



The
**Prisoner
Ombudsman**
for Northern Ireland

**SUMMARY AND RECOMMENDATIONS OF
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 summary document**

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SUMMARY OF INVESTIGATION

Alan Ruddy was committed on remand to Maghaberry Prison on 30 November 2007. On 20 December 2007, Alan was sentenced to an eight month and a four month prison term to run concurrently. Alan's earliest release date, taking into account 50% remission, was 19 April 2008.

Alan was found dead in his cell on the morning of 31 January 2008, eight weeks after his committal to prison.

Following his committal on 30 November 2007, Alan was housed in Roe House where he participated in the Prison Service's induction programme. He remained in Roe House until 4 December 2007.

An initial health committal screening was carried out by a nurse in the medical room in Roe House. This was to ascertain any previous and ongoing medical history.

The nurse identified that Alan was suffering from a number of medical conditions, including epilepsy (usually petit mal type seizures), anxiety and depression. Alan was in possession of a number of medications prescribed by his general practitioner. These were: Rivitril, Cipralex, Amitriptyline, Omeprazole, Tramadol and Temazepam as an 'acute' medication.

The nurse made a referral for Alan to be seen by a prison doctor because of the number of medications he was receiving and the medical conditions, which he had reported.

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The next day, 1 December 2007, Alan was seen by a prison doctor and had a further medical screening. The doctor assessed Alan's medication. The doctor prescribed all of Alan's regular medicines, with the exception of Tramadol and Temazepam. The non prescription of Temazepam was consistent with Prison Service policy, as Temazepam has a particular potential for abuse in prison.

After checking Alan's medication history with his GP the prison doctor, on 3 December 2007, prescribed Tramadol and Phenergan for three nights as an alternative to Temazepam.

It was the opinion of the Clinical Reviewer that it was quite clear from the nurse's initial assessment questionnaire and the nature of the drugs that Alan was taking that he had some type of previous/ongoing medical history. The Clinical Reviewer felt, therefore, that this should have been examined further and that this may then have determined further management.

Alan's medical records were requested from his GP, seven weeks after his committal, when he presented to a Prison Doctor with back pain. It was also the view of the Clinical Reviewer that the notes should have been requested sooner.

Following his committal, Alan was given his medicines on a daily basis until 29 December 2007. On 29 December it is recorded that Alan was assessed as being suitable for, "*self administration*" of his medication. He was then given a weekly supply of his medicine.

Following committal, Alan's time in prison was largely uneventful up until the morning of 5 January 2008, when he reported to a nurse that he had taken an overdose of his prescribed medication. The

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nurse assessed the situation and arranged for Alan to be transferred, as an emergency, to the Belfast City Hospital.

At the hospital, Alan was immediately examined and his general health was assessed as “*satisfactory*”. Alan was kept in hospital overnight for observation.

The next day, 6 January 2008, Alan was examined by a duty senior house officer psychiatrist. The psychiatrist noted that Alan had no suicidal thoughts or plans.

Alan explained to the psychiatrist that he “*felt that he can be helped*” by taking Temazepam at night, but that this had been taken away from him and he was greatly annoyed by this. Alan was assessed as having “*no obsessional or delusional thoughts or perceptual disturbance and his cognition was intact*”. The psychiatrist concluded that Alan was not depressed and did not intend to kill himself. He just wanted his usual tablets.

The psychiatrist’s impression was, therefore, that this was an impulsive act of self-harm. Her plan was to discharge Alan and recommend that his tablets should be dispensed on a daily basis and taken in front of prison staff. The psychiatrist also recommended that Alan’s Temazepam should be recommenced at night and that the duty prison doctor reassess his need for two other prescribed drugs.

Alan was discharged back to Maghaberry Prison on the afternoon of 6 January 2008 and was re-located back to his cell in Roe House.

A handwritten note from Belfast City Hospital, sent with Alan, reads: “*No change to regular meds.*” “*Ensure Temazepam given at night.*”

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“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.”

