The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF FRANCIS GERARD MCALARY WHO DIED ON 25 DECEMBER 2010 FOUR DAYS AFTER LEAVING MAGHABERRY PRISON

[17 February 2012]

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Please note that where applicable, names have been removed to anonymised the following report

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PREFACE

Mr Francis Gerard McAlary was 49 years old when he died by suicide on 25 December 2010 after being released on bail from Maghaberry Prison on 21 December 2010. I offer my sincere condolences to Mr McAlary's family for their sad loss. I met with Mr McAlary's family and shared the content of this report with them and responded to the questions they raised.

This report contains this preface and a summary followed by my recommendations, an introduction and my findings. My findings and conclusions are presented in six sections:

Section 1: Background Information
Section 2: Mr McAlary's early months in Prison
Section 3: Mr McAlary's Time in Healthcare
Section 4: Mr McAlary's Time on the REACH landing
Section 5: Events Surrounding Mr McAlary's Release on 21 December 2010
Section 6: Autopsy Report

As part of the investigation into Mr McAlary's death, Dr Keith J.B. Rix, Consultant Forensic Psychiatrist at Cygnet Hospital, Wyke, was commissioned to carry out a clinical review of Mr McAlary's mental health needs and medical treatment whilst in prison. I am grateful to Dr Rix for his assistance.

I will, if required at a later date, add anything else which comes to light in connection with the circumstances of the death of Mr McAlary by way of an addendum to this report and will notify all concerned.

It has been my practice to include in death in custody investigation reports recommendations for action that would lead to improved standards of inmate care and may help to prevent serious incidents or deaths in the future.

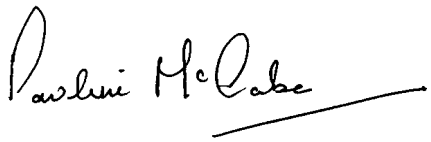
In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that *"An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become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

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

In light of Dame Anne's comments and in order to support the development of a more strategic and joined up approach to service development, I took a decision in June 2011 not to, for the time being, make recommendations following death in custody investigations. I decided that I would instead detail issues of concern that I would expect the Prison Service and SEHSCT to fully address in the context of their programmes for change, with appropriate urgency.

I shall keep this approach under review and revert to making recommendations if I am not satisfied that the response of the Prison Service and / or Trust is adequate. In the case of Mr McAlary I identify six matters of concern.

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



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
17 February 2012

SUMMARY

Mr Francis Gerard McAlary was 49 years old when he died by suicide on 25 December 2010, after being released on bail from Maghaberry Prison on 21 December 2010.

When Mr McAlary was 38 years old, he was referred to psychiatric services due to depression associated with problems related to childhood experiences and current speech problems and difficulties with communicating and socialising. In 2000, he was diagnosed as having an alcohol dependence syndrome, personality disorder (avoidant type), an anxiety state and an advanced level of addiction.

Between 2007 and 2010 Mr McAlary saw a consultant psychiatrist several times. He was reported to be feeling depressed and to have feelings of hopelessness and occasional suicidal ideas, but no active suicide plans. He was given various antidepressant, antipsychotic, benzodiazepine[1] and sedative medication. He declined offers of alcohol counselling and speech therapy and attended only a few of the appointments arranged for him with the Community Addictions Team. He did, however, agree to consider detoxification and abstained from alcohol for a period starting in 2007.

In October 2008, Mr McAlary reported that he was drinking again and in 2009 he was assessed to be suffering from "*a severe depressive episode with psychotic symptoms*" and "*depression not otherwise specified.*"

In February 2010, Mr McAlary was assessed by a Consultant Psychiatrist and was reported to be keeping well. An EEG was arranged to rule out the possibility of epilepsy as he had described having blackouts.

1 Benzodiazepines are a group of medicines that are also known as sleeping tablets. They work on the brain to help with severe sleeping difficulties. Benzodiazepines are also used to treat anxiety and sometimes epilepsy.

On 12 April 2010, Mr McAlary rang his GP and told him that he was going to hang himself if he didn't get something stronger than Diazepam[2]. It is recorded that he was anxious about going to court and that he was given Librium (Chlordiazepoxide[3]), which made him more relaxed.

Prior to his committal on 26 April 2010, Mr McAlary's prescription medication was Chlordiazepoxide 10mg twice daily, Venlafaxine (Efexor MR)[4] 75 mg once daily and Mirtazapine[5] 45 mg at night. At his committal interview Mr McAlary told a nurse that he was drinking six units of alcohol per week. He was continued on his medication by prison healthcare staff. Mr McAlary was given bail four days later.

On 5 May 2010 Mr McAlary was re-committed to Maghaberry Prison having breached his bail conditions and it is recorded that he told the committal nurse that he had a history of chronic alcoholism in remission, consumed 42 units of alcohol per week and was seeing a psychiatrist in connection with his alcohol abuse. The nurse noted that he had no thoughts of self harm and that his mental state was stable. He continued to take his prescribed medication.

Between 17 May and 22 June 2010, Mr McAlary was transferred to the Special Supervision Unit (SSU) on four occasions for allegedly threatening or/and attempting to assault staff. On 24 June, whilst in the SSU, Mr McAlary was examined by a prison doctor and it is recorded that he was *"dishevelled, writing over both arms, ripped clothes, poor eye contact, over excitable, giggling inappropriately and very distractible. His speech is pressured and rambling with flight of ideas and rhyming and punning. It is difficult to elicit any delusional beliefs due to the degree of thought disorder. Francis states that he does have special powers and abilities, but would not expand on this. He admitted to hearing voices, but refused to expand. He*

[2] Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects.
[3] Chlordiazepoxide, also known as Librium, is a sedative/ hypnotic type drug and is used on short term treatment of anxiety and also in the treatment of the management of acute alcohol withdrawal syndrome.
[4] Efexor XL, also known as Venlafaxine, is an antidepressant used in the treatment of moderate to severe general anxiety disorder and moderate to severe social anxiety disorder/ social phobia.
[5] Mirtazapine is an antidepressant used in the treatment for major depressive disorders and found to be useful in the conditions such as generalized anxiety disorders, obsessive compulsive disorder and insomnia.

admits to thoughts racing, not being able to sleep and increased energy. He also has written lists - some are coherent and others are not…He was recently on both Venlafaxine and Mirtazapine, but both have been discontinued due to his elation."

The doctor concluded that Mr McAlary was suffering from a hypomanic episode[6] and he was transferred to the in-patient healthcare centre in Maghaberry, where he remained until 29 October 2010. He was prescribed Olanzapine[7] 10mg at night and a SPAR[8] booklet was opened for four days.

Mr McAlary's family were concerned that whilst he was in prison, Mr McAlary had not received appropriate psychiatric treatment and they wanted to know why he was not on any medication when he was released from prison.

The investigation found that, during Mr McAlary's period in healthcare, he was reviewed by a psychiatrist on 22 occasions.

On 24 June, Mr McAlary was assessed by a prison psychiatrist who noted that he "*Denies thoughts of life not worth living or suicidal ideation. Inappropriate smiling, laughter and jokes throughout the interview. During the interview, talked in bizarre themes but unable to identify clear psychotic ideation…* The psychiatrist recorded her impression as "*one of a deteriorated medical state with evidence of elation."* She considered that this might be caused by Mr McAlary's previously prescribed medications, might be the emergence of bipolarity of Mr McAlary's mood disorder or might result from organic brain symptoms.

The psychiatrist requested full routine blood tests, a urine drug screen and asked for Mr McAlary's consent to be obtained to request his previous psychiatric records. She confirmed that his antidepressants should be stopped and confirmed also that he should be commenced on Olanzapine 10mg at night, as prescribed. She said also that Mr McAlary's mental state

6 Hypomania is a mood state characterized by persistent and pervasive elevated (euphoric) or irritable mood, as well as thoughts and behaviours that are consistent with such a mood state.
[7] Olanzapine is classed as an atypical antipsychotic drug which is used in the treatment of schizophrenia, manic depression, and bi-polar affective disorder.
[8] Supporting Prisoners at Risk (SPAR) booklets are used when prisoners become vulnerable to the risk of self harm or suicide.

should be monitored and his SPAR document should remain open, with hourly observations.

Mr McAlary's psychiatric records were requested and received on 25 June 2010. His general practitioner medical records were requested but not received. Mr McAlary's general practitioner spoke to prison healthcare on 19 July and it is noted that he said that *"Gerry is known to psychiatry and was being treated for depressive illness by antidepressants. In his consultations with Gerry he has never found any evidence of depression or any other treatable mental illness, and described a history of drug seeking especially for benzodiazepine derivatives. He outlined that Gerry has a history of substance misuse - alcohol and cannabis, and a history of aggressive behaviour."*

On 29 June, the prison psychiatrist again reviewed Mr McAlary and noted that he remained agitated and that there was evidence of psychotic symptoms, in that he had delusional beliefs. Mr McAlary's Olanzapine was increased to 20mg and an EEG was requested, in light of his possible history of seizures. It was noted that Mr McAlary remained "*elated and bizarre"* and that he thought that he had special abilities to read the thoughts of others and see the future. Diazepam 5mg was prescribed three times daily for his acute agitation and irritability.

During the early part of July, it is recorded that Mr McAlary threatened to cut a nurse's throat, attempted to dismantle his cell, continually activated his cell alarm and threatened to self harm with a ligature made from a bed sheet and was placed on a SPAR. Mr McAlary was assessed by a prison consultant psychiatrist on 5 July and it was noted that he had spent a weekend in a *"near hypomanic state."* The consultant thought that he was suffering from a florid[9] mental illness. A ten point care plan was developed which included the introduction of Chlorpromazine[10] and the phasing out of Olanzapine.

