The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

GEOFFREY SINGLETON

AGED 42

IN MAGHABERRY PRISON

ON 6th MAY 2013

[13th November 2014]

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Unit 2, Walled Garden, Stormont Estate, Belfast BT4 3SH
T 028 9052 7771 F 028 9052 7752 www.niprisonerombudsman.gov.uk

CONTENTS **PAGE**

GLOSSARY **3**

PREFACE **4**

SUMMARY **6**

RECOMMENDATIONS **8**

MAGHABERRY PRISON **11**

FINDINGS

Section 1: Background 12

Section 2: Event's that led to Mr Singleton's return to Maghaberry 14

Section 3: Mr Singleton's Committal 15

Section 4: Event's that led to Mr Singleton's admission to hospital 18

Section 5: Mr Singleton's return to Maghaberry from hospital 20

Section 6: Events on the day Mr Singleton died 24

Section 7: Response once Mr Singleton was found 28

Section 8: Autopsy Findings 30

Section 9: Events After Mr Singleton's Death 31

Section 10: Findings of the SEHSCT's Root Cause Analysis Review 32

Glossary

CJI	Criminal Justice Inspectorate
CSU	Care and Supervision Unit
ECR	Emergency Control Room
EMIS	Egton Medical Information System
HMIP	Her Majesty's Inspectorate of Prisons
LVH	Lagan Valley Hospital
MAR	Medication Administration Record
NOMS	National Offender Management Service
PER	Prisoner Escort Record
NIPS	Northern Ireland Prison Service
PECCS	Prisoner Escort Court Custody Service
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust
SPAR	Supporting Prisoners at Risk

PREFACE

As Prisoner Ombudsman for Northern Ireland I have responsibility for investigating all deaths in prison custody in Northern Ireland. My investigators and I are completely independent of the Northern Ireland Prison Service (NIPS). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

I make recommendations for improvement where appropriate; and my investigation reports are published subject to consent of the next of kin in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for Prisoner Ombudsman investigations of deaths in custody are to:

- establish the circumstances and events surrounding the death, including the care provided by the NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust (SEHSCT);
- examine whether any changes in NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation 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 practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. In this case, Dr J Victoria Evans, Senior Consultant Forensic

Physician with Greater Manchester Police undertook a clinical review of the healthcare provided to Mr Singleton in connection with the circumstances which led to his demise.

This report is structured to provide background information on Mr Singleton and a sequence of events which lead to his demise.

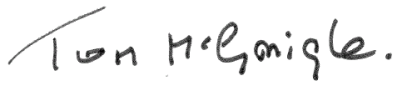
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. I first met with Mr Singleton's next of kin in June 2013, and contact has been maintained with them throughout the investigation.

Although this report will inform several interested parties, it is written primarily with Mr Singleton's family in mind.

I am grateful to Mr Singleton's family, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contributions to this investigation.

I offer my sincere condolences to Mr Singleton's family for their sad loss.



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
13th November 2014

SUMMARY

Geoffrey Singleton had a lengthy history of abusing drugs, and had spent a considerable amount of time in prison since 1993. His family cared about him, and he wanted to abstain from drugs, but was unable to maintain his abstinence efforts. Life in the community was difficult for Mr Singleton, and he had a particular problem in adhering to a licence condition surrounding the approval of where he could live. On this occasion it led to him being returned to prison four days after release.

Our clinical reviewer did not criticise Mr Singleton's medical care during previous periods in prison; and said that appropriate referrals had been made to community addiction services.

As he was recommitted at the start of a bank holiday weekend, there was a delay in providing antidepressant and anxiety medication which he had been prescribed in the community. This contributed to an aggressive outburst, but his mood was generally positive.

Mr Singleton had overdosed on heroin before returning to prison, and shortly after committal disclosed that he had swallowed a package of heroin. There was a suggestion he manufactured the situation in an attempt to resolve his medication issues.

He was subsequently taken to outside hospital, but discharged himself and returned to Maghaberry. Tablets were found in the van that was used to transport him, though it is not known if he had taken any of these.

Poor communication from the hospital meant radiological evidence that he had actually swallowed something was not made known to the governor, who then inappropriately placed Mr Singleton in a dry cell in the CSU. A care plan should have been put in place to address the possibility of a toxic overdose from leakage of heroin in the gut.

Ultimately his autopsy revealed that, with the exception of cannabis, which could have been taken before he was returned to prison, all of the drugs found within Mr Singleton's system were reflective of the prescribed medication that he had recently received.

Mr Singleton's death was unpredictable. While he had attempted suicide in the community, there was only one incident of self-harm in prison, and staff and prisoners who knew him were very surprised when he took his own life. His family appreciated the support they subsequently received from Maghaberry's chaplaincy team.

This investigation has generated 20 recommendations for improvement, with communication breakdowns a particular theme. Five of the recommendations have been previously made to the NIPS and SEHSCT – Recommendation 2 was made in March 2010 but rejected; recommendation 7 was made and accepted in November 2008; recommendation 11 was made and accepted in March 2010 and December 2012; recommendation 12 was made and accepted in June 2010, and recommendation 17 was made and accepted in February 2011.

The NIPS and SEHSCT have accepted all of the recommendations in this investigation.

