SUPPORTING APPENDICES BOOKLET FOR THE

REPORT BY THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

ALAN WILLIAM VIKTOR RUDDY

AGED 29

IN MAGHABERRY PRISON

ON 31 JANUARY 2008

18 MARCH 2010

Please note that where applicable, names have been removed to anonymise the following appendices booklet

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CONTENTS **PAGE**

Appendix 1 - Prisoner Ombudsman's Terms of Reference 3

Appendix 2 - Clinical Review Report 8

Appendix 3 – Background Information - Maghaberry Prison and Prison Policies and Procedures 50

APPENDIX 1

PRISONER OMBUDSMAN TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

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

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

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

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

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

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

Clinical Issues

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

Other Investigations

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

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

Disclosure of Information

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

Reports of Investigations

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

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

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the 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.

APPENDIX 2

Clinical Review Report

Report into the Standard of Medical Care Given

to

Mr Alan Ruddy (d.o.b. 29th August 1978)

at H.M.P. Maghaberry from 30/11/07 to 31/01/08.

Statement of: Dr Neil Daniel Lloyd-Jones

Age: over 21

Occupation of Witness: Medical Practitioner

Address: Newcastle Medical Centre

Claremont Road

Newcastle Upon Tyne

NE1 7RU

This statement consisting of 57 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.)

Dated this 7th day of October 2008

Signature [signed]

This report is divided up under the following headings and sections:

1.0 Introduction

2.0 Remit of Report

3.0 Summary, Conclusion and Points to Consider

4.0 Background

5.0 Résumé of Chronology of Psychiatric History

6.0 Résumé of Therapeutic Drugs that Mr Ruddy was Known to Have had Prescribed

7.0 Résumé of Drugs Found at Post Mortem

8.0 Extracts from General Practice Records

9.0 Chronology of Consultations and Events at H.M.P. Maghaberry With Comments

10.0 Opinion

11.0 Analysis of Daily log

12.0 Documents Received and Examined

13.0 My Clinical Experience and Qualifications.

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 my Report

2.01 To review the medical and healthcare records of Alan Ruddy.

- To review his general healthcare, including medication prescribed, whilst in custody from 30 November 2007 up to his death on 31 January 2008.
- The reduction/withdrawal of drugs, particularly Temazepam, days after his committal to Maghaberry Prison.
- The failure to follow the recommendation from the Psychiatrist, who attended to him on 6 January 2008 in Belfast City Hospital following his earlier overdose, to re-instate his Temazepam.
- To make any other observations as I feel appropriate as part of my review.

3.00 Summary, Conclusion and Points to Consider

3.01 At the age of 29 years, Mr Alan Ruddy was admitted to H.M.P. Maghaberry to serve a prison sentence.

3.02 He was a known epileptic and possibly had periodic back pain. He also had an ongoing psychiatric history in that he had periods of depression. However, he also, at times, threatened to harm himself and/or impulsively take overdoses of paracetamol. Importantly with his psychiatric history at no time did he have the conviction or desire to actually end his life. I would emphasise that the overdoses were very much 'spur of the moment acts' as a reaction to life events. For all of the above medical problems he received a variety of prescribed medication. He was also known to be a heavy drinker and to take illicit drugs.

3.03 As is custom and practice, when a person is admitted to H.M.P. Maghaberry, he underwent an initial "health screening". On this aspect it is my opinion that some parts of the process were common and acceptable medical practice, whilst other parts fell below common and acceptable medical practice.

3.04 I also note that a request from his general practitioner for his previous medical records was not made until 7 weeks into his sentence time.

3.05 Bearing in mind the nature of his ongoing problems it is my opinion that one of the medical staff should have telephoned his G.P. for a résumé of his previous/ongoing medical history and to have requested his medical records sooner rather than later. The request need not have been urgent and I would say that 2 weeks would have been par for the course. Therefore on this aspect it is my opinion that his standard of medical care fell below common and acceptable medical practice.

3.06 Following the medical induction screening the medical officer felt that adjustments to his medication were indicated. That was his medical prerogative. As a reaction and/or rebellion to this Mr Ruddy took an overdose of some of his medication. The medical staff immediately arranged for him to be transferred to the local hospital. On this aspect of his care it is my opinion that it was common and good medical practice.

3.07 For this impulsive overdose he was treated by the medical team but was also seen by his duty psychiatrist. The psychiatric team concluded that *"…this was an impulsive act of self-harm, he [had] no clear mental illness and there was no suicidal intent."* When he was discharged back to the prison the psychiatric team *"recommended that his tablets are dispensed on a daily basis and taken in front of the prison staff."* It was also recommended *"that his Temazepam recommenced at night and that the duty prison officer reassess his need for Tramadol and Omeprazole."*

3.08 From the documents that I have it is not clear as to whether there was any change in the prescribing pattern. In other words, whether or not he was unsupervised pre-overdose and then supervised post-overdose. Examination of his records would lead me to believe that pre and post-overdose he was receiving medication on set drug rounds. Clarification on this should be sort from the prison authority. Also I can find no evidence that at any time, pre or post-overdose, that he was prescribed/taking Temazepam.

(PRISONER OMBUDSMAN NOTE: The prescribing pattern did change after Alan's overdose. This was fully explained on page 41.)

3.09 If the recommendations of the duty psychiatrist were not implemented, then in the absence of specific criteria from the duty medical officer to

justify not implementing the advice, then it is my opinion that his standard of medical care post discharge from hospital would have fallen below common and acceptable medical practice.

3.10 It is also my opinion that on returning to prison from hospital the duty M.O. should have been informed of his return and that he in turn should have consulted with Mr Ruddy vis-à-vis the whole episode, i.e. how and why/what happened. Also the M.O. should then have discussed the reason for the overdose i.e. the change in his medication regime.

3.11 Therefore the fact that the M.O. was not apparently informed and that he did not consult with Mr Ruddy would mean that in my opinion his standard of medical care would have fallen below common and acceptable medical practice.

3.12 Be this as it may, on being re-admitted to the prison on 6th January 2008 a formal reassessment of his situation vis-à-vis level of observations etc, took place. It is my opinion that this was good practice.

3.13 On the 8th January 2008 one of the nursing staff decided to step down/end this heightened level of observation. In the opinion section of my report I discuss this aspect of stepping down the level of supervision further and so I shall not say any more on it here.

3.14 Over the following week or so he consulted with the medical officer with regard to back pain and an allegation of assault, and Mr Ruddy also made some complaints. Suffice it is to say, though, that Mr Ruddy's prison life would appear to carry on without any major untoward events.

3.15 On the 30th January 2008 he was sharing a cell with another inmate. The inmate said that Mr Ruddy was in possession of prescribed and/or illegal drugs. On the morning of 31st January Mr Ruddy was found dead. A post mortem was held and the cause of his death was aspiration pneumonia due to the effects of morphine, diazepam, citalopram and amitriptyline. The metabolite of cannabis was also found in his blood but was not felt to be a contributory factor to his death.

