The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF PATRICK KELLY AGED 46 ON 20th MARCH 2015

29th August 2016

[Published: 28th September 2016]

Names have been removed from this report, and redactions applied. All facts and analysis remain the same.

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GLOSSARY

CMHS	Community Mental Health Services
EMIS	Egton Medical Information System
FMO	Forensic Medical Officer
GP	General Practitioner
ICU	Intensive Care Unit
IMB	Independent Monitoring Board
IP	In-possession
MAR	Medication Administration Record
MDT	Multi-Disciplinary Team
MHT	Mental Health Team
MAR	Medication Administration Record
NIECR	Northern Ireland Electronic Care Record
NIPS	Northern Ireland Prison Service
NMC	Nursing and Midwifery Council
PECCS	Prisoner Escort and Court Custody Services
PER	Prisoner Escort Record
PRISM	Prison Record and Inmate System Management
PSST	Prisoner Safety and Support Team
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure
SPAR	Supporting Prisoners at Risk process/document

PREFACE

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

I make recommendations for improvement where appropriate; and I take next of kin views into account when considering publication. My preference is to publish investigation reports in full so that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

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

- establish the circumstances and events surrounding the death, including the care provided by the NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust (SEHSCT);
- examine whether any changes in NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

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

In this case, Jane Mackenzie, a retired Mental Health Nurse (RMN) and General Nurse (RGN) who has experience of conducting clinical reviews of prison deaths in Wales, reviewed the mental health care that was provided to Mr Kelly.

In addition, a peer on peer review was undertaken by Dr Rob Hall, a retired GP from Suffolk, who also has experience of undertaking clinical reviews of prison deaths in England, Wales and Northern Ireland.

This report is structured to outline the chronology of events up to and including Mr Kelly's demise.

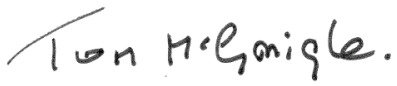
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. I first met with members of Mr Kelly's family in March 2015, and contact has been maintained with them throughout the investigation.

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

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

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



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
29th August 2016

SUMMARY

Patrick Kelly was remanded to Maghaberry Prison for two short periods in February 2015. He took an overdose of his prescribed medication on the second occasion, and died two days later at outside hospital. The post-mortem report attributes his death to '*Probable Drugs Toxicity in association with Coronary Artery Atheroma*.'

Mr Kelly had been heavily dependent on medication for physical and mental health problems for several years. These problems were clearly highlighted in the documents that accompanied him when he was brought to Maghaberry. However prison officers and nurses who assessed him upon committal overlooked them and relied instead on his self-reports and immediate presentation. Particularly in his most recent committal, they did not recognise the significance of a Forensic Medical Officer's assessment of him being at high risk of self-harm, nor share this information with colleagues. Several opportunities to address Mr Kelly's risks were consequently missed.

The NIPS and SEHSCT needs to address this matter; and I must again emphasise the importance of Prison and Healthcare personnel paying heed to information they receive from external agencies, and sharing it with everyone who needs to know within the prison.

The safeguarding measures that were put in place for Mr Kelly consisted of medication and instruction to place him in a lower bunk in a shared cell. However some of his existing prescriptions were not continued when he came into Maghaberry on both occasions. This was done without him being seen by a doctor or consideration of alternatives to alleviate his symptoms. When coupled with an eleven day delay in providing new prescriptions that were subsequently written, and inconsistent prescribing (medication which he had been refused during his first remand was approved just a few weeks later on the second occasion, and vice versa), it is clear that medication management in the prison needs to be improved.

Mr Kelly recognised his own risks and asked not to be allowed to retain his tablets as he was afraid he would take them all at once. Unfortunately his prophetic request was only briefly heeded. After four days on "supervised swallow" he was returned to "In-possession" status, without any protective measures in place to mitigate the risk of overdosing. He appears to have hoarded his repeat prescriptions and ultimately used them to overdose.

The person (a nurse) who most probably took the decision to return Mr Kelly to holding his own medication asserted that she had no recollection of doing so. As a result of serious concern about the management of Mr Kelly's medication and the apparent link to his death, I highlighted these issues to the South Eastern Health and Social Care Trust in September 2015. The Trust requested our assistance with their internal investigation, which established that the house nurse and pharmacy technician were the only people who issued medication in Bann House on 6th March 2015, and therefore were the only people likely to have modified his medication status.

The emergency response was very good when Mr Kelly disclosed that he had overdosed on 18th March.

The clinical reviewers reached different conclusions in this case: one said Mr Kelly's death was not foreseeable, but his overdose was foreseeable; the other concluded that Mr Kelly's death was both predictable and preventable. The Trust disputed both of these conclusions. However, following an internal review of Mr Kelly's death and in working closely with the Prisoner Ombudsman, the Trust accepts that Mr Kelly's overdose was preventable.

This report makes 21 recommendations for improvement and the most significant areas are highlighted in this summary.

RECOMMENDATIONS

NIPS –

1. **Committal Procedures –** The NIPS should promptly address the persistent shortcomings in the committal process, and ensure all available information is actively used to support new prisoners. This should include:
    - Thorough analysis of PER/PACE 15 and 16 forms
    - Review of any previous Safer Custody Profile
    - Identify the reason for committal and any associated risks
    - Self-harm history, including triggers
    - Accurately record all identified risks and safeguarding measures implemented
    - Sharing the above with all relevant personnel, including their Trust colleagues. (Pages 13, 18 – 20, 23, 32)

2. **Record Keeping** – The NIPS should remind all staff of their responsibility to make contemporaneous journal entries. It is particularly important to record information about a prisoner's mood and anything that may contribute to safeguarding. (Page 14)

3. **Samaritans Listener Scheme –** The NIPS should remind all staff of Governor's Order 7-22, in particular the requirement to log all requests for a Listener visit and the need for vigilance when such a request is made as the prisoner may require additional safeguarding measures. (Pages 14 & 23)

4. **Warrant Details** – The NIPS should ensure a full list of charges is available for committal officers, regardless of the location the prisoner was committed from. (Page 18)

5. **Staff Training** – The NIPS should conduct a training needs analysis for staff particularly in relation to committal processes/procedures and the SPAR process. (Pages 18-21 & 26-27)

