The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF MR PATRICK DUFFY WHO DIED WHILST IN THE CUSTODY OF MAGHABERRY PRISON ON 23 JUNE 2011 AGED 49

[7 June 2012]

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PREFACE

Mr Patrick Duffy was born on 11 February 1962. He was 49 years old when he died of *"Poisoning by Dihydrocodeine, Diazepam, and Chlordiazepoxide"* whilst in the custody of Maghaberry Prison on Thursday 23 June 2011.

I offer my sincere condolences to Mr Duffy's family for their loss. I have met with Mr Duffy's family and shared the content of this report with them and responded to the questions and issues they raised.

The report contains this preface, a summary of the investigation, issues of concern followed by my introduction and my findings.

As part of the investigation into Mr Duffy's death, Dr Judith Victoria Evans, Independent Senior Consultant Forensic Physician with the Greater Manchester Police, was commissioned to carry out a clinical review of Mr Duffy's medical treatment whilst in prison. I am grateful to Dr Evans for her assistance.

In the event that anything else comes to light in connection with the matters addressed in this investigation, I shall produce an addendum to this report and notify all concerned of the additions or changes.

It is my practice to make recommendations for action that might lead to improved standards of inmate care and may help to prevent serious incidents or deaths in the future.

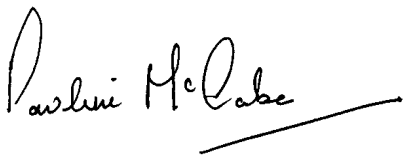
In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that *"An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become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

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

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

In the case of Mr Duffy, **fourteen** matters of concern have been identified.

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



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

SUMMARY

Mr Patrick Duffy was 49 years old when he died, on Thursday 23 June 2011, whilst in the custody of Maghaberry Prison

A review of Mr Duffy's GP records shows that he had a long and complex medical history. This included a spinal fusion in 1992 and spinal cord compression in 1993 which required regular opiate pain relief; self harm incidents (overdoses) from 1994; a diagnosis of depression in 1995; alcohol dependence syndrome and illicit drug abuse from 1997; a diagnosis of adjustment disorder and borderline personality disorder and dependency on benzodiazepines[1] and dihydrocodeine (strong analgesic) in 2000 and a diagnosis of lumbar spinal stenosis (narrowing of the central canal in the spine in the lower back) in 2007. In 2007 also, Mr Duffy was involved in an assault which resulted in a fracture and right subdural hemorrhage that subsequently caused seizures.

These health problems were set against a background of antisocial behavior and involvement in frequent assaults, either as the aggressor or the victim.

Prison medical records in 2008, make reference to past and current self harm, suicidal thoughts, substance abuse, heavy alcohol use and a previous psychiatric admission in England in the 1990's. At the time Mr Duffy was prescribed temazepam and diazepam amongst other drugs. In April 2010, there is a reference to Mr Duffy having been an intravenous drug user for the previous eight years and a very heavy drinker.

On 18 April 2011, whilst in Police custody, Mr Duffy took an overdose of medication, which he had *"hidden on his person"*. It is recorded in his GP records that he allegedly took 20 dihydrocodeine and 70 diazepam tablets *"to try and kill myself."* Mr Duffy was admitted to hospital in the early hours of 19 April. The assessment by the A&E department, however, was not congruent with him having taken this amount of medication. At an assessment by the Deliberate Self Harm Team at Altnagelvin hospital it was recorded that Mr Duffy denied suicidal ideation and stated that he had taken the overdose as he was afraid of going back to prison. It is to note that Mr Duffy was not being prescribed diazepam at the time of this overdose.

[1] Benzodiazepines are a group of medicines that are sometimes used to treat anxiety, sleeping disorders and other conditions.

On 20 April, Mr Duffy was committed on remand into the custody of Maghaberry Prison. The nurse and prison officer who assessed Mr Duffy as part of the '*First Night*' committal process noted that Mr Duffy had taken an overdose two days earlier, that he had a history of alcoholism, a history of seizures, that he was *"feeling good"* and had no thoughts of self harm.

The following morning, a committal nurse carried out a full healthcare assessment of Mr Duffy. She noted that that he had epileptic seizures secondary to a head injury, the last one of which was over a year ago, had taken an overdose on 19 April *"due to being arrested"* and that he had no current thoughts of self harm or suicide. At interview, the nurse said that she had previous experience of Mr Duffy's medical problems and *"from what I remember of him, he would have always come in with issues relating to alcohol and also issues related to medication, prescribed medication… He used to be found to be over using his prescribed medication and then try to get extra medication on top of that."*

On 22 April, the same nurse carried out a medication in-possession assessment to determine how Mr Duffy should receive his medication. The nurse questioned him about how he would manage his medication in the community and determined that Mr Duffy was suitable to receive a weekly supply. The nurse said that she did consider Mr Duffy's overdose three days earlier, *"but the fact that he had no thoughts of self harm when he came in, he was showing no signs of any mental health issues at that point, or anything like that, so that would have been why we would assess him for weekly medication."*

Mr Duffy was prescribed all of the medication that he advised that he had been taking in the community. No contact was made with his GP to confirm his prescription and no request was made for his community medical records at this or any other time during his committal.

It was also the case that no consideration was given to referring Mr Duffy to Maghaberry mental health services. One of the criteria for referral to the mental health team in place at the time of Mr Duffy's committal was "*a significant risk of persistent self harm.*" Given his history on his previous committals as well as the overdose in police custody, Mr Duffy would appear to have met this criterion.

Commenting on Mr Duffy's committal in her clinical review report, Dr Evans said that: *"At the time of committal when the initial clinical assessments were undertaken, [the committal nurse] was content to accept Mr Duffy's explanation for the overdose in police custody without any further probing, and the overdose was not considered to be a reason for Mr Duffy being placed on supervised swallow or daily in-possession medications, nor for a SPAR[2] to be opened for him, or for him being referred to the mental health team or an urgent referral being made through to ADEPT [drug and alcohol services], this despite the fact that past deliberate self harm or attempted suicide is a strong predictor of future suicide.*

Considering the decision to issue Mr Duffy with his medication on a weekly, in-possession basis, in relation to the policy guidance available to healthcare staff at that time, Dr Evans said that;

"In my opinion, it is hard to see how weekly IP (in-possession) medication can be justified for dihydrocodeine and even pregabalin (to treat epilepsy) given there would have to be very sound positive reasons for doing so even in the absence of the recent overdose in police custody – the presumption being that the dihydrocodeine would be given by supervised swallow. The 'halfway house' of IP daily possession was also available which does not seem to have been considered."

On 26 April, Mr Duffy was found to have taken too much of his dihydrocodeine medication *"because of the pain"* and he *"cut himself to get painkillers by his own admission."* On 6 May, Mr Duffy said that his cell mate had stolen his dihydrocodeine and because of this, and because he didn't have money for the phone to speak to his partner who had suffered a family bereavement, he self harmed by cutting his wrist. Both of these incidents resulted in Supporting Prisoner At Risk (SPAR) booklets being opened.

Commenting on the first medication and self harm incident on 26 April, the clinical reviewer, Dr Evans said *"This was a missed opportunity to review Mr Duffy's medical history and notes and his medication and for consideration to be given as to whether he should be placed on daily medication or supervised swallow. It was also an opportunity to refer Mr Duffy to the mental health services within the prison."*

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

Following the second medication and self harm incident on 6 May, Mr Duffy was placed on *'supervised swallow',* which meant that he had to receive his medication daily from a nurse. Dr Evans said, *"At this time there had been one overdose in police custody, two 'medication incidents' and two episodes of deliberate self harm by cutting all within a period of less than three weeks, and this still did not trigger a referral to the mental health care team for review*

On 9 May, Mr Duffy was seen by ADEPT following a self-referral, which would suggest that he recognised that he had a problem with his dependence on drugs and alcohol. On 13 May, he was selected for a mandatory drug test. The result, which wasn't received until 8 June, showed Mr Duffy had been abusing a benzodiazepine based drug called oxazepam[3].

On 15 May, a review of Mr Duffy's medication administration arrangement was carried out by a house nurse (Nurse Name Redacted). Even though Mr Duffy had had two previous medication incidents during this committal, one overdose of prescribed medication in police custody just prior to his committal and two episodes of deliberate self harm resulting in the opening of SPAR booklets, the nurse assessed him as being suitable to return to weekly in-possession of his medication. The nurse recorded that Mr Duffy "*denies any history of deliberate self harm or suicide intent.*"

Dr Evans noted that the decision was, again, taken despite *"there being a presumption that according to the IP [in-possession] medication policy, dihydrocodeine was not to be given IP without good justification…." [The nurse] does not seem to be aware of the option for IP daily medication"*

On 25 May, another SPAR booklet was opened as Mr Duffy intended to *"hurt himself by cutting as his mood is currently low."* It is recorded that Mr Duffy had also been taking his medication inappropriately and "*may have been bullied for his medication."* As a result, he was again placed on supervised swallow but there was still no consideration of any need for a referral to the mental health team. Dr Evans noted also that "*there appears to have been no consideration as to whether Mr Duffy needed care on the hospital wing."* It was her view that this option may have been assessed as unnecessary but should have been discussed.

[3] Oxazepam is used in the treatment of anxiety and insomnia and in the control of symptoms of alcohol withdrawal.

On 8 June, eleven days after Mr Duffy's SPAR booklet was closed, a house nurse (Nurse Name Redacted) carried out a medication assessment and decided that it was appropriate to return Mr Duffy to weekly in-possession medication. It was recorded on the assessment form that he was *"willing and keen to manage meds weekly."* When asked, at interview, what triggered this review, the nurse could not remember, but thought that Mr Duffy may have requested it. Dr Evans said this decision was "*Given this individual's previous history prior to and since being committed.... an unjustifiable decision with regard to the dihydrocodeine in particular."*

On 9 June, Mr Duffy was informed that he had failed the drug test taken on 13 May and he was referred to ADEPT, due to the abuse of a benzodiazepine based drug. No adjustment was made, however, to the weekly in-possession arrangement for the administration of his medication.

