



The
**Prisoner
Ombudsman**
for Northern Ireland

SUPPORTING APPENDICES BOOKLET

FOR THE REPORT BY

THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

JOHN MARTIN GERARD KENNEWAY

[DOB 12/05/1962]

IN MAGHABERRY PRISON

ON 8 JUNE 2007

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APPENDIX 1

PRISONER OMBUDSMAN FOR NORTHERN IRELAND

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 NHS, 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 NHS, the NHS 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 NHS, 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 NHS 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 Secretary of State for Northern Ireland (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 Secretary of State for Northern Ireland. 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 Secretary of State for Northern Ireland.
16. Annex 'A' contains a more detailed description of the usual reporting procedure.

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 Secretary of State (or appropriate representative). 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 Secretary of State for Northern Ireland. 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 Secretary of State for Northern Ireland. 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.

PRISON RULES AND POLICIES

The following is a summary of Rules and Procedures referred to in this report. They are available from the Prisoner Ombudsman Office on request.

Prison Rules

1. **Rule 27(1) of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995** gives the authority under which a prisoner can be temporarily released from custody, as follows:

Temporary release

27. – (1) A prisoner to whom this rule applies may be temporarily released for any period or periods and subject to any conditions.

(2) A prisoner may be temporarily released under this rule for any special purpose or to enable him to have medical treatment to engage in employment, to receive Instruction or training or to assist him in his transition from prison to outside life.

(3) A prisoner released under this rule may be recalled to prison at any time whether the conditions of his release have been broken or not.

(4) This rule applies to prisoners other than persons-

(a) remanded in custody by any court; or

(b) committed in custody for trial; or

(c) committed to be sentenced or otherwise dealt with before or by the Crown Court.

2. **Rule 32 of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995** gives the authority under which a prisoner's association can be restricted, as follows:

Restriction of association

32. –(1) Where it is necessary for the maintenance of good order or discipline, or in his 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.

(2) A prisoner's association under this rule may not be restricted under this rule for a period of more than 48 hours without the agreement of a member of the board of visitors or of the Secretary of State.

(3) An extension of the period of restriction under paragraph(2) shall be for a period not exceeding one month, but may be renewed for further periods each not exceeding one month.

(4) The governor may arrange at his discretion for such a prisoner as aforesaid to resume full or increased association with other prisoners and shall do so if in any case the medical officer so advises on medical grounds.

(5) Rule 55(1) shall not apply to a prisoner who is subject to restriction of association under this rule but such a prisoner shall be entitled to one hour of exercise each day which shall be taken in the open air, weather permitting.

3. **Rule 55(1) of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995** provides that all prisoners shall be given the opportunity to exercise, as follows:

Exercise and association

55. –(1) Every prisoner shall be given the opportunity of association for not less than one hour each day which may be taken as exercise in the open air, weather permitting.

Standard Operating Procedures

4. **SOP 26 – “Incident Management of SSU”** details the policy for the management of a life threatening incident in the SSU, as follows:

In life-threatening situations, staff will immediately adopt the following procedures:-

1. *Activate the nearest alarm.*
2. *Inform ECR / Security / Standby Search Team, giving brief details.*
3. *Draw keys from Safe in the downstairs office.*
4. *Await arrival of Security and Standby Search Team before unlocking the cell. Two staff to be present at any emergency unlock.*
5. *Cell key to remain in possession of unlocking staff.*
6. *The third member of staff will remain in the Block Control Room and observe the unlock on the Wing camera.*

NB: In life-threatening situations, staff must act with the following in mind: CONTROL, SECURITY AND STAFF SAFETY.

Death in Custody Contingency Plan

5. **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.

Governor's Orders

6. 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.
7. **Governor's Order 3-12 'Preservation of Evidence'**: sets out the procedures to be followed on discovery of a serious incident, what considerations need to be addressed to ensure evidence is preserved and the avoidance of contamination and overall scene management.
8. **Governor's Order 5-1 'Special Supervision Unit'**: sets out guidance and instructions for staff on the management of prisoners in the SSU. These instructions include information on searching prisoners, what a prisoner is entitled to have in his possession, exercise entitlements, entitlement to privileges and opportunity to attend religious services/access to a Chaplain.
9. **Governor's Order 5-3 'Authorisation of Rule 32 and Regime'**: provides information on the authorisation of Prison Rule 32 and the Regime to be followed for prisoners in the SSU.
10. **Governor's Order 7-19 'Body Checks/Roll Checks'**: provides information and instructions to staff on how prisoners should be checked at specific times of the day and night and to ensure there are no defects in the fabric of the establishment.

Self-Harm and Suicide Prevention Policy

11. **The Self-Harm and Suicide Prevention Policy** was developed by the Prison Service in order to improve its arrangements for dealing with vulnerable prisoners, the Prison Service revised its Self-Harm and Suicide Prevention policy in September 2006.

12. The revised policy 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.”

PAR 1 ‘Prisoner at Risk’ Booklet

13. A Prisoner at Risk (PAR 1) Booklet is an authorisation and observation booklet which is opened when a prisoner is put under closer observation, usually in his own cell, for his own protection and safety.

14. **PREPS – Progressive Regime and Earned Privileges**

PREPS hinges on motivating prisoners to engage with the constructive activities outlined on their agreed resettlement plan. Constructive activities include any form of training, education, work or other activity, as specified on the plan. PREPS works towards these objectives of allocating privileges according to different regime levels. Privilege and regime levels are based on a three tier system: Basic, Standard and Enhanced.

APPENDIX 3

**Report into the Standard of Medical Care given to
Mr John Martin Gerard Kenneway (d.o.b. 12/05/1962)
by Various General Practitioners During his Stay at
H. M. Prison Maghaberry**

Report prepared by:
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Statement of: Dr Neil Daniel Lloyd-Jones

Age: over 21

Occupation of Witness: Medical Practitioner

Address: Newcastle Medical Centre
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This statement consisting of 32 pages, each signed by me, is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have willfully stated in it anything, which I know to be false or do not believe to be true.

(Criminal Justice Act 1967, s9: M.C. Act 1980, 5A (3A) and 5B; M.C. Rules 1981, R.70.)

This report is divided up under the following sections.

- 1.0** Introduction.
- 2.0** Remit of report.
- 3.0** Summary and conclusion.
- 4.0** Chronology of consultations and other relevant facts.
- 5.0** Opinion.
- 6.0** Documents received and examined.

1.0 Introduction

I am a general practitioner. I qualified in medicine in 1984 and have worked in general practice since 1989. I have the following degrees **M.B.B.S.** (bachelor of medicine and bachelor of surgery) from the University of Newcastle upon Tyne. **LLB** (honours degree in law) from the University of Northumbria. **LLM (LAMP)** (masters degree in the Legal Aspects of Medical Practice) from the University of Cardiff. I am a member of the Royal College of General Practitioners (**M.R.C.G.P.**). I am approved under **Section 12(2)** Mental Health Act. I hold the **B.V.C.** (Bar Vocational Course) from the University of Northumbria. I was called to the Bar in 2002. I am member of the Honourable Society of the Middle Temple. I am also a qualified Alternative Dispute Resolution Mediator.

2.0 Remit of report

2.01 On the 12th June 2007 I was contacted by the Prisoner Ombudsman's Office for Northern Ireland. They informed me that they were making enquiries into the death of Mr John Martin Gerard Kenneway (d.o.b. 12/05/1962) who died at H.M. Prison Maghaberry on 8th June 2007.

2.02 To that end they supplied me with the list of documents as listed in Section 6.0. They asked me to study those documents and to give my medical opinion on the standard of medical care given to Mr Kenneway.

2.03 They also asked me to give any other comments and/or opinions as may be germane to the above enquiry.

3.0 Summary and Conclusion

3.01 Mr John Kenneway was born on 12th May 1962. He left school at the age of thirteen years and was illiterate. At the age of nineteen years he deliberately cut his wrists and then at the age of twenty years he took two overdoses. So began his psychiatric history of repeated episodes of:

- anxiety,
- insomnia,
- periodic depression and
- acts of deliberate self-harm.

3.02 At some stage in his life he started mixing political and criminal activities to the extent that he came into the criminal justice system and served various prison sentences. He appeared to have entered prison in 1989. Over the following years he periodically suffered from the above set of symptoms and saw several psychiatrists. He received treatment for his psychiatric problems both in the community and in prison.

3.03 In February 2007 he re-entered prison. Whilst the initial medical assessment and management was common and acceptable medical practice I feel that at some stage over the following months a clinical review should have taken place to establish a “clinical benchmark” as to further clinical management. This did not occur. Therefore it is my opinion that here the standard of medical care fell below common and acceptable medical practice.

3.04 On the 7th June 2007 he consulted with the prison doctor, one of the prison medical officers. Essentially there were two components to that consultation.

- 3.05** One part involved a possible chest infection. Here it is my opinion that his standard of medical care was common and acceptable medical practice.
- 3.06** The second part of the consultation involved a psychiatric component. Importantly some of the symptoms that he reported were those of deliberate self-harm/ending his life.
- 3.07** I understand from the Ombudsman's Office that if the prison doctor had felt that John Kenneway was at an increased risk of harming himself/taking his life he could have requested increased vigilance/supervision.
- 3.08** Be that as it may it is my opinion that the prison doctor did not take a sufficiently objective clinical psychiatric history to determine whether or not increased supervision was needed.
- 3.09** Therefore the fact that he did not make a more comprehensive psychiatric assessment would mean that, with the history as portrayed by Mr John Kenneway, that he should, a fortiori, have requested an increase in supervision so that a better psychiatric assessment could have been made.
- 3.10** Therefore in conclusion the fact that he did not follow the previous clinical rationale would mean that, in my opinion, on the balance of probability, the standard of medical care had fallen below common and acceptable medical practice.

4.0 Chronology of consultations and other relevant facts

4.01 I have studied all the medical records and other prison papers as listed in “Documents Received and Examined.” I have chronologically documented those consultations and entries that I feel assist in building up a picture of John Kenneway.

4.02 In parts I have quoted the consultation verbatim and in others I have précised it. However I should point out that the reader should not make any inferences and/or interpretations from those sections that have not been included. These may be of equal importance to the case.

4.03 I would point out that there are a considerable number of consultations that show, in many parts common general practice consultations for a number of “common” everyday medical problems. I have not commented on these.

4.04 Essentially I have concentrated on those consultations/entries that have a “common psychiatric theme.” I will initially examine those consultations that took place in prison and then those that took place with his general practitioner in the community.

4.05 12th September 1989

“Complaining of poor sleep pattern. He claims to lie awake all night worrying about his wife and children. He imagines his wife is going out with another man... I would suggest we refer this man to the psychiatrist for further assessment.”

There is a corresponding referral letter dated 29th September 1989 from a doctor. Amongst other things it stated:-

“He complains of poor sleep pattern. He is concerned about his wife and children and

4.06 October 1989

“Requesting a psychiatric appointment. I have explained to him that this request has already been dealt with.”

4.07 16th October 1989

“Anxiety and poor sleep pattern. Prescribed Melleril 50 mg nocte for one week.”

4.08 24th October 1989 Psychiatric Consultation

“I saw this man on the 23rd October 1989. He feels bad, cannot sleep, worries about his wife and children and is finding difficulty in doing his sentence. He is due for release at Christmas 1990.... He also slashed his wrists in 1981 because of a dispute with his then girlfriend who later became his wife. He took an overdose on two occasions about 1982 again because of disputes with his wife.He left school at thirteen years, hardly ever went to school and now cannot read or write. He can count to some extent. He was married in 1982...his wife is twenty five years old. They have three children all in good health. ...He admits that he is extremely jealous and possessive type of person. ...This man is very small only about five feet two inches.... I also feel he has a personality problem. He acts hastily, seems to show lack of self control and does not seem to learn from experience. Anxiety is his main problem although there is some depression present. I suggest he be given Prothiaden 75 mg nocte. He should also be given Melleril 50 mg mane. I will see him again in three months.”

4.09 8th January 1990 Psychiatric Consultation

“...He feels reasonable at the moment. Has no major problem. His domestic situation seems to be quite good. Still attends the education classes. On no drugs at present. I feel he is in reasonable form. I will see him again.”