SEHSCT –

6. **First Night Safeguarding** – The SEHSCT should ensure that first night safeguarding procedures in the initial committal assessment include the risks associated with actual or reported mental ill-health in a patient. This assessment should consider all the information available to the committal nurse, including the information from previous committals, Northern Ireland Electronic Care Record (NIECR), Police custody reports and appropriately shared information via NIPS reception staff. The assessment should incorporate the current presentation of the patient and the self- reported information during the committal assessment. This should include opening a SPAR until the mental health team are satisfied there is no current risk of self-harm or suicidal ideation. (Pages 14 & 23)

7. **Staffing** - The SEHSCT should undertake a review of the nursing establishment within Maghaberry prison, in particular the staffing levels and skills mix on Reception. (Pages 20 & 23)

8. **Performance Management -** The SEHSCT should conduct a Training Needs Analysis of healthcare staff in relation to committal procedures/processes, SPAR policy & STORM where relevant. The Trust should also ensure all healthcare staff have access to regular performance reviews and, where relevant, access to clinical managerial supervision, and reflective practice discussions to support their revalidation process. (Pages 21 & 27)

9. **Review Scheduling** - The SEHSCT should put systems in place to ensure that patients are reviewed at the intervals specified in their care plan (e.g. blood pressure monitoring). When a review has not taken place the reason should be fully recorded on EMIS and the care plan updated accordingly. (Page 15)

10. **Healthcare Records** – The SEHSCT should remind all Healthcare staff of their professional responsibilities as outlined in the Nursing and Midwifery Council (NMC) Code for Nurses and Midwives (2015) NMC Standards for Medicine Management (2010) and NMC Record Keeping Guidance for Nurses (2009), namely that healthcare records are completed fully and accurately on appropriate documentation, names signed and printed, and the date of entries are recorded. (Page 15/16 & 23)

11. **Medication Cessation** – When medication that was previously prescribed to a patient is no longer continued, the SEHSCT should ensure the cessation/reduction regimes are implemented according to best practice. The rationale for such changes should be recorded on EMIS. (Page 16)

12. **In-Possession Policy** – The SEHSCT should use learning from previous policy updates to address all shortfalls, including the lack of IP risk assessment outcomes recorded on EMIS. (Pages 20-22 & 26)

13. **Medication Management** - The Trust should ensure the following issues regarding medication management are addressed:
    - Medications reconciliation on committal, including the sole reliance of NIECR where recent, relevant prison healthcare records are available;
    - Process delays in the prescription getting to pharmacy for dispensing;
    - Appropriate substitution of tradable/abusable medication, where relevant
    - Omitted doses. (Page 25)

14. **FMO Contact** – The SEHSCT should liaise with the PSNI to establish a process which ensures FMO concerns about risks, recommendations for a psychiatric assessment and/or risk of self-harm or suicide are promptly and fully received by Trust staff at point of committal. (Page 19)

15. **EMIS Development** – The SEHSCT should assess the adequacy of the current EMIS IT system in relation to its capacity to fulfil the following:
    - Create committal templates which ensure comprehensive information is captured, including all negative answers.
    - Create a prescribing and dispensing module, which also captures IP risk assessments and automatic review scheduling
    - Create a Care Plan module with automatic review scheduling.

    If EMIS cannot deliver the service required, the Trust should also investigate alternative IT support. (Page 24)

16. **Access to Mental Health** – The SEHSCT should ensure that the Mental Health Team (MHT) have access to and consider records from EMIS, PACE and previous mental healthcare provision where available, as part of their clinical decision making and risk management of prisoners referred to them for mental health assessment. Where a prisoner is recommitted within a short timeframe, consideration should be given to maintaining their previous position on the MHT's list, or escalating it based on their current needs. (Pages 22 - 24)

17. **Existing medication** – The SEHSCT should ensure staff fully record all medication brought into prison by a newly committed patient. (Page 22)

18. **Review of Records** – The SEHSCT should remind all Healthcare staff of the responsibility and need to review a patient's EMIS record prior to every consultation or assessment. (Page 20)

19. **Pharmacy Technician SOP** – The SEHSCT should ensure all pharmacy technicians are reminded of their duties in line with their SOP and lessons learned from this report are shared. (Page 25)

NIPS & SEHSCT

20. **Performance Management –** The NIPS and SEHSCT should consider whether performance management measures should be implemented to address the shortfalls highlighted in this report.

21. **Governance** – The SEHSCT and NIPS should ensure recommendations which are accepted from this report and other investigations and clinical reviews are communicated to staff, factored into quality improvement processes, and used to prioritise audit activity. (Pages 19 – 20)

MAGHABERRY PRISON

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

Procedures to support prisoners at risk of suicide or self-harm include a Suicide and Self-Harm Prevention policy, Supporting Prisoners at Risk (SPAR) process and an associated safer custody meeting structure.

Maghaberry established its Prisoner Safety and Support Team (PSST) in 2011. The team comprises a governor and three members of staff. Their responsibilities include a role to support vulnerable prisoners, some of whom are managed under the SPAR process. Mr Kelly was not known to the PSST.

Responsibility for delivery of healthcare at Maghaberry prison transferred from the NIPS to the SEHSCT in 2008; and following a period of transition all Healthcare staff were employed by the Trust by April 2012. The Trust has subsequently increased the numbers of healthcare staff and the range of services provided. Healthcare is planned and delivered in line with primary care services in the community.

The Trust has introduced a Primary Care Pathway with a dedicated committals team providing a first health screening and a comprehensive health screening within 72 hours of admission to the prison. The Trust also introduced a Mental Health Pathway, and an Addictions Team was created in 2014.

An inspection report on the safety of prisoners in Northern Ireland was jointly published by the Criminal Justice Inspectorate and Regulation & Quality Improvement Authority (who inspect healthcare) in October 2014. While inspectors saw evidence of good work being undertaken by Prison Service and Healthcare staff in dealing with damaged and vulnerable prisoners, they also said joint strategies between the NIPS and the SEHSCT were urgently needed to address the risks of suicide and self-harm and access to illegal and prescribed drugs.

The subsequent report of an inspection of Maghaberry Prison, published in November 2015, found that rates of self-harm had increased and inspectors were very concerned that aspects of healthcare provision had deteriorated. A follow-up inspection report that was published in February 2016 found *"While some aspects of primary health care had improved since May 2015, it was very worrying that mental health provision had deteriorated as a result of staff shortages and now needed urgent attention."*

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Their 2014-15 annual report highlighted concerns about the quantity and accessibility of drugs (both prescription and illicit) and poor participation in, and outcomes of at Drug Strategy Meetings.