At a review on 15 July the prison psychiatrist saw an improvement in Mr McAlary's condition and recorded that he was pleasant and co-operative.

[9] Florid – Fully developed

[10] Chlorpromazine is classed as a low potency antipsychotic drug used in various treatments for chronic psychoses such as schizophrenia and bi-polar disorder as well as insomnia.

She noted *"some elation but less marked. No thoughts of life not worth living or suicidal ideation. Some concerns about double agents working in the prison setting."* The psychiatrist documented the plan to reduce Mr McAlary's Olanzapine and also noted that he was to commence on a multivitamin. A number of days later, Mr McAlary's EEG results were received and they were normal.

Mr McAlary was reviewed by the psychiatrist on three further occasions in July and, on two of these, requested to be put back on the antidepressant Mirtazapine to help him sleep. He also told the psychiatrist that he had been using Cannabis in prison (prior to being transferred to healthcare). The psychiatrist resisted Mr McAlary's request for antidepressants, stating that there was no indication for these. He was given night sedation for seven nights to help him to sleep. On 16 July, Mr McAlary commenced occupational therapy sessions.

During the month of August, Mr McAlary was seen by the prison psychiatrist on eight occasions and continued to request Mirtazapine. It was the psychiatrist's assessment that there was *"no evidence of psychosis or hallucinations"*, *"mild elation of mood in the morning"*, *"stable mental state"*, *"no evidence of mental illness"*, and *"no clinical indication for the use of an antidepressant medication."* The psychiatrist increased Mr McAlary's Chlorpromazine for a short period when his mood was mildly elated and then decreased it again. His Diazepam was also reduced. The psychiatrist agreed to the short-term use of Zopiclone for Mr McAlary's insomnia until his sleep pattern could be established and a sleep chart was commenced to evidence his sleep disturbance. On 26 August it was noted that Mr McAlary was currently settled and consideration was given to him using a prison garden.

The psychiatrist saw Mr McAlary again on 30 August 2010 and no abnormality was noted. He told her, however, that if he was moved to another landing he "*would like to wreck all around me."* It was decided that he should stay in healthcare for the time being.

In September, the psychiatrist saw Mr McAlary and recorded that his mental state was stable *"with no evidence of emergent psychopathology. There is a background history of alcohol and polysubstance misuse and currently evidence of medication seeking behaviours in the absence of current clinical indication. Plan for ongoing reductions in psychotropic medications to discontinuation, at which point to consider relocating Mr McAlary to normal location within the Prison setting."*

Mr McAlary had further reviews on 13 September and 28 September 2010 and remained medication focused. The prison psychiatrist felt that psychotropic medications would have a limited role in his long term management. Her impression was that he was of a stable mental state with a longstanding history of anxiety symptoms and chronic sleep disturbance. A referral for cognitive behavioural therapy (CBT)[11] was made.

By 5 October, Mr McAlary's Chlorpromazine was discontinued and he was no longer on any further prescription medication. He was assessed as being suitable for discharge from healthcare.

On 19 October, a further EEG report was received which showed some activity with a note that it "*may indicate an epileptic tendency*." Mr McAlary was referred for a CT scan of the brain and, on 21 October, the psychiatrist also referred him for a neurological opinion. She indicated in her referral letter that Mr McAlary now presented as mentally stable and she wanted an opinion on whether or not his EEG anomalies could have been associated with his previous behavioural disturbances.

On 29 October, Mr McAlary was transferred to the REACH[12] landing with an advisory note that he should only be considered for the commencement of antidepressants in the future after referral to the mental health team and the psychiatric clinic.

[11] CBT aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure in the present. CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders.

[12] At the time, the REACH Landing was in Lagan House was which was established in April 2007. This is a facility which the Prison Service states "identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working and person centred planning." This has now been replaced with the new Donard Centre which was officially opened on 3 November 2011.

Commenting on Mr McAlary's psychiatric care whilst in healthcare the Clinical Reviewer, Dr Rix, noted that his psychiatrist had explored his psychopathology carefully and found there was no indication for antidepressant drug treatment. The clinical reviewer noted that Mr McAlary was not presenting with a depressive syndrome of a nature or degree that was indicative of a need for, or of a favourable response to, antidepressant drug therapy. He said that *"the indications are that (Mr McAlary's) expressions of unhappiness or depression were related to his personality and how he coped with adverse events and circumstances. There is no indication that the depressive symptoms for which he had been treated in the past were relieved by antidepressants. There was no convincing evidence that he suffered from a unipolar depressive illness or a bipolar affective disorder with typical depressive phases."*

The Clinical Reviewer further stated that it was his opinion that the prison provided Mr McAlary with a standard of psychiatric care at least comparable to that which exists in psychiatric services outside prison and that he *"would go so far as to commend (the psychiatrist) who is, or was then, a staff grade psychiatrist, for the care and skill that she demonstrated in a case that was not straightforward and which would have been a difficult one for a consultant psychiatrist."*

Commenting on whether the prescription and cessation of Mr McAlary's medication was appropriate, the Clinical Reviewer stated that when Mr McAlary was in the throes of a manic or hypomanic episode his psychiatrist correctly recognised that this could have been a side effect of the two antidepressants that Mr McAlary was taking, it could have been the spontaneous or natural emergence of the manic phase of an underlying but hitherto only partially expressed manic depressive or bipolar disorder or, given the pointers to some brain disease or brain damage, it might have been an organic mania.

He said that Mr McAlary *"was first prescribed a benzodiazepine sedative. This was reasonable in that it afforded him some sedation but did not alter the nature of his symptoms. Thus, it was subsequently possible to base the*

diagnosis on a much more complete psychopathological picture than would have been so, if antipsychotic drugs had been prescribed at the very beginning of the episode. When it was clear what the diagnosis was, (Mr McAlary) was appropriately treated with a modern antipsychotic in the form of Olanzapine and when this did not work it was changed to a much older and better tested antipsychotic in the form of Chlorpromazine. Further benzodiazepines were used appropriately for sedation on a short-term basis."

The clinical reviewer further noted that the antipsychotic and benzodiazepine drugs were gradually withdrawn after the manic psychosis resolved and he concluded that this was reasonable. He said that *"It was particularly important not to leave Mr McAlary on benzodiazepines. First, there is a risk of dependence. Secondly, they can exaggerate some personality difficulties. Thirdly, they have been associated with suicidal ideas in people who are depressed and are not on antidepressants so, for this reason, the manufacturers' advise that in someone with depression they should not be used without an antidepressant."* Dr Rix also noted that once (Mr McAlary) had been withdrawn from his medication, he was appropriately assessed for, and began treatment with, cognitive behavioural therapy (CBT) and that his records also demonstrated the value and importance of occupational therapy in his care.

The clinical reviewer concluded that the prescription, administration, management, withdrawal and cessation of Mr McAlary's medication *"was appropriate and managed accordingly."*

Mr McAlary attended CBT three times from 29 October, when he was relocated to the REACH landing until his discharge.

On 5 November, Mr McAlary made a phone call to his mother and during the conversation, he told her that he was not getting on so well since moving location, was having difficulties sleeping and was not being allowed medication to help. He also told her that there was nothing *"exciting going on"* and under his breath he said that the he would *"be better dead."* It was clear that his mother did not hear this comment.

A further telephone call was made to his mother on 9 November, during which he said under his breath, *"look after yourself; I don't know if I'll come out of this place alive."* When his mother asked him to repeat what he had said, he replied *"look after yourself."*

On 11 November, Mr McAlary was seen by the psychiatrist who was of the opinion that his difficulties were *"one of adjustment issues related to his recent transfer to the REACH setting compounded by long term anxiety symptoms and perpetuated by his pending legal situation."* She encouraged him to participate in the REACH activities including occupational therapy in the REACH gardens.

That day Mr McAlary engaged in his last CBT session and it is recorded that he *"states mood and sleep have improved slightly, more spontaneous in session. Discussed behavioural activation strategies and their use as mood enhancers. Review in 1 week."* Regrettably no further sessions were arranged, due to the extended sickness absence of the therapist.

On 23 November, Mr McAlary was reviewed by a mental health nurse and it is noted that he was pleasant and reactive in conversation but was anxious about being due in court on 25 November. He was concerned that he would not get bail. It was noted that he found that working in the REACH gardens helped him.

On 9 December 2010, Mr McAlary was assessed for the last time by his prison psychiatrist and she noted that his mood was subjectively lowered although fully reactive throughout the interview; his sleep was disturbed; he had no thoughts of life not worth living and no suicidal ideation; there was no evidence of psychosis and he was not experiencing hallucinations. The psychologist was of the opinion that his symptoms were due to adjustment difficulties because of the pending court proceedings, rather than severe mental illness such as depression or psychosis. She recorded that she felt "*…there was no current indication for the prescription of psychotropic medications."*

Commenting on Mr McAlary's care whilst on the REACH landing, the Clinical Reviewer said that Mr McAlary *"was appropriately assessed for and began treatment with cognitive behavioural therapy far sooner than would have probably happened in many psychiatric services outside prison where waiting lists for cognitive behavioural therapy are measured not just in months but in years."*

Dr Rix said also that *"as (Mr McAlary's) court date approached, there was some worsening of his mental state but in a form and of a nature consistent with his difficulty in adjusting to his circumstances, that is a form of adjustment reaction, rather than a relapse or recurrence of mental illness as such."*

On 21 December 2010, Mr McAlary was released on bail and returned home to live with his mother.

