The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR GEOFFREY ELLISON
AGED 58

IN
MAGILLIGAN PRISON
ON 28th MARCH 2015

11th October 2016

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

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Glossary

CJI	Criminal Justice Inspectorate
CRP	C-reactive Protein Test
CSU	Care and Supervision Unit
CT Scan	Computerised Tomography Scan
ECG	Echocardiogram
EMIS	Egton Medical Information System
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
NIPS	Northern Ireland Prison Service
OMU	Offender Management Unit
PSNI	Police Service Northern Ireland
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust
SIR	Security Information Report

PREFACE

As Prisoner Ombudsman for Northern Ireland I have responsibility for investigating all deaths in prison custody in Northern Ireland. My investigators and I are completely independent of the Northern Ireland Prison Service (NIPS). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

I make recommendations for improvement where appropriate; and my 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 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.

In this case, Ms Jane Mackenzie, a retired RGN and RMN undertook a clinical review of the care provided to Mr Ellison. Ms Mackenzie has experience of completing clinical reviews for deaths in custody in Wales.

This report is structured to detail the events leading up to, and the emergency response to Mr Ellison's death on 28th March 2015.

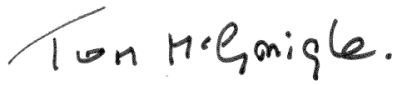
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. The office first spoke with Mr Ellison's brother in April 2015, and contact has been maintained with him throughout the investigation.

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

I am grateful to Mr Ellison's brother, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contributions to this investigation.

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



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
11th October 2016

SUMMARY

Geoffrey Ellison came from England but was arrested in Northern Ireland and subsequently sentenced to imprisonment here. He was 58 years old when he was found hanging in his cell at Magilligan Prison on 28th March 2015, two months before he was due for release.

He had appeared content in Magilligan, got along well with staff and other prisoners and was actively planning for return home to England. However he was on medication for clinical depression and had attempted suicide a number of times, most recently just two months before his committal to prison in September 2014. He also had physical health problems which were well-managed in prison, though they added to his anxiety.

In the days immediately before his death, Mr Ellison was not presenting with overt symptoms of deteriorating mental health or impending suicide. He lived in a low supervision area and worked as an orderly. However around 36 hours before his death he received an upsetting letter from home.

One of the implications of this letter was that Mr Ellison could have difficulty obtaining an address following release, and might therefore be compelled to remain in Northern Ireland. Although that concern was quickly dispelled when his brother offered to accommodate him, other important aspects of his future remained uncertain. He tried to address them by phone but was unable to do so.

The letter censor and an officer on his landing immediately recognised the potential impact of this letter and shared their concerns with relevant colleagues. However two officers on his landing who knew about the contents of the letter did not have undue concerns for Mr Ellison: they thought his main anxiety was about obtaining an address - which had been resolved - and consequently did not take any further steps to mitigate the risks.

There was a delay in obtaining access to Mr Ellison's cell when his body was found, and unclear notification to the emergency response nurse who was tasked to attend the scene. It was too late to have made any difference to Mr Ellison, but these matters need to be addressed, otherwise they could have negative consequences in a similar future scenario.

While our clinical reviewer criticised the level of attention to Mr Ellison's emotional state and felt his death was predictable, she concluded that it could not be determined with any certainty that it could have been prevented.

This report makes nine recommendations for improvement, all of which have been accepted. Two recommendations were previously made to, and accepted by the SEHSCT and NIPS – Recommendation 1 in March 2014 and Recommendation 9 in November 2014.

RECOMMENDATIONS

NIPS

1. **Information Sharing:** The Prison Service should review the processes for recording and sharing information relating to care of prisoners, particularly at handovers, and develop a more collaborative approach to communication and information-sharing between all levels of staff. (Pages 13-14)

2. **Officers' performance:** The NIPS should satisfy itself about the compliance by the landing officers with the NIPS SSHP policy after Mr Ellison received a letter that contained upsetting news, and take any necessary action to address the concerns that are raised in this report. (Pages 13-16)

3. **Suicide & Self-Harm Prevention (SSHP) Policy:** The NIPS should ensure all relevant staff have access to the Policy and associated Standard Operating Procedures, and are trained in its application. (Pages 13-16)