FINDINGS

SECTION 1: BACKGROUND

Patrick Kelly was 46 years old when he was remanded to Maghaberry Prison on 13th February 2015 for alleged breach of a Non-Molestation Order which had been granted to his wife.

This was his third time in custody: he had previously served a ten month sentence in 1992 and spent four days on remand in 1993.

Mr Kelly was married with eight children, though the relationship faced difficulties which were directly linked to his current remands. He had overdosed as far back as 1991 due to marital difficulties. He recovered from the overdose but failed to attend mental health appointments that were subsequently offered.

Mr Kelly's medical records were comprehensive. For many years he suffered from depression, raised blood pressure, high cholesterol, arthritis and poor sleep. He had often sought assistance from community healthcare services and a lot of effort had been invested to establish the most suitable medication. There were also indications that he did not fully adhere to his medicines regime.

In late 2014 Mr Kelly engaged with community services and his GP to help cope with recent events that were affecting his mental health. These included his marital breakdown and high profile court proceedings for serious offences against family members, in which he was not the perpetrator.

Consequently from January 2015, Mr Kelly was prescribed short-term medication in addition to existing long-term medication. Immediately before his committal to Maghaberry he was taking:

1. Perindopril Erbumine – long term treatment for hypertension (high blood pressure)
2. Tildiem – long term treatment for hypertension
3. Atorvastatin – long term treatment for hypertension and cholesterol
4. Sertraline – long term treatment for depression
5. Naproxen – long term treatment for joint and arthritic pain
6. Tramodol – short term treatment for joint and arthritic pain
7. Diazepam – short term treatment for anxiety
8. Zopiclone – short term treatment for sleeplessness

SECTION 2: FIRST CUSTODIAL PERIOD – FEBRUARY 2015

Handover

Having been in police custody for around 24 hours, Mr Kelly arrived into Maghaberry Prison on the afternoon of 13th February 2015. The documentation that was given by his PECCS[1] escort to NIPS Reception staff comprised:

- New Committal Form, completed by PECCS
- PSNI PACE 16 Prisoner Escort Record Form (which included vulnerability and custodial information)
- PSNI PACE 15 Detained Person's Medical Form
- PSNI PACE 15/1 Detained Person's Medication Form

Reception Officer Interview and Assessment

The front page of the PACE 16 highlighted that Mr Kelly was at *"exceptional risk"* due to depression and his suggestion that he was on hunger strike in protest at the charges which were proffered against him.

The Reception Officer recorded on PRISM[2] that he was made aware Mr Kelly had self-harmed about five years earlier. No further details were recorded to explain the type of self-harm or any subsequent treatment.

As part of a vulnerability assessment[3] the officer again recorded that Mr Kelly had a history of self-harm and had engaged with community mental health services (CMHS). The assessment pro-forma also queried whether anything had happened recently that may increase his thoughts of suicide or self-harm, such as a relationship breakdown. The officer inaccurately recorded *'No'* in answer to this question, despite also recording that Mr Kelly knew why he was imprisoned and was prohibited from contact with his wife.

Although acknowledging receipt of the PACE 16 form, which highlighted Mr Kelly as being at *"exceptional"* risk due to depression and hunger strike, the reception officer only recorded the allegation of hunger strike as requiring further consideration.

Initial Healthcare Screening

Each new prisoner receives an initial healthcare assessment - to determine if they have any critical needs that require urgent attention, assess vulnerability and risk and keep the

[1] The Prisoner Escort and Court Custody Service, which transports prisoners between police, courts and prisons.
[2] A PRISM (Prison Records and Inmate System Management) Committal Record allows other NIPS staff to electronically access information obtained at committal.
[3] The vulnerability assessment is a section of the Committal Record which assesses whether the new prisoner might require a care plan.

patient safe – and a comprehensive assessment shortly afterwards. They may also be assessed in relation to mental health and other matters such as suitability to hold their personal medication "In-Possession" (IP).

The committal nurse also recorded that Mr Kelly had alleged he was on hunger strike, adding that it would be dealt with by NIPS officers. She also recorded his self-report that he had a diagnosis of depression, self-harmed by cutting his wrists 24 years ago, attempted suicide by hanging when he was last in prison and had seen his Community Mental Health Services (CMHS) two weeks earlier.

The nurse could not recall conducting Mr Kelly's assessment but confirmed that anything she discussed with him would be in the records. There was no further exploration of his depression, self-harm history or reason for engaging with CMHS two weeks earlier. Consequently no safeguarding measures were considered in advance of his mental health screening which took place three days later.

Following these interviews Mr Kelly was moved to the committal landing in Bann House where officers were provided with the committal form that highlighted him being on hunger strike only.

Bann House journal recorded that Mr Kelly terminated his hunger strike at 14.30hrs the following day. The reason for the cessation was not recorded.

The Residential Manager said that Mr Kelly was agitated when he arrived at Bann House and was therefore permitted a number of family phone calls. This was a positive gesture, though it was not reflected in the manager's journal or the landing journal.

Comprehensive Healthcare Assessment

Mr Kelly was next interviewed and assessed on 15th February when a nurse conducted his Comprehensive Committal Assessment. The EMIS record shows a prison officer was brought in to address his queries about court, to request a Listener[4] and arrange a phone call to settle his anxiety, all of which demonstrated good practice by this nurse.

NIPS Governor's Order 7-22 'Samaritan's Listener Scheme' specifies that landing staff and the senior officer should separately log all requests for a Listener in their respective journals. No such records were made.

The nurse recorded that Mr Kelly had *"hypertensive disease"* and his blood pressure was raised. She recorded that his blood pressure was to be reviewed in three to four days, but this was not done.

[4] The Listener Scheme is available to support prisoners at any time if they are feeling distressed or suicidal.

On 18th February when the Bann House Nurse went to conduct the review, she learned Mr Kelly had moved to Lagan House. The nurse then generated an action on EMIS to alert the Lagan House nurse that a daily blood pressure check was required. Despite an EMIS audit report confirming this action, there is no evidence of his blood pressure being re-checked. Nor was this matter picked up by the House Nurse in Lagan House who triaged him on 20th February.