RECOMMENDATIONS

NIPS -

1. **ECR Occurrence Log Entries** – All contact by landing staff with the ECR in relation to the welfare of a prisoner should be recorded in the ECR occurrence log. (Page 18)

2. **Dry Cell Use:** A policy should be developed on the use of dry cells for retrieving concealed, unauthorised articles. The policy should take account of the needs of the prisoner, the NIPS and the findings of Judicial Review STEC5916. (Pages 21-23)

3. **Night Guard CSU:** When prisoners are brought to the CSU during the night, night guard staff should be able to produce the appropriate supporting documentation; and CSU Officers should be fully briefed on the reason for their arrival. (Page 22)

4. **Placement of Prisoners who require Treatment or Medical Observation:** The NIPS should update their policy for locating prisoners who require treatment or medical observations, to ensure they are located in the most appropriate place. This should include the possibility of using observation cells in certain circumstances. (Page 23)

5. **Evidence Handling:** A training needs analysis should be undertaken for all CSU staff in relation to identification and handling of evidence, which may be required for adjudication or a criminal case. (Page 24-25)

6. **Hoffman Knife Availability**: The NIPS should consider the feasibility of all landing staff carrying a Hoffman knife. (Page 28)

7. **ECR Attendance at Hot Debrief Meetings:** The NIPS should ensure that the ECR is represented during hot debrief meetings. (Page 31)

8. **Debrief Action Plans** – All criticisms / learning points identified during debrief meetings should be transferred into an action plan that contains clear timeframes and allocates responsibility for implementation. (Page 31)

SEHSCT –

9. **"Through the Door" Addiction Support Schemes:** The SEHSCT should work with other Trusts to develop robust support for prisoners already known to prison

addiction services and who are at high risk of relapse or overdose, within 24 hours of their release. (Page 12)

10. **Prisoner Medication Prescribed by Police Doctors** – The SEHSCT should consider extending the work they are currently undertaking with A&E departments around the packaging of medication issued to prisoners, to the PSNI. (Pages 15-16)

11. **Medication Administration Recording:** The SEHSCT should ensure all healthcare staff responsible for issuing medications are fully trained in the In-possession Medication Policy, and the recording requirements for Medication Administration Records. (Page 16)

12. **EMIS Entries:** All requests for a nurse to visit a prisoner should be recorded on EMIS, and a full explanation provided when the visit is not made. (Page 18)

13. **Outside Hospital Discharge Information**: The SEHSCT should ensure there is a robust system in place to transmit discharge information to the prison when a prisoner has been treated at outside hospital. If discharge information is not received on the prisoner's return, healthcare staff should promptly request it. (Pages 20-23)

14. **Care Plans on Return from Outside Hospital**: The SEHSCT should ensure that an immediate review is undertaken when a prisoner returns from outside hospital following emergency care to establish whether a new or altered care plan is required for the individual. (Pages 20-23)

15. **CSU Healthcare Assessments**: The SEHSCT should remind all healthcare staff who work in the CSU that their policy stipulates medical assessments should be carried out in the medical room and not in the prisoner's cell. (Page 25)

16. **Drugs Toxicity Training Needs Analysis**: The SEHSCT should ensure that, where an individual is suspected of ingesting substances that could result in toxic overdose, a care plan is put in place which details the appropriate level of medical monitoring required. (Page 25-26)

17. **EMIS Reviews by Nursing Staff**: Robust procedures should be put in place to ensure EMIS records are adequately reviewed by healthcare staff at the earliest opportunity when dealing with a patient or entering information in the prisoners medical records. (Page 27)

18. **Paramedic Handovers:** The SEHSCT should ensure that all their staff understand the importance of effectively communicating all relevant medical information, including recent history and known risk factors, to paramedics, and of documenting that this has been done. (Page 28)

Both NIPS and SEHSCT: -

19. **Communication between NIPS and SEHSCT relating to Medical Matters**: The SEHSCT and NIPS should ensure there is a robust system in place to ensure that healthcare staff are given all information by NIPS staff which might affect an individual prisoner's health. A record should be retained of the information provided, and any actions subsequently taken by healthcare staff. (Pages 20-21)

20. **Sharing of Self-Harm Related Information**: Robust procedures should be developed to ensure that recent self-harm incidents are communicated to every person who has responsibility for the prisoner's care. (Page 24-25)

MAGHBERRY PRISON

Maghaberry is a high security prison which holds male adult sentenced and remand prisoners. It was opened in 1987.

Maghaberry established a Prisoner Support and Safety Team (PSST) in 2011. The team comprises a governor and five members of staff. They have several responsibilities including a role to support vulnerable prisoners. Mr Singleton was not engaged with PSST at the time of his death.

There have been two deaths from natural causes in Maghaberry since Mr Singleton died.

The last CJI / HMI Prisons inspection of Maghaberry was conducted in March 2012 and published on 17th December 2012. Several of the findings and recommendations in that report are relevant to the healthcare provision, opiate substitution therapy waiting times and treatment, and substance misuse.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Maghaberry IMB's 2012-13 annual report did not make any recommendations that are relevant to Mr Singleton's death.

FINDINGS

SECTION 1: BACKGROUND

Geoffrey Singleton was 42 years old when he died, apparently by suicide[1] on 6th May 2013, in Maghaberry Prison.

Mr Singleton had a custodial history dating back to 1993, which included five periods of remand and five sentences ranging from nine months to eight years. An officer who had known him for a number of years said that recently Mr Singleton had been very helpful working as an orderly on the landing. He described him as someone who was proactive in his work and liked to keep busy.

Misuse of Drugs

Records show that Mr Singleton had a long history of substance misuse including solvents, alcohol, opiates (which in later years he injected), cocaine, amphetamines and ecstasy. His family queried why he was not rehabilitated in relation to his drug misuse during his numerous spells of imprisonment. Records show that support services were provided for him while in prison, and while he engaged on occasions, he was unable to sustain his abstinence.

In her clinical review report, Dr Evans said that Mr Singleton was referred to drug and alcohol addiction services appropriately throughout his various detentions in prison, although his engagement with them was not consistent. She said that like many people who have spent a great deal of time in prison, Mr Singleton seemed to recognise that he had difficulties in coping with life in the community and within a short period of time reverted to misusing heroin with resultant accidental overdose. The possibility of a naloxone (a drug which can reverse the effects of heroin and buy time to get medical help) prescription had been discussed and rejected by him before a previous release. She suggested a "Through the Door" scheme, which would have linked him to addiction support within 24 hours of release, might have prevented relapse.