3.16 If I compare and contrast the drugs found at post mortem with those that I know he had been prescribed therapeutically then, beyond reasonable doubt, he was taking illicit drugs that he brought in or had smuggled into the prison.

3.17 It will be remembered that on 5th January 2008 Mr Ruddy took an impulsive overdose of prescribed medication. This was very much in common and followed the ‘theme’ of his life in general. However, on the 31st of January he died as a consequence of taking a number of drugs, some of which were not prescribed. I note the account given by Mr Ruddy’s cell mate for the 30th January. I note the reference to the fact that Mr Ruddy had in his possession *“8-10 tablets”* and that *“Alan was always popping drugs, prescription or illegal.”* Importantly I note the absence in Mr Ruddy’s cell mate’s account of any anger/rebellion etc on the part of Mr Ruddy towards the prison authority. In other words Mr Ruddy had not apparently given any indication that he intended to take any medication in overdose form as an impulsive reaction to some other event. Therefore in the absence of an up to date psychiatric assessment of Mr Ruddy, my interpretation of the taking of the drugs that lead to his death was that, in lay terms, it was not an overdose per sè, but rather an accidental death as a result of the side effects of a cocktail of drugs.

3.18 Points to Consider

3.19 Here I provide a list of those points/aspects of the case that I feel may require further consideration:-

- What was the rationale for the M.O. not completing the formal part of the initial screen assessment?
- A lack of elaboration on question 10 in the first part of the initial screen form.
- A lack of elaboration/no follow up on the part of the medical officer vis-à-vis question 4, first part of the initial screening form, i.e. was the recent epileptic fit par for the course or was his epilepsy becoming unstable?
- Lack of elaboration generally by the M.O. on the first part of the initial screening form.
- Length of time taken to obtain/resource previous G.P. medical records.
- It is unclear whether he was or was not self-medicating pre and post-overdose.
- Clarification is needed on timing/communication from hospital staff to prison staff on recommendations.
- Compare and contrast short discharge letter from the hospital with formal consultant letters. Details missing in short letter vis-à-vis closely supervise/watch of taking medication.
- On discharge back to prison M.O. should have been informed and M.O. should then have followed up case.
- Consideration needs to be given as to who can/should step down the level of supervision.
- When his level of supervision was stepped down staff said they would discuss his case with the M.O. Did this occur? If not why not?
- Were the recommendations of the duty psychiatrist passed on?

- Were the recommendations to observe his medication being taken and to restart Temazepam implemented? If not, why not?
- How did the illicit drugs finish up in Mr Ruddy's possession?

4.0 Background

4.01 Mr Alan William Viktor Ruddy
D.O.B. 29/08/1978

4.02 He was born and bred in Newry. His parents were both alive and he had one brother and two sisters. He left school without any qualifications and then trained in gardening and plumbing. Whilst he was married, he did not live with his wife and had been living alone. He had four children aged between 3 and 12 years. He was claiming disability living allowance following a stabbing incident.

4.03 He had been on remand in custody since 30th November 2007. On 20th December 2007 he was sentenced to an 8 and 4 month prison term, both to run concurrently. He was to serve his sentence at H.M.P. Maghaberry.

5.0 Résumé of Chronology of Psychiatric History

5.01 In this section I have studied the photocopies of his general practice records and chronologically pieced together a picture of his previous and ongoing psychiatric history. I have not included all aspects of his previous psychiatric history, but rather it is an overview to give an overall picture. No significance should be paid to those parts which I have omitted.

5.02 3rd April 1995
At this stage Alan was aged 17 years.

Letter from a Consultant Child Psychiatrist stated:-

"[Alan] took [an] overdose [of Paracetamol] following his girlfriend telling him that their relationship was over. There was no planning or premeditation to this episode and he regretted it…. he is not clinically depressed…"

5.03 11th April 1997

Letter from a Senior Health Officer to another doctor in the Newry and Mourne Health and Social Services Trust.

"I reviewed [Alan] at Daisy Hill Mental Health Department on 11th August 1997. He was discharged from Ward 3, St Lukes Hospital last week. He feels quite well at present and has no thoughts that life is not worth living. He says he has not taken any alcohol since his discharge….he is taking Seroxat…"

5.04 11th August 1997

Letter from a Consultant Psychiatrist.

"Mr Ruddy was admitted to the Intensive Care Unit at St Lukes Hospital on 02/08/1997. He had absconded from Craigavan Psychiatric Unit the previous day. He had contacted his mother from a phone box and was threatening to hang himself…he admitted to abusing large amounts of alcohol and also to regular substance misuse……whilst in the ward we did not see any signs of depression.

Diagnosis:- acute intoxication of alcohol and psycho active substances."

5.05 12th May 1999

A letter from a Senior Health Officer to a doctor in Newry Mental Health Department.

"…There are long standing problems in the relationship…he does not give a history of heavy drinking at present. He does continue to smoke cannabis…he has only really felt depressed over the past 3 days…also

[we should] restart with antidepressant to see if it might be of benefit… He should start Efexor XL 75mgs.”…..”It does seem that the problems lie in the difficulties with his relationship with his girlfriend rather than mental illness and a trial of anti-depressants will probably not be the most important feature in his improvement.”

5.06 25th October 2001

Letter from a Senior Health Officer to a doctor at the Newry Mental Health Department.

“Full psychiatric history and examination led us to believe that there was little of psychiatric nature at the moment. ….I have advised him to cut down on the alcohol and the other illicit drug use.”

5.07 5th November 2003

Letter from a Consultant Psychiatrist.

“Thank you for asking me to see Alan urgently. He had been threatening to hang himself earlier today. ….he is missing his children. He had been drinking excessively ….recent events have led him to become more clinically depressed. He is currently taking Dothiepin.”

5.08 23rd September 2004

Letter from a Consultant Psychiatrist, stated:-

“Alan’s mood fluctuates. There was an incident a few months ago when he again contemplated hanging himself…. I have been encouraging Alan to face up to his fears and try to overcome his agoraphobia. He remains on Dothiepin 150mg daily.”

5.09 24th March 2005

Letter from a Consultant Psychiatrist, stated:-

…..“Alan continues to drink heavily consuming at least 12 cans of beer a day. He has no plans to try and cut down. Alan has been taking

Dothiepin for well over a year. He is not clinically depressed and agrees he does not need to remain on Prothiaden… Alan does not require ongoing psychiatric review and I am discharging him from the clinic."

5.10 30th May 2006

Alan was admitted to hospital having had a mixed impulsive overdose of Tramadol, Dosulepin, Solpadol and alcohol.

Letter dated **12th June 2006** from a Senior Health Officer to a doctor at Daisy Hill Hospital, stated:-

"Problems. 1. Mixed overdose.