Initial Mental Health Screening

On 16th February a Mental Health Nurse reviewed Mr Kelly's healthcare notes and as he had reportedly seen CMHS in the past two weeks she called them for more information and was advised he was not currently on their caseload.

Notwithstanding this, the nurse referred Mr Kelly to Maghaberry's mental health team, who meet daily (Monday-Friday) to consider referrals.

Medication Management

In-Possession (IP) Risk Assessments should be carried out with prisoner patients for a number of reasons. These include when a new prescription is issued or when it is suspected that a patient is hoarding, abusing or trading his medicines. The assessment aims to determine whether a patient can safely manage their personal medication.

On 13th February the committal nurse deemed Mr Kelly unsuitable to hold his medication in-possession: she considered him unpredictable as he was on hunger strike. She recorded this on the risk assessment form and also indicated that Mr Kelly was to be re-assessed in one week. The nurse expected the House Nurse or Pharmacy Technician would conduct the re-assessment, although the IP policy only permits nurses to conduct this assessment.

The risk assessment form is part of the medication administration record (MAR), which is a paper record that is not transferred to the patient's electronic record (EMIS). Consequently any information held in the MAR is not readily available to Healthcare colleagues.

Records indicate that no further IP risk assessments were completed during this period in custody. However a handwritten comment on the front of Mr Kelly's MAR suggests he was reassessed four days later - on 17th February - and remained unsuitable for In-possession. The comment is undated and does not indicate who wrote it, what preceded it or possible next steps.

In her clinical review report, Ms Mackenzie described the handwritten comment as "*inappropriate, confusing and potentially dangerous.*" She found "*no evidence of a systematic process that would trigger this review* (re-assessment)."

She added that the note "*does not reflect the expectations of local and professional standards and guidance for best practice in medication management or record keeping.*"

Seven out of the eight prescriptions which Mr Kelly had been receiving in the community were re-prescribed on 13th February by a prison doctor. The remaining one - zopiclone - is not prescribed in any of the Northern Ireland prisons because it has been regularly abused and traded.

Neither clinical reviewer was critical of the cessation of zopiclone, but both agreed it should not have ceased so abruptly and Mr Kelly's sleeplessness should have been addressed by an alternative method.

Medical records show that despite repeated requests and expressions of concern by Mr Kelly, he did not receive any of his medication until 24th February – 11 days after they had been prescribed. During that time he had not received any treatment for his depression (which had been deemed an *"exceptional risk"*), high blood pressure, high cholesterol, joint and arthritic pain and anxiety.

Both clinical reviewers stated that sudden cessation of Mr Kelly's medications for depression and hypertension could have had serious consequences. Ms Mackenzie added that it *"would certainly have compounded the problems relating to sleeplessness, anxiety and depression.*" Dr Hall concluded "*Mr Kelly's medication was managed poorly and did not reflect the best practice, as seen in other prisons.*"

Mental Health Referral Screening

The mental health team considered Mr Kelly's referral on 17th February. They identified him as likely to have difficulty in adjusting to prison and in coping with stressful situations. The entry also states that Mr Kelly was being treated for dysphoric mood by medication and was to be allocated a routine mental health assessment within nine weeks - he was released prior to this assessment.

Social contact

Mr Kelly phoned his son or daughter on a few occasions almost every day. He also spoke directly and indirectly with his wife. Topics included obtaining a bail surety, his relationship with his wife, and the withdrawal of her statement, which had led to his incarceration.

Mr Kelly had a family visit on 17th February. He regularly left his cell for recreation though did not associate with anyone in particular.

SECTION 3: BAIL AND RECOMMITTAL

Mr Kelly was granted bail on Wednesday 25th February 2015 and released at 19.30hrs with conditions that required him to reside at a specified address, observe a curfew and refrain from all contact, directly or indirectly, with his wife.

He ignored these conditions and less than five hours after release was arrested for breach of the Non-Molestation Order and of his bail conditions. Mr Kelly was also charged with harassment of his wife. He remained in police custody until he was remanded back to Maghaberry on Friday 27th February.

Re-Committal

Mr Kelly arrived in Maghaberry late in the evening of Friday 27th February. The following standard documentation was given to NIPS reception staff by his escort:

- New Committal Form, completed by PECCS
- PSNI PACE 16 Prisoner Escort Record (PER) Form (which included vulnerability and custodial information)
- PSNI PACE 15 Detained Person's Medical Form
- PSNI PACE 15/1 Detained Person's Medication Form

On this occasion the police FMO (Forensic Medical Officer) reported in the PACE 16 that Mr Kelly was at *"exceptional risk"* for a number of reasons including suffering depression and high blood pressure. The form also stated he was at '*high risk of self-harm.*'

The FMO said the risk level he identified was due to the combination of depression, history of serious deliberate self-harm and Mr Kelly's knowledge that he was going into custody.

In the absence of Mr Kelly's warrant (which can take up to 24 hours to arrive from court) the escort form did not provide sufficient details about the domestic element of the charges against Mr Kelly to alert prison officers and Healthcare staff.

Reception Interview

A new committal interview and cell-sharing risk assessment were completed by a Reception Officer. The PRISM record that he created was inaccurate in the following respects:

- The officer recorded he had received the PACE 15 and 16, but they did not indicate self-harm. He later said he did not know why he recorded this inaccurate information; and

- In the vulnerability assessment record the officer noted that Mr Kelly had a history of self-harm. However no further details were recorded to explain the detail or history of his self-harm, or any subsequent treatment.

The vulnerability assessment is also designed to elicit whether anything happened recently that may increase the risk of suicide or self-harm, such as a relationship breakdown. The officer recorded *'No'* in answer to this question. This was completely inaccurate and contradictory evidence was readily available from Mr Kelly's recent custodial history.

The officer said the answers he recorded were based on information provided by Mr Kelly and confirmed that he had not tried to establish whether Mr Kelly's warrant had arrived electronically. He also said he does not routinely refer to previous committal records when carrying out committal assessments, nor has he ever contacted an FMO to discuss concerns that are raised in the PACE 16 or PACE 15 forms.

The officer added that he did not consider depression or the risk identified in the PACE 16 form because he based his assessment on Mr Kelly's presentation when they met. Consequently he was content that Mr Kelly was well.