The following day the discharge liaison nurse contacted his general practitioner by telephone and informed them of his release. At interview, the nurse said that the general practitioner's secretary said to her *"could you just simply send us his medication, his discharge medication, he is well known."*

An eight page fax was sent to Mr McAlary's general practitioner with a covering letter enclosing a copy of his EEG report, a CT scan, a statement that his medication on release was Thiamine Hydrochloride (Vitamin B) Tablets and a copy of a letter dated 21 October 2010 addressed to Mr McAlary's consultant neurologist. The letter to the consultant neurologist provided a brief overview of Mr McAlary's medical history prior to and after committal stating that he was *"unmanageable within the normal prison location"* and that he had been prescribed benzodiazepines and Chlorpromazine in the healthcare setting until his mental state settled and then his psychotropic medication was discontinued. The psychiatrist sought the neurologist's opinion as to whether a prescription of an anticonvulsant medication was clinically indicated and whether the neurologist was of the opinion that the results of the EEG could explain Mr McAlary's behaviour.

Two pages of Mr McAlary's twenty page EMIS[13] print out was also included in the fax. These noted that Mr McAlary had an epilepsy blackout in April 2010, smoked 30 cigarettes a day, had commenced vitamin tablets and that he had a conversation with an occupational therapist on 20 December 2010 and that she had found him pleasant and co-operative.

On 23 December, the discharge liaison nurse rang Mr McAlary's community psychiatrist and spoke to his secretary to inform them of Mr McAlary's release. She recorded that she was told that Mr McAlary was due to be seen by the psychiatrist in April 2011.

Commenting on the information provided to the general practitioner the Clinical Reviewer said *"…the general practitioner was not provided with all of the details of (Mr McAlary's) primary and specialist mental health care while he was temporarily out of the care of the general practitioner. The two computerised summary pages that were sent, gave no indication of the complex and serious mental health problems that had been treated in the prison."*

Dr Rix also said that the summary *"made no reference to his mental health which had been the main reason for his contact with the prison healthcare service. The general practitioner was given no indication of the medication that he had been prescribed, only the medication he was prescribed upon release and there was no explanation for that. Most importantly the general practitioner was not informed that, at the time he was released on bail that Mr McAlary was under the care of a specialist psychiatrist, he was under the care of the mental health care team, he was part of the way through, or had started but prematurely ended, cognitive behavioural therapy and he had been having occupational therapy."*

He added that *"It was particularly important for (the community psychiatrist) and the general practitioner to know about the psychiatric treatment that was ongoing at the point Mr McAlary was released on bail. Something similar was*

[13] EMIS – Egton Medical Information System, which is the database the prison healthcare team use to record all of a patients medical notes.

going to have to be arranged for (him) in the community if there was going to be a continuity of care and a consolidation of the progress achieved in Prison. However, even if it had not been a few days before Christmas, there would have been something of a hiatus, nevertheless, if (Mr McAlary's) general practitioner had been fully informed, it is probable that, between his release on bail and Christmas Day an assessment could have been arranged by the Crisis Response Team. If there were concerns about (Mr McAlary) over the Christmas period, this team could probably have provided monitoring and support until the holiday period was over and other services were put in place."

Responding to Dr Rix' report, the South Eastern Health and Social Care Trust, said that Mr McAlary's last psychiatric assessment in December 2010 showed that he had no thoughts of life not worth living; no suicidal ideation; no evidence of psychosis and no hallucinations. They also noted that prior to Mr McAlary's release he was found to be *"pleasant and co-operative"* by an occupational therapist and that the discharge liaison nurse had spoken to Mr McAlary's community psychiatrist and he was to be reviewed in April 2011.

The investigation found that the nurse had also contacted Mr McAlary's mother to ensure that he *"had arrived safely and to advise that further appointments will be coming. She [Mrs McAlary] advised that the trial starts on 31/1/11."* The nurse said that Mr McAlary's mother did not raise any concerns with her about her son's behaviour or his medication.

Notwithstanding the above, it was Dr Rix's view that there was a requirement for short term follow up following discharge and that the information provided to his general practitioner was not suitable. He pointed out that Mr McAlary was in effect being discharged from something very like psychiatric inpatient care.

The efforts made by the discharge liaison nurse in making contact with the key people who had an interest in Mr McAlary's release are recognised and it is not possible to say what short term follow up would have been

implemented if Mr McAlary's general practitioner had received a full report on his healthcare in prison. It is, however, clearly the case that nurses responsible for discharge letters should be fully aware of the need for this to be sufficiently comprehensive. This is reflected in the list of concerns arising from this investigation.

On 25 December 2010, Mr McAlary took his own life and following an autopsy, the assistant state pathologist noted that death was due to hanging with a ligature. A toxicological report was commissioned by the Prisoner Ombudsman and showed that no alcohol was present in Mr McAlary's blood at the time of death. 0.041 milligrams of Diazepam was, however, detected along with a low concentration of Desmethyldiazepam[14], caffeine and nicotine.

It is not known how Mr McAlary obtained Diazepam following his release from prison as this was not within the remit of the Prisoner Ombudsman investigation.

Whilst the investigation found that Mr McAlary was anxious about his trial, it is not known whether this contributed to his death or whether, following his release from prison, any other matter caused him concern or anxiety.

14 Desmethyldiazepam is a class of drugs called Benzodiazepines. It also possesses anticonvulsant, muscle relaxant and sedative properties.

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, were identified during the investigation into the death of Mr Francis Gerard McAlary. I have asked the Director General of the Prison Service and Chief Executive of the Trust to confirm to me that these issues will be addressed.

- No action was taken at the time of either of Mr McAlary's committals to request his community general practitioner or psychiatric records.

- Prison healthcare did not ensure that Mr McAlary's Cognitive Behavioural Therapy continued during his therapist's period of absence.

- The names of attendees at multi disciplinary meetings, to discuss Mr McAlary, were not documented on EMIS by the Discharge Liaison Team. It was, therefore, not possible to establish what medical staff contributed to decision making in respect of Mr McAlary's care.

- Non pharmacological treatments received by Mr McAlary whilst in the healthcare centre were not adequately documented.

- Prison healthcare were not given full access to Mr McAlary's general practitioners medical records or fully informed of his medical history.

- The discharge letter and the information provided to Mr McAlary's general practitioner from Prison Healthcare did not provide adequate detail about Mr McAlary's full medical history and treatment whilst in prison.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[15] for Northern Ireland, I have responsibility for investigating the death of Mr Francis Gerard McAlary. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached at Appendix 1 to this report.

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

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

Objectives

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

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

- to examine any relevant healthcare issues and assess clinical care afforded by the Prison Service;

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

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

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

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

Family Liaison

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

6. It is important for the investigation to learn more about a prisoner who dies in or within days of leaving prison custody, from family members and to listen to any concerns or questions they may have.

7. I am grateful to Mr McAlary's family for meeting my investigators on 5 January 2011 and for the insight they provided into his personal circumstances before he died.

8. Although my report will inform many interested parties, I write it primarily with Mr McAlary's family in mind. The following questions were asked by them:

    - Why was Gerard not receiving the medication that he had been receiving in the community to treat his depression when he was in prison?

- Did Gerard receive the appropriate psychiatric support in prison?

- Why did Gerard leave prison without medication?

INVESTIGATION METHODOLOGY

Notification

9. On the afternoon of 26 December 2010, the Prisoner Ombudsman's Office was notified by the Police Service of Northern Ireland of Mr McAlary's death.

Notices Issued

10. On 10 January 2011, Notices of Investigation were issued to Prison Service Headquarters, the Governing Governor of Maghaberry Prison, the Coroner and the IMB announcing the investigation into Mr McAlary's death.

Prison Records and Interviews

11. All of the prison records relating to Mr McAlary's period of custody were obtained.

12. Interviews were carried out with prison staff to obtain information about the circumstances surrounding Mr McAlary's death.

Telephone Calls

13. Telephone recordings are normally retained by the Prison Service for 90 days. In this instance, however, the Prison Service said that they were only able to provide recordings from 22 October 2010 onwards because of fluid damage to some of the stored discs. Mr McAlary made 14 telephone calls between 22 October 2010 and 21 December 2010, which were all listened to.

Maghaberry Prison, Prison Rules and Policies

14. Background information on Maghaberry Prison and a summary of Prison Rules and Procedures referred to in the report are attached at Appendix 2.

Autopsy Report

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

Clinical Review

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

    I am grateful to Dr Keith J.B. Rix, Consultant Forensic Psychiatrist at Cygnet Hospital, Wyke.

17. Dr Rix's clinical review report was forwarded to the South Eastern Health and Social Care Trust for comment. I have included the Trust's response at appropriate places in this report.

Factual Accuracy Check

18. Before completing the investigation I submitted a draft report to the Director General of the Northern Ireland Prison Service and Director of Adult Services and Prison Health for SEHSCT for a factual accuracy check.

19. The Prison Service and SEHSCT had no issues with the factual accuracy of this report.

FINDINGS

SECTION 1: BACKGROUND INFORMATION

1. Mr McAlary

Mr McAlary was committed to Maghaberry Prison on 26 April 2010 and given bail four days later. On 5 May 2010, having breached his bail conditions, Mr McAlary was re-committed to Maghaberry Prison and was again released on bail on 21 December 2010. Four days later, on 25 December 2010, Mr McAlary was found in the grounds of his mother's home having died by suicide.