History of Self-harm

There was evidence that Mr Singleton had a long history of deliberate self-harm including swallowing various objects/drugs, overdose, cutting, including a laceration that required surgery; and in 2007 he attempted to hang himself.

[1] At the time of completing this investigation, the inquest to determine the cause of Mr Singleton's death had not been held.

The NIPS and SEHSCT were unaware of the detail of this history and there had only been one incident of self-harm in prison since 1993: in June 2012 he attempted to cut out spots on his scalp which he believed were cancerous.

In April 2012 Mr Singleton self-referred to the Prisoner Safety and Support Team (PSST) because he needed help with his past. He remained under their review until February 2013 when he was discharged due to his imminent release. During this period Mr Singleton refused to engage with Ad:Ept[2] or the Donard Programme[3] and failed to attend appointments with the SEHSCT's Addiction Clinic. As they knew that Mr Singleton would be homeless upon release, the PSST referred him to the Housing Rights Service[4].

In October 2012 the PSST requested a family officer to contact a family member who was visiting Mr Singleton, because they were concerned about him spending long periods of time in his cell and self-isolating. The family officer reported that she had an open conversation with the family member, and learned that Mr Singleton had concerns about being released to live on his own, which he did not like. His family were also concerned that he was institutionalised, could never admit what was wrong with him, and that he might take his own life.

Mr Singleton's Previous Period in Custody

Mr Singleton was released on 25th February 2013, but rearrested three days later for breaching one of the conditions of his release by not residing at an approved address. It was very difficult to obtain a suitable private rental address, because he had to inform the landlord that he was a notifiable offender. This embarrassed Mr Singleton, so he refused to cooperate, and consequently had previous recalls to prison.

On 1st March 2013 Mr Singleton returned to Maghaberry Prison, where he remained for the next two months.

Commenting on the medical care Mr Singleton received, prior to his last committal, the clinical reviewer, Dr Evans said:

"I have seen nothing in his medical records which would suggest that Mr Singleton did not receive good medical care whilst in prison. Appropriate referrals were made to the community addiction services prior to his release."

[2] Ad:Ept – **A**lcohol and **D**rugs: **E**mpowering **P**eople through **T**herapy provides therapeutic services for people with alcohol and drug addictions.

[3] The Donard Programme is a specialised unit for prisoners who have been assessed as requiring additional support because of their vulnerabilities, mental health

[4] Housing Rights Service works to improve lives by tackling homelessness and housing problems in Northern Ireland.

SECTION 2: EVENTS THAT LED TO MR SINGLETON'S RETURN TO MAGHABERRY

When he was released on 29th April 2013 Mr Singleton was required to notify Police of his address. He told them on 1st May that he was living with a family member.

Later on 1st May, Mr Singleton was taken by ambulance to Craigavon Area Hospital, having overdosed on heroin. The following morning when he was picked up from hospital, he told a family member that *"It did not work this time."* The meaning of this was not clear. A prisoner who had known Mr Singleton well said that when they spoke about the overdose after his return to Maghaberry, Mr Singleton said he had asked a friend to *"Put him over,"* but did not want to die. Mr Singleton told the prisoner that if he overdosed, he believed it would help ease the license conditions to which he was having difficulty in adhering.

On 2nd May Police confirmed Mr Singleton had not been staying at the address he gave them, and indeed he was prohibited from staying at the address where he had actually resided.

Mr Singleton was subsequently arrested on 3rd May on suspicion of breaching one of his licence conditions and providing false information to Police. He spent the night in Police custody before being remanded at court the following morning and taken to Maghaberry Prison on 4th May 2013.

SECTION 3: MR SINGLETON'S COMMITTAL

At 12.07 on Saturday 4th May 2013 Mr Singleton arrived at Maghaberry Prison. The accompanying Prisoner Escort Record (PER) included details about his history of self-harm and addiction to heroin, and confirmed that Police had supplied the prison with his evening medication. The full list of medication supplied by Police is unknown as a record was not retained. Records do however indicate that it included a supply of diazepam.

Mr Singleton underwent a committal interview at which he informed the officer that he did not consider himself vulnerable, nor at risk; and he had no thoughts of self-harm.

A nurse then took a detailed history from him, and completed an Opiate Withdrawal Scale which resulted in a low score of one. Mr Singleton told the nurse that his medications on committal were Prozac 40 mgs (also known as fluoxetine – an antidepressant), pregabalin 225mgs (commonly prescribed for neuropathic pain and generalised anxiety disorder), diazepam 5 mgs, temazepam 20 mgs (to help aid sleep) and dihydrocodeine (medium strength opioid pain killer, also prescribed to help people who are withdrawing from heroin).

Mr Singleton then demanded the diazepam which had been provided by the Police doctor, but it was refused on the basis that it would be against SEHSCT policy to give it to him. Mr Singleton reacted aggressively.

Noting that Mr Singleton had not been prescribed diazepam during his most recent custodial period, the nurse contacted his community pharmacist to verify whether Mr Singleton was telling the truth – which was confirmed. She then sought advice from the out of hours GP service on the appropriate medication for Mr Singleton. A prescription for seven days fluoxetine, pregabalin and diazepam was approved. However, only the diazepam was available as the other medicines were not kept in the Emergency Medicine Cupboard, which is used when the pharmacy is closed.

The pharmacy opening hours (Monday to Friday 9am - 5pm excluding Bank Holidays) meant that Mr Singleton would not receive his antidepressant medication of fluoxetine or pregabalin until Tuesday 7th May, as it was a Bank Holiday weekend.