4. **Emergency Radio Communications**: The NIPS should ensure radio controllers in the ECR fully understand the importance of relaying accurate information to responders, to ensure the correct personnel attend an emergency, and they are properly equipped. (Pages 18)

5. **Professional Conduct:** The Prison Service should ensure all staff deal sensitively and respectfully with a death in custody. (Page 18)

SEHSCT

6. **Mental Health Monitoring:** The SEHSCT should ensure previous known mental history is taken into account and addressed at the point of a prisoner's committal to custody. (Page 9)

7. **Anxiety Symptoms:** The SEHSCT should provide guidance to help staff recognise symptoms that indicate acute anxiety. (Page 12)

8. **Emergency Medical Equipment:** The SEHSCT should ensure all clinical staff have access to and take appropriate emergency equipment to all emergency callouts as a matter of policy. (Pages 17-18)

9. **Medication In-Possession Risk Assessments:** The SEHSCT should ensure that nurses clearly record risks and the rationale for their decisions when completing IP risk assessments. They should also ensure that the risk assessment is reviewed regularly in line with SEHSCT policy; and when the risk of self-harm or suicide is considered to be high, it should be shared with NIPS staff and incorporated within a joint risk management plan. (Page 19)

MAGILLIGAN PRISON

Magilligan is a medium security prison which accommodates sentenced prisoners only. All are classified as Category B or lower risk level. The aim of Magilligan Prison is to provide safe, secure and decent custody with a focus on pre-release preparation, risk management and resettlement.

FINDINGS

SECTION 1: INTRODUCTION

Geoffrey Ellison was committed to Maghaberry Prison on 17th September 2014 on a sentence of one year in custody and 18 months on licence. He transferred to Magilligan Prison on 16th October 2014. He had been in prison once before - in England in 1994.

Mr Ellison was 58 years old when he was found in his cell on 28th March 2015, having died by hanging, nine weeks before he was due for release.

He had a long history of mental health problems and attended his GP and Community Mental Health Team (CMHT) to address a diagnosis of depression and history of self-harm. His most recent episode of self harm was two months prior to committal when he was admitted to a psychiatric ward following a deliberate overdose. His community medical records also noted that Mr Ellison was prescribed sertraline hydrochloride to treat his depression and anxiety, and he continued to receive it in prison.

In her clinical review Ms Mackenzie said, in relation to the healthcare Mr Ellison received in the days after his committal, that his physical health was covered *"in some detail"* (relating to previous heart attacks), but limited attention was paid to his mental health. She noted that while medical records and information relating to Mr Ellison's previous medical history was limited, there was a record provided to prison Healthcare by his GP, on a fax dated 24th September 2014, of his ongoing mental health problems and a number of suicide attempts since 1977**,** the most recent being two months before his imprisonment. This corroborated Mr Ellison's self-report.

Ms Mackenzie said "*Despite his known history of mental health problems, his diagnosis and treatment of depression, there was no formal mental health assessment completed and he was not referred to, or seen by a mental health nurse, or other mental health professional."* Ms Mackenzie criticised the absence of monitoring in relation to his depression, the impact of imprisonment, physical health problems and personal matters on his mental health.

Mr Ellison's committal procedures identified his self-harm history and medical markers were generated to indicate a history of self-harm. However there was no indication of self-harm or suicidal ideation in Magilligan or Maghaberry prior to his death.

Prison officers described him as a quiet, polite and pleasant man who was keen to work as an orderly and caused no concern.

On 9th February 2015, Mr Ellison moved to Alpha House and over the following week he described it as a *"brilliant lovely place"* which was having a positive impact on his health as he was more relaxed due to the quieter atmosphere, and no longer experiencing chest pains.

SECTION 2: PHYSICAL HEALTH CONCERNS

Prostate Cancer Concern

On Friday 6th March Mr Ellison saw a nurse as he was complaining of passing blood in his urine. The nurse suspected he was suffering from prostatitis[1] and planned to obtain a blood sample the following Monday and schedule an emergency GP appointment.