Dictated but not signed.

4.10 There is also a “Referral/Assessment of suspected suicide risk” form dated 6th February 1992. I provide a photocopy of that document overleaf.

4.11 7th December 1992 Psychiatric Opinion

“History of, one day last week cut arm on Friday.

Complaining of:

“I just want to die.”

“Problems.”

“I’ve nothing left – I’ve lost everything – wife and kids.”

Angry about charges

...Can’t cope with thoughts of losing wife and family. Wife came up last Tuesday and since then has felt depressed and hopeless.

Feels LNWL (life not worth living) – expresses suicidal ideation.

Can’t sleep. Thinking ++. ...No previous psychiatric history.

Alcohol x 1-2/wk – “I get drunk.”

6 pints 3-4 shorts.

No drug abuse.

Impression

Adjustment reaction to break up of marriage.

Active suicidal ideation.

Management

Requires close observation in hospital.

Melleril 25 mg three times a day.

4.12 8th December 1992

“... He remains however at risk of further self-harm – keep under observation....

3pm

“Suicidal ideation remains – obscure!

...Refuses to have arm wounds dressed or any attempt at suture.”

4.13 10th December 1992

“Wife visited today.

Angry ++ today.

Continues to express thoughts of self-harm.

To remain in hospital.”

Senior Registrar in Psychiatry

4.14 12th December 1992

“No change today. Remains angry and continued thoughts of self-harm. To remain in the hospital.”

Senior Registrar in Psychiatry

There is a letter (photocopy overleaf) dated 12th December 1992 signed by John Kenneway in which he expressed his sadness and despair at splitting up from his wife. It is unclear whether he wrote the letter himself (given that he was illiterate on leaving school) or whether he dictated it to someone to write on his behalf.

4.15 17th December 1992

“Much calmer today ... future “seems much brighter.” We will discuss with psychiatrist but I think he could soon return to the wing.”

4.16 17th December 1992

“He tells me things are now resolved. ...He expressed a wish to return to the wing. He denied any thoughts of self-harm. This man appears to be well settled. I suggest that he is returned to ordinary location.”

Consultant Forensic Psychiatrist

4.17 28th December 1992

“He has settled well but still [is] complaining of insomnia. Rx Temazepam 20 mg for 5 days.”

4.18 8th January 1993

“Patient still complaining of insomnia and anxiety. Could Dr please see him again.”

4.19 6th February 1993

“... Note overdose in December 1992 ... says he feels very anxious and not sleeping. ... Diazepam 5 mg twice a day for 48 hours.”

4.20 23rd February 1993

“This man remains anxious and worried. Please ensure that he sees the psychiatrist as soon as possible.”

4.21 There is a corresponding referral letter to a Consultant Forensic Psychiatrist, dated 25th February 1993 from an M.O. Amongst other things it stated:-

“I would appreciate if you could see this man urgently. He is familiar to you from previous attendances. At present he is

feeling very tense and anxious. He is obviously unsettled. ... his marriage has now broken up.”

4.22 ? date February 1993

“Not sleeping. Still remains anxious. His marriage has now broken up and this would seem to be at the root of the present problem. He requests to be reviewed by the psychiatrist and something to help him sleep.”

4.23 23rd March 1993

“This man is awaiting an urgent appointment with the Psychiatrist. He is very agitated and disturbed. Sweating and shaking even during interview and certainly requires to be seen as soon as possible.

I would suggest Temazepam 20 mg nocte for the next five nights.”

4.24 7th March 1997

“Claims marital problems, not sleeping, anxiety.”

4.25 28th April 1997

“Appears anxious. Seen in PSU following hostage incident. Denies any medical complaints or injury. Currently on no medication.”

M.O.

4.26 2nd May 1997

“... Transfer from Maghaberry. History in 1992 of ... some depression re medical problem.”

4.27 I now turn to the “Initial Screening Form” for Maghaberry Prison, dated 3rd February 2007. I have provided photocopies overleaf of the relevant sections on:-

- Mental health; and

- Medical officers committal assessment.

I would ask the reader to study the following sections:-

- Mental health, 10, 11 and 12.
- Medical officers committal assessment.
- “Additional medical history.”
- “Mental state” (and the bottom of the page).
- “Medication plan.”

4.28 From my discussion with the Prison Ombudsman’s Office, I understand that there is a medical kardex that would list the medication – prescribed whilst in prison. I have requested this but to date have not had sight of it.

4.29 At this point in my report I would ask the reader purely to note what has, and in other parts, has not been written. I shall be returning to discuss these in my section entitled “Opinion.”

4.30 Under the papers on “**Staff Reports**” there are the following possible relevant entries. I am unable to say, however, whether they appertain to his mental state, physical state or a combination of both.

4.31 2nd June 2007

“Spent most of day in bed, said he had not slept well last night. We asked the medic to have a talk with him as he was acting out of character, said he was fine.”

4.32 3rd June 2007

“Spent today in bed again, requested the M.O. Still OK according to the medic.”

4.33 5th June 2007

“Kenneway is not well. He has requested the doctor twice. Still not seen one. Used shower and phone, given TV for one night as reward for finding 250 pills in visits area.”

4.34 6th June 2007

“Prisoner is being more and more like himself today. Spent the morning in the video link, went to yard pm and used the phone. Was interviewed by the governor.”

4.35 7th June 2007

“Still not well! Seen doctor pm, used phone, otherwise OK.”

4.36 The computerised medical records read as follows:-

20th April 2007. Nurse at Maghaberry Prison.

Problems (first). “Tension headache ... Is having domestic difficulties currently. Felt that room was closing in on him last night, describes feeling his heart pounding. Feels himself it was a panic attack. Also complaining of not sleeping well at present... Comment. Spoke to the prison doctor Prescribed Phenergan 25 mg for 7 nights.”

4.37 7th June 2007. The prison doctor at Maghaberry Prison.

SSU Rule 32

“Complaints of possible chest infection Describes purulent phlegm when he coughs occasionally. This has been going on for 2 months. Smokes upwards of 4 ounces per week. Temperature 36. Normal colour. Not obviously short of breath. No audible wheeze. Chest clinically clear throughout lung fields.

Plan: Sputum for culture and sensitivity.

Problem:

Proceeded to describe himself as a soldier – INLA. Was initially a life sentence prisoner but was returned on account of a further allegation for which he was remanded. He describes feelings of flashbacks of activities that he was involved in in the past. He appears to be quite troubled by them. Has had thoughts of deliberate self-harm/ending his life but is determined to stay strong on account of his 6 year old and 4 year old children. When he was released he sought and got employment in the South of Ireland.

Plan: refer to Psychiatrist.”

4.38 8th June 2007

At approximately 17:15 Mr Kenneway was found by a prison officer hanging by his throat with a black coloured lace. Cardiopulmonary resuscitation was attempted but he was pronounced dead shortly afterwards.

4.39 Resume of general practice records

I would first of all point out that with the bundle of medical records there is a letter from the Family Doctors. The salient details of her letter were that she had amongst other things said, *“Mr Kenneway only registered with the practice on 19th June 2001 and these are the only records we received about him from the Central Services Agency. ... It is likely that his original medical records never came out of the Maze Prison upon his release and this has been our experience in similar cases over the years.”*

4.40 Chronologically the salient entries were as follows:-

7th September 2001 There is an incapacity benefit form.

In a nutshell it is stated that he suffered from:-

1) Nervous disability with anxiety and depression since October 2000.

2) Post traumatic stress disorder.

His present medication was:

- Cipramil,
- Diazepam,
- Temazepam.

4.41 Other salient entries on the form were:-

“Suicidal, would neglect self, not wash, dress, change clothes or get up.”

“Often does not sleep at night, tends to be more depressed at night.”

“Overdose 1993. Has cut wrists in past.”

There were other incapacity benefit forms dated 9th May 2003 and 14th August 2003. Again his disorders were listed as:-

- Nervous disability,
- Severe depression,
- Anxiety state,
- Post traumatic stress disorder.

4.42 22nd January 2001

“Diazepam 5mg

Cannot settle from got out of jail. ↓ weight, sleep and appetite.

Paroxetine 20mg mane 28.”

4.43 8th October 2001

“Efexor (antidepressant medication).”

4.44 10th December 2001

“Med 3 (sick note) for 13 weeks. “Depression”

4.45 25th March 2002

“Efexor 75 mg x 56”

4.46 8th May 2002

“Repeat”

4.47 12th June 2002

“Repeat”

4.48 10th July 2002

“Repeat”

4.49 10th October 2006 Consultation with a doctor

“S: This gentleman was in INLA many years ago. He is having flashbacks to incidents he was involved in and having nightmares which prevent him sleeping. He is depressed and agitated. No ideas suicide.

Rx: Chlorpromazine Hydrochloride tablets 25 mg.

Psychiatric referral, Royal Victoria Hospital. Would be grateful for out patient assessment.”

4.50 24th October 2006 Consultation with a doctor

“S: Still feels anxious, low in mood agitated. Private line for court. Unable to attend due to anxiety/depression.

O: Objectively very anxious/agitated.

Rx: Chlorpromazine Hydrochloride tablets 50 mg.”

4.51 7th November 2006 Consultation with a doctor

“Med 3 (sick note) for 4 weeks. Depression. Private line for court to adjourn court case this Friday.”

There is also an outpatient letter that reads as follows:-

“1st February 2007

Dear Dr

RE: MR JOHN KENNEWAY, DOB: 12.05.62

Your patient failed to attend a new patient appointment at the clinic in the Mater Hospital on Thursday 1st February 2007.

We are discharging him from the clinic but would be happy to see him again at your request.

Yours sincerely

Dr

MRCPsych

Consultant Psychiatrist"

5.0 Opinion

5.01 I have been asked to give my opinion on the medical care given to Mr John Martin Gerard Kenneway (d.o.b. 12/05/1962), who died at Maghaberry Prison on 8th June 2007 having been found hanging in his cell with a black lace round his neck. I cannot say what the cause of his death was.

5.02 He attended very little at school and left at the age of thirteen years being illiterate. He was married at the age of twenty and had three children. At some stage in his life he started mixing political and criminal activities to the extent that he came into the criminal justice system and served various prison sentences. From the notes that I have he appeared to have entered prison in 1989. At that time he was aged twenty seven years.

5.03 At some stage whilst serving this prison sentence he started to suffer from:

- anxiety; and
- insomnia.

Accordingly he was referred to a consultant psychiatrist in October 1989. Amongst other things he noted that:

- In 1981 he had slashed his wrists following a dispute with his then girlfriend. He was then aged nineteen years.

- In 1982 he also took two overdoses. He was then aged twenty years.

5.04 In essence the consultant psychiatrist felt that he had:

- anxiety;
- depression; and
- a personality problem.

He commenced him on a course of antidepressant medication together with a form of anti-psychotic medication. At this time he was noted not to be taking illicit drugs. From the medical records I have, it is not clear whether he did or did not take the medication and if so for how long.

5.05 Chronologically with regard to psychiatric problems, the next entry was in 1992. In the intervening period I am unable to say to what extent he spent this in prison. Suffice it is to say by December 1992 he was in prison and had been referred again to a consultant psychiatrist for his opinion. At this consultation the senior registrar noted that in the previous week Mr Kenneway had cut his arm. He also noted that Mr Kenneway did not feel that life was worth living and was experiencing suicidal ideation. He concluded that the above symptoms were a reaction to the break up of his marriage and that he required close observation in hospital and medication.

5.06 He was duly admitted to the hospital wing of the prison. On 17th December 1992 he was reviewed by a consultant psychiatrist, who felt that he was well enough to be discharged back to the wing cell.

5.07 However by the end of December 1992 he still had insomnia and there was reference in his notes to taking an overdose of some type of medication. By early January 1993 he still had

anxiety and insomnia and was therefore referred back to the consultant psychiatrist for a further opinion.

5.08 In February and March 1993 there were several references to the effect that he needed to see the consultant psychiatrist, but I am unable to find any documentation that he did actually consult with him.