At interview, a prisoner [prisoner A] who was located in a cell next to Mr Duffy, said that the only times he spoke to Mr Duffy was to tell him to *"shut up"*, when he was making too much noise shouting out of the window to find out where his drugs were. The prisoner also said that Mr Duffy regularly swapped his medication for illegal substances stating, *"as soon as he got them he swapped them."* The prisoner said also *"it's really easy to get your hands on whatever [drugs] you want in here."*

Another prisoner (prisoner B) said at interview, that he was aware Mr Duffy took Subutex[4]. Mr Duffy was not prescribed Subutex but in a phone call on 3 June, Mr Duffy told his partner *"The fellas in here are on Subutex."*

On 21 June, the dining hall in Lagan House where Mr Duffy was located, was set on fire by a number of prisoners. Mr Duffy's family explained to the Prisoner Ombudsman that he suffered from anxiety and paranoia and asked whether, in light of this, anxiety about the fire incident could have contributed to his death.

The investigation found that Mr Duffy and his cell mate were in their cell at the time of the incident and, due to the heavy smoke, they and the rest of the prisoners on the landing were moved onto another landing. At interview, one of the officers (Officer Name Redacted) who assisted in moving Mr Duffy's landing said that the prisoners were moved across to Lagan 5 at around 15.00 and remained there until about 23.00.

[4] Subutex is a trade name for buprenorphine – an opioid drug that is similar to heroin

The officer said that he only assisted in moving the prisoners and wasn't aware of this incident causing any anxiety to any of them. Although Mr Duffy did talk about the fire, his cell mate (Prisoner Name Redacted) said "*I didn't notice that this affected him or upset him."*

Mr Duffy was due to go to court on 23 June and expected to be given bail. His cell mate said "*the few days before he was getting ready for court, Patrick was quite quiet, but I don't know if that's because he didn't know me. He never once went out into the yards and I would describe him as being surly, quite withdrawn.... he changed the day before he had court, he was chirpy and a lot more talkative. I remember him talking about a shirt that his partner had bought him that he was going to wear in court – asking me if he looked well in it."*

Later that evening, Mr Duffy was transferred from Lagan House to Foyle House to be located on the 'early court landing'[5]. CCTV shows that at 19.08 on 22 June Mr Duffy, along with two other inmates who were also being moved, arrived in Foyle House.

At interview, one of the inmates (Prisoner Name Redacted) who was transferred with Mr Duffy, and who also knew him from outside of Prison, said *"On the night that we were both taken to Foyle House, I remember seeing that he had foam coming from his mouth – not just the sides of his mouth but his full mouth. I said to him that he'd taken too many tablets and he said that he'd be fine. You could see that he wasn't fine because he was unbalanced on his feet, and the staff should have noticed.....I didn't tell the officer I was worried about him. For no more than ten minutes after we were locked up I spoke to Paddy [Mr Duffy] through the cell wall, but he told me he was going to his bed because he was too out of it. I don't know if Paddy had taken anything other than his medication that night, but I know that he had two tablets in his pocket for the following morning."*

At interview, the officer (Officer Name Redacted) who escorted Mr Duffy and the other prisoners to Foyle house from Lagan House said that Mr Duffy would go to get his medication two to three times a day from the nurse and the medication he received *"definitely made him a bit drowsy."* He said, *"the only conversation I had [during the transfer to Foyle House] - he was talking about things he was going to do. He was*

[5] The early court landing is used for prisoners who have a court appearance in Londonderry/Derry and have to leave the prison earlier than those attending court, for example, in Belfast.

getting out the next day and his wife had jobs for him to do when he did get out so he was going to, he was going to do painting or whatever you know." The officer said also that Mr Duffy *"was no different to what he normally was"* when he took him to Foyle House. He said that he was not foaming at the mouth or unbalanced on his feet.

At 19.40 on 22 June, Foyle House was handed over to the night custody officers and all prisoners were accounted for and locked in their cells. A further five checks took place that night and the night custody officer said that when he carried out the check at 00.25, he remembered that Mr Duffy was watching the television and waved at him when he shone his torch into the cell.

It is recorded on the night custody officer's staff communication sheet (completed following an incident) that at 01.40, Mr Duffy's television was on loudly so he went to ask him to turn it down. The officer said that he could not get a response from Mr Duffy so he contacted the senior officer, who was carrying out checks in a house at the far end of the prison, and asked him to perform an unlock in order for the television to be turned down. The officer said *"when I went down and rapped the door I wasn't sure whether the inmate had fallen asleep and was just a deep sleeper, or he couldn't hear me above the noise of the TV, or he could have had his medication.....It's not unusual, even at morning unlock, where you don't get a response straight away."* He said that he didn't know whether Mr Duffy was on any medication, but that it wasn't uncommon for inmates to be on sleeping tablets.

At 01.46, before the senior officer arrived, the night custody officer heard a loud bang, and found an inmate in another cell hanging. The inmate was resuscitated and it was 01.58 when the night custody officer and senior officer were satisfied that they could leave this incident in order to unlock Mr Duffy's cell.

When the two officers entered Mr Duffy's cell, they found him lying on his stomach with his head slightly tilted forwards towards the television and an arm extended. One of the officers noted that Mr Duffy's hand was cold and he turned him over onto his back in order to commence CPR. At interview, the officer said that he remembered that Mr Duffy's chest was warm. Shortly afterwards a nurse officer took over CPR and was assisted by another night custody office until paramedics took over at 02.17. The on call doctor arrived in the prison at 02.38 and pronounced Mr Duffy dead at 02.51.

On 22 June, the day before he was found, the investigation found that Mr Duffy was issued with one weeks supply of medication, comprising 14 dihydrocodeine (strong analgesic) 120mg tablets, 14 pregalabin (to treat epilepsy) 150 mg tablets, 14 fluoxetine (an antidepressant) 20 mg tablets and 21 levothyroxine (for thyroid problems) 25mcg tablets. A search of Mr Duffy's cell after his death uncovered two tablets which were later identified as dihydrocodeine. The rest of the medication, which had been given to him, was not in his cell

Mr Duffy's Autopsy Report recorded his cause of death as "Poisoning by dihydrocodeine, diazepam and chlordiazepoxide." At the time of his death, Mr Duffy was not prescribed diazepam (a benzodiazepine used for treating anxiety and insomnia) or chlordiazepoxide (a sedative/hypnotic drug and benzodiazepine).

The investigation identified significant concerns relating to the management of Mr Duffy's medication administration, his mental health management and the availability and trading of medication / illicit substances. These and other concerns are detailed in the section that follows.

ISSUES OF CONCERN REQUIRING ACTION

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

1. Medication reviews showed evidence of:
    a. Inadequate checking of medical records to look for evidence of recent self harming / medication abuse.
    b. A lack of appreciation of the significance of a recent overdose of prescribed medication.
    c. A lack of appreciation of the principles that underpin the use of supervised swallow.
    d. A lack of clarity as to when supervised swallow should be reviewed.
    e. A lack of understanding as to the appropriate medication arrangements that should apply to inmates on supervised swallow when leaving prison.

2. Mr Duffy's community General Practitioner notes were not requested.

3. Police custody paperwork alerted staff at Maghaberry to the fact that Mr Duffy had taken an overdose of diazepam whilst in police custody. Mr Duffy was not prescribed diazepam at the time of the overdose. This was not checked.

4. There is no evidence that healthcare staff checked Mr Duffy's prescribed medication at the time he was committed to Maghaberry. They appear to have accepted Mr Duffy's account.

5. In spite of current evidence and a previous history of persistent self harm; abuse of medication; substance addiction and open SPAR's, appropriate consideration was never given to the possible need for a review by a prison doctor or by the mental health team.

6. No consideration appears to have been given to referring Mr Duffy to ADEPT at the time of his committal assessment.

7. Despite a Prisoner Ombudsman recommendation made in July 2010, there is no process in place for notifying the healthcare team of failed drugs test. Failed tests do not, therefore, prompt a review of in-possession medication and are not considered when changes to medication administration arrangements are being risk assessed.

8. When Mr Duffy was taken to Foyle House, no information was provided to ensure that the staff responsible for him were aware of his vulnerabilities.

9. Mr Duffy's SPAR booklet did not, at times, remain with him when he moved between locations and appropriate conversational checks did not always take place.

10. There does not appear to have been adequate investigation / follow up action of allegations of bullying related to medication.

11. Mr Duffy was accessing non prescribed drugs and trading his medication.

12. Residential and healthcare staff carrying out prisoner performance reviews; considering incidents of self harm and completing SPAR booklets did not consider the possible relevance of staff comments recorded in Mr Duffy's initial staff report.

13. The manner of communication of Mr Duffy's death to his family caused distress and no attempt was made to deliver this information in person.

14. The cold de-brief[6] did not take place within the 14 days required by Prison Service policy. This has been the subject of a previous Prisoner Ombudsman recommendation.

[6] A cold de-brief is a de-brief meeting for those staff involved in the incident, to be able to reflect on the events that took place and discuss any issues or concerns they may have had.

NIPS AND SEHSCT RESPONSE TO THE AREAS OF CONCERN IDENTIFIED IN THE REPORT INTO THE DEATH IN CUSTODY OF PATRICK GERARD DUFFY

NIPS

The Director General confirmed that action would be taken in respect of all of the matters of concern related to the Prison Service.

SEHSCT

The Chief Executive of the SEHSCT wrote to the Prisoner Ombudsman notifying improvements and progress that have been made in respect of the areas of concern identified.

He stated:

- **Medications Reviews.** A new medicines management policy for prison healthcare is now in place. A revised and robust assessment form has also been designed and after completion of a pilot, is now in full use across all three prison sites. Staff have stated that they feel much safer in completing the risk assessments which now includes history of self harm, history of drug abuse, ability to manage own medication and susceptibility to bullying. This information was traditionally collected immediately on committal and taken prima fascia.

  Although not yet in place, it is planned that all prisoners will have category "A" drugs administered on a "see to take" basis during their first week in custody. It is anticipated that the risk assessment will take place at this stage and will therefore be much more objective with patterns of healthcare issues already emerging.

- **General Practitioner Notes.** The Trust has a new system in place whereby all GP's are contacted for any patient committed who claims to be on medication. This consists of a template that requests past medical history, current medical history, current medication and any other relevant information. This is again service wide and rolling audits against compliance have been commenced.

- **Referral to Prison doctor and/or Mental Health.** Pathways in relation to referral to mental health and primary care are now in place. Awareness around the use of these pathways has been provided. The mental health lead for prison healthcare

was appointed on 5 April 2012. Her plans include a mental health nurse for committals and clear pathways through the mental health service with key workers and planned exit strategies when appropriate. The mental health lead has already consulted with ADEPT in relation to a seamless interface between clinical addictions and the psychosocial interventions for patients with addictions.

