The Prisoner Ombudsman for Northern Ireland

# INVESTIGATION REPORT
# INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

# 'MR I'

# WHILE IN THE CUSTODY OF
# THE NORTHERN IRELAND PRISON SERVICE

12th October 2016

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

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**CONTENTS** **PAGE**

## 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 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, Dr Rob Hall, a retired GP from Suffolk, undertook a clinical review of the care provided to Mr I. Dr Hall has experience of completing clinical reviews for deaths in custody in England and Wales.

This report is structured to detail the events leading up to, and the emergency response following Mr I's collapse. It also addresses concerns that were raised by Mr I's father.

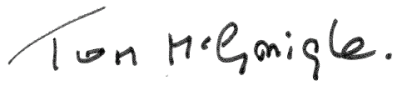
## Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. Contact has been maintained with Mr I's father throughout the investigation.

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

I am grateful to Mr I's father, 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 my sincere condolences to Mr I's family for their sad loss.



**TOM McGONIGLE**
**Prisoner Ombudsman for Northern Ireland**
12th October 2016

## SUMMARY

Mr I collapsed in his cell when in the custody of the Northern Ireland Prison Service. He was taken to outside hospital but never regained consciousness. His life support machine was turned off two days later. The post mortem examination reported his death was due to a heart attack and tramadol toxicity.

He had a longstanding history of abusing prescribed medication and illicit drugs, and it transpired that he had taken significant overdoses of his prescribed medication during the lunchtime lockup. His eligibility to hold his own medication "In-Possession" was not reviewed when it should have been, which led to him being allowed to retain his medicines for four weeks prior to his death.

Mr I had previously complained of chest pains and had collapsed in the past. However even after hospitalisation and ECG tests, the causes of his chest pains and collapses were never diagnosed.

The clinical reviewer, Dr Hall, identified aspects of Mr I's care which were better in prison than they would have been in the community, such as the fact that he was seen regularly by a psychiatrist and his mental healthcare was regularly reviewed. He had daily access to a nurse while in the Care & Supervision Unit (CSU), was seen frequently by a GP and the nursing records made while he was detained in the CSU were detailed and of high quality.

Dr Hall's fundamental conclusion was that Mr I's death was not foreseeable. However it may have been preventable had the causes of his chest pains and collapses been diagnosed. He also said some aspects of the resuscitation attempt were well-managed. Others could be improved, in particular the SEHSCTs maintenance of its emergency equipment, though this would not have impacted on the outcome for Mr I.

This report makes 11 recommendations for improvement, all of which have been accepted. Most significant are that the SEHSCT needs to improve reviews of In-Possession medication and feedback from outside hospital appointments. The NIPS needs to notify prison Healthcare Departments about failed drug tests and evidence of prisoners trading medications.

## RECOMMENDATIONS

**SEHSCT and NIPS: -**

1. **Medical Emergencies** – The NIPS and SEHSCT should review and update the current approach to a medical emergency to ensure that appropriate mechanisms are in place for the provision of emergency care and the request of an emergency ambulance when required. The updated approach should ensure there is no delay in summoning an ambulance in critical Code Red and Code Blue emergencies. (Page 14 & 17)

2. **Outpatient Appointments/Discharge Information** – The NIPS and SEHSCT should develop a system to ensure that Prison Healthcare Departments are provided with confirmation of attendance/non-attendance at outpatient appointments, and discharge information following emergency admissions. The SEHSCT should also ensure a system for follow-up is put in place as clinically appropriate and that all outcomes are recorded on EMIS. (Pages 18-20, 22 & 23)

3. **Medication Monitoring** – The NIPS and SEHSCT should introduce new measures to ensure the most appropriate and robust system is in place for managing in-possession medication. This should include monitoring prisoner/patient compliance with taking their medication(s), sharing and recording positive and negative drug test results, and taking corrective action where necessary. (Pages 21, 24-25)

**NIPS -**

4. **Staff Radios –** The NIPS should assess the feasibility of providing all operational officers with radios. (Page 14 & 17)

**SEHSCT –**

5. **Emergency Response Equipment** – The SEHSCT should ensure that Papa call signs always respond to incidents with the relevant emergency response bag. The SEHSCT should also ensure that all emergency response equipment is checked weekly and a record retained. (Pages 15-17)

6. **GP Role during a Medical Emergency** – The SEHSCT should ensure the role of a prison GP is clearly defined when responding to a Code Blue or Code Red emergency, and that all prison GP's are fully informed. (Pages 15-17 & 28)

7. **Chest Pain Investigations** – The SEHSCT should develop guidance on the action to be taken when a patient complains of chest pain. The guidance should include the following:

    - What examination should be conducted?
    - What symptoms should lead to requesting an ambulance immediately?
    - Should a 999 ambulance be called if the ECG reading is abnormal?
    - When can a patient be safely left without intervention?
    - When should cardiac enzymes be measured?
    - Appropriate responses at all times including out of hours. (Pages 18-20)