2. Medical History

A review of Mr McAlary's community medical records showed that on 28 April 1999, his general practitioner referred him to Psychiatric Services due to depression connected with problems related to childhood experiences and current speech problems and difficulties with communicating and socialising.

Having failed to attend previous appointments, Mr McAlary's first psychiatric assessment took place on 7 November 2000 and he was diagnosed with having alcohol dependence syndrome, personality disorder (avoidant type) and an anxiety state. Mr McAlary's medication was changed from Dothiepin[16], which had been prescribed by his general practitioner, to Mirtazapine[17], and he was referred to the Community Addiction Team.

Mr McAlary attended a further psychiatric appointment in March 2001, but was subsequently discharged having failed to attend two other appointments later that year. Mr McAlary also failed to attend appointments with the Community Addictions Team but on the one occasion that he did attend, in April 2001, it is recorded that he had a very advanced level of addiction.

There are no further records of referral to psychiatric services until 23 May 2007, but Mr McAlary did see his general practitioner a number of times. He was offered, but declined, counselling and speech therapy but he did agree to consider detoxification and he abstained from alcohol use for a period of time.

In October 2007, Mr McAlary attended a psychiatric outpatient clinic and it is recorded that he claimed to have been off alcohol for three years, that he had started smoking Cannabis three months previously

[16] Dothiepin is a relatively mild antidepressant used for low level anxiety, depression and similar disorders.
[17] Mirtazapine is an antidepressant used in the treatment for major depressive disorders and found to be useful in the conditions such as generalized anxiety disorders, obsessive compulsive disorder and insomnia.

and that he reported feeling anxious, tense and depressed intermittently. It is recorded that the psychiatrist's impression was that Mr McAlary's problem was his Cannabis misuse and he documented the possibility that he might have a drug-induced psychosis. Mr McAlary was at this time taking Diazepam[18] and the psychiatrist reduced his prescription to 5 mg twice daily and added Chlorpromazine[19] 25 mg three times daily and 50 mg at night, in addition to Mr McAlary's Mirtazapine 30 mg at night. A further referral to the Community Addiction Team was made.

In 2008, Mr McAlary attended four appointments with his psychiatrist. At each assessment, it is recorded that Mr McAlary continued to complain of feeling depressed, felt hopelessness and occasional suicidal ideation, but had no active suicide plans. At an appointment on 2 October 2008, Mr McAlary reported that he was drinking again. Various adjustments were made to his medication including the prescription of Efexor XL (Venlafaxine)[20].

Mr McAlary had not kept further appointments with the Community Addictions Team and in December he also refused to be referred to an alcohol counsellor. He did, however, see the Community Addictions Team on or just before 22 December 2008.

On 28 April 2009, diagnoses were made by Mr McAlary's psychiatrist of *'severe depressive episode with psychotic symptoms'* and *'depression not otherwise specified'.*

A further psychiatric assessment took place on 13 May 2009 and it is recorded that Mr McAlary had similar depressive symptoms to previously. He again refused alcohol counselling.

[18] Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects.
[19] Chlorpromazine is classed as a low potency antipsychotic drug used in various treatments for chronic psychoses such as schizophrenia and bi-polar disorder as well as insomnia.
[20] Efexor XL also known as Venlafaxine is an antidepressant used in the treatment of moderate to sever general anxiety disorder and moderate to severe social anxiety disorder/ social phobia.

3. Medical Records 2010 – Before Mr McAlary's Committal to Prison

On 3 February 2010, Mr McAlary was assessed again by a consultant psychiatrist and was reported to be keeping well. Mr McAlary described leading a fairly isolated life, but said that he occasionally walked his dog. He also described having blackouts and an EEG examination was ordered, to rule out the possibility of epilepsy. Mr McAlary was to be reviewed in four to six months when the result of the EEG would be considered.

On 12 April 2010, it is recorded that Mr McAlary made a phone call to his general practitioner saying that he was going to hang himself if he didn't get something stronger than Diazepam. It is recorded that he was anxious about going to court. A further telephone call is referred to on 13 April and it is recorded that Mr McAlary had been given Librium instead of Diazepam and was more relaxed.

On 16 April, Mr McAlary was in police custody and his general practitioner gave advice as to his medication.

Prior to his committal on 26 April 2010, Mr McAlary's prescription medication was as follows:

- Chlordiazepoxide[21] (Librium) 10mg twice daily
- Venlafaxine (Efexor MR) 75 mg once daily
- Mirtazapine 45 mg at night

[21] Chlordiazepoxide is a sedative/ hypnotic type drug and is used on short term treatment of anxiety and also in the treatment of the management of acute alcohol withdrawal syndrome.

SECTION 2: MR MCALARY'S EARLY MONTHS IN PRISON

4. Mr McAlary's Prison Committals

26 April 2010

It is recorded in Mr McAlary's medical records that during his committal interview with a nurse officer on 26 April 2010, he said that he was a teetotaller who was drinking six units of alcohol per week and that he was under investigation for epilepsy. It is recorded that he had *"No thoughts of self-harm currently"* and that he appeared anxious and said that he preferred to be on his own. It is also recorded that Mr McAlary told the nurse that his medications were Diazepam, Ibuprofen, Paracetamol and Librium.

The following day, a prison doctor assessed Mr McAlary and noted that he had a history of blackouts and that an appointment had been arranged for him at a neurology clinic. The same day contact was made with Mr McAlary's general practitioner and it is recorded that healthcare staff were advised that Mr McAlary had been prescribed Chlordiazepoxide 10 mg twice daily, Efexor MR 75mg daily, Mirtazapine 45mg at night.

Mr McAlary was assessed as being suitable for his medication to be issued daily and from 27 April until 30 April 2010, when he was released on bail, Mr McAlary was prescribed and issued with Chlordiazepoxide 10mg two to be taken three times a day, Venlafaxine (Efexor) MR 75mgs one to be taken twice a day and Zopiclone[22] 7.5mg one to be taken at night.

[22] Zopiclone has sedative properties often used for the short term treatment of insomnia. Tolerance, dependence and addiction can occur with long term use.

Re-committal to Maghaberry

Having breached his bail conditions, Mr McAlary was re-committed to Maghaberry Prison on 5 May 2010. During his committal interview a nurse officer recorded the following:

- History of chronic alcoholism in remission
- Consumes 42 units of alcohol per week
- Psychiatrist involved regarding his alcohol abuse
- No thoughts of self harm currently and mental state stable

It is also recorded that he informed the nurse officer that he was currently prescribed Librium (Chlordiazepoxide) 10mg twice a day, Efexor 75 mg daily, Zispin (Mirtazapine) 45 mg at night, Diazepam 5 mg twice daily and Temazepam[23] 10 mg at night.

There is, however, no record of Mr McAlary seeing his general practitioner between his release from prison on 30 April and his re-committal on 5 May to have his medication changed. In a letter dated 10 May 2010 from Mr McAlary's general practitioner to his solicitor, Mr McAlary's medication is noted as:

- Chlordiazepoxide 10mg twice daily
- Venlafaxine (Efexor MR) 75 mg once daily
- Mirtazapine 45 mg at night

The letter, which was scanned onto Mr McAlary's prison records, also notes that Mr McAlary *"should remain on Venlafaxine and Mirtazapine and be slowly weaned off Chlordiazepoxide (and that Mr McAlary had) a long history of anxiety, depression and poor ability to retain information."*

[23] Temazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative and anxiety-relieving effects.

It is to note that no action was taken at the time of either committal to request Mr McAlary's community general practitioner or psychiatric records.

On his re-committal, Mr McAlary was provided with a weekly supply of Venlafaxine and Mirtazapine and was given Chlordiazepoxide on a daily basis at doses consistent with his community prescription.

Clinical Reviewer's Comment

Commenting on whether Mr McAlary's medication on committal was appropriate, Dr Rix stated *"When (Mr McAlary) was first remanded in custody, the drug treatment that he had received outside prison was continued. This was appropriate."*

5. Transfer to the Special Supervision Unit (SSU)

The SSU houses prisoners serving periods of restriction of association under Prison Rule 32. This can be for prisoners own protection, the protection of others or "*for reasons related to good order and discipline.*"

Between 17 May 2010 and 22 June 2010, Mr McAlary was transferred to the SSU on four occasions, as follows:

Date	Duration of stay in SSU	Reason
17 May 2010	Two Days	It was alleged that Mr McAlary had injured staff
24 May 2010	Two Days	It was alleged that Mr McAlary threatened to cut the throat of the first officer that opened his cell door
14 June 2010	Five Days	It was alleged that Mr McAlary assaulted and tried to bite an officer
22 June 2010	Two Days	It was alleged that Mr McAlary attempted to assault staff

The investigation found that none of these allegations resulted in disciplinary adjudications.

Prison Service policy states that prisoners held in the SSU must be assessed by a member of healthcare on their arrival and each day that they remain in the SSU. Mr McAlary was assessed by a member of healthcare each time he was transferred to the SSU and a member of healthcare saw or attempted to see him on each subsequent day that he remained there.

The following notes were made in Mr McAlary's medical records in connection with his periods in the SSU:

First Period in the SSU

On 17 May 2010 Mr McAlary was seen by a nurse officer and it is noted that he was *"uptight because staff took his weekly medications off him before going to cell - advised it is not good practice to take bags of medications into yard for his own safety. Phoned house nurse who tells me the incident happened when staff were relocating Francis to another cell."*

Later that day, Mr McAlary was seen by a prison doctor who noted that he had been in a fracas with staff and said that he was innocent. It is recorded that the doctor "*asked staff to make sure (Mr McAlary) had his meds. He is more settled now; his observations were normal and no (obvious) withdrawal symptoms."*

On 18 May, the nurse who was due to see Mr McAlary recorded, *"Not seen this morning - attending legal visit. Staff report no difficulties."*

On 19 May, it is recorded that Mr McAlary had no medical complaints when seen by a nurse officer.