2. Depression.

3. Myoclonus."

5.11 12th September 2006 Letter from a locum consultant psychiatrist stated:-

"Thank you for re-referring this 28 year old man to the outpatient clinic for psychiatric assessment.

Alan…… drinks a lot.

…..Alan does not complain of depression or any anxiety symptoms. He describes dissociating whenever he is made angry and attacking whoever has angered him…..Alan does not have any evidence of psychosis and does not have any evidence of any other Axis I mental disorder. He does have chronic psychological difficulties, the main problem with that presently being his anger…..he continues to drink heavily."

5.12 Comment on Psychiatric History.

Clearly Mr Ruddy's psychiatric history started when he was aged 17 years. This was with an impulsive overdose of paracetamol following an argument with his then girlfriend. Over the following years he started to drink heavily and use illicit drugs. However, over time a

'theme' started to emerge. In 2003 he had threatened to harm himself and in May of 2006 again he took another impulsive overdose. He was also periodically treated with courses of antidepressants.

5.13 In summary, here we had a man who drank heavily and also took illegal drugs. At times he suffered from depression and he had relationship problems that culminated in impulsive threats and overdoses. However, importantly what also comes over in his history is that psychiatrically, at no time did he have the conviction or desire to end his life. His overdosing and other behaviours were very much as a reaction to life events.

6.0 Resumé of therapeutic drugs that Mr Ruddy was known to have been prescribed at some stage.

1. **Rivotril (Clonazepam)**
   Indications: all forms of epilepsy;
   Myoclonus, status epilepticus.

2. **Cipralex (Escitalopram)**
   Indications: depressive illness, panic disorder, social anxiety disorder.

3. **Amitriptyline (Amitriptyline Hydrochloride)**
   Indications: depressive illness.

4. **Omeprazole**
   Indications: benign gastric and duodenal ulcers, gastric acid reduction.

5. **Temazepam**
   Indications: insomnia.

6. **Tramadol Hydrochloride**
   Indications: moderate to severe pain.

Cautions: ….history of epilepsy (convulsions reported usually after rapid intravenous injection).

7. **Phenergan (Promethazine Hydrochloride)**
   Indications: …sedation.

7.0 Resume of Drugs Found at Post Mortem

1. **Morphine.**

2. **Amitriptyline.**

3. **Citalopram.**

4. **Diazepam.**

5. **Il-nor-delta-9-tetrahydrocannabinolic acid (a metabolite of cannabis).**

8.0 Extracts from General Practice Records

8.01 I now provide 2 verbatim printouts from his general practice medical records. The first purports to list those drugs that he was prescribed in the previous 2 years (2006 – 2008). The other is a reference dated 04/03/03 by his G.P. to the prescribing of the drug Tramadol. I have to say that I am unable to reconcile all the aspects of prescribing/non-prescribing of his medication.

8.02 Printout dated 15/09/08
Patient Record. Prescriptions issued in the last 2 years.

02.11.2007 Temazepam (28 days)

05.10.2007 Cancelled Temazepam

24/07/2007 Temazepam (28 days)

04.07.2007 Zolpidem (14 days)

13.06.2007 Zolpidem (28 days)

? 06.02.2007 Amitriptyline tablets, repeat 17 authorised until 03.07.2008 10 issued last on 26/10/2007

06.02.2007 Cipralex (28 tablets)

01.11.2006 Eumovate cream

06.10.2006 Escitalopram tablets 20mg, repeat 22 authorised until 03.07.2008, 15 issued, last on 26.10.2007.

8.03 04.02.2003 Alan's G.P
Tramadol capsules 50mg, take one or two as required, 60 capsules supplied (repeat) 65 authorised until 03.07.2008. 58 issued, last on 26.10.2007.

9.0 Chronology of Consultations and Events with Comments

9.01 On 30th November 2007 Mr Ruddy was committed to H.M.P. Maghaberry. As was custom and practice an initial medical screening was undertaken. This was to ascertain any relevant previous and ongoing medical history. Accordingly, an *"Initial Committal Screening Form"* was completed. Normally the first part of the assessment would be undertaken by a nurse and the second part by a medical officer.

9.02 The salient details to come out of this assessment form were as follows:-

“2. Are you taking any prescribed medications? “Yes”
(including anti-depressants and anti-psychotic medication).
If yes, list current prescribed medication and how long taking each of them.

Rivotril 2mg b.d. (twice a day)
Cipralex 20mg o.d. (one a day)
Amitriptyline 10mg (20mg at night)
Omeprazole 20mg o.d. (one a day)
Temazepam 10mg
Tramadol 50mg 2 tablets 3 times a day

Would you normally self-administer medication? “Yes”

4. Do you have problems?…………
If yes, detail below

“Epileptic – on medication – 4 years ago, (last seizures 2-3 weeks ago).

No known allergies.”

Under “Mental Health” the questions and answers were as follows:-

“10. Have you ever been admitted to a Psychiatric Hospital or received treatment from a psychiatrist/CPN/or key worker for mental health problems in the last 5 years? “Yes”
If yes, who, where and what was the nature of the problem?
Cipralex for depression

(PRISONER OMBUDSMAN NOTE: Alan did in fact answer “NO”)

11. *Are you currently on anti-depressant or anti-psychotic medication? "Yes"*

12. *Have you ever tried to harm yourself? "No"*

13. *For some people coming into prison it can be difficult, and a few find it so hard that they may consider harming themselves. Do you feel like that? "No"*

Signed: H/Staff Signature

Under "Planned Action" it then reads:-

"Referred to Doctor – re:- Medication."

There is also an A4 signed form headed *"Assessment for Self-Administration of Medication."* It is dated 29/12/07.

9.03 Of interest I note question 7 and the answer given. Basically it reads as follows:-

"7. Are there any other factors, environmental, social or personal that would suggest that the person would be unsuitable for self-administration of medication?"

9.04 The above question had been answered as *"No"* and also the following notes had been added:-
"States no history of overdose.
- *same checked on E.M.I.S."*

9.05 If the reader compares and contrasts the above with the resumé of his

previous psychiatric history, then Mr Ruddy had clearly not been truthful to the nurse.

9.06 From an e-mail dated 29/09/08 from an Investigating Officer in the Prisoner Ombudsman's Office, I understand that the second part of the pro-forma of the initial committal screen form was not completed for Mr Ruddy. Apparently this was because the M.O. only completes the second part if he sees the prisoner on the same day as his committal. I have to say that I cannot see the clinical rationale or logic for this. I am also informed that in this case the medical officers' initial assessment was therefore recorded as a computer generated consultation. Ergo in this case the second part of the initial committal assessment was that dated **01/12/07 by a doctor.**

9.07 01/12/2007 A doctor at Maghaberry Prison

"Problem: *History of road traffic accident with some back pain, epilepsy.*

Examination: *No tenderness back or abdomen, chest clear.*

Comment: *drug sheet, check to other medication with G.P, analgesia available from nurse if required.*

Medication: *Clonazepam tablets 2mg 28 tablets, are to be taken twice a day.*
Escitalopram tablets 20mg 28 tablets more.
Amitriptyline Hydrochloride tablets 10mg 56 tablets. 2 at night.
Omeprazole capsules (Gastro-resistant) 20mg 20 capsules. One to be taken each day."