8. **Medication In-Possession (IP) Risk Assessments** – The SEHSCT should ensure all staff follow the current IP policy and use the up to date IP Risk Assessment form. Outdated versions of the IP assessment form should be removed from use. The outcomes of all IP assessments should also be recorded on EMIS. (Pages 23-25 & 27)

9. **Tramadol, Pregabalin and Mirtazapine Prescriptions** – The SEHSCT should consider the prescribing practices at HMP Parc (South Wales) in relation to tramadol, pregabalin and mirtazapine and decide whether such practices could be applied across all NIPS establishments. Any changes should engage the co-operation of all GPs, mental health team, psychiatrists and the Pharmacy. (Page 23)

10. **Cholesterol Levels** – The SEHSCT should ensure an appropriate cardiovascular risk assessment, advice, guidance (and treatment where applicable) is offered for patients with rising cholesterol levels who are known to Prison Healthcare services. (Pages 27-28)

11. **Staff Support** – The SEHSCT should provide a more supportive strategy for clinical staff involved in serious incidents or deaths in custody, to incorporate ongoing monitoring and access to counselling services if required. (Page 29)

## PRISONER SAFETY AND CARE

Mr I was a sentenced prisoner in one of the prisons in Northern Ireland. For most of Mr I's custodial period, this prison had an established Prisoner Support and Safety Team (PSST).

The PSST team have several responsibilities including a role to support vulnerable prisoners. Mr I had come to PSST attention once in the previous 12 months when notified that he had declared being on hunger strike due to problems with his request for a transfer to another prison. The hunger strike lasted intermittently for approximately one week.

Responsibility for delivery of healthcare in Northern Ireland prisons transferred from the Northern Ireland Prison Service (NIPS) to the South Eastern Health and Social Care Trust (SEHSCT) in 2008; and following a period of transition all Healthcare staff were employed by the Trust by April 2012. The Trust has subsequently increased its 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 a first health screening and a comprehensive health screening within 72 hours of admission to the prison. It also introduced a Mental Health Pathway, and an Addictions Team was established in 2014.

The report of an unannounced prison inspection by the Criminal Justice Inspectorate which was published in December 2012 welcomed the introduction of mandatory drug testing in prison, but expressed concern around the diversion of prescription medication and poor drug treatment processes in the prison.

An inspection of prisoner safety that was published in October 2014 acknowledged the NIPS and SEHSCT's work to improve prisoner safety, but recommended that, as a matter of urgency they should introduce joint strategies to address suicide, self-harm, bullying and violence reduction and the availability and access to illegal and prescription drugs.

Prisons in Northern Ireland have an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Their 2014-15 annual report made recommendations in connection with concerns about the quantity and accessibility of drugs (both prescription and illicit) and poor participation in, and outcomes at Drug Strategy Meetings.

## FINDINGS

## SECTION 1: INTRODUCTION

Mr I was committed to prison on remand and subsequently sentenced.

He collapsed in his cell and later died in outside hospital from coronary atheroma (heart attack) and tramadol toxicity. The post mortem report stated:

*"At autopsy there was no obvious anatomical cause of death. Examination of the heart revealed what appeared to be a moderate degree of coronary artery narrowing due to a degenerative process known as atheroma. However, subsequent microscopic examination of tissue sections indicated that the degree of narrowing in one of the major coronary arteries was far greater than appreciated on naked eye examination and was in fact severe. Coronary artery atheroma is a common cause of heart attacks and sudden death as it impairs the flow of blood to the heart rendering the heart muscle prone to injury and the heart susceptible to sudden fatal disturbances of rhythm (arrhythmias).*

*Toxicological analysis of a sample of blood taken in hospital revealed the presence of the commonly prescribed opioid analgesic drug tramadol at a concentration that lay above its therapeutic range and, indeed, within the range associated with fatal toxicity. This blood sample was also found to contain a low level of the commonly prescribed antidepressant drug mirtazapine.*

*The history indicated that his initial collapse and cardiac arrest occurred within a very short period of time and, on balance, this would favour a heart attack playing the major role in his death. It is not quite clear to what relative extent tramadol toxicity may have played a role in his death, however it undoubtedly warrants inclusion as a contributing factor."*

Forensic Science Northern Ireland who provided the toxicology report suggested that, given the time his sample was taken (21.34hrs), the blood tramadol level may have been higher at the time of Mr I's collapse (approximately 14.15hrs). Anything above 2.0mg/l is considered potentially lethal - at 21.34hrs Mr I's was 3.19mg/l.

Mr I's father was particularly concerned that his son spent a considerable period in the Care & Supervision Unit during his time in the prison. While the Prison Service made significant efforts to reintegrate him into the general population, these were usually short-lived and indeed Mr I indicated more than once that he preferred to remain in the CSU. The negative psychological and sometimes physiological symptoms that can arise from prolonged periods of segregation are well-recognised in penal research.

They can impair the prospects of successful resettlement within the prison and also within normal society. Mr I had been living in the general prison population for over a month at the time of his death, but unfortunately his demise meant he did not manage to put a difficult period behind him and resume a normal life.