During phone calls made on the same day Mr Ellison indicated it was possible he had a problem with his prostate and that it could be cancer. This news continued to be the focus of calls he made that weekend.

The sample was taken on Monday 9th March, but the doctor was unable to see him. A further doctor's appointment was arranged for 12th March by which time his results would be available.

Mr Ellison indicated in phone calls on 9th March that he had been unofficially told that he had prostate cancer by nursing staff, but said he felt well.

On 12th March 2015 Mr Ellison saw a prison doctor (Dr A) who recorded his PSA level as 1.66 and that blood continued to be present in his urine. As a result a 'Red Flag[2]' referral was made to urology for further advice. No appointment was received prior to his death on 28th March 2015.

During a phone call on 21st March 2015 Mr Ellison expressed frustration that nothing further had happened since the referral.

Heart Disease

Mr Ellison had a history of severe heart disease, including four heart attacks, for which he was receiving medication. His most recent heart attack had been in 2013, and he was on a waiting list for bypass surgery prior to being committed to prison. Due to ongoing angina symptoms and shortness of breath, Dr A made an urgent referral to cardiology.

Phone calls indicated that throughout March 2015 Mr Ellison's cardiology appointment appeared to be adding to existing concerns about his impending urology appointment. An officer (Officer A) said that on the day of his cardiology appointment Mr Ellison looked a bit worried.

[1] Prostatitis is the name given to a set of symptoms which are thought to be caused by an infection or inflammation of the prostate gland. It is not a form of prostate cancer.
[2] A red flag referral is used when a GP suspects cancer. The anticipated waiting time is two weeks.

On 26th March Mr Ellison attended his cardiology appointment. The consultant wrote to Magilligan Prison advising that he was *"now passing blood and had clots in his urine. This would have to be cleared up before anything was actually done or considered with regard to cardiac intervention."*

Commenting on Mr Ellison's physical healthcare in prison, Ms Mackenzie said, "*During his four months in Magilligan prison, he experienced several episodes of chest pain and symptoms associated with angina, or a heart attack and most recently he was passing blood in his urine and he believed he had cancer of the prostate. From the records, the healthcare team appeared to have responded to each clinical episode promptly, appropriately and thoroughly, other than one evening, (27th January 2015) when it would have been good practice to have referred Mr Ellison to an out of hours GP because of his cardiac symptoms. However the symptoms that night subsided and subsequently he was monitored regularly by medical and nursing staff and appropriate tests and observations were made. An urgent referral was made to the Cardiologist for his heart problems and also to the Urologist seeking advice to determine whether problems he was experiencing with his prostate may have been an infection, or symptoms of cancer. These referrals were made appropriately and in a timely manner.*"

Ms Mackenzie considered what effect, if any, these health concerns had on Mr Ellison's state of mind. She said "*He had a heart disorder and was suffering intermittent chest pain and more recently had found blood on passing urine, these health concerns were likely to have been quite worrying for him. He was seen a number of times by medical and nursing staff presenting with breathlessness and pain and other symptoms relating to cardiac disorders and despite further investigations there were no abnormalities detected at that time. A number of these symptoms are also associated with acute anxiety, yet despite having numerous interactions with Healthcare staff about his physical health, the impact these health concerns may have had on his mental and emotional state and the possibility these symptoms may have been related to his level of anxiety was not seemingly discussed, or further explored*."

SECTION 3: NEWS FROM HOME

On 22nd March Mr Ellison made numerous phone calls to his home which went unanswered. In comparison to previous phone calls, which were generally amicable, with only an occasional disagreement that was immediately resolved, it is clear from the answer phone messages that he was becoming increasingly anxious and frustrated.

The following day, when his phone calls were answered, the person he spoke with told him they had been too ill to answer his calls on 22nd March.

Between 23rd and 26th March Mr Ellison made 33 unanswered calls and left an answer phone message on almost every occasion. These messages again evidenced that he was becoming increasingly anxious, suspicious, frustrated and upset that his calls were not being answered.