A follow up discharge note from the consultant physician who attended to Alan in the Belfast City Hospital was received on 17 January 2008. A typed discharge letter from the duty psychiatrist at Belfast City Hospital was received by the prison on 16 January 2008.

Alan was not re-assessed by a doctor upon his return to prison from Belfast City Hospital. He was not, however, allowed to self administer his medicines until 15 January 2008 and was, from that date, given his medicines on a daily basis until 31 January 2008, the date of his death.

It is the opinion of the Clinical Reviewer that it would have been common and acceptable medical practice for the duty prison doctor to have seen Alan to discuss his recent admission, what had happened, how it had happened and to deal with the care issues as to why he took the impulsive overdose, i.e. the change in his prescribed medication.

When Alan returned to his cell in Roe House at 15.55, a Prisoner at Risk¹ (PAR 1) Booklet was opened by landing staff in response to his overdose of prescribed medication.

¹ PAR 1 definition – 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. Observations are carried out and recorded every hour, unless the authorisation requires more frequent checks.

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The PAR 1 procedure required hourly observation of Alan. The hourly entries on Alan's daily log over the next 3 days are largely uneventful recording things such as "*watching TV*", "*appears asleep*", and "*lying on bed awake*".

It is, however, recorded that on 7 January 2008 Alan raised three complaints through the Prison Service's internal complaint process.

The first complaint Alan made on 7 January 2008 related to an incident he alleged took place on 4 January 2008. Alan said that he had been slapped on the back of his head by an officer.

Alan's mother was concerned that this complaint had been ignored. She stated that Alan's arm had been "*black and blue*" during a visit she made to Alan on 8 January 2008 and that Alan had mentioned to her that an officer had "*slapped him*".

Following this complaint being made, a senior officer asked for Alan to be seen by a nurse. A nurse examined Alan on 7 January 2008 and wrote up an injury assessment form saying "*there were no marks or injuries noted.*" [It subsequently became evident that the allegation of assault related to 5 January 2008, not 4 January 2008.]

The second complaint made on 7 January 2008 related to the fact that Alan was not happy that he had not been prescribed Temazepam by the prison doctors. The third complaint was in connection with the prison not notifying Alan's family when he was admitted to Belfast City Hospital on 5 January 2008.

Alan did not progress his second and third complaints beyond Stage One of the Prison Service's internal complaint process. A police

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investigation into the first complaint was ongoing at the time of Alan's death.

Alan's complaints are examined in the report.

At 15.45 on 8 January 2008, a health care assessment was completed by a nurse, which led to the closure of Alan's PAR 1. The entry made by the nurse on the PAR 1 reads:

"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".

A case conference also took place at the same time on the landing in Roe House between the nurse and landing staff. A further note written by the nurse on the PAR 1 reads:

"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 the PAR 1 open as prisoner has admitted to this..."

Alan was taken off the PAR 1 at 16.00 and remained in his cell in Roe House.

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The Clinical Reviewer said that the opening of the PAR 1 booklet demonstrated “*good management of Alan’s problem.*” He raised concerns, however, about the absence of medical/ psychiatric input and the arrangements for closing the PAR 1.

The Northern Ireland Prison Service Alcohol and Substance Misuse Policy places a strong emphasis on providing rehabilitation and treatment for prisoners with addiction problems. There is no evidence that Alan was offered or accessed any drug counselling services either before or after his drugs overdose on 5 January 2008.

On 10 January 2008, Alan was re-located, due to normal operational moves, to Bann House (Cell 16 Landing 3) to share a cell with another prisoner.

It is recorded that Alan made a further complaint on 10 January 2008 about a visit he attended on 8 January 2008. The visit was terminated by prison staff as they suspected that unauthorised articles had been passed over to him. Alan did not progress this complaint beyond Stage One of the Prison Service’s internal complaint process.

The days preceding Alan’s death on 31 January 2008 were largely uneventful with Alan’s landing reports in Bann House recording that he “*had settled into the wing routine and was causing no problems*”.

Alan had further visits on 15, 26 and 29 January 2008, which took place without incident.