## SECTION 2: EVENTS PRIOR TO MR I'S COLLAPSE

### Morning Yard & Staff Contact

Two prisoners (Prisoner A and Prisoner B) said they heard Mr I asking an officer if he could see a nurse on the morning he collapsed, because he felt unwell. An EMIS entry at 13.17hrs notes that he was triaged by a nurse in relation to diarrhoea.

At around 10.30hrs, Mr I went out to the yard and walked with other prisoners. Those prisoners (Prisoners C, D and E) said there was nothing out of the ordinary with his appearance or behaviour and there were no complaints of him feeling unwell. In fact one of them said Mr I was upbeat.

The officer (Officer A) who locked Mr I at lunchtime (12.30hrs) recalled he had appeared to be quite relaxed and content that morning and showed no indication of any problems or concerns. The officer said that he knew Mr I would often attend the medical room or Healthcare Centre and asked about his health. Mr I outlined to the officer that he had a pre-existing heart condition for which he was receiving medication. The officer said he had no reason to doubt this when locking him up, nor any reason to suspect he was ill. Mr I was not receiving medication for a heart condition.

### Telephone Calls

Mr I called his father almost every day and often multiple times during the day. On the day he collapsed, he called his father five times. During the first four calls their conversation included Mr I's impending transfer to another prison and a relative whom he believed had just been committed to prison.

During one call Mr I also talked about how a prison manager had commented on how well he was looking since his move to his final location, and he responded by explaining he was feeling physically and mentally well, and thought the regime was good in that location.

During his last call, at 14.01hrs, Mr I's speech was noticeably slower / calmer than it had been in the previous calls that day, to the extent that his father asked whether he had taken any medication as he thought he sounded drowsy. They spoke for over five minutes about events outside prison and a consultation that Mr I was scheduled to have with his psychiatrist that afternoon. The conversation ended with plans to call his father again later that day but Mr I was found in a collapsed state shortly afterwards and never regained consciousness.

Following this call, Mr I spoke to two officers about his forthcoming psychiatric appointment. One of the officers said that there was nothing significant about Mr I's presentation.

Prisoner Accounts

On the day Mr I collapsed, a prisoner (Prisoner F) who considered Mr I as his best friend had a cup of tea with him at around 08.30hrs. He described his form as normal and said he seemed *"really happy, bouncing about the landing, messing and slagging other inmates"* – indicating that was Mr I's normal demeanour. As an orderly this prisoner was unlocked earlier than Mr I after lunchtime. He went to Mr I's cell at approximately 14.00hrs to tell him he could not cut his hair that afternoon as he had to attend education. When he spoke with Mr I through the flap in the cell door he noticed that he looked very pale. Mr I said he felt shaky and the prisoner told him to lie down and hit the alarm if he started to feel worse. Mr I replied *"f*** off, I'll be alright, I took a couple of buds and a couple of trams."* The prisoner asked Mr I how many he had taken and was told he had taken seven x 300mg pregabalin and five x 300mg tramadol. The prisoner was concerned that this amount constituted an overdose, but Mr I responded that he had taken that amount before and said he would be OK. The prisoner described him looking as though he had taken a *"whitey[1]".* This was the last time this prisoner saw Mr I, as he then went to education.

The prisoner in the next cell (Prisoner C) said that Mr I shouted to let him know the phone was free after he had completed his 14.01hrs call. The prisoner thought this was around 14.15hrs. As his cell door was being unlocked the prisoner heard a sound, like a chair moving and then a thud. He called Mr I to ask him what had happened but did not receive a reply, and continued down the landing to use the phone. He was on the phone for approximately five minutes and then returned to his cell. The prisoner said that within a couple of minutes he heard another prisoner at Mr I's cell shouting for a prison officer to come as he could see him lying face down in the cell with blood on the floor.

The prisoner (Prisoner G) who found Mr I said he went to his cell to borrow tea bags. He opened Mr I's cell door flap and saw him face down on the ground. The prisoner told an officer (Officer A) who was nearby, and Mr I's cell was immediately opened. He was lying on the floor with blood around his head. The alarm was raised and staff ran to the cell.

[1] Whitey - an undesirable reaction to taking drugs which gets its name from the paleness of the sufferer as blood drains from the capillaries.

## SECTION 3: EMERGENCY RESPONSE WHEN MR I WAS FOUND IN A COLLAPSED STATE

Emergency Response – Sequence of Events

As Mr I's location does not have CCTV cameras on the landings, the following sequence of events has been collated from CCTV footage of the entrance and ground floor circle along with records, statements and interviews.

14.15hrs Mr I was escorted back to his cell by an officer following his last phone call. The officer said Mr I looked and sounded perfectly normal.

14.38hrs The alarm was raised after Mr I was found collapsed in his cell. Officer A said he immediately placed Mr I in the recovery position, describing him as feeling *"very, very cold,"* blue in colour, with no pulse and not breathing. The officer said Mr I's nose looked as though it had broken, which suggested to him that he was unable to save himself when falling.