5.09 Whilst his medical records continue to have entries with regard to various physical problems, there is a distinct “gap” in his notes with regard to any psychiatric entries, between March 1993 and March 1997 (i.e. four years). To that end it is possible that he did not have any psychiatric problems or alternatively it is possible that there is another set of notes.

5.10 Be that as it may, in March 1997 the same type of “theme” to his psychiatric problem arose again i.e. anxiety and insomnia, both being secondary to other incidents. This time it was a hostage incident. At that time it was noted that he was not on any medication.

5.11 After 1997 medical records continued to be made until 2000, but these entries were for run of the mill medical problems, with no reference being made to psychiatric problems. There was then an abrupt cessation of all medical records from September 2000 onwards and his medical records did not resume again until February 2007.

5.12 At this junction, on the balance of probability, Mr Kenneway was readmitted to prison having had some time outside of prison (*note: Mr Kenneway was readmitted to prison*). On entering prison all prisoners undergo an initial “committal screening.” On the balance of probability, this would have been

carried out by a nurse or some other type of health screening worker. The object of the exercise is to gather as much information as possible with regard to the general state of an inmates health and to record other social matters.

5.13 At this point I would refer the reader to the three photocopied documents that I have given in the chronology of consultations. I refer initially to the first page of the screening programme entitled “Mental Health” where the health care worker had asked him about his attendance/treatment with psychiatric services. Here, in a nutshell, he has said that he had previously been referred to a consultant psychiatrist, but he was unable to remember his name. This was on an outpatient basis and the main reason for the referral was insomnia. Apparently he did not attend for the appointment.

5.14 I also note his answer to question 12. Basically here he was asked if he had ever tried to harm himself. The answer was recorded as “no.” Clearly, though, from his previous history this was not the case. On the balance of probability he may have given a false answer to this question.

5.15 The next section of the initial committal assessment was dealt with by the acting medical officer. Essentially he/she would/should have had access to the documentation made by the nurse/health care worker. He would have then performed his own assessment.

5.16 I note the following points:

- Under “Additional Medical History” the doctor had recorded “*History of depression – unclear what type.*”
- Under “Mental State” there is no clinical entry.
- Under “Medication Plan” he has stated

*“Advised Temazepam after non addictive sleeper.
Continue with Diazepam 10 mg twice daily clarifying with GP
Monday.
Non steroidal anti-inflammatory drugs for neck strain.
Continue with antidepressants.
Is aware for need to be truthful re Diazepam intake and safety
and that I [illegible] 10 mg three times a day as [illegible] to be
confirmed.”*

5.17 Underneath this entry a different handwriting appeared. On the balance of probability this was the nurse/health care worker and he/she had written:-

“Diazepam reduced to 5 mg daily as per GP and Efexor XL 75 mg prescribed by Dr ... 5th February 2007.”

5.18 In a nutshell the doctor had noted his history of depression and the fact that he was on various types of medication. Some of these needed to be confirmed vis-à-vis type and dose by contacting his previous general practitioner who was in the community. I note that John Kenneway was taken to prison on 2nd February 2007 and that the nurse had made an entry on 5th February 2007. On the balance of probability either the M.O. or the nurse had telephoned his general practitioner to clarify his present medication regime.

5.19 As an initial assessment screening programme, I would say that overall the foregoing was common and acceptable medical practice. However, I would have expected that at some stage over the next month or so, that a fuller/more comprehensive review of his state of health would then have taken place to basically ascertain the “current state of play.”

5.20 I feel it would have been good and acceptable practice for one of the medical officers to have:-

- reviewed any previous prison medical records;
- to have spoken to, or requested in writing, a resume of his previous/ongoing medical problems from his previous general practitioner;
- in the light of the above information to have consulted with John Kenneway to form a new clinical bench mark of his current mental state;
- formed a management plan with a review date etc.

5.21 I am unable to find any evidence of the foregoing and therefore it is my opinion that on this aspect the standard of care would have fallen below common and acceptable medical practice.

5.22 There were no references to any psychiatric problems until that of 20th April 2007 (over two months since his admission). He then consulted with a Nurse with regard to a possible panic attack and difficulty sleeping. She in turn spoke to the prison doctor and he was prescribed Phenergan to assist his insomnia.

5.23 Of itself it is my opinion that this consultation per se was common and acceptable medical practice. Having said that, I have already said that it is my opinion that a total review of his mental state/problem and prescribing would have been common and acceptable practice.

5.24 In his medical records there is then a further gap/paucity of entries vis-à-vis any psychiatric problems. Following the consultation with the Nurse on 20th April 2007, the next medical entry of a psychiatric nature was not until 7th June 2007 with the prison doctor. I shall return to that consultation in a moment. Suffice it is to say at this junction that under the

“Staff Reports” sheets there were further entries made on the following dates:-

2nd June 2007

3rd June 2007

5th June 2007

6th June 2007

5.25 On 7th June 2007, John Kenneway consulted with the prison doctor, the M.O. The consultation was basically divided into two parts/problems. The first part dealt with a possible chest infection. Here it is my opinion that his history and management was common and good general practice. The second part of the consultation dealt with a psychiatric problem. The consultation read as follows:-

“Problem

Proceeded to describe himself as a soldier – INLA. Was initially a life sentence prisoner but was returned on account of a further allegation for which he was remanded. He describes feelings of flashbacks of activities that he was involved in in the past. He appears to be quite troubled by them. Has had thoughts of deliberate self-harm/ending his life but is determined to stay strong on account of his 6 year old and 4 year old children. When he was released he sought and got employment in the South of Ireland. Please refer to psychiatrist.”

5.26 On this aspect of the consultation I would make the following observations/comments:

- the prison doctor may or may not have been consulting with John Kenneway for the first time. If it was for the first time then he would be at a disadvantage in assimilating a previous/ongoing clinical picture of him. Having said this his medical training would allow/cater for that.

- Immediate management wise the sin qua non of the consultation was in the following documentation.
“He has had thoughts of deliberate self-harm/ending his life, but is determined to stay strong...”
Faced with this statement it is my opinion that a more thorough mental state examination was called for to home in on the *intent* or otherwise of those words.

5.27 I shall give a short example to elaborate on this:-

Mental State at Interview

1) Appearance and Behaviour

How was he composed/sitting at the consultation? i.e. was he sitting comfortably or looking anxious/moving around/wringing his hands. What was his eye contact like? Was it good or did he avoid eye contact.

2) Mood

What was his mood like?
Did he sound like a person that was depressed or manic in nature?

3) Talk

What was his speech like?
Was it a slow and quiet in volume or fast and loud?

4) Thought

What were his thought processes?

5.28 Here I would link into what he had said i.e. thoughts of deliberate self-harm/ending his life.

In other words, to elaborate on those points.

What actually were his thoughts?

Were they credible/possible?

Did they have any psychotic features?

What had he actually thought of?

How would he do it?

Has he ever attempted it before and if so did he regret that he did not succeed?

Then asking him about how, when, how many times he had harmed himself.

In a nutshell the object of the exercise is to attempt to get a degree of objectivity to the assessment process. The type of scenario that the prison doctor found himself in was, sadly, very common in general practice. The doctor is faced with making a decision on the likelihood of the patient carrying out the threat.

5.29 To assist the reader I shall take verbatim the words that John Kenneway stated and then given two entirely different outcomes.

Mr Kenneway's statement read:-

"He has had thoughts of deliberate self-harm/ending his life but is determined to stay strong..."

5.30 Scenario Number 1

Taking Dr "A" and Patient "Billy"

Dr A: *"Billy, you have said that you want to harm yourself and end your life. Have you ever tried to harm yourself or kill yourself before?"*

Billy: (who is sitting comfortably with a good eye contact)

"Well I tried taking some Paracetamol – I took five tablets and two cans of beer. After that I felt really sick and vomited the lot. I thought about cutting my wrist with a razor blade, but I can't stand the sight of blood. Overall I suppose I am a bit of a coward."

Dr A: *"So Billy when you say that you want to harm yourself and end your life, what have you thought of doing?"*

Billy: *"I haven't really thought about it."*

Dr A: *"Well do you think you would kill yourself?"*

Billy: *"No, if push comes to shove, I could not bear to leave her/the children."*

5.31 Scenario Number 2

Taking Dr "A" and Patient "Peter"

Dr A: *"Peter, you have said that you want to harm yourself and end your life. Have you ever tried to harm yourself or kill yourself before?"*

Peter: (Who is sitting hunched forward, wringing his hands, slightly tearful and with poor eye contact staring at the floor.)
"Yes several times."

Dr A: *"Well tell me about them."*

Peter: *"The first time I took two bottles of Paracetamol and a bottle of whisky. I had left a note telling my girlfriend that I loved her."*

Dr A: *"What happened next?"*

Peter: *I had locked myself in my flat. My girlfriend got worried and telephoned the police. They broke in. I finished up in hospital."*

Dr A: *"Tell me about other times."*

Peter: *"My girlfriend said that she did not love me and had found someone else. I tried to hang myself with my belt, but it did not work, I slipped off the table and broke my wrist."*

Dr A: *"Any other times?"*

Peter: *"Well when they let me out of hospital I saw this bus, and I just stood there – in front of it."*

Dr A: *"What happened?"*

Peter: *"Some bloke pushed me away."*

Dr A: *"Do you regret that you have never succeeded?"*

Peter: *"Yes. I just want to die. I just want to be left alone."*

Dr A: *"What have you thought about doing next?"*

Peter: *“Well I have been stock piling some tablets that my doctor has been giving me and I reckon I can take them when the lass goes to pick up the kids.”*

5.32 In conclusion Billy or Peter could go on to harm themselves or take their own lives. However, for the doctor faced with these clinical scenarios, and all other things being equal, the chances would be greater that Peter may harm or kill himself than Billy. The reader must appreciate that when I use the word “chances” I am not considering national psychiatric statistics for these “types” of scenarios which will vary with age, social class, gender, etc. etc, I am merely trying to portray the clinical situation for an “average” general practitioner when faced with an “average” scenario such as this.

5.33 I am mindful of the fact that in the prison system the M.O. may have the facility to request a higher degree of observation on those prisoners who, in his opinion are at increased risk of harming themselves. Be that as it may it is my opinion that the prison doctor needed to assess whether that situation had arisen. He had not done that. Therefore it is my opinion that:

- at the consultation with regard to psychiatric/mental state assessment examination, a more comprehensive examination was needed to determine further management;
- failing that, the fact that a more comprehensive examination was not performed would mean a fortiori that given the presenting history that increased observation of Mr John Kenneway was needed until an appropriate comprehensive mental state examination had taken place.

SEE ADDENDUM FOR SECTION 6

7.0 Documents received and examined

- 1.** Letter of instruction. The Prison Ombudsman for Northern Ireland, dated 13th June 2007.
- 2.** Northern Ireland Prison Service, H.M.P. Maghaberry, Escape pack, 1 page.
- 3.** Prison Service Northern Ireland, Staff Communications Sheet, dated 8th June 2007, Officer, 1 page.
- 4.** Prison Service Northern Ireland Staff Communications Sheet, dated 8th June 2007, Officer, 1 page.
- 5.** Prison Service Northern Ireland Staff Communications Sheet, dated 8th June 2007, Officer, 1 page.
- 6.** Class Officers Journal, dated 8th June 2007, Location SSU 3 and 4, 1 page.
- 7.** H.M.P. Maghaberry ECR Incident/Situation Report, 13 pages.
- 8.** Confidential, H.M. Prison Maghaberry Notification of Next of Kin, Annex B, 1 page.
- 9.** Governors Committal Review, dated 3rd February 2007, 3 pages.
- 10.** H.M.P. Maghaberry Inmate, Location History Report, 1 page.
- 11.** H.M.P. Maghaberry Rule 32 Restriction of Association, 3 pages.
- 12.** H.M.P. Maghaberry, Special Supervision Unit, 6 pages.
- 13.** Prison Service Northern Ireland Progressive Regimes and Earned Privileges Scheme (Preps) Introduction, 2 pages.
- 14.** Television Rental Agreement, dated 4th February 2007, 1 page.
- 15.** Initial Staff Report, 2 pages.
- 16.** Maghaberry Prison, Drug Test Unit, Drug Test Result, 3 pages.