This case provides further evidence to support concerns about NIPS staff relying unduly on a prisoner's self-report and immediate presentation, in preference to documented history and professional assessments of risk and vulnerability provided by community agencies. This practice has led to recent criticism from bereaved families and their representatives. Our office has made recommendations, which have been accepted by the NIPS, for performance management with the personnel concerned. However the problem persists. Continued failure to effectively address it may compromise the safety of future prisoners, and render the NIPS and individual members of staff liable to reputational damage and legal challenge on the basis of a systemic failing.

The Reception officer's failings in this case also highlight an inherent risk in conducting a cell-sharing risk assessment which is based upon a false premise if they do not take into account the full circumstances when a new prisoner arrives into their custody.

<u>Initial Healthcare Assessment</u>

The same nurse who conducted Mr Kelly's initial assessment on 13th February did so again on 27th February 2015. Her EMIS entry on this occasion included reference to the fact that he was being treated for depression; had recently attended community mental health services; had been identified as likely to have difficulty coping in prison; and had previously attempted suicide in custody and in the community.

The nurse said that, irrespective of the fact that Mr Kelly had been committed to Maghaberry within the very recent past; a full Healthcare assessment should still be carried out. She also said that:

- Previous SPAR records are not routinely considered as part of the committal process;

- Previous risk assessments for in-possession medication are not considered during the Initial Healthcare Committal Screening; and in any event they would not have been accessible during this process as they are not entered onto EMIS;
- When undertaking her assessment on 27th February, she did not compare the information obtained on 13th February;
- She does not have time to consider every prisoner's previous history;
- The PACE 16 form dated 27th February 2015, which identified Mr Kelly as being at exceptionally high risk of self-harm, was either not provided to her prior to the assessment, or she overlooked it;
- Any discussions she had with Mr Kelly about his medical conditions, treatment, care plans or referrals, are as recorded in EMIS.

Previous recommendations for Healthcare staff to refer to EMIS records when assessing a patient's suitability to hold medicines in-possession, and to assess their healthcare needs rather than rely on a self-report - have been accepted by the SEHSCT. However this nurse indicated that she had never been made aware of these accepted recommendations nor instructed accordingly.

She also said "*I do not routinely look up medical records and base my assessment on the patient's self-report combined with previous experience with that patient. The review of medical records would be an impossible task with the amount of work needed to be done in committals, with a long list of committals coming into prison and me conducting committal screening on my own.*"

Despite the risks identified by a doctor on the PACE 16 form, the information already contained in EMIS and Mr Kelly's deteriorating family circumstances, the nurse's assessment concluded there were no risks that required management or support, and consequently no care plan nor referrals to other services were required.

Even with hindsight, the nurse said she was content with her assessment of Mr Kelly on 27th February and would not complete it any differently now. She explained that staff shortages and heavy workloads make it impossible to do otherwise. This is concerning as it indicates the nurse is considerably out of step with her employers requirements for conducting committal interviews. This matter needs to be explored and resolved in the interests of patient safety. The Trust accepts that there are concerns with the committal process which are being addressed.

Neither the Reception Officer nor the nurse compared Mr Kelly's committal on 27th February with his previous committal period, and therefore neither identified that some of his responses were untruthful (e.g. in relation to restrictions on contacting his wife, self-harm history, and mental health support).

The SEHSCT aims to apply the NI Prison Service's Suicide and Self-Harm Prevention Policy to support vulnerable prisoners. It states "*At first reception interview, Healthcare staff will play an important role in identifying vulnerability as they complete the health screening form and make an initial assessment of the potential risk of self-harm or suicide. Care must be taken to gain as much information as necessary as this will inform comparative*

assessments at any subsequent reception interviews. All forms will be retained on the prisoner's medical record – with as much information as possible recorded on EMIS."

The nurse who conducted Mr Kelly's committal assessments on 13th and 27th February has 15 years' experience of prison health. She told this investigation that she had not been trained in the Suicide and Self-Harm Prevention Policy.

Comprehensive Committal Healthcare Assessment

On 28th February a Comprehensive Committal Assessment and an In-Possession Medication Risk Assessment were completed by a nurse. She advised that a full comprehensive healthcare assessment is conducted even if someone returns to prison within a short time of their previous release, in order to establish whether there have been any changes in circumstance. The nurse said this process includes reviewing EMIS records and previous committal information. She also explained that the comprehensive assessment would not generate a care plan to deal with the risks identified on Mr Kelly's PACE 16, as the initial assessment should generate such a plan.

Consequently on 28th February the comprehensive assessment did not address any risks to Mr Kelly or identify any support mechanisms that needed to be put in place.

However the nurse who conducted his initial assessment said exactly the opposite. She expected that any necessary treatment, care plan or referrals would be completed in the comprehensive assessment.

The nurse who conducted Mr Kelly's initial assessment told this investigation she has never been specifically trained in the role of Committal Nurse, having received only a brief demonstration of the template document.

On 28th February, the nurse who undertook the comprehensive assessment deemed Mr Kelly suitable to hold his personal medication In-Possession. She did not consult the previous In-Possession Risk Assessments as they were not accessible on EMIS, and consequently she was unaware that he had twice recently been assessed as unsuitable for in-possession medication - on 13th February and again on 17th February.

This nurse said she was content with the In-Possession Risk Assessment she completed, based on her expectation that the vulnerability assessments are completed during the Initial Healthcare Committal Screening; and said she followed the steps laid out in the In-Possession Risk Assessment Form. However the forms completed for Mr Kelly on both the 13th and 28th February 2015 were outdated versions which should not have still been in use. The variation between the outdated version and the new version would not have made a material difference to the outcome of this assessment. The Trust acknowledges that the failings around the IP Risk Assessment process were due to human error.
In line with SEHSCT Standard Operating Procedure, she also issued Mr Kelly with some of the medication he had brought into prison, fully packaged and labelled; and recorded the existence and issue of this medication.

There is however no record of Mr Kelly bringing this medication into prison in the records completed by the nurse who conducted his initial committal assessment. EMIS records are meant to ensure all clinical staff have relevant and up to date information upon which to base their clinical and risk management decisions. The nurse could not explain the reason for her failure to record this important information.