Another landing officer immediately arrived at the cell and helped turn Mr I onto his back to commence CPR (chest compressions only). Officer B said Mr I appeared to be dead. Officer B ran to the class office to inform the Emergency Control Room and request medical assistance, while Officer A started chest compressions. Officer B said that he did not request an ambulance, citing a lack of authority to do so.

When the alarm was raised, another officer responded from the circle and ran upstairs to Mr I's landing, followed shortly afterwards by a security officer (Officer D) and security senior officer (Officer E). As a result of the information provided by Officers A and B and his assessment of the scene, the security officer instructed a colleague to retrieve the defibrillator from downstairs, while the security senior officer instructed them to move Mr I onto the landing to provide more room to work on him.

The senior officer also radioed the ECR to task an emergency ambulance and additional nursing support. The senior officer said there was no capillary refill in Mr I's finger tips, which indicated to him that his heart had stopped.

14.40hrs Another officer and a nurse (Nurse A) (Papa 2), who was carrying a response bag, arrived and went upstairs to the landing. Shortly afterwards an officer (Officer F) ran downstairs to retrieve the defibrillator and then ran back upstairs.

Chest compressions continued to be rotated amongst three officers (Officers G, H and B) and the senior officer attached the defibrillator once it arrived.

Contrary to the accounts of some prisoners, the defibrillator was working but as there was no heart rhythm detected, no shock was discharged.

Upon arrival the nurse quickly assessed that Mr I required oxygen and placed a mask over his face which was attached to an Ambu-Bag[2]. Shortly after this an Igel airway was inserted into Mr I's throat to ensure oxygen was entering his lungs.

While Mr I's airway was not entirely clear of fluid, both the security officer (Officer D) and nurse could see his chest rising each time oxygen entered his chest.

14.41hrs The house nurse (Nurse B) returned and went to the medical room.

14.42hrs The house nurse went upstairs with additional medical bags, shortly after which a third nurse (Nurse C) (Papa 4) arrived and went upstairs.

14.44hrs The house nurse went back downstairs and shortly after returned upstairs with an electric-powered suction machine. This machine failed to function.

14.51hrs A senior nurse (Senior Nurse D) (Papa 1) and doctor arrived and went upstairs. The senior nurse was carrying a more modern, battery-powered suction machine. She said she did not bring medical bags as she had heard on the radio that a response nurse had already arrived.

Prison officers stated the nurses panicked because neither of the two suction machines were working.

The security officer (Officer D) said when the doctor arrived on the landing, he briefly observed the scene and left again without asking any questions or carrying out an examination. The officer was surprised that the doctor did not intervene. Resuscitation efforts had been ongoing for 20 minutes without any response from Mr I so the officer expected the doctor to pronounce Mr I dead.

The first responding nurse also thought the doctor should have assisted. However the doctor later explained to him that as the nurses were doing everything he would have done, he saw no reason to intervene.

[2]An AmbuBag is a hand-held manual resuscitator or self-inflating bag used to provide ventilation to patients who are not breathing.

The doctor said he knew the ambulance had been called and could see that the three nurses had the situation under control. He said he offered his help, but the nurses said that they were happy to continue. He said his only involvement was in trying to get the suction machines to work and he left the house at 15.16hrs.

No EMIS entry was made by the doctor.

14.53hrs The house nurse left the location as a police officer and other prison staff arrived.

14.58hrs The house nurse returned along with two further nurses. There were now five nurses on the landing. One of the nurses also brought a battery powered suction machine.

Despite EMIS recording that a suction machine was used, the security officer said this third suction machine failed to work also and the doctor said that he attempted to fix one battery powered machine with parts from the other, which suggests that neither worked.

14.59hrs A response vehicle and an ambulance arrived in the prison and were escorted to the respective location.

15.03hrs Paramedics entered the location. Between 15.03hrs and 15.22hrs they administered two rounds of adrenalin and a cardiac output was re-established.

The senior nurse said that prior to this, the ECG machine attached by the paramedics showed no cardiac output.

15.07hrs A Chaplain arrived and went upstairs.

15.22hrs A paramedic who had left the house three minutes earlier, returned with a stretcher.

15.34hrs Mr I was stretchered out of the location.

15.43hrs The ambulance started its journey through the prison.

15.48hrs The ambulance left the prison to take Mr I to hospital.

16.08hrs Mr I's heart arrested and the paramedics commenced CPR, which continued until his arrival in A&E at 16.20hrs.

Mr I remained on a life support machine for two days, during which time two consultants reviewed his brain stem reflexes. There was no response and his life support machine was switched off at 10.47hrs.

Mr I's cell and landing were sealed as soon as he left the prison, and they remained sealed for PSNI and Prisoner Ombudsman examination.

Dr Hall said some aspects of the resuscitation were well managed while others could have been improved. The swiftness of the prison officers to commence chest compressions and continued CPR by nursing staff until the arrival of the paramedics was positive, along with the use of an airway and oxygen bag by the first responding nurse (Nurse A), and the regularity of readings that were taken of Mr I's vital signs.