Second Period in the SSU

On the morning of 24 May 2010, it is recorded by a nurse officer that Mr McAlary was in the SSU due to him threatening that he would "*cut the throat of any staff who came near him".* Because of this his Chlordiazepoxide was not administered. It is also recorded that Mr McAlary had been disruptive overnight.

Later that afternoon, Mr McAlary was seen by a nurse officer who recorded that *"he has told me that he has not had his medication today and I have advised him that I will follow this up with his house nurse*

after lock up." The records indicate that Mr McAlary received his medication the same day.

On 25 and 26 May 2010, Mr McAlary was seen by a nurse officer and it is recorded that he had no medical complaints.

Third Period in the SSU

On 14 June 2010, Mr McAlary was seen by a nurse officer in the morning and afternoon. It is recorded that he had *"nil thoughts of self harm or suicide but quick rambling speech at times. Aggressive mood fluctuating during conversation. Will advise mental health team, it would be beneficial for them to see Francis."*

A mental health nurse officer saw Mr McAlary that day and because of his mental state, she was unable to complete her assessment. The nurse officer recorded that *"he appeared elated, with pressure of speech, laughing inappropriately, unable to answer direct questions, flight of ideas and poor concentration evident, discussed with (a prison consultant psychiatrist) discontinuation of 2 antidepressants given current presentation, agreeable to this, also discussed sedation, following tel. conversation with (a prison doctor) Chlordiazepoxide prescribed, for further monitoring of mental state."*

On 15, 16 and 17 June 2010, it is recorded, by healthcare staff who visited Mr McAlary in the SSU that he had *"no medical complaints."*

On 18 June 2010, Mr McAlary was assessed by a mental health nurse and it is recorded that *"at first (his) behaviour was appropriate but then (the) content of conversation became sexually disinhibited. He states he is fit and well and appears well nourished and clean although I did observe he has been drawing over his arms with pen. I spoke to him re his comments and stated that we would call to see him periodically as part of ongoing mental health review."*

On 19 June 2010, a nurse officer recorded that Mr McAlary was fit and well and due to go back to Lagan House that afternoon. She also noted that the senior officer was concerned regarding staff safety because Mr McAlary *"had already injured staff."*

Fourth Period in the SSU

On 22 June 2010, Mr McAlary was assessed by a nurse officer and it is recorded that during the assessment he told the nurse that *"he was fine and had no complaints (and then) struck himself twice to prove this…"*

On the morning of 23 and 24 June 2010, Mr McAlary was seen by nurse officers and it is recorded that there were *"no medical complaints".*

On 24 June 2010, a prison doctor was urgently requested to assess Mr McAlary in the SSU. It is recorded that he was *"dishevelled, writing over both arms, ripped clothes, poor eye contact, over excitable, giggling inappropriately and very distractible. His speech is pressured and rambling with flight of ideas and rhyming and punning. It is difficult to elicit any delusional beliefs due to the degree of thought disorder. Francis states that he does have special powers and abilities, but would not expand on this. He admitted to hearing voices, but refused to expand. He admits to thoughts racing, not being able to sleep and increased energy. He also has written lists - some are coherent and others are not…He was recently on both Venlafaxine and Mirtazapine, but both have been discontinued due to his elation."*

The doctor concluded that Mr McAlary was suffering from a hypomanic episode[24]. At her request he was immediately taken to the

[24] Hypomania is a mood state characterized by persistent and pervasive elevated (euphoric) or irritable mood, as well as thoughts and behaviours that are consistent with such a mood state.

in-patient healthcare centre in Maghaberry and prescribed Olanzapine 10mg at night. A SPAR[25] booklet was opened.

[25] Supporting Prisoners at Risk (SPAR) booklets are used when prisoners become vulnerable to the risk of self harm or suicide.

SECTION 3: MR MCALARY'S TIME IN HEALTHCARE

6. Psychiatric Intervention and Medicine Management whilst in the Healthcare Centre

Mr McAlary's family raised three concerns in relation to his last custodial period which they felt might be relevant to his death. They wanted to know whether Mr McAlary had been provided with appropriate psychiatric treatment in prison; why he did not receive the medication in prison that he had been receiving in the community to treat his depression; and why he had been released without any medication. They explained that Mr McAlary had been receiving psychiatric care and was taking medication, before his committal to Maghaberry.

Mr McAlary remained an in-patient in Maghaberry's healthcare centre until 29 October 2010 and the investigation found that, during this period, he was reviewed by a psychiatrist on 22 occasions.

Psychiatric Reviews / Care - June 2010

Following Mr McAlary's transfer to the healthcare centre on 24 June, he was assessed by a prison psychiatrist, who recorded the following:

"*Denies thoughts of life not worth living or suicidal ideation. Inappropriate smiling, laughter and jokes throughout the interview. During the interview, talked in bizarre themes but unable to identify clear psychotic ideation…"* She recorded her impression as "*one of a deteriorated medical state with evidence of elation which may be on the basis of medications previously prescribed, emergence of bipolarity of his mood disorder or on the basis of organic brain symptoms…."*

The psychiatrist decided to admit Mr McAlary to the healthcare centre and requested full routine blood tests and a urine drug screen. She asked for Mr McAlary's consent to be obtained to request his previous psychiatric records. She confirmed that his antidepressants should be stopped and that he should be commenced on Olanzapine [26] 10 mg at night. She also said that Mr McAlary's mental state should be monitored and his SPAR document should remain open with hourly observations. Mr McAlary's SPAR was closed four days later following a case conference and it is recorded *"while Francis remains disruptive, he has no plans or thoughts of self harm. All agreed to close SPAR."*

Mr McAlary's psychiatric records were requested and were received on 25 June 2010.

An *Inpatient Unit Mental Health Nursing Assessment and Action Plan* was then drawn up on 26 June which, in addition to the information already noted, included a reference to Mr McAlary "*taking a few lines of cocaine but not into heavy drugs."*

The psychiatrist reviewed Mr McAlary again on 29 June and found him to be agitated and unsettled. His speech was rapid and pressurised, his mood was elated and his sleep disturbed and there was evidence of psychotic symptoms in that he had delusional beliefs. The psychiatrist's handwritten notes refer to "*people being killed..." "I know who they were..." "I'm going to be got....." "I can hear the screams..." "I know what's happening."*

Mr McAlary's Olanzapine was increased to 20mg and an EEG was requested in view of the previous possible history of seizures. At a case conference on 1 July 2010, it was noted that Mr McAlary remained *"elated and bizarre"* and had similar manic symptoms to those noted previously. It was also noted that he thought that he had special abilities – to read the thoughts of others and see the future.

[26] Olanzapine is classed as an atypical antipsychotic drug which is used in the treatment of schizophrenia, manic depression, and bi-polar affective disorder.

His Olanzapine was continued and 5 mg Diazepam three times daily was added, in view of his acute agitation and irritability.

Psychiatric Reviews / Care - July 2010

On 3 July, after threatening to cut a nurse's throat, attempting to dismantle his cell, continually activating the cell alarm and threatening self harm with a ligature made from a bed sheet, SPAR documentation was opened and Mr McAlary was placed on 15 minute observations.

Ten Point Management Plan

The prison consultant psychiatrist assessed Mr McAlary on 5 July 2010 and noted that he had spent the weekend in a *"near hypomanic state."* It was his opinion that Mr McAlary was suffering from a florid mental illness, most probably an effective psychosis and he set out a ten point plan:

1. Introduce Chlorpromazine
2. Phase out Olanzapine
3. Ensure adequate fluid and food intake
4. If possible, exercise on his own in the yard
5. Possibility of accidental fatal self injury
6. Continue SPAR protocols
7. 15 minute observations
8. Ensure not provided with harmful materials such as lighter and sharp pens
9. If out of cell on exercise, staff to be aware of whereabouts at all times
10. Interaction with staff to occur as often as possible to prevent him engaging in long periods of unchecked disturbance

In a further case conference on 8 July it was noted that Mr McAlary continued to be unsettled with periods of elation and his Chlorpromazine was increased to 100 mg three times daily and his Olanzapine was reduced to 15 mg at night.

At a review on 15 July, Mr McAlary's regular psychiatrist saw an improvement in his condition and recorded that he was pleasant and co-operative. She noted *"some elation but less marked. No thoughts of life not worth living or suicidal ideation. Some concerns about double agents working in the prison setting."* The psychiatrist documented the plan to reduce Mr McAlary's Olanzapine and also noted that he was to commence on a multivitamin.

On 20 July 2010, a normal EEG was recorded.

Between 20 and 29 July 2010, Mr McAlary was reviewed on three further occasions by the psychiatrist. During his first two consultations he requested to be put back on his antidepressant medication Mirtazapine to help him sleep. He also disclosed that he had been using Cannabis in prison (prior to being transferred to healthcare). The psychiatrist resisted Mr McAlary's requests stating that there was no indication for antidepressant treatment. He was, however, given night sedation, Zopiclone, for seven nights to help him to sleep.

On 27 July, Mr McAlary attended occupational therapy and was much more settled than he had been when he had attended for the first time on 16 July. During the following two sessions there was noted to be a marked improvement in Mr McAlary's demeanour and ability to participate in group discussion.