9.08 03/12/2007 A nurse at Maghaberry Prison

Comment: *"I have checked with his G.P. surgery this morning. Patient is prescribed Tramadol 50mg, one or two as*

required as a repeat.
Temezepam 10mg at night as ………., last issue on 02/11/2007."

9.09 03/12/2007 A nurse at Maghaberry Prison

Comment: *"Has been prescribed Tramadol 100mg S.R. once daily by G.P. Awaiting script from Boots. Also Pherghan 25mg for three nights."*

9.10 20/12/2007 EMIS entry

Comment: *"Sentenced"*

9.11 05/01/2008 A nurse at Maghaberry Prison

Problem: *"Claims to have taken O.D. of own prescribed medication, Amitriptyline 10mg x 14, Clonazepam 0.5mg x 56, Cipralex 20mg x 7."*

Examination: "Alert and orientated.
B.P. 120/75, pulse 130 regular, PERLA senior officer contacted and emergency ambulance arranged for transfer to B.C.H. A/E."

Comment

As can be seen from the above documentation the nurse consulted with Mr Ruddy and was told that he had taken a mixture of his prescribed medication in an overdose form. She did an initial clinical assessment, informed her superior, and then arranged for his transfer to the accident and emergency department of Belfast City Hospital. It is my opinion that her standard of care was common and acceptable medical practice.

9.12 There is a corresponding letter from a Consultant Physician,

B.C.H. dated 11/01/2008

The salient details of this letter were that he confirmed that Mr Ruddy was admitted to his ward on 05/01/2008 and discharged on 06/01/2008 having taken a mixture of Clonazepam, Amitriptyline and Cipralex in overdose. He confirmed that he was alright and that whilst in hospital he was seen by the liaison psychiatrist. He concluded his letter by saying *"there was no suicidal intent. It was suggested that after discharge the tablets should be dispensed on a daily basis and taken in front of staff. No routine review."*

9.13 There is a corresponding letter from the department of psychiatry. I have provided a photocopy of this and draw the reader's attention to the final paragraph on page 2.

9.14 On returning to prison on 6th January a **"prison at risk"** assessment was initiated by the prison staff. Basically the fact that he had taken an overdose of drugs meant that the staff were on a heightened degree of awareness. I attach a copy of this document overleaf.

9.15 The salient details to come out of the assessment were:-

- that the increased risk assessment was initiated because he had taken an overdose of medication;
- that *"Mr Ruddy claims he did this because medical staff had taken him off his medication;"*
- that the staff felt that the best way forward/course of action was for observation of Mr Ruddy combined with consulting the medical staff responsible for the change in his medication.

The assessment was undertaken by a senior officer.

N.B: I would draw the reader's attention to the above entry …*"combined with consulting the medical staff responsible for the change in his medication."* Basically I can find no evidence that the medical staff, M.O. or nurses were consulted vis-à-vis the change in his

medication.

9.16 Chronologically the next event is then in his general practice records. It reads as follows:-

07/01/2008 A nurse at Maghaberry Prison

Problem: *"Alleged Assault:*
Asked by a senior officer to see this inmate as he states he was assaulted by an officer on Friday 4th January 2008. I.M.R. 12 completed. No previous marks or injuries noted. Inmate refused to make written statement. He also complained about his medication and the fact that we did not issue Temazepam. Allowed to ventilate. Explained to him that I will look for his Kardex and issue any medication that is due. To be interviewed by a governor re allegation."

9.17 Chronologically the next event was the reduction in his level of observation. This was at 15.45 hrs on 8th January. To enable this to take place **A Health Care Assessment** was completed. I have provided a photocopy of this document that was signed by the completing nurse.

9.18 The entry reads as follows:-
"Claims he took a weeks supply of his Amitriptyline and Clonazepam on Saturday because he wasn't getting what he felt was the correct medication i.e. Temazepam. States he has no thoughts of life not worth living. Supervise administration of medication. PAR 1 can be closed as this prisoner was manipulating to get medication."

9.19 There was a corresponding entry in his general practice records that reads as follows:-

08/01/2008 A nurse at Maghaberry Prison

Problem: *"PAR 1 review.*

Stated that he took a weeks supply of Amitriptyline and Clonazepam nil else. No thoughts of life not worth living and stated that he did it as he felt he should be getting Temazepam. Advised re dangers of this. PAR 1 can be closed prisoner advised of this."

9.20 A case conference between the Nurse Officer and Discipline Officers then took place with regard to the opening and closing of PAR 1.
I am providing a photocopy of the recordings from this conference.

9.21 The entry reads as follows:-
"After the weekend's episode it was concluded that Alan Ruddy was attempting to manipulate health care staff in order to get medication. It was explained to him that his medication was not available in this prison. He was basically trying to cause inconvenience. If he had taken anything like the amount of tablets he said he had taken then he would have been at least a bit unwell. In light of this there is no need to keep PAR 1 open as prison has admitted to this and I believe the Health Care Senior Officer is providing an Adverse Report."

9.22 Chronologically the next event/entry in his medical records was:-

23/01/2008 A doctor at Maghaberry Prison

"Problem:	*Still c/o (complaining of) back pain.*
History:	*Road traffic accident.*
Examination:	*Points to mid-lumbar area.*
	No tender to touch. Limited flexion.
	No neurological signs.
Medication:	*Tramadol Hydrochloride M/R tablets.*
	100mg 56. Tablets are to be taken twice a day.

Phenergon tablets 25mg, 5 tablets. One to be taken at night."

9.23 24/01/2008 EMIS Entry

"EMIS attachment reference code letter to G.P. requesting copies of medical notes."

9.24 Comment:

Clearly one of the prison staff, medical or administrative, has decided to contact his general practitioner vìs-a-vìs his previous and ongoing medical history. There is a corresponding letter to Mr Ruddy's G.P dated 24th January 2008. Amongst other things it stated:-

"it would be helpful if I and or my medical colleagues could have sight of any medical notes which relate to this patient.

Yours faithfully

Senior Medical Officer

H.M.P. Maghaberry"

9.25 The fact that the medical department have written to his general practitioner to ask for copies of his medical records is in my opinion common and good medical practice. However, I note that he had now been in prison for over one month before a request for his notes had been made. On this aspect taking into account:-

- his disclosed previous/ongoing medical history;
- his prescribed medications;
- the length of his prison sentence.

then it is my opinion that, on the balance of probability, it would have been better to have made this request sooner rather than later. I do not know if there are guidelines on the time aspect, but if I compare and contrast this to a general practice scenario with a new patient registration then leaving aside that notes can now be automatically/ electronically requested, one to two weeks to request medical records

would be good practice.