In January 2014 the list of medications available out of hours was revised to include pregabalin. The SEHSCT are also drafting Standard Operating Procedures which will provide access to critical, or non-critical but urgent, medications, that are not stocked in the Emergency Medicine Cabinet, out of hours. Work is also ongoing with A&E departments to ensure medication supplied to a prisoner at A&E is packaged appropriately, to enable nurses to legally administer them in prison. Consideration should also be given to extending this to include the PSNI, so that when prisoners arrive into NIPS custody with medication supplied by a Forensic Medical Officer, as

happened in Mr Singleton's case, it is packaged to enable legal administration by a nurse.

Due to Mr Singleton's recent overdose, he was assessed as not being suitable to have his medication in-possession, which meant he would have to swallow it in front of a nurse each day ("supervised swallow"). There is however, no corresponding Medication Administration Record (MAR) to reflect that he was given his diazepam by supervised swallow. The only MAR available suggests that Mr Singleton was provided his diazepam as daily in-possession, which is against SEHSCT policy.

The committal officer raised concerns with his senior officer about Mr Singleton's behaviour whilst in the holding cell, so the Duty Governor was asked to assess whether he was suitable to cell share. The governor described Mr Singleton as very aggressive, and confirmed he would pose a risk to other prisoners if he were to share a cell.

Commenting on the lack of medication for Mr Singleton on committal, Dr Evans said the inability of the prison healthcare staff to administer the drugs which he had been taking on a regular basis and which had been prescribed for him by the forensic physician whilst in Police custody, and subsequently by the prison out of hours GP, was detrimental to good medical care.

She said that, as a result, Mr Singleton was not provided with the same level of care that he could have expected had he not been detained and been free to either take the medication dispensed to him by the forensic physician, or to take the prescription to an emergency community pharmacist.

In addition to this Dr Evans said the combination of an antidepressant such as fluoxetine with pregablin will enhance the effects of the pregablin and should not be stopped suddenly, but tapered off over a minimum of one week as recommended by the British National Formulary. Dr Evans said that although there is no recognised physical discontinuation syndrome as such, if the drug is stopped abruptly, concentration levels will quickly fall (and may precipitate withdrawal fits if used as an adjunct to anticonvulsant therapy), pain will return and anxiety levels increase. The exact effects will vary from one individual to another. It is increasingly recognised that in some susceptible individuals psychological dependence on pregabalin may develop. It is likely therefore that the failure to have regular pregabalin resulted in him becoming increasingly anxious and suffering increasing pain (that had been a longstanding problem) in his foot.

The absence of fluoxetine was unlikely to have had any immediate noticeable effect, though unless this was carefully explained to Mr Singleton, it may have further increased his anxiety levels.

Consequently Mr Singleton was moved to a single cell in Bann House. He could not be placed on the committal landing, as it did not have a single cell; and a clear instruction was issued that Mr Singleton was to use the lower bunk in his cell due to the risks associated with possible withdrawal from drugs.

An officer said that Mr Singleton was in his usual form when he arrived on the landing and was welcomed by the other prisoners, without any issues or concerns.

Mr Singleton had another aggressive outburst that evening when he discovered his tobacco was stolen, and he threatened the prisoner who had taken it. An officer who witnessed the event submitted a Security Information Report (SIR) detailing her concerns for the other prisoner and indicating that Mr Singleton was under the influence of drugs.

The senior officer said that because Mr Singleton was placed straight into a cell upon arrival, the officers kept a close eye on him to make sure he was OK. They told the senior officer that Mr Singleton was in good form and there was no cause for concern.

An officer who had known Mr Singleton throughout his custodial career said that when he was locking him up for the night, his last words were that he would see him on Tuesday when the officer was next back on shift. He also asked after the officer's wife by her name, as Mr Singleton knew she was not well.

SECTION 4: EVENTS THAT LED TO MR SINGLETON'S ADMISSION TO HOSPITAL

At 00.45 on Sunday 5th May 2013 Mr Singleton used his cell alarm and asked for his medication. Records indicate that he had received his daily amount of diazepam for 4th May. It is therefore likely that he was seeking his fluoxetine and pregabalin, though these were unavailable. The class officer's journal records that the Healthcare Department was contacted by the Emergency Control Room (ECR). The ECR officer was informed that healthcare staff do not have access to medication during the night, which is not accurate.

There is no entry in Mr Singleton's medical records to reflect this conversation between ECR and healthcare, nor is there an entry in the ECR occurrence log.

At unlock the next morning the senior officer spoke with Mr Singleton. He made no requests and they had a brief conversation.

The senior officer later received a phone call from a member of Mr Singleton's family who was concerned about his wellbeing. The senior officer tried to reassure them that he seemed to be OK, and had not raised any concerns with staff.

Mr Singleton was called to see the nurse on at least three occasions but he did not attend the medical room. He finally saw the nurse at 11.34. An Opiate Withdrawal Scale Test was completed, which resulted in a score of zero. Mr Singleton was given his diazepam, and he requested the medications that were not available (pregabalin and fluoxetine). He was again advised that he would have to wait until the pharmacy opened on 7th May. The nurse said Mr Singleton was not happy about this and requested Britloflex, which is provided for relief of withdrawal symptoms from opiates such as heroin. The nurse advised that he would need to see the doctor or a member of the addictions team to have Britloflex prescribed, and assured him that his withdrawal scale would be monitored daily and symptoms treated as they arose.

At 15.06 Mr Singleton made three consecutive phone calls to a family member, which were unanswered.

At 15.39 the same nurse was walking through Bann House when she was stopped by Mr Singleton. He told her that he had accidently swallowed about 4g of heroin that was contained in a sealed bag. He was immediately taken to the medical room and examined for symptoms of overdosing. The senior nurse in Maghaberry and the out of hours GP were contacted for advice. While awaiting a return call from the GP, Mr Singleton was returned to his cell and prison staff were asked to look out for signs which would indicate a deterioration in his condition. He was also to have his medical observations rechecked in half an hour.