- 17.** H.M.P. Maghaberry, Inmate Tuck-shop Receipt for 3rd May 2007, 1 page
- 18.** Part C – To be Completed by the Governor Authorising any Payment and Form PC (1) Claim for Missing/Damaged Article(s) of Personal Property, 2 pages.
- 19.** List of Items/Cost, 4 pages.
- 20.** Prison Service H.M.P. Maghaberry, Cell Sharing Risk Assessment, 2 pages
- 21.** Northern Ireland Prison Service, Application for Compassionate Temporary Release, 6 pages.
- 22.** Staff Reports, 16 pages.
- 23.** Special Supervision Unit, 2 pages.
- 24.** Registration Details, Patient Number 2537, 3 pages.
- 25.** Medical records, John Kenneway, 121 pages.
- 26.** Autopsy report on John Kenneway, dated 14th June 2007, 7 pages.
- 27.** General practice medical records, 34 pages.

ADDENDUM TO DR NEIL LLOYD-JONES' CLINICAL REVIEW

Mrs Pauline McCabe
Prisoner Ombudsman for Northern Ireland
22nd Floor
Windsor House
Belfast

7th July 2009

Dear Mrs McCabe

Re: Mr Martin John Kenneway (d.o.b. 12/05/1962)

Thank you for your letter and enclosures received on the 27th of June 2009 with regard to your investigation into the death of John Kenneway (d.o.b. 12/05/1962).

I note that you have asked me to include the information and questions in the body of my report, rather than as an addendum. Overall the information that you have given does not change my opinion. Therefore to assist matters in the reading of my report, I have dealt with your questions by simply forming a new section, that being Section 6. Here I deal with each question and give specific answers. I hope that this is satisfactory, but I felt that the report would become very disjointed to deal with it in any other way.

I am attaching a nominal fee note for this and I hope I can assist you on other cases in the future.

Yours sincerely

Dr N D Lloyd-Jones
M.B.B.S, M.R.C.G.P, L.L.B, L.L.M, Barrister

Enc

6.0 Answers to specific questions raised by HMP Ombudsman

6.01 Interpretation of Medicine Kardex

Examination of his medicine kardex shows that he was being prescribed:-

- Venlafaxine XL 75mg twice a day. This was started on 5th February 2007 and this continued up to the time of his death. Venlafaxine is an anti-depressant medication.
- Arthrotec 75mg twice a day. This was commenced on 26th February 2007 and continued up to the time of his death. This is a non-steroidal anti-inflammatory drug and presumably would have been prescribed for some type of musculoskeletal pain.
- Diazepam; he received this at a dose of 5 days at 5mg and 5 days at 2mg, between the 5th and 14th of February 2007. i.e. none was being prescribed at or around the time of his death.
- Phenergan; he received this on 16th of February for 7 nights and on 20th April for 7 nights. This is a sedative anti-histamine. On the balance of probability this would have been given to help him sleep.
- Zopiclone; on the 12th of April he received 7.5mg of this for 3 nights. This is a sleeping tablet.

In summary and conclusion the only prescribed medication that he was taking at the time of his death was:-

- Venlafaxine; and
- Arthrotec.

6.02 Interpretation of Autopsy Forensic Science Report

There were three drugs found in analysis of his blood. These were:-

- Diazepam plus metabolite.
- Venlafaxine; and
- 11 nordelta 9 tetrahydrocannabinolic acid.

Essentially the Venlafaxine would be compatible with that which he was prescribed. The Diazepam would not concur with his prescribed medication; and would be from an illicit source. The 11 nordelta 9 tetrahydrocannabinolic acid would be a derivative of Cannabis and of course would be from an illicit source.

6.03 The impact of taking non-prescribed drugs (as listed above) on his mental state:-

I would say that this is outside my area of expertise and you would need to take advice from a forensic toxicologist.

6.04 The issues, if any, of combining above drugs with prescribed drugs:-

I would say that this is outside my area of expertise and you would need to take advice from a forensic toxicologist.

6.05 The use of blue tablets vis à vis his state of mind:-

I would say that this is outside my area of expertise and you would need to take advice from a forensic toxicologist.

6.06 The link of UDA blues and suicide:-

I would say that this is outside my area of expertise and you would need to take advice from a forensic toxicologist.

6.07 Does the information on the medicine Kardex affect my opinion on his standard of medical care:-

To this I would say no, it does not change my opinion as outlined in my report.

6.08 Does the additional information that I have been given change my opinion of the prison doctors' management of the consultation on 7th June 2007:-

To this I would say no, there is no change in my opinion.

6.09 **In the week leading up to his death he apparently displayed some “warning signs.” What would be the significance of these and his drug use:-**

I would say that this is outside my area of expertise and you would need to take advice from a forensic toxicologist. However, the “warning signs” should have been brought to the notice of the duty doctors.

APPENDIX 4

**The death in custody of Mr John Kenneway at Magheraberry Prison
on 8 June 2007**

EXPERT MEDICAL REPORT

Prepared by

Professor Roy McClelland

on

Mr John Kenneway

Date of Birth: 12 June 1962

Date of Incident: 8 June 2007

Date of Report: 24 July 2009

Requested by Mr Brian Coulter and subsequently by

Ms Pauline McCabe

Prisoner Ombudsman for Northern Ireland

INTRODUCTION

I have been requested by Mr Brian Coulter, and subsequently by Pauline McCabe, Prisoner Ombudsman for Northern Ireland, to review the medical and healthcare records of Mr John Kenneway and prepare a report based on my expert clinical opinion on:

The referral on 7 June 2007 for Mr Kenneway to be seen by Dr A (Prison Doctor)

The content of the consultation Mr Kenneway had with Dr A on 7 June 2007

The outcome of the referral, the subsequent referral to Dr B and Dr A notation in the medical records file.

This report is based on a review of the following documentation:

External General Practitioner records for Mr John Kenneway
Medical Records, including Kardex – John Kenneway (Northern Ireland Prison Service)

Northern Ireland Prison Staff Report on Mr John Kenneway
Northern Ireland Prison Service Prisoner request forms – John Kenneway

Autopsy reports: Professor J Crane, State Pathologist, including forensic science report (8 June 2007); Dr JL Carson, Consultant Pathologist (14 June 2007).

Notes and transcripts of telephone calls by Mr Kenneway over the period 6 May - 8 June 2007.

REVIEW OF CLINICAL FACTS

The review focuses on Mr Kenneway's mental health history and related matters.

Time line analysis of available records

An overview of all available records indicates that Mr Kenneway entered prison in June 1983 at age 21. He spent much of the interval between 1983 and 2000 that is between ages 21 and 38, within the prison system. Between September 2000 and February 2007, that is from age 38 until age 44, Mr Kenneway lived in the community.

From the prison records Mr Kenneway had 10 committals between 1983 and 1989. The reports of medical assessments at each committal over this period consistently describe Mr Kenneway's health as "good". Nevertheless reference is made in the 1989 committal to self-inflicted slashing of the left wrist in 1981 and a stabbing to the left side in 1983.

Mr Kenneway was in prison continuously between 20 September 1989 and 20 December 1990. During this period Mr Kenneway did have mental health problems, first noted on 22 September 1989 and assessed by Dr C, psychiatrist, 24 October 1989. During this period in prison Mr Kenneway was seen 39 times by prison health staff, 7 consultations being for issues related

to mental health. Other health concerns included several falls, constipation, dental needs, backache, itch, groin strain, rash, athlete's foot.

Mr Kenneway appears to have been continuously within the prison system between December 1991 and September 2000. Over this period there are records of 196 separate consultations with prison health staff. In addition to those related to mental health issues (reviewed below) Mr Kenneway had a range of health complaints. Chest pain was a common complaint, and on which he appears to have been anxious, also headache. In addition he complained from visual difficulties, groin pain, back pain, pain in RIF, cough and wheeze, colds, ear wax, nausea, constipation and minor injuries related to falls.

From the GP records, following discharge from prison in September 2000 the GP entry on 22 February 2001 indicates that Mr Kenneway was having difficulties settling since leaving prison with reduced weight, sleep and appetite. He was prescribed an antidepressant (Paroxetine). This medication was changed to the antidepressant Efexor in May 2001 and there is evidence of repeat prescriptions from then until July 2002. There are no further handwritten medical entries other than that a DLA form was completed on 14 August 2003.

DLA form copies are available from September 2001, December 2001; May 2003, August 2003; March 2005, May 2005. These consistently refer to nervous debility, depression, anxiety, PTSD. The 2005 forms also refer to fibromyalgia and arthritis.

The first computerised entry on 25 March 2005 refers to the incapacity form (above).

On 14 September 2005 the record notes a significant history of anxiety and depression. The entry for 10 October 2006 states that Mr Kenneway has been having flashbacks to incidents he was involved in and having nightmares which prevent him sleeping. Also that he is depressed and agitated. It also states that there were no ideas of suicide. A psychiatric referral was initiated.

On 24 October 2006 Mr Kenneway is noted still to be complaining of anxiety and depression and unable to attend court because of this. The antidepressant Efexor was recommenced on 18 December 2006.

Computerised diary follow-up entry for 9 March 2007 states that Mr Kenneway was due for a repeat prescription of Efexor.

Mr Kenneway re-entered prison on the last occasion in early February 2007.

GP Medical Records and Correspondence

These are reviewed at Annex.

Most Recent Prison Medical Records

2 February 2007. Committal screening states that the current charges were “driving offences and two threats to kill”. Current prescribed medication: “Diazepam, Temazepam, Efexor XL also mobic”. The record also states that the GP was contacted on 5 February 2007. It records that Mr Kenneway had an outpatient appointment at the Mater Hospital but did not attend – “poor sleep”. On additional medical history the report records a history of “depression”.

26th February 2007. “Says he can’t sleep”. “Has been on Efexor 75 mg bd – script ordered”.

12 February 2007. “No medical complaints”.

7 March 2007. “No medical complaints”.

2 April 2007. “difficulty sleeping. Zopiclone 7.5 mg – (?) for 3 nights”.

20 April 2007. “tension headache, dizziness symptoms. Complains of a throbbing headache rising from the back of his neck over the top of his head. Comes and goes over past 2 weeks. Says having domestic difficulties currently. Felt that the room was closing in on him at night and describes feeling his heart pounding. Feels himself it was a panic attack. Also complaining of not sleeping well at present”. Also “spoke with Dr A”. Phenergan 25 mg x 7 was prescribed.

May 2007. Mr Kenneway was seen on three occasions during May 2007 by a prison nurse. On each occasion the single medical issue was wax in the ears.

7 June 2007. Mr Kenneway was seen by Dr A. The record states “complains of possible chest infection – describes purulent phlegm when he coughs occasionally”. It states that Mr Kenneway “proceeded to describe himself as a soldier – INLA. Was initially a Life Sentence prisoner but has been returned on account of further allegations for which he has been remanded. He describes feeling of flashbacks of activities that he was involved in in the past. He appears to be quite troubled by them. Has had thoughts of deliberate self-harm/ending his life but determined to stay strong on account of his 6 year old and 4 year old children”. “Plan – letter to Dr B”.

8 June 2007. “Dr D called 6.10 pm. Seen 6.50 pm. Patient deceased. Hung himself by bootlace from window frame in SSU. Last seen 4.30 pm and found hanging at 1715. CPR attempted but asytole. Now lying on floor no sign of life. Ligature mark around the throat. Patient pronounced dead”. A handwritten entry states “entry made by Dr D”.

Mr Kenneway was prescribed a range of medication, principally psychotropic, antihistamine/anti-allergic and medication for arthritis.

5 February 2007. Mr Kenneway was commenced on Promethazine, an antihistamine, also used for treating insomnia. It was to be dispensed in the evening, which suggests that it was for the latter use. He was also commenced on Diazepam, a minor tranquiliser, for 5 nights to be dispensed in the morning and Efexor XL 75 mg, an antidepressant, also prescribed in the morning. The antidepressant was increased to twice daily on 15 March. Also on 15 March he was commenced on Arthrotec, for arthritis.

On 12 April Mr Kenneway was prescribed the night sedation Zopiclone for 3 nights and on 20 April Phenergan nightly for 7 nights. He remained on Venlafaxine 75 mg twice daily until his death.