9.26 Chronologically the next significant event that I have been given evidence of was contained in the Prison Ombudsman's letter dated 4th September 2008. This appertained to **Wednesday 30th January**. Her letter stated the following:-

"*The prisoner who shared Alan's cell, recalled the evening before Alan died. In a statement he said:*

"On Wednesday 30th January, Alan and I were in the recreation area late afternoon before returning to our cell, which is Cell 16, Bann House, at around 7.30pm lock-up time. When we got back, we watched TV and drank tea for a while before playing cards. About one and a half hours after lock-up Alan produced from his jeans pocket, a lump of toilet roll, inside which he had about 8-10 small grey, round tablets. He offered me one which I took and sat on my bed. Alan was always popping drugs, prescription or illegal and I thought nothing of it when he took 8 or 9 tablets before falling asleep in the chair around 10.30pm. I took the tablet he gave me around 10.00pm and eventually became quite drowsy. Between 11.00pm and 11.30pm approximately Alan was still asleep and snoring in the chair with his head back when I tried to rouse him, he was or appeared stoned. I lifted him from the chair and put him into the bottom bunk which was my bed. He was too heavy for me to lift into the top bunk. I got into the top bunk and watched TV until about 12.30am or 1.00am the following morning when I knocked the TV off. Alan was still snoring when I fell asleep. When the door opened in the cells the next morning around 8.40am I got up and made myself a cup of tea. Alan was still asleep and snoring. A Warder left the milk in as normal and I didn't suspect anything was wrong. I then left the cell and went to Landing 4 to see my cousin who was transferring before returning about 10 – 15 minutes later. When I returned Alan was very pale, hardly breathing and I tried to check his pulse. When I couldn't get a sign of life I went into the hallway and

called a Warder to tell him I thought something was wrong. When I checked Alan, the Warder shouted to a colleague to raise the alarm. I was put into a cell nearby before a priest informed me shortly after that Alan was dead. I had never met Alan Ruddy before sharing a cell with him in Maghaberry and during our 3 weeks inside together we got on well.

Some minutes after Alan was found and the alarm being raised, health care staff and the prison doctor arrived at the scene. The prison doctor pronounced Alan dead at 9.22am."

Opinion

10.01 I have been asked to give my opinion on the standard of medical care given to Mr Alan Ruddy who, at the age of 29 years, was admitted to H.M.P. Maghaberry to serve a prison sentence.

10.02 He was born and bred in Newry. His parents were both alive and he had one brother and two sisters.

10.03 He did not have any academic qualifications and had worked in gardening and plumbing. Though married with four children he lived alone.

10.04 His previous medical history showed that he was a known epileptic. Many years previously he had sustained a nasty abdominal stab wound he also possibly had recurrent back pain. I say "possibly" and "recurrent" as the only evidence that I can find to this is in a life insurance assessment form that was completed by his general practitioner in 1997 where it stated "February 95 *Recurrent low back pain."* Essentially I am unable to find any objective medical evidence in his records to substantiate the claim of low back pain and it later transpires that the claim to this back pain was the justification for prescribing of various analgesics.

10.05 He also had a previous and ongoing psychiatric history that started at the age of 17 years, when following an argument with his then girlfriend he impulsively took an overdose of paracetamol. Over the years that followed he started to drink heavily and use illicit drugs. A 'theme' then started to emerge. In 2003 he had threatened to harm himself and in May of 2006 he again took another impulsive overdose. He was referred for a psychiatric opinion and was periodically treated with courses of antidepressants. Importantly though what was clear from his psychiatric history was that at no time did he have the conviction or desire to end his life.

10.06 On the 30th November 2007 he was committed to H.M.P. Maghaberry. As was custom and practice he underwent an initial health screening. This was to establish a base line with the new prisoner's state of health etc. The first part of the assessment was carried out by a nurse and the second part by one of the resident medical officers.

10.07 At this junction I would ask the reader to refer to that part of my report which deals with **"Chronology of Consultations and Events with Comments."**

10.08 Essentially, in the first part of the health screening assessment Mr Ruddy had given the nurse a potted previous medical history. There was evidence that he informed the nurse of his previous psychiatric history and that he suffered from epilepsy. Importantly I would draw the reader's attention to the questions and answers given to numbers 10 and 12, and compare and contrast these with the known state of affairs. With question 10, there could have been further elaboration either by the nurse or by the M.O. Of course I am unable to say whether this lack was caused on the part of Mr Ruddy or by poor documentation on behalf of the nurse. The answer he gave to 12 was

at total variance to his known previous psychiatric history.

10.09 Mr Ruddy also provided the nurse with a list of his current medication and informed the nurse that he self-administered the medication.

10.10 The first part of the screening process was concluded by the nurse deciding, quite rightly, that Mr Ruddy's care needed to be referred to the resident medical officer, so that his medication needs could be sorted out.

10.11 On the 1 December 2007 Mr Ruddy then consulted with a doctor. This was as part of the second part of the health screening assessment. I note his potted previous medical history, namely *"history of road traffic accident with some back pain, epilepsy,"* and I also note his physical examination findings, namely *"no tenderness back or abdomen, chest clear."* I also note that he had requested that verification on some of Mr Ruddy's medication be sort from his general practitioner. This was with regard to the use of his Tramadol. It is my opinion that all these aspects of the consultation were common and good acceptable medical practice.

10.12 I also understand that following the consultation, the doctor made a decision to prescribe some of Mr Ruddy's 'usual' medication and omit others. This would have been his prerogative clinical decision.

10.13 There are other aspects of this consultation that I wish to discuss. First of all in the nurse screening assessment Mr Ruddy had stated *"Epileptic – on medication – 4 years ago (last seizure 2-3 weeks ago)."* Here I feel that it would have been good practice to 'tease out' his medical history regarding his epilepsy. For instance, was his epilepsy normally well controlled? Further questioning on his epileptic attacks in the last 2-3 weeks would also have been needed. Basically was this

epileptic fit par for the course or was his epilepsy becoming unstable and if so why? Essentially the answers to these types of questions would then determine further possible management. Therefore on this aspect it is my opinion that his standard of medical care had fallen below common and acceptable medical practice.

10.14 Moving on. From the nurse's initial assessment questionnaire and the nature of the drugs that Mr Ruddy was taking, it is quite clear that he had 'some type' of previous/ongoing psychiatric history. Faced with this I then feel that it would have been common and acceptable medical practice to have used these facts as a 'launching pad' to have examined his psychiatric history further and the questions and answers to that may have then determined further management.

10.15 Therefore on this aspect it is my opinion that his standard of medical care had fallen below common and acceptable medical practice.