- **Failed Drugs Test**. Healthcare did accept the previous recommendation regarding failed drug tests and a SOP was introduced. It is accepted that the implementation of this SOP has not been followed through on all of the sites and while there is evidence of good practice, we fully acknowledge that further work is needed at the interface between healthcare and discipline to ensure equity of prison-wide. This point will be escalated through the lessons learned group.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[7] for Northern Ireland, I have responsibility for investigating the death of Mr Patrick Duffy. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached at Appendix 1 to this report.

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

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

Objectives

4. The objectives for the investigation into Mr Duffy's death were:

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

- To examine any relevant healthcare issues and assess clinical care afforded by the Prison Service and South Eastern Health and Social Care Trust.

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

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

- To ensure that Mr Duffy's family have an opportunity to raise any concerns that they may have and that these are taken into account in the investigation.

- To assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

Family Liaison

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

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

7. I first met with Mr Duffy's family on 1 August 2011 and my investigators were grateful for the opportunity to update them at intervals on the progress of the investigation. On 31 May 2012, I met with Mr Duffy's family to explain and discuss the findings and issues of concern within this report.

8. It was important for the investigation to learn more about Mr Duffy's background, history and personal circumstances before he died and I would like to thank Mr Duffy's family for giving me the opportunity to talk with them.

9. Although the report will inform many interested parties, it is written primarily with Mr Duffy's family in mind. It is also written in the trust that it will inform policy or practice, which may help to prevent a similar death in the future at Maghaberry Prison or any other Northern Ireland Prison Establishment.

10. The following questions were raised by Mr Duffy's family:

- Did Patrick receive the proper medication and medical treatment whilst in prison?

- Did Patrick see a psychiatrist while in prison?

- Why was Patrick not located in the hospital wing?

- Considering that Patrick suffered from paranoia and anxiety, could the trouble that was taking place in Lagan House have contributed to Patrick's death in anyway?

- What were the circumstances surrounding Patrick's death and how and when was he found?

- Why were the family informed of Patrick's death by phone and not in person?

FINDINGS

SECTION 1: BACKGROUND INFORMATION

A review of Mr Duffy's GP records shows that he had a long and complex medical history. Of relevance is a history of back problems with operative treatment for a spinal fusion in 1992 and spinal cord compression in 1993. He was first prescribed regular opiate pain relief in 1993.

In 1994 Mr Duffy took the first of a number of overdoses and, in 1995, he was diagnosed with depression. By 1997 it was recognized that he had alcohol dependence syndrome and there are references in his medical notes to illicit drug abuse. These health problems were set against a background of antisocial behavior and involvement in frequent assaults, either as the aggressor or the victim.

In 2000, a psychiatric assessment, following an overdose, notes that Mr Duffy had had three previous overdoses and three previous admissions for deliberate self harm. He was considered to be suffering from an adjustment disorder and borderline personality disorder. The most recent overdose was thought to be precipitated by flashbacks to serious problems he experienced as a child. It is recorded that, at this time, Mr Duffy was dependent on benzodiazepines and dihydrocodeine.

In 2007, Mr Duffy was confirmed to have lumbar spinal stenosis (narrowing of the central canal in the spine in the lower back.) The same year he was involved in an assault which resulted in a fracture and right subdural hemorrhage. This subsequently resulted in seizures.

Prison medical records in 2008, make reference to past and current self harm, suicidal thoughts, substance abuse, heavy alcohol use and a previous psychiatric admission in England in the 1990's. At the time Mr Duffy was prescribed temazepam and diazepam amongst other drugs.

In April 2010, Mr Duffy's prison medical records make reference to him having been an intravenous drug user for the previous eight years and to him being a very heavy drinker.

On 18 April 2011, whilst in Police custody, Mr Duffy took an overdose of medication, which he had *"hidden on his person"*. It is recorded in his GP records that he allegedly took 20 dihydrocodeine and 70 diazepam tablets *"to try and kill myself."* Mr Duffy was admitted to hospital in early hours of 19 April. The assessment by the A&E department, however, was not congruent with him having taken this amount of medication. At an assessment by the Deliberate Self Harm Team at Altnagelvin hospital it was recorded that Mr Duffy denied suicidal ideation and stated that he had taken the overdose as he was afraid of going back to prison.

The Clinical reviewer, Dr Evans was asked to comment on the significance of Mr Duffy's alcohol and substance dependence, at the time of his committal to Maghaberry. She noted that Mr Duffy had a long history of dependence on dihydrocodeine dating back to his back problems and a spinal fusion in 1993. She noted also Mr Duffy's long history of dependence on both benzodiazepines and alcohol.

Dr Evans said that each of these drugs act at similar receptors in the brain, which is why benzodiazazepines are used to manage a controlled withdrawal from alcohol and *"Intoxication with either can lead to similar symptoms with disinhibited behaviour, slurred speech, ataxia [unsteady gait] and cerebral and respiratory depression. Sometimes those with an opiate dependency, if there is no opiate available to them, will use benzodiazepines or alcohol to try and mitigate the situation."*

Dr Evans noted also that Mr Duffy had a history of past misuse of illicit drugs including cocaine and heroin. She said that, given the length of Mr Duffy's dependency, *"I would expect him to be skilled in trying to manipulate those prescribing for him to gain more medication and this is borne out by his medical records, especially before his head injury and subdural hemorrhage." In my experience, if opiate dependent individuals experience pain despite their usual dose of, e.g. dihydrocodeine, the options are either to greatly escalate the dose of dihydrocodeine or another opiate, or, to use an adjuvant analgesic with a different mode of action. The former would usually be avoided if at all possible….as this would simply make the dependence more complex to manage."*

SECTION 2: MR DUFFY'S COMMITTAL TO MAGHABERRY PRISON 2011

20 April 2011

On 20 April 2011, Mr Duffy was committed on remand, into the custody of Maghaberry Prison. As part of the committal procedures, Mr Duffy was interviewed by a prison officer and a nurse. The prison officer noted that Mr Duffy had taken an overdose two days earlier, but that he had no thoughts of self harm and was *"feeling good".* The officer also recorded that Mr Duffy had self harmed when he was last in prison in 2008, and that whilst he was assessed as being not of immediate risk (to himself), *"the situation would need to be reviewed regularly."*

The nurse (Nurse Name Redacted), who carried out the 'First Night in Prison' health assessment, recorded that Mr Duffy had a history of alcoholism, a history of seizures and had a cut to his left finger, which Mr Duffy told him occurred whilst he was in police custody. It is recorded on Mr Duffy's medical records that he would need a full committal health assessment in the morning and basic health care plans for residential staff use were completed - one for alcohol withdrawal and one for epilepsy. The care plan listed the following points for residential staff to consider:

- Report any health care concerns immediately to house nurse or healthcare centre.
- Do not allocate top bunk to prisoner.
- Liaise with house nurse regarding work placement.
- If prisoner feels unwell contact house nurse or healthcare centre.

Full Healthcare Assessment

On 21 April, a full healthcare committal assessment was carried out. The committal nurse (Nurse Name Redacted) recorded on Mr Duffy's medical records that he had epileptic seizures secondary to a head injury, the last one of which was over a year ago. She also noted that he had no current thoughts of self harm and that he had taken an overdose on 19 April, *"due to being arrested - no thoughts of suicide….no thoughts of self harm currently."* At interview, the nurse said that the information about the epileptic seizures was provided by Mr Duffy and that the information about the overdose had come from the documentation sent from the police station.

In the paperwork from the PSNI filed with the initial committal form it states "*Return from A & E after overdose of valium."* It is to note that Mr Duffy was not being prescribed valium (diazepam) by his GP at the time of this overdose.

At interview, the nurse described Mr Duffy, whom she knew from previous custodial periods in Maghaberry, as being *"in good form - there wasn't any huge changes from the last times he'd been in. There wasn't really an awful lot to come out of that [the standard committal questions] to be honest."* [It is to note that Mr Duffy had last been released from Maghaberry in May 2010.]

Due to the way in which the computer system was set up the nurse did not, during the committal assessment, have access to Mr Duffy's previous prison medical records. The nurse did, however, have knowledge of Mr Duffy's previous medical problems. She said that *"Patrick had been in with us quite a few times and I had seen him a few times just sort of day-to-day. Patrick was a very pleasant guy. From what I remember of him, he would have always come in with issues relating to alcohol and also issues related to medication, prescribed medication. He would have flagged up a few issues, whenever he was in, about his medication and that sort of thing but he was never really a problem to us as such…..He used to be found to be over using his prescribed medication and then try to get extra medication on top of that."*

Despite Mr Duffy's recent overdose and the nurse's knowledge of his *"issues"* with over using his prescribed medication, the nurse did not refer him to ADEPT [prison drug and alcohol services]. Although the nurse had noted in the record of her assessment that Mr Duffy was receiving weekly alcohol counseling and surveillance at Woodlea House in the community, she said that the reason for her non referral was that Mr Duffy was not withdrawing from alcohol. It was also the case that no referral was made to the mental health team and no consideration was given to the opening of a SPAR booklet[8].

The nurse recorded the medication that Mr Duffy had told her he had been taking in the community as dihydrocodeine (strong analgesic), levothyroxine (for thyroid problems), ferrous fumarate (iron tablets) and fluoxetine (antidepressant). At interview she said that Mr Duffy's medication would have been *"automatically"* confirmed with

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

his GP before being prescribed by the prison doctor, *"given the nature of the medication he was taking."* She said that, as a result of her assessment, she had no concerns that required Mr Duffy to be seen by the doctor and that Mr Duffy did not make a request to see a doctor. There is no evidence that depression as a risk factor and the fact that he was taking fluoxetine (an antidepressant) was discussed.

It is to note that there is no record of Mr Duffy's GP ever being contacted during his last period in Maghaberry. He was, nevertheless, prescribed the medication that he had advised that he was taking before being committed to prison as well as pregabalin[9].