Dr Hall considered that Mr Kelly's medical records were poor in comparison to medical records in prisons in Wales and England: he explained that the initial committal records were less comprehensive; the use of the committal template did not reflect good practice and did not capture all the information about Mr Kelly; some committal details were handwritten and never entered on the electronic records, so were not accessible at Mr Kelly's re-committal; and Medication Administration Records (MAR) were all handwritten with many illegible signatures/initials.

He added that "*There are problems with medical records at Maghaberry prison. Like many health organisations, the prison is struggling with a dual system – some of the records are on the computer and some are handwritten. The aim should be that as much as possible is on the computer as written entries. This would ensure that staff could easily look back in the records for previous data and assessments.*"

Ms Mackenzie reported that "*Handwritten notes attached to Kardex (MAR) or other records, with no signatures are unacceptable and not reflective of the Nursing and Midwifery Council (NMC) Record Keeping Guidance for Nurses*."

Mental Health Screening

Following an initial Mental Health Screening on Monday 2nd March, Mr Kelly was again referred to the Mental Health Team. He was considered by the multidisciplinary team the next day and again designated as requiring a "routine" full assessment. This meant he should be seen within nine weeks. Despite the deterioration in domestic circumstances that had led to his re-arrest within five hours of release and subsequent return to custody, plus the prison psychiatrists recognition that he would have difficulty in coping, he had to have a fresh referral.

As on the previous occasion, the mental health nurse did not interview Mr Kelly. She completed his referral by examining electronic records. However the records which she used did not contain any information about the circumstances of his return to prison, so no consideration could be given to managing those risks.

Ms Mackenzie found that "*The current assessment process and documentation used at Maghaberry prison does not reflect a full or informative mental health assessment process to support the assessor in further decision making.*"

In summary the clinical reviewers both found that Mr Kelly's committal experiences in February 2015 were insufficient to maximise the opportunities for keeping him safe. Despite a history of mental health issues, previous suicide attempts, current risks identified by the FMO and domestic relationship pressures, his clinical pathway was based simply on his presentation at the time the assessments were conducted. Information that had been provided by community agencies for the very purpose of helping to keep him safe in custody was not appropriately considered. Nor was that information entered into SEHSCT or NIPS records in a manner that would inform prison-based colleagues in future assessments, or care plans by others.

Various SEHSCT and NIPS staff explained that it is not routine practice to access all records, record in detail or proactively share information as they have limited time due to a high number of daily admissions to Maghaberry and low staffing levels.

Risk and Vulnerability Assessments

Vulnerability triggers - such as medication not being taken as prescribed, court outcomes and his relationship breakdown - were not a consideration in Mr Kelly's case, and no monitoring or safeguarding measures were put in place other than medication. Even then, assumptions by professionals that his medication was being supplied, or taken as prescribed, were incorrect.

Both clinical reviewers identified the following missed opportunities to manage Mr Kelly's risks:

a) From the first committal interviews and assessments:
   - Depression and anxiety were not supported until his medication arrived 11 days later;
   - Previous suicide attempts were not explored;
   - Risks which were identified, were not explored with the patient;
   - Reasons for referral to CMHS were not explored with him or with the CMHS when they were contacted;
   - When Mr Kelly asked for a Listener, there was no exploration of whether this assisted or if further assistance was required. Nor is there a record of whether a Listener was provided.

b) Mr Kelly's return to prison on 27th February presented a second chance to address the missed opportunities but the same failings were repeated;

c) The FMO's identification of an exceptional risk of self-harm on 27th February should have triggered a SPAR until Mr Kelly's mental state was assessed and a care plan put in place. If this had been done even as late as 27th February, he should have been regularly assessed by prison officers and Healthcare staff. A SPAR may also have triggered a more urgent mental health assessment.

Committal Screens

Dr Hall suggested that some of the weaknesses in the committal process may be due to the information systems in use at Maghaberry. He said that the NIPS Committal Interview simply collects information, and does not provide conclusions or triggers for others about problems that require attention.

A number of committal templates, each with a specific clinical topic, are available on EMIS. Nurses have an option to complete any of these, but nothing highlights gaps if some are not accessed. The process therefore relies on a nurse working through each individual template.

In addition, negative answers are not recorded on EMIS. A better design is therefore necessary to prevent an empty template from being considered as having been completed.

Dr Hall explained that prisons in England and Wales use a single template for initial and comprehensive committals. It is lengthy but nurses do not have to pick through individual templates, must complete all sections, and must also record negative answers. Clinical conclusions, such as fitness for work and vulnerability levels are also recorded. Dr Hall said that "*In comparison to the process in Welsh and English prisons, the (SEHSCT) initial and comprehensive assessments are sparse.*"

SECTION 4: MEDICATION MANAGEMENT

When he was recommitted to Maghaberry on 27th February 2015, Mr Kelly brought in two (Atorvastatin and Naproxen) of the seven medications which he had previously been prescribed in the prison. The nurse issued him with enough of these to last until Monday 2nd March, when a new prescription could be written.

A prison doctor re-prescribed his medications on 2nd March, and they were issued on 3rd March. Mr Kelly was re-prescribed five of the seven current medications, and two (Perindopril Erbumine and Tramodol) were not re-prescribed. The doctor said he did not prescribe these because they had not been prescribed in the community for the previous two months. However this was inconsistent: Mr Kelly had been prescribed them during his very recent incarceration; and on 2nd March he was prescribed Naproxen, which was not previously prescribed for him.

In line with the In-Possession (IP) Medication Policy and the risk assessment that had been completed on 28th February, Mr Kelly was allowed to hold four of his five medications IP. He had to take the remaining one (Diazepam) under "Supervised Swallow" arrangements.

IP medication is given to a patient in quantities that equate to a week's or month's supply. The patient is then responsible for taking their medication as prescribed. Pharmacy Technicians can issue IP medication only, and all supervised swallows must be administered by the House Nurse and taken immediately in the presence of the nurse.

On 3rd March when a Pharmacy Technician handed Mr Kelly his IP medications, he asked not to be given them as he was afraid he would take them all at once. Mr Kelly said he would prefer that his medication be given to him daily. The Technician said that in response to this she took all the medications back, wrote what Mr Kelly had said on his Medication Administration Record (MAR, which is a paper record) and then returned Mr Kelly's medication to the House Nurse, telling her what Mr Kelly had said and showing the nurse the MAR. Mr Kelly was then placed on supervised swallow by the House Nurse for all his medications.

