The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF MR AARON WAYNE HOGG (AGED 21) WHILST IN THE CUSTODY OF MAGHABERRY PRISON ON 22 MAY 2011

[18 June 2012]

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PREFACE

Mr Aaron Wayne Hogg was born on 29 August 1989. He was 21 years old when he died by suicide on Sunday 22 May 2011, whilst in the custody of Maghaberry Prison.

I offer my sincere condolences to Mr Hogg's family for their sad loss. I met with Mr Hogg's mother following his death and met with her again to share the content of this report.

Within his family, Mr Hogg was known as 'Aaron' and with the agreement of his family that is the name that I have used throughout my report.

As part of the investigation into Aaron's death, Dr Malcolm VandenBurg, Specialist in General Medicine and Consultant Pharmaceutical Physician, was commissioned to carry out a medical and pharmaceutical clinical review of Aaron's healthcare in prison. I am grateful to Dr VandenBurg for his assistance.

I am also grateful to Dr Keith Rix, Consultant Forensic Psychiatrist at The Grange Cleckheaton, who was commissioned to provide a mental health report.

In the event that anything else comes to light in connection with the circumstances of the death of Aaron, I shall record this in an addendum to this report and notify all concerned.

It has been my practice to include in my reports, recommendations for action that would lead to improved standards of inmate care and may help to prevent serious incidents or deaths in the future.

In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that *"An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become a barrier rather than a stimulus to progress, with a plethora of action plans at local and central level, and a focus on servicing the plans rather than acting on them. This has led to*

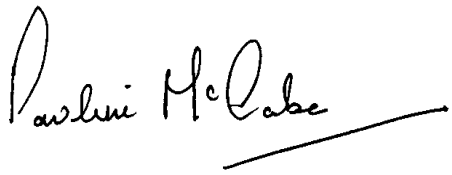
inspection and monitoring being defined as a problem within the service, rather than a solution and a driver for change."

The Prison Service and South Eastern Health and Social Care Trust (SEHSCT) are currently engaged in two programmes of work with the aim of achieving significant change in Northern Ireland prisons. These are the Strategic Efficiency and Effectiveness (SEE) Programme and the SEHSCT's Service Improvement Boards.

In light of Dame Owers' comments and in order to support the development of a more strategic and joined up approach to service development, I took a decision in June 2011 that, for the time being, I would not make recommendations following death in custody investigations and would instead detail issues of concern that I would expect the Prison Service and SEHSCT to fully address, with appropriate urgency, in the context of their programmes for change. I shall keep this approach under review and revert to making recommendations if I am not satisfied that the response of the Prison Service and / or Trust is appropriate.

In the case of Aaron, I identify **twenty four** matters of concern.

I would like to thank all those from the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and other agencies who assisted with this investigation.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
[18 June 2012]

SUMMARY

Aaron Wayne Hogg was 21 years old when he died by suicide on 22 May 2011, whilst in the custody of Maghaberry Prison.

A review of Aaron's community medical records provide evidence of significant behavioural problems from a very early age and abuse of medicines from as early as 2005/6, when Aaron was at secondary school. Aaron was reported to have overdosed twice around this time, on one occasion by taking medication that belonged to his grandmother. The recorded reasons for his overdoses include that he had taken the tablets to see what effect they would have and because he was *"in debt to"*, and *"in receipt of threats from"*, paramilitaries.

There is evidence of involvement with paramilitaries from an early age. Aaron was assaulted and taken to hospital numerous times; his movements were at times restricted and he left Northern Ireland on a number of occasions.

Aaron frequently reported that he was *"paranoid"* and at times he experienced panic and anxiety attacks. Doctors, however, pointed out on several occasions, that Aaron's fear for his safety, his agitation and hyper vigilance were related to *"actual"* ongoing safety issues and were not a symptom of paranoia.

From 2007, Aaron reported, at times, hearing voices which were noted to be *"nocturnal."* In September 2007, a family member found Aaron in his loft, with a rope hanging. He had written a note and was planning to die by suicide. In September 2007, it is recorded that Aaron was hearing "*threatening auditory hallucinations and visual hallucinations of paramilitaries…..They commanded him to self harm and he did this by his attempted hanging."* It is recorded by a psychiatrist who assessed Aaron in November 2007 that the "*suicide attempt by hanging"* was "*in the context of an overdose of sleeping medications."*

There are also many references in Aaron's notes to him experiencing thoughts of *"self harm"* or *"suicidal ideation"*, but with no plans or intent. In October 2009, a Social Worker recorded that "*Aaron reported symptoms of low mood including suicidal ideation on a daily basis."*

There is also significant evidence that Aaron suffered from severe sleep disturbance which appeared to trouble him greatly. He was prescribed medication on many occasions to help him sleep. The sleep disturbance was linked to hyper vigilance and, as stated, he also heard voices at night.

Aaron had many contacts with psychiatric services in the community and was assessed by psychiatrists on several occasions. In November 2007, Aaron was noted to have a *"Psychopathic Disorder not otherwise specified"*, Conduct Disorder, Anti-social Personality Disorder and a Personality Disorder NOS (no other symptom) with narcissistic and borderline features. The psychiatrist who assessed Aaron noted his "*history of impulsiveness, explosive anger, mood and affective liability, recurrent suicidal and homicidal ideation and history of disciplinary and conduct problems as a child*". He concluded Aaron did not suffer from a mental illness, but rather from a psychopathic disorder. Aaron was started on Quetiapine[1] 50mg twice daily to address anger, aggression, agitation, impulsivity and mood swings and zopiclone[2] 7.5mg at night for two weeks, to help him sleep.

In April 2008, a psychiatrist noted that Aaron was *"increasingly paranoid and the effect of Seroquel (Quetiapine) was wearing off……His sleep pattern is reversed but this is due to inactivity."* Aaron's medication of Quetiapine was increased.

In October 2008, Aaron was a psychiatric in-patient for one week.

In February 2009, it is recorded in Aaron's GP records that he had a diagnosis of psychopathic personality.

At a further assessment in 2010, a psychiatrist recorded his impression that Aaron presented with an anti-social personality with borderline features associated with low mood and paranoid ideation. The psychiatrist found Aaron had no energy or motivation and reportedly spent most of the night awake and slept between 06.00 and 16.00. Aaron's medication was increased and there was to be a review in three months with a view to discharging him once his symptoms were stable.

[1] Quetiapine, which is also known as Seroquel, is an atypical antipsychotic approved for the treatment of schizophrenia and bi-polar disorder.
[2] Zopiclone is a sleeping tablet.

Aaron's final medication in the community, prior to his prison committal on 20 September 2010 was: Sertraline[3] 150mg at night; Quetiapine, 50mg at midday, 75mg at teatime and 125mg at night and Temazepam[4] 10mg at night.

Aaron's community medical records also evidence the fact that Aaron used illicit drugs including Cannabis and Ecstasy.

Prior to his final committal to prison, Aaron was committed four times, the first on 11 March 2008. Two of the committals were for non-payment of fines, another was for a number of charges and three breaches of a probation order and the final one was for breaching bail conditions. Aaron was in prison for periods of three days; five days; seven weeks; and eleven days during these four prior committals. The investigation found that during his committals, information was recorded on his prison medical records relating to his abuse of alcohol and drugs; his contact with community psychiatric services; his previous admission to a psychiatric hospital and the fact that he had taken an overdose.

On 20 September 2010, Aaron was committed to Hydebank Wood Young Offender's Centre and commenced his final period in prison custody. During his healthcare committal interview, it was recorded that Aaron told the nurse (name redacted) that he had anxiety and depression; that his medication was Quetiapine, Sertraline and Diazepam[5]; that his alcohol consumption was 25 units per week; that he had literacy problems and that he had no thoughts of self harm. The nurse also noted that Aaron had been due to attend an appointment at the Mater Hospital that day, to investigate whether he had Cushing's Disease[6]. The nurse recorded *"Planned action - no immediate action required."*

[3] Sertraline is an antidepressant primarily used to treat major depression in adult outpatients as well as obsessive compulsive, panic, and social anxiety disorders in both adults and children.
[4] Temazepam is used for the short-term treatment of insomnia and for symptoms of anxiety.
[5] Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects.
6 Cushing's disease is caused by a tumour or excess growth (hyperplasia) of the pituitary gland. This gland is located at the base of the brain. People with Cushing's disease have too much adrenocorticotropic hormone (ACTH). ACTH stimulates the production and release of cortisol, a stress hormone. Too much ACTH means too much cortisol. Cortisol is normally released during stressful situations.

Even though Aaron said that he was on the antipsychotic drug Quetiapine and the antidepressant Sertraline, Aaron's GP was not contacted to confirm his medication and, whilst Aaron had told the nurse that he was on Diazepam, his GP had actually prescribed Temazepam, to help with his sleep problems. There is also no evidence that the Mater Hospital was contacted to rearrange the appointment that Aaron had reportedly missed or to ascertain the reason for the appointment; that his prison healthcare records were reviewed to check previous medical history or that his hospital records were requested and the reasons for his current medication checked.

Following his committal assessment Aaron was put on repeat prescription of Quetiapine 50mg each morning, 75mg at lunchtime and 125mg at night and Sertraline 150mg to be taken at night.

At a *"72 hour assessment,"* a nurse (name redacted) noted Aaron's previous psychiatric admission to the Mater Hospital and that he had been prescribed Quetiapine for *"mental problems".* She also noted that Aaron had *"a history of deliberate self harm outside prison (attempted overdose)"* but that he had no current thoughts of self harm and that he had said that his *"mental state feels fine."*

Aaron was placed on 'daily in-possession' medication until 5 October 2010. This meant that he was issued with his medication each morning. Over the following 11 days, Aaron was gradually issued with increasing supplies of medication in order that he could self administer a number of days at a time. From 16 October, he was issued with his medication on a weekly in-possession basis.

On 31 October 2010, Aaron passed a drug test and on 1 December, he was transferred from Hydebank Wood to Maghaberry Prison.

During Aaron's committal to Maghaberry, a prison officer recorded that Aaron said that he had no thoughts of self harm and no history of self harm. The nurse (name redacted) who carried out the healthcare committal assessment recorded *"Prison Transfer. Self administration of medication – yes. Medication on committal Sertraline 100mg & 50mg daily, Seroquel (Quetiapine) 100mg nocte* (at night)*…Prisoners own prescribed medication to be used."* She also noted on the '*First Night in Prison*'

committal form that Aaron did not have any medical markers, did not have any alcohol or drug related problems and did not have any thoughts of self harm. Aaron's daytime Quetiapine was not recorded but it was not flagged up as an immediate problem because Aaron had arrived at Maghaberry with a supply of his medication.

At interview, the nurse said that if Hydebank Wood had any concerns regarding Aaron's health or mental health, Maghaberry's healthcare team would have been notified or a note would have accompanied him on transfer. She said as this was not the case, no referral to mental health or any other healthcare services were made and no request was made for Aaron's community medical records, advice about his psychiatric history or information about the reasons for him being prescribed antipsychotic and antidepressant medication. His medication prescription at Hydebank Wood was also not checked.

On 13 December 2010, it is recorded that Aaron was issued with Co-codamol tablets 30mg Codeine / 500 mg paracetamol. This is the only mention in Aaron's medical records of Codeine, which was found in Aaron's body at the time of his death.

On 19 December 2010, a risk assessment for Aaron to have in-possession medication was completed. The nurse who completed the risk assessment recorded that Aaron had a history of self harm and that he had attempted to hang himself in 2007. She noted also that Aaron's medication had a high risk from overdose and that he had a history of depression. The nurse concluded that Aaron was suitable for weekly in-possession medication.

On 21 December 2010, Aaron transferred from the committal landing in Maghaberry to Lagan House. At interview, a prisoner who shared a cell with Aaron in Lagan House (name redacted) said that *"Aaron used to take a handful of his tablets every day and he'd get into bed, go to sleep, wake up, eat all the food, probably start snarling at me about something, then get back into bed, fall asleep, wake back up, neck a handful more tablets and then get back in and go to sleep. And that was literally all Aaron would do, was just neck a whole handful of them tablets, go to sleep and he'd end up probably having to do two or three days without*

tablets and I used to say to him, "why do you take so much and leave yourself short? Why don't you take what you're supposed to take?" And he said because he wasn't on enough; there wasn't enough medication."

On 14, 17 and 27 January, there are three separate entries in Aaron's medical records regarding his prescription of Quetiapine 100mgs. Aaron believed that he had not been issued with the correct dose of his medication. For reasons that are not clear, a check of Aaron's prescription confirmed that he was now to receive 100mg less Quetiapine at night.

On 25 January 2011, Aaron passed a random drug test. This was the only test he was asked to take during his five months at Maghaberry. On 17 February, he returned his Sertraline (antidepressant) medication to a nurse because he said that he no longer wanted them. The nurse carried out a medication spot check of all of Aaron's tablets and found that he had the correct amount left.

In a subsequent phone call, listened to by the Prisoner Ombudsman investigation, Aaron says that the Seroquel (Quetiapine) *"doesn't calm my head."* He says that they *"just slow me down"* and that that is why he doesn't take them outside of prison.

On 23 and 24 February, Aaron saw a nurse again and told her that he was still adamant that he was missing his Quetiapine 100mgs at night. She recorded that *"there appears to be some confusion over the 100mg Seroquel nocte."* On 24 February, the nurse contacted Aaron's GP who confirmed that he had been getting 125mg of Quetiapine at night and, as a result, the nurse requested that Aaron's prescription be amended *"asap and sent as urgent."* The following day, Aaron received the additional 100mgs of Quetiapine that he had been taking up to the middle of January.

On 27 February, Aaron was involved in a fight with another prisoner. Aaron was sent to the Special Supervision Unit (SSU) where he remained on a very restricted regime for six weeks. There is evidence in Aaron's phone calls that he found his time in the SSU difficult and the investigation identified concerns in connection with the way that governors took decisions to extend Aaron's time there. It is,

however, to note that during his time in the SSU, Aaron's medication was administered by a nurse and, in phone calls, he can be heard to say that he feels *"better in myself"* when on supervised medication.

During a telephone call on 7 March, however, Aaron is heard to ask someone if they have heard of pain killers called OxyContin[7] – he says that they cost £45 for one tablet in prison and knock you out for nearly two days like heroin. On 13 March, he says in a phone call that he's on 17 (tape unclear) Diazepam a week; on 23 March, he says that you "*can get drugs in Maghaberry quicker than you can on the streets"* and on 24 March, he talks about "*blues[8]"* and says that the last lot were rubbish. On 11 April, Aaron's speech can be heard to be slurred on the phone.

On 12 April, Aaron was moved from the Special Supervision Unit (SSU) to Roe House where he remained for the rest of his time in Maghaberry. On the same day, during a telephone conversation, he asks someone to buy steroids for him. In numerous conversations between 12 April and his death, Aaron asks people to get Danabol steroids and, subsequently, *"Oxi 50's"* (the most powerful steroid available) for him. He says that he can't go to the gym without them (steroids) because everyone has them. It is apparent in later conversations that Aaron has obtained and is taking steroids.

On 13 April, a nurse was requested by prison staff to confirm some medication that was found in a Seven Seas vitamin tub in Aaron's cell. The nurse identified them as four Quetiapine (antipsychotic) tablets, three of which were partially melted. It would appear that Aaron had taken the tablets in front of a nurse but then spat them out afterwards. The subsequent entry in Aaron's medical records states *"to remain on supervised swallow until reassessed by house medic. To be charged with concealing unidentified tablets in original blister packs while currently on daily issue medication."* Aaron was not asked why he had been storing the tablets and no consideration was given to referring him to mental health or prison addiction support services.

[7] OxyContin is an opioid pain reliever similar to morphine.
[8] 'Blues' are a street name for diazepam.

A review of Aaron's medication administration records shows that he did not continue to be on supervised swallow as ordered by the nurse. On 13 April, the date that the nurse's entry was written, Aaron was issued with a week's supply of in-possession medication.

On 13 April, Aaron can be heard in a phone call to ask someone to bring in *"anything"* they can because he is finding it hard to sleep. He says that he was charged for spitting his Seroquel (Quetiapine) out and that he was caught storing his tablets so he *"could sleep better at night."*

On 15 April, Aaron says in a phone call that he couldn't talk to (name redacted) properly yesterday because he felt drunk after taking some tablets. On 28 April, he asks someone to get a *"quarter"* so that he can give it to (name redacted) and also asks if there's anything else being brought up on Saturday. He is told that there's *"nothing else getting bought"* unless he's got the money for it.

On 1 May 2011, Aaron says during a phone call that he took "*six Amitriptyline's"* (a combined antidepressant and painkiller). He says that he was hallucinating on them. On 9 May, Aaron says in a call that there should be £20 coming to the person called. He says that if it does come, they are to get (name redacted) to get an *"ounce"* for him. Aaron says that if he gets an *"ounce"* that will be him sorted for his tuck shop for about two months. Aaron also talks about giving someone a *"score"* and then them owing him tuck shop items in return.

On 9 May, Aaron's speech can be heard to be a little slurred on the phone.

On 11 May 2011, Aaron was with visitors, whom he was particularly fond of, when it was reported that a member of staff saw an unauthorised article being passed to him, which he then swallowed. The visit was then suspended, Aaron's visitors were stopped from seeing him and he was told that any future visits with other visitors had to be closed, meaning that there would be glass separating Aaron from his visitors. Aaron was told that he would be adjudicated for the incident, but no consideration was given to referring him to addiction support services.

During a phone call on 12 May, Aaron discusses the fact that his visitors are barred from the Prison. He says that there's no point getting visits if they're closed visits and he says that he's *"not worried"*. He asks the person called to ask (name redacted) to make sure that he has the steroids on him on Saturday so that he can arrange for someone else to bring them into the prison. Aaron also says that he thinks that the stuff that (name redacted) passed to him on the visit was heroin because it's *"eating his brain"* because *"stuff is coming out of his head when he's sleeping"* and he's *"paranoid"*.

Aaron discusses getting drugs into prison in a number of further phone calls. On 15 May, his speech can be heard to be slurred.

At interview, Aaron's cellmate at this time (name redacted) said that after being placed on closed visits, Aaron went *"downhill."* On 13 May a relative of Aaron's wrote to the Prison Service expressing concerns about the effect of banning his visitors on Aaron's well being. He described Aaron as having *"a personality disorder and being vulnerable."*

On 17 May, a letter was sent to Maghaberry Prison from Aaron's solicitor. The letter stated, *"as you are aware Mr Hogg is particularly vulnerable and struggles to cope with the prison environment. Visits from (names redacted) provide a stabilising influence and are enormously beneficial to his mental health and well being."* The solicitor asked whether disciplinary proceedings were to be taken against Aaron and whether the visiting rights of those affected could be restored. No reply was received by the time of Aaron's death on 22 May.