10.16 Finally, I note that the doctor had requested verification of some of Mr Ruddy's medication and as I have said I feel that was good and acceptable medical practice. However, faced with this 'type' of medical history I feel that it would have been common and acceptable medical practice for the doctor personally or for him to have instructed the nurse to gain a very brief 'potted' résumé from his G.P. vis-à-vis his ongoing/previous medical history. I note that on or about the 24th of January i.e. over 7 weeks later, after entering the prison medical service, a request was made to his general practitioner for his previous medical records. The fact that the request was made was of itself common and acceptable medical practice. However, if I consider all the known aspects of this case then on the balance of probability it is my opinion that the request for his medical records should have been made sooner rather than later. I do not know if there are guidelines on the time aspect, but if I compare and contrast this to the average

general practice scenario with a new patient registration, then leaving aside that notes can now be automatically/electronically requested, then one to two weeks to request his notes would be acceptable practice. Therefore on this aspect it is my opinion that the standard of medical care had fallen below common and acceptable medical practice.

10.17 Nothing untoward appeared to happen until 5th January 2008 i.e. just over 4 weeks after being admitted to prison. Mr Ruddy then took an overdose of his prescribed medication and he informed the nurse of this. She assessed the situation and arranged for him to be transferred to Belfast City Hospital. It is my opinion that her medical care was common and good acceptable medical practice.

10.18 It later transpired that he took this overdose as a reaction to not receiving all the medication that *he* felt he should have had. In his own words, *"he did not intend to end his life, but to make screws pay attention."*

10.19 Accordingly, he was transferred to the care of the physicians and they dealt with his overdose. Whilst in hospital he was also seen by the duty psychiatrist.

10.20 In her discharge letter dated 10th January 2008, the duty Senior Health Officer in psychiatry stated, amongst other things:-
"My impression was that this was an impulsive act of self-harm, he has no clear mental illness and there was no suicide intent."
She continued:-
"…I would recommend that his tablets are dispensed on a daily basis and taken in front of the prison staff. I would recommend that his Temazepam is recommenced at night and that the duty prison doctor reassesses his need for Tramadol and Omeprazole. This gentleman

can be referred in future if need be."

10.21 Having been admitted to hospital on 5th of January he was discharged back to prison on care. Following his discharge back to the prison, I feel that it would have been common and acceptable medical practice for the duty medical officer to have been informed of his return and for him to have then seen Mr Ruddy to discuss his recent admission – basically what had happened, how it had happened and to deal with the care issue as to why he took the impulsive overdose i.e. the change in his prescribed medication.

10.22 Therefore the fact that the M.O. was not apparently informed of his return and accordingly he did not consult with the M.O. would mean that in my opinion his standard of medical care would have fallen below common and acceptable medical practice.

10.23 **N.B:** I would point out the following:-

- the discharge letter from the consultant physician was not typed until 14/01/08. I cannot say when the M.O. received it;
- the discharge letter from the duty psychiatrist was dated 10/01/08 but was not received by the M.O. until 16/01/08.

10.24 It is my opinion that the latter may have had some significance in the unfolding events. Essentially from the evidence that I have it is not clear as to whether or not the above recommendations were immediately passed and if they were, when they were. There is a hand written discharge note headed *"Belfast City Hospital Pharmacy Coding and Discharge Form."* This reads as follows:-

"No change to regular meds."

"Ensure Temazepam given at night."

"Your patient was admitted with an Amitriptyline overdose. He was treated conservatively and observed overnight. He was reviewed by

psychiatry who felt there was no suicidal intent. They recommend that Temazepam should be given at night as the patient felt he was not getting enough medications. Please review his medications." On the balance of probability this letter would have accompanied Mr Ruddy with the prison officers when he was taken back to prison.

10.25 As can be seen from the above extracts the immediate hand written letter did not state the need to closely supervise/watch him taking his medication.

10.26 I have also examined the photocopies of his medicine Kardex i.e. the forms that state the medications prescribed and when they were taken. From this there was no change in the pattern of the prescribing pre and post-overdose. In other words I am unable to say whether pre-overdose his medication was not supervised and post-overdose that it was supervised, or indeed what was happening.

10.27 The evidence though would suggest that he had been assessed for self-administration but that in actual fact his medication was being given by the nurses on a regular basis i.e. he was not self-administering.

10.28 However, I can say that I cannot find any evidence of Temazepam being prescribed pre-overdose and any reinstatement post overdose. Suffice it is to say though that on his return on 06/01/08 the prison staff carried out a "prison at risk" assessment. Please see the enclosed photocopy of this assessment sheet dated 06/01/08. Basically this assessment would have been to make the staff aware/more aware of the problem and to formulate a plan of management. The fact that this assessment was initiated did, in my opinion, demonstrate good management of his problem. However, importantly I note the absence to any reference of his management from the medical and psychiatric teams i.e. they may not have known of the recommendations vis-à-vis

his drug management, supervision and the use of Temazepam.

10.29 On the 07/01/08 there was reference to a possible assault. Overall I do not feel that this is relevant to the gist of this report and so I move on to the next salient event that was on 08/01/08. At this point a further assessment took place to assess his management.

10.30 This assessment was undertaken by a nurse. In his medical records she has stated:-
"PAR 1 review.
Stated that he took a weeks supply of Amitriptyline and Clonazepam nil else. No thoughts of life not worth living and stated that he did it as he felt he should be getting Temazepam. Advised re dangers of this PAR 1 can be closed prisoner advised of this.

10.31 In his health care assessment under **"Level of Supervision"** it was stated *"Supervise administration of medication." I n*ote that the *"Health Care Assessment"* form dated 08/01/08 did make a reference to the need for supervision of his medication. However, his medical records per se do not have this reference. The important points that I feel emerge from this are the following:-

1. Was the nurse by 08/01/08 aware of the hospital's recommendations vis-à-vis his medication and its supervision?
2. If she was aware how had she been made aware?
3. Was there 'knowledge' by the prison officer of these recommendations when he was discharged on 06/01/08?
4. Importantly if and when the prison nursing staff did have knowledge of the recommendations, were they implemented?
5. Finally, if they were not implemented, then why not?

10.32 In conclusion, if the recommendations were not implemented then the standard of care would have fallen below common and acceptable

medical practice. However, I would recommend that further enquiries are made as to if and when the prison became aware of the recommendations.

10.33 Further enquiries should also be made to ascertain as to why he was not apparently prescribed Temazepam at night.

10.34 At this junction I would make some further observations. I note that the "health care assessment" was done to enable staff to be made aware and manage his problem. Equally the decision to step down the level of supervision was made by the nursing staff/or administrative staff. Whilst I would accept that the heightened care can easily be initiated by one of the nursing staff/or prison officer, I put forward the suggestion that, in some cases, consideration should be given as to the nature of the person who stops it. Of course each case must be taken on its merits, but I would have thought, and possibly this is/was the case, that the experience/qualifications (psychiatric wise) of the person who stops the level of supervision must be considered on a sliding scale basis. In simple lay terms there is no harm in being overcautious and implementing care management. However, de-implementation can, in some cases, be problematic.