The Standard Operating Procedure for Pharmacy Technicians requires that the reason must be recorded clearly on the MAR and in EMIS if a prescribed medication is not given, and the House Nurse must be informed. The handwritten notes on the MAR are not clear, and no record was made on EMIS.

The MAR indicates that the House Nurse subsequently administered all Mr Kelly's medication by supervised swallow from 3rd to 6th March inclusive. However at some point on 6th March he was returned to In-Possession status, even though no new In-Possession Risk Assessment was conducted between 3rd and 6th March, or thereafter.

The Pharmacy Technician told this investigation (on 29th July 2015) that on 6th March the same House Nurse had told her Mr Kelly was to return to In-Possession status, so she issued him with his medications as instructed (with the exception of diazepam as this

medicine is always administered as supervised swallow). The Technician said Mr Kelly made no comment about returning to In-Possession status. Records show he was given further medication supplies on 12th and 16th March.

As a result of serious concern about the management of Mr Kelly's medication and the apparent link to his death, I highlighted these issues to the South Eastern Health and Social Care Trust in September 2015. The Trust undertook to address these issues as part of their internal investigation.

The Pharmacy Technician's recall was less clear during the SEHSCT's internal Serious Adverse Incident investigation of this case. Both the Technician and the Bann House Nurse participated in an open group discussion on 23rd September 2015 as part of that investigation. At that stage the Technician said that she could no longer recall which nurse instructed her that Mr Kelly was to return to In-Possession status.

The House Nurse said she had no recollection of any of her dealings with Mr Kelly about medicines administration but believed she was not involved in any decision to return him to In-Possession status on 6th March.

While the SEHSCT advised that the House Nurse was the only nurse rostered for duty in Bann House between 3rd – 6th March 2015 and therefore the only person eligible to conduct a new risk assessment in Bann House during those dates, the Trust also explained that another nurse might have been sent to assist in Bann House. However our joint enquiries established that no other nurse or Pharmacy Technician administered medication in Bann House on 6th March. It is therefore highly probably that it was the House Nurse who instructed the Pharmacy Technician to issue Mr Kelly's medication as in-possession.

The In-Possession (IP) Medication Policy Key Policy Principles state that patients who are assessed as suitable for IP should have their risk assessment reviewed if a trigger factor occurs. Examples of trigger factors are provided: they include medication non-concordance (intentional or unintentional), a change in emotional state such as upsetting news from home, changing from supervised swallow to IP, deteriorating mental health or a SPAR being opened.

Mr Kelly should therefore have remained on supervised swallow until an IP risk assessment concluded otherwise. The Standard Operating Procedure for Pharmacy Technicians also requires a Technician to check that an IP Risk Assessment form has been completed by a nurse prior to issuing medication. No such check was conducted in this instance.

There are no EMIS entries which suggest Mr Kelly's medication was not given as prescribed, or which indicate his change of status from 'In-Possession' on 3rd March, or from 'Supervised Swallow' on 6th March. Nor is there any evidence of protective measures being introduced to mitigate the risk of him overdosing, such as a SPAR being opened, consultation with NIPS staff, spot checks on medication, providing a Listener, referral to the PSST or to the Mental Health Team.

The Suicide and Self-Harm Prevention Policy states that "*All prisoners identified as being at risk of self-harm will be placed on a SPAR."* When Mr Kelly told staff that he would take all his medication if given to him, a SPAR should at least have been considered.

Dr Hall said this was another missed opportunity to provide support to Mr Kelly. He concluded that "*Mr Kelly's death was not foreseeable, however his overdose was foreseeable*".

Pharmacy Technicians are not trained in the NIPS Suicide and Self-Harm Prevention policy and initiation of the SPAR process in Mr Kelly's circumstance would have been the responsibility of the House Nurse.

The Bann House Nurse was an agency nurse. The SEHSCT does not provide specific formal training for agency nurses, but they do provide induction in respect of Prison Healthcare, during which the In-Possession Medication Policy and SPAR are addressed.

SECTION 5: SOCIAL CONTACT AND COURT HEARINGS DURING MR KELLY'S SECOND CUSTODIAL PERIOD

Family Contact

Throughout the 19 days of his second period in custody Mr Kelly maintained almost daily contact with his family via phone calls to his son and daughter. He also spoke directly and indirectly with his wife, which caused distress to everyone.

Although court recommendations were again not identified, the domestic nature of his charges meant the three phone numbers he provided were checked. As these were not his wife's numbers, no restrictions were imposed in relation to contact with his wife by phone, letter or through visits.

The conversations were about his marital relationship, visits, his charges and the possible outcome at court.

A family visit that was planned for 28th February did not proceed. However family members visited him on 4th March and a further visit was planned for 19th March.

From 3rd March onwards Mr Kelly was told almost daily that his case would progress to court, and despite repeated reassurances he was extremely agitated about the state of his marital relationship.

On 11th March Mr Kelly said during a phone call that he would not serve a lengthy prison sentence. The Prison Service operates an intelligence-based approach to monitoring prisoner's phone calls. As Mr Kelly's calls were not being monitored, NIPS staff were unaware of the content of his conversations.

Court Appearances

Mr Kelly's case was listed on 3rd, 10th and 12th March when it was adjourned to be heard again on 24th March 2015. He told his family he expected it would result in a prison sentence of three or five year's duration.

Time Out of Cell

Mr Kelly regularly went to the yard for exercise and to the recreation room. He interacted with other prisoners though did not associate with anyone in particular while in prison.

Request for transfer to Separated Accommodation

During his first custodial remand Mr Kelly moved locations, which is quite normal. However he remained in the same cell during his second remand pending a decision about an application for separated accommodation which he lodged on 4th March.

On 10th March a Governor interviewed him in relation to this application. Mr Kelly did not indicate why he wanted separation, though told his family it was because he did not know anyone in Bann House. He did not appear to meet the criteria and in any event nothing happened in relation to the matter before his demise.

SECTION 6: 18th MARCH 2015

On the evening of 18th March 2015, Mr Kelly made three short phone calls at 19.18hrs, 19.22hrs and 19.25hrs.

During these phone calls, Mr Kelly was told, amongst other matters relating to their failing relationship, that his wife had left the family home and that she planned to proceed with the court case. At the end of the third call he said he would see the family members with whom he had been speaking at a visit that was planned for the following morning.