On 25th March a letter censor (Officer B) noted that a letter addressed to Mr Ellison contained news which he suspected would have been very upsetting. As a result the officer immediately phoned Alpha House to inform staff that Mr Ellison would be receiving an upsetting letter and advised the officer to whom he was speaking (Officer C) to *"keep an extra eye"* on him for a couple of days *"in case he would try and do something silly."* The letter could not be found following Mr Ellison's death.

The letter censor expected that an officer in Alpha House would speak to Mr Ellison to find out if he was OK and try to lighten his mood if he was down. He said that if he worked in Alpha House, he would also have informed Mr Ellison's probation officer, the House senior officer, any places he was going to (e.g. Visits or work). He would also have hoped that his close friends (other prisoners) would have been informed, so that he could have been supported.

Mr Ellison did not receive the letter until the following morning. In anticipation of the impact an officer in Alpha House (Officer C) informed two colleagues (Officers A & D) about the letter as she knew she was going to be off duty for the next couple of days. No written record was made of the phone call received from Letter Censors or that the information had been passed to two other Alpha House Officers.

A previous Prisoner Ombudsman Report recommended that when information has been received which identifies a prisoner may be vulnerable, then a contemporaneous note should be recorded in all relevant journals, the ECR occurrence log, as well as a note of the action taken. This recommendation was accepted in March 2014 by the Prison Service.

At 0930hrs on 26th March 2015 Mr Ellison met with his probation officer. He was informed that the English Probation Service had provisionally agreed to supervise his licence after release and he had been allocated a probation officer.

This was positive news for Mr Ellison as it meant he would not have to spend his licence period in a hostel in Northern Ireland. The probation officer said Mr Ellison was delighted with this news.

Later that morning Officer A, who had been informed of the letters contents gave it to Mr Ellison. He read it in the communal area, then said that he did not want to eat his lunch and returned to his cell. She said he seemed angry but she did not consider it necessary to go to his cell to check to see if he was OK.

Commenting on how staff handled the fact that Mr Ellison had received upsetting news Ms Mackenzie said, "*Mr Ellison had a history of self-harm and attempting suicide and a number of triggers and risk factors were present, yet a Supporting Prisoners At Risk (SPAR) was not opened.*" … "*The Prison Officer in the censor's office had told the wing staff that the letter* (contained upsetting news) *was on the way to Mr Ellison and advised the staff to keep an eye on him. The wing staff, although sharing this information verbally between themselves at the time, did not share or record it anywhere, pass the information on to oncoming staff, or consider escalating the information to a senior manager, or any one in Healthcare. Despite a number of risk factors described in the Northern Ireland Prison Service (NIPS) Suicide and Self-harm Prevention policy, particularly previous suicide attempts, history of mental health issues and* (upsetting news)*, being present, further action to monitor these risks was not considered necessary. Despite Mr Ellison's past history and other risk factors being present….it seems that information was not shared, or recorded systematically or appropriately between Prison staff, or from Prison staff to Healthcare staff."*

That afternoon Mr Ellison made 17 unanswered phone calls to the author of the letter, leaving a message on each occasion. He was clearly very upset with the contents of the letter and believed it would have consequences for his ability to secure an address in England for his licence period.

Mr Ellison subsequently told his brother about the letter during a phone call. He stated that his life had gone from bad to worse, and discussed his concerns that it meant he would have to stay in Northern Ireland for his 18 month licence period. His brother promptly offered to accommodate him, which Mr Ellison accepted, thus quickly resolving a fundamental concern.

In his final answer phone message that evening - to the author of the letter - Mr Ellison said that he was going to *"put a rope"* around his neck. Although prisoners' phone calls can be monitored, this is usually done on an intelligence-led basis, and on this occasion the Prison Service was unaware of any need to monitor Mr Ellison's calls.

The recipient of the answer phone message contacted Magilligan the following morning to express concern for his welfare, but by that time Mr Ellison had already died.

Two prisoners (Prisoners A & B) described how Mr Ellison became very low after receiving the letter. He did not come out of his cell for lunch or dinner on 26th March, and became emotional when discussing the letter. He also expressed concern to them that he would not have an address to go to during his licence period. They said he smashed gifts which he had made to take home and ripped up photographs. However they did not alert prison staff to Mr Ellison's deteriorating mood.