On 18 May, Aaron was seen by a member of prison staff. It is believed that this may have resulted from the receipt of the letter from Aaron's relative. The staff member wrote a note for Aaron which said *"I am on medication for depression and mood swings and I look forward to my visits as a stabilising influence. I need to talk to somebody about my problems, personal issues and about my difficult times in prison, (prohibited visitor - name redacted) is elderly and ill."* Aaron did not receive a response to his note before he died.

Over his weeks in prison, Aaron talked a number of times during phone calls about matters on the outside relating to paramilitary organisations and events. Aaron can be heard to be concerned about the well being of family members who he is very close to and, from 21 April, is constantly urging them to move house. Talking about his own living arrangements, Aaron says that he doesn't want to go back to the area of his family home when he leaves prison.

In Aaron's last phone calls his speech is slurred and it is very evident that he is affected by medication/drugs.

On 19 May 2011, Aaron says in a phone call that he has *"got over 150 tablets"* and that he is taking the tablets to get to sleep. He says that he wants to see a doctor but can't see *"a proper doctor in here"* (Maghaberry). The person called comments that Aaron saw the doctor last week and he should have said something. Aaron says that he has to see a *"mental health one."* He says that the tablets have ruined his ability to think and that he thinks he's hearing voices, but doesn't know if he's just confused.

On 20 May 2011, Aaron talks about taking some *"blues"* and says that he's never felt better. The person called says that Aaron shouldn't be taking *"other peoples stuff"*. Aaron shouts that they don't know what its like for him. He brings up incidents from outside prison to do with getting his legs broken and having people after him.

He says that the tablets that he's been taking (non-prescribed) make him feel much better and that he and his cell mate were saying that the Seroquel (antipsychotic) tablets that he's been on for two years are *"putting his head away"* – making him slur his words and not get his words out. Aaron says that people are calling him *"Dopey Hogger"*. He says again that he's hearing voices in his head and that he's been thinking about "*killing people with swords*" because (redacted - name of paramilitary group) have bullied him for years and he's getting to *"boiling point."* He says that he is psychologically *"hurt in the head"* and hearing voices – two people in his head telling him what to do – and it's scaring him. He says that he's coming close to being suicidal because he "*can't take it*" or "*suffer it*" for the rest of his life.

Aaron says that he doesn't want to kill himself in Maghaberry because people will think that he *"couldn't hack it"*, and that when he gets out of prison he'll be close to being suicidal. He says he can't stop it. Aaron asks the person called to arrange for one of his solicitors to visit him because he wants to talk to him about medical problems. He says the voices have only started since he's been in jail because he has too much time to think. The person called tells him he needs to tell the doctor, but Aaron says he doesn't want anyone knowing that he's *"a schizophrenic".*

In a further call on 20 May 2011, Aaron has badly slurred speech. He says he's *"getting it tight as f..k"* because he's had no drugs and his *"head's melted"*. He asks the person called if they can bring 200 (tape inaudible) in for him.

In a third call on 20 May, Aaron mentions that he took five Valium (Diazepam) tablets the previous night and *"had the best sleep ever."* He says that the tablets are causing him to think *"slow"* and he feels embarrassed and paranoid because of it. He says that people think he's *"a big idiot"* because he can't get his words out. Aaron says that he's hearing voices and its making him think *"bad things."*

The person called tells him to get his medication cut down and then to try and get some Diazepam now and again. Aaron says that he was talking to (name redacted) and he's going to try and bring a couple of hundred of them (Diazepam) in. Aaron says that his *"head's away at the minute"*, he says that he's been bullied for the past six years by (Redacted – name of paramilitary group) and he's going to end up *"killing one of them."* The person called tells him he's safe in there but Aaron says he doesn't care about being safe because he's thinking about things he doesn't want to. He said it's like *"there's someone else in the room – two voices in his head – one good and one bad".* He says that when he gets up he's fine and can't hear them and then they'll come back during the day. The person called tells him to put it behind him; Aaron says that he can't because he has nothing to occupy him because he's lying in his cell for 20 something hours a day. He says there are over 160 prescription tablets sitting in his locker because they're giving them out monthly now. He shouts at the person called, telling them that the voices are getting worse.

At interview, Aaron's cell mate said that *"a supply of illegal blues"* (Diazepam) was on the landing on 20 May and that he and Aaron had taken these and smoked a small amount of *"grass"* (Cannabis).

In his last call on 21 May 2011, Aaron's speech is again slurred. His call is short because he had little money left. He talks about putting money on a bet and asks the person called when they will be allowed back into prison. They say that they don't know. He briefly discusses his tablets.

The investigation found no evidence that staff, at any time, took any action in response to Aaron's very clearly slurred speech.

Aaron's cell mate said that, on the night of 21 May 2011, he witnessed Aaron boiling up his medication, which he hadn't seen him do before. Aaron then went to bed early.

It is recorded that at 01.25 a supervised check was carried out on Aaron's landing and that nothing untoward was reported. CCTV shows that at 05.18 two night custody officers commenced a further check of all prisoners and an officer said that Aaron *"looked as if he was lying over the end of the bed, but I wasn't sure."*

On entering Aaron's cell, one of the night custody officers (name redacted) saw that Aaron had a ligature around his neck, which had already been cut. It transpired that Aaron's cell mate had been woken up by the officers banging on the door and, seeing what Aaron had done, used a razor to cut the ligature.

Cardiopulmonary resuscitation (CPR) was commenced straight away, but due to there being no signs of life, this was discontinued following an assessment by a nurse. Following the arrival of the on-call prison doctor, Aaron's time of death was recorded as 06.34.

The autopsy report recorded that: *"Death was due to hanging. There was a ligature mark on the neck and its position was such that when the ligature tightened, with the weight or partial weight of the body, it would have interfered with breathing and the flow of blood to and from the head. Unconsciousness would probably have*

occurred quite rapidly with death supervening within a few minutes. Apart from the ligature mark on the neck there were no further serious marks of violence."

The report of Forensic Science Northern Ireland states that at the time of Aaron's death *"there was no alcohol in the body. Further analysis of a sample of blood taken during the postmortem examination revealed a number of drugs. The tranquilliser drugs Chlordiazepoxide and Diazepam, as well as the antipsychotic drug Quetiapine and the painkiller Codeine, were detected within their respective therapeutic ranges. In addition, a therapeutic level of the painkiller Morphine was detected, but this probably represents a breakdown product of Codeine. Further analysis revealed the antidepressant Mirtazepine at a level just above its normal therapeutic range. However, the concentration detected would not have been expected to produce toxic symptoms. Low levels of the painkillers DihydroCodeine and Tramadol were also detected. In addition, a breakdown product of the commonly abused drug Cannabis was detected in both the blood and urine. However, the presence of this breakdown product does not confirm recent usage of the drug, as it can persist in the body for a number of days."*

It is to note that Aaron was not, at the time of his death, prescribed Chlordiazepoxide, Mirtazapine, Codeine, Diazepam, Tramadol, DihydroCodeine or Morphine (this could be a breakdown of the Codeine.)

Aaron's family asked why he died by suicide. In his clinical review report, Dr Rix said that Aaron *"was at increased risk of suicide, [because] Childhood Conduct Disorder and anti-social or psychopathic disorder are disorders associated with an increased risk of suicide. He had a history of deliberate self-harm and this is also a risk factor for completed suicide."*

Aaron's involvement with paramilitaries from a young age; his paranoia and anxiety; his abuse of medication and illicit substances; his extreme sleeping difficulties and his experience of threatening auditory hallucinations are well documented in his community medical records. As noted earlier, in 2007, when Aaron was experiencing similar hallucinations, he was found preparing to hang himself. It is recorded that the *"suicide attempt by hanging"* was *"in the context of an overdose of sleeping medications."*

There is clear evidence that Aaron continued to experience sleeping difficulties in prison, was abusing prescribed medication and illegal drugs, continued to be apprehensive about matters concerning paramilitaries and things that had happened to him in the past and, in his last days, was very troubled by hallucinations.

Dr Rix said that it was probable that drug effects made a material contribution to Aaron's state of mind on the night of his death. He said that it was *"highly relevant"* that Aaron had taken benzodiazepines shortly before he died, that such drugs are contraindicated in people with personality disorder, such as Aaron, and that *"they have been associated with the release of suicidal behaviour."* Dr Rix advised that the manufacturers of such drugs state that *"in the case of people with depression they should not be prescribed other than in combination with an antidepressant."* Aaron stopped taking his antidepressant medication on 17 February 2011. Dr Rix concluded that *"benzodiazepines could have caused him [Aaron] to act on suicidal ideas and disinhibited him"* and that *"it was probable"* that Aaron's experience of auditory pseudo-hallucinations [hearing voices, good and bad] *"contributed to his suicidal state."*

Dr VandenBurg also pointed out the direct and disinhibiting effect that Diazepam might have had on Aaron and said also that, in people of Aaron's age, Quetiapine is associated with an increase in suicidal behaviour. He said that, as well as this, not taking his Quetiapine regularly would have made Aaron's mental health issues worse. He said that *"I have no doubt that his irregular use of Quetiapine was a major etiological factor"* (cause) and *"very high on the list of etiological factors was Mr Hogg being placed on in- possession medication when he left the SSU."*

Dr VandenBurg said that *"Mirtazapine* (an antidepressant) *has similar warnings and patients are most at risk when the dosage is increased or decreased. A sudden change as could have happened in Aaron's case increases the risk, as does the fact that the Mirtazapine in the blood concentration was high."* He said also that *"the steroids could possibly have played a part."*

Dr VandenBurg concluded that *"the combination found within him would not have been helpful and their effects would have been at least additive, if not synergistic, particularly the two benzodiazepines, with Mirtazapine and Quetiapine as well as the opioids*[9]*. All of these can cause abnormal behaviours and the benzodiazepines could combine to produce disinhibited behaviour. His long term use of Marijuana (Cannabis) could have been a precipitating factor."*

Both of the clinical reviewers also commented on the impact on Aaron of some of his visitors being banned and his other visits being restricted, from 11 May. Dr Rix said that *"it was probable"* that the fact that Aaron was restricted to closed visits would have had an adverse effect on his mental state, and probably made a material contribution to his suicidal state. Dr VandenBurg said that *"if the letter from his solicitor on 17 May and his statement of 18 May had been actioned, and he had been allowed to recommence visits from his* (visitors - names redacted) *behind glass, his mood may have improved. I do understand that the authorities thought some form of reprimand was necessary; however, these visits appear to have been key to his well being."*

The investigation found that it was the case that there were many respects in which Aaron did not act in his own best interest. It was noted, in particular, that Aaron did not tell staff on the landing or healthcare staff about the deterioration in his mental health; stopped taking his Sertraline (anti-depressant); asked visitors to source illegal substances for him; did not take his tablets as prescribed and took non-prescribed medication and Cannabis.

The investigation also, however, identified significant issues of concern in connection with Aaron's care in prison. These related to the committal process; contact with outside care providers; Aaron's time in the SSU; arrangements for risk assessing his medication; the management of his medication; the lack of consideration of mental health or/and psychiatric input; the absence of a referral to addiction support services; the staff response when Aaron was slurring his speech on several consecutive days; the availability of illicit drugs in Maghaberry; the use of steroids and the adequacy and use made of medical records. These concerns are listed on the next page and detailed in full in Section 10.

[9] Opioids are very strong painkillers.

ISSUES OF CONCERN REQUIRING ACTION

As explained in the preface, the following issues of concern, requiring action by the Northern Ireland Prison Service and South Eastern Health and Social Care Trust [SEHSCT], were identified during the investigation into the death of Aaron. I have asked the Director General of the Prison Service and Chief Executive of the SEHSCT to confirm to me that these issues will be addressed.

1. Prison healthcare staff did not check Aaron's prison medical records at the time of committal or, at times, when his medication was being reviewed.

2. Even though Aaron was receiving antipsychotic and antidepressant medication, his community medical notes were not requested.

3. Even though Aaron was on antipsychotic and antidepressant medication; was seeing a community psychiatrist; had been a psychiatric hospital in-patient; had a history of self harming and was known to abuse alcohol and his medication, during his last committal:
   a. No consideration was given to referring him to the Mental Health Team.
   b. No consideration was given to referring him for a psychiatric assessment.
   c. No psychotherapeutic intervention was considered.

4. Risk assessments for in-possession medication were inadequate and not repeated at appropriate times.

5. Aaron was able to stockpile his prescription medication.

6. Aaron was able to obtain illicit substances/non-prescribed medication.

7. Missed hospital appointments were not followed up.

8. Aaron only took one drugs test during his five months in Maghaberry.

9. When Aaron's speech was slow and slurred, as a result of him taking too much medication/illicit drugs, no consideration was given by prison staff to:

   a. Asking healthcare for advice/to see Aaron
   b. Carrying out cell searches for drugs
   c. Opening a SPAR[10]
   d. Real time monitoring of phone calls

10. Aaron's community medication prescription was incorrectly recorded when he transferred to Maghaberry from Hydebank Wood Prison and Young Offender's Centre.

11. Prescriptions of Aaron's Quetiapine (antipsychotic medication) were variable with no reasons recorded.

12. Delays occurred in giving Aaron his prescribed medication and doses were at times missed.

13. Staff did not ask Aaron why he was saving his medication on 13 April 2011 or find out that he was prescribed medication for sleep problems in the community. His difficulty sleeping was, therefore, never discovered and addressed.

14. No action was taken when Aaron, assisted by a member of staff, wrote a note on 18 May 2011 which said *"I need to talk to somebody about my problems both personal issues and about my difficult time in prison."*

15. On 13 April 2011, Aaron was given in-possession medication immediately after he had been stockpiling his medication, even though a nurse had recorded in his medical records that he should be on supervised swallow.

16. When Aaron received an illicit substance during a visit, he was punished but no action was taken to refer him to the prison drugs counselling service or notify healthcare staff.

[10] Supporting Prisoners at Risk (SPAR) booklets are used at times when staff assess an inmate as vulnerable to self harm and suicide - to provide increased observations and support for inmate.

17. Aaron said that one of the reasons he took drugs was because he had nothing to do and had *"too much time to think".* In a phone call on 20 May 2011, two days before his death, Aaron said that he couldn't stop thinking about past problems because he was *"lying in his cell for 20 something hours a day."*

18. By the time of Aaron's death he was being given a month's supply of antipsychotic medication at a time, without a new risk assessment for in-possession medication being completed even though: he had a history of illicit drugs/medication abuse; was known to have overdosed outside of prisons', had stockpiled tablets during the current committal and had swallowed an illicit substance from a visitor.

19. The summary section of EMIS[11] was not being used correctly. This resulted in important information not being available in the places where healthcare staff would look for it.

20. The time it took for the Hogg family to learn of Aaron's death was unacceptable.

21. Visitors at the Quaker Visitor Centre who were waiting to see prisoners on Aaron's landing were aware that there had been a death, on 22 May 2011, but the information was not made available in a timely manner to inform them that their loved ones were safe. This caused great distress.

22. There are no written criteria to ensure a consistent or proportionate approach to the authorisation of extensions to the time a prisoner is held in the SSU (Special Supervision Unit).

23. Prison management said that decisions for extensions to periods in the SSU took account of the fact that the extensions were <u>up to</u> the time specified. No evidence was found of any mechanism for reviews to take place in advance of the extension expiry date.

[11] EMIS – Egton Medical Information System is the database in which a prisoner's medical information is recorded.

24. Aaron should have been identified as requiring to be dealt with under the 2009 *'Promoting Quality Care. Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services'* Care Programme Approach.[12]

[12] A Care Programme Approach is the process of how mental health services assess users, identify needs, plan ways to meet them and check that they are being met.

RESPONSE TO AREAS OF CONCERN

Northern Ireland Prison Service

The Director General accepted in full the ten matters directly related to NIPS and said that appropriate action would be taken.

South Eastern Health and Social Care Trust

The Trust Chief Executive responded as follows:

Issues 1-5 are directly related to the committal process. A recent Her Majesty's Inspector of Prisons inspection, a more recent Prisoner Ombudsman's Death In Custody report and an ever increasing volume of people being committed to jail have indicated that systems in relation to the committal process need reviewed. Already implemented is the new system whereby community GP records are requested and checked. This will allow for information such as outstanding hospital appointments to be shared with prison healthcare staff. Practice against this standard is being audited on a regular basis. South Eastern Health and Social Care Trust staff have been taking forward an initiative so that all community GP notes can be accessed 24/7. Patient information will therefore always be available to healthcare staff.

A "Committals Review Team" has been established to consider all current and high risk issues and to develop a new model that meets the needs of the user.

Proposed changes are:

- *A short, initial screen to reduce immediate risk overnight, followed by a more in-depth detailed committal screen within 48 hours.* Prisoners are, by and large, more settled after a few days in prison and an in-depth screen at this stage will result in more accurate gleaning of information. It will also allow the nursing staff to plan ahead in terms of time. Having been allowed to reflect on this and the last DIC Report, nursing staff have commented on the often rushed nature of the current committal process, especially in the evening before lock-up.

- The appointment of a new "*Mental Health Committal Nurse*". The in-depth committal screen will prompt the committal nurse in relation to an appropriate mental health referral. All such referrals will be seen immediately by the mental health committal nurse who will do a full assessment and decide on future management based on clinical need.
- *The in-possession medication risk assessment will take place much later (after a week at least) following committal to prison.* Supervised swallow will therefore be applicable for all patients receiving Category "A" drugs during this time. The In Possession Risk Assessment Policy was changed in September 2011 to a more objective, lower risk, evidence based version.

The In Possession Medication Policy is also under review. We have learned from colleagues in NIPS that it is not possible to totally control the amount of illicit drugs entering the prison environment. Furthermore, NIPS staff have explained that it is extremely difficult to manage bullying behaviour. With this in mind, we must consider the environmental factors as part of the in-possession policy. This will almost certainly involve implementing a "supervised swallow" status on most prisoners. This will have major resource implications to both NIPS and South Eastern Health and Social Care Trust and will require prisoners to be unlocked at night to receive their medication. An agreed, signed off policy will need to be formulated so that each organisation may be held to account.

On 4 April 2012, the 'Mental health lead' for prisoner healthcare was appointed. She has already begun to plan and implement a pathway through prison for those patients with mental health needs.