Alan consulted with a prison doctor on 23 January 2008 because of back pain and was prescribed Tramadol.

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At interview, the prisoner who shared Alan's cell, described the evening of 30 January 2008, the day before Alan died. He explained that, after lock-up time at 19.30, both he and Alan watched TV in their double cell and drank tea for a while before playing cards.

He then said that at about 21.00, Alan produced *"from his jeans pocket, a lump of toilet roll, inside which he had about 8 – 10 small, grey round tablets."* He explained that Alan offered him one tablet which he took and added that *"Alan was always popping drugs, prescription or illegal."*

He observed Alan taking eight or nine tablets before falling asleep on the chair around 22.30. Alan was, he said, asleep and snoring, with his head back. Between 23.00 to 23.30 he tried to raise Alan but he still *"appeared stoned"* so he lifted him onto the bottom bunk bed.

Alan's cell mate said that he also took a single tablet, which Alan had given him, around midnight and eventually became *"quite drowsy"*. He then got into the top bunk bed and watched TV, until he turned it off between 00.30 – 01.00. He remembers Alan was still snoring when he fell asleep.

In line with Prison Service policy prisoners are checked at regular intervals throughout the night. The night custody officer who carried out the checks on Alan's cell on the night of 30 January and morning of 31 January 2008 said, at interview, that checks were carried out at 20.15, 22.20, 01.30 and 05.30 and 07.15. These checks are recorded in the class officer's journal.

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Alan's cell mate said that, on the morning of 31 January 2008, their cell door was opened at around 08.40 and he got up, made himself a cup of tea and cleaned the cell as part of his normal routine. Alan was still sleeping and snoring. An officer left a carton of milk to their cell as normal. Alan's cell mate said that he did not suspect anything was wrong at that point.

Alan's cell mate said that he then left their cell to go to another landing in the house and returned 10-15 minutes later. When he returned, he recalled that Alan was "*very pale, hardly breathing.*" He said he tried to check Alan's pulse and when there was no sign of life he went into the corridor to call for help.

Two officers quickly ran to the cell after they heard Alan's cell mate shout "*you better look at this boy*". This was at 09.05.

Both officers entered Alan's cell and saw what they described, at interview, as "*a male lying on the bottom bunk with the sheets down.*"

One officer approached Alan, sat on the end of the bed and checked for signs of life, while the other officer left the cell and sounded the alarm.

Some moments later, a nurse who was on duty in Bann House medical room, arrived at the scene. She later made a note about the incident saying that when she checked Alan, there were "*no signs of life, his pupils were fixed and dilated, no breathing or pulses, hands and face cold and grey in colour, mottling on right side of abdomen*". She added that because of his condition, no medical intervention was carried out.

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The prison doctor arrived at the scene and pronounced Alan dead at 09.22.

A post mortem examination carried out on 1 February 2008 gave the cause of Alan's death as:

- 1 (a) Aspiration pneumonia
due to effects of
- (b) morphine, diazepam and amitriptyline.

The metabolite of one of the active constituents of cannabis was also detected, indicating usage in the days prior to death. It could not be stated with certainty, however, that he was under the influence of this when he died.

From the account given by Alan's cell mate, there is no evidence to suggest that, unlike previously, Alan intended to take an overdose of medication.

Dr Neil Lloyd-Jones, in his clinical review of Alan's healthcare and medical treatment whilst in prison, concluded, that in respect of Alan's death:

"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."

Telephone calls made by prisoners are recorded routinely. A random sample is monitored by the Prison Service and other calls are

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monitored where there is information or intelligence to suggest that this is necessary.

Both prisoners, and those to whom they make the calls, are aware of these procedures.

The investigation team listened to the telephone calls made by Alan over the period 24 – 30 January 2008.

There is evidence in the phone calls to suggest that Alan may have been having money transferred into the accounts of other prisoners, to pay for drugs he was accessing in prison. A number of requests are made for money to be transferred and it is confirmed a number of times that money has been paid in as requested. The prisoner account numbers are supplied. No reason for the transfer of the money is ever given.