The out of hours GP advised Mr Singleton should be taken to an Accident and Emergency (A&E) department for further assessment. At 17.15 he left Maghaberry under escort, with an explanatory letter for A&E.

Commenting on the actions of the nurse to whom Mr Singleton had spoken about swallowing the bag of heroin, Dr Evans said her actions, including the letter that accompanied him, demonstrated good professional practice and that appropriate steps were taken to minimise risk to Mr Singleton's safety.

A prisoner in Bann House who knew Mr Singleton well said that Mr Singleton wanted to visit outside hospital to see if they could give him something to deal with withdrawal sickness. He believed Mr Singleton had swallowed one or two glove fingers of either coffee or tea leaves. The prisoner also said that if Mr Singleton had a *"stash"* of heroin, then he would have been happy to remain in his cell, and would not have asked for his medication or wanted to go to outside hospital.

SECTION5: MR SINGLETON'S RETURN TO MAGHABERRY FROM HOSPITAL

Return to Maghaberry Prison

At Lagan Valley Hospital (LVH) Mr Singleton underwent an x-ray that showed he had swallowed two objects. The doctor wanted to admit him to enable observation for signs of opiate toxicity, in case either or both of the packages ruptured. If this had been the case, the doctor said Mr Singleton would have required immediate treatment.

At 19.40 the escorting officers were contacted by a senior officer who told them that they were to keep Mr Singleton in ratchet handcuffs. The bedwatch journal records that Mr Singleton was unhappy with this because the handcuffs were uncomfortable. One of the escorting officers said that he was also annoyed that the doctors would not give him any further medication.

Because LVH's A&E department closed relatively early, the doctor wanted to transfer Mr Singleton to the Ulster Hospital. Mr Singleton told the doctor that he would only transfer if he was given medication. The doctor refused his demand and as a result Mr Singleton became angry and wanted to sign himself out. The doctor explained the risks of returning to prison before passing the swallowed items, but Mr Singleton ignored this advice and signed himself out.

At 21.25 Mr Singleton returned to Maghaberry and was taken to the Care and Supervision Unit (CSU). The van that transported him was searched and an officer reported finding five tablets (later found out to be methocarbamol - a muscle relaxant with sedative properties) that he believed were not there before Mr Singleton was transported. The officer said he carried out a cursory search of the van cell before Mr Singleton entered, and the tablets were not obviously in view. Given the level of supervision that Mr Singleton was under whilst at outside hospital, it is not clear, how - if he had in fact dropped these tablets - he acquired them.

There was no entry in Mr Singleton's medical records to note that he had returned from hospital, the reason for his return, the findings of the hospital investigations or the fact that methocarbamol tablets had been found in the van that transported him. Had he taken any methocarbamol, it would have combined with the diazepam he was already taking to further affect his central nervous system.

Dr Evans said that this was a pivotal omission as there was no reference to the fact that he was believed at that time to have swallowed bags containing about four grams of heroin, and there was radiological evidence of bags in his gut. He had refused admission to hospital and discharged himself against medical advice.

Dr Evans continued that, although Mr Singleton was under the care and custody of two prison officers while at hospital, it should not be assumed by anyone that prison officers would understand the significance of information they overheard, nor should they be expected to convey such information to healthcare staff at the prison.

She concluded that if this information about the presence of bags in his gut had been passed to the prison healthcare staff and recorded, it would have alerted them to the continuing risk of heroin overdose, the need for a care plan, regular observations for signs of opiate toxicity, access to naloxone injection, should this become necessary, and consideration of the most appropriate placement for him in the prison.

In relation to the tablets that were found in the prison van Dr Evans said that the fact healthcare staff were not made aware of this was detrimental to the quality of his medical care.

Transfer to a Dry Cell in the Care and Supervision Unit (CSU)

The decision to move Mr Singleton to a dry cell was made by the Duty Governor. A dry cell is devoid of furniture and sanitation facilities, and their use is governed by Prison Rule 32 (ii) and two separate Instructions to Governors (IG).

Prison Rule 32 (ii) states that restriction of association can be in a cell equipped to aid retrieval of any prohibited article, such as a dry cell. In October 2007 an IG was issued regarding Passive Drug Dog Deployment that mirrors Prison Rule 32 (ii). The IG states that a dry cell can be used for up to 48 hours when a dog has indicated that a prisoner has drugs concealed on their person, for the purpose of retrieving the drugs. In December 2007 a Judicial Review (Judicial Review STEC5916) found no issue with the application of Rule 32 (ii), or use of a dry cell for the purpose of retrieving drugs. Rule 32 (ii) has not been superseded.

This however conflicts with another current IG, dated December 2007, which says that a dry cell is only to be used for a calming down period when dealing with violent and unmanageable prisoners. While not applicable in Northern Ireland, the NOMS (National Offender Management Service) Prison Rules state that a dry cell must not be used for retrieval of drugs; and this position has been reiterated in prison inspection reports.

The Duty Governor weighed up the information passed to him by the Duty Manager and the risks associated with Mr Singleton's return to prison. He concluded that the risks to the prison, should the alleged packages of heroin be shared among the prison population, swayed his decision to place Mr Singleton in the dry cell. Whilst this decision did not breach Prison Rules, it did contravene the December 2007 IG.

Although little can be done when someone in the community discharges themselves from hospital, the duty of care upon the NIPS and SEHSCT suggests a care plan that included increased observations and alternative accommodation, such as an observation cell, where signs of opiate toxicity could have been monitored, should have been considered.

The governor considered that additional observations required for Mr Singleton due to the medical risks associated with swallowing heroin, would have to be decided by healthcare professionals; and he could not recall receiving any information from healthcare staff about this matter.