At 21.30hrs Mr Kelly informed prison officers that he had taken a large quantity of his prescribed medication and complained of chest pains. Nursing staff were immediately called and two responded.

One of the nurses checked Mr Kelly's medical records to establish his prescriptions. He told them what he had taken and the nurses estimated the quantity at 66 Diltiazem 200mg, 20-26 Naproxen 500mg and 28 Atorvastatin. This would suggest he had been hoarding most of his in-possession medication that was issued since 6th March. There had not been any reported effect of him failing to take this medication during the intervening period. While one nurse remained with Mr Kelly to obtain clinical observations, the other went to check ToxBase[5] to determine what action should be taken when these medications were overdosed.

The nurses said they considered treatment that would counteract the absorption of the medication into his body, but assessed this would not have worked because of the time Mr Kelly said he took the overdose.

After accessing ToxBase and identifying the fatal consequences of overdosing on Diltiazem a nurse immediately requested an emergency ambulance. He then returned to update his colleague and they agreed that clinical observations would be conducted every fifteen minutes.

Mr Kelly's first set of clinical observations were within the normal range, as were the second set fifteen minutes later. The ambulance arrived before the third set of observations were taken.

CCTV footage shows that Mr Kelly walked calmly with the paramedics, without any signs of distress, as he left Bann House. Around 22.30hrs, one hour after disclosing his overdose, he was taken to the Accident and Emergency Department of Craigavon Area Hospital.

Mr Kelly's condition did not improve after treatment in hospital and he was admitted to the Intensive Care Unit (ICU). Despite aggressive care[6], his health continued to deteriorate rapidly, requiring multi-organ support.

[5] Toxbase – Pharmacological database of the National Poisons Information Service.
[6] Aggressive Care – When a patient receives every medication, technology, tool and means that doctors can obtain to treat their illness.

Mr Kelly died in hospital on 20th March 2015. The post-mortem report attributes his death to '*Probable Drugs Toxicity in association with Coronary Artery Atheroma*.'

The family queried whether Mr Kelly had taken any other drugs, apart from his own medication. A low level of quetiapine (antipsychotic medication) was found. It is not known where he obtained this.

Both clinical reviewers said the emergency response on the 18th March was very good and commended all the staff involved.

SECTION 7: INFORMATION SHARING

NIPS Committal Sheet

Newly committed prisoners are moved quickly from Reception to the committal landing after their initial interviews. Comprehensive Healthcare assessments and mental health screening are often conducted on the committal landing.

The Committal Nurses and Reception Officer explained that, unless there is a specific concern, the only information provided to staff on the committal landing is the NIPS Committal Process Sheet.

The PACE 16 form that was given to the Committal Nurses and Reception Officer on both the 13th and 27th February identified a total of six exceptional risks. However neither NIPS and SEHSCT personnel who saw him when he came into prison on 13th February or 27th February had any specific concerns about Mr Kelly; and although on both occasions he gave the SEHSCT consent to share information with other agencies if appropriate, only one of the six risks was recorded on the Committal Process Summary Sheets.

The only information on his Committal Process Summary Sheet for 13th February was '*States he will be going on Hunger Strike.'*

The only information on his Committal Process Summary Sheet for 27th February related to one of his charges and an indication that a lower bunk was required.

It is difficult to understand how such limited information would have been of any benefit to the prison officers and Healthcare staff who subsequently had to manage and look after him. They and others who were involved in matters such as IP Risk Assessments, Mental Health Screening and medication management, were not made aware of any of the following:

1) A FMO concluded on 27th February that Mr Kelly "***is*** *high risk of SH (self-harm),*" and was also at risk due to depression, high blood pressure and back pain;
2) The risks identified were being treated solely with medication;
3) Uncertainty about whether he was receiving his medication;
4) Mr Kelly had limited experience of custody and had previously attempted to hang himself in prison;
5) His community GP records indicated he had previously taken an overdose of prescribed medication following relationship difficulties that were similar to those which led to his remands in February 2015.

In summary the records of Mr Kelly's committals in February 2015, and the information-sharing that followed, were quite inadequate.

SECTION 8: COMPARISON OF MR KELLY'S PRISON AND COMMUNITY HEALTHCARE

The clinical reviews that were conducted as part of this investigation considered the SEHSCT's objective that the standard of healthcare provided in prison ought to equate with healthcare in the community.

Ms Mackenzie reported that the policies and standards which she considered were up to date, informative and evidence-based. The fact that initial and comprehensive assessments, and referrals to the mental health team were completed within prescribed timescales, was also reported as good practice.

Otherwise the clinical reviewers concluded that Mr Kelly's care was better in the community than in Maghaberry prison, noting the following:

- When he changed doctors in the community - as he did several times during 2014-15 - he saw a doctor in the practice to review his medication on each first appointment with the new GP. However Mr Kelly did not see a doctor on either of the two periods he spent in prison in 2015; (However prison doctors do have access to a prisoner's electronic care record which details medication currently prescribed in the community.)

- Mr Kelly had access to all his medication while in the community. However in prison he was without seven medications for eleven days during his first custodial period; and without three medications for three days during his second custodial period;

- Some of his medications were terminated without consultation or consideration of an alternative to alleviate the symptoms for which they were prescribed;

- When Mr Kelly changed doctors in the community, his blood pressure was closely monitored. However until his overdose, Mr Kelly's blood pressure was recorded only once in prison and a planned review of his blood pressure never took place;

- In December 2014 after initial appointment letters failed to reach Mr Kelly, his community GP referred him to the community mental health team for an assessment, which was completed twelve days later. While he was referred twice for a mental health assessment in prison, he was never seen by a member of the MHT during a total of 30 days in custody in early 2015.

Dr Hall concluded that "*Mr Kelly's (health) needs were identified but not managed in accordance with best practice whilst he was in prison.*"

Ms Mackenzie concluded that "*The mental healthcare screening and monitoring provided to Mr Kelly was inadequate and his mental healthcare provision did not fully meet his clinical needs. Clinical risk assessment was of a poor standard, not always based on policy, guidelines or best practice, and risk factors that were present were not clearly identified, or managed systematically. Important information relating to his mental health and risks were not communicated or shared, which limited continuity in his care and risk*

management plan. Therefore based on the available information and on the balance of probability, the review has concluded that Mr Kelly's death was both predictable and preventable."