10.35 A case conference then took place, and I would ask the reader to study the relevant entry.

10.36 Moving on the next significant event was not until 23/01/08. Basically Mr Ruddy consulted with the duty medical officer with regard to back pain. He decided to treat that problem with Tramadol analgesia. With regard to medication the entry reads:-
"Tramadol Hydrochloride M/R tablets 100mg 56. One to be taken twice a day."

10.37 With regard to this consultation I would say the following. It is not clear whether the doctor actually allowed/gave Mr Ruddy the Tramadol to self-medicate or to be prescribed by the nurse. I would also say that, as a general practitioner, caution is needed in prescribing this drug for a known epileptic. The doctor may have exercised that caution. It is also not clear as to whether or not he knew/had knowledge of the degree of supervision or not of his other medications. Be this as it may the level of supervision of the Tramadol and some of his other drugs is irrelevant to the final scenario that took place.

10.38 According to his drug chart and the coding, the drugs that were prescribed to him on 30/01/2008 and 31/01/2008 were:-
Code
K twice
M twice
N one
P one
Where
K = Tramadol
M = Clonazepam
N = Cipralex (Escitalopram)
P = Phenergan
On 30/01/2008 or 31.01.2008 Mr Ruddy died and the cause of his death as given as aspiration pneumonia due to the effects of:-

- Morphine;
- Diazepam;
- Amitriptyline.

The metabolite of cannabis was also found in his blood.
Citalopram was also found but this would not have contributed to the fatal outcome.

10.39 If I compare and contrast the drugs found at post mortem with

those that I do know that he had been prescribed therapeutically then, beyond reasonable doubt, he was taking illicit drugs that he brought in or had smuggled in to the prison for him.

10.40 It will be noted that on entry to H.M.P. Maghaberry on 5th January 2008 Mr Ruddy took an impulsive overdose of prescribed medication. This was very much in common and followed the ‘theme’ of his life in general. However, on the 30th of January he died as a consequence of taking a number of drugs some of which would not have been prescribed. I note the account given by Mr Ruddy’s cell mate on 30th January. I note the reference to the ease with which Mr Ruddy had in his possession 8-10 tablets and that “*Alan was always popping drugs, prescription or illegal.”* Importantly I note the absence in Mr Ruddy’s cell mate’s account of any apparent anger/rebellion etc on the part of Mr Ruddy towards the prison authority. In other words he had not said that Mr Ruddy had given any indication that he intended to take any medication in overdose form as an impulsive reaction to some other event.

10.41 Therefore in the absence of an up-to-date psychiatric assessment of Mr Ruddy my interpretation of the taking of the drugs that lead to his death was that in lay terms it was not an overdose per sé but rather an accidental death as a result of the side effects of taking a cocktail of drugs.

11.0 Analysis of Daily Log

I provide photocopies of Mr Ruddy’s daily log for the period 06/01/08, 07/01/08 and 08/01/08. I note these are the only log tables given to me i.e. there is nothing pre 06/01/08 or post 08/01/08.

12.0 Documents Received and Examined

1. Letter of instruction from Ms Pauline McCabe, Prison Ombudsman for Northern Ireland, dated 4th September 2008.
2. Post Mortem report attached to letter from Coroner's Office, dated 26th August 2008.
3. General Practice Medical Records Computerised 4 pages.
4. Belfast City Hospital Discharge Letter, 1 page.
5. Northern Ireland Prison Service Prescription and Administration Record Card for 2007, 7 pages.
6. Prison Medical Records self-administration of medication appertaining to 2006, 8 pages.
7. Letter from S.M.O. H.M.P. Maghaberry to Mr Ruddy's G.P dated 24th January 2008, 1 page.
8. Hospital Correspondence – for 2008, 5 pages.
9. PAR1 Prison at Risk Booklet and related documents, 7 pages.
10. Medical questionnaire and related document appertaining to 2006.
11. Computerised prison medical records, 2 pages.
12. Initial Committal Screening Form, 6 pages.
13. Detained Persons Medication Form and Medical Form, 4 pages.
14. Initial Committal Screening Form for 2006, 5 pages.
15. Planned Action Form, dated 12/06/08, 1 page.
16. Medical Officers Committal Assessment 2006, 3 pages.
17. Initial Committal Screening Form 2006, 6 pages.
18. Medical Officers Committal Assessment and various other documents appertaining to previous prison admissions, 24 pages.
19. G.P. Notes and Records. Bundle 124 pages.
20. Prison log and other photocopies, 72 pages.

13.0 My Experience and Qualifications

DR NEIL DANIEL LLOYD-JONES

Telephone Number – Work - 0191 2322973

QUALIFICATIONS

MBBS	Bachelor of Medicine and Bachelor of Surgery. University of Newcastle upon Tyne 1984.
MRCGP	Membership of the Royal College of General Practitioners 1989. Section 12(2) Mental Health Act Approval 2000. Renewed 2005.
LLB	University of Northumbria 2000. 2:2 Degree obtained whilst working in full time General Practice and completing LLM (see below).
LLM	Subject: The Legal Aspects of Medical Practice. (LAMP) University of Cardiff 2000.
BVC	**Very Competent**. University of Northumbria 2002. Called 2002, Middle Temple.
CERT. FORENSIC SCIENCE	University of Lancaster 2004
ADR	Accredited Mediator. London 2005. (Civil and Family).

AREAS OF MEDICO-LEGAL WORK UNDERTAKEN

I undertake both Criminal and Civil work. The following is a resume of the type of work I undertake in both areas:-

- Reviewing of medical records/results/treatment and care regimes;
- Duty and standard of medical care;
- Common and good acceptable medical practice with reference to:-
  - medical care in general;
  - medical examination techniques;
  - the use of chaperones;
  - drug treatment, prescribing, opiod use in the community;
- General Medical Council (G.M.C.), Royal College and N.I.C.E. (National Institute of Clinical Excellence) guidelines on good medical practice;
- Review of and use of medical protocols, procedures and guidelines;
- Management/care of patients in:-
  - General practice;
  - Nursing homes;
  - Care homes;
- Investigation of:
  - deaths in community; } with particular reference to duty
  - deaths in custody; } and standard of medical care
- Consent/informed consent to treatment;
- Care of psychiatric patients in the community and the use of the Mental Health Act;
- Standard of medical record documentation;
- Interface between general practice, Primary Care Trusts and Prescription Pricing Bureau.

In addition, in Civil Law, I undertake Personal Injury work in the following areas:-

- Road traffic accidents, e.g. whiplash injuries;
- Work based accidents, e.g. trip and slip, falls etc;

- Psychiatric reports; covering general areas of psychiatry – depression, anxiety, obsessional compulsive disorder, phobias;
- Competence e.g. formation of Wills etc.