This, notwithstanding, the Trust accepts that the afore-mentioned systems and processes need to be improved and to that end, I trust that this letter goes someway to assuring you that we are fully addressing your issues of concern.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[13] for Northern Ireland, I have responsibility for investigating the death of Mr Aaron Wayne Hogg, who died on 22 May 2011, whilst in the custody of Maghaberry Prison. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Appendix 1.

2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. I am independent of the Prison Service as are my investigators. As required by law, the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives

4. The objectives for my investigation into Aaron's death are:

- To establish the circumstances and events surrounding his death, including the care provided by the Prison Service.

- To examine any relevant healthcare issues and assess the clinical care afforded by the Prison Service.

- To examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future.

[13] The Prisoner Ombudsman took over the investigation of deaths in prison custody in Northern Ireland from 1 September 2005.

- To ensure that Aaron's family have the opportunity to raise any concerns that they may have and that these are taken into account in my investigation.
- To assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising 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 action or practice is identified, and any lessons from the death are learned.

Family Liaison

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the family.

6. It is important for the investigation to learn more about a prisoner who dies in prison custody from family members and to listen to any questions or concerns they may have.

7. I first met with Aaron's mother on 16 June 2011 and my investigators were grateful for the opportunity to keep in contact with her solicitor to provide updates on the progress of the investigation. I met with Aaron's mother again to explain and discuss the findings and recommendations within this report. I would like to thank Aaron's mother for giving me the opportunity to talk with her. On 15 June 2012, I met with Aaron's family to explain and discuss the findings and issues of concern within this report.

8. Although my report will inform many interested parties, I write it primarily with Aaron's family in mind. I also write it in the trust that it will inform policy or practice which may make a contribution to the prevention of a similar death in future within the Northern Ireland Prison Service.

9. Aaron's mother asked the following questions:

    - Did Aaron receive the proper medication and medical treatment whilst in Maghaberry Prison?

- Did Aaron see a psychiatrist whilst in Maghaberry Prison?
- Why was Aaron detained in the Specialist Supervision Unit (SSU) for six weeks and two days?
- What was the reason for the Prison Service stopping visits to Aaron from 11 May 2011 onwards?
- Was Aaron bullied whilst in Maghaberry Prison?
- Was Aaron cell sharing at the time of his death?
- Was Aaron kept on a landing with all Catholic prisoners?
- Was Aaron having difficulty integrating with other prisoners prior to his death?
- What caused Aaron to take his life?

FINDINGS

SECTION 1: BACKGROUND & COMMUNITY MEDICAL HISTORY

Aaron Wayne Hogg was 21 years old when he died by suicide on 22 May 2011, whilst in the custody of Maghaberry Prison. A review of Aaron's community medical records provided important information and insight into his background history and medical diagnoses and problems. It is to note that Aaron's community medical records were never requested by the Prison Service and South East Health and Social Services Care Trust (SEHSCT).

An examination of Aaron's medical records identified the following areas as having possible relevance to his care needs in prison.

Behavioural Problems/Violence

There is evidence in Aaron's medical notes of significant behavioural problems from a very early age. This includes evidence of highly disruptive and violent behaviour. Aaron's parents had trouble controlling him and a family member said that Aaron had no concentration and he did not think of the consequences of his actions.

Early Abuse of Medication

There is evidence of Aaron abusing medicines as early as 2005/6, when he was at secondary school. Aaron is reported to have overdosed twice around this time, on one occasion by taking medication that belonged to his grandmother. The recorded reasons for his overdoses include that he *"had taken the tablets to see what effect they would have"* and because he was *"in debt to"*, and *"in receipt of threats from"*, paramilitaries.

Involvement with Paramilitaries

There is evidence of involvement with paramilitaries from an early age. Aaron was assaulted and taken to hospital numerous times, his movements were at times restricted and he left Northern Ireland on a number of occasions.

Paranoia

Aaron frequently reported that he was *"paranoid"* and at times he experienced panic and anxiety attacks. He carried a knife and other weapons for his own protection. Doctors, however, pointed out on several occasions, that Aaron's fear for his safety, his agitation and hyper vigilance were related to *"actual"* ongoing safety issues and were not a symptom of paranoia.

Hearing Voices/ Self Harm and Suicidal Ideation

From 2007, Aaron reported, at times, hearing voices which were reported to be *"nocturnal."* At one point he was reported to be *"seeing faces"*. His main issue was noted to be fear of paramilitaries. In September 2007, a family member found Aaron in his loft, with a rope hanging. He had written a note and was planning to die by suicide. It was recorded that Aaron was hearing *"threatening auditory hallucinations and visual hallucinations of paramilitaries…..They commanded him to self harm and he did this by his attempted hanging."* It was noted by a psychiatrist who assessed Aaron in November 2007 that the *"suicide attempt by hanging"* was *"in the context of an overdose of sleeping medications."*

There are also many references in Aaron's community medical notes to him experiencing *"self harm"* or *"suicidal ideation"*, but with no plans or intent. In October 2009, a Social Worker recorded that *"Aaron reported symptoms of low mood including suicidal ideation on a daily basis."*

Sleep Disturbance

There is evidence, throughout Aaron's medical records, that he suffered from severe sleep disturbance which appeared to trouble him greatly. He was prescribed medication on many occasions to help him sleep. The sleep disturbance was linked in his notes to hyper vigilance and, as stated, he also heard voices at night.

Clinical Diagnosis

Aaron had many contacts with psychiatric services in the community and was assessed by psychiatrists on several occasions. The following diagnoses' were made:

- In October 2007, following treatment for an assault at the Mater Hospital, the discharge letter to Aaron's GP notes: *"acute Post Traumatic Stress Disorder with psychosis and acute Post Traumatic Stress Disorder with suicidal ideation."*

- In November 2007, following an assessment at a psychiatric outpatient clinic, Aaron was noted to have a *"Psychopathic Disorder not otherwise specified"*, Conduct Disorder, Anti-social Personality Disorder and a Personality Disorder NOS (no other symptom) with narcissistic and borderline features. The psychiatrist who assessed Aaron noted his *"history of impulsiveness, explosive anger, mood and affective liability, recurrent suicidal and homicidal ideation and history of disciplinary and conduct problems as a child."* The psychiatrist concluded that there was no sufficient evidence to support that Aaron had Attention Deficit Hyperactivity Disorder, (ADHD,) which family members had said they felt may have been part of his problem, and that there was no evidence of genuine psychotic or delusional symptoms. The final conclusion was that *"with a reasonable degree of medical certainty Mr Hogg is a dangerous individual,"* who did not suffer from a mental illness, but rather from a psychopathic disorder. Aaron was started on Quetiapine[14] 50mg twice daily to address anger, aggression, agitation, impulsivity and mood swings and zopiclone[15] 7.5mg at night for two weeks.

- In April 2008, Aaron was seen at an outpatient psychiatric clinic. The psychiatrist noted that he was *"increasingly paranoid and the effect of Seroquel (Quetiapine) was wearing off……His sleep pattern is reversed but this is again due to inactivity."* Aaron's medication of Quetiapine was changed to 50mg in the morning, 25mg at mid-day, 50mg during the evening and 100mg at night.

[14] Quetiapine, which is also known as Seroquel, is an atypical antipsychotic approved for the treatment of schizophrenia and bi-polar disorder.
[15] Zopicline is a sleeping tablet.

- In October 2008, Aaron was a psychiatric in-patient for one week.

- In February 2009, it is recorded in Aaron's GP records that he had a diagnosis of psychopathic personality.

- In July 2010, a further referral was made to psychiatric services, which appears to have been prompted by Aaron's mother who remained concerned that Aaron had ADHD. The psychiatrist impression was that Aaron presented with an antisocial personality with borderline features associated with low mood and paranoid ideation. The psychiatrist found Aaron had no energy or motivation and he reportedly spent most of the night awake and slept between 06.00 and 16.00. The psychiatrist noted that there was no evidence to suggest a diagnosis of ADHD. Aaron's medication, at the time, was increased and there was to be a review in three months with a view to discharging him once his symptoms were stable.

Medication

From 2007, Aaron was prescribed Quetiapine and over the years the dose was increased. By early 2010, in addition to the Quetiapine, Aaron was prescribed Sertraline[16] and Temazepam[17]. Aaron's prescribed medication in the community, prior to his prison committal on 20 September 2010, was as follows:

- Sertraline - 150mg at night
- Quetiapine - 50mg to be taken at midday, 75mg to be taken at teatime and 125mg to be taken at night
- Temazepam – 10mg at night

It is to note that Aaron's medication was prescribed to him on a weekly basis. The reasons for this are not recorded.

Aaron's community medical records also include evidence of Aaron using illicit drugs including Cannabis and Ecstasy.

[16] Sertraline is an antidepressant primarily used to treat major depression in adult outpatients as well as obsessive compulsive, panic, and social anxiety disorders in both adults and children.
[17] Temazepam is used for the short-term treatment of insomnia and for symptoms of anxiety.

SECTION 2: HISTORY OF PRISON COMMITTALS

Final Committal

On 20 September 2010, Aaron was committed to prison for the last time. Prior to this, he had been committed to prison on four occasions. In light of the fact that prison healthcare staff did not request Aaron's community medical records at the time of his final committal, the investigation reviewed his previous committals in order to establish what was known about his medical history and matters that might make him vulnerable in prison.

First Committal

On 11 March 2008, Aaron was committed to Hydebank Wood's Young Offender's Centre for non payment of fines relating to traffic offences. The police papers that accompanied Aaron to Hydebank Wood noted that he had overdosed on tablets about one to two years previously. The nurse (name redacted) who carried out the healthcare committal interview recorded that Aaron's alcohol consumption was 30 units per week and that he had a psychiatric appointment scheduled for 23 March at the Mater Hospital. The nurse recorded that Aaron was engaging in community psychiatric services due to paranoia, drug misuse and a previous admission to a psychiatric hospital regarding paranoia. She recorded also that he had a history of deliberate self harm outside prison (overdose).

The nurse noted that Aaron had no thoughts of self harm; that he was receiving medication for paranoia; that he had been homeless within the past year and that his mental state was good.

It is also noted in Aaron's prison medical records that his community GP was contacted in order to confirm his medication. The medication was recorded as Quetiapine 25mg in the morning and 100mg at night. Aaron's community or hospital medical records were not requested.

It is to note that, in light of Aaron's offence, staff would have been aware that he was likely to remain in prison for a very short period. His history would, however, make him vulnerable. In the event, Aaron was released from Hydebank Wood on 14 March 2008.

Second Committal

On 6 September 2009, Aaron was committed to Hydebank Wood for the second time, again for non payment of fines. On this occasion, the police papers stated that Aaron had overdosed five years ago. The nurse (name redacted) who carried out the healthcare committal interview noted that Aaron had been a psychiatric in-patient in October 2008 for one week and that he was discharged with no follow-up. She also noted that Aaron stated he had a *"long history of antisocial behaviour with paramilitaries and had received punishment beatings."* She noted that, in the week before coming into custody, Aaron had been binge drinking for four days in a row (until his money ran out) and that he admitted to having issues with drugs, which in the past month included the use of Ecstasy, Cocaine and snorting 'Speed' (Amphetamine). It is recorded that the nurse advised Aaron to consider contact with Opportunity Youth[18] for support on discharge, but Aaron declined. Aaron's medication on committal was recorded as Quetiapine 25mgs four times a day and 100mg at night as well as Temazepam 10mgs at night.

There is no evidence of any further contact with Aaron's GP to confirm his latest medication or to obtain further medical information.

On 11 September 2009, Aaron was again released from Hydebank Wood.

Third Committal

On 18 March 2010, Aaron had his third committal to Hydebank Wood in connection with a number of charges and a breach of three probation orders. The police papers that accompanied Aaron noted that he had taken 10 overdoses two years ago. The same nurse (name redacted) who had carried out Aaron's healthcare interview when he was committed for the second time recorded that Aaron was a light drinker, taking one to two units of alcohol per day and that he had no thoughts of self harm. Aaron's medication was recorded as Quetiapine 25mgs twice a day and 100mgs at night; Sertraline 100mgs and Temazepam 10mgs at night.

[18] Opportunity Youth provide a comprehensive range of personal development and therapeutic services dedicated to meet the needs of young people, including a substance misuse service.

There is no evidence that Aaron's GP was contacted to confirm his medication.

On 6 May 2010, Aaron was released on bail.

Fourth Committal

On 10 May 2010, Aaron breached his bail conditions and was committed to Hydebank Wood for the fourth time. The police papers noted that Aaron had tried to overdose in the past and that he suffered from depression and anxiety. The nurse (name redacted) who carried out the committal healthcare interview had not carried out any previous committal interview with Aaron. She recorded that Aaron had learning difficulties; that Behaviour Conduct Disorder had been diagnosed at the Mater Hospital two years previously; that he was a teetotaller and that he had no thoughts of self harm. His medication on this committal was noted as Quetiapine and Sertraline. The following day a different nurse (name redacted) recorded in Aaron's prison medical records that he was to recommence his medication, supervised, until moved off the committal landing.

There is again, no evidence that Aaron's GP was contacted to confirm his medication or to obtain further details about his medical history.

On 21 May 2010, Aaron was released on bail.

SECTION 3: CHRONOLOGY OF AARON'S FINAL COMMITTAL TO HYDEBANK WOOD YOUNG OFFENDER'S CENTRE

On 20 September 2010, Aaron commenced his final period in prison custody. During his healthcare committal interview, it is recorded that Aaron told the nurse (name redacted) that he had anxiety and depression; that his medication was Quetiapine, Sertraline and Diazepam; that his alcohol consumption was 25 units per week; that he had literacy problems and that he had no thoughts of self harm. The nurse also noted that Aaron had been due to attend an appointment at the Mater Hospital that day, to investigate whether he had Cushing's Disease[19]. The nurse recorded *"Planned action - no immediate action required."*

There is no evidence that Aaron's GP was contacted to confirm his medication. Whilst Aaron had told the nurse that he was on Diazepam[20], he was, in fact, prescribed Temazepam.

Aaron's prescription of the antipsychotic drug Quetiapine should also have flagged up to staff that his mental health issues were more complicated than just anxiety and depression. Other relevant information was documented in prison records.

There is, however, no evidence that:

- The Mater Hospital was contacted to rearrange the appointment that Aaron had reportedly missed or to ascertain the reason for the appointment.
- Aaron's previous prison healthcare records were reviewed to check previous medical history in prison.
- Aaron's medical and hospital records were requested and the reasons for his current medication checked.

19 Cushing's disease is caused by a tumour or excess growth (hyperplasia) of the pituitary gland. This gland is located at the base of the brain. People with Cushing's disease have too much adrenocorticotropic hormone (ACTH). ACTH stimulates the production and release of cortisol, a stress hormone. Too much ACTH means too much cortisol. Cortisol is normally released during stressful situations.

[20] Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects.

Following his committal assessment Aaron was put on a repeat prescription of Quetiapine 50mgs each morning, 75mgs at lunchtime and 125mgs at night and Sertraline 150mgs to be taken at night.

On 22 September 2010, Aaron had a *"72 hour assessment"* by a nurse (name redacted). The nurse noted Aaron's previous psychiatric admission to the Mater Hospital and that he had been prescribed Quetiapine for *"mental problems".* She also noted that Aaron had *"a history of deliberate self harm outside prison (attempted overdose)"* but that he had no current thoughts of self harm and he said his *"mental state feels fine."*

On 10 October 2010, An injury report form was completed. It is recorded that Aaron had been *"involved in an incident with another inmate. OE (on examination) slight redness to forehead. No medication required."*

From 16 October 2010, Aaron was issued with his medication on a weekly in-possession basis. On committal he had been placed on 'daily in-possession' medication until 5 October 2010. This meant that he was issued with his medication each morning. Over the following 11 days, Aaron was gradually issued with increasing supplies of medication in order that he could self administer a number of days at a time.

On 31 October, Aaron passed a drug test.

On 1 December, Aaron was transferred from Hydebank Wood Young Offender's Centre to Maghaberry Prison.

SECTION 4: AARON'S TIME IN MAGHABERRY PRISON – CHRONOLOGY OF KEY EVENTS

1 December 2010 – Aaron's Committal

During Aaron's committal to Maghaberry on 1 December 2010, a prison officer recorded that Aaron had said that he had no thoughts of self harm and no history of self harm. The nurse (name redacted) who carried out the healthcare committal assessment recorded *"Prison Transfer. Self administration of medication – yes. Medication on committal Sertraline 100mg & 50mg daily. Seroquel (Quetiapine) 100mg nocte (at night)…Prisoners own prescribed medication to be used."* On transfer Aaron, who had been issued with his weekly prescription the day before, brought his medication with him from Hydebank Wood and it would appear that Aaron's daytime Quetiapine was not recorded. It is to note that the prescription was not correctly recorded on EMIS.

The nurse also noted on the '*First Night in Prison*' committal form that Aaron did not have any medical markers, did not have any alcohol or drug related problems and did not have any thoughts of self harm.

At interview the nurse could not remember the consultation with Aaron but said that it was possible that she only recorded 100mgs of Quetiapine because that may have been what Aaron brought with him on transfer. It is to note that, if it was the case that Aaron only brought his night-time Quetiapine from Hydebank Wood, this would suggest that he had not been taking his medication correctly. It would suggest also that staff at Maghaberry did not check what medication Aaron was prescribed at Hydebank Wood.

The nurse said that when a prisoner transfers from one of the other prisons in Northern Ireland, a full committal health assessment would not be completed. The nurse said that *"A transfer generally is a meet and greet. You basically just meet them, check that they're okay, do a set of observations, clinical observations and make sure that there's no outstanding medical problems with them because all of*

those entries should already be on the EMIS[21] system." The nurse also said that generally there are no medical papers that accompany the prisoner on transfer, but that staff would have EMIS to refer to.

The nurse said also that if Hydebank Wood had any concerns regarding Aaron's health or mental health, the Maghaberry's healthcare team would have been notified or a note would have accompanied him on transfer. The nurse said that as this was not the case, no referral to mental health or any other healthcare services was made.

13 December 2010 - Issue of Co-codamol

On 13 December, it is recorded that Aaron was issued with Co-codamol tablets 30mg Codeine / 500 mg Paracetamol. This is the only mention in his medical records of Codeine, which was found in his body at the time of his death.