Routine checks at 21.30, 22.15, 00.15, 02.15, 04.30 and 07.00 were conducted on Mr Singleton overnight. The objective of those checks was to ensure he was in his cell and that there were signs of life through observing movement or eliciting a verbal response. These checks were not to monitor the symptoms of opiate toxicity[5]. Nothing untoward was reported during these checks. The night guard manager said Mr Singleton seemed quite normal when he spoke with him at around 21.20.

An officer who was not involved in settling him into the dry cell heard Mr Singleton swearing angrily at the officers who were placing him there, but was not close enough to hear why he was annoyed.

The same officer, who was responsible for Mr Singleton's landing, said he was not given any specific instructions or care plan, nor was he aware of the reasons why he was placed in a dry cell. Neither was any information entered in the journal about the reasons for Mr Singleton being placed in a dry cell.

Documentation should be prepared in respect of all prisoners who are detained in the CSU, to detail the reason they are being held, and the Prison Rule which provides the authority to do so. During the day this document is generated at the earliest opportunity and a copy is attached outside the prisoner's cell so that staff are fully informed. However officers are unable to generate this document if a prisoner is transferred to the CSU during the night.

[5] Specific signs of opioid poisoning include small pupils, shallow breathing, extreme sleepiness or loss of alertness.

Dr Evans said that it was not appropriate to place Mr Singleton in the CSU upon his return to prison. She said that, had there been a proper healthcare review, a care plan should have been in place which recognised the possibility of catastrophic overdose from leakage of a package of heroin in the gut. An observation cell where regular observations, at 30 minute intervals to check that he was breathing and could be easily aroused, should have taken place through the night, equivalent to that offered in a Police cell in a similar situation.

Dr Evans stated that the method of rousing does not require any clinical training and can be summarised as follows:

- Can the prisoner be woken?
- Go into the cell, call their name, shake them gently;
- Can they give appropriate answers to questions such as – What is your name? Where do you think you are?
- Can they respond appropriately to commands such as – Open your eyes, lift one arm and now the other.

If the prisoner failed to meet any of the above, Dr Evans' expectation would be that an appropriate healthcare professional, with access to injectable naloxone if required, and/or an ambulance would be called immediately.

There are no in-patient/healthcare beds in Maghaberry and the policy on the use of CCTV observation cells states that *"Only prisoners assessed as having a serious and immediate intent to self-harm will be placed in an observation cell."* The policy surrounding the use of these cells should, therefore, be changed.

SECTION 6: EVENTS ON THE DAY MR SINGLETON DIED

Duty Governor Contact

During the handover from the night guard manager to the Duty Governor on Monday 6th May 2013, the reason why Mr Singleton was held in the CSU and the results of his x-ray were discussed. The governor was not informed of a care plan in relation to possible opiate toxicity, or the fact that methocarbamol tablets had been found in the van that transported him back from hospital.

Neither manager was aware that Mr Singleton had overdosed shortly before his return to prison. The Duty Governor said that if he had known, he would have handled the matter differently – he would have considered opening a SPAR since Mr Singleton's intention in swallowing the package of heroin may have been to self-harm.

At 08.30 on 6th May 2013, the Duty Governor spoke with Mr Singleton in his cell in order to explain the reason for continuing his placement in the CSU. The governor explained his concerns to Mr Singleton for his safety and the safety of other prisoners if he passed packages of heroin; and because of that he was placing him on Rule 32. Mr Singleton's response to the governor was quite adamant, to the effect that he would not hand over the packages.

The governor said that Mr Singleton was well-known to him, and at no time during their conversation did he have any concern about him being at risk of self-harm.

When the governor returned later Mr Singleton informed him that the packages did not in fact contain heroin, but coffee wrapped in black plastic. He explained the change in his story was due to difficulties with his medication in prison, and he knew an admission of swallowing drugs would result in him being taken to outside hospital, where he believed he could have his medication issue resolved. The Duty Governor expected Mr Singleton's medication issues to have been addressed at committal, and did not pursue the matter any further.

The Duty Governor subsequently allowed Mr Singleton to use the toilet, with an agreement that he would hand over any packages he passed. He knew there was a risk that Mr Singleton may not hand over the packages, but was prepared to take the risk because he felt that Mr Singleton had been in a dry cell for too long, and he preferred to relocate him to a normal cell.

Mr Singleton did not subsequently hand over any packages to the governor. Mindful of the fact that there was no evidence that the packages had been passed, the governor continued his detention in the CSU on Rule 32 but agreed that he could get showered and placed in a normal cell.

When asked whether the risk to Mr Singleton's health was considered during the decision-making process, the governor said he had discussed it openly with him. The governor believed that, because Mr Singleton had refused to stay at outside hospital where his health could have been monitored safely, there was no longer an option for him to have the medical risks addressed.

After Mr Singleton's death it transpired that he had handed over a small piece of white plastic wrapped in toilet tissue, to an officer, and advised that was all that remained of the packages he alleged to have passed. The officer informed the senior officer and threw the toilet tissue in the bin as he believed it was only a piece of toilet paper that had been handed to him. The Duty Governor was not aware of this when deciding about Mr Singleton's cell location.

Nurses Assessment for Cellular Confinement

After meeting the governor, Mr Singleton was seen by the house nurse who assessed him to determine whether he was fit for adjudication and cellular confinement. Contrary to SEHSCT policy, the nurse's assessment was conducted in Mr Singleton's cell.

The nurse recorded that Mr Singleton was enquiring about his medication and that he was told Bann House would be contacted to retrieve his medication and medication administration record. The nurse was, at that time, unaware that Mr Singleton was being supplied with medication from the Emergency Medication Cabinet. The nurse recorded that the Opiate Withdrawal Scale Test was completed, and that his observations were stable. However no form was used to record this information, as required. The nurse also appeared to accept at face value Mr Singleton's assertion that it was coffee he swallowed, rather than heroin.