Assessment for Medication Management

On 22 April, the committal nurse completed an assessment to determine how Mr Duffy's medication should be dispensed to him. This form was only partially completed with *"in-possession medication"* and *"weekly"* circled. At interview, the nurse stated that she did not know why the dates required on the form or the section for clinical comments, were not filled in. She did say that *"the clinical comment [section] isn't always filled in – obviously it's just dependent…."* and said that she reached her decision that Mr Duffy should receive weekly in-possession medication by questioning him about how he would manage his medication in the community. The nurse said that she did consider Mr Duffy's overdose three days earlier, *"but the fact that he had no thoughts of self harm when he came in, he was showing no signs of any mental health issues at that point, or anything like that, so that would have been why we would assess him for weekly medication."*

It is to note that the policy in place at this time in respect of undertaking a risk assessment with respect to in-possession [IP] medication[10] states that:

Three areas will be taken into account when making assessments:

- *Patient factors e.g. whether a patient has a history of overdose or self harm*
- *Environmental factors e.g. whether the prisoner is sharing a cell*

[9] Pregabalin is used to relieve neuropathic pain, fibromyalgia, and in conjunction with other medication, to treat certain types of seizures.
[10] 'In-possession Medication Policy. South Eastern Health and Social Care Trust: Northern Ireland Prison Service. November 2010 - November 2011.

- *Medicine factors e.g. how potentially dangerous a medicine is in overdose or liable to misuse.*

The policy was further updated in September 2011, after Mr Duffy's death, to include *"overdose of prescribed medication"* as a contraindication.

The policy document includes a template rating the risks associated with different medications which recommends that dihydrocodeine should not be given in-possession and, where it is, the reasons must be explained in the *"clinical comments"* section of the Risk Assessment.

Induction Information and Support Sessions

On 22 April, as part of the general committal process Mr Duffy, along with other newly committed inmates, attended an induction to family support session run by the Offender Management Team, and a Core Harm Reduction information session run by ADEPT, which is open to all new committals. The Core Harm Reduction session includes information on drugs, drug use in prison and the associated risks, drugs and overdose, and describes the support services available in prison and on release.

Clinical Reviewer's Comments

Commenting on the Mr Duffy's committal, in her clinical review report, Dr Evans said the following:

"Prior to committal Mr Duffy took an overdose whilst in police custody of dihydrocodeine and diazepam. His GP records show that all of his medication at that time was issued weekly and that he had last been issued a script for diazepam 2mg on 28 January 2011 i.e. some three months previously. If, as suggested by [the committal nurse], Mr Duffy's medication was checked by the prison staff with his GP [there is no record this was done either in the prison records I have seen or in the GP records], the weekly nature of the medications would have been confirmed and also would have flagged up that Mr Duffy must have been either abusing or hoarding diazepam at the time of his arrest, given that the documentation from PSNI on transfer to prison stated the drugs taken in overdose."

"At the time of committal when the initial clinical assessments were undertaken, [the committal nurse] was content to accept Mr Duffy's explanation for the overdose in police custody without any further probing, and the overdose was not considered to be a reason for Mr Duffy being placed on supervised swallow or daily in-possession medications, nor for a SPAR to be opened for him, or for him being referred to the mental health team or an urgent referral being made through to ADEPT, this despite the fact that past deliberate self harm or attempted suicide is a strong predictor of future suicide.

Mr Duffy had an additional risk factor in that he had suffered a documented serious head injury with brain damage and therefore might be more susceptible to acting on impulse. I understand that one of the criteria for referral to the mental health team in place at the time of Mr Duffy's committal was "a significant risk of persistent self harm." Given his history on his previous committals as well as the overdose in police custody, Mr Duffy would appear to have met this criterion."

Considering the decision to issue Mr Duffy with his medication on a weekly, in-possession basis, Dr Evans said that;

"Using the template available in the policy document, with respect to the medication prescribed to Mr Duffy:

- *Dihydrocodeine HIGH risk (score 5). Recommended non-IP (in-possession) as used in drug dependence treatment. If given IP justify in clinical comments section.*
- *Pregabalin HIGH/ medium risk (score 3)*
- *Fluoxetine Medium/ low risk (score 1)*
- *Levothyroxine - not listed*

In my opinion, it is hard to see how weekly IP medication can be justified for dihydrocodeine and even pregabalin given there would have to be very sound positive reasons for doing so even in the absence of the recent overdose in police custody – the presumption being that the dihydrocodeine would be given by supervised swallow. The 'halfway house' of IP daily possession was also available which does not seem to have been considered."

SECTION 3: SPAR BOOKLET - 26 TO 28 APRIL 2011

Events Leading to the Opening of the SPAR Booklet

At 16.04 on 26 April, a non-urgent call out was made by landing staff for a nurse (Nurse Name Redacted) to see Mr Duffy. The nurse recorded *"complaining of back pain. Pr [prisoner] does not have the DHC [dihydrocodeine) issued to him in his possession. He says he has taken it early because of the pain. Paracetamol offered but declined. Advised to request GP instead of taking analgesia too early."*

Later on that evening at 19.34, another nurse (Nurse Name Redacted) saw Mr Duffy and recorded *"Informed me that he had taken one too many DHC this morning and wanted me to give him some more. Asked to speak to house nurse in the morning. Offered paracetamol and refused."*

It is to note that on 21 April, Mr Duffy was issued with 14 dihydrocodeine tablets – one to be taken twice a day. He should, therefore, have had four or five tablets left on 25 April, depending on what time of day he took his second tablet. Mr Duffy was not due to be issued with further medication until 28 April.

Mr Duffy called his partner at 10.46 on 26 April and told her that he was waiting to see the nurse to get his tablets. In a second call at 14.18, he told his partner that he was not getting his tablets and was, therefore, going to cut himself. He said also that his tablets were ordered, but that the prison staff were stopping him from getting them.

At 19.10 a SPAR booklet was opened. The reason recorded is *"Patrick has issues about his meds. He says that he 'might as well cut off his legs' for all the good his medication does. He has cut himself to get pain killers by his own admission."*

The "*Immediate Keep Safe"* action/care plan notes note that Mr Duffy was to remain in his own cell, as *"he gets on well with cell mate,"* and to be placed on hourly observations. It is also recorded that it was Mr Duffy's perception of his problem that he was in pain from an operation and had been prescribed medication, but was not happy with his prescription. Support mechanisms in place were noted as family

phone calls and it was noted that Mr Duffy enjoys family visits. It was noted that Mr Duffy said he had *"no thoughts or intentions"* of suicide.

It was acknowledged that there have been many previous suicide attempts and that Mr Duffy had an alcohol problem.

27 & 28 April 2011

On 27 April, a prison doctor was contacted and prescribed a further week's supply of dihydrocodeine tablets. The doctor does not appear to have seen Mr Duffy.

The following day a SPAR case review took place, where all in attendance agreed that Mr Duffy's SPAR booklet could be closed. The reason recorded was *"Patrick admitted he cut out of frustration. However his medication has been sorted out."*

During a telephone conversation with his partner the same day, Mr Duffy said that he would "*cut his fists*" if he didn't get out of Maghaberry soon.

Even though Mr Duffy had clearly not taken his dihydrocodeine as prescribed, no action was taken to review the appropriateness of him continuing to administer all his own medication.

SPAR Observation Logs

A review of the observation logs shows that checks were carried out, in accordance with the initial action plan, at intervals of no more than an hour. The SPAR booklet is, however, an important means of recording and sharing with other staff information related to the well being of a vulnerable prisoner and the logs do show that the SPAR booklet did not always stay with Mr Duffy, as required by Prison Service policy, when he moved between locations. It is also the case that although the Prison Service's Self Harm and Suicide Prevention policy (February 2011) says that staff should *"Ensure a minimum of two conversational checks are carried out daily by staff and all logs signed accordingly,"* there is little evidence of this taking place. The policy further states that *"If conversational checks are not being carried out, the Residential Manager should make an entry in the log including the names of staff they have spoken to about the lack of conversational checks."* There is no evidence of this occurring.

Clinical Reviewer's Comments

Commenting on how the healthcare team responded to Mr Duffy's self harm episode, the clinical reviewer, Dr Evans, said:

"On 26 April 2011 a SPAR was opened following a medication 'incident' and self harm [cutting]. This was a missed opportunity to review Mr Duffy's medical history and notes and his medication and for consideration to be given as to whether he should be placed on daily medication or supervised swallow. It was also an opportunity to refer Mr Duffy to the mental health services within the prison.

The following day there appears to have been a 'GP review' but there is no record that the doctor actually saw Mr Duffy or that Mr Duffy's medication was reviewed and consideration given as to whether, given his history, he should have been placed on in-possession medication, daily medication or supervised swallow: rather, a prescription was given in response to a telephone contact by [a nurse]. Given that Mr Duffy had clearly abused his prescribed medication, if he was to be prescribed more then surely supervised swallow for at least the dihydrocodeine was indicated."

SECTION 4: OPENING OF SECOND SPAR BOOKLET

Following the closure of Mr Duffy's SPAR booklet on 28 April, he had visits from his partner on 1, 3 and 5 May.

On 3 May, an officer in the committal/induction unit of Maghaberry Prison, where Mr Duffy was located, until he moved to Lagan House later that day, wrote on Mr Duffy's 'Initial Staff Report', that he was a *"very needy inmate who is extremely paranoid."* On this date also, Mr Duffy was issued, one day early, with a further week's supply of dihydrocodeine. It is recorded that this was because Mr Duffy was scheduled to be in court on 4 May and would not be available to receive his medication.

Missing Medication

At 11.49 on 6 May, Mr Duffy saw a nurse (Nurse Name Redacted) because he wanted more of his medication. Mr Duffy should have had nine dihydrocodeine tablets left. At interview, the nurse stated that having listened to Mr Duffy's reason for requesting his medication, she then spoke to landing staff who confirmed that Mr Duffy's cell mate had admitted to taking all of Mr Duffy's dihydrocodeine and some of his pregabalin.

The nurse recorded *"Patrick advised of need to keep his medication safe and locker closed at all times, he says his is usually very aware of this but was only out of cell for two minutes and forgot to take the key with him. As cell mate has admitted to taking these, I will get meds from pharmacy to replace stolen ones and advised that if this happens again he could be placed on supervised swallow as he has signed a contract to keep his meds safe."* At interview, the senior officer in Lagan House, (Officer Name Redacted) could not recall what action was taken with regards to Mr Duffy's cell mate admitting to taking the medication.