19 December 2010 – Medication Risk Assessment

On 19 December 2010, a risk assessment for In-Possession Medication was completed. It is not clear why this risk assessment had not been carried out before as Aaron had already been issued with medication in-possession since arriving in Maghaberry Prison. The nurse who completed the risk assessment recorded that Aaron had a history of self harm and that he had attempted to hang himself in 2007. She noted also that Aaron's medication had a high risk from overdose and that he had a history of depression. The nurse concluded that Aaron was suitable for weekly in-possession medication and he was issued with his medication.

21 December 2010– Location Transfer

On 21 December Aaron transferred from the committal landing to Lagan House.

At interview, a prisoner who shared a cell with Aaron in Lagan House (name redacted) said that:

[21] EMIS – Egton Medical Information System is the database in which a prisoner medical information is recorded.

"Aaron used to take a handful of his tablets every day and he'd get into bed, go to sleep, wake up, eat all the food, probably start snarling at me about something, then get back into bed, fall asleep, wake back up, neck a handful more tablets and then get back in and go to sleep. And that was literally all Aaron would do, was just neck a whole handful of them tablets, go to sleep and he'd end up probably having to do two or three days without tablets and I used to say to him, "Why do you take so much and leave yourself short? Why don't you take what you're supposed to take?" And he said because he wasn't on enough; there wasn't enough medication, and I was thinking to myself Jesus Christ the amount of tablets he takes how would there not be enough. I don't know what was going on through his head. I thought maybe he did need more tablets, I don't know."

3 January 2011 – Medication Issue

On 3 January, Aaron was seen by a nurse (name redacted) to receive his medication. Aaron was last issued with his medication on 26 December and was, therefore, due to receive a further week's supply. The nurse recorded that Aaron's medication was issued and that he had *"no further medical concerns."*

7 January 2011 – Phone Call From Aaron's Mother

A family officer recorded that Aaron's mother had been in contact on 7 January to tell them that Aaron had been trying to see a nurse but had been unable to. The family officer recorded *"call made to Lagan 6 and staff were to deal with the request."* The next entry in Aaron's prison medical records, on 10 January, is by a prison doctor (name redacted) and states *"Pt* (patient) *at gym, despite multiple requests to be seen and complaints through family officer asking for pt to be seen, pt classed as having DNA'd* (did not attend)*."*

10 January 2011- Letter from Aaron's Solicitor to the Prison Service

On 10 January 2011 Aaron's solicitor wrote to Maghaberry Prison stating that Aaron had not received his antidepressant medication for one week. He said that Aaron *"instructs that he will self harm if he does not receive his medication. Please*

confirm by return our client will receive his medication immediately or alternatively provide reasons as to why not.

Finally our client instructs that he has been refused an opportunity to discuss his medical issues with a nurse in private. Please confirm by return that he will be afforded this fundamental right."

The solicitor advised that no reply was received.

11-27 January 2011- Medication Delay

On 11 January, a nurse (name redacted) recorded in Aaron's prison medical records that he was not happy because his medication was due and had not been provided to him. The nurse recorded that Aaron had not re-ordered his medication as required and advised him of this. She also recorded that she had left a note in the diary for his prescription to be done the following morning. The following morning, Aaron received his medication.

On 14, 17 and 27 January, there are three separate entries in Aaron's medical records regarding his prescription of Quetiapine 100mg. Aaron believed that he had not been issued with the correct dose of his medication. On 27 January it is recorded *"It appears there is a line through the label in the Kardex* (medication administration record), *however, there is no note on EMIS to say if it is discontinued or current, I will speak to pharmacy to see if I can clarify the situation."* A further entry in Aaron's records note *"Pharmacist contacted. It appears that the Seroquel (Quetiapine) 100mg tabs and 25mg tabs which prisoner has been taking at night are now incorporated into the script which instructs 25mg 2 in the morning, 3 at lunchtime and 1 at night. The 100mg tabs have therefore been removed from pharmacy and destroyed by the pharmacy staff."*

It is not clear from Aaron's medical records why the prison doctor reduced Aaron's night time Quetiapine from the previous dose of 125mgs to only 25mgs.

25 January 2011 – Drug test

On 25 January, Aaron passed a random drug test. This was the only drug test he was asked to take during his five months in Maghaberry.

30 January 2011– Threat to Cell Mate

It is recorded in Aaron's prison records that he refused to be locked in his cell and that if staff *"put him back into the cell he could not guarantee his cell mate's safety……Hogg also stated that he would cut himself to make sure he would not be doubled up as he wanted a single cell."* Aaron was moved to a different landing in Lagan House.

1 February 2011– Disciplinary Adjudication

On 1 February, as a result of Aaron refusing to be locked in his cell the previous day he was adjudicated and lost his evening association for 14 days.

15 February 2011– Repeat Prescription

On 15 February, Aaron was issued with a repeat prescription without being seen. No reference was made to his 100mg Quetiapine night time tablet.

17 February 2011– Return of Medication

On 17 February, Aaron returned his Sertraline (anti depressant) medication to a nurse saying that he no longer wanted it. The nurse recorded *"I have offered an appointment on Mon to discuss with GP although he has refused and is aware to speak to house nurse if any changes in mind/mental state. I have tried to encourage him to stay on same until a discussion with Dr. Aaron denied any thoughts of suicide or DSH (deliberate self harm) and says he feels well presently."* The nurse carried out a medication spot check of all of Aaron's tablets and found that he had the correct amount left.

23 and 24 February 2011 - Consultations with Nurse

Aaron saw a nurse on 23 February and, again on 24 February, and told her that he was still adamant that he was missing his Quetiapine 100mgs at night. She recorded that *"there appears to be some confusion over the 100mg Seroquel* (Quetiapine) *nocte (at night)."* On 24 February, the nurse contacted Aaron's GP who confirmed that he should be getting 125mgs of Quetiapine at night and, as a result, the nurse requested his prescription be amended *"asap and sent as urgent."* The following day, Aaron received the additional 100mgs of Quetiapine that he had been taking up to the middle of January. It would appear to be the case that Aaron's medication was wrongly prescribed between 11 January and 24 February.

27 February 2011– Fight with Another Prisoner / Removal to SSU

On 27 February, Aaron was involved in a fight with another prisoner. CCTV of the incident shows Aaron in the recreation room with the rest of his landing. Aaron is seen to walk up to one of the telephone booths, drag a prisoner out of the phone booth and throw him to the ground. He is then seen to land a number of punches on the other prisoner before throwing him across the floor, resulting in his face slamming off the floor. The other prisoner is then seen to get up, pick up a pool cue and walk towards Aaron. Aaron then throws a couple more punches to the other prisoner's face and walks off.

It is reported that this incident occurred because Aaron believed that the other prisoner was wearing his T-Shirt. The other prisoner was taken to outside hospital to receive treatment and Aaron was taken to the Specialist Supervision Unit (SSU) under Prison Rule 35 (4), pending a disciplinary adjudication.

On arrival at the SSU, Aaron was seen by a nurse who recorded *"seen in the SSU, no injuries or complaints."* On an injury report form completed by the nurse, it was recorded *"no injuries apparent or voiced."*

Aaron remained in the SSU for a further six weeks, was placed on supervised swallow of his medication and was, as required by Prison Service policy, seen daily

by a nurse. In Aaron's telephone calls to his family Aaron said that he felt *"better in myself"* when on supervised medication in the SSU.

Aaron's time spent in the SSU is discussed further in section 10a of this report.

13-23 March 2011- Aaron's Dental problem

Between 13 and 23 March, Aaron was seen by a nurse in the SSU and on each occasion he was noted to have *"no medical complaints."* On 23 March, Maghaberry's dentist noted in Aaron's medical records *"from dentist, phone call from the family. Apparently this prisoner's mum has been in touch stating he is in pain. Check requests – none re dental pain and no entries on EMIS from nurse covering SSU daily – advised him of same."* The following day, Aaron told the SSU nurse that he had toothache and was issued with two paracetamol 500mg tablets.

Between 24 and 28 March, when he was seen by the dentist, Aaron continued to have toothache. The dentist wrote *"no infection/ abscess present."*

8 April 2011

On 8 April 2011 Aaron's solicitor wrote to the prison service saying: *"Our client's mother has indicated that Aaron has made suicidal remarks to her and accordingly we would be obliged if you would confirm by return that all steps will be taken to ensure Mr Hogg's safety."*

Between 13 and 23 March, Aaron was seen by a nurse in the SSU and on each occasion he was noted to have *"no medical complaints."*

12 April 2011 – Return to Normal Location

On 12 April, Aaron was moved from the SSU to Roe House where he remained for the rest of his time in Maghaberry.

One of the concerns raised by Aaron's family was that he had been located on a landing with only Catholic prisoners. A report showing the breakdown of religious

backgrounds of those prisoners who were located on Aaron's landing, Roe 1, notes that between 12 April and 22 May, on average 57.19% of the prisoners were Catholic, 25.76% were Protestant and 17.05% defined themselves as *"Other"*. It was not, therefore, the case that Aaron was placed on a landing where all of the other prisoners were Catholic. The investigation also found evidence that Aaron had a very positive relationship with a Catholic prisoner with whom he shared a cell. At interview, two protestant prisoners on Roe 1 said that they felt that *"it was like a silent intimidation from Catholics"*, because there were more Catholics than protestants. Other protestant prisoners said that they got on well with Catholic inmates.

13 April 2011 – Stored Medication

On 13 April, a nurse was requested by prison staff to identify some medication that was found in a Seven Seas vitamin tub in Aaron's cell. The nurse identified the medication as four Quetiapine tablets, three of which had partially melted. It would appear that Aaron had taken the tablets in front of a nurse but then spat them out afterwards. The entry in Aaron's medical records states *"to remain on supervised swallow until reassessed by house medic. To be charged with concealing unidentified tablets in original blister packs while currently on daily issue medication."*

A review of Aaron's medication administration records shows that he did not, however, continue to be on supervised swallow as ordered by the nurse. On 13 April, the date that the nurse's entry was written, Aaron was issued with a week's supply of in-possession medication.

13 April 2011 - Alleged Incident in Recreation Room

Following a visit with Aaron on the afternoon of 13 April, his mother spoke to a family officer and said that Aaron had a mark on his head from being punched in the recreation room and that he was not receiving his medication. It is recorded that the family officer contacted Aaron's landing and was told that *"they would do the paperwork and get him seen on the landing. Aaron is on supervised swallow but had excess meds in his cell this morning."*

It is recorded in a Security Information Report (SIR), written by an officer on Aaron's landing and submitted to Maghaberry's security department, that Aaron alleged he had been hit in the face by another prisoner, whilst in the recreation room. The SIR notes *"Inmate stated he did not want to stay on Roe 1 as he had just spent six weeks in the block (SSU) and does not want to fight and go back there. There were no witnesses to the alleged incident and review of the CCTV revealed nothing."*

Later that afternoon, in order to be charged with the offence of concealing unidentified tablets, Aaron was taken to the SSU under close escort using Control and Restraint procedures. The nurse who assessed Aaron in the SSU noted *"Slight swell above right eye. No tenderness or bruising. Under close escort and C&R* (Control and Restraint procedure)*."*

After he was charged, Aaron was returned to his landing and phoned his mother. During the call Aaron told her that he's been charged *"because he spat his Seroquel (Quetiapine) out and was caught storing them up for the night so that I could sleep better at night."*

2 May 2011 - Cell Search / Recreation Room Incident

On 2 May, a search of Aaron and his cell was carried out. The unauthorised articles found in his cell included *"1 mattress, swing line[22], 3 fishing flies and razor blades."*

That night there was an incident in Aaron's recreation room and the room was damaged. On 3 May, a Security Information Report (SIR) was submitted by a principal officer to the security department naming the prisoners involved in *"orchestrating the wreck up in the rec room last night."* Aaron was one of those named.

[22] Swing lines are used by prisoners to pass articles from one cell window to another.

11 May 2011- Passing of Unauthorised Article During Visit

On 11 May 2011, Aaron was at a visit with some family members with whom he was particularly close, when it was reported that a member of staff saw Aaron swallow an unauthorised article passed to him in a cup by one of his visitors. The visit was then suspended, Aaron's visitors were stopped from seeing him and he was told that any future visits with other visitors had to be closed, meaning that there would be glass separating Aaron from his visitors. All three visitors were banned, even though only one of them appears to have been involved in passing an illicit substance to Aaron.

On 13 May, Aaron's adjudication for the incident at his visit was adjourned until 20 May.

When notifying the visitors of their ban, the Prison Service invited them to make any representations they wished to have considered in connection with the decision made.

On 13 May also, a relative of Aaron said that he wrote to the prison service saying that Aaron *"has a personality disorder problem and he is vulnerable. He can go from being very low to being up high … it is important that he has visits from some of his family."*

On 17 May Aaron's solicitor wrote to the prison service, arguing that two visitors had no knowledge of or involvement in, the incident and should not have been banned. The letter said *"as you are aware Mr Hogg is particularly vulnerable and struggles to cope with the prison environment. Visits from (names redacted) provide a stabilising influence and are enormously beneficial to his mental health and well being."*

The solicitor asked for visiting access to be restored and asked also whether disciplinary proceedings were to be taken against Aaron. At the time of Aaron's death on 22 May, no reply had been issued by Maghaberry.

At interview, Aaron's cellmate (name redacted) stated that after being placed on closed visits, Aaron went *"downhill."*

18 May 2011 – Aaron's Letter

On 18 May, a member of prison staff wrote a note on behalf of Aaron in which he recorded *"I am on medication for depression and mood swings and I look forward to my visits as a stabilising influence. I need to talk to somebody about my problems, personal issues and about my difficult times in prison, (prohibited visitor - name redacted) is elderly and ill."*

It is understood that the prison officer spoke with Aaron following receipt of the letter from Aaron's relative.

At the time of Aaron's death, no one had responded to Aaron's letter of 18 May.

20 May 2011 – Illicit Dugs

CCTV shows that at 14.11 Aaron left the landing with a number of other prisoners who were attending the gym with him. It also shows Aaron neck hugging and fake sparring with other prisoners and he appears to be the most sociable of the group of prisoners.

At interview, Aaron's cellmate (name redacted) said that *"a supply of illegal blues"* (Diazepam) were available on the landing and that both he and Aaron had taken approximately 20 each that night. He also said that they smoked a small amount of *"grass"* (Cannabis).

In his clinical review report, Dr VandenBurg said that the blood concentration of Diazepam found at Aaron's post mortem was too low for him to have taken this amount.

SECTION 5: THE HOURS LEADING UP TO AARON'S DEATH

21 May 2011

On 21 May, CCTV shows Aaron walking about the landing and speaking to other prisoners.

The same day he attended a visit at 14.00. The investigation attempted to make contact with those who attended the visit, via Aaron's solicitor but no response was received.

At interview, Aaron's cell mate said that on the night of 21 May he and Aaron *"had had a bit of banter and slagging"*, but that he couldn't remember what they had been saying to one other.

Aaron's cellmate said that Aaron's speech was slurred more than normal, but that he thought that this was down to the medication that he was on. He said that Aaron used to go to the gym three times a week and would regularly use the cross trainer in the recreation room and ask him to help him with sit-ups in their cell. He said, however, that Aaron hadn't asked for help him with sit-ups during the last few days he was alive.

The cellmate said that on the night of 21 May they ate their tea in their cell and that he witnessed Aaron boiling up his medication and another unprescribed drug. He said that this was *"something which I had never seen him do before."* He said also that they had played cards that night. *"Aaron lost… Normally if he loses he would want to play on to try and win them back but that night he didn't seem to want to know. Sometimes after we play cards we would then play chess but again Aaron wasn't interested. He just lay up on his bunk to watch TV… During the evening when we were watching TV there was no real conversation that I can recall… I know he was definitely asleep at 10pm because I could hear him snoring."*

The cellmate couldn't remember how long they played cards for, or what time they finished, but he remembered an officer coming in to see if Aaron wanted to use the

phone, because he'd put his name on the list. The cellmate said that Aaron didn't want to use the phone, but he couldn't remember the reason why.

The cellmate said that Aaron went to his bed early that night, *"like he had in the past when he'd taken a lot of his medication."* He said there were two previous occasions he remembered Aaron going to bed early when he had made bail requests. He said that Aaron *"pumped the Seroquel (Quetiapine) tablets into him and he was in bed right and early on both occasions."*

It is recorded in the class officer's journal that at 17.50 phone requests commenced and at 19.25 the landing was locked.

22 May 2011

At 01.25 a supervised check was carried out on Aaron's landing, which means that a night custody officer checked each cell in the presence of a senior officer. Nothing untoward was reported during this check.

CCTV shows that at 05.18 two night custody officers commenced a further check of all prisoners. In his staff communication sheet, completed after Aaron was found, the night custody officer (name redacted) who checked Aaron's cell, wrote that *"something was not right."* He said that Aaron *"looked as if he was lying over the end of the bed, but I wasn't sure."* The night custody officer called for his colleague to ask his opinion and, unsure of what they were looking at, the officers raised the alarm and carried out an emergency unlock.

On entering Aaron's cell, one of the night custody officers (name redacted) saw that Aaron had the cord of a bathrobe around his neck which had already been cut. It transpired that Aaron's cell mate had been woken up by the officers banging on the door and, seeing what Aaron had done, used a razor to cut the bath robe cord. It is recorded that one of the night custody officers commenced cardiopulmonary resuscitation (CPR) straight away.

In a police statement, one of the night custody officers (name redacted) who carried out CPR, described Aaron as having *"stiffness"* in his limbs, which he believed was *"due to rigor mortis."*

CCTV shows that at 05.24, the senior officer who arrived in response to the raised alarm, assisted in bringing Aaron out of the cell onto the landing. A nurse officer who had responded to the alarm assessed Aaron and it was decided that due to him having no signs of life, a blocked airway and stiffness in his limbs, CPR would not be continued. CCTV confirms the nurse's account of Aaron's appearance.

Aaron was covered with a sheet and at 05.57 CCTV shows that paramedics arrived on the landing. They carried out an assessment of Aaron and covered him again.

At 06.02, CCTV shows officers placing a privacy screen around Aaron.

Following the arrival of the on-call prison doctor, Aaron's time of death was recorded as 06.34

SECTION 6: AARON'S TELEPHONE CALLS

The investigation obtained and listened to all of Aaron's telephone calls made from Maghaberry, that were still held on the recording system. These date back to 28 February 2011.

During the calls, Aaron talks about family matters, other interests, and a range of other topics.

Below are extracts which are relevant to Aaron's experience in prison and matters related to his care.