By 29 July, the psychiatrist noted that if Mr McAlary continued to progress as he was, then he could be considered for discharge the following week.

Psychiatric Reviews / Care August 2010

During the month of August, Mr McAlary was seen by the psychiatrist on eight occasions. He continued to request Mirtazapine despite the psychiatrist's assessments that there was *"no evidence of psychosis or hallucinations", "mild elation of mood in the morning", "stable mental state", "no evidence of mental illness",* and *"no clinical indication for the use of an antidepressant medication."* Mr McAlary's Chlorpromazine was increased for a short period when his mood was mildly elated and then decreased again. His Diazepam was also reduced. The psychiatrist did, however, agree to the short-term use of Zopiclone for insomnia until Mr McAlary's sleep pattern could be established, and a sleep chart was commenced to evidence his sleep disturbance.

On 3 August and 31 August, it is noted that Mr McAlary continued to participate in occupational therapy but needed *"prompting and encouragement to play an active role in the session."*

At a case conference on 26 August, it was noted that Mr McAlary was currently settled. There was no evidence of mental illness and consideration was to be given to him using a prison garden.

The psychiatrist saw Mr McAlary again on 30 August 2010. No abnormality was noted but he did say that if he was moved to another landing he *"would like to wreck all around me."* It was decided that he should stay in healthcare for the time being.

Psychiatric Reviews / Care - September and October 2010

On 3 September, the psychiatrist saw Mr McAlary and recorded that his mental state was stable *"with no evidence of emergent psychopathology. There is a background history of alcohol and polysubstance misuse and currently evidence of medication seeking behaviours in the absence of current clinical indication. Plan for ongoing reductions in psychotropic medications to discontinuation, at which*

point to consider relocating Mr McAlary to normal location within the prison setting." The position remained the same at a further review on 6 September and at a case conference on 9 September plans were made for contacting Mr McAlary's general practitioner and external consultant psychiatrist in the event that he was released unplanned.

Further reviews took place on 13 September and 28 September 2010. On 28 September, Mr McAlary remained medication focused but the psychiatrist felt that psychotropic medications would have a limited role in his long term management. Her impression was of a stable mental state with a longstanding history of anxiety symptoms and chronic sleep disturbance. A referral for cognitive behavioural therapy (CBT)[27] was made.

On 24 September 2010, an occupational therapist recorded that Mr McAlary was "*less animated, interactive and sociable than observed in previous occupational therapy sessions (and Mr McAlary) reported that he has been experiencing the feelings of lower mood for approx. 3 weeks. Francis required regular breaks throughout the session as he reported he could not settle."*

Four days later, at the next session, Mr McAlary was recorded as being *"quiet throughout."*

However, by 5 October, Mr McAlary's Chlorpromazine was discontinued and he was no longer on any further prescription medication. He was assessed as being suitable for discharge from healthcare.

[27] CBT aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure in the present. CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders.

EEG Report

An EEG report was received on 19 October 2010. Whilst otherwise normal for age, the EEG showed some activity that it was reported "*may indicate an epileptic tendency.*" Mr McAlary was referred for a CT scan of the brain and, on 21 October, the psychiatrist also referred him for a neurological opinion. She indicated that Mr McAlary now presented as mentally stable and she wanted an opinion on whether or not his EEG anomalies could have been associated with his previous behavioural disturbances. The result of the CT scan, which was carried out on 15 December 2010, was not received by the prison until after Mr McAlary's death.

On 29 October, Mr McAlary was transferred to the REACH[28] landing with an advisory note on his medical records that if in the future Mr McAlary was to be considered for antidepressants, then the decision should only be taken after a referral to the mental health team and the psychiatric clinic.

[28] The REACH Landing in Lagan House was established in April 2007. This is a facility which the Prison Service states "identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working and person centred planning." This has now been replaced with the new Donard Centre which was officially opened on 3 November 2011.

7. Clinical Reviewer's Assessment of Mr McAlary's Psychiatric Care whilst in the Healthcare Centre

Commenting on Mr McAlary's psychiatric care whilst in the healthcare centre, Dr Rix noted that his psychiatrist had explored his psychopathology carefully and found there was no indication for antidepressant drug treatment. The clinical reviewer noted that Mr McAlary was not presenting with a depressive syndrome of a nature or degree that was indicative of a need for, or of a favourable response to, antidepressant drug therapy. He said that *"the indications are that (Mr McAlary's) expressions of unhappiness or depression were related to his personality and how he coped with adverse events and circumstances. There is no indication that the depressive symptoms for which he had been treated in the past were relieved by antidepressants. There was no convincing evidence that he suffered from a unipolar depressive illness or a bipolar affective disorder with typical depressive phases."*

Dr Rix further stated that Mr McAlary *"was thoroughly and carefully assessed, especially by (the psychiatrist) mainly responsible for his care."* He said that it was his opinion that the prison provided Mr McAlary with a standard of psychiatric care at least comparable to that which exists in psychiatric services outside prison and that he *"would go so far as to commend (the psychiatrist) who is, or was then, a staff grade psychiatrist, for the care and skill that she demonstrated in a case that was not straightforward and which would have been a difficult one for a consultant psychiatrist."*

Commenting on whether the prescription and cessation of Mr McAlary's medication was appropriate, Dr Rix stated that when Mr McAlary was in the throes of a manic or hypomanic episode his psychiatrist correctly recognised that this could have been a side effect of the two antidepressants that Mr McAlary was taking, it could have been the spontaneous or natural emergence of the manic phase

of an underlying but hitherto only partially expressed manic depressive or bipolar disorder or, given the pointers to some brain disease or brain damage, it might have been an organic mania. When Mr McAlary subsequently revealed that he had been using Cannabis just prior to this episode, it was reasonable to have suspected that this was a drug-induced psychosis. After the manic episode resolved, (Mr McAlary) presented mainly with his longstanding insomnia, depressive symptoms that were not accompanied by the depressive symptoms found in a depressive illness or episode and symptoms of social anxiety.

He said that Mr McAlary *"was first prescribed a benzodiazepine sedative. This was reasonable in that it afforded him some sedation but did not alter the nature of his symptoms. Thus, it was subsequently possible to base the diagnosis on a much more complete psychopathological picture than would have been so, if antipsychotic drugs had been prescribed at the very beginning of the episode. When it was clear what the diagnosis was, (Mr McAlary) was appropriately treated with a modern antipsychotic in the form of Olanzapine and when this did not work it was changed to a much older and better tested antipsychotic in the form of Chlorpromazine. Further benzodiazepines were used appropriately for sedation on a short-term basis."*

Dr Rix noted that the antipsychotic and benzodiazepine drugs were gradually withdrawn after the manic psychosis resolved and he concluded that this was reasonable. He said that *"It was particularly important not to leave Mr McAlary on benzodiazepines. First, there is a risk of dependence. Secondly, they can exaggerate some personality difficulties. Thirdly, they have been associated with suicidal ideas in people who are depressed and are not on antidepressants so, for this reason, the manufacturers' advise that in someone with depression they should not be used without an antidepressant."* Dr Rix further noted that once (Mr McAlary) had been withdrawn from his

medication, he was appropriately assessed for, and began treatment with, cognitive behavioural therapy. He said also that Mr McAlary's records demonstrated the value and importance of occupational therapy in his care.

In conclusion, Dr Rix stated that the prescription, administration, management, withdrawal and cessation of Mr McAlary's medication *"was appropriate and managed accordingly."*

Dr Rix's only criticism during this period of Mr McAlary's care was in relation to the lack of documented records in relation to non pharmacological treatments that Mr McAlary may, or may not, have received. Dr Rix did state, however, that the ten point plan (described above) does demonstrate to some extent the care that was given to this aspect of Mr McAlary's treatment.

8. Request for GP Records

On 29 June 2010, a member of healthcare staff faxed a letter to Mr McAlary's general practitioner informing them that Mr McAlary was in prison and asking for his medical records.

The following day, Mr McAlary's general practitioner replied stating that due to Data Protection Regulations his practice no longer sent medical notes in the post. The general practitioner added that if Mr McAlary was going to be in the care of the prison for more than three months, his medical care should be moved to the prison and his notes would then follow. The general practitioner ended his letter by stating, *"If you require any further information I will be happy to advise you by telephone or send a photocopy of notes for a standard fee of £50.00."*

On 19 July 2010, a further request to Mr McAlary's general practitioner was noted as follows:

"Telephone contact with (Mr McAlary's GP): (He) reiterated the cost implications for sending a copy of notes but agreed to share information via the phone. He stated that Gerry is known to psychiatry and was being treated for depressive illness by antidepressants. In his consultations with Gerry he has never found any evidence of depression or any other treatable mental illness, and described a history of drug seeking especially for benzodiazepine derivatives. He outlined that Gerry has a history of substance misuse - alcohol and cannabis, and a history of aggressive behaviour."

Mr McAlary's medical records were never received by the prison.

Clinical Reviewer's Comments

Commenting on the absence of the medical notes, Dr Rix said:

"I do not think that what I regard as the failure to send (Mr McAlary's) general practitioner records to the prison had any adverse effect on the treatment he received…partly because copies of correspondence from the hospital records were provided [and] partly it was down to the thoroughness of (the prison psychiatrist) assessment of (Mr McAlary)."

Dr Rix did say, however, that the prison psychiatrist's understanding of the complexity of Mr McAlary's case would have been assisted by a detailed medical history, even though the outcome would not have been any different. He noted his concern about the unacceptable difficulties the prison had experienced in accessing the medical notes.