Dr Hall stated the following areas could have been improved:

- Ensuring that after a Code Blue/Red is called the ECR order an ambulance immediately;
- As in other prisons, all landing staff carry a radio;
- Ensuring that the Resus Bag has all the correct equipment which is up to date and working;
- Ensuring that all who respond to an emergency have the correct equipment and the correct training;
- Ensuring that the role of the GP, if present, is well defined.

Dr Hall stated that although there were some problems and delays in his resuscitation at the prison, these problems and delays would have made no difference to the overall outcome.

Dr Hall's opinion was that Mr I's death may have been preventable had his chest pains and collapses been fully diagnosed, but it was not foreseeable.

## SECTION 4: CHEST INVESTIGATIONS

Mr I's father was concerned that his son had been waiting for a chest x-ray for 18 months. While Mr I had openly advised prisoners and staff that he had a heart problem and had previously suffered a heart attack, there is no evidence of such a diagnosis being made or that he was referred for a chest x-ray. However a number of complaints about chest pain are recorded in his medical records.

### Initial Report of Chest Pain

Four years before he died, Mr I developed chest pain and was advised to go to hospital. His blood pressure was 150/80 (high to normal) and the nurse noted "*describes chest pain as sharp, not constant, radiating to left arm and pins and needles in neck and jaw...denies taking any illicit substances...initially reluctant to attend hospital but when pain did not ease he relented.*"

Although there are no records in Mr I's medical file of an admission to hospital, he actually attended hospital for approximately three hours where blood tests, an ECG and chest x-ray were undertaken. He was discharged with one sleeping tablet and no follow-up plan.

The next day he denied feeling any chest pain or pins and needles in his jaw.

### Subsequent Reports of Chest Pain

Relative to his initial report of chest pain, Mr I also reported chest pain, among others symptoms, on the following occasions:

- 3 months later – Gaviscon was provided when he complained of reflux and chest pain;
- 7 months later – He was seen by a nurse after complaining of chest pain to prison officers. Observations were normal and no pains were reported to the nurse. He was advised to inform staff if there were any changes.

### 11 Months Later

Following three days of vomiting and being assessed daily by either a nurse or doctor, an emergency call was made to Healthcare for Mr I to be seen in his cell as he was complaining of chest pains, headache and sweating excessively. An ambulance was requested and the crew's ECG reading determined that he had a severe heart injury and was currently experiencing a myocardial infarction (heart attack).

He was transferred to hospital where further tests were carried out in respect of his vomiting only. He was discharged the following day.

Although two further ECG's were carried out in hospital when Mr I arrived, one of which provided an abnormal reading, no further heart investigations were conducted.

The discharge letter was incorrectly sent to Mr I's community GP and not forwarded to prison healthcare.

Three weeks later Mr I saw a prison doctor to enquire about what the hospital had found in relation to his heart attack. As no discharge summary was received, an enquiry was subsequently made with the hospital and it established that no chest investigations were carried out by the hospital. No further action was taken by Prison Healthcare to follow this up.

- 12 months later (twice) - during a review with his psychiatrist Mr I complained of physical chest pain, although the psychiatrist related this to his anxiety;
- 16 months later – Mr I told a nurse that he had chest pain above the bottom of his rib cage. He disclosed that he had been taking *"hundreds and hundreds"* of diazepam a day and believed that his pain was related to his anxiety. No action was taken as a result of this disclosure;
- 16 months later – Mr I mentioned chest tightness during a psychiatric review.

<u>17 Months Later</u>

Mr I told his psychiatrist on four occasions that his chest pains were ongoing.

On one occasion 17 months after his initial report of chest pain, a nurse examined Mr I and conducted an ECG. The ECG report said *"consider inferior myocardial damage"* (damage to the heart muscle) and he was placed on the doctor's list to be seen two days later.

Dr Hall was of the opinion that Mr I should have been admitted to hospital for investigation at this point, in view of the chest pain and the abnormal ECG, which indicated he was having a heart attack.

The following day Mr I complained of chest pain again. The nurse noted that the pain was not bad and that he believed the pain was related to being unable to relax. Mr I remained on the doctors list to be seen the following day.

Dr Hall said this was another missed opportunity for him to be assessed that day by a doctor.

When Mr I saw a prison doctor as planned an 'urgent' referral was made to a hospital Cardiology Department. This led to an appointment for Mr I to attend the Rapid Access Chest Pain Clinic three months later. Waiting times at outside hospitals cannot be influenced by prison Healthcare.

Mr I did not attend this appointment. A handwritten note on the original referral form indicates that the hospital contacted the prison about the missed appointment and was informed that he refused to attend, which resulted in him being discharged. The note does not indicate who was spoken to in the prison and no discharge letter was sent to the prison Healthcare Department. Once again the hospital discharge letter was issued to Mr I's community GP who did not forward it to the prison.

The Rapid Access Chest Pain Clinic appointment was scheduled for 09.15hrs and in line with policy, Mr I should have been informed of it that morning. There are various reasons for a prisoner failing to attend an appointment, including personal choice, ill-health and unavailability of escort officers. On all occasions this should be recorded on a 'refusal to attend' form, but that was not done on this occasion and there was no supporting entry in EMIS.