Period in the Special Supervised Unit (SSU)

Aaron talks about being in the *"block"* (the SSU) for fighting with a Chinese prisoner. He says he was fighting because the Chinese prisoner was wearing his top and that the Chinese prisoner ended up in outside hospital. Aaron says he doesn't know how long he will be in the SSU for. He says that he only gets out of his cell for a shower and ten minutes in the yard and that it doesn't matter if he tells a doctor that he has a mental health condition, they will make him stay in there anyway. Aaron talks about not liking the SSU. On 9 March he says "*you have to get me outta here."* He says that he's forgotten what it's like outside.

On 14 March 2011, Aaron says that he has seen the governor and that the governor was asking him if he had problems with foreign nationals and whether he has any history with them outside. Aaron says that he (the governor) was asking if he gets into violence outside and that Aaron told him it was none of his business. Aaron says that he has been told that he is going to be kept in the SSU until the police investigation has been concluded and when he asked how long that would take he was told that it could take up to three months.

On 15 March, Aaron says that he has got another 28 days in the SSU because the governor told him that he doesn't want to put him in with other prisoners because he's violent. Aaron's says his argument was that this fight was only because the other inmate had stolen his T-Shirt

On 22 March, Aaron says that he was talking to his solicitor and that there was no chance of him getting out of the SSU. In another call, he mentions that he's been in the SSU for six weeks and one day and says that they gave him a letter for him to write to say why he thinks he should be let out of the SSU. Aaron said that he can't write so he didn't do anything with it.

In a number of conversations, Aaron mentions that he has been better having his medication given to him three times a day whilst in the SSU. Those speaking to Aaron agree that he has been better whilst having his medication administered to him on a regular basis.

Steroids

On 12 April 2011, Aaron asks the person called to buy steroids and the person called says no. Aaron questions why they'll buy him "*blues but not steroids?"* The person called says that they are *"not going to anymore."*

In numerous conversations between 12 April and his death Aaron calls someone to ask them to buy him Danabol steroids. He says he can't go to the gym without them (steroids) because everyone has them. He subsequently asks for "*Oxi 50's*" (the most powerful steroid available). The person spoken to appears very reluctant to get steroids for Aaron.

On 9 May, Aaron is annoyed because he is on steroids and *"not getting to the gym."* On 14 May, the person called asks Aaron how he felt after taking the steroids. He says he has been *"fine"* and doesn't think that they're doing anything.

Drugs

There is significant evidence in phone calls that Aaron arranged for drugs to be brought into prison; traded drugs and prescription medicines; took illicit drugs; abused prescribed medication and stockpiled his medication.

Examples include:

- 7 March 2011: Aaron asks if the person called has ever heard of pain killers called OxyContin[23] – he says that they cost £45 for one tablet in prison and *"knock you out for nearly two days like heroin."*

- 13 March 2011: Aaron says that he's on 17 (tape unclear) Diazepam a week.

- 23 March 2011: Aaron says that you can get drugs in Maghaberry "*quicker than you can on the streets."*

- 24 March 2011: Aaron talks about *"blues"* and says that the last lot were *"rubbish."*

- 11 April 2011: Aaron says that the Seroquel[24] (prescribed) doesn't *"calm his head,"* he says that they just slow him down and that's why he doesn't take them outside.

- 12 April 2011: Aaron asks the person called to see if (name redacted) can get him "*something*" (drugs).

- 13 April 2011: Aaron asks the person called to bring in *"anything they can"* because he is finding it hard to sleep, says he got charged for spitting his Seroquel out and was caught storing them up so he *"could sleep better at night."*

- 15 April 2011: Aaron tells the person called that he couldn't talk to (name redacted) properly yesterday because he felt *"drunk"* after taking some tablets.

- 28 April 2011: Aaron asks the person called to get a *"quarter"* (drugs related) so that he can give it to (name redacted).

[23] OxyContin is an opioid pain reliever similar to morphine.
[24] Seroquel is the trade name for quetiapine, the antipsychotic drug Aaron was prescribed.

- 28 April 2011: Aaron asks the person called if there is *"anything else being brought up on Saturday."* Aaron is told that *"there's nothing else getting bought"* unless he's got the money for it.

- 1 May 2011: The person called tells Aaron that *"he shouldn't be taking them"* and says that they got another *"one"* for Aaron from (name redacted) and *"it's about a quarter."*

- 1 May 2011: Aaron tells the person called that he took six Amitriptyline (a combined antidepressant and painkiller) he tells them that he was hallucinating on them.

- 9 May 2011: Aaron says that there should be *"£20 coming"* to the person called. Aaron says if it does come they are to get (name redacted) to get an ounce for him. Aaron says that if he gets an ounce that will be him sorted for his tuck shop for about two months. Aaron talks about giving someone *"a score"* and them owing him tuck in return.

- 11 May 2011: Aaron talks about being caught receiving unauthorised articles during a visit. Aaron mentions that he'll not be able to get his steroids in now.

- 12 May 2011: Aaron discusses the fact that his visitors are barred from the prison. He says that there's no point getting visits if they're closed visits but that he's not worried. Aaron asks the person called to tell (name redacted) to make sure that he has the *"steroids on him on Saturday"* so that he can arrange for someone else to bring them into the Prison**.** Aaron says he thinks *"that the stuff"* that (name redacted) passed to him on the visit was heroin because it's *"eating his brain"* and *"stuff is coming out of his head"* when he's sleeping and he's paranoid.

- 10 May 2011: The person called says they have some more *"stuff."* Aaron asks for *"one"* to be brought in on Wednesday and one on Saturday as well as the tablets on Saturday.

- 10 May 2011: Aaron tells the person called to give *"the two bits"* to (name redacted) tomorrow.

- 16 May 2011: Aaron asks (name redacted) to put 10 painkillers into the packet that he's giving (name redacted).

Aaron's Slurred Speech

Aaron's speech can be heard to be slurred in telephone conversations on 11 April, 9 May (a little), 15 May, 19 May (a little), 20 May (very badly) and 21 May (badly).

Hydebank Wood Prison Deaths

Two prisoners died by suicide in Hydebank Wood prison on 4 May 2011. Aaron discusses the deaths briefly in two subsequent calls. He does not appear concerned about them.

Paramilitaries

Over his weeks in prison, Aaron talks a number of times during phone calls about matters on the outside relating to paramilitary organisations and events.

Aaron is concerned about the well being of family members who he is very close to and, from 21 April, is constantly urging them to move house.

Talking about his own living arrangements, Aaron says that he doesn't want to go back to the area of his family home when he leaves prison.

From 16 May, Aaron is concerned about issues to do with his case and, in particular, the need for (name redacted) to *"put the record straight"* or *"he'll get his legs broken."*

Aaron's Last Calls

In Aaron's last calls his speech is slurred and it is very evident that he is affected by medication/drugs. Five of his last calls include the following:

19 May 2011

Aaron slurring a little

Aaron says that he's fed up taking the Seroquel tablets because they're *"doing his head in"* and he's not going to take them anymore because they're making him *"stupid."* He says that he's got over 150 tablets. He says that he wants to see a doctor. He then says that he is taking them (the tablets) to get to sleep. He says that he can't see a *"proper doctor in here"* (Maghaberry).

The person called says that he (Aaron) saw the doctor last week and he should have said something. Aaron says that he has to see a *"mental health one."* He says that the tablets have ruined his ability to think. The person called says that Aaron *"sounds slow on them"* and Aaron says that he isn't even on them *"now"*. He says that if he doesn't take tablets he can't sleep.

The person called tells Aaron to cut down on the tablets, but he says that he can't. He mentions that he thinks he's hearing voices, but doesn't know if he's just confused.

20 May 2011

Aaron's speech is slurred.

Aaron talks about taking some *"blues"* and says that he's never felt better. The person called says that he shouldn't be taking other peoples stuff and that they *"can hear that he's on something because he's talking shit."* Aaron shouts at the person called that they don't know what it's like for him – he brings up incidents from outside prison, re getting his legs broken and having people after him.

The person called asks if Aaron's got *"them other things."* Aaron says that the tablets that he's been taking (non-prescribed) make him feel much better and he and his cell mate were saying that the Seroquel tablets that he's been on for two years are *"putting his head away"* – making him slur his words and not get his words out. The person called says that they told him to cut them down – he says that he has started to but thinks that because he's been taking them that long his head's still going to be *"duuuhhhh".* He says that people are calling him *"Dopey Hogger".* Aaron says that he's hearing voices in his head.

Aaron says that he's been thinking about killing people and the person called says that he had better tell the doctor. Aaron tells the person called to contact his (outside) doctor – the person called tells him that his own doctor will only tell him that there are very good doctors in Maghaberry and to go to them.

Aaron goes on to say that he's thinking about killing people with swords because the (redacted – name of paramilitary group) have bullied him since he was 15 and he's getting to *"boiling point."* The person called says *"it's a good job"* that he's in Maghaberry and Aaron says that he'll do it when he gets out and *"doesn't care about doing life"* when he kills one.

Aaron says that he is *"psychologically hurt in the head"* and hearing voices – two people in his head telling him what to do – and it's scaring him. He says he's *"coming close to being suicidal"* because he can't take it and suffer it for the rest of his life. The person called says that maybe he is schizophrenic – Aaron says that he just wants help. He says they're "*telling him evil stuff.*" The person called says that they'll get the solicitor to tell someone in Maghaberry and that he needs to tell someone in Maghaberry. Aaron says that he's not going to tell anyone unless they're *"from the mental health team".*

Aaron says he doesn't want to kill himself in Maghaberry because people will think that he *"couldn't hack it,"* but that when he gets outside he'll be close to being suicidal. He says he can't stop it. Aaron asks the person called to arrange for one of his solicitors to visit him because he wants to talk to him about medical problems. He says the voices have only started since he's been in jail because he

has too much time to think. The person called tells him he needs to tell the doctor, but Aaron says he doesn't want anyone knowing that he's a *"schizophrenic."*

20 May 2011 (to a different person)

Aaron has badly slurred speech

Aaron says he's *"getting it tight as f..k"* because he's had no drugs and his *"head's melted."* Aaron is slurring badly and the person called asks what he's on, but Aaron says *"nothing."* Aaron asks the person called if he can bring 200 (tape inaudible) in for him.

Aaron and the person called then discuss events outside to do with bullying and drugs.

Aaron asks for 25 *"E's"* (Ecstasy tablets) and the person called questions why he wants *"E's"* saying that they'll put his *"head away"* in prison. Aaron says he's bench pressing 100 weight in the gym three times a weeks. (Aaron is then not making sense because of his speech.)

Aaron says that the landing is full of *"Taigs"* and they all hate him. They talk about guys in the community. Aaron talks about "*getting 100 in*" and the person called says that they have stopped dealing in them now so it'll be hard to get. Aaron insists he wants E's but the person called says he'll not get him those because it'll put his *"head away"*, he says that he'll get him some *"Dubs"*.

20 May 2011 (to a different person)

Aaron has very slurred speech

Aaron discusses his medication and the person called tells him to half his dose of Seroquel (because Aaron says they are making him slow). The person called tells him to ask for Valium (Diazepam). Aaron says that he took five Valium tablets last night and he had the best sleep ever and woke up feeling the best and that's what he thinks he needs. He says that he can't think normally, the tablets are causing

him to think *"slow"* and he feels embarrassed and paranoid because of it. He wants to be able to talk and have a friendly conversation with people. Aaron thinks people think he's *"a big idiot"* because he can't get his words out.

Aaron says the doctor should never have put him on that strong a dose and that he's hearing voices and its making him think *"bad things."* The person called tells him to tell the doctor in prison but Aaron said he's not going to talk to the doctors in prison because *"they're all shit"* and he's going to wait until he's out.

The person called tells him to get his medication cut down and then to try and get some Diazepam now and again. Aaron says that he was talking to (name redacted) and he's going to try and bring a couple hundred of them (Diazepam) up.

Aaron says that his *"head's away at the minute,"* he says that he's been bullied for the past six years by the (redacted – name of paramilitary group) and he's *"going to end up killing one of them."* The person called tells him he's safe in there but Aaron says he doesn't care about being safe because he's thinking about things he doesn't want to. He said *"it's like there's someone else in the room"* – two voices in his head – *"one good and one bad."* He says that when he gets up he's fine and can't hear them and then they'll come back during the day. The person called tells him to put it behind him and Aaron says that he can't because he has nothing to occupy him because he's lying in his cell for *"20 something hours a day."* He says that he read a book which he liked and might get more out.

Aaron says there are over 160 prescription tablets sitting in his locker because *"they're giving them out monthly now."* He says he doesn't know what to do about the voices. The person called says they'll go away and Aaron shouts at them that they're getting worse.

Aaron then speaks to a different person and says that he knows that his speech is all slurred because some person in the prison has told him. He asks why the person called hasn't said anything to him. The person called says that anyone on medication would have slurred speech. Aaron is annoyed that the people he calls didn't tell him he sounded *"slow."*

21 May 2011 (Aaron's last call)

Aaron has slurred speech

Aaron asks the person called not to bring the £40 in because he wants to put it on a bet instead. Aaron asks when the person called is going to be allowed to visit and they say they don't know. Aaron says he has hardly any money for his phone because it's run out quickly due to him calling a mobile. The person called tells him that he can't keep taking the tablets (because he sounds slurred during the call). Aaron says he hasn't stopped taking his medication and the person called tells him to slow down on them. Aaron says that his tablets are worse and the person called tells him to take less of them (*it's not clear whether this refers to Aaron's medication or other drugs*). The person called tells Aaron that he is taking far too many when he's going to sleep at night. Aaron asks the person called to keep £10 back for the bet and to have the rest left in when (names redacted) visit today.

SECTION 7: AARON'S MEDICATION

Aaron's medication in the community, prior to his prison committal on 20 September 2010, was as follows:

- Sertraline - 150mg at night
- Quetiapine - 50mg to be taken at midday, 75mg to be taken at teatime and 125mg to be taken at night
- Temazepam – 10mg at night

When Aaron was committed to Hydebank Wood, he was issued with:

- Quetiapine - 50mg to be taken in the morning, 75mg to be taken at lunchtime and 125mg to be taken at night
- Sertraline – 150mgs at night

Aaron was prescribed Temazepam because of his sleeping difficulties and there is evidence that his ongoing difficulty in sleeping was linked to his abuse of medication in prison. There is no evidence in Aaron's medical records that consideration was given to the reason that he was prescribed Temazepam.

When Aaron was transferred to Maghaberry Prison on 1 December 2010, he initially continued to take the same medication that he had been receiving in Hydebank Wood. However, from the middle of January to the end of February 2011 Aaron's Quetiapine 125mgs at night was reduced to 25mgs due to a prescribing error. It is also to note that on 17 February, Aaron returned his Sertraline tablets because he said he no longer wanted them.

At the time of his death, Aaron was only prescribed Quetiapine.

Quetiapine

The British National Formulary (BNF) which is a publication on which doctors are instructed to rely, states that Quetiapine may be used *"short term to calm patients who appear to be disturbed including those with schizophrenia"*, but also including other diseases which may cause disturbance, such as mania or agitated

depression. The BNF also notes that *"long term treatment is usually only indicated for patients with schizophrenia."*

In his clinical review report, Dr VandenBurg noted that Quetiapine's *"approved therapeutic indications other than schizophrenia, are manic episodes associated with bipolar disorder, major depressive episodes in bipolar disorder preventing recurrence in bipolar disorder in patients whose manic, mixed or depressive episode has responded to Quetiapine treatment."* He also advised that *"It is used clinically by experienced psychiatrists and psychiatric pharmacologists as a treatment for many other patients including those with impulsive activity, labile (unstable) mood, severe depression and psychotic symptoms including paranoia, hallucinations and delusions. In these patients where it is being used outside of its licensed therapeutic indications it is beholden on the clinician to regularly monitor its efficacy and its side effect profile."*

There is no evidence that Aaron had any face to face medication review by a doctor to monitor the efficacy and side effect profile of his use of Quetiapine.

Dr VandenBurg also noted that Quetiapine *"is not recommended for use in adolescents below 18 years of age. The SPC (Summary of Product Characteristics) warns that when it is used in bipolar disorder, in those aged under 25 there is a risk of suicide related events. Additionally, cessation of Quetiapine may precipitate suicide related events."*

There is no evidence that Aaron was diagnosed as having bipolar disorder, however, Dr VandenBurg said *"in people the age of Mr Hogg, Quetiapine is associated with an increase in suicidal behaviour."*

In his clinical review report, Dr Rix stated *"In addition to being prescribed for its licensed indications, Quetiapine is sometimes used in people with personality disorder, as in this case, to target anger, aggression, agitation, impulsivity and mood swings. The evidence for its effectiveness when so used is not very strong but it is strong enough for this use of Quetiapine to be supported by a responsible and reasonable body of medical opinion."*

Sertraline

In his clinical review report, Dr Rix said *"The deceased was also being prescribed Sertraline. The indication for this is questionable as he did not have clinical depression. However, he had experienced some benefit when it was first prescribed and unless a psychiatrist had said that it should be stopped, which was not the case here, it was reasonable to continue it in prison. It was eventually stopped when the deceased said that he did not want to take it any more."*

Commenting on Aaron's decision to stop taking his Sertraline, Dr VandenBurg stated *"abrupt discontinuation should be avoided. When stopping treatment with Sertraline the dose should be gradually reduced over a period of at least one to two weeks in order to reduce the risk of withdrawal reactions. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose, but at a more gradual rate'.*

Dr Vandenberg said that 23 per cent of those discontinuing Sertraline will experience a withdrawal reaction. Agitation and anxiety are common and behavioral problems may also occur. It is to note that Aaron had, discontinued his Sertraline on 17 February, nearly seven weeks before he died. When Aaron said that he wanted to stop taking his Sertraline on 17 February, the nurse did offer him an appointment with the prison doctor to discuss this but Aaron refused. The nurse also advised him that if his mood or mental health changed, he should notify the house nurse.

SECTION 8: AUTOPSY REPORT

A post mortem examination was carried out on 23 May 2011 and gave the cause of Aaron's death as:

I(a) Hanging

The autopsy report states:

"The post mortem examination revealed slight enlargement of the heart, but this was just an incidental finding. Death was due to hanging. There was a ligature mark on the neck and its position was such that when the ligature tightened, with the weight or partial weight of the body, it would have interfered with breathing and the flow of blood to and from the head. Unconsciousness would probably have occurred quite rapidly with death supervening within a few minutes. Apart from the ligature mark on the neck there were no further serious marks of violence.