SECTION 4: MR MCALARY'S TIME ON THE REACH LANDING

9. Cognitive Behavioural Therapy and Mental Health Support

On 29 October 2010, Mr McAlary attended his first session of cognitive behavioural therapy (CBT). The therapist recorded that she had attempted to explain to Mr McAlary how the treatment sessions would run and what her objectives were but noted that his concentration level and attention were reduced and that he appeared *"dull, mood flat but was forthcoming."*

On 2 November 2010, Mr McAlary was seen again by the CBT therapist who then wrote a letter to the mental health team saying:

"He appears quite depressed with the usual biological markers present, i.e. low mood, sleep disturbance, diurnal variation, reduced concentration and attention span with ideas that life is not worth living, however he denies any active suicidal thoughts at present. In addition, he also complains of anxiety type symptoms of butterflies in his stomach, tremulousness and breathlessness. As stated this man is quite depressed and I feel at this stage that his mood may be too low to enable him to engage in cognitive behavioural therapy at this stage."

On 5 November 2010, Mr McAlary was assessed by a mental health nurse and she recorded that his mood was low possibly due to his, *"premorbid personality."* She also recorded that Mr McAlary said he had a tendency to isolate himself on the landing and had lost interest in activities that he had previously enjoyed, such as attending the gym and writing letters. The nurse also noted that Mr McAlary was content to have ongoing input from mental health services with a view to improving his social functioning.

That morning, Mr McAlary made a phone call to his mother. They talked about Mr McAlary's next court appearance and about matters

happening outside of prison. During the conversation, Mr McAlary told his mother that he was not getting on so well since moving location, was having difficulties sleeping and was not being allowed medication to help. He also told her that there was nothing *"exciting going on"* and under his breath he said that the he would *"be better dead."* It was clear that his mother did not hear this comment.

At 08.47 on 9 November 2010, Mr McAlary made another phone call to his mother. He talked about the fact that he had been visited by his brother, about matters relating to his case, about what was going on outside of prison and said that his sleep was not *"great"*. Under his breath, he said *"look after yourself; I don't know if I'll come out of this place alive."* When his mother asked him to repeat what he had said, he replied *"look after yourself."*

It is to note that Mr McAlary made eight other telephone calls to his mother between 22 October and 21 December 2010 and no other references of this nature were made. In the other calls, he talked about his court case and general matters and only in one other occasion did he talk about not sleeping well.

On 11 November 2010, in response to the letter issued by the CBT therapist on 2 November, Mr McAlary was assessed by his regular psychiatrist. She recorded that her impression was that Mr McAlary's difficulties were *"one of adjustment issues related to his recent transfer to the REACH setting compounded by long term anxiety symptoms and perpetuated by his pending legal situation."* She noted that she encouraged Mr McAlary to participate in activities in the REACH setting including occupational therapy in the REACH gardens and that he agreed to do this. The psychiatrist wrote to Mr McAlary's CBT therapist saying *"At interview, I could find no evidence to suggest that Mr McAlary is suffering from a significant depressive episode. I would be very grateful if you could arrange to see Mr McAlary again, and I will review him at the Psychiatric Clinic in the near future."*

The same day, Mr McAlary was seen by his CBT therapist and she recorded *"states mood and sleep have improved slightly, more spontaneous in session. Discussed behavioural activation strategies and their use as mood enhancers. Review in 1 week."*

Due to sickness absence of the therapist, Mr McAlary had no further sessions of CBT before he left prison. At interview the therapist said that as the delivery of CBT had only commenced in the prison in January 2010, it was her understanding that there was no one available to replace her during her absence. She said that, more recently, the South Eastern Health and Social Care Trust has employed specialist nurses with the necessary training to cover her role in the event of absence.

On 23 November 2010, Mr McAlary was reviewed by a mental health nurse. She recorded that Mr McAlary was *"pleasant and reactive at times in conversation, but admits to increased anxiety as due in court on Thursday 25th. Francis feels that working in the gardens helps distract his thoughts, but he did become a little emotional when discussing the fact that he may not get bail. He denies any thoughts of self harm, and no psychotic phenomena evident, agreeable to monitoring of mental state every 2 weeks."*

The following day, Mr McAlary was seen by another mental health nurse who recorded *"Spoke to Francis on REACH landing, he appeared anxious and stated that he has lost weight recently, this may be due to the possibility of not getting bail. He stated that he was enjoying REACH getting out in the gardens."*

On 6 December 2010, Mr McAlary had his two week follow-up mental health review. The mental health nurse recorded that Mr McAlary, *"appeared lower in mood describes himself as two out of ten. Some paranoia re inmates and staff, he believes they may be talking about him."* Mr McAlary told the nurse that he was getting approximately

one hour's sleep a night, had lost interest in life in general, that his concentration and memory were deteriorating and that he was anxious about his court case which was due on Friday.

On 9 December 2010, Mr McAlary was assessed for the last time by his prison psychiatrist and the following was recorded:

"Discussed pending legal proceedings and concerns regarding possible custodial sentence. Remains in the REACH landing and attends REACH gardens and Occupational Therapy programme. Pleasant and co-operative throughout the interview. Eye contact fair. Mood subjectively lowered although fully reactive throughout the interview. Sleep chronically disturbed, but increased disturbance over the last few weeks with initial insomnia and restlessness but no early morning wakening. Appetite maintained. He states that he has lost weight although this was not grossly evident at interview. No thoughts of life not worth living or suicidal ideation. No evidence of psychosis. No hallucinations. States that at one point he was concerned that others may be talking about his legal situation but not currently. Cognition and insight intact. Impression is one of adjustment difficulties in relation to his pending court proceedings rather than emergent symptoms of severe mental illness such as depression or psychosis. In view of this I would feel that there was no current indication for the prescription of psychotropic medications."

No further mental health or psychiatric reviews were conducted prior to Mr McAlary's release on 21 December 2010.

On 17 November 2010, Mr McAlary participated in his last occupational therapy session which was cooking. It is recorded that *"Francis was noted to engage in minimal conversation with other group members (and) noted at times to display appropriate reaction. On speaking to Francis he appeared slightly warmer and relaxed in demeanour. Plan: O.T to report back to appropriate staff involved with*

Francis and continue to engage in O.T. as he appears to get benefit from the sessions."

On 20 December 2010, Mr McAlary spoke to his occupational therapist for the last time, when she stopped at his cell to chat to him. She noted that she encouraged him to engage in any future occupational therapy sessions and that he was *"pleasant and co-operative"* in response.

Clinical Reviewer's Comments

Commenting on Mr McAlary's care whilst on the REACH landing, the clinical reviewer Dr Rix said that he *"was appropriately assessed for and began treatment with cognitive behavioural therapy far sooner than would have probably happened in many psychiatric services outside prison where waiting lists for cognitive behavioural therapy are measured not just in months but in years."*

Dr Rix said that *"as (Mr McAlary's) court date approached, there was some worsening of his mental state but in a form and of a nature consistent with his difficulty in adjusting to his circumstances, that is a form of adjustment reaction, rather than a relapse or recurrence of mental illness as such. I should add that I do not agree with (the CBT therapist) that (Mr McAlary) had biological symptoms of depression but this is not of significance."*

Commenting on the occupational therapy Mr McAlary received during his time in prison, Dr Rix said that occupational therapy played an important role in Mr McAlary's care and that *"the availability of occupational therapy was better than in many psychiatric services outside prison."*

Dr Rix did, however, express concern about the *"failure to continue his cognitive behavioural therapy"* beyond 11 November 2010.

SECTION 5: EVENTS SURROUNDING MR MCALARY'S RELEASE ON 21 DECEMBER 2010

10. The Role of the Discharge Liaison Team

In June 2009, a discharge liaison team (DLT) was set up to assist in managing the safe and effective discharge of prisoners with complex health and mental health needs, in line with the requirements of Promoting Quality Care Guidelines (PQCG) 2009[29]. The guidelines describe the principles of best practice to assist individual mental health and learning disability care professionals, multi-disciplinary teams and the organisations within which they work, to make decisions about managing the potential risk that service users may cause harm to themselves or others (including the staff who care for them, their families, carers or the general public). The guidelines emphasise the need for effective verbal and written communication which, it is stated, is fundamental to risk minimisation.

The investigation was told that, if a patient is categorised as requiring *"DLT management,"* the care he or she receives includes multi-agency case conferences to ensure that an appropriate care package is in place prior to them leaving custody. Where there is evidence from an assessment that a patient does not suffer from an enduring mental illness, then they are deemed to require *"DLT co-ordination"* and the DLT will then act as a communication conduit for relevant information to the patient's general practitioner and psychiatrist.

On 23 June 2010, Mr McAlary was referred to the discharge liaison team. Four case conferences were held between 1 July and 12 August and it was agreed that Mr McAlary met the criteria requiring 'DLT management,' in order that, in the event that he left prison, there was

[29] Promoting Quality Care Guidelines (PQCG) 2009 was to developed as regional guidance to ensure that mental health provider organisations have robust risk assessment and management processes embedded in their practice to minimise, as far as possible, the occurrence of adverse incidents.

a *"co-ordinated network setup"* to ensure his medical needs were met. At interview, the discharge liaison nurse said that as time passed, the team discussed Mr McAlary and *"....it was decided that Mr McAlary's mental health did not warrant the discharge liaison team to manage his case..."*

On 18 November 2010, a further multi disciplinary team meeting took place and it is recorded that *"Gerry's mental state is well settled and he is managing well in REACH. Due same he has been down-graded from DLT management to co-ordination."*

The investigation endeavoured to establish who was involved in making this decision and, in particular, whether Mr McAlary's psychiatrist was present at the multi disciplinary team meeting. Staff were unable to confirm for sure who was present and this information is not recorded on the EMIS record of the meeting.