On another occasion Alan asks the person he has called for £50 to be brought in for him, which the person agrees to. Alan then asks for a further £50 and when asked what it is for, Alan responds “*what do you think.*” The person then tells Alan that they wouldn’t be able to get the £50 in.

There is evidence also of people Alan speaks to, resisting his requests for money to be brought into prison or paid into other prisoners accounts.

Evidence in prison records also shows that people Alan called had, around the time that the phone calls were made, deposited money into other prisoners’ accounts.

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As part of this investigation the content of a phone call made by a prisoner, into whose account Alan was arranging for money to be paid, was considered.

There is evidence in this call that, in the days before Alan's death, the prisoner is arranging for drugs to be brought into the prison. These may or may not have subsequently been supplied to Alan.

There is also evidence supplied on a confidential basis that, following Alan's death, a member of healthcare staff notified the Security Department to register their concern about the availability of illegal drugs in Bann House. The person referred specifically to information provided by a prisoner.

In respect of Alan's reasons for taking drugs on 30 January 2008, Dr Lloyd-Jones concluded that, in the absence of any indication that Alan was, on this occasion, taking the drugs to draw attention to something he was angry about, his interpretation of the taking of the drugs that led to his death was, in the absence of an up to date psychiatric assessment 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."*

A copy of Dr Lloyd-Jones' clinical review report is attached as Appendix 2.

RECOMMENDATIONS

As a result of my investigation, I make **nine recommendations** to the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust.

Recommendation 1

I recommend that the Prison Service and the South Eastern Health and Social Care Trust (SEHSCT) review the arrangements for contacting prisoners' community General Practitioners. This should include a review of the adequacy of the information requested and timeliness of requests being made in circumstances where prisoners present at committal with medical or mental health problems.

Recommendation 2

I further recommend that the Prison Service and the SEHSCT ensure that it is a specific requirement of every committal review that consideration is given to the need for a further comprehensive healthcare assessment to establish a clinical baseline for healthcare management and that an appropriate plan for any review is put in place.

Recommendation 3

I recommend to the Prison Service and the SEHSCT that, where a prisoner returns from hospital after an incident of self-harm, he/she should be seen and assessed by the duty doctor as soon as practicable.

Recommendation 4

I recommend that the Prison Service and the SEHSCT review the arrangements for deciding who should be in attendance at a case conference where the option of closing a PAR 1/SPAR booklet is being considered. In particular, the need for a medical and/or psychiatric input should always be considered.

Recommendation 5

I recommend that all senior staff, should be made aware of the need to carry out a more comprehensive cold de-brief, with the staff on duty at the time of a death in custody, within 14 days.

Recommendation 6

I recommend that the Prison Service adheres to Section 7.5 of the Self Harm and Suicide Prevention Policy and ensures that internal investigation is always conducted following an incident of serious self-harm. Where a formal investigation is considered not to be required, the reasons should be recorded.

Recommendation 7

I recommend that the Prison Service appoints a family liaison officer to advise and provide appropriate support for bereaved families following the death of any prisoner in custody.

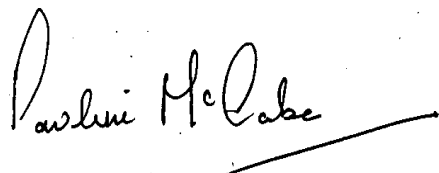
Recommendation 8

I recommend that the Prison Service comprehensively audits the implementation of the Prison Service Action Plan produced in response to the recommendations of the Report on Minimising the Supply of Drugs in Northern Ireland Prisons July 2008.

Recommendation 9

I recommend that the Prison Service and Trust further review the arrangements for monitoring, supporting and referring to specialist services, prisoners with drug addiction problems.

I shall request updates on the implementation of these recommendations in line with the action plan provided by the Prison Service.

A handwritten signature in black ink, reading "Pauline McCabe", with a horizontal line underneath it.

Prisoner Ombudsman for Northern Ireland

18 March 2010