The report of Forensic Science Northern Ireland shows that at the time of his death there was no alcohol in the body. Further analysis of a sample of blood taken during the post mortem examination revealed a number of drugs. The tranquilliser drugs Chlordiazepoxide and Diazepam, as well as the antipsychotic drug Quetiapine and the painkiller Codeine, were detected within their respective therapeutic ranges. In addition, a therapeutic level of the painkiller Morphine was detected, but this probably represents a breakdown product of Codeine. Further analysis revealed the antidepressant Mirtazepine at a level just above its normal therapeutic range. However, the concentration detected would not have been expected to produce toxic symptoms. Low levels of the painkillers DihydroCodeine and Tramadol were also detected. In addition, a breakdown product of the commonly abused drug Cannabis was detected in both the blood and urine. However, the presence of this breakdown product does not confirm recent usage of the drug, as it can persist in the body for a number of days."

It is to note that Aaron was not, at the time of his death, prescribed Chlordiazepoxide, Mirtazapine, Codeine, Diazepam, Tramadol, DihydroCodeine or Morphine (this could be a breakdown of the Codeine).

In his clinical review report, Dr VandenBurg stated that, contrary to the findings of the Autopsy Report *"Quetiapine and mirtazapine, as well as the other substances noted have considerable neuropsychiatric side effects which could have relevance to this case at normal therapeutic doses and concentrations. They also have withdrawal effects as well as neuropsychiatric effects which may continue after regular dosing."*

Commenting on how the combination of drugs found in Aaron's body may have contributed to his death, Dr VandenBurg said:

"The combination found within him would not have been helpful and their effects would at least have been additive, if not synergistic, particularly the two benzodiazepines[25] (Chlordiazepoxide and Diazepam), with mirtazapine and Quetiapine as well as the opioids[26] (Codeine, Tramadol and DihydroCodeine). All of these can cause somnolence (drowsiness) and confusion, they may also cause abnormal behaviours and the benzodiazepines could combine to produce disinhibited behaviour."

Dr VandenBurg said also that Aaron's *"long term use of marijuana could have been a precipitating factor"* and *"I have no doubt that his irregular use of Quetiapine was a major etiological factor"* (cause).

Commenting on the fact that Aaron was seen to boil his medication, Dr VandenBurg said:

"Mr Hogg was noted to have been boiling his medicine. This is a usual procedure if patients are going to inject the substances, although there is no evidence of this. Addicts commonly do it with slow release preparations so that they get the effects as a single, early hit and it may be therefore that although he was not on a slow release preparation he had learnt or he thought he may have got a better effect by making sure the substances were dissolved prior to taking them. There is of course the possibility that he would have destroyed active substances or produced new substances with unknown effects."

[25] Benzodiazepines are a group of medicines that are sometimes used to treat anxiety, sleeping disorders and other conditions.
[26] Opioids are a group of medicines used to treat pain relief.

SECTION 9: EVENTS FOLLOWING AARON'S DEATH

Death in Custody Contingency

The Prison Service policy documents *"Contingency Plans Forty Four and Forty Five – Death of a Prisoner"* clearly detail the roles and responsibilities of all members of staff upon notification of a possible death.

Using the contingency plans, the Emergency Control Room, which controls and records all movements around the prison, immediately notified the appropriate personnel of Aaron's death.

Those notified included the Police Service of Northern Ireland and the Prisoner Ombudsman.

Hot De-Brief

The Prison Service's Self Harm and Suicide Prevention policy, issued February 2011 states:

"In all cases involving a serious incident of self harm or death in custody, hot de-briefing will take place and will involve all of the staff (where possible) who were closely involved with the incident.

The hot de-brief will be held by the Duty Governor or the most senior manager at the time (depending on the circumstances of the case) and will take place as soon after the incident has been brought under control as possible. During the hot de-brief staff should have the opportunity to express their views in relation to how the situation was discovered, managed and any additional support or learning that could have assisted. In addition, the hot de-brief is an opportunity to identify if staff themselves require specific support."

The policy also requires that a record of the hot de-brief will be completed and a copy made available to the Head of Custody Branch and to the Prisoner Ombudsman.

A hot de-brief took place on 22 May 2011. It is recorded that all staff were given the opportunity to discuss the incident, how they were feeling and the support services available to them.

Cold De-Brief

The Self Harm and Suicide Prevention policy also states that *"a cold de-brief will take place within 14 days of the incident to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional learning from the events. The cold de-brief* ***is not*** *intended to be a comprehensive investigation into the circumstances. Rather, it is an opportunity for staff to express their views and share their thoughts about the incident and their role and involvement in it. A member from PSHQ Custody Branch will attend the cold de-brief to support the Governor conducting it."* It is also a requirement of the policy that a record of the cold de-brief is made.

On 31 May 2011, a cold de-brief took place with the staff involved in the incident. A record of the de-brief notes a number of actions to be taken as follows:

Actions

- *To find out whether the staff who had not been interviewed by police, were still required for interview.*
- *To obtain and provide staff with a copy of their police statements.*
- *For an updated list of on-call doctors and Independent Monitoring Board (IMB)[27] member telephone numbers to be provided to the Emergency Control Room on a weekly basis, as the list that was available when Aaron died was out of date and caused a delay in them being contacted.*
- *For practice sessions to be arranged for the Night Custody Officer's to use the emergency button[28] on their radios, as some staff were not sure of how to use it correctly.*

[27] IMB members are independent, unpaid and work an average of 2-3 days per month. Their role is to monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.
[28] There is an emergency button on the top of the officer's radio's which allows staff to have instant talk through on the radio network in an emergency situation.

- *For alternative radio ear pieces to be sought as the current ones are too big and fall off the ears of some staff.*
- *To ensure that there are extension pieces available for the night guard belts, as the length of the current belts are not suitable for all staff.*

Information received from the governor who chaired this de-brief meeting advised that all of the action required was taken.

Police Investigation

At 06.19 on 22 May 2011, CCTV shows PSNI officers arriving on Roe 1 Landing and a police investigation into the circumstances surrounding Aaron's death commenced. CCTV shows that Aaron's body was not removed from the scene until 17.26 on 22 May.

The Police subsequently notified the Prisoner Ombudsman that, Aaron's death was *"non suspicious."*

During the early hours of the police investigation, the police ordered that there should be no communication of the incident to anyone outside of the landing, including Aaron's family, until they authorised this. Both the Prisoner Ombudsman and an IMB member made it known that they were unhappy with this decision, because of the possibility of news of the death being leaked to the family inappropriately.

The Coordinating Chaplain at Maghaberry Prison provided the following account of events on the Sunday morning of Aaron's death:

ECR rang both Church of Ireland Chaplains before 08:30 to ask them to break the news to the family of the death of their son. (name redacted) was unable to undertake the task as he had 3 church services that morning. The other, (name redacted) was prepared to do so, but before he did so, he received a second call at 09:10 from Duty Governor to countermand the first request. Since PSNI had deemed it to be a scene of crime, the notification of the family was the responsibility of the Police Liaison officer.

(name redacted) rang me at 09:30 to inform me of the death in custody; as Coordinating Chaplain I made my way to the jail, and arrived after 10am.

Aaron's mother explained that she was not informed of Aaron's death until 10.45am when two police officers visited her home to break the news to her. Some time later she checked text messages, some received before 10.45am, and found a number telling her that there was an incident at Maghaberry and one asking her if it *"was true that Aaron had died."* She said that she could not imagine how she would have felt if she had happened to check her messages before the police arrived.

The delay in notifying Aaron's family of his death was very regrettable.

Incident – Quakers Visitor Centre

In response to the Prisoner Ombudsman's 'Notices of Investigation' that were displayed throughout Maghaberry Prison, the investigation was informed that there was a 'significant incident' in the Quakers Visitors Centre on the morning of Aaron's death.

The investigation found that on the morning of 22 May 2012, visitors who were due to see two prisoners on Aaron's landing were aware that there had been a death on the landing, but had not been informed that it was not their family members who had died. It is understood that the visitors concerned were deeply distressed.

At interview, the centre manager said that when he attempted to contact Maghaberry's security department to find out if the visitors' loved ones were safe, he was told that *"NIPS cannot comment at this stage"* and *"you'll have to go through the family officer."* The manager said that after 35 minutes, and through his persistence, he was informed that the two prisoners he was enquiring about were safe. The manager said that the role of the Quakers centre is to provide support to families, which he said was very difficult, given the uncertainty.
It is to note that Maghaberry staff were in fact trying to protect the confidentiality of the Hogg family until such time as the family themselves had direct knowledge of the death of their son.

It is again very regrettable that the PSNI requirement for an extended delay of any communication to those affected resulted in the distress caused to other families.

SECTION 10: ISSUES ARISING FROM AARON'S CARE IN PRISON

Introduction

The investigation found that there were many respects in which Aaron did not act in his own best interest. It was noted, in particular, that Aaron:

- Did not tell staff on the landing or healthcare staff about the deterioration in his mental health. (Although Aaron did try to alert staff to his need for help in a note written for him four days before his death.)
- Stopped taking his Sertraline and refused to discuss this with a doctor.
- Asked visitors to source illegal substances for him.
- Did not take his tablets as prescribed.
- Took non-prescribed medication and Cannabis.

A significant number of issues of concern have, however, also been identified as a result of the investigation into Aaron's death. These are detailed in the sub-sections that follow.

SECTION 10A: AAARON'S TIME IN THE SPECIAL SUPERVISION UNIT (SSU)

One of the questions raised by Aaron's family was why he was kept in the SSU for nearly seven weeks.

As previously stated, on 27 February 2011, Aaron was moved to the SSU as a result of a violent incident which took place between Aaron and another prisoner. Aaron remained in the SSU until 12 April 2011.

The SSU is a part of Maghaberry Prison used for accommodating prisoners away from the mainstream prison population, usually with significant limitations on their access to the normal regime and little out of cell time. Prisoners can be held in the SSU as a punishment following adjudication, for good order, for their own safety or, pending an adjudication under Prison Rule 35(4). More recently, the unit has been re-named the Special Care Unit (SSU) but, at the time of Aaron's death, it was still known as the SSU.

On 27 February, Aaron was located in the SSU under Prison Rule 35(4). Prisoners can only be held under this rule, for up to 48 hours and only where it is considered that they pose a continuing threat to good order and discipline or, will likely interfere with witnesses/evidence.

In line with Prison Service policy, Aaron was notified of the reason why he was being kept in the SSU and his stay was authorised by a governor.

On 1 March, Aaron's continued restriction of association was authorised under Rule 32(2)[29]. Prison Service policy states that prisoners will only be placed under Rule 32(2) restrictions with the written authority of the governor, who may authorise an extension for up to 72 hours. The rule states that requests for extensions of more than 72 hours must be considered and, if necessary, authorised

[29] Prison Rule 32(2) allows the Governor of a prison to restrict a prisoners association by holding them in the SSU for good order or discipline, or to ensure the safety of officers, prisoners or any other person, or for the prisoners own interest. A prisoner's association under this rule may not be restricted under this rule for a period of more than 72 hours without the agreement of the Department of Justice.

in writing by the Deputy Director[30], Head of Operations at Prison Service Headquarters, acting on behalf of the Department of Justice. The policy also states that Rule 32 Boards will be convened as required to assess the continued need for such restrictions.

The policy notes that *"Rule 32 will only be used in those exceptional cases where it is not possible to accommodate prisoners in normal location. Rule 32 will only be imposed for as long as necessary and any review will take into consideration the requirement to provide an action plan to facilitate a return to normal location. Isolation long term is potentially detrimental to a prisoners well being."*

On 1 March, Aaron's continued restriction of association was authorised in line with Prison Service policy.

On 2 March, a Rule 32 Review Board was convened to consider a further extension of Aaron's restriction of association under Rule 32. In attendance were two officers from the SSU, an Independent Monitoring Board (IMB) member and a residential governor (name redacted) who acted as Chairperson. A record of the meeting states *"Adjudicating Governor has referred the incident to the PSNI for investigation. Given the seriousness of the alleged offence it is recommended a continuation of Rule 32 for 14 days."*

At interview, the governor who chaired the review stated that *"we reviewed the reasons why Aaron was in the SSU....We discussed his current behaviour - a lot of that comes from the SSU Manager and the staff and the staff notes, and, in some cases it would be the comments from the individual themselves - how they feel and where they are at that point in time. And then, what we do then, we bring the individual in and have a conversation with them and just discuss it. And in some cases challenge them, if their behaviour's still quite adverse."*

Under Rule 32, the governor had the option to recommend Aaron be returned to normal location or have his stay in the SSU extended for a period of up to 28 days.

[30] The Deputy Direction, Head of Operations may delegate responsibility for considering extension of Rule 32 requests to Senior Staff from Prison Service Headquarters acting on his behalf.

At interview, the governor said that the reason he recommended an extension of up to 14 days was that *"I was notified that the case review was due, the case review was organised by the Unit Manager. I chaired it.....we spoke to Aaron at the time. My decision was based on the evidence of how his behaviour had progressed satisfactorily and he had moved on. He had contributed to that and he was engaging well with staff and I recommended that he remain on Rule 32 to try and get organised a strategy to remove him from the SSU at that time.....I didn't have enough information at that moment in time, to remove him completely but I recommended for a reduced period of time, for the Unit Manager to work on an exit strategy and that was to put together the right mechanisms to remove him from the SSU...The rationale behind that is you're moving from quite a sort of bleak confinement area to back in the normal population. You want to make sure that transition is as smooth as possible for the individual..... Because of his behaviour, it was deemed necessary that anything over 14 days, in my view, would be excessive."*

Whilst it would appear the governor's reason for this extension was to allow time for an exit strategy to be put in place for Aaron to return to normal location, this was not documented in the summary of the Rule 32 Review Board that he chaired. There is also no record of the discussion that took place with Aaron.

In line with Prison Service policy, the Board's recommendation was considered, and agreed by an *"authorising person on behalf of the Department of Justice."*

On 14 March, a further Rule 32 Review Board was convened and chaired by a different governor. With the exception of one officer, those in attendance were different from the staff that convened the Review Board that was held on 2 March.

The recommendation subsequently put forward by the Board was recorded as follows:

"The committee met to discuss the options of Aaron Hogg with regard to his Rule 32 position. He was placed on Rule 32, following a serious assault on another inmate in Lagan House, which resulted in the inmate requiring treatment at an outside hospital. Although Hogg was compliant towards the Special Supervision Unit regimes during his stay in the Unit, it was felt by the committee that due to the

serious nature of the assault, he still posed a risk to other inmates at this stage. Consequently, the recommendation of the committee would be to seek an extension of Rule 32 for a period of up to 28 days."

At interview, the governor (name redacted) who chaired the review board said, *"I think the key here is up to 28 days and obviously that can be reviewed at any time during that period..... and indeed obviously the person signing off has the discretion to alter that as well"* (the authorising person on behalf of the Department of Justice).

The governor said that the reason that he thought that Aaron was not ready to be returned to normal location was because of Aaron's demeanour when he was interviewed as part of the review. The governor said, *"at one stage during the case conference they brought him in for interview and he displayed signs of very concealed aggression at that stage...Indeed one of the questions I posed to him was, was he a racist or did he have a problem, a difficulty with anybody from another country or background and he said that he didn't but he seemed to get a bit agitated when I posed those questions. I referred to his previous record and indeed the charges that he faced through the courts or would be facing through the courts and there seemed to be an underlying anger issue there....And certainly he was somewhat agitated because he said well the reason he had attacked this person was because he was wearing a top belonging to him and I said, well do you not think there was other ways of perhaps addressing that problem but he just... he saw it as really his right to deal with this in the way that he did."*

It is to note that, in a telephone conversation of 14 March, Aaron said that he had seen the governor and that the governor asked him if he had problems with foreign nationals and whether he had any history with them outside. Aaron said that he (the governor) was asking if he gets into violence outside and Aaron told him it was none of his business. Aaron also said that he was told that he was going to be kept in the SSU until the police investigation had been concluded and when he asked how long that would take the governor said that it could take up to three months.

There is, again, no written record of the discussion with Aaron in the review notes. It is to note that the 'Behaviour Record' for that day, which was written by an

officer on Aaron's landing, records that Aaron *"complied with all regime requirement, good interaction with staff, nothing adverse or unusual to report."* It is also to note that all of Aaron's behaviour records throughout his period in the SSU indicated that his behaviour and attitude towards staff was to a high standard at all times.

The recommendations of the Review Board were assessed by the *"authorising person on behalf of the Department of Justice"* (name redacted) and, having carried out his own interview with Aaron, he supported the recommendations of the Review Board to extend Aaron's stay in the SSU for up to a further 28 days. At interview, the authorising person also said that Aaron showed signs of aggression during his interview with him and further emphasised that the extension was for a period of up to 28 days.

The investigation found that there are no written guidelines for governors, or those persons authorising Rule 32 extensions on behalf of the Department of Justice, to determine what factors must be taken into consideration when making recommendations or to determine the appropriate length of an extension. As explained, the governor who chaired the review board on 2 March thought that an extension of Aaron's stay for up to a further 28 days would have been *"excessive."* The governor who chaired the review board on 14 March thought, however, that an extension of up to 28 days (and possible longer according to Aaron's account) was reasonable, based on his interview with Aaron.

During the interviews with those who made the recommendations to extend Aaron's period of stay in the SSU, or who authorised them (all of whom were senior governors), much emphasis was placed on the fact that any extension of Rule 32 is for a period of up to the period being authorised and that it is up to the SSU manager, a senior officer grade, to convene a Review Board when they think the person should be returned to normal location. Despite Aaron's exemplary Behaviour Reports whilst in the SSU, there is no evidence that a review was ever considered before the expiry date of each period of extension.

SECTION 10B: ISSUES RELATED TO THE COMMITTAL PROCEDURE

Checking of Prison Medical Records

For each of the occasions that Aaron was committed to prison, there is no evidence that healthcare staff read his previous prison medical records. His prison medical history was not, therefore, considered at the committal healthcare assessment or recorded when committal documentation was completed. In his clinical review report, Dr VandenBurg stated that, in his view, there was a need to read all previous records to ascertain Aaron's medical history.

Given that it was known on committal that Aaron was taking Quetiapine, an antipsychotic drug and Sertraline, an antidepressant and might, therefore, be a prisoner at risk, there was a particular case for fully checking his prison medical history to see what relevant information might be immediately available.

Follow up of Missed Hospital Appointment

When Aaron was committed on 20 September 2010, he informed healthcare staff that he had, that day, missed an appointment at the Mater Hospital to investigate the possibility of him having Cushing's Disease[31]. There is no evidence that any follow up action to ascertain the reason for the appointment, or to reschedule a further appointment for him was considered.