Prison Staff Record

On 31 May 2007 Mr Kenneway was issued a refusal for compassionate leave. On 2 and 3 June Mr Kenneway was observed to spend most of these days and staff asked the "medic" to have a talk with him as he was "acting out of character". He was reported as being "OK according to the medic". On 5 June 2007 Mr Kenneway was reported as "not well" and that he had requested the doctor twice and not yet seen one. On 6 June he was reported as being "more like himself" and on the afternoon was interviewed by the Governor. On 7 June he was described as being "still not well".

Review of Previous Prison Medical Records

17 June 1983. This is the earliest dated entry in the prison medical notes and coincides with the date of a committal. No entry under mental/emotional state.

23 June 1983	}	
7 December 1983	}	
17 February 1984	}	Re-committal medical examination reports that Mr 1987 Kenneway's prison health is "good" and that he
24 February 1986	}	
3 October 1987	}	is not on any medication:
7 October 1987	}	

9 January 1989. Medical state on committal – self-inflicted injuries – overdoses – "81 (slashed (L) wrist) domestic. Regrets action now. Not on any medication.

15 May 1989. Medical state on committal. Not on any medication. In relation to self-inflicted injuries/overdoses: "slashed wrists, C2H5OH – fight with wife".

29 June 1989. Medical state on committal. Not on any medication. Reference is made to self-injury: "s/w to R wrist, 1982".

22 September 1989. "C/O poor sleep pattern. Claims to lie awake all night worrying about his wife and children. He imagines that his wife is going out with other men and feels very disturbed with this and has requested some

form of night sedation. I would suggest we refer this man to the psychiatrist for further assessment”.

16 October 1989. “Anxiety and poor sleeping pattern”. Prescribed Melleril 50 mg nocte 1 week.

24 October 1989. A detailed report is provided by Dr C which states that he saw Mr Kenneway on 23 October 1989. He states that Mr Kenneway complained of sleep difficulties, worries about his wife and children and found it “difficult in doing his sentence”. It also states “he slashed his wrists in 1981 because of a dispute with his then girlfriend who later became his wife. He took an overdose on two occasions about 1982 again because of disputes with his wife”. It goes on to state that Mr Kenneway “left school at 13 years, hardly ever went to school and now cannot read or write”. That Mr Kenneway “admits that he is an extremely jealous and possessive type of person. He feels inferior, says his wife is good looking and he wonders why she stays with him. He seems to torture himself by feeling that his wife must be looking elsewhere”. That his father gave him a “hard time”. Dr C also notes Mr Kenneway’s small stature, his illiteracy and feelings of inferiority. He considers him to have “a personality problem”, that he acts “hastily, seems to show lack of self-control and does not seem to learn from experience”. He states that “anxiety is his main problem although there is some depression present”. He recommends the antidepressant Prothiaden, that he should be given Melleril (a major tranquiliser) and that he would be reviewed in 3 months time.

28 January 1990. Dr C states that Mr Kenneway “feels reasonable at the moment. Has no major problems. His domestic situation seems to be quite good.” Also that he continues to attend education classes and is “in reasonable form”.

14 May 1990. The record states that although due to be reviewed by Dr C, Mr Kenneway does not wish to see him and has requested that his name be removed from the list.

9 January 1992. The clinical notes record that Mr Kenneway has been having “recurrent episodes of chest tightness and numbness in both arms. He becomes quite anxious about these.” Also that his father-in-law has similar symptoms and that he had a myocardial infarction.

15 January 1992. “Still having episodes of chest pain”. He was reassured.

30 January 1992. The report states that Mr Kenneway was “complaining today about the inability to visit the toilet at the required times and appears distressed and upset as a result of this. He is now being charged”.

17 November 1992. “He is still complaining of same (chest pain)”. “He is a rather tense individual”.

3 December 1992. “Feels depressed – worried re family problems”.

4 December 1992. "This man is well settled. Refuses to see the psychiatrist. He appears to have resolved his problems. Clinically well."

6 December 1992. "Returned to prison after DSH. Cut forearm (L) with razorblade".

7 December 1992. "Psychiatric opinion. H/O OD last week – cut arm on Friday. C/O "I just want to die, problems, I have nothing left, I have lost everything – wife and kids". Angry ++ about charges". "Impression: adjustment reaction to break-up of marriage. Acute suicidal ideation. Management: requires close observation in hospital. Melleril 25 mg tid."

8 December 1992. "Suicidal ideation remains – observe: Temazepam 10 mg nocte 3/7. Refused to have arm wounds dressed or any attempts at suture".

10 December 1992. "Continues to express thoughts of self-harm. To remain in hospital".

14 December 1992. "Remains angry and continues thoughts of self-harm. To remain in hospital".

December 1992. Reviewed by a Consultant Forensic Psychiatrist "he tells me things are now resolved". "Mr Kenneway seemed bright and cheerful at interview. He told me he had started eating again. He expressed a wish to return to the wing. He denied any thoughts of self-harm. This man appears well settled. I suggest he is returned to ordinary location".

8 January 1993. "Patient still C/O insomnia and anxiety".

15 February 1993. "This man remains very anxious and worried about medication for his constant headache and this may damage his liver".

23 February 1993. "This man remains anxious and worried".

25 February 1993. "Not sleeping. Still remains anxious. His marriage is now broken up and this would seem to be at the route of the present problem. He requests to be reviewed by the psychiatrist to help him sleep. Prescribed Temazepam 10 mg nocte for 4 nights".

23 March 1993. "This man is awaiting an urgent appointment with the psychiatrist. He is very agitated and disturbed. Sweating and shaking even during interview and certainly requires to be seen as soon as possible. I would suggest Temazepam 20 mgs nocte for the next 3 nights".

26 March 1993. "Patient has self-inflicted injury L wrist. Attempting to remove his tattoos".

5 April 1993. "In psychiatric referral".

20 December 1994. "Worried" – "recent personal problems – poor sleep" – "prob psychological".

4 April 1996. "Still feels unsettled. Unable to take the Melleril. Give him Diazepam 2 mg twice a week for a week".

30 April 1996. "Anxiety". "Treatment Melleril 25 mg tid for one week".

7 March 1997. "Claims marital problems, not sleeping, anxiety. Treatment: Phenergan 25 mg nocte for 5 nights".

28 April 1997. "Appears anxious. Seen in PSU following hostage incident".

Referral to Specialist Services

7 June 2007. Dr A in his referral letter to the Consultant Psychiatrist states that Mr Kenneway "appears to be affected by his environment in that he only sees any officer who deliver meals to him. Only recently has he started taking a period of exercise in the yard. He also described flashbacks of events in his life for which he was in prison prior to 2000. This involves a very high profile death in HMP Maze. He also perceives himself to be under definite threat from other paramilitaries. He also perceives that the authorities are in some way punishing him. Please see and assess".

25 February 1993. Dr E, Medical Officer in his letter of referral to Dr F states that Mr Kenneway is "feeling very tense and anxious. He is obviously unsettled". This was part of an urgent referral. Behind this in the bundle of papers is what appears to be a letter from Mr Kenneway in which he states "I just can't go on without her sunny, but I don't want to hurt her anymore. I really don't know what to do. I only wish I had done the job right last week because I'm really in so much pain and no-one can help me". Also "I don't think I've ever felt as lonely as this in my whole life mate. I tried to get back to the wing but the know the next chance I get I'll do the job right, but I'm still going to do it no matter where."

16 November 1992. Referral/assessment of suspected suicide risk. This states that Mr Kenneway is uncharacteristically withdrawn into himself not wanting to associate with other prisoners and requests to be locked in his cell during exercise periods. His cell mate has approached me voicing his concern and asking if I could arrange for a hospital officer or doctor to have a look at him." It also states "this prisoner has already taken an overdose of drugs in the last week and I feel from information received that this prisoner is at risk of self harm and should be seen by medical staff".

Autopsy Reports

The autopsy report by Professor J Crane (late June 2007) notes that Mr Kenneway had made a number of telephone calls in the afternoon of 8 June and that he had become quite agitated because his family members had failed to visit him that morning. He refused his usual meal at around 3.30 pm.

At about 5.16 pm the Prison Officer check found Mr Kenneway hanging from the cell window. Post mortem findings included several linear scars along the fold of the elbow, the front of the mid-forearm and wrist of the left upper limb.

Microscopy of the heart revealed sphere atheromatous narrowing of the left coronary artery and fairly extensive fibrosis in the lateral wall of the left ventricle.

Forensic science revealed the following:

Diazepam plus metabolite in a concentration of 0.5 micrograms per ml. I am advised that the normal therapeutic range for Diazepam is 0.1-1.0 micrograms per ml.

Venlafaxine in a concentration of 0.10 micrograms per ml

11-nor δ 9-tetra hydrocannabinolic acid, also detected in the urine. I understand that Cannabis, because of its high uptake into body fat stores, has a very long half-life. A positive result therefore may still be obtained many days after recent consumption.

Forensic screening for medication and drugs routinely include screening for a wide range of substance misuse including amphetamine, Ecstasy, cocaine, opiates together with a range of psychotropic medication. It can reasonably be assumed therefore that apart from the substances actually detected, Mr Kenneway would not have had any other psycho-active substance in his bloodstream.

The autopsy report by Dr JL Carson (14 June 2007) states “old linear scars across the front of left elbow, forearm and wrist were indicative of previous injuries, of a type usually self-inflicted”.

Review of telephone calls

Mr Kenneway made approximately 50 calls during the period 6 May – 8 June 2007. Calls, several in any one day, were made on all but 6 days during this period.

From the conversations it would appear that Mr Kenneway was describing drugs. These were referred to as “smokes, Diaze’s”, “Canaries”. It would seem that arrangements were being made to bring substances to Mr Kenneway in prison. I note conversations on these issues on 18 of the 27 days on which we have transcripts.

On 3 June Mr Kenneway described having had a “party” and “out of my head there for 2 days”. Also that he “woke up at lunchtime there was breakfast, lunches, dinners – teas, everything sitting at the door”. (Note prison staff record for 3 June).

On 5 June 2007 Mr Kenneway described finding a bag containing a large number of tablets (on 4 June 2007) – “Diaze’s” in the prison waiting area where he had been meeting with his solicitor. He described “a thousand tablets” and “they were wrapped in 20’s – 2 x 20 packets”. Elsewhere (4

June) he described handing the tablets over to the Prison Officers, but elsewhere (5 June) “I got as many between my cheeks as possible and then called the screw”.

I understand that the Prison Service confirmed that 300 unidentified blue tablets were discovered in the Visitor’s area.

Mr Kenneway expressed various degrees of stress, sense of isolation, loneliness and being depressed in conversations over 9 of the 27 days for which there are transcripts. The majority of these negative descriptions of his situation and status were made in late May and June – that is, on 7 of the 10 last days on which we have recordings between 27 May and 8 June.

From the transcripts of the 3 calls Mr Kenneway made on the afternoon of 8 June it is evident that he was very distressed at the failed visit. He referred to a sense of isolation, feeling let down, “I might as well be dead” and “I’m at the lowest point of my life”.

SUMMARY AND OPINION

Earlier history

From review of the prison staff, prison health and general practitioner medical records Mr Kenneway spent much of his adult life within the prison system. In 1983, the time of his first committal, he would have been 21 years of age. There are some 11 committals between 1983 and 1990. Between 1991 and 2000 he was continuously within the prison system. Over this 17 year period there are a number of entries in the records reporting Mr Kenneway presenting to prison staff or healthcare staff with mental health symptoms. These mostly consisted of anxiety or depression. In some instances these symptoms were associated with loss of appetite and/or disturbed sleep. Most episodes appear to be relatively brief, weeks only. They were mostly associated with Mr Kenneway’s perceived relationship and marital difficulties and his concerns about these.

There are also several documented instances of self-harm and in some of which there appear to have been a degree of suicidal intent. Several health interviews refer to an instance of wrist slashing in 1981 and possibly 2 overdoses in 1982 that is before Mr Kenneway entered the prison system.