PROFESSIONAL EXPERIENCE IN LEGAL WORK

1. **Clinical complaints advisor to the Medical Defence Union and the Medical Protection Society** (2000 to present)
2. **Expert witness for the MDU** (2000 to present)
3. **NHS ombudsman work** (2000 to present)
4. **Advisor to clients who come before the General Medical Council** (2000 to present)
5. **Medico-legal adviser to the National Crime Faculty** (2000 to present)
6. **Expert witness to H.M. Police** (2000 to present)
7. **Expert witness for Crown Prosecution Service** (2000 to present)
   Examples of some cases that I have been the main expert witness include:-
   - R v Anders (murder)
   - R v Fuller (murder/manslaughter)
   - R v Jackman (gross indecency)
   - R v Gore (indecent assault)
   - R v Sinha (gross negligence/manslaughter)
8. **Expert witness for H.M. Coroner** (2000 to present)
9. **Expert witness for various solicitors** (2000 to present)
10. **Medical examiner for personal injury claims** (2000 to present)
11. **ADR.** I am registered with the Alternative Dispute Resolution Group as an ADR Mediator. I also undertake Family Mediation work.

PROFESSIONAL EXPERIENCE IN MEDICINE

After qualifying I did my house jobs in medicine and general surgery. I then undertook the three-year General Practice Training Scheme gaining more experience in general medicine, obstetrics and gynaecology, casualty and orthopaedics, and psychiatry. I then completed a further year training in psychiatry, both adult and child-psychiatry.

In 1991 I decided to enter general practice as a principal and was appointed a Medical Officer to Newcastle University. A year after joining the University Health Service I became the Senior Partner. When the health service became an independent practice I was solely responsible for writing the new staff contracts, negotiating the contract between the University and the new medical centre and establishing new links with the Health Authority. As a GP I provide a full range of general medical services.

Since independence in 1992 I have remained the Senior Partner of the University Medical Centre. It is a City Centre Practice with 8000 patients and a very successful MASTA travel clinic.

OTHER MEDICAL POSITIONS

1. Doctors Deputising Service (1990 – 1995).
2. Benefits Agency Doctor (1993 – 1995).
3. Health Screening Doctor at Nuffield (1999 – 2001).
4. School Medical Officer (2001 to date).
5. Section 12(2) of the Mental Health Act Approved.

SOCIETY AND OTHER MEMBERSHIPS

1. Member of the Royal College of General Practitioners.
2. Member British Medical Association.
3. Member of Royal Society of Medicine.
4. Member of Honourable Society of Middle Temple.
5. Member of the Expert Witness Institute.

LEGAL TRAINING COURSES ATTENDED

1. Training days for Clinical Complaints Adviser for the Medical Defence Union.
2. “Expert evidence in civil disputes” – Expert Witness Institute.
3. “Single joint expert training” – Bond Solon.
4. “Excellence in Report Writing” – Bond Solon.
5. “Courtroom Skills Training” – Bond Solon.
6. “Report Writing and expert evidence” – Medical and Legal Training Services.
7. “Cross-examination training” – Bond Solon.
8. “Role of the Coroner” – Medical Protection Society.
9. Middle Temple Advocacy Course.
10. Expert witness training – Medical Defence Union, November 2003.

“Beyond Reasonable Doubt”: Medical Experts in The Criminal Court, Royal Society of Medicine

APPENDIX 3

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a relatively modern high security Prison which accommodates male long-term sentenced and remand prisoners, in both separated[1] and integrated[2] conditions.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. The complex includes four Square Houses - Bann, Erne, Foyle and Lagan. Roe and Bush Houses were built in the late 1990's and were used for several years for "ordinary" remand and sentenced prisoners, before half of each block was given out to separated accommodation in 2004. Roe House also has a separate wing dedicated to accommodating prisoner on committal where they undergo an induction programme before being transferred to an appropriate residential location within Maghaberry. Harry was located in the separated loyalist wing of Bush House.

There are two lower risk houses within the Mourne Complex of Maghaberry Prison, called Wilson and Martin Houses. These are used specifically to house life sentence prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU) located at Crumlin Road, Belfast.

[1] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.

[2] Integrated – general residential accommodation houses accommodating all prisoners

There is also a Landing called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Lagan House, called the REACH[3] Landing. The REACH Landing is a service which identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working.

A Healthcare Centre incorporates the prison hospital.

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

Maghaberry Prison was built to accommodate 682 prisoners, however, there were over 800 prisoners in Maghaberry on the day that Alan died.

The last reported inspection of Maghaberry Prison by HM Inspectorate of Prisons was carried out in January 2009. The report of this inspection was published on 21 July 2009.

[3] REACH Landing definition – **R**eaching out to prisoners through **E**ngagement, **A**ssessment, **C**ollaborative working **H**olistic approach.

Prison Service Policies and Procedures

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

Death in Custody Contingency Plan

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

Governor's Orders

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners.

Governor's Order 7-19 Body Checks/Roll Checks

This Governor's Order 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

The Prison Service's Self-Harm and Suicide Prevention Policy revised in September 2006 also outlines the action to be taken following a death in custody. This includes the arrangements for

the immediate family or next of kin to be informed of the prisoner's death and the post incident needs of any staff and prisoners involved in the vicinity of the incident.

An addendum to the 2006 policy was made in January 2009. It provides additional clarification of matters highlighted in the 2006 policy and also reflects the Prison Service's response to the recommendations from recent death in custody investigations.

Section 7.5 of the Self-Harm and Suicide Prevention Policy states that *"formal investigations should be conducted into incidents of serious self-harm to establish what, if anything, the prison can do to prevent a recurrence. Self-Harm/Attempted Suicide Summary Forms must be countersigned by a governor grade who will be responsible for determining and recording whether a formal investigation is required."*

Standard Operating Procedure for requesting Ambulance Service Support

The Prison Service issued new guidance in April 2009 on the procedures to be followed when considering requesting an ambulance.

Operational Performance Standards – Death in Custody

The Prison Service issued operational performance standards in July 2007 relating to handling deaths of prisoners in custody. The standard states: Northern Ireland Prison Service staff will work constructively, openly and sensitively with the appropriate agencies and bereaved families in achieving fulfilment of the

investigative obligation arising. The standards detail a list of required outcomes and key audit baselines and the policy references for this standard are:

- Contingency plans for handling a death in custody
- Self Harm and Suicide Prevention Policy
- Local Instructions for Handling a Death in Custody
- Section 8.1c Coroner's Act 1988
- NI Prison Rule 29
- NIPS Standing Orders 1.7 and 1.3.22
- The Human Rights Act Article 2.

Prison Service Policy on Alcohol and Substance Misuse

The Prison Service issued its policy on alcohol and substance misuse in July 2006. The policy deals with reducing the supply of substances subject to misuse in prison; reducing demand and treatment and rehabilitation and public health.