Community GP Records

As evidenced in Section1 of this report, Aaron's community medical notes contain detailed information about his personal circumstances, mental health issues, extreme sleep problems, addiction problems, self harm history and diagnoses. Aaron's notes were never requested by healthcare staff at Hydebank Wood or Maghaberry prisons even though he was known to be taking antipsychotic and antidepressant medication.

31 Cushing's disease is caused by a tumour or excess growth (hyperplasia) of the pituitary gland. This gland is located at the base of the brain. People with Cushing's disease have too much adrenocorticotropic hormone (ACTH). ACTH stimulates the production and release of cortisol, a stress hormone. Too much ACTH means too much cortisol. Cortisol is normally released during stressful situations.

Commenting on the absence of these medical records, Dr VandenBurg stated *"The community medical records show that Aaron's problems are far greater than any simple diagnostic category and illustrate the fact that mental health problems, particularly where there is an interaction of behavioural problems, personality issues, complex symptomatology and various mental health diagnostic criteria, interact with social difficulties."*

Dr VandenBurg concluded that a review of Aaron's GP records *"would have made clear to any competent doctor that this was a patient at high risk."* He goes on to say *"For this to have been accomplished, it would be my suggestion that those instructing recommend that just as GP records follow a patient from GP to GP, that they follow a patient into a custodial situation."*

It is to note that the South Eastern Health and Social Care Trust's *'Key Performance Indicators 18/19 No.4'* does state that a prisoner's GP should be contacted as soon after committal as possible.

SECTION 10C: REFERRAL TO MENTAL HEALTH SERVICES

One of the questions raised by Aaron's family was whether he was seen by a psychiatrist whilst in prison.

It is the experience of the Prisoner Ombudsman that different psychiatric specialist clinical reviewers have offered different responses to this family concern, in similar circumstances. Some specialists have argued that anyone committed to prison that is under the care of a psychiatrist in the community and taking antipsychotic medication, should be referred to the prison mental health team and a psychiatrist.

It is the case that those taking antipsychotics in prison are at risk of death in custody, through many different causes.

In the case of Aaron, Dr Rix stated *"It does not appear to me, as a psychiatrist, that the deceased received anything other than proper medication and medical treatment in prison. This is not an expert opinion as the deceased's treatment was in the hands of what I take to have been general practitioners and non psychiatric nursing staff."*

Dr Rix said that *"The deceased gave no indication to prison health care professionals that his mental health was a cause of concern. There was no reason for referring him to a psychiatrist."*

Dr Rix did, however, also say that *"It is very probable that if the deceased had seen a doctor between 19 and 21 May 2011* (the two days before Aaron's death) *he would have been referred for assessment by a mental health professional if not by an actual psychiatrist. Even if the deceased had been seen by a psychiatrist between 19 and 21 May 2011 it is uncertain if the outcome would have been any different. As in the past, he may not have admitted to his multiple drug misuse. However, in view of his history and likely presentation, if he had told a prison doctor or a mental health professional that the voices were driving him to contemplate suicide, this would have resulted in the deceased being treated as a potential suicide risk and although this would not have made suicide impossible the likelihood of suicide would have been reduced."*

Aaron was never referred to mental health or psychiatric services during any of his times in prison. It was, however, the case that the prison healthcare teams prescribed antipsychotic and antidepressant medications for him and his previous and current prison medical records noted that he had been seeing a psychiatrist in the community and more recently that he had been admitted to the Mater Hospital's psychiatric ward.

The South Eastern Health and Social Care Trust guidance notes for referrals to the mental health team include, amongst others, the following reason for referral:

"Major mental illness such as Schizophrenia, Chronic Depression or Bipolar effective disorder, and is on an Antipsychotic/Neuroleptic medication or a mood stabiliser."

Aaron did not have a diagnosis of a major mental illness, but he was taking antipsychotic and antidepressant medication and, in the absence of a request for his community medical records, staff did not know what his diagnosis was. There was also evidence in his community medical notes that he may have satisfied other criteria in the referral policy where a referral to the mental health team, a psychiatrist or other support services might be considered. In the event, Aaron was not offered psychotherapeutic or other interventions, for his mental health problems. He was also not offered any support for his self reported addiction problems.

On 13 April 2011, a nurse found Aaron to be storing his antipsychotic medication. It would appear, from his telephone calls that one of the reasons that Aaron did this was because of his difficulty sleeping, a problem that is comprehensively documented in his community medical records. There is no evidence that any consideration was given as to why Aaron was hoarding his antipsychotic medication.

It is to note that a further indication that Aaron might have a problem with drugs occurred when he was seen to receive and swallow an item in a cup during a visit. Whilst he was charged in connection with this incident, there is, again, no indication that this was discussed with him or that a referral to drugs counselling services was considered.

SECTION 10D: RISK ASSESSMENT ARRANGEMENTS FOR IN-POSSESSION MEDICATION

During Aaron's time in prison, healthcare staff had the option of issuing him with his medication either supervised (to be taken in front of a nurse), daily in-possession (IP), weekly IP or monthly IP. The Northern Ireland Prison Service In-Possession Medication Policy, at the time of Aaron's committal and death specified that Aaron's antipsychotic medication should be treated as a medication at high risk of overdose and with a high currency value.

The Policy specifies three areas to be taken into account when making in-possession medication assessments:

- Patient factors e.g. whether a patient has a history of overdose or self-harm
- Environmental factors e.g. whether the prisoner is sharing a cell
- Medicine factors e.g. how potentially dangerous a medicine is in overdose

The risk assessment is made on an individual basis at a particular point in time. The checklist of risk factors acts to support the member of healthcare staff in reaching their decision. It is intended that they should record in the 'clinical comments' section of the assessment the rationale for their decision. The healthcare staff member and the prisoner must both sign the IP Risk Assessment.

When Aaron was committed to Hydebank Wood on 20 September 2010, an IP risk assessment was carried out and the nurse assessed him as suitable for daily IP. Between 5 and 16 October, Aaron was given his medication for four days IP, three days IP and a further three days IP before being placed on weekly IP on 16 October. There is no evidence that any further IP risk assessment was carried out, at the time when Aaron's medication administration arrangements were changed.

Following his transfer to Maghaberry, a further risk assessment for In-Possession Medication was completed on 19 December. It is not clear why this risk assessment had not been carried out before as Aaron had already been issued with medication in-possession since arriving in Maghaberry Prison. The nurse who completed the risk assessment recorded that Aaron had a history of self harm and

that he had attempted to hang himself in 2007. She noted also that Aaron's medication had a high risk from overdose and that he had a history of depression. The nurse concluded that Aaron was suitable for weekly in-possession (IP) medication and he was issued with his medication.

Aaron remained on weekly IP until 27 February 2011, when he was placed on supervised swallow following his transfer to the Special Supervision Unit (SSU).

Between 7 February and 12 April 2011, Aaron remained in the SSU on supervised swallow. On 13 April, when Aaron returned to normal prison location, he was returned to weekly IP. Again, there is no evidence that an IP risk assessment was carried out. It is also to note that on 13 April, Aaron was found to have been stockpiling his medication and a nurse recorded that he was to remain on supervised swallow.

Aaron remained on weekly IP until 9 May. He was then, again without a risk assessment, given a month's supply of his Quetiapine 100mg tablets and a 10 day supply of his Quetiapine 25mg tablets IP. It is to note that Aaron was not due a further issue of his medication until 11 May. On 18 May, Aaron was given a further 10 days supply of his Quetiapine 25mg tablets and on 19 May, a further 8 days.

At the time of Aaron's death, if he had been taking his Quetiapine as prescribed he should have had 96 x 25mg tablets and 17 x 100mg tablets remaining. It was the case, however, that police found just one Quetiapine 25mg tablet in his cell.

In his clinical review Dr VandenBurg, commenting on the last IP risk assessment completed on 19 December 2010, said *"not only was this form filled in at best carelessly and at worse negligently, I am surprised that I have not seen a record of it having been repeated at any time."*

The risk assessment includes the following areas of concern:

- The question *"Does the prisoner have a history of substance misuse/ dependency?"* is answered *"no."* There is, however, evidence in prison

medical records on 11 March 2008 of *"Drug misuse behaviour" "HO (history of) deliberate self harm outside prison took tablets"* and on 7 September 2009 that Aaron was a self reported *"binge drinker"* and *"admitted to using drugs in the past month of E's (Ecstasy), Cocaine and snorting speed (amphetamines)."*

- The response to the question *"Is the prisoner a target for bullying?"* is answered *"no."* Prison medical records clearly state on 7 September 2009 that Aaron had received punishment beatings from paramilitaries. It is not, therefore, unreasonable to conclude that he could be vulnerable in prison.

Dr VandenBurg said that he was particularly surprised that no other in-possession risk assessment was documented after the events of 13 April 2011, when Aaron was found to be storing his antipsychotic medication.

Dr VandenBurg concluded that *"This level of carelessness is I believe inexcusable. If a Risk Assessment is to be done, it should be accurate, repeated on an ongoing basis, interpreted correctly and actioned appropriately. There is no evidence this took place."*

As previously mentioned, there is evidence in Aaron's telephone calls with his family that he felt better in himself when on supervised medication in the SSU.

SECTION 10E: ADEQUACY OF PRISON HEALTHCARE RECORDS

EMIS[32] was introduced in 2007 and is intended to be the means by which healthcare staff can efficiently access patient medical information. The record includes a summary which captures important information under a number of different headings. It is intended that the summaries can provide staff with easily accessible key medical information relevant to decision making.

In his clinical review, Dr VandenBurg comments that the *"summary"* of Aaron's active and past problems on EMIS is *"completely inadequate given the content of the prison medical records."* Dr VandenBurg said that, in his opinion, if the summary of Aaron's active and past problems had fully reflected the prison medical records, staff would have been more aware of Aaron's mental health, past problems and the possible consequences.

The investigation found that the reason that the summary section of Aaron's healthcare records are *"inadequate" is* because healthcare staff are not selecting the correct *"drop down box"* when inputting their EMIS entries. For example, the investigation found that, on 20 September 2010, when a nurse recorded that Aaron had an outstanding appointment in the Mater Hospital to investigate whether he had Cushing's disease, this was filtered into the '*Other Observations*' section of the summary pages instead of into the '*Overdue Diary Entries*' area. A review of the '*Other Observations*' section of Aaron's medical records shows that this section is being used incorrectly and important information could, therefore, easily be missed.

[32] EMIS – Egton Medical Information System is the database in which a prisoner's medical information is recorded.

SECTION 10F: THE MANAGEMENT OF DRUGS IN PRISON

Drug Availability

In phone calls, Aaron commented on the availability of illegal substances in Maghaberry and said that he could get drugs quicker in prison than he could on the outside. It was also evident from phone calls that Aaron was sourcing steroids and other substances from outside of prison. Real time monitoring of Aaron's later phone calls would have highlighted this to prison staff, particularly as it was evident that Aaron was, at times, not taking his prescribed medication correctly and appeared to receive and swallow an illicit substance during a visit.

Interviews with other prisoners and the results of Aaron's autopsy clearly evidence the extent to which Aaron was abusing prescribed and illicit drugs in prison.

Drugs have played a part in several of the deaths in custody investigated by the Prisoner Ombudsman and concerns about the availability of illicit drugs in prison, the abuse of prescribed medicines and the need to address this vigorously has been highlighted in previous Death in Custody investigations. The Prisoner Ombudsman has emphasised the need not only to address drug supply and related bullying issues, but also the requirement to ensure that the delivery of adequate addiction services, drug testing, drugs counselling services, purposeful regime and care of vulnerable prisoners, are fully addressed, in a joint up way, in the drugs prevention strategy.

Staff Response to Aaron's Slurred Speech 11 April, 9 May and between 15 and 21 May 2011

In phone calls on 11 April, 9 May and in the days leading up to Aaron's death, it can clearly be heard that his speech is slurred. This is noted to be the case on 15 May 2011 and it is again noted on 19 May 2011, when Aaron tells the person called that he has over 150 tablets stored and is taking them to go to sleep. Aaron also says that he is hearing voices that are telling him to kill people and that he is close to being suicidal.

Prison staff would have been unaware of the content of Aaron's phone calls but should have known from their contact with Aaron that his speech was slurred and, as a minimum, sought medical advice as to whether this was caused by an adjustment to Aaron's medication.

Aaron's speech is again heard to be slurred during two calls on 20 May and he tells the person called about taking some *"blues"* (Diazepam). On 21 May 2011, Aaron's last phone call, his speech is again slurred.

The investigation found no evidence that prison staff took action, at any time, in response to a concern that Aaron may have been taking illicit drugs or too much prescription medication.

As well as requesting an assessment by a nurse, actions that might reasonably have been considered by staff include carrying out cell searches to look for illicit substances and/or stored medication, additional drugs testing and real time monitoring of phone calls. Crucially, staff might also have considered opening a SPAR (Supporting Prisoner at Risk Booklet)[33] which would have led to regular observation of Aaron and a case conference to assess his care needs.

Aaron's Letter to Staff Regarding His Loss of Visits

As noted earlier, on 18 May 2011, a member of staff who spoke with Aaron after his visits were suspended assisted him in writing a note. In the note Aaron said *"I need to talk to somebody about my problems both personal issues and about my difficult time in prison."* Regrettably, this opportunity for staff to find out about Aaron's medication and illicit substance misuse and mental health difficulties was not acted upon.

Drugs Tests

Aaron's prison records show evidence of only one drugs test during his five and a half months in Maghaberry.

[33] Supporting Prisoners at Risk (SPAR) booklets are used at times when staff deem an inmate as vulnerable to self harm and suicide - to provide increased observations and support for inmate.

SECTION 10G: USE OF STEROIDS

In Aaron's phone calls he persistently asked for steroids to be brought into prison and says *"I can't go to the gym without them, because everyone has them."*

The gym manager at Maghaberry (name redacted) advised that, where there is evidence a prisoner is using steroids, he would be put forward for a drugs test. The manager said that the Prison Service's drug testing policy does not routinely test for steroids, in part because of the cost. He said that prisoners are very seldom put forward for a steroid drug test because it is difficult to obtain evidence that they are taking steroids. He said that, unless a prisoner starts lifting weights that are far heavier than they were lifting previously, there is no way of knowing. The gym manager said also that even where gym staff discuss with a prisoner any concerns about the weight being lifted, the prisoner will say that they have started taking protein shakes, which can be bought from the tuck shop.

Information provided by the governor in charge of the drug testing unit (name redacted) shows that in the past 12 months, three prisoners have been tested for steroids. All three tested positive. The cost of each steroid test was found to be £210 plus VAT.

In his clinical review report, Dr VandenBurg stated that most clinicians would now accept that, although it has not been proven beyond doubt, anabolic steroids cause mental health problems. He stated that *"in those who are pre-disposed to psychosis, mania and depression, it is highly likely that anabolic steroids would make them worse or cause a recurrence of symptomatology (the combined symptoms of a disease.)"*

Advisory posters and leaflets are available in the gym and accommodation blocks informing prisoners of the risks of taking steroids. These posters do not, however, inform prisoners of the risk of taking steroids whilst on some prescription medication.

The gym manager stated that he did not know Aaron personally, and that his staff had not talked to him about being a potential steroid user.

SECTION 11: FINDINGS OF THE INDEPENDENT CLINICAL REVIEWS

Clinical reviewers

Dr Keith Rix is a consultant psychiatrist and specialist in forensic psychiatry. Dr Malcolm VandenBurg is a specialist in general medicine and a consulting pharmaceutical physician

Findings

The findings of Dr Rix and Dr VandenBurg have been included at appropriate places throughout the report.

The following is a summary of other observations they make.

Dr Rix Clinical Review

Dr Rix, in line with his area of expertise, used his clinical review to comment on mental health indicators. He did not comment on other administrative, organisational or systems issues relevant to Aaron's care.

Aaron's Diagnoses

Dr Rix said that there was no convincing evidence that Aaron suffered from a psychotic mental illness. He noted references to *"paranoia"* but said that it appeared that Aaron's suspicions and fears were based in reality.

Dr Rix also said that there was no convincing evidence that Aaron suffered from a depressive illness or what is sometimes called *"clinical depression"* or from Attention Deficit Hyperactivity Disorder (ADHD) or Post-Traumatic Stress Disorder (PTSD). Dr Rix said that the only symptom that was suggestive of PTSD was Aaron's hyper vigilance which he said, in his case, was normal and not pathological, because he had good reason to be vigilant.

Dr Rix noted that Aaron had been thoroughly assessed in the community and he concluded that it was more probable than not, that Aaron had a personality disorder with psychopathic or anti-social, narcissistic and emotionally unstable features.

Medical Treatment in Prison

Dr Rix said that whether or not Aaron received the proper medical treatment in prison depended upon his diagnosis. He noted that Aaron gave no indication to health professionals that his mental health was a cause for concern. This being the case, he felt that *"having regard to what these health professionals knew or could reasonably have been expected to know"* there was no reason for referring Aaron to mental health professionals or a psychiatrist.

Dr Rix pointed out that for the period of time that Aaron was in the SSU, he had an almost daily assessment by a nurse and on no occasion did Aaron voice any complaints about his mental health. (It is to note, however, that during this period of time, Aaron was placed on supervised swallow and it was possibly the only time that he had taken his medication as prescribed. There is also evidence in Aaron's phone calls that he "felt better" in himself whilst taking his medication regularly in the SSU.)

Dr Rix did say that *"it is very probable that if the deceased had seen a doctor between 19 and 21 May 2011 he would have been referred to a mental health professional if not an actual psychiatrist."* He added that *"even if the deceased had been seen by a psychiatrist between 19 and 21 May 2011 it is uncertain if the outcome would have been any different."* He noted, however, that pseudo-hallucinatory voices[34] occur in some people with personality disorder and these complaints were similar to ones Aaron had made previously. He said that, in view of his history and likely presentation, if Aaron had told a doctor or mental health professional that the voices were driving him to contemplate suicide, this would

[34] A **pseudohallucination** is an involuntary sensory experience vivid enough to be regarded as a hallucination, but recognised by the patient not to be the result of external stimuli. In other words, it is a hallucination that is recognized as a hallucination, as opposed to a "normal" hallucination which would be perceived as real. An example used in psychiatry is the hearing of voices which are **inside the head** according to the patient.

have resulted in him being treated as a potential suicide risk. He said this would not have made suicide impossible, but it would have reduced the likelihood.

