The Prisoner Ombudsman for Northern Ireland

SUMMARY AND ISSUES OF CONCERN IN THE REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF MR AARON HOGG WHO DIED WHILST IN THE CUSTODY OF MAGHABERRY PRISON ON 22 MAY 2011 AGED 21

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Please note that where applicable, names have been removed to anonynmise the following document

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SUMMARY

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

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

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

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

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

There are also many references in Aaron's notes to him experiencing thoughts of *"self harm"* or *"suicidal ideation"*, but with no plans or intent. In October 2009, a

Social Worker recorded that "*Aaron reported symptoms of low mood including suicidal ideation on a daily basis.*"

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

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

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

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

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

At a further assessment in 2010, a psychiatrist recorded his impression that Aaron presented with an anti-social personality with borderline features associated with low mood and paranoid ideation. The psychiatrist found Aaron had no energy or motivation and reportedly spent most of the night awake and slept between 06.00

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

and 16.00. Aaron's medication was increased and there was to be a review in three months with a view to discharging him once his symptoms were stable.

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

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

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

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

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

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

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

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

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

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

production and release of cortisol, a stress hormone. Too much ACTH means too much cortisol. Cortisol is normally released during stressful situations.

During Aaron's committal to Maghaberry, a prison officer recorded that Aaron said that he had no thoughts of self harm and no history of self harm. The nurse (name redacted) who carried out the healthcare committal assessment recorded *"Prison Transfer. Self administration of medication – yes. Medication on committal Sertraline 100mg & 50mg daily, Seroquel (Quetiapine) 100mg nocte* (at night)*…Prisoners own prescribed medication to be used."* She also noted on the '*First Night in Prison*' committal form that Aaron did not have any medical markers, did not have any alcohol or drug related problems and did not have any thoughts of self harm. Aaron's daytime Quetiapine was not recorded but it was not flagged up as an immediate problem because Aaron had arrived at Maghaberry with a supply of his medication.

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

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

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

On 21 December 2010, Aaron transferred from the committal landing in Maghaberry to Lagan House. At interview, a prisoner who shared a cell with Aaron in Lagan House (name redacted) said that *"Aaron used to take a handful of his tablets every day and he'd get into bed, go to sleep, wake up, eat all the food, probably start snarling at me about something, then get back into bed, fall asleep, wake back up, neck a handful more tablets and then get back in and go to sleep. And that was literally all Aaron would do, was just neck a whole handful of them tablets, go to sleep and he'd end up probably having to do two or three days without tablets and I used to say to him, "why do you take so much and leave yourself short? Why don't you take what you're supposed to take?" And he said because he wasn't on enough; there wasn't enough medication."*

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

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

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

On 23 and 24 February, Aaron saw a nurse again and told her that he was still adamant that he was missing his Quetiapine 100mgs at night. She recorded that *"there appears to be some confusion over the 100mg Seroquel nocte."* On 24 February, the nurse contacted Aaron's GP who confirmed that he had been getting 125mg of Quetiapine at night and, as a result, the nurse requested that Aaron's

prescription be amended *"asap and sent as urgent."* The following day, Aaron received the additional 100mgs of Quetiapine that he had been taking up to the middle of January.

On 27 February, Aaron was involved in a fight with another prisoner. Aaron was sent to the Special Supervision Unit (SSU) where he remained on a very restricted regime for six weeks. There is evidence in Aaron's phone calls that he found his time in the SSU difficult and the investigation identified concerns in connection with the way that governors took decisions to extend Aaron's time there. It is, however, to note that during his time in the SSU, Aaron's medication was administered by a nurse and, in phone calls, he can be heard to say that he feels *"better in myself"* when on supervised medication.

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

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

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

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

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

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

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

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

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

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

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

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

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

On 17 May, a letter was sent to Maghaberry Prison from Aaron's solicitor. The letter stated, *"as you are aware Mr Hogg is particularly vulnerable and struggles to cope with the prison environment. Visits from (names redacted) provide a stabilising influence and are enormously beneficial to his mental health and well being."* The solicitor asked whether disciplinary proceedings were to be taken against Aaron

and whether the visiting rights of those affected could be restored. No reply was received by the time of Aaron's death on 22 May.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The autopsy report recorded that: *"Death was due to hanging. There was a ligature mark on the neck and its position was such that when the ligature tightened, with the weight or partial weight of the body, it would have interfered with breathing and the flow of blood to and from the head. Unconsciousness would probably have occurred quite rapidly with death supervening within a few minutes. Apart from the ligature mark on the neck there were no further serious marks of violence."*

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

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

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

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

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

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

Aaron's experience of auditory pseudo-hallucinations [hearing voices, good and bad] *"contributed to his suicidal state."*

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

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

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

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

[9] Opioids are very strong painkillers.

some form of reprimand was necessary; however, these visits appear to have been key to his well being."

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

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

ISSUES OF CONCERN REQUIRING ACTION

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

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

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

3. Even though Aaron was on antipsychotic and antidepressant medication; was seeing a community psychiatrist; had been a psychiatric hospital in-patient; had a history of self harming and was known to abuse alcohol and his medication, during his last committal:

   a. No consideration was given to referring him to the Mental Health Team.
   b. No consideration was given to referring him for a psychiatric assessment.
   c. No psychotherapeutic intervention was considered.

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

5. Aaron was able to stockpile his prescription medication.

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

7. Missed hospital appointments were not followed up.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESPONSE TO AREAS OF CONCERN

Northern Ireland Prison Service

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

South Eastern Health and Social Care Trust

The Trust Chief Executive responded as follows:

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

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

Proposed changes are:

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

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

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

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

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