTS AFTER MR M WAS FOUND

30th November 2016

The Night Guard Journal records regular PEG[2] checks throughout the night and two bodychecks supervised by the Senior Officer at 21:10 and 01:10. A further bodycheck was commenced at 04:30. Mr M was accommodated in Cell 20 and when the Night Custody Officer (Officer B) looked into the cell he saw Mr M lying on the floor. He was unresponsive. The NCO called to his colleague (NCO Officer C) who had just begun to make his way down the other side of the landing. The alarm was raised immediately and an urgent message sent to the Emergency Control Room (ECR). The ECR tasked an emergency ambulance. The SO arrived in Quoile House at 04:37. The NCOs entered the cell and one of the officers (Officer B) moved Mr M onto his back and checked for a pulse. He also attempted to open Mr M's mouth but was unable to do so. The NCO commenced CPR while the other officer contacted the ECR by telephone to provide an update.

Two nurses who were in the Healthcare Department when the alarm was raised, responded immediately. The first (Nurse H) arrived in Quoile House at 04:39. She went to the treatment room, collected the emergency equipment and ran to the landing. On entering the cell, she said Mr M was lying on the floor; his limbs were cold, he had no pulse and his pupils were fixed and dilated. She was advised that prison staff had found Mr M lying on his stomach and had turned him over in order to commence CPR.

Within seconds of her arrival, a prison officer brought the Automated External Defibrillator but no shock was advised at any stage during the resuscitation effort. The Nurse attempted to insert an i-gel airway but Mr M's jaw was locked. The first Nurse was quickly joined by the second Nurse (Nurse I) who also tried to open Mr M's jaw but he too was unsuccessful. An ambu bag was placed over Mr M's face. The nurses and prison staff continued CPR until the arrival of paramedics at 05:00. A second crew arrived approximately 15 minutes later but all attempts to resuscitate Mr M were unsuccessful. He was pronounced dead at 05:27.

Both nurses noted that there was brown vomit on the bed and splatter up the wall and one (Nurse H) recorded seeing a wet patch on the bed, thought to be urine.

The prison's Death in Custody procedures were initiated and efforts made to contact Mr M's next of kin.

[2] A PEG check is a recorded patrol of landings by night guard officers. The patrols are recorded on a pegging system at appropriate locations during patrols. Maghaberry's Governor's Order 8-1 advises that patrols will be made and recorded at intervals of no more than one hour or more frequently as directed by the Governor.

Dr Rees was satisfied the resuscitation was conducted as efficiently as possible given the location of Quoile house in relation to the prison's Healthcare Department. She noted that the reports suggested that Mr M had been dead for some time before he was found and his body was in the early stages of rigor mortis.

She concluded it was entirely reasonable for the prison staff and nurses to start CPR given that Mr M's death was unexpected.

On the afternoon of the **30th November**, the Class officer's Journal records that a prison chaplain and a representative of the mental health team visited the landing to offer support to prisoners. It was also noted that the House Governor (Governor A) authorised televisions should be temporarily provided to two prisoners who were on basic regime.

The PSNI Investigating Officer confirmed that the medication in Mr M's cell at the time of his death appeared to be in line with his prescribed medication.

Hot and cold debriefs

A hot debrief took place at 07:50 on 30th November and was chaired by a senior Governor (Governor B). Attendees included the prison officers and nurses who had responded when Mr M was found and a number of managers. The timeline of events leading up to and following Mr M's death was established and the efforts of those who responded to the incident were discussed. The hot debrief addressed the elements outlined in the NIPS Suicide and Self Harm Prevention Policy 2011 (updated October 2013). No follow up action was identified as being necessary. The SEHSCT Operational Nurse Manager advised that work continued on new resuscitation protocols. The meeting concluded with staff being made aware of support services.

The cold debrief did not take place until 26th January 2017 which is outside the normal timeframe of 14 days. The meeting was chaired by the same Governor who had led the hot debrief. The two night custody officers who had found Mr M and the SO on duty that night attended. The Trust was represented by the Nurse Operational Manager and a member of the Prisoner Safety and Support Team also attended. The Independent Monitoring Board was not represented.

It was noted that the cause of Mr M's death was undetermined and further toxicology tests were being conducted. Officers were appreciative of being given the night off following Mr M's death. The SO reported she had detailed staff to locations other than Quoile House but there had been an issue, the detail of which was not recorded in the record of the meeting. The actions staff who attempted to resuscitate Mr M were commended and the Trust representative again referenced the work being conducted to develop new resuscitation protocols.

As in other such meetings the focus of discussion was on the actions taken after Mr M was found. In this case, without a known cause of death, a broader review of learning was inevitably limited.

Conclusions of the clinical reviewer

Dr Rees concluded that Mr M was a vulnerable man with a history of anxiety, depression and panic attacks.

> 'Although not directly related to his death, in failing to carry out a mental health assessment and failing to prescribe an antidepressant despite evidence of severe depression the care Mr M received in HMP Maghaberry was not equivalent to the care he would have received in the community.
>
> 'The resuscitation was conducted as efficiently as possible given the location of Quoile House from the location of the prison's healthcare department. The emergency care was at least as good that that available in the community.
>
> 'The rapid availability of podiatry services and the plans to give Mr M toenail surgery within the prison is care that is at least as good as podiatry services would be available in the community.'