In 2 documented episodes of mental health difficulty Mr Kenneway was seen by specialist psychiatrists whilst in prison. The first was in 1989 (age 27). During this episode anxiety and depression were both confirmed and Mr Kenneway was prescribed the antidepressant Prothiaden as well as the tranquilliser Melleril. In the clinical assessment he was described as a man of quite small stature who could neither read nor write who admitted to being jealous and possessive by nature and felt inferior to others.

In November and December 1992 Mr Kenneway had a further period of mental health difficulty and was considered at risk of self-harm. He appears to have taken several small overdoses. Psychiatric assessment at the time led to a diagnosis of adjustment disorder. He was commenced on the tranquilliser Melleril and close observations were advised.

Mr Kenneway had further brief episodes of mental health symptoms in 1993, 1996 and 1997.

During the period 1991 – 2000 Mr Kenneway had frequent visits to prison health services with minor physical complaints; my estimate is approximately 22 visits per year. This is a high rate of referral and suggests he may have had anxieties about his physical well-being. The autopsy findings indicate that Mr Kenneway had quite advanced disease of his left coronary artery. The presence of fibrosis of the heart muscle in the area of this arteries distribution suggests that the heart muscle itself was diseased. It is outside my area of expertise whether such findings indicate a history of previous myocardial infarction.

Mr Kenneway left prison in 2000 and came under the care of his General Practitioner. Early in 2001 there is a record of Mr Kenneway having mental health difficulties. He was described as being unable to settle since getting out of prison with reduced appetite, impaired sleep and loss of interest. He was commenced on Efexor in May 2001 remaining on it until July 2002. There are no entries in the GP records between July 2002 and March 2005. However there are copies of DLA submissions for 2001, 2003 and 2005. The 2001 entry refers to nervous debility, anxiety, depression, Post Traumatic Stress Disorder. These issues are again noted on the DLA forms for 2003 and 2005.

The GP records for October 2006 state that Mr Kenneway was depressed and agitated. He was also complaining of having flashbacks and nightmares. A psychiatric referral was initiated and antidepressant medication (Efexor) was recommenced in December 2006.

In summary Mr Kenneway, from a psychological perspective, was a rather vulnerable man with a poor self-image. From time to time he manifested symptoms of psychological difficulty and distress. There are also several documented instances of deliberate self-harm. On at least one occasion within the prison system, when describing low mood, he was placed on special observation. He used prison health services frequently throughout his periods in prison and seemed concerned about his physical well-being.

Prior to Mr Kenneway's last committal he had been referred to specialist psychiatric services because of depression, anxiety and symptoms suggestive of Post Traumatic Stress Disorder. However apart from this referral, and in spite of earlier symptoms of mental distress and difficulty, between 2001 and 2006 he had not been referred to specialist mental health services.

Committal in February 2007

The committal assessment in February 2007 correctly notes that Mr Kenneway had a history of depression, had had a psychiatric referral with complaints of poor sleep, and had been prescribed an antidepressant (Efexor). From the kardex he was commenced on Efexor antidepressant medication on 5 February at a dosage of 75 mg daily, which appeared to be the dosage he was receiving prior to committal. He was also prescribed Diazepam for 5 days and Promethazine. On 9 February he was again prescribed Diazepam for a further 5 days and on 16 February more Promethazine.

The prison health record for 26 February 2007 states that Mr Kenneway had difficulty sleeping, had been on Efexor and that a script had been ordered. The kardex indicates that the Efexor medication was increased to twice daily. He was then on Venlafaxine (Efexor) 150 mg per day. This is an adequate dosage of an effective antidepressant. The use of this drug at this dosage would have been appropriate given Mr Kenneway's recent history including sleep disturbance following committal.

Mr Kenneway was again noted to have difficulty sleeping in early April 2007 and night sedation (Zopiclone 7.5 mg) was prescribed for 3 nights.

Referral on 7 June to Dr A (Prison Doctor)

A nurse on 20 April 2007 records that Mr Kenneway saw her, complained of dizzy symptoms and tension headache and that he felt himself to be having a panic attack. He also referred to domestic difficulties and was complaining of not sleeping well. A nurse records that she spoke with Dr A regarding wax removal and also that a prescription of Phenergan 25 mg for 7 nights was initiated. Although Phenergan is primarily an antihistamine it is also prescribed for mild insomnia.

Mr Kenneway was seen on 3 subsequent occasions during May by staff nurses, exclusively related to ear symptoms. No mention in the record is made of further mental health symptoms or screening for such symptoms. Also in May it was recommended that Mr Kenneway be seen by the doctor because of his ear symptoms.

The Prison Officer reports on 2nd June note that Mr Kenneway had not been well, spending most of the day in bed and acting out of character. It records that the medic had been asked to have a talk with him and that the outcome was that he was fine. The entry for 3 June again reports that Mr Kenneway spent the day in bed, but was again reported to be OK according to the medic. There is no record of Mr Kenneway's consultation with healthcare for these 2 referrals.

The entry for 5 June again states that Mr Kenneway was "not well" and that he had requested to see the doctor twice. He was considered to be "more like himself" on 6 June but on 7 June was considered "not well".

Consultation with Dr A (Prison Doctor) (7 June 2007)

When seen by Dr A on 7 June Mr Kenneway's complaint was in relation to his chest. Nevertheless he did go on to describe psychological symptoms including flashbacks and the doctor noted that he appeared to be quite troubled by them and that he had been having thoughts of deliberate self-harm. The prison doctor initiated a psychiatric referral.

It is evident from Dr A's note and from his referral letter that he was sufficiently concerned about Mr Kenneway's mental wellbeing to refer him to the psychiatrist. No mention is made of current or recent mental health problems or of current medication.

There is no documentation of any assessment of mood or assessment of risk factors for suicide. It is unclear whether the written or electronic records, including Kardex, were available to the doctor at the time of consultation. If such information was not available then assessment of risk would come down to direct clinical assessment. This nevertheless is a key part of the risk assessment and should be documented.

In his letter of referral the doctor refers both to flashback symptoms and also that Mr Kenneway perceived himself to be under threat not only from paramilitaries but that the authorities were in some way punishing him. It is not clear whether the doctor considered Mr Kenneway's perceptions as largely groundless and therefore part of some psychological elaboration, which in itself might be further evidence of mental health difficulty. Or that Mr Kenneway reasonably perceived these threats, because of his situation, and therefore a significant source of distress.

From the available documentation there is no evidence that Dr A suspected Mr Kenneway of being at significantly increased risk of suicide sufficient to initiate the PAR 1 arrangements.

Comment and Opinion

1. Vulnerability. From the documented evidence, and as noted above, Mr Kenneway was a vulnerable man, vulnerable to psychological distress. On a number of occasions he manifested such distress and either sought referral to prison medical services or the help of his General Practitioner. On several occasions during adult life he made attempts at deliberate self-harm and expressed feelings of wanting to die.

Mr Kenneway's prison health records contain substantial evidence of mental health vulnerability including previous history of mental health problems, episodes of low mood, mental distress and documented instances of deliberate self-harm. All of these are risk factors which would need to be considered in the context of the mental health health and behavioural problems arising in the course of the present committal.

A number of risk factors were present during the present committal. Mr Kenneway was on antidepressant medication. By June 2007 he had been within the Special Supervision Unit for approximately 3 months in conditions of significant isolation. It is my understanding that outside of infrequent visits he would have been in the confines of his cell on his own about 22 hours per day. There is documented evidence of altered behaviour in early June.

2. Healthcare and healthcare provisions. Mr Kenneway presented to prison services in 2007 with a recent history of depression and having been on antidepressants. These facts are documented in the committal forms. Mr Kenneway was commenced on antidepressant medication following committal, consistent with his treatment immediately prior to entering prison. The dosage was increased, in my opinion appropriately, in late February 2007. He was from time to time prescribed minor tranquilisers and night sedation. It is also my impression that Phenorgan, an antihistamine, was used intermittently for its sedative effects.

There appears to have been concern among prison staff that Mr Kenneway's behaviour was altered in the early part of June 2007. What is unclear is whether or not staff were considering a psychological basis to such altered behaviour but the reassurances from the "medic" on those occasions was a sufficient override. It is also unclear whether the "medic" assessments in early June gave serious consideration to suicidal risk.

It is ultimately the responsibility of a mental health professional to carry out specialist psychiatric assessment, taking full account of all available information, from all available sources, and within a multi-disciplinary context. Nevertheless it is the responsibility of all staff to consider the possibility of suicidal risk in at-risk prisoners. As a General Practitioner the prison doctor would not have been responsible for a detailed mental health assessment risk on Mr Kenneway. He did make a psychiatric referral. However in the absence of a specialist assessment of suicidal risk all staff, including healthcare staff, must consider the introduction of the PAR 1 process as a safety net. These lessons were again learnt in our recent review of prison deaths in 2005.

Professional risk assessment of suicide must include a consideration of the recognised risk factors. It is not clear whether all of the foregoing facts were available to the prison doctor at the time of assessment.

If the information at committal and the further information on Mr Kenneway's health was available at the time of assessment this should have provided sufficient information, in addition to the findings at interview with Mr Kenneway on 7 June, to have triggered the introduction of the PAR 1 process.

3. Communication and documentation. While it would appear that a nurse in April 2007 had some concern regarding Mr Kenneway's mental wellbeing, including the raising of a prescription for Phenergan, there is no documented monitoring of these issues. Prison staff had concerns in early June and

requested a “medic” opinion on two occasions. Documentation of such considerations, opinions and actions are an important part of professional practice and risk management. Earlier documented evidence of poor sleep and admission evidence of a history of depression and antidepressant medication should have been available to healthcare staff.

There is no evidence that any concerns regarding Mr Kenneway’s mental wellbeing was transmitted by healthcare staff to the prison doctor when he saw Mr Kenneway on 7 June.

As noted above it is not clear if the documentation on the risk factors in Mr Kenneway’s past history, mental health issues recorded in the recent committal documentation, subsequent sleep difficulties and concerns, altered behaviour in early June were readily available to the prison doctor. The importance of medical practitioners and other healthcare staff having ready access to health history information must be stressed. If not readily available it points to a significant deficiency in healthcare communication within the prison establishment.

4. Operating guidelines for the introduction of the PAR 1 process. These may need to be revisited in the light of the present experience. The guidance for all staff on the use of the PAR 1 arrangement should make explicit the threshold criteria for its introduction. For example: where there is an alteration in the usual pattern of behaviour or mood, where known risk factors are present. Such arrangements should prevail until an appropriate professional assessment of suicidal risk has been completed.

Suicide risk assessment is an inexact science. Many of the associated risk factors for completed suicide, for example previous history of depression are simply statistical pointers to increased risk. Such statistical factors must be linked to thorough clinical assessment. Such clinical assessment must be grounded on appropriate training, including Continuing Professional Development, qualifications and experience. These would be the usual attributes of a mental health professional.

5. Additional information on Mr Kenneway’s mental health in May and June 2007 – telephone calls and forensic tests. Analysis of telephone calls made by Mr Kenneway provide some additional information on Mr Kenneway’s mental health over this period. From my analysis of this information two main issues emerge.

The first is that Mr Kenneway was using illicit and non-prescribed drugs. However the most objective evidence for this is in the forensic analysis of urine and blood. From this it can be concluded that he had consumed Cannabis and the Benzodiazepine drug Diazepam.

There are strong suspicions from the telephone conversations that Mr Kenneway had been obtaining substances from both visitors and fellow inmates. On 3 June he described being “out of it”, “stoned” and waking up at lunchtime with meals outside. These descriptions accord with the Prison

Officer observations and concerns around this time that he had been taking to his bed and his behaviour being out of character. The most likely explanation therefore for Mr Kenneway's altered behaviour at this time was drug intoxication.

Second scrutiny of the telephone conversations also gives some insights into Mr Kenneway's general mood state over this period. He made several telephone calls on most days and appeared to engage readily with the various callers – family and friends. On occasions he did refer to his sense of boredom and, particularly in late May and early June, his increasing sense of isolation.

It would also appear that, in addition to Mr Kenneway's situation of relative isolation and boredom, problems in relation to visits greatly amplified his level of distress. On two separate occasions he described himself as being depressed or low – 29 May, 8 June. On the former this appeared to be in the context of difficulties surrounding a planned visit.