The referring doctor did not know that Mr I had not attended his appointment and there is no system to monitor outpatient appointments.

As a result Mr I never had his chest complaints diagnosed and although he saw Healthcare staff on a weekly basis, there are only five further EMIS records – between 18 – 22 months after his initial chest pain report – which mention chest pain. Explanations of an inflamed rib, muscular pain and anxiety-related symptoms were recorded.

Mr I's chest pains were never diagnosed and nurses' diagnoses of rib problems and reflux were never confirmed. Dr Hall said the pains could have been caused by his coronary artery disease, but some patients with severe coronary artery disease have no symptoms before suffering a catastrophic heart attack.

Dr Hall outlined practice in other prisons where cardiac enzymes have been measured in prisoners with chest pain in an attempt to ensure a diagnosis of a heart attack is not missed. Mr I's cardiac enzymes were never measured.

Dr Hall said no one will ever know if the pains in Mr I's chest were caused by his heart. The post mortem revealed severe coronary artery disease and had Mr I been fully investigated in the months prior to his death, he could have received treatment.

Dr Hall concluded that Mr I's chest pains would have been treated differently had he been living in the community.

## SECTION 5: DRUGS MISUSE

In light of the post mortem finding of 'tramadol toxicity', a review of the extent to which Mr I abused his medication was undertaken. Records indicate he had a longstanding history of abusing both illicit drugs and prescribed medication

Drug Testing

Mr I underwent eight drug tests:

- He failed three;
- He failed a further two tests. However these were reclassified as "Passes" after additional external testing was completed which took account of his then prescribed medications;
- Three further tests were passed on the day of testing. If Mr I had been taking his medication as prescribed, these tests should have resulted in an initial fail.

Despite a previously accepted Prisoner Ombudsman recommendation in March 2010 for the NIPS to notify failed drug tests to Healthcare and Ad:Ept, there is no evidence that this was done after Mr I's three failed drug tests, apart from one Ad:Ept follow-up three months after a failed test.

We recommended in March 2010 that all drug tests which are passed on the day of testing should be notified to the Healthcare Department, in order to identify prisoners who are not taking their medication as prescribed. This recommendation was not accepted by the NIPS because they said the prisoner is responsible for taking their medication as prescribed, and there are systems in place to identify and deal with prisoners who sell or give away their medication.

Given the experience in this case and current indications of medication and drugs misuse within Northern Ireland prisons, it still seems relevant that prison Healthcare Departments should be notified of such drug test passes as another means to identify and address the problem.

All the prisoners we interviewed said that Mr I did not abuse prohibited substances. However some who were close to him said it was common knowledge that he would on occasions take a lot of his prescribed medication. One said Mr I would borrow medication from other prisoners when his own supply was low and pay them back the following week when he received his new allocation. The same prisoner described this as common practise among prisoners.

Ad:Ept[3] Interventions

Three years before he died, Mr I had agreed to engage with Ad:Ept due to finding life difficult in relation to his drug use. He completed 12 counselling sessions. Following these sessions Mr I suggested he was extremely motivated to change his life during his sentence and upon release.

He was reassessed 18 months later as he wanted to cease taking opiates. Mr I completed a further eight sessions. Mr I subsequently said he recognised the impact of his feelings on his behaviour, and believed that living in the CSU was helping him to control his substance abuse.

Previous Collapses

Mr I's medical records indicate that he collapsed twice in one month, just over one year before he died. One of these occurrences resulted in him being unresponsive and bleeding from a facial wound. The day before this collapse, he had been given his weekly prescription of medications, and although he denied overdosing, a nurse who responded at the time discovered he had none of his tramadol or pregabalin remaining. Two weeks later Mr I admitted to a doctor that he had overdosed on tramadol and pregabalin.

This collapse led to an admission to hospital. After regaining consciousness he advised staff that he had also collapsed without warning 10 days earlier, for approximately two to three minutes, and injured his nose in the process. There is no evidence that Healthcare or landing staff were made aware of this.

Blood tests and an ECG were conducted in hospital and showed normal results except for a slightly elevated CRP[4] (C-reactive Protein). A CT scan[5] showed there was no change to an existing cyst or other changes. The main diagnosis was that Mr I had suffered either a seizure or an arrhythmia (sudden irregular heart beat).

He was discharged two days later with a plan to be seen urgently by a neurologist and to change his tramadol to co-codamol due to the contraindications of tramadol for patients who suffer from seizures. Mr I was unable to attend the initial neurologist's appointment due to sciatic pain and tiredness. No further appointment was offered and the possible consequences of not attending were not discussed with him.

[3] Ad:Ept (Alcohol and Drugs: Empowering People through Therapy) provides substance misuse therapy services throughout the NIPS and upon release in the community.

[4] The level of C-reactive protein (CRP) increases when there is inflammation in the body.

[5] A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body. CT scans are sometimes referred to as CAT scans or computed tomography scans.