The probation officer described how important his home life was to Mr Ellison; and it is clear from three months of phone calls that he was making positive plans for his release. Phone conversations suggest his plans were reciprocated and the content of the letter would probably therefore have come as a surprise to him.

SECTION 4: 27th MARCH

The officer (Officer A) who had handed Mr Ellison the letter on 26th March said he got up as normal the following morning (27th March) and carried out his orderly duties. Later that afternoon he told her he had received an upsetting letter. She described how he seemed resigned to the fact that he could not change what had been written and was most worried about not having an address upon release.

He later provided this officer with the new address which his brother had offered, and the officer shared it with his sentence manager and probation officer in Mr Ellison's presence. The officer reassured him the probation officer and sentence manager would see him the following week and sort things out. She considered he was fine during their conversation and content that the new address had been shared.

During a subsequent phone call to a family member Mr Ellison discussed the letter, a concern that he had little money to get back to England and the new address which had been passed to his sentence manager. He explained that a probation officer would be in contact to assess the suitability of their address.

Neither officer (A or D) who was aware of the letter's contents knew Mr Ellison particularly well. They had no concerns about him when they left work on 26th and 27th March, because his greatest worry – about not having an address post-release – had been resolved, and also because he was angry rather than visibly distressed. In addition neither prisoners nor Mr Ellison himself indicated that he was upset.

If the officers had identified the risk and recognised a need to address it, then in order to comply with the NIPS Suicide & Self Harm policy they should have:

- Discussed with Mr Ellison and relevant others e.g. his sentence manager, probation officer, Healthcare professionals and prisoner friends how to support him through this difficult phase;
- Observed his behaviour, including eating habits and changes to routine and acted upon any concerns;
- Checked PRISM – which would have shown a history of severe mental illness and self-harm - to ascertain his history of self-harm and factored the findings into a care plan.

Mr Ellison left seven messages on the answering machine of the letter author. In his final message at 18.41hrs on 27th March he said *"Goodbye"* after saying he was going to take his own life.

At 19.12hrs the grille to Mr Ellison's landing was locked for the night. The relaxed regime in Alpha House meant no further checks were conducted until the following morning.

SECTION 5: 28th MARCH

At 08.49hrs on 28th March during morning headcount, an officer (Officer E) heard a prisoner (Prisoner A) shouting outside Mr Ellison's cell. The officer ran straight to the cell and called his colleague (Officer F) for assistance.

On reaching the cell there were already a number of prisoners at Mr Ellison's door, trying to force it open. The officer looked through the door flap and could see Mr Ellison hanging near the window. He was grey in colour and showed no signs of life. The officer attempted to open the door with his override key, but was unable to, so he started to shoulder charge the door.

As the override key was bent from his continuous attempts to open the door, he then went to the class officer's desk to get a second set of keys. Two other officers (Officers F & G) had now arrived and were also trying to force the door open. The second key did not open the door either.

Three officers from the response team arrived very soon after the second key had been unsuccessful, and one of them (Officer H) succeeded in forcing the door open. CCTV footage shows it took one minute and 56 seconds to gain entry to Mr Ellison's cell.

The cause of the key failures was more than likely as a result of prisoners and officers efforts to force the door open. The doors in Alpha House are wooden-framed and Mr Ellison's lock was found to be damaged after this incident.

Within three days of Mr Ellison's death a governor confirmed that all cell doors in Alpha House had been checked to confirm that they could be opened without difficulty. In addition a one person mini door ram was placed in Alpha House and another in the CSU vehicle which responds to emergency incidents in the prison.

Once the door was opened three members of the response team (Officers H, I & J) and two landing officers (Officers E & G) entered the cell. One of the landing officers (Officer E) cut the ligature and described how Mr Ellison's body remained in an upright position, due to rigor mortis.

All staff said no signs of life were present.