Self Harming Incident

At 13.17 on 6 May, a further entry in Mr Duffy's medical records by a different nurse, notes that Mr Duffy had self harmed and had lacerations to his left wrist that required suturing. It is recorded that the reason that Mr Duffy self harmed was because his medication had gone missing and because he wanted to make a phone call to his

partner who had suffered a recent family bereavement, but had no credit on his account. A SPAR booklet was opened and it is recorded that landing staff arranged for Mr Duffy to make a phone call to his partner at 14.00, which appeared *"to have lifted his mood considerably."*

That afternoon, Mr Duffy had his lacerations sutured by a prison doctor and a nurse (Nurse Name Redacted) carried out a medication review and placed him on supervised swallow. The reason recorded for carrying out this review was *"due to incident today regarding tablets missing and cutting himself over lunchtime."* The nurse also noted *"I see he self harmed last month regarding medication issues also so remain supervised for time being. Patrick is fully aware of need to come to medical room and have tablets under supervision twice daily."*

It was recorded on the *"Immediate Keep Safe"* action/care plan of the SPAR booklet that Mr Duffy was to be observed at hourly intervals, was to have two conversational checks per day and was to be doubled up with another prisoner.

On 8 May, a SPAR case review took place and all in attendance agreed that Mr Duffy's SPAR booklet could be closed. Mr Duffy attended the review and it is recorded that *"he stated he had cut his wrist because he had his medication stolen and he needs it. He was upset because he felt it had been taken by his cell mate although nothing could be proven."* It is to note that his account is different to that given on 6 May, when the nurse said that landing staff had confirmed to her that Mr Duffy's cell mate had admitted taking the medication. The SPAR case review also noted that Mr Duffy *"claimed not to have any suicidal thoughts or feelings at this time. His medication is now supervised so this is no longer an issue."*

There is no evidence that the comment recorded by the officer on the Initial Staff report that Mr Duffy was *"extremely paranoid"* was ever followed up or explored further during the SPAR review process.

SPAR Observation Logs

A review of the observation logs for the period of Mr Duffy's second SPAR, shows that checks were carried out, as required, at intervals of no more than one hour. Some of the checks were not, however, at irregular intervals, as required by Prison Service

policy. There is also once again evidence that the SPAR booklet did not stay with Mr Duffy when he moved between locations, for example, to see the nurse.

Clinical Reviewer's Comments

In her clinical review report, Dr Evans stated:

"At this time there had been one overdose in police custody, two 'medication incidents' and two episodes of deliberate self harm by cutting all within a period of less than three weeks, and this still did not trigger a referral to the mental health care team for review.

It is not specifically documented in the medical notes whether consideration was given as to whether Mr Duffy needed care and assessment as an in-patient in the prison hospital, but it may be that it was felt there was some degree of monitoring of his mental state in that he was "doubled up" with another [presumably different to his previous cell mate] prisoner in Lagan."

Mr Duffy's location history report shows that on 6 May, Mr Duffy did move to another cell and was no longer sharing with the inmate whom he said had taken his medication.

SECTION 5: KEY EVENTS BETWEEN 9 AND 24 MAY 2011

ADEPT Assessment

On 9 May, Mr Duffy was seen by ADEPT for an Addictions Severity Index Assessment, following a self referral. It would appear, therefore, that he recognised that he had problems with his dependence on drugs and alcohol. Information provided by ADEPT notes that during this assessment, Mr Duffy stated that he had been sectioned under the Mental Health Act whilst in England in 1998, and that this resulted in him being in hospital for two months. It is also recorded that Mr Duffy mentioned his self harm on 6 May, but said that he was not suicidal and was looking forward to the prospect of getting out on bail the following week. When discussing suicide, he said that he would not do this to his partner (die by suicide) because he had spoken to her and she had told him how much she loved him and needed him.

Mr Duffy was placed on a waiting list for casework with ADEPT, but this did not take place before he died on 23 June.

On the same day, a doctor (Doctor Name Redacted) who did not see Mr Duffy, noted on EMIS[11] that *"should check this man's meds, as not due DHC (dihydrocodeine) for 11 days and not on diazepam."* It is not clear why diazepam was mentioned and why the doctor was unaware that Mr Duffy was on supervised swallow.

13 May – Drugs Test and Alleged Difficulties with Cell Mate

On 13 May, Mr Duffy was selected for a random drug test. The result, which wasn't received until 8 June, showed Mr Duffy had been abusing a benzodiazepine based drug called oxazepam[12].

Mr Duffy also had a SPAR post closure review where it was recorded *"Prisoner has none of the original concerns, however during the course of the interview, prisoner admitted he cut to manipulate. He also stated that if he "self-harmed" again his partner would leave him."*

[11] EMIS – Egton Medical Information System which stores patient medical records.
[12] Oxazepam is used in the treatment of anxiety and insomnia and in the control of symptoms of alcohol withdrawal.

The same day, Mr Duffy made two telephone calls to his partner. In the first call he told her that his cell mate was stealing his tobacco and threatening to beat him up. He told her that he told a senior officer about it and that if he wasn't moved he would slash his wrists. In the second call, Mr Duffy's partner told him that she had been in touch with the prison, who had told her that the incident was already being looked into.

Later that day, Mr Duffy was moved to a different landing in Lagan House.

Medication Arrangements Review

On 15 May a review of Mr Duffy's medication administration arrangement was carried out by a house nurse (Nurse Name Redacted), who assessed him as being suitable to return to weekly in-possession of his medication. At interview, the nurse could not recall what triggered the review and said that she thought that Mr Duffy may have requested it. She said also that *"You would only assess on the mood that day, you know a lot of our guys have a history of self-harm but they are not on supervised swallow."*

At the review, the nurse recorded that Mr Duffy *"denies any history of deliberate self harm or suicide intent."* She recorded also that Mr Duffy had not, within the last 12 months or since coming into custody, abused any substances. She also noted that he was not dependent on any substances.

There was evidence in Mr Duffy's prison medical records that the information recorded by the nurse was very clearly incorrect. At interview, the nurse said that even if Mr Duffy had answered yes to her questions, it would not have affected the outcome of the assessment, due to the way the outcome was calculated at that time. The nurse also pointed out that a new assessment flow chart is now being used, which is much easier to use.

It is to note that when the nurse was asked whether she checked PRISM[13] for any recent drug test results relating to Mr Duffy, she said that it would not be usual for her to do so. In April 2010, reporting on the death of Richard Gilmore who died in Magilligan Prison of a drugs overdose, the Prisoner Ombudsman made a

[13] PRISM is the prison database that stores all information about the individual.

recommendation, which was accepted by the Prison Service and SEHSCT, that a new process be implemented across all Northern Ireland Prison establishments, to ensure that healthcare staff are notified of all failed drug tests. This recommendation was made to ensure that healthcare staff could take account of failed tests when carrying out risk assessments for medicine administration arrangements. At interview, the nurse said that there was no such system in place in Maghaberry Prison.

In this instance, it was the case that results of Mr Duffy's failed drugs test were not received at Maghaberry until 8 June 2011 and would not, therefore, have been available if the nurse had checked.

When asked whether she considered, in the first instance, placing Mr Duffy on daily in-possession medication and then building him up to two or three days in-possession before returning to a weekly in-possession arrangement, the nurse said the only options available to her are either supervised swallow or weekly in-possession medication. She said that if she was to issue, for example, four days of a weeks worth of prescription, this would amount to secondary dispensing, which *"we're not allowed to do."*

The nurse manager (Nurse Name Redacted), who was present at the interview, did say, however, that there was room for a nurse to use his or her discretion and just give three or four days medication before returning them to weekly in-possession from supervised swallow. It was also the case that the Medication Policy, at that time, specifically included the option of daily in-possession.

Clinical Reviewer's Comments

Commenting on the nurse's medication review, Dr Evans said:

"On 15 May 2011 [a nurse] completed a further medication review. Despite the fact that this prisoner had had two previous medication incidents during this committal, one overdose of prescribed medication just prior to his committal in police custody and two episodes of deliberate self harm resulting in the opening of SPAR booklets, and there being a presumption that according to the IP medication policy dihydrocodeine was not to be given IP without good justification, she took the decision to give him a weekly script of IP medication. [The nurse] does not seem to be aware of the option for IP daily

medication. Whilst this option has been withdrawn in the medication policy introduced from September 2011, this option would appear to still have been available in May 2011."

21 May 2011

In a telephone conversation with his partner on 24 May, Mr Duffy told her that his new cell mate was *"dead on."*

SECTION 6: SPAR BOOKLET – 25 MAY 2011

On 25 May, another SPAR booklet was opened for Mr Duffy. The reason was recorded as *"Patrick stated that he intends to hurt himself by cutting as his mood is currently very low. Has been taking medication inappropriately. Also raised issue of cellmate being unsuitable to share with because of drug use."*

It is recorded in the *'Immediate Keep Safe"* action/care plan that Mr Duffy was to be observed at 30 minute intervals; that a listener[14] was to be arranged; that consideration was to be given to a cell move the following day and that all *'sharps'* were to be removed from his cell.

A nurse (Nurse Name Redacted) who assessed Mr Duffy that day noted that he did not really want to cut himself, but did it to create the opportunity to talk to the nurse because he was being bullied for his medication. The nurse noted that he advised him that all he had to do was ask to be put back on supervised swallow due to bullying. The nurse recorded that Mr Duffy *"may have been bullied for his medication. He is now on supervised swallow."* The nurse also recorded that his mood was very low, that he had not being taking his medication as prescribed and that he *"stated that he was also having problems with his cell mate who was abusing illegal drugs. SO [senior officer] informed of this with recommendation to consider change of cell."*

As stated above, in a telephone conversation with his partner four days earlier, Mr Duffy had described his cell mate as *"dead on".*

Request for Medication 26 May

At 09.00 on 26 May, Mr Duffy saw a nurse (Nurse Name Redacted) in connection with a minor ailment. She recorded that during the consultation he was requesting his dihydrocodeine. The nurse, who was unaware that Mr Duffy had been placed on supervised swallow, recorded that she *"advised him he was issued a weeks supply on 20th [and that] he would not receive anymore until tomorrow – 27 May – Pr [prisoner] was very unhappy with this and stated he would cut - already on SPAR and said "you can get the Dr [doctor] to stitch me up" – advised this behaviour will not get meds any sooner. Landing staff informed and SPAR documented."*

[14] The 'Listener Scheme' is a peer support scheme, whereby selected prisoners are trained and supported by Samaritans, using their same guidelines, to listen in complete confidence to their fellow prisoners who may be experiencing feelings of distress or despair, including those which may lead to suicide.