Dr Hall stated that not only was Mr I's non-attendance not followed up, but the prison was not informed to ensure their own procedures could be implemented, as would be the case for prisoners who have been diagnosed or suspected of having epilepsy. One provisional change would have been to ensure Mr I had a ground floor cell with a cellmate.

In relation to prescribing of tramadol, pregabalin and mirtazapine - all of which are known to be abused in prisons - Dr Hall said this review should be the trigger to overhaul prescribing in Northern Ireland prisons. He acknowledged that it will not be easy but advised there is sufficient evidence that alternatives to pregabalin, tramadol and mirtazapine can be safely used. There are some prisons (such as HMP Parc in Wales) where tramadol and pregabalin are not prescribed.

Instances which should trigger an In-Possession (IP) Risk Assessment

The purpose of an IP assessment is to ensure that all patients/prisoners are individually assessed to determine their ability to store and manage their own medications. All new committals will be assessed and reassessments should be conducted when a patient is found abusing, hoarding / trading medication, or there is a change to medicines which are deemed high-risk for overdose or misuse.

When a prisoner is located in the Care and Supervision Unit (CSU), they are automatically placed on daily 'supervised swallow' by a nurse. Even then prisoners can still deceive Healthcare staff that their medication has been consumed, resulting in small-scale hoarding and trading.

A security information report dated four months before he died notes that an officer overheard Mr I enquiring of another prisoner if he would give him his medication in exchange for tuck shop purchases. There is no evidence in EMIS that prison Healthcare was informed of Mr I's attempt to obtain/abuse someone else's medication. Had this information been communicated, a new IP assessment ought to have been undertaken and recorded.

Two months before he died Mr I commenced a prescription of Zamadol (slow release tramadol), which is deemed high-risk for overdose and misuse. No new IP assessment was undertaken, and there was no evidence to indicate consideration of his previous possible seizure and overdose.

A month before he died when Mr I returned from the CSU to normal location, no IP reassessment was undertaken, despite his documented history of medication/drugs abuse in EMIS, and his being prescribed three 'Red List[6]' medications. Mr I was given his medication as weekly In-Possession as follows:

- 14 x pregabalin 300mg capsules (one to be taken twice a day)
- 7 x mirtazapine 45mg tablets (one to be taken at night)
- 7 x Zamadol (tramadol) 24hrs 300mg tablets (one to be taken each morning)

An IP reassessment should have been conducted, with the outcome that Mr I should have remained on supervised swallow due to his history of abusing medication.

Medication Packets found in Mr I's Cell

Medication packets seized by the police from Mr I's cell after he was found collapsed included:

- A packet of Zamadol 300mgs. This ought to have had six tablets remaining as they were given to him that morning, but there were none in the packet;

- A plastic pharmacy bag which had 14 pregabalin 300 mgs that were given to him that morning – one to be taken twice daily. This bag was also empty;

- A packet of mirtazapine had seven tablets remaining, all of which were given to him that morning;

- A packet of Lansoprazole had two tablets remaining. If Mr I had been taking these daily as prescribed, there should have been none remaining.

A friend of Mr I said that on the day he collapsed, Mr I repaid medication debts and then consumed the rest of his new prescription. The prisoner said that he owed three *"buds"* (pregabalin) to one prisoner, two *"buds"* to another and one Tramadol each to two other prisoners. The friend said that he learned this in the yard that morning from overhearing Mr I talking to another prisoner, with whom he regularly traded, that he had consumed the remaining tablets.

Medication Spot-Checks

The SEHSCT current Medication In-Possession policy states *"The NIPS, in conjunction with the PSNI, will be responsible for addressing issues around bullying, misuse and trading of medications by patients. This includes intelligence led cell searches and spot checks."*

[6] Medications on the 'Red List' have a high risk of overdose and / or misuse/trading.

Medication spot-checks were previously the responsibility of Healthcare staff. However as this procedure is not applied in the community, the SEHSCT considers it to be a NIPS responsibility.

While officers may incidentally discover medication that needs checked e.g. during the course of a cell search, stand alone medication spot checks are not currently being carried out by NIPS staff. Incidental finds result in contact with Healthcare to determine whether the prisoner is legitimately in-possession of the medication.

## SECTION 6: DR HALL'S OTHER FINDINGS

Dr Hall considered whether the care Mr I received in prison was as good as he would have received in the community. Dr Hall said there were aspects of Mr I's care which were better in prison: he had daily access to a nurse while in the CSU, and he was seen frequently by a GP. He also said the daily nursing records made when Mr I was in the CSU were full, consistent, detailed and of high quality.

### Mental Health Support

Mr I was seen regularly by a psychiatrist and his case was regularly discussed at an MDT (multi-disciplinary meeting) of the mental health team.

Dr Hall said the quality, regularity and consistency of the contact of the psychiatrist with Mr I was very good. He said in comparison to other prisons, it was most unusual for a psychiatrist to see a patient so regularly.

### Medication Management

Mr I's father described how his son frequently had difficulties obtaining his medication when a particular nurse was on duty.