A nurse also responded to the incident. He arrived at 08.52hrs, without emergency medical equipment. The nurse recorded "*On examination marked post mortem rigidity had set in. I also noted marked mottling of the face and extremities of his arms. Breath sounds were absent and no cardiac output detected. Resuscitation was not attempted due to the degree of post mortem rigidity and absence of life signs.*"

The nurse was not available for interview as he no longer works for the SEHSCT. Radio transmissions confirmed that the nurse received a "non-coded"[3] call and was simply told to make his way to Alpha immediately. When the nurse requested further information, the ECR said that it did not have any further information and that he was "*just to go there immediately.*"

In respect of the fact that no emergency equipment was brought to the scene of the incident Ms Mackenzie commented "*The nurse who received the emergency call out was not informed by prison staff of the type of emergency he was attending … he was not expecting the call out to be a death in custody and did not routinely pick up emergency equipment to take to the scene. In this case, as Mr Ellison had clearly been dead for some time, this decision would not have affected the tragic outcome. However in other circumstances taking lifesaving equipment to the scene of any emergency call out would be an expected good practice and may well contribute to a more positive health outcome, or saving a life.*"

At 09.25hrs paramedics who arrived at Alpha House confirmed there were no signs of life.

At 09.50hrs a Governor received a telephone call from a person who knew Mr Ellison. This person informed the Governor they were concerned for Mr Ellison as he had left a telephone message indicating that he would take his own life.

Mr Ellison's time of death was subsequently recorded by a forensic medical officer at 11.15hrs. The FMO advised that post-mortem rigidity indicated death would have occurred six to eight hours before his body was discovered.

Records indicate Mr Ellison was fully clothed when he was found, and that his bed had not been slept in. No note was found in his cell.

Prisoners who were nearby during the incident reported that the officer who was carrying out the headcount shouted down to his colleague "*We've got a swinger*" to describe what he had seen through the flap when he reached Mr Ellison's cell. This unprofessional language was also recorded in the ECR log.

[3] A "non-coded" call means there was no indication of the nature of the emergency.

SECTION 6: OTHER MATTERS

Independent Clinical Review by Ms Jane Mackenzie MSc, RN (G), RMN

Findings of Ms Mackenzie's clinical review have been included where relevant in this report. She considered that Mr Ellison's physical healthcare needs were adequately met in Magilligan. She also believed that had his past history and presenting risk factors been addressed, then his death could have been predicted. However she ultimately suggested it cannot be concluded with any certainty that Mr Ellison's death could have been prevented.

Ms Mackenzie concluded that no discipline or individual was to blame for Mr Ellison's death. Nonetheless she suggested there is a responsibility on both the SEHSCT and NIPS to address the issues identified in this report in order to minimise the risk of this happening again. She suggested that additional RMNs would promote a clearer mental health focus in the prison and contribute to a more balanced and multidisciplinary health service provision at Magilligan prison.

Medication Management

Ms Mackenzie noted that Mr Ellison received his medication promptly upon arrival at Magilligan and throughout his stay, and the prescriptions appeared appropriate to meet his physical and mental health needs. Supervised swallow was appropriate, based on his overdose of drugs two months before committal to prison.

However he did not have a monthly IP Risk Assessment, as required by the IP policy, and when reviewed in March 2015, there was no rationale recorded for a change in status, despite the presence of a number of risk factors.

A member of the Healthcare team suggested the reason for changing Mr Ellison from supervised swallow to IP medication was so that he would not have to walk to the Healthcare centre each morning in the cold to get his medication. This rationale was entirely appropriate since Mr Ellison suffered from angina. However it should have been recorded in the interests of continuity of care and best professional practice.

Illicit substance

After Mr Ellison's death a cell search revealed a liquid substance in a plastic tub which was labelled "*Valupak Vitamins, Cod Liver Oil, 400mg, 30 capsules.*" The tub contained approximately six millilitres of light brown liquid similar in appearance and smell to coffee liqueur.

This substance was submitted to Forensic Science Northern Ireland for analysis. The analysis proved negative for alcohol, but a drug test by the NIPS produced a positive result for Methadone - a substitute drug used for the treatment of morphine and heroin addiction. Mr Ellison was not known to be a drug user and it may be that he was holding this for someone else, which meant NIPS staff would only have discovered this substance if Mr Ellison's name appeared on the computer-generated list for 'Random' searches. In the 12 months preceding his death, 147 random searches were carried out in Alpha House and 18 intelligence-led searches, two of which (both in February 2015) resulted in illegal substances being found.