Mr Kenneway appeared to be at his most distressed state on the 8 June. The direct cause for his distress appears to have been a failed visit on that day. He described a sense of isolation, feeling "I might as well be dead" and "in the lowest point of my life". I understand that after the last of the three afternoon telephone calls on 8 June he refused his late afternoon meal.

While I have noted a number of vulnerabilities with Mr Kenneway and within his situation it is my impression that a likely trigger for his suicidal action was the distress arising from this failed visit.

6. Drugs and mental health. I have earlier referred to Mr Kenneway probably being intoxicated on 2/3 June. I understand that around 4 June fellow inmates had been moved from SSU. He had no further visits. Access to illicit drugs therefore would have been very limited. From his telephone conversations he appeared to be concerned about getting more drugs on his next prison visit. However Mr Kenneway also described finding drugs in the visitor's area on 4 June and, while handing these in, described retaining some. He described them as "Diazos" and were described by the Prison Officers as blue tablets. They are likely to have been Diazepam. The positive forensic tests for Diazepam and the amount found being at the high end of the normal range for therapeutic use, confirms Mr Kenneway's recent use of Diazepam. While his blood and urine also tested positive for Cannabis metabolites I understand this substance remains for quite a long time in the body following consumption. The test result probably reflects drug use on 2/3 June when he appeared to have been intoxicated.

I understand that on 8 June Mr Kenneway was late to get up and to get washed and dressed, in spite of an anticipated visit. We do not have information on the telephone calls he made on 7 June. However on the days prior to this there is no mention of depression or feeling low, which if present could have been a contributory factor.

Possible contribution of drug use is raised. It is possible that ongoing use of Diazepam from 4 June, may have contributed. Recent use was confirmed by the forensic test findings. While the amount detected was within the therapeutic range, assuming he took the substance during the night of 7 June, the actual levels at that time could have been rather higher.

Cannabis. Taking all of the information, the various observations of Mr Kenneway, including his telephone conversations, and the medical literature(see below), it is unlikely that Cannabis use per se on June 2/3 contributed significantly to alteration in behaviour on 8 June.

Drug interactions. In addition to substance misuse Mr Kenneway was also taking prescribed drugs. Venlafaxine, an antidepressant, was the only psychotropic medication he had been receiving since late April. Having checked I am unaware of specific interactions between Cannabis and venlafaxine. While diazepam can be prescribed with this antidepressant sedative effects may be increased. .

7. Substance misuse and suicide. Review of the literature suggests that heavy Cannabis use may increase depressive symptoms among some users. While there is evidence of a link between Cannabis and suicide this is principally with chronic use and also with the development of a psychosis.

Psycho-active substances including Diazepam and Cannabis can also increase the risk of self-harm behaviour through their disinhibiting effects. On balance I consider this to be unlikely in this particular instance for the following reasons. The level of Diazepam and metabolites noted in the blood were within the therapeutic range only at the time of death. There is no evidence that Mr Kenneway was continuing to access Cannabis after 3 June. No other substances including alcohol were found in his blood.

8. Public health implications. As noted there is evidence that Mr Kenneway was readily able to access drugs of misuse, even whilst within the relatively secure provisions of the Special Services Unit. It is a matter of concern for the general wellbeing of prisoners that this can happen. Mental health and general health problems can arise from substance misuse.

There are also wider public health issues. Mr Kenneway appears to have been enabled by family and friends to have access to substances of misuse. This reflects a wider cultural problem. There are implications for regulation, health promotion and education within the wider community.

Roy McClelland
Emeritus Professor of Mental Health

ANNEX. Review of Mr Kenneway's GP Medical Records and Correspondence

The Practice Manager states that Mr Kenneway registered with Hall's Family Doctors on 19 June 2001. I had available to me a copy of contemporaneous records from 22 February 2001 until 5 February 2007. However the entry for 2 February 2007 states that Mr Kenneway was in Magheraberry prison. The last entry which appears to be related to a clinical consultation was on 7 December 2006.

From the computerised record of "all consultations" I note the following:

14 September 2005. "significant history anxiety/depression".

10 October 2006. "having flashbacks to incidents he was involved in and having nightmares which prevent him sleeping. He is depressed and agitated. No ideas of suicide". Medication Chlorpromazine 25 mg. A psychiatric referral to Royal Victoria Hospital was initiated.

24 October 2006. Private line for court. "Unable to attend due to anxiety/depression." "Objectively very anxious/agitated". Prescribed Chlorpromazine 50 mg.

7 November 2006. "Depression".

From the computerised patient summary I note the following:

7 September 2001. "symptoms of depression", "nerves", – "nervousness: nervous debility".

January 2005. "anxiety with depression".

Repeat prescriptions:

18 December 2006. Efexor XL 75 mg (an antidepressant), Diazepam 5 mg (a minor tranquiliser).

9 March 2007. "due for next Efexor XL".

From the handwritten GP medical notes I note the following previous mental health history:

22 February 2001. "Diazepam". "Can't settle from got out of jail". "↓ interest, sleep, appetite".

10 May 2001. "Efexor".

27 June. Repeat prescription for Efexor.

10 August 2001. Repeat prescription for Efexor.

8 October 2001 "Efexor".

10 December 2001. "Depression".

25 March 2003. "Efexor 75 mg".

8 May 2001. Repeat prescription.

12 June 2002. Repeat prescription.

10 July 2002. Repeat prescription.

Entries on DLA application forms:

7 September 2001. Mention is made of "nervous debility with anxiety, depression, post traumatic stress disorder". Medication is stated to be Cipramil (an antidepressant), Diazepam and Temazepam (minor tranquilisers).

4 December 2001. Is stated to be suffering from “treatment resistant depression, suicidal, would neglect himself”. Mention is also made of an overdose in 1993 – “has cut wrists in past”. Diagnosis is given as “depression, anxiety and post traumatic stress disorder”. Medication is stated to be Efexor, Diazepam, Temazepam.

9 May 2003. Mental health problems stated to be “depression, anxiety, panic, phobic state”.

14 August 2003. Is stated to be depressed and medication Temazepam, Diazepam, Efexor.

25 March 2005. Stated to have suicidal thoughts. Depression.

9 May 2005. Stated to be suffering from “nervous debility, severe depression, anxiety, post traumatic stress disorder”.

Medical Correspondence

1 February 2007. The Consultant Psychiatrist states that Mr John Kenneway failed to attend a new patient appointment on 1 February 2007.

Witness Statement

(C.J. Act 1967, s. 9 MC Act 1980, ss 5A (3a) and 5B Criminal Procedure Rules 2005, r 27.1)

Statement of Pauline Marjorie LAX BSc (Hons)
Age Over 18
Occupation Forensic Scientist

with

LGC Forensics (a division of LGC Ltd)
Culham Science Centre, Abingdon, Oxfordshire, OX14 3ED

This statement, consisting of 10 pages each signed by me, is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated the 24th day of September 2009

Qualifications and Experience

I am a Bachelor of Science (Honours) in Biochemistry. I was employed for over 16 years by the Home Office Forensic Science Service as a forensic scientist specialising in the analysis of body fluids and other materials for the presence of alcohol, drugs and poisons. The analyses were commissioned mainly by police forces and H M Coroners. Since August 1998 I have been employed by Forensic Alliance Limited, Culham, Oxfordshire and now by LGC Forensics in a similar capacity.

Case Reference Number FAL-009829-09 (Police Ref: John Kenneway)

Information

I understand that on the 8th of June 2007 at 17:16 hours, John Martin Gerard Kenneway was found hanging in his cell at Maghaberry Prison, Northern Ireland. He was last seen alive at approximately 15:30 hours the same day.

Prior to preparing this statement I have had access to the following information:

- **A letter from Pauline McCabe, Prisoner Ombudsman for Northern Ireland dated the 23rd July 2009**

This letter summarises the autopsy report prepared by Professor Crane. It also refers to recorded telephone calls made by the deceased in the days leading up to his death. In these calls it appears that Mr Kenneway may have had access to drugs, possibly cannabis and diazepam, which may have been supplied by visitors and/or other prisoners. In particular, one phone call on the 5th June 2007 (the letter actually states 2008, but I will assume that it was 2007) Mr Kenneway tells his caller that he found a bag of tablets which he calls “diazis”. The Prison Service has confirmed that 300 unidentified blue tablets were discovered in the visitors area but no analysis appears to have been undertaken. On the 6th June in another phone call Mr Kenneway asks if ‘the cannabis has been sorted out’. On the day of his death he was expecting a visit which [the visitors] were unable to make.

- **A copy of Mr Kenneway’s prescribed medication while he was in Maghaberry Prison**

I note from these record sheets that Mr Kenneway had been prescribed venlafaxine (‘Efexor’) (75 milligrams twice a day) at the time of his death. On the day of his death he had been given one dose of this drug. On the day prior to his death it appears that he may have refused his morning dose of this drug but he had taken his evening dose. Prior to this it appears that he had been taking venlafaxine regularly and had first been prescribed it in February 2007.

The record sheets indicate that Mr Kenneway was also prescribed 'Arthrotec' (diclofenac and misoprostol) at the time of his death but from his records it appears that he was not given this drug in the days before his death.

According to the record sheets Mr Kenneway had not been prescribed any other medication at the time of his death. I note that Mr Kenneway was not prescribed diazepam at the time of his death and that he was last prescribed diazepam (2 milligrams) on the 15th February 2007.

- **A copy of Professor Cranes autopsy report from the post-mortem of John Kenneway carried out on the 9th June 2007**

In this report the cause of death was given as hanging. The report refers to toxicology analyses undertaken by Forensic Science Northern Ireland (see below). This report indicates that no alcohol was detected in the blood or urine samples

- **A copy of the statement prepared by Forensic Science Northern Ireland (FSNI), dated the 10th August 2009**

This statement (reference FSNI No 2803/07, IPC No 137790) refers to analyses carried out at Forensic Science Northern Ireland. It reports the following results:

The blood sample (item JC10) was found to contain:

“0.84 micrograms diazepam plus metabolites per ml
0.10 micrograms venlafaxine per ml
11-nor-delta-9- tetrahydrocannabinolic acid”
(concentration not measured)

The blood was also analysed for a range of commonly abused drugs and a general basic drugs screen but no other drugs were detected.

The urine sample (item JC10) was found to contain:

11-nor-delta-9- tetrahydrocannabinolic acid
(concentration not measured)

The urine was also analysed for a range of commonly abused drugs but no other drugs were detected.

The analyses of the blood and urine samples for alcohol is not mentioned in this statement but I have been informed in the autopsy report (see above) that no alcohol was detected in either of the samples.

- **Further communication from Forensic Science Northern Ireland (3/08/09)**

The diazepam concentration in the blood sample which was referred to in FSNI's statement was made up of the following:

0.37 micrograms diazepam per ml
0.45 micrograms nordiazepam per ml
0.02 micrograms temazepam per ml

Receipt of Items

On the 20th of August 2009 the following item was received at the laboratory from the Forensic Science Northern Ireland Laboratory (FSNI No 2803/07, IPC No 137790):

Taken from John Kenneway at post-mortem examination, 09/06/2007

JC10 Blood + Urine for tox

Purpose

I have been asked to analyse the blood sample taken from Mr Kenneway for the presence of a range of cannabinoids, and if present, to ascertain whether or not they may have affected his behaviour.

I have also been asked to interpret the information referred to in the information section above and to give assistance with the following questions:

1. Given the fact that diazepam was reported as being at a therapeutic level how does this relate to JK's prescribed medication and his apparent taking of blue tablets found on the 4th June? What is the half life of diazepam?
2. The day before he died a prison doctor who saw JK said that he considered him to be in reasonably good form. The morning of his death there is evidence that JK may have been very down. There have been reports of 'UDA blues' being linked to suicides/attempted suicides. There are also reports of the drugs producing a 'high' followed the next day by feeling very bad. Might JK, as a result of taking blue tablets, have experienced a high, followed by a severe low on the day of his death?
3. JK was looking forward to a visit on the morning of his death which the [visitors] were unable to make. JK appeared to expect that they would be bringing drugs for him. If he had been continually using drugs over the previous week(s), as his calls suggest, what might be the effect of his supply of drugs being halted?