During the nine months before he died, Mr I was seen daily by a nurse and was supervised while taking his medication. From one month before he died, he was provided with his medication as weekly in-possession. He voiced his frustration during phone calls to his father over delays in receiving his medication on three occasions shortly before his death.

A review of his medication administration records shows that he was given his prescription of pregabalin and mirtazapine two weeks before his death, but not his tramadol, because it had not been reordered. This was given to him the following day, which meant that the following week, when his pregabalin and mirtazapine were due, his tramadol was not for renewal until the next day. This along with his borrowing/abusing habits as detailed by a prisoner, was a probable cause for his frustration. There were different Healthcare staff involved with Mr I on each of these dates, which therefore does not support the contention that an individual nurse made things difficult for him.

The following week a senior nurse issued him all of his medication on the same day.

A year before his death, Mr I's tramadol had been changed to co-codamol due to his possible seizure. However Tramadol was restarted a year later without explanation and without him being seen. Nor was consideration given to the contra-indications in patients who have suffered a seizure, or the fact that he had previously overdosed on tramadol. IP medication risk assessments were therefore not completed in line with the SEHSCT's own policy.

Dr Hall recognised that Mr I was a challenging person to prescribe for on the following grounds:

- Upon committal to prison he was already prescribed mirtazapine. It is an antidepressant which some prisons have attempted to reduce due to weight gain in those who take little exercise or do not heed health promotion advice;
- He had chest pains which were never diagnosed;
- His back and leg pain was never diagnosed and at the time of his death he was still awaiting injections for his back. Various painkillers had been prescribed but were not always effective in tackling the problem;
- He had an apparent seizure which was never fully diagnosed;
- He took overdoses, only some of which were known to staff.

Headache Investigations

Mr I's father was concerned that the prison Healthcare Department had not fully investigated his son's complaining of severe headaches for over 18 months. While this was not material to his demise, Dr Hall said Mr I's headaches were investigated quickly and the diagnosis of an arachnoid cyst was made following a brain scan. He saw a neurologist and a scan was repeated five months later. Dr Hall found it curious that Mr I attended all hospital appointments related to this diagnosis, while he did not attend all appointments in relation to his chest pain and seizure investigations.

A prison doctor said that, despite a neurologist diagnosing Mr I's cyst and reassuring him that there was no connection between it and a subarachnoid haemorrhage - from which his mother had died - he frequently talked to the prison doctor about his fear the cyst would rot in his head. This concern was unfounded.

Cholesterol Levels

Mr I's cholesterol level was raised on several occasions when tested, and his cholesterol/HDL (high density lipoprotein) ratio was also raised. There were no records of any action taken or advice given to Mr I about these matters. However Dr Hall said the current cardiovascular risk assessment (QRisk2) indicated Mr I's risk would total 0.6%, which is well below the figure of 10% needed for additional treatment such as tablets.

Spina Bifida and associated Back Pain

Mr I had spina bifida and associated back pain. He was seen by a neurosurgeon, an orthopaedic surgeon and a pain clinic consultant but did not receive any treatment, and there was no apparent urgency in facilitating injections of his facet joints.

Orthopaedic Mattress

Mr I's father said that his son had been assessed as requiring an orthopaedic mattress, but he had not received one by the time of his death.

However the occupational therapist, who would carry out this assessment in conjunction with a specialist nurse, said that while currently there are no pathways for such an assessment to take place in prison, Mr I would not have qualified for a specialist orthopaedic bed, using the criteria applied in the community.

Doctor's Involvement

As detailed previously, a doctor attended when the alarm was raised that Mr I had collapsed. The doctor's role in the resuscitation efforts was limited to assisting efforts to fix the faulty suction machines, and there was no EMIS entry that he attended the scene.

Dr Hall provided three examples from his own experience of doctors' contributions in other prisons during similar instances:

1. Some got involved by helping with CPR, airway and cannula insertion to provide intravenous fluids;

2. Some let the nurses and prison officers continue resuscitation efforts if all was going well, and ensure that a full written medical summary was available to the ambulance crew as they departed;

3. Some co-ordinated the resuscitation by ensuring staff rotate through using the airway to giving chest compression and regularly checking the reading on the defibrillator. In this co-ordination they also kept an eye on the time and how long the resuscitation has been in process. Dr Hall has also known other doctors to seek consensus that the patient is deceased from all the professionals involved.

None of these options were carried out by the doctor who attended.

## SECTION 7: OTHER MATTERS

### Staff Issues

Mr I's father was concerned that his son had been treated differently by some staff because of his political beliefs.

While two prisoners were aware that Mr I held a negative view of prison officers that was linked to his political beliefs, they said he had no issues with staff and was treated the same as any other prisoner in his location.

Telephone calls made by Mr I also indicated he was happy in that location.

### Staff Support following the Incident

One officer involved in the resuscitation attempt said he received various offers of support following this incident and he appreciated not having to return to the landing to finish his shift. Another involved in the resuscitation attempt found it quite difficult to return to work on the same landing two days later. He said he would not actively use Carecall and would have preferred to have someone contact him to enquire about how he was coping.

Healthcare staff said there was no support for them and they found it difficult to continue with their duties.