The nurse said that during the verbal handover that morning, he was told that Mr Singleton had been to hospital because it was possible that he had swallowed something. The nurse said that at the time he did not know what he was supposed to have swallowed, and that there was no specific plan for Mr Singleton other than to conduct an Opiate Withdrawal Scale Test. The nurse could not recall whether he had seen a discharge letter from the hospital.

Despite this information, there was no recognition in the nurse's entry in Mr Singleton's medical record that he had been to outside hospital the previous evening.

As a matter of good practice, Dr Evans expected the nurse would have ascertained what had been ingested and what had happened at the hospital from a discharge letter, or even telephone contact with the A & E department, including whether he had received any medication.

Dr Evans commented that the substance alleged to have been ingested was clearly documented on EMIS, as was the fact that a suspect object had been found on x-ray, and so some of the information was readily available. In the absence of a record being made the previous evening on Mr Singleton's return from hospital, this was an opportunity for the medical records to be clarified and updated.

Had the significance of this information been recognised - i.e. there was an ongoing risk of the package of heroin leaking, resulting in opiate toxicity - a proper care plan might have been instigated, and more informed consideration given to Mr Singleton's fitness for adjudication and to remain in the CSU.

Commenting on the nurse's observations, Dr Evans said that as there was no care plan, there was no clarity as to what clinical signs were being sought and recorded – an example of which was that an opiate withdrawal scale was conducted, rather than a test for opiate or other drug toxicity. She also noted that the nurse carried out this assessment in Mr Singleton's cell, contrary to prison policy. If the nurse was looking for signs of opiate withdrawal or toxicity, the poor lighting in the cell would have made the accurate discernment of pupil size more difficult.

Cell Move

At 10.47 on 6th May 2013 Mr Singleton was moved from the dry cell on landing 1 to a normal cell on landing 2 in the CSU. He was served his lunch at midday and the landing was locked between 12.30 and 13.50.

An officer who spoke with Mr Singleton during cell checks said that he seemed fine, apart from wondering where his medication was.

Other prisoners said that they heard Mr Singleton asking for his medication around lunch time, and saying that if he did not get it by 2pm he would kill himself. One of the prisoners who had known him for a long time said that when he heard Mr Singleton saying this, he thought it was simply an attempt to get his medication and that he did not think Mr Singleton was the type of person who would kill himself. An officer said that he was only aware of Mr Singleton asking for his medication once, and if he had threatened suicide, he would have opened a SPAR straight away. None of the CSU officers or the nurse who saw Mr Singleton heard him threaten suicide.

Telephone Calls

Having rung his in-cell buzzer and requested to use the phone, at 14.13 and 14.14, Mr Singleton made two calls to a family member. The first attempt was incorrectly dialled and the second was unanswered. The officer who escorted Mr Singleton back to his cell after these attempts said he appeared to be OK.

Medication Request

At around 15.00, the same nurse who had dealt with Mr Singleton that morning spoke with him as he was enquiring about his medication again. The nurse told Mr Singleton that he had checked with Bann House to see if a Medication Administration Record (MAR) had been started for him, and was told this had not been done. However a copy of Mr Singleton's MAR, clearly showed it was initiated at committal, and that the committal nurse had already contacted the out of hours GP on 4th May regarding a prescription for Mr Singleton. However instead of checking EMIS the nurse who saw Mr Singleton on 6th May made a further call to the out of hours GP.

A further prescription for diazepam was provided and, as on 4th May, Mr Singleton was again told he would have to wait until 7th May to receive his antidepressant medication and pregabalin. The nurse said that he went straight to the emergency cupboard in the healthcare department to retrieve the diazepam.

The nurse said that at no point did Mr Singleton appear to be annoyed. Rather he was pleased that efforts were being made to sort out his medication.

Medication Unlock and Finding Mr Singleton Hanging

The nurse returned at 15.14 with Mr Singleton's medication, and when the cell was unlocked, Mr Singleton was found hanging from the window hinge by a ligature.

SECTION 7: RESPONSE ONCE MR SINGLETON WAS FOUND

Due to a fault with the CCTV system in the CSU, which had been reported to engineers on 3rd May 2013, it was not possible to obtain footage to corroborate the accounts and records of the events that follow.

Upon finding Mr Singleton hanging, the alarm was raised immediately and staff from other CSU landings responded.

The nurse immediately raised Mr Singleton to reduce the pressure on his neck, while landing officers retrieved the Hoffman knife from the senior officer's office, which is around the corner from Mr Singleton's landing, in order to cut him down. Despite concern being raised by the Prisoner Ombudsman in April 2013 about Hoffman knives' location in the CSU, at the time of Mr Singleton's death they were still not immediately available. Since this incident, all CSU staff now carry Hoffman knives on their belts, but this is not the practice throughout Maghaberry.

Once placed on the ground, Mr Singleton was assessed as unresponsive and advanced life support and cardiopulmonary resuscitation (CPR) commenced. Three nurses worked with Mr Singleton, with a defibrillator; they inserted a naso pharengeal tube and Gluedel airway, and injected adrenaline to try and restart his heart.

Advanced life support / CPR continued until paramedics arrived and took over at 15.38. Advanced life support continued by the paramedics and further injections of adrenaline administered. A faint pulse was detected and Mr Singleton was prepared for removal to the ambulance and onward journey to outside hospital.

While in the ambulance, which was parked outside the CSU, Mr Singleton's heart trace was lost. Following advice from a doctor at Lagan Valley Hospital, life support was ceased by the paramedics at 16.15. His life was pronounced extinct at 17.29 by a Forensic Medical Officer.

Whilst Dr Evans was not critical of the life support given by the Healthcare staff, she highlighted that there was no evidence to show paramedics were informed of the suspected package, and its contents, that Mr Singleton had swallowed. Dr Evans said that had this information been shared with them, they may have considered giving Mr Singleton naloxone to reverse any possible opiate toxicity.