Use of Assistants

In carrying out this work I was assisted by another scientist and I have taken her contribution into account when preparing this statement. A full record of this work is available at the Laboratory and statements can be prepared by the other scientist involved if sufficient notice is given.

Nature of Examination

The blood sample was analysed specifically for the presence of the following range of cannabinoids: delta-9-tetrahydrocannabinol (THC, the major active constituent of cannabis and cannabis resin); 11-hydroxy-delta-9-tetrahydrocannabinol (hydroxy-THC); 11-nor-delta-9-tetrahydrocannabinolic acid (carboxy-THC, a metabolite of THC) and cannabidiol (another cannabinoid).

No further analyses were carried out on the blood sample taken from Mr Kenneway and the urine sample was not examined.

Results

The following substance was detected in the blood at the concentration stated:

Carboxy-THC	0.011 milligrams per litre of blood
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None of the other cannabinoids, including THC, were detected.

Comments

Comments on post-mortem redistribution

Concentrations of some drugs in post-mortem blood samples may be higher than the blood concentrations circulating at the time of death. This is due to the diffusion of drugs from tissues and other locations where the drug is more concentrated, such as the stomach and liver,

into the blood, after death. This effect can be minimised if the post-mortem blood is taken from peripheral sites, such as the femoral vein.

Cannabinoids

THC is the major active constituent of cannabis and cannabis resin, and is largely responsible for the effects experienced by users. THC is broken down in the body firstly to hydroxy-THC, which is also pharmacologically active. This is then further converted to carboxy-THC, which is not pharmacologically active and is eliminated from the body primarily in the form of a glucuronic acid conjugate (that is, with the addition of a sugar-derived molecule which renders it water soluble).

The presence of cannabinoids in blood samples is often demonstrated by confirming the presence of carboxy-THC; however, carboxy-THC can persist in the body for several hours (long after the effects which follow smoking have worn off) and in cases of heavy and/or prolonged use it can be detected days later. This causes a problem in the interpretation of the results, since it is not safe to conclude from the presence of carboxy-THC (or unspecified "cannabinoids") that the person concerned was under the influence of cannabis at the time the sample was taken. This problem does not occur with THC, the concentration of which in the blood is known to fall off rapidly after smoking cannabis or cannabis resin, generally becoming undetectable after several hours. However it is reported that, particularly in heavy cannabis users, low levels of THC can be detected in blood for longer periods of time.

Carboxy-THC was detected in Mr Kenneway's blood at a low concentration and no THC or hydroxy-THC was detected. Due to the absence of THC and hydroxy-THC, these results would usually be consistent with the non-recent use of cannabis/cannabis resin. This

use would be likely to be either very light use within a few hours of death or heavier use many hours or even days before death. In either of these circumstances it would be unlikely that he would have been under the influence of cannabis at the time of his death. The Forensic Science Northern Ireland Laboratory, who carried out the original analysis, also detected carboxy-THC but they did not measure the concentration. They also did not analyse the samples for THC or hydroxy-THC. There are several reports in the scientific literature which indicate that cannabinoids and in particular THC and hydroxy-THC may not be stable in blood samples if stored for long periods of time. If the samples are stored frozen, as they were in this case, the stability appears to be better, however as these samples had been stored for over 2 years it seems likely that there would be at least some deterioration. It has also been shown that samples stored in plastic sample tubes are more likely to lose THC than those stored in glass tubes as THC is known to bind to plastic. The blood sample in this case was in a plastic tube and this may therefore have further contributed to the loss of THC. Therefore, although no THC or hydroxy-THC was detected in Mr Kenneway's blood sample, I cannot conclude that this would have been the situation at the time of his death. The concentration of carboxy-THC that we detected in the blood is low. Although carboxy-THC is thought to be more stable than THC it is likely, after this period of time, that there may have been some loss and this low concentration may not reflect the concentration present at the time of Mr Kenneway's death.

Cannabis and cannabis resin are normally abused by mixing the drug with tobacco, preparing a hand-rolled cigarette (usually called a "reefer", "joint" or "spliff"), and smoking the mixture. The effects of cannabis are reported to vary with the amount used, the setting, and the experience and expectation of the user. These effects may include euphoria and relaxation, distortion in the perception of space and

time, disturbance of memory and judgement, irritability, and deterioration in co-ordination. The onset of these effects follows quickly after smoking the drug, the effects reach a peak in about 20 to 30 minutes, and then gradually dissipate over the following 3 to 4 hours. Cannabis is normally a relaxing, sociable drug, which is unlikely to cause hyperactivity however anxiety or panic reactions may occur, particularly in inexperienced users and psychoses have been reported as an adverse effect in some individuals.

Benzodiazepines

Diazepam is a benzodiazepine drug used in the treatment of anxiety and in acute alcohol withdrawal. It is also commonly taken by drug users to alleviate dysphoria when regular drugs of abuse are not available. It is converted in the body to desmethyldiazepam and to a limited extent to temazepam and oxazepam all of which are pharmacologically active. The recorded side effects of diazepam therapy include dizziness, drowsiness, lack of co-ordination, disorientation, reduced alertness and slowed reactions, but someone who is receiving low regular doses may experience few if any of these.

The concentrations of diazepam and desmethyldiazepam detected together with a low concentration of temazepam are consistent with Mr Kenneway having taken regular therapeutic doses of diazepam prior to his death. The ratio of diazepam to desmethyldiazepam may indicate that Mr Kenneway had not have taken any diazepam in the hours leading up to his death (for a further discussion of these results see below).

Venlafaxine

Venlafaxine is a drug that inhibits the reuptake of certain neurotransmitters, and is prescribed for the treatment of depression. Adverse effects associated with the ingestion of venlafaxine include nausea, vomiting, dizziness, anxiety, tremor and blurred vision with overdose causing hypertension or hypotension, cardiac arrhythmia, seizures and coma.

As indicated by FSNI's statement, the concentration of venlafaxine detected in the blood from Mr Kenneway is broadly consistent with the therapeutic use of this drug and I am informed that it had been prescribed to him.

Comments specific to the questions outlined in the 'Purpose' section above

Given the fact that diazepam was reported as being at a therapeutic level how does this relate to JK's prescribed medication and his apparent taking of blue tablets found on the 4th June? What is the half life of diazepam?

As mentioned above and in FSNI's statement, the levels of diazepam and its breakdown products are typical of the levels reported in individuals who are taking therapeutic doses of diazepam on a regular basis. It appears from Mr Kenneway's list of prescribed medication that he was not being prescribed diazepam at the time of his death.

Diazepam is broken down in the body to desmethyldiazepam and as the desmethyldiazepam is slightly higher than the diazepam it is likely to indicate that Mr Kenneway had not taken a very recent dose of diazepam and it may have been some hours since he took his last dose. However as both the levels are relatively high it is consistent with him having taken diazepam on a regular basis and having taken

his last dose relatively recently and possibly within the last day or two preceding his death. Diazepam does take a relatively long time to be eliminated from the body (half life 21-37 hours) but the metabolite desmethyldiazepam takes considerably longer (half life 50-99 hours). The half-life of a drug is the time that it takes to eliminate half of a particular concentration of the drug from the blood. If an individual has not taken diazepam for some days then the level of desmethyldiazepam would be expected to be considerably higher than the level of diazepam. If Mr Kenneway had taken a number of diazepam tablets on the 4th June, four days before his death, and taken none since that time I would have expected the ratio of desmethyldiazepam to diazepam to be higher.

The day before he died a prison doctor who saw JK said that he considered him to be in reasonably good form. The morning of his death there is evidence that JK may have been very down. There have been reports of 'UDA blues' being linked to suicides/attempted suicides. There are also reports of the drugs producing a 'high' followed the next day by feeling very bad. Might JK, as a result of taking blue tablets, have experienced a high, followed by a severe low on the day of his death?

It is not clear what the drugs referred to as 'UDA blues' actually contain. Drugs referred to as 'blues' are often diazepam 10 milligram tablets which are blue in colour. However I have seen reference to tablets called 'loyalist blues' which are said to contain 'ecstasy' and ketamine. With reference to the analyses carried out by the Northern Ireland Forensic Laboratory it seems likely that Mr Kenneway had not taken ketamine and 'ecstasy' in the hours leading up to his death as these drugs were not detected in the blood or urine samples. However if he had taken them a number of days before his death then they may well have been eliminated from his body by the time of death.

As diazepam was detected in Mr Kenneway's blood it seems most likely that the tablets referred to were diazepam tablets. The development of dependence is common after regular use of benzodiazepine drugs such as diazepam, even in therapeutic doses for short periods, and is particularly likely in patients with a history of drug or alcohol abuse and in those with marked personality disorders. Symptoms of benzodiazepine withdrawal may include anxiety, depression, headache and irritability. Rarely more serious symptoms such as psychosis, convulsions and hallucinations may occur. However, benzodiazepines do not produce the acute withdrawal symptoms which are associated with drugs such as heroin. Symptoms typical of withdrawal have occurred despite continued use of benzodiazepines and may be due to the development of tolerance. 'Pseudowithdrawal' has also been reported in patients who believed incorrectly that their dose of benzodiazepines was being reduced.

As diazepam is a long-acting benzodiazepine withdrawal symptoms are likely to take longer to develop, however, if Mr Kenneway believed that he no longer had access to diazepam I cannot exclude the possibility that he may have suffered some sort of 'pseudowithdrawal' as described above.

MDMA, which is commonly known as "Ecstasy", is widely abused, and has been a popular recreational drug on the dance/club scene for many years. It is a stimulant and mildly hallucinogenic drug, which is chemically related to amphetamine. MDMA is reported to produce feelings of euphoria and benevolence to others, with a blunting of inhibitions, a heightened awareness of sensory stimuli such as sight and touch, and an altered perception of time. As with other stimulants, the stimulant effects may be followed by fatigue, depression and reduced physical performance, which can result in impaired judgement. Therefore if Mr Kenneway had taken MDMA a day or two before his death it is possible that, although it had been

eliminated from his body, he may still have been experiencing some of the after effects at the time of his death

Ketamine is an anaesthetic used, now rarely, in general anaesthesia for diagnostic or short surgical operations that do not require skeletal muscle relaxation, for the induction of anaesthesia to be maintained with other drugs, and as a supplementary anaesthetic. Adverse effects associated with ketamine may include delirium, irrational behaviour, blurred vision, slurred speech, tachycardia, palpitations and depressed respiration. Ketamine is now commonly abused for its hallucigenic effects, which include floating sensations, perceived dissociation of the body from the mind and feelings of arousal and euphoria. Ketamine is eliminated from the body relatively quickly and as none was detected in Mr Kenneway's blood it is unlikely to have had any adverse effects at the time of his death.

It should be noted that if any of the tablets found at the prison were still available it would be useful to analyse them.

JK was looking forward to a visit on the morning of his death which the [visitors] were unable to make. JK appeared to expect that they would be bringing drugs for him. If he had been continually using drugs over the previous week(s), as his calls suggest, what might be the effect of his supply of drugs being halted?

As in the answer to the previous question, if Mr Kenneway had been expecting his [visitors] to bring him diazepam, I cannot exclude the possibility that he may have suffered some sort of 'pseudowithdrawal' if he thought that he would no longer have access to this drug. It is possible that this may have added to any psychological

disappointment that he may have suffered as a result of not seeing his [visitors].

Conclusions

1. THC and hydroxy-THC were not detected in the blood from Mr Kenneway. Although this may indicate non-recent use of cannabis, the absence of these substances may well be due to the deterioration of the sample over the two year period that it had been stored.
2. The carboxy-THC detected is consistent with previous use of cannabis or cannabis resin. The concentration detected was low and if this reflects the concentration at the time of death then it is likely to be due to relatively light use. However it is possible that the concentration would have been higher at the time of death.
3. The diazepam and its breakdown products that were detected are consistent with regular therapeutic use of diazepam, as described above. Mr Kenneway does not appear to have been prescribed diazepam at the time of his death
4. The venlafaxine detected in the blood is broadly consistent with its therapeutic use and I am informed that Mr Kenneway had been prescribed venlafaxine at the time of his death.