11. Mr McAlary's Release on 21 December 2010

Mr McAlary was released on bail on Tuesday 21 December 2010.

At 13.00 on 22 December 2010, it is recorded that the discharge liaison nurse was informed that Mr McAlary had been released on bail from Maghaberry.

At 14.00 on 22 December, it is recorded that the nurse contacted Mr McAlary's general practitioner and informed the practice of his release. At interview, the nurse said that the general practitioner's secretary said to her *"could you just simply send us his medication, his discharge medication, he is well known."*

Records show that at 09.11 on 23 December, the nurse faxed eight pages to Mr McAlary's general practitioner with a covering letter stating the following:

"The above named patient had been recently released from Maghaberry Prison; please find attached a copy of the EEG report completed on the 12/10/2010 following this he has been referred for a Neurological opinion and for a CT scan (both requests enclosed.) Given that he has since been released on bail these appointments may require follow up. Medication on release: Thiamine Hydrochloride (Vitamin B) Tablets - 100 mg — two to be taken each morning. Should you require any further information do not hesitate in contacting us."

Also included in the fax was a copy of a letter that Mr McAlary's prison psychiatrist had written to a consultant neurologist on 21 October 2010 which provided a brief over view of Mr McAlary's medical history prior to and after committal. She stated that Mr McAlary was *"unmanageable within the normal prison location"* and following transfer to the healthcare setting he had been prescribed benzodiazepine and Chlorpromazine and when his mental state

settled, his psychotropic medications were discontinued. The psychiatrist sought the consultant's opinion as to whether a prescription of an anticonvulsant medication was clinically indicated, and asked whether the consultant was of the opinion that the results of the EEG could explain Mr McAlary's behaviour prior to transfer to healthcare. A two page print out of EMIS[30] records was also attached which noted that Mr McAlary had an epilepsy blackout in April 2010, smoked 30 cigarettes a day, had commenced Thiamine Hydrochloride tablets and had a conversation with an occupational therapist on 20 December 2010. It is to note that Mr McAlary's EMIS records are 20 pages long.

At 09.40 on 23 December 2010, it is recorded that the discharge liaison nurse rang Mr McAlary's community psychiatrist and spoke to his secretary to inform them of Mr McAlary's release. The nurse recorded that she *"advised that Francis has been released from prison to enable review appointment is forwarded."* At interview, the nurse said that she was told by the secretary that Mr McAlary was due to be seen by the psychiatrist in April 2011.

At 09.40 on 23 December, it is recorded that the nurse also contacted Mr McAlary's mother to ensure that he *"had arrived safely and to advise that further appointments will be coming. She [Mrs McAlary] advised that the trial starts on 31/1/11."*

At interview, the nurse said that during the conversation, Mrs McAlary said that *"…her biggest concern was that (Mr McAlary) had to report to the Police Station in Maghera and they lived out in the country, it was snowing and he couldn't get there so I got them a number of the police station and told them to phone and explain the situation. And that's really where I left it. She told me the trial was starting on the 31st and I told her about the further appointment from the psychiatrist*

[30] EMIS – Egton Medical Information System, which is the database the prison healthcare team use to record all of a patients medical notes.

would be coming at that point." The nurse said that Mr McAlary's mother did not raise any concerns with her about her son's behaviour or his medication.

On 25 December 2010, Mr McAlary died by suicide.

Clinical Reviewer Comments

Commenting on the information provided to the general practitioner Dr Rix said:

"…the general practitioner was not provided with all of the details of (Mr McAlary's) primary and specialist mental health care while he was temporarily out of the care of the general practitioner. The two computerised summary pages that were sent, gave no indication of the complex and serious mental health problems that had been treated in the prison." He said also that the summary *"made no reference to his mental health which had been the main reason for his contact with the prison healthcare service. The general practitioner was given no indication of the medication that he had been prescribed, only the medication he was prescribed upon release and there was no explanation for that. Most importantly the general practitioner was not informed that, at the time he was released on bail, (Mr McAlary) was under the care of a specialist psychiatrist, he was under the care of the mental health care team, he was part of the way through, or had started but prematurely ended, cognitive behavioural therapy and he had been having occupational therapy."*

"If nurses are to be responsible for discharge letters they should be trained by those who have hitherto been responsible for them, that is hospital doctors, and specifically in this case, psychiatrists. …The general practitioner should receive in such a case, as full and as comprehensive a discharge summary as would be prepared if the

prisoner is admitted under the care of specialist mental health services outside prison…"

Dr Rix went on to say that *"It was particularly important for (the community psychiatrist) and the general practitioner to know about the psychiatric treatment that was ongoing at the point (Mr McAlary) was released on bail. Something similar was going to have to be arranged for (him) in the community if there was going to be a continuity of care and a consolidation of the progress achieved in prison. However, even if it had not been a few days before Christmas, there would have been something of a hiatus, nevertheless, if (Mr McAlary's) general practitioner had been fully informed, it is probable that, between his release on bail and Christmas Day an assessment could have been arranged by the (Crisis Response Team). If there were concerns about (Mr McAlary) over the Christmas period, this team could probably have provided monitoring and support until the holiday period was over and other services were put in place."*

Response by the South Eastern Health and Social Care Trust to Dr Rix's Comments

In response to the comments made by Dr Rix in respect of the care arrangements for Mr McAlary's release, the South Eastern Health and Social Care Trust said that:

"the patient was last seen by [his regular prison] psychiatrist on 9 December 2010. That assessment showed:

- *No thought of life not worth living*
- *No suicidal ideation*
- *No evidence of psychosis*
- *No hallucinations*
- *The patient would be subject to follow-up review.*

The last contact the patient had with Health Care Services on 20 December 2010 by occupational therapy, it notes that he was pleasant and co-operative. In those circumstances it is difficult to understand why a referral would be made for crisis response and intensive home treatment."

It is to note that some of the information not included in the summary prepared for the general practitioner was included in the letter to the Clinical Neurologist which was faxed to the general practitioner. It is the case that, had this opinion not been sought, the general practitioner would have had no information relating, for example, to Mr McAlary's medication history in prison.

The clinical reviewer was asked to comment on the Trust's response and Dr Rix said that he believed that his concern remained valid. He noted that:

"In many services where community mental health teams have been disbanded and replaced by assertive outreach teams, early intervention teams, crisis resolution and (intensive) home treatment teams, it is the crisis resolution and (intensive) home treatment teams that often provide short-term follow-up following discharge and, in effect, (Mr McAlary) was being discharged from something very much like psychiatric inpatient care."

SECTION 6: AUTOPSY REPORT

12. Findings of the Autopsy Report

An autopsy examination was carried out on 26 December 2010 and gave the cause of Mr McAlary's death as:

I (a) Hanging

The assistant state pathologist noted that death was due to hanging with a ligature.

As part of this investigation, a toxicological examination of Mr McAlary's blood was instructed to determine whether Mr McAlary had recently taken any alcohol or drugs. The toxicological report shows that no alcohol was present at the time of Mr McAlary's death. There were, however, substances detected as follows:

Diazepam	0.041 milligrams per litre of blood
Desmethyldiazepam	low concentration detected
Caffeine	detected
Nicotine	detected

The report stated:

"Diazepam and its metabolite Desmethyldiazepam were detected in Mr McAlary's blood at concentrations consistent with the therapeutic use of the drug."

Prisoner Ombudsman Comment

It is not known how Mr McAlary obtained Diazepam following his release from prison. Investigation of this falls outside of the remit of the Prisoner Ombudsman.

Whilst the investigation found that Mr McAlary was anxious about his trial, it is not known whether this contributed to his death or whether, following his release from prison, any other matter caused him concern or anxiety.

APPENDICES

APPENDIX 1

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

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

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

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

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

   - Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
   - Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.

- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

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

Clinical Issues

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

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the

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

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

Disclosure of Information

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

Reports of Investigations

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

recommendations to the Prison Service and the responses to those recommendations.

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

Review of Reports

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

Publication of Reports

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

Follow-up of Recommendations

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

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

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

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

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

3. The Service responds within 28 days. The response:

   (a) draws attention to any factual inaccuracies or omissions;

(b) draws attention to any material the Service consider should not be disclosed;

(c) includes any comments from identifiable staff criticised in the draft; and

(d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe).

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

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

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

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

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not

include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request). If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.

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

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

APPENDIX 2

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[31] and integrated[32] conditions.

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

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

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

There is also a Landing within Maghaberry Prison called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Foyle House, which is used for housing poor coping prisoners who attend the Donard Unit[33].

[31] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.
[32] Integrated – general residential accommodation houses accommodating all prisoners.
[33] The Donard Unit has been specifically designed to facilitate purposeful activity for poor coping prisoners.

There is also a Care and Supervision Unit[34] (CSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.

The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and resettlement of which addressing offending behaviour is an element.

Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[35] (PREPS).

Maghaberry Prison was last inspected by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[36] in Northern Ireland in July 2009.

[34] Care and Supervision Unit (CSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

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

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

POLICIES AND PRISON RULES

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

Prison Rules

Rule 85(2) of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 – In the absence of the medical officer, his duties shall be performed by a registered medical practitioner approved by the chief medical officer and the Secretary of State.

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

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

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

Governor's Orders

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