Dr Rix said that it was unfortunate that Aaron did not take the advice of those he spoke with on the telephone and speak to a doctor.

Medication in Prison

Dr Rix said that Quetiapine is used in people with personality disorder, as in Aaron's case, to target anger, aggression, agitation, impulsivity and mood swings. He said that whilst the evidence for its use is not very strong, it is strong enough for its use to be supported by a responsible and reasonable body of medical opinion. Considering Aaron's Sertraline prescription. Dr Rix said that the indication for this was questionable as Aaron did not have clinical depression. However, as Aaron had said that he experienced some benefit when it was first prescribed, he said that it was reasonable to continue it in prison, as a psychiatrist had not said it should be stopped.

Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services

The South Eastern Health and Social Care Trust's 'Prison Health Performance Audit – Measures of Quality' relies on the Department of Health's 2009 *'Promoting Quality Care. Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services'*, to measure the quality of care being provided to prisoners. When Aaron was committed into custody, he should have been identified as being subject to this guidance, because he was under the care of mental health services in the community. Aaron was not identified and, as a result, there was a failure to apply the *"Care Programme Approach.*[35]*"*

Commenting on the fact that there was a failure to apply the 'Care Programme Approach [CPA]' for Aaron, Dr Rix said that on 29 July 2010, when Aaron was last assessed by a psychiatrist in the community, the psychiatrist's plan was to review

[35] A Care Programme Approach is the process by which mental health services assess users, identify needs, plan ways to meet them and check that they are being met.

him in three months and discharge him if his symptoms were stable. Given that this was the case, it was Dr Rix's view that if the CPA had been applied when Aaron was committed on 20 September 2010, *"he would probably have been discharged from it by the end of October 2010, because his condition remained stable."*

Dr VandenBurg's Clinical Review

Aaron's Diagnoses

Dr VandenBurg said that he would leave Aaron's diagnosis to Dr Rix as a specialist in psychiatry.

He commented, however, that that Aaron clearly *"could not be trusted to act in his own best interest"* and *"this should have been flagged."* He noted that Aaron stopped taking his antidepressant; asked his visitors to source illegal substances for him; signed declaration forms for In-Possession medication and did not comply with the responsibilities applied to him; did not take his medication as prescribed; took many non prescribed medications and Cannabis and did not tell healthcare staff that he was thinking of self harm. Dr VandenBurg said that *"this should surprise nobody and is a feature of patients with similar mental health issues to Mr Hogg and adequate care involves understanding and counteracting the patient's desire to be 'unhelpful'."*

Dr VandenBurg said that Aaron's problems were far greater than any simple diagnostic category *"and illustrate the fact that mental health problems, particularly where this is an interaction of behavioural problems, personality issues, complex symptonatology and various mental health diagnostic criteria, interact with social difficulties."* He said that *"treatment of such patients is difficult, few drugs have been well researched and psychotherapeutic interventions are largely unproven. They are particularly difficult in patients where the history begins at as young an age as him, and there is a clear inter-relationship with social and cultural factors…"*

Medical Treatment in Prison

In light of the above, Dr VandenBurg said *"It is surprising to me that throughout his time in prison Mr Hogg did not see a psychiatrist and that nobody thought that as he*

was seeing a psychiatrist in the community, had a booked appointment that was to be missed, that such specialist consultant care should be ongoing in custody."

Dr VandenBurg also noted concerns about a number of other aspects of Aaron's care including: the failure to request his community medical records and to check prison medical records; lack of follow up of hospital appointments; the failure to identify Aaron as a prisoner at risk and to seek input from the mental health team; the availability of medication and illicit substances in Maghaberry; the inadequate completion of committal paperwork and the lack of consideration of therapeutic inputs. These issues have been discussed earlier in this Report.

Medication in Prison

Dr VandenBurg noted significant concerns about the risk assessment and decision making related to Aaron's medicine administration arrangements. He said that *"If a risk assessment is to be done it should be accurate, repeated on an ongoing basis, interpreted correctly and actioned appropriately. There is no evidence this took place."* Dr VandenBurg also noted that Aaron's Quetiapine administration was variable without explanation, that confirmation of his medicine in the community was incorrectly recorded and that his sleep problems were not identified and addressed.

Overall Assessment

Dr VandenBurg concluded *"This review highlights several episodes where healthcare procedures, treatment and assessment of risk are inadequate. This occurs so frequently that…the entire system appears to need attention."* He added *"I do not minimise the difficulties of integrating adequate care and protection of those with mental health issues into a penal system."*

SECTION 12: FACTORS WHICH MAY HAVE CONTRIBUTED TO AARON'S DEATH

Aaron's family asked why he died by suicide.

In one of Aaron's last phone calls, when he was describing the voices he was hearing in his head, he said that he was coming close to being suicidal, but that he wouldn't kill himself in Maghaberry, because people would think that he *"couldn't hack it."*

It was very evidently the case that Aaron was abusing his prescription medicines and other substances during his time in Maghaberry. This was particularly evident during his last days in prison when Aaron's voice could clearly be heard to be very slurred when he was speaking on the telephone. During the conversations Aaron said that his *"head's melted,"* that the tablets were causing him to "*think slow*" and that he was *"embarrassed and paranoid"* because people thought he was a "*big idiot*" because he "*can't get his words out.*" He said they were calling him "*Dopey Hogger.*"

It was also clearly the case that Aaron was stockpiling medication to take at night because of his sleeping difficulties.

In his final calls Aaron was also heard to reflect on past events involving paramilitaries and the impact these had had on him. He talked also about hearing the voices and *"two people in his head telling him what to do"* and he said that it was scaring him.

Aaron's involvement with paramilitaries from a young age; his paranoia and anxiety; his abuse of medication and illicit substances; his extreme sleeping difficulties and his experience of threatening auditory hallucinations are well documented in his community medical records. It is particularly to note that in 2007, when Aaron was experiencing similar hallucinations, he was found preparing to hang himself. It is recorded that the *"suicide attempt by hanging"* was *"in the context of an overdose of sleeping medications."*

In his clinical review report, Dr Rix said that Aaron *"was at increased risk of suicide, [because] Childhood Conduct Disorder and antisocial or psychopathic disorder are disorders associated with an increased risk of suicide. He had a history of deliberate self-harm and this is also a risk factor for completed suicide."*

Dr Rix said also that it was probable that drug effects made a material contribution to Aaron's state of mind on the night of his death. He said that it was *"highly relevant"* that Aaron had taken benzodiazepines (Chlordiazepoxide and Diazepam) shortly before he died. He said that such drugs are contraindicated in people with personality disorder, such as Aaron, and *"they have been associated with the release of suicidal behaviour."* Dr Rix advises that the manufacturers of such drugs state that *"in the case of people with depression they should not be prescribed other than in combination with an antidepressant."* Aaron stopped taking his antidepressant medication on 17 February 2011. Dr Rix concluded that *"benzodiazepines could have caused him [Aaron] to act on suicidal ideas and disinhibited him"* and that *"it was probable"* that the Aaron's experience of auditory pseudo-hallucinations [hearing voices good and bad] *"contributed to his suicidal state."*

Dr VandenBurg also pointed out the direct and disinhibiting effect that Diazepam might have had on Aaron and said as well that, in people of Aaron's age, Quetiapine is associated with an increase in suicidal behaviour. He said that, as well as this, not taking his Quetiapine regularly would have made Aaron's mental health issues worse. He said that *"I have no doubt that his irregular use of Quetiapine was a major etiological factor"* and *"very high on the list of etiological factors was Mr Hogg being placed on In- Possession medication when he left the SSU."*

Dr VandenBurg said that *"Mirtazapine has similar warnings and patients are most at risk when the dosage is increased or decreased. A sudden change as could have happened in Aaron's case increases the risk, as does the fact that the Mirtazapine in the blood concentration was high."* He said also that *"the steroids could possibly have played a part."*

Dr VandenBurg concluded that "*the combination found within him would not have been helpful and their effects would have been at least additive, if not synergistic, particularly the two benzodiazepines (Chlordiazepoxide and Diazepam), with Mirtazapine and Quetiapine as well as the opioids (Codeine, Tramadol and DihydroCodeine). All of these can cause abnormal behaviours and the benzodiazepines could combine to produce disinhibited behaviour. His long term use of Marijuana could have been a precipitating factor."*

Both of the clinical reviewers also commented on the impact on Aaron of some of his visitors being banned and his other visits being restricted, from 11 May. Dr Rix said that *"it was probable"* that the fact that Aaron was restricted to closed visits would have had an adverse effect on his mental state, and probably made a material contribution to his suicidal state. Dr VandenBurg said that *"if the letter from his solicitor on 17 May and his statement of 18 May had been actioned, and he had been allowed to recommence visits from (names redacted) behind glass, his mood may have improved. I do understand that the authorities thought some form of reprimand was necessary, however, these visits appear to have been key to his well being."*

It is to note that, as well as being close to his banned visitors, there is evidence that Aaron was concerned about the effect of his visit restrictions on his ability to access prohibited substances.

Response of the South Eastern Health and Social Care Trust to Dr Rix's and Dr VandenBurg's Clinical Review Reports

Responding to Dr Rix's and Dr VandeBurg's clinical reviews, the South Eastern Health and Social Care Trust made the following comments:

"The Trust recognises that the reports appear to provide a fair and objective view in relation to the care that was provided to Mr Hogg by Prison Healthcare prior to the taking of his own life.

Prison Healthcare had not been aware that Mr Hogg was being managed in the community prior to committal under the 2009 Guidance (as revised in May 2010) but

as Dr Rix quite rightly highlights, even if Guidance had been applied, Mr Hogg would probably have been discharged from the 'Care Programme Approach'. This particular issue again highlights a probable deficit/break down of communication/links, in relation to the continuation of a care pathway for patient, between a Community Mental Health Team and the Prison Healthcare Team."

We are also encouraged by the overall comment of Dr Rix when he states *"It does not appear to me, as a psychiatrist, that the deceased received anything other than proper medication and medical treatment in prison".*

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

   - **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

   - Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
   - Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
   - In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
   - Provide explanations and insight for the bereaved relatives.
   - Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising 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 action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the

Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Minister for Justice (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Minister for Justice. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Minister for Justice.

16. Annex ‘A’ contains a more detailed description of the usual reporting procedure.

ANNEX A

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

3. The Service responds within 28 days. The response:
   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Minister for Justice. The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Minister for Justice. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Minister for Justice. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

APPENDIX 2

INVESTIGATION METHODOLOGY

Notification

1. On Sunday 22 May 2011, the Prisoner Ombudsman's office was notified by the Prison Service about Aaron's death.

2. A member of the Ombudsman's investigation team attended Maghaberry Prison on 22 May 2011 to be briefed about the series of events leading up to Aaron's death.

3. On 24 May 2011, Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison, inviting anyone with information relevant to Aaron's death to contact the investigation team.

Prison Records and Interviews

4. All prison records relating to Aaron's period of custody were obtained.

5. Interviews were carried out with prison management, staff and prisoners in order to obtain information about Mr Hogg and the circumstances surrounding his death.

Telephone Calls

6. Between 28 February and 21 May 2011, Mr Hogg made 117 telephone calls. All 117 telephone calls were obtained and listened to.

CCTV Footage

7. CCTV from Aaron's landing between 20 and 22 May 2011 was obtained and reviewed.

Maghaberry Prison

8. Background information on Maghaberry Prison is attached at Appendix 3.

Autopsy Report

9. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy report.

Clinical Review

10. As part of the investigation into Aaron's death, Dr Malcolm VandenBurg, Specialist in General Medicine and Consultant Pharmaceutical Physician, was commissioned to carry out a medical and pharmaceutical clinical review, whilst he was in prison. I am grateful to Dr VandenBurg for his assistance.

11. I am also grateful to Dr Keith Rix, Consultant Forensic Psychiatrist at The Grange Cleckheaton, who was commissioned to provide a report on whether Mr Hogg suffered from any mental health problems, and if so, whether these were adequately addressed in prison.

12. Dr VandenBurg's and Dr Rix's clinical review reports were forwarded to the South Eastern Health and Social Care Trust (SEHSCT) for comment. The Trust responded and I have included the comments made at the appropriate places in this report.

Criminal Justice Inspectorate/Other Reports

13. Previous recommendations made to the Northern Ireland Prison Service by the Prisoner Ombudsman and the Criminal Justice Inspectorate which are relevant to the circumstances surrounding Aaron's death have been considered as part of this investigation.

Factual Accuracy Check

14. I submitted my draft report to the Director of the Northern Ireland Prison Service and the Chief Executive of the SEHSCT for a factual accuracy check.

15. The Prison Service and SEHSCT responded with comments for my consideration. I have fully considered these comments and made amendments or included them where appropriate.

APPENDIX 3

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[36] and integrated[37] conditions.

Maghaberry Prison was built to accommodate 682 prisoners, however, there were 925 prisoners in Maghaberry on the day Aaron died.

Maghaberry Prison is one of three Prison establishments managed by the Northern Ireland Prison Service, the others being Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. Four Square Houses - Bann, Erne, Foyle and Lagan, along with purpose built separated accommodation houses of Roe and Bush, make up the present residential house accommodation.

There are three lower risk houses within the Mourne Complex of Maghaberry Prison, called Braid, Wilson and Martin Houses. These are usually used to house lifer prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU).

There is also a Landing within Maghaberry Prison called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Foyle House, which is used for housing poor coping prisoners who attend the Donard Unit[38].

[36] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.
[37] Integrated – general residential accommodation houses accommodating all prisoners.
[38] The Donard Unit has been specifically designed to facilitate purposeful activity for poor coping prisoners.

There is also a Care and Supervision Unit[39] (CSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.

The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and resettlement of which addressing offending behaviour is an element.

Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[40] (PREPS).

The last reported inspection of Maghaberry Prison by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[41] in Northern Ireland was in July 2009. Findings of a further inspection in March 2012 have not yet been reported.

[39] Care and Supervision Unit (CSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

[40] Progressive Regimes and Earned Privileges (PREPS) - There are three levels of regime. Basic - for those prisoners who, through their behaviour and attitude, demonstrate their refusal to comply with prison rules generally and/or co-operate with staff. Standard - for those prisoners whose behaviour is generally acceptable but who may have difficulty in adapting their attitude or who may not be actively participating in a sentence management plan. Enhanced - for those prisoners whose behaviour is continuously of a very high standard and who co-operate fully with staff and other professionals in managing their time in custody. Eligibility to this level also depends on full participation in Sentence Management Planning.

[41] Website link - http://inspectorates.homeoffice.gov.uk/hmiprisons/inspect_reports/547939/551446/maghaberry.pdf?view=Binary

APPENDIX 4

PRISON POLICIES AND PROCEDURES

The following is a summary of Prison Service policies and procedures relevant to my investigation. They are available from the Prisoner Ombudsman's Office on request.

Prison Rules

Rule 85(2) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – In the absence of the medical officer, his duties shall be performed by a registered medical practitioner approved by the chief medical officer and the Secretary of State.

Rule 85(2A) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – In the absence of the medical officer a registered nurse may perform the duties of the medical officer set out In rules 17(4) (medicine in possession on reception) 21(1) and (2) (medical examination on reception), 26(2) and (3) (transfer), 28(2) (discharge), 41(2) (award cellular confinement), 47(5) (daily visit in cellular confinement), 51(3) (fitness for work), 55(3) (fitness for recreation) and 86(4) (prisoners who complain of illness).

Rule 85(2B) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – If a prisoner is examined, seen, considered or visited by a registered nurse under the rules set out in (2A) and the registered nurse is of the view that it is necessary for the prisoner to be examined, seen, considered or visited by the medical officer he shall make arrangements for that to occur as soon as reasonably practicable.

Rule 85(3) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – Arrangements shall be made at every prison to ensure that at all times a registered medical officer is either present at the prison or is able to attend the prison without delay in cases of emergency.

Rule 32 Restriction of Association - Where it is necessary for the maintenance of good order or discipline, or in the Governor's own interests that the association permitted to a prisoner should be restricted, either generally or for particular purposes, the Governor may arrange for the restriction of his association

Rule 73(5) 'Control of Visitors to Prisoners' states that If there are reasonable grounds for suspecting that anyone visiting a prisoner is bringing in or taking out any article for an improper purpose, or contrary to the rules and regulations of the prison, or that his conduct may tend to subvert discipline or good order, the governor may suspend his visit and remove him from the prison.

Death in Custody Contingency Plan

The Death in Custody Contingency Plan provides step by step guidance for all staff in how to deal with and manage the death of a prisoner in custody.

Prison Service and Maghaberry's Policies

Northern Ireland Prison Service In-Possession Medication Policy (September 2008) In conjunction with the South Eastern Health and Social Care Trust, the Northern Ireland Prison Service's In-Possession Medication policy outlines how a prisoner will be assessed on their suitability for storing and taking their own prescribed medication.

Alcohol and Substance Misuse Policy (July 2006) details the Prison Service's aims of reducing the supply of substances subject to misuse, reducing demand, treatment and rehabilitation.

Maghaberry Prison – Special Supervision Unit Management Guidance sets out the procedures and actions that must be followed in relation to the accommodation, care, discipline and control of prisoners while in the Unit and their subsequent relocation to normal accommodation. It also details when prisoners will be subjected to closed visits.

Self Harm and Suicide Prevention Policy (February 2011)

The Prison Service Self-Harm and Suicide Prevention policy updated and re-issued in February 2011 states that it:

"aims to identify prisoners at risk of suicide or self harm and provide the necessary support and care to minimise the harm an individual may cause to him or herself. The Service recognises that this is an important priority and one that demands a holistic approach. Prisoners become vulnerable for many reasons. Vulnerability is often presented as an inability to cope with personal situations and/or the prison environment and where, without some form of intervention the likelihood of self-harm or loss of life is imminent. The Service's definition of a vulnerable prisoner is;

An individual whose inability to cope with personal situations within the prison environment may lead them to self harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication."

Governor's Orders

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners. The following orders have been considered as part of this investigation:

Governor's Order 5-1 'Special Supervision Unit (SSU)' (28 June 2010) details the regime of the SSU.

Governor's Order 5-2 'Prisoner Misconduct and Adjudication' (28 June 2010) explains when the Governor can place a prisoner on Prison Rule 35 (4) for the purpose of adjudication.

Governor's Order 5-3 'Rule 32 Authorisation and Regime' (28 June 2010) details the authorisations procedures for placing a prisoner on Rule 32. It also details the regime that the prisoner will follow whilst in the Special Supervision Unit (SSU).