At interview, when asked why she wasn't aware that Mr Duffy had been placed on supervised swallow the previous evening, the nurse said that she would have had the 'supervised swallow' folder but could not recall the specifics of why she wasn't aware that Mr Duffy was on supervised swallow. It would appear that the nurse did not review the last entry on EMIS or Mr Duffy's SPAR booklet, both of which clearly stated that that he was on supervised swallow. Mr Duffy's medication records show that, as a result, he did not receive his medication on 26 May.

On 28 May, Mr Duffy called his partner at 16.29 and told her that his back was hurting and he had not yet had his medication. He said that if he did not get his medication he would "*slash*" himself. His partner tries to reassure and calm him.

In a call on 3 June 2011, Mr Duffy told his partner that *"The fellas in here are on Subutex[15]."*

SPAR Observation Logs

On 28 May, a SPAR case review was carried out and it was agreed that Mr Duffy's SPAR could be closed. It is recorded in the summary of the review that *"This case review was scheduled for 24/05/2011 but due to unforeseen circumstances, didn't take place until 28/05/2011. Information received from [a senior officer], nurse officer and landing staff and from speaking with Patrick, have led me to believe that the SPAR can be closed. Patrick appeared in good spirits and has no intention of further self harming.....Said his self harming was impulsive*."

SPAR Observation Logs

A review of the SPAR observation logs shows that the SPAR booklet did not accompany Mr Duffy when he moved locations and some staff observations were not made at irregular intervals.

Clinical Reviewer's Comments

Commenting on the actions taken by staff during the period of this SPAR, Dr Evans said that *"despite Mr Duffy's history prior to and during this committal, no referral to mental health services for assessment was made and there appears to have been no consideration as to whether Mr Duffy needed care on the hospital wing."*

[15] Subutex is a trade name for buprenorphine – an opioid drug that is similar to heroin

SECTION 7: EVENTS IN THE WEEKS LEADING UP TO MR DUFFY'S DEATH

On 8 June, 11 days after Mr Duffy's SPAR booklet - that was opened due to the threat of self harm and Mr Duffy taking his medication inappropriately - was closed, a house nurse (Nurse Name Redacted) carried out a medication assessment and decided that it was appropriate to return Mr Duffy to weekly in-possession medication. It was recorded on the assessment form that he was *"willing and keen to manage meds weekly."* When asked, at interview, what triggered this review, the nurse could not remember.

Commenting on the nurse's decision to place Mr Duffy back onto weekly in-possession medication, Dr Evans said *"Given this individual's previous history prior to and since being committed, this seems an unjustifiable decision with regard to the dihydrocodeine in particular."*

On 9 June, Mr Duffy was informed that he had failed the drug test taken on 13 May. Mr Duffy had tested positive for oxazepam and he was referred to ADEPT, due to the abuse of a benzodiazepine based drug. No adjustment was made to the weekly in-possession arrangement for the administration of his medication.

At interview, a prisoner who was located in a cell next to Mr Duffy, said that the only times he spoke to Mr Duffy was to tell him to *"shut up"*, when he was making too much noise shouting out of the window to find out where his drugs were. The prisoner also said that Mr Duffy regularly swapped his medication for illegal substances stating, *"as soon as he got them he swapped them."* The prisoner added that *"it's really easy to get your hands on whatever [drugs] you want in here."*

Another prisoner (Prisoner Name Redacted) said, at interview, that he was aware Mr Duffy took Subutex. Mr Duffy was not prescribed with Subutex. In a phone call on 3 June, Mr Duffy told his partner *"The fellas in here are on Subutex."*

On 18 June, in a telephone call with his partner, they discussed the fact that at his court appearance on Thursday [23 June], Mr Duffy was expected to be released.

On 21 June, Mr Duffy had a visit from his partner at around 14.00. At interview, she said that he was *"in good form"* and that he appeared to be fit and healthy *"as strong as an ox."* She also said that he was looking forward to leaving prison on Thursday (23 June).

Later that afternoon, the dining hall in Lagan House was set on fire by a number of prisoners. Mr Duffy's family explained to the Prisoner Ombudsman that Mr Duffy suffered from anxiety and paranoia and asked whether, in light of this, anxiety about the fire incident could have contributed to his death.

The investigation found that Mr Duffy and his cell mate were in their cell at the time of the incident and, due to the heavy smoke, they and the rest of the prisoners on the landing were moved onto another landing. At interview, one of the officers (Officer Name Redacted) who assisted in moving Mr Duffy's landing said that the prisoners were moved across to Lagan 5 at around 15.00 and remained there until about 23.00. The officer said that he only assisted in moving the prisoners and wasn't aware of this incident causing any anxiety to any of them.

Although Mr Duffy talked about the fire with other inmates, his cell mate (Prisoner Name Redacted) said "*I didn't notice that this affected him or upset him."*

SECTION 8: EVENTS OF 22 JUNE 2011, THE DAY BEFORE MR DUFFY'S DEATH

The class officer's journal shows that on the afternoon of 22 June, Mr Duffy's landing went out to the yard. CCTV shows that Mr Duffy did not go to the yard, but accounts from officers in Lagan House, and a review of his prisoner history reports, show that this was not unusual for him.

Discussion with Listener

At 15.00, it is recorded in the landing journal that a listener came to see Mr Duffy and was with him for almost ten minutes. Listeners are prisoners trained by the Samaritans to provide a confidential listening service. Prisoners can request a listener if they feel depressed or stressed in any way of if they simply want to chat to someone on a confidential basis.

Mr Duffy's Cell Mate

At interview, Mr Duffy's cell mate (Prisoner Name Redacted) said that he had only been sharing a cell with Mr Duffy for approximately one week before he died. He said *"the few days before he was getting ready for court, Patrick was quite quiet, but I don't know if that's because he didn't know me. He never once went out to the yards and I would describe him as being surly, quite withdrawn……he changed the day before he had court (22 June), he was chirpy and a lot more talkative. I remember him talking about a shirt that his partner had bought him that he was going to wear in court – asking me if he looked well in it."*

Final Medication Issue

The investigation found that on 22 June, Mr Duffy was issued with a week's supply of his medication, as follows:

- 14 x Dihydrocodeine 120mg one twice daily
- 14 x Pregabalin 150 mg one twice daily
- 14 x Fluoxetine 20 mg two each morning
- 21 x Levothyroxine 25 mcg three daily
- 1 x tube Fucidin ointment.

Mr Duffy had last been issued with his medication on 15 June and, because he was on weekly issue, he was due to have the above issued to him, irrespective of whether or not he was released the following day.

At interview, a nurse (Nurse Name Redacted) and her nurse manager (Nurse Name Redacted) confirmed that, depending upon the medication risk assessment at the time, the usual policy is to give three to seven days worth of medication to a prisoner, when it is known that they are going to be released. Neither of the nurses was clear about what would happen if the prisoner to be released was on supervised swallow.

Transfer to Foyle House

At 19.08 on 22 June, Mr Duffy was moved from Lagan House to the 'early court landing[16]' in Foyle House. CCTV shows Mr Duffy, along with an officer and two other inmates, arriving in Foyle House.

At interview, one of the prisoners (Prisoner Name Redacted) who was transferred to Foyle House along with Mr Duffy, and who also knew him from outside of Prison, said *"On the night that we were both taken to Foyle House, I remember seeing that he had foam coming from his mouth – not just the sides of his mouth but his full mouth. I said to him that he'd taken too many tablets and he said that he'd be fine. You could see that he wasn't fine because he was unbalanced on his feet, and the staff should have noticed. I asked one of the officers, a male, if I could be doubled up with him because I knew Paddy (Mr Duffy), but they said no. I didn't tell the officer I was worried about him. For no more than ten minutes after we were locked up I spoke to Paddy through the cell wall, but he told me he was going to his bed because he was too out of it. I don't know if Paddy had taken anything other than his medication that night, but I know that he had two tablets in his pocket for the following morning."*

At interview, another prisoner (Prisoner Name Redacted) said, *"the night that he died, Patrick had taken too many 'buds', which is what we call them, but they're called 'Lycra' as a medicine."* 'Lycra', or Lyrica, is another name for pregabalin, which Mr Duffy was prescribed and it is to note that therapeutic levels of pregabalin were

[16] The early court landing is used for prisoners who have a court appearance in Londonderry/Derry and have to leave the prison earlier than those attending court, for example, in Belfast.

found in Mr Duffy's system at the time of his death, but were not thought to have contributed to the fatal outcome.

At interview, the officer (Officer Name Redacted) who escorted Mr Duffy and the other prisoners to Foyle house from Lagan House said *"I have known him [Mr Duffy] from when he was in before, this was his second maybe third time but.....there was no problem with him you know he just run up and down for his medication and that was him you know..... Just come in, done his time and generally I had no problems with him."*

Speaking about escorting Mr Duffy over to Foyle House the officer said *"the only conversation I had - he was talking about things he was going to do. He was getting out the next day and his wife had jobs for him to do when he did get out so he was going to, he was going to do painting or whatever you know."* The officer said that he had doubts whether Mr Duffy would be fit to do painting or other jobs around the house because of him *"being on the drugs....you know he got medication daily [and] he wasn't....that mobile once he got the medication you know, he never went to the yard that much, he stayed in his cell so I didn't think he would have been fit for it."*

The officer said that Mr Duffy would go to get his medication two to three times a day from the nurse and the medication he received *"definitely made him a bit drowsy."* He said Mr Duffy was always able to converse with him, but that he wasn't *"bright [like] someone that wasn't on drugs."* The officer said that Mr Duffy *"was no different to what he normally was"* when he took him to Foyle House. He said that he was not foaming at the mouth or unbalanced on his feet.

It is not possible to tell from the available CCTV whether Mr Duffy was foaming at the mouth. In the very limited amount of CCTV which captured Mr Duffy's transfer to Foyle House, he is not seen to be unsteady on his feet.

The escorting officer said that there are no handover procedures when taking prisoners over to the 'early court landing' other than when they are on a SPAR booklet. He said that he was not asked by one of the prisoners if he could be doubled up with Mr Duffy. He said that such a decision would be down to the officers in Foyle House.
At 19.40 on 22 June, Foyle House was handed over to the night custody officers and all prisoners were accounted for and locked in their cells.