Allegations of Inappropriate Behaviour by Nursing Staff

Other CSU prisoners allege that they heard a female nurse laughing during the resuscitation efforts. Officers reported that prisoners were shouting abuse, including

the allegation about laughing, at the nurses while they were trying to resuscitate Mr Singleton. Neither NIPS nor Healthcare staff support the allegation about laughing. However a senior officer said that one of the nurses may have made a noise similar to a laugh, which he perceived to be her way of coping with the situation, rather than laughing at the situation.

The nurse said that it was an emergency situation where people unfortunately respond differently. She could not recall whether she inadvertently laughed. She said she was completely involved in the tense situation; focused on what she had to do, and dealt with it as professionally as she could.

Staff who knew Mr Singleton were very shocked that he had died by suicide, as they did not view him as suicidal, and they had never noted any likelihood of him self-harming in the past.

SECTION 8: AUTOPSY FINDINGS

The autopsy report recorded Mr Singleton's cause of death as hanging. In relation to toxicological findings it notes:

"Toxicological analysis of a sample of blood taken at autopsy revealed the presence of a number of drugs. The commonly prescribed tranquilliser drug diazepam (Valium) and the commonly prescribed antidepressant drug fluoxetine were both detected at concentrations that lay within their respective therapeutic ranges. The anticonvulsant drug pregabalin was detected at a concentration that lay below its therapeutic range. The commonly used opioid analgesic (painkilling) drug codeine was detected at a low level. Morphine was detected in the urine sample; in this instance this was probably derived from the breakdown of codeine in the blood.

A breakdown product (metabolite) of the commonly abused drug cannabis was detected in the blood sample. This metabolite may persist in the blood for several days after the last instance of cannabis use; therefore its presence does not necessarily indicate that he was under the influence of this drug at the time of this death.

Toxicological analysis of samples of blood and urine taken at autopsy excluded the presence of alcohol."

A "wrap" was found in Mr Singleton's large intestine. Toxicological analysis of its contents tested negative for the presence of a range of controlled drugs, including heroin.

With the exception of cannabis, all of the drugs found within his system are reflective of the medication Mr Singleton had recently received. He took his last dose of fluoxetine whilst in Police custody, and its long half-life explains the therapeutic levels found in his system.

SECTION 9: EVENTS AFTER MR SINGLETON'S DEATH

Family Notification of Mr Singleton's Death & Chaplaincy Support

At 16.57 on 6th May 2013 a chaplain from Maghaberry contacted Mr Singleton's family to inform them of his death. The family were upset that the news was given to them over the phone, and would have preferred the news to have been shared with them in person.

This is a difficult situation as the NIPS need to inform families of their loved one's death at the earliest opportunity, due to the risk of them learning from another source.

Later that evening a member of the chaplaincy team attended Mr Singleton's family home and support continued up to and including the funeral. The family expressed their appreciation of the chaplains, and the help they provided at a difficult time.

Hot Debrief

As required by Prison Service policy, a hot debrief was conducted with almost all staff directly involved in the incident. The purpose of this debrief is to discuss the events that took place and identify what went well and any difficulties staff faced. It is also one of the first opportunities to ensure staff are aware of the support available to them.

ECR staff are pivotal in coordinating the response to serious incidents and ensure the emergency services gain access as swiftly as possible, and for that reason it is important that they attend this meeting. Despite a previous Prisoner Ombudsman recommendation about this matter, which was accepted there was no member of the ECR at the hot debrief.

Cold Debrief

In line with Prison Service policy, a cold debrief was conducted on 15th May 2013. The purpose of this debrief is to discuss the events that took place, what went well and identify any learning. This debrief takes place within 14 days of the incident to allow staff involved in the incident time to reflect on the events.

The actions of the staff in response to finding Mr Singleton were praised. Despite highlighting criticisms about the length of time the dry cell was used, and the fact the Hoffman knife had to be retrieved from the senior officer's office, no action points were generated.

SECTION 10: FINDINGS OF THE SEHSCT'S ROOT CAUSE ANALYSIS REVIEW

The SEHSCT's review team concluded the death of Mr Singleton was unpredictable and that the resuscitation efforts by the nursing staff were well-managed. The review identified several issues that were considered to not directly contribute to his death, but were worthy of recommendation to improve care delivery in the future.

The recommendations – two of which (No's 1 and 3) have been made in previous Prisoner Ombudsman Death in Custody investigations - were as follows:

1. Nursing staff must cease the practice of assessing prisoners, located in the CSU, in their cells. The Lead Nurse for Primary care should meet with the Governor of Maghaberry to request that prison staff support the practice of ensuring prisoners are brought to the treatment room. The Operational Nurse Manager must ensure that all nursing staff adhere to the Standard Operating Procedure regarding assessment of patients in the CSU.

To be completed by 1st April 2014

2. A Senior Nurse should be allocated line management duties for agency nurses working in Prison Healthcare and formal induction programmes should be devised. Agency staff should be made aware of their core roles and responsibilities working within prison healthcare. All competencies and skills should be formally recorded. Agency staff should not be permitted to administer IV drugs nor carry out specialist roles unless they have received Trust approved training and deemed competent to perform the task.

To be completed by 1st September 2014

3. All nurses should be reminded by memo or minuted at staff meetings of their responsibility to record contemporaneous patient notes and ensure all records are timed.

To be completed by 1st March 2014

4. In the event of a Serious Adverse Incident occurring, a nominated person should ensure all notes are collated and secured. All senior managers to familiarise themselves with the Trust's policy on securing records.

To be completed by 1st April 2014

5. When a patient returns from an external emergency A&E assessment nursing staff should be informed. A process should be put in place with NIPS to ensure this is communicated.

To be completed by 1st July 2014

The SEHSCT confirmed that recommendations 1, 3, 4 and 5 above have been addressed. Recommendation 2 is partially complete as the induction programme for agency staff is being agreed and progressed in partnership with the NIPS.