SECTION 9: EVENTS THAT LEAD TO THE DISCOVERY OF MR DUFFY DEAD IN HIS CELL

Night Checks

Following the head count check that took place at 19.40 on 22 June, it is recorded that a night custody officer (Officer Name Redacted) carried out the following checks:

21.21	-	Supervised Head Count Check with a Senior Officer
22.30	-	Peg Patrol[17]
23.30	-	Peg Patrol
00.25	-	Unsupervised Body Check (i.e. not with a senior officer)

At interview, the night custody officer said that all inmates were accounted for, but that it had been quite busy early on that night because four cells had been wrecked and there was some flooding on the landing which he cleaned up between his checks. The night custody officer said that when he carried out the unsupervised body check at 00.25, he remembered that Mr Duffy was watching the television and waved at him when he shone his torch into the cell.

At 01.25 on 23 June, the night custody officer carried out a further peg patrol of the landings and nothing out of the ordinary was noted.

It is recorded on the night custody officer's staff communication sheet (completed by each staff member involved in an incident) that, at 01.40, Mr Duffy's television was on loudly so he went to ask him to turn it down. The officer stated that he could not get a response from Mr Duffy so he contacted the senior officer, who was carrying out checks in a house at the far end of the prison, and asked him to perform an unlock in order for the television to be turned down. At interview, the officer stated that he asked the senior officer to perform the unlock, rather than using his radio to call for emergency assistance, because at that stage he didn't believe that he was dealing with an emergency.

[17] Peg patrols are when officers walk the landings and insert a key to register that they have been on the landing at a certain time. Prisoners are not routinely checked during peg patrols.

The officer said *"when I went down and rapped the door I wasn't sure whether the inmate had fallen asleep and was just a deep sleeper, or he couldn't hear me above the noise of the TV, or he could have had his medication…..It's not unusual, even at morning unlock, where you don't get a response straight away."* He said that he didn't know whether Mr Duffy was on any medication, but that it wasn't uncommon for inmates to be on sleeping tablets.

Self Harm Incident Involving Another Prisoner

The officer recorded that, at 01.46, as he left the class office, he heard a loud bang from one of the cells and went to investigate. At interview, he said that he didn't know whether the noise was something that had been kicked over or whether the earlier disturbances were starting up again. The officer said that in the second or third cell that he checked on landing six in Foyle House, he found an inmate [not Mr Duffy] hanging with a ligature around his neck. The officer said that he immediately used his radio and informed the emergency control room that he was performing an emergency unlock. He said that as soon as he entered the cell he cut the ligature and started to perform cardiopulmonary resuscitation (CPR). He recorded that at 01.52, the senior officer and nurse officer arrived and assisted in the resuscitation efforts.

Unlock of Mr Duffy's Cell

Having established that the inmate found hanging was *"coming around a bit and talking,"* the night custody officer and senior officer went, at 1.58, to unlock Mr Duffy's cell. The officer recorded that Mr Duffy was lying on his stomach with his head slightly tilted forwards towards the television, with an arm extended. He noted that Mr Duffy's hand was cold and he turned him over onto his back in order to commence CPR. At interview, the officer said that he remembered that Mr Duffy's chest was warm when he started CPR.

Whilst the night custody officer was administering CPR, the senior officer ran to get the nurse officer who was around the corner attending to the inmate who had been found hanging. The nurse officer took over CPR and was assisted by another night custody officer who had responded from another house to the earlier emergency.

At interview, the night custody officer, who had raised the alarm, said that whilst the nurse and other night custody officer were carrying out CPR on Mr Duffy he had to go back to the other inmate's cell because he made a further two attempts at self harm.

Prison staff continued to apply CPR until this was taken over by paramedics at 02.17. The on call doctor arrived at 02.38 and pronounced Mr Duffy dead at 02.51.

SECTION 10: EVENTS FOLLOWING MR DUFFY'S DEATH

Death in Custody Contingency

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

Using the contingency plans the communications room, which controls and records all movements around the prison, immediately notified the appropriate personnel of Mr Duffy's death. Those notified included the Police and the Prisoner Ombudsman.

Police Cell Search

At 03.24, police attended Foyle House and a search of Mr Duffy's cell uncovered two tablets which were later identified as dihydrocodeine. The rest of the medications, which had been issued to Mr Duffy the day before, were not in his cell.

Family Notification of Mr Duffy's Death

At around 04.46 on 23 June 2011, it is recorded in the Emergency Control Room occurrence log that Mr Duffy's niece was informed of his death. Mr Duffy's niece was not listed as his next of kin, but answered the phone of her mother, who was the next of kin. Mr Duffy's family informed the investigation that this caused his niece great distress and said also that they were concerned that they were notified of Mr Duffy's death by phone and not in person.

News of Mr Duffy's death was delivered to his family by one of Maghaberry's Priests (Priest Name Redacted). There is no recorded evidence that consideration was given to asking local Police or the Parish Priest to visit Mr Duffy's family to inform them in person of his death.

I have now been assured by the Prison Service that arrangements for contacting a family following a death in custody are being fully considered as part of a current review of the Suicide and Self Harm Prevention Policy.

SECTION 11: STAFF SUPPORT AND DE-BRIEF MEETINGS

Hot De-Brief

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

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

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

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

A hot de-brief, organised by the duty governor, took place at 07.00 on 23 June 2011 in Foyle House. It was attended by the two night custody officers and the senior officer who dealt with this incident. It is recorded that support was offered and that there was not *"any learning gained at this point or any significant points of concern."*

Cold De-Brief

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

cold de-brief to support the Governor conducting it." It is also a requirement of the policy that a record of the cold de-brief is made.

A cold de-brief took place on 25 October 2011, four months after Mr Duffy's death. The meeting was convened by a governor and attended by the two night custody officers, the nurse officer and the senior officer who dealt with this incident. A member of PSHQ Custody Branch did not attend and there is no recorded reason as to why the cold de-brief did not take place within 14 days of the incident. It is recorded that only one area of concern, relating to the disclosure of medical information, was raised and discussed at the meeting.

At interview, the night custody officer who found Mr Duffy said that there was no explanation as to why the cold de-brief didn't take place until October, but that he thought that this might have been because of holidays. The officer said that he received all the help and support that he needed and that *"I don't think the Prison Service could have done anymore. They've been very helpful."*

SECTION 12: AUTOPSY REPORT

An autopsy examination was carried out on 24 June 2011 and gave the cause of Mr Duffy's death as:

I(a) Poisoning by Dihydrocodeine, Diazepam and Chlordiazepoxide

The report states:

"Death was due to poisoning by drugs. The report of Forensic Science Northern Ireland shows that at the time of his death there was a high level of the opioid painkiller dihydrocodeine in the bloodstream as well as therapeutic levels of the anxiolytics diazepam and chlordiazepoxide. The combined effects of these drugs would have had a marked depressant effect on the central nervous system, in particular the area of the brain responsible for the control of respiration, and it was this effect which was responsible for his death. There was also a slightly elevated level of the antidepressant fluoxetine in the blood as well as a therapeutic level of the antiepileptic drug pregabalin but these drugs are unlikely to have contributed to the fatal outcome. All of the detected drugs had been prescribed to him.

The autopsy also revealed that he had sustained a head injury in the past but this played no part in his death.

There were no serious marks of violence just two small bruises on the chest, an abrasion on the right index finger, a bruise on the left arm and spots of abrasion on the shins. These played no part in the fatal outcome. There were also the scars of self-inflicted wounds on both arms."

It is to note that at the time of Mr Duffy's death he had **not** been prescribed diazepam or chlordiazepoxide.

SECTION 13: FINDINGS OF THE EXPERT CLINICAL REVIEW

Findings of the Clinical Review have been included at the appropriate places throughout the report.

Considering Mr Duffy's death, Dr Evans also made the following observations:

Alcohol and Substance Dependence

Dr Evans pointed out that Mr Duffy had a long history of dependence on both benzodiazepines and alcohol and that each of these drugs act at similar receptors in the brain which is why benzodiazepines are used to manage a controlled withdrawal from alcohol. She said that *"Intoxication with either can lead to similar symptoms with disinhibited behaviour, slurred speech, ataxia [unsteady gait] and cerebral and respiratory depression. Sometimes those with an opiate dependency, if there is no opiate available to them, will use benzodiazepines or alcohol to try and mitigate the situation."*

Dr Evans noted also that Mr Duffy also had a history of past misuse of illicit drugs including cocaine and heroin. She said that, given the length of Mr Duffy's dependency, *"I would expect him to be skilled in trying to manipulate those prescribing for him to gain more medication and this is borne out by his medical records, especially before his head injury and subdural hemorrhage." In my experience, if opiate dependent individuals experience pain despite their usual dose of, e.g. dihydrocodeine, the options are either to greatly escalate the dose of dihydrocodeine or another opiate, or, to use an adjuvant analgesic with a different mode of action. The former would usually be avoided if at all possible e.g. this might be considered for the control of pain due to malignancy, as this would simply make the dependence more complex to manage."*

Medication Management

Dr Evans said that the continued prescription of the regular medication which Mr Duffy had had prior to his arrest and committal was in her opinion, entirely appropriate, allowing continuity of care. She said, however, that *"there were serious omissions at the time of Mr Duffy's committal to appreciate:*

(a) that the overdose taken in police custody was a significant risk factor which should have precluded having dihydrocodeine and also probably pregabalin in possession;

(b) the significance of the fact that the overdose he took in police custody was of dihydrocodeine [prescribed] and diazepam [a benzodiazepine: not prescribed] . This should have been an absolute contraindication to the administration of dihydrocodeine in possession.

Dr Evans said that, Given that these salient facts were overlooked initially, the subsequent medication assessments undertaken during Mr Duffy's stay in Maghaberry never seemed to have prompted a fresh review of his medical notes and history and seemed to have underestimated the risk weekly in possession [IP] medication might pose. She said that this occurred for a number of reasons:

"(a) There was a failure to give due weight to the overdose in police custody.

(b) The significance of benzodiazepine abuse was not flagged up or taken into account at the initial assessment or subsequently.

c) The medication policy clearly states that for high risk medications scoring 5 e.g. dihydrocodeine, whilst there is no absolute ban on IP prescription, the default position should be supervised swallow unless there are very good reasons for IP. Previous recent behaviour [overdose, deliberate self harm by cutting], which all the evidence shows is the best predictor of future behaviour, seems to have been less important to the reviewing officers than whether or not the prisoner claimed to have any thoughts of self harm at the time of the assessment.

(d) The persistent failure of the nursing staff to consider Mr Duffy's behaviour in respect of his medication and self harm in the context of his long term vulnerabilities whilst in prison highlights an inability on their part to appreciate that supervised swallow was a positive therapeutic option, the purpose of which was to reduce risk of overdose to the individual prisoner as well as the risk of diversion of medication on to the 'drugs market' within the institution This may be a training issue. In the case of a vulnerable prisoner supervised swallow also

means that there is, as a direct consequence, regular daily contact [at least] with healthcare staff administering medication giving the opportunity for them to notice any mood change or development of other signs of mental distress or illness at an early stage and intervene.

(e) The documentation of risk assessments for IP medication, the communication of changes to a prisoner's status e.g. opening and closing of SPAR booklets, changes to the method of administration of medication do not seem to be easily accessible to healthcare staff at the time they are administering medication or undertaking medication review.

(f) Where a 'GP review' was apparently undertaken this seems to have been a paper exercise or at best depended on a nursing assessment, at no time is there any record that Mr Duffy saw a doctor until he had a physical problem [anaemia]. There seems to have been no consideration that where there was a second medication or self harm incident this should automatically trigger a face to face GP or mental health review so that a care plan to reduce risk could be devised and implemented.

(g) It is not clear at all what happened at the end of May, particularly in respect of dihydrocodeine as the medication records are missing. In my view Mr Duffy should have been on supervised swallow or daily IP medication throughout his committal at least with respect to dihydrocodeine. In fairness, the new IP medication policy brought in from September 2011 is much clearer than its predecessor, has clarity around the significance of a previous overdose in the three months prior to any medication assessment, and has a risk assessment flow diagram which is much easier to use."

Mental Health Management

Dr Evans said that, in her opinion, Mr Duffy should have been referred to the mental health care team for expert assessment of his current mental health given that he had demonstrated *'persistent self harm'*. She said that such a referral would have allowed the previous information on record about Mr Duffy's medical and mental health history, including that of substance misuse, alcohol dependence, depression, brain damage and poor coping mechanisms to be properly assessed alongside his current

mental state and recent self harm history and a care plan put into place with clear signposts for review. *"There were"* she said *"several opportunities for staff to initiate such a referral as detailed above but this was not done."*

Consideration of Locating Mr Duffy in the In-Patient Healthcare Facility

One of the concerns raised by Mr Duffy's family was whether he should have been located in Maghaberry's in-patient healthcare facility. Dr Evans said that:

"Admission to the prison in-patient health care facility can be used to achieve a number of objectives with respect to mental health issues which include:

(a) Continuous observation and assessment of mental state over a period of time either where the mental state is uncertain and serious mental illness or suicide risk is a concern, or, the effects of drugs given for treatment of mental illness needs to be monitored;
(b) Continuous observation to prevent suicide;
(c) Care of a prisoner with known mental illness who cannot cope on normal location."

She said that, in her opinion Mr Duffy's overdose prior to committal and each episode of self harm should have led to consideration of in-patient treatment. She noted that *"whether or not this was appropriate would depend on a skilled mental state and risk assessment and on the purpose of in-patient admission."*

Dr Evans said that the information recorded by the nursing staff at medication reviews and when they had other contact with Mr Duffy, would suggest that admission to the healthcare centre was not warranted but she said that *"I am aware their assessment could be considered 'superficial' and incomplete and no overview of Mr Duffy's mental health and coping ability was undertaken during this committal. It is disappointing that there is no clear evidence in the medical and nursing records that such admission was ever considered and certainly no reasons for rejecting such a course of action recorded.*

I am conscious from my work in the prison environment that nursing and healthcare staff are often working under a lot of pressure, but the use of a simple decision flow chart such as has been devised for the assessment of IP medication to be completed at each overdose or incident of self harm could be a quick and clear method of recording

how decisions were made to refer to the mental health team or not and whether or not in-patient admission was deemed appropriate."

Mr Duffy's Anxiety

Mr Duffy's family explained that he suffered from anxiety and paranoia outside of prison and they wanted to know whether he showed signs of anxiety in prison and whether this was treated appropriately.

The investigation found that there was evidence that Mr Duffy was suffering from anxiety both about his arrest and committal to prison and around his medication during his stay. Dr Evans said that, in her opinion, this was not addressed adequately. She said that *"Such anxieties were never explored and the single positive step which could have reduced anxiety around the regular availability of his medication and the possibility of bullying - the institution of supervised swallow for the foreseeable future was not taken. His anxiety and poor ability to cope within the prison context was highlighted with each medication incident and episode of self harm during his committal. There was a single staff report dated 03 May 2011 within the records which states "very needy inmate who is extremely paranoid". This was never followed up and it was not clear whether other staff were even aware of this assessment. It is certainly not referred to by [a nurse] at the time of the next medication 'incident' on 06 May 2011."*

Other Observations

"There seems to be a lack of clarity around a number of processes arising out of the policies in the prison at the time. Some of these may be training issues, some have been addressed by the new IP medication policy adopted from September 2011. Such issues include:

- *lack of appreciation of the significance of a recent overdose of prescribed medication;*
- *lack of appreciation of the principles that underpin the use of supervised swallow;*
- *lack of clarity as to when supervised swallow should be reviewed;*
- *poor communication between healthcare staff when the method of administration of medication has changed;*

- *lack of clarity as to the purpose of a 'GP review' and whether this should involve a face to face assessment with the patient and/or involve a formal mental state assessment;*
- *lack of clarity as to when self harm should trigger a GP or mental health review and the nature of that review;*
- *the fact and nature of failure of a mandatory drug test should be explicitly communicated to healthcare staff and should prompt an IP medication review;*
- *consideration as to whether there should be a system of 'red flags' which should accompany the prisoner when treatment is changed or he is relocated to alert all staff to long term factors which should be considered when assessing care for an individual prisoner: in the instant case, this would have included epilepsy, brain injury, depression, recent overdose and self harm, alcohol and drug dependence."*

South Eastern Health and Social Care Trust's Response to the Clinical Review

Having reviewed Dr Evan's clinical review report, the South Eastern Health and Social Care Trust confirmed that they had no issues with the factual accuracy of her report.

APPENDICES

APPENDIX 1

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

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

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

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

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

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

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

Clinical Issues

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

Other Investigations

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

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

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in

exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

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

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

Review of Reports

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

Publication of Reports

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

Follow-up of Recommendations

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

Annual, Other and Special Reports

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

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

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

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

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

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

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

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

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

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

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Minister for Justice (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 Minister for Justice. The Ombudsman may also publish material from published reports in other reports.

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

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

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

APPENDIX 2

INVESTIGATION METHODOLOGY

Notification

1. In the early hours of Thursday 23 June 2011, the Prisoner Ombudsman's office was notified by the Northern Ireland Prison Service about Mr Duffy's death in Maghaberry Prison.

2. A member of the Ombudsman's investigation team attended Maghaberry Prison to be briefed about the series of events leading up to Mr Duffy's death.

Notices to Prisoners/Inmates

3. On 23 June 2011, Notices of Investigation were issued to Prison Service Headquarters and to staff and inmates at Maghaberry Prison announcing the Prisoner Ombudsman's investigation and inviting anyone with information relating to Mr Duffy's death to contact the Investigation Team.

Prison Records and Interviews

4. All of the prison and prison healthcare records relating to Mr Duffy's period of custody were obtained.

5. Interviews were carried out with prison management, staff and inmates, in order to obtain information about the circumstances surrounding Mr Duffy's death.

Telephone Calls

6. Records show that Mr Duffy made 49 telephone calls between 22 April and 20 June 2011. Recordings of these calls were obtained.

CCTV Footage

7. CCTV cameras are not situated on the landing where Mr Duffy was located; however, CCTV from the entrance to Foyle House and the circle[18] were obtained.

Autopsy & Toxicology Report

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

Clinical Review

9. As part of the investigation into Mr Duffy's death, an independent clinical review was commissioned to examine Mr Duffy's healthcare needs and the medical treatment he received in Maghaberry Prison.

10. I am grateful to Dr Judith Victoria Evans, Independent Senior Consultant Forensic Physician with the Greater Manchester Police, who carried out the clinical review.

11. Dr Evan's clinical review report was forwarded to the South Eastern Health and Social Care Trust for comment. The Trust responded and I have included the comments made at the appropriate places in this report.

Factual Accuracy Check

12. Before completing the investigation I submitted the draft report to the Director General of the Northern Ireland Prison Service and the Director of Adult Services and Prison Health for the South Eastern Health and Social Care Trust for a factual accuracy check.

13. The Prison Service and Trust responded with list of comments for my consideration.

14. I have fully considered these comments and made amendments where I felt that this was appropriate.

[18] The circle area is on the ground floor and links the entrance, recreation room/ dining hall, yards, and other linking corridors as well as the stairs up to the prisoner's landings.

APPENDIX 3

MAGHABERRY PRISON

Maghaberry Prison

Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[19] and integrated[20] conditions. It was built to accommodate 682 prisoners, however, there were 914 prisoners in Maghaberry on the day Mr Duffy died.

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

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

There are three lower risk houses within the Mourne Complex of Maghaberry Prison, called Braid, Wilson and Martin Houses. These are usually used to house lifer prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU). There is also a Landing within Maghaberry Prison called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Foyle House, which is used for housing poor coping prisoners who attend the Donard Unit[21]. There is also a Care and Supervision Unit[22] (CSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.
The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect,

[19] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.
[20] Integrated – general residential accommodation houses accommodating all prisoners.
[21] The Donard Unit has been specifically designed to facilitate purposeful activity for poor coping prisoners.
[22] Care and Supervision Unit (CSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

constructive activity and resettlement of which addressing offending behaviour is an element.

Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[23] (PREPS).

Maghaberry Prison was last inspected by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[24] in Northern Ireland in July 2009.

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

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

APPENDIX 4

POLICIES AND PRISON RULES

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

Prison Rules

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

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

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

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

Death in Custody Contingency Plan

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

Prison Service and Maghaberry's Policies

Self Harm and Suicide Prevention Policy (2011)

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

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

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

Governor's Orders

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