The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

ALAN WILLIAM VIKTOR RUDDY

AGED 29

IN MAGHABERRY PRISON

ON 31 JANUARY 2008

18 MARCH 2010

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

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PLEASE NOTE THAT THERE IS A SEPARATE APPENDICES BOOKLET WHICH SUPPORTS THIS REPORT

PREFACE

This is my investigation report into the circumstances surrounding the death of Alan William Viktor Ruddy who was 29 years old when he was found dead in Cell 16, Landing 3, Bann House in Maghaberry Prison on the morning of 31 January 2008.

Within his family, Mr Ruddy was known as 'Alan' and with the agreement of his mother that is the name that I have used throughout my report.

I offer my condolences to Alan's family for their sad loss. Brian Coulter, my predecessor, met with Alan's mother after his death and I recently met with her and her legal representatives to share the content of this report.

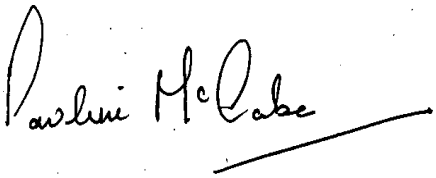
As part of my investigation, I commissioned a clinical review of Alan's healthcare needs and medical treatment whilst he was in prison custody in Northern Ireland. I am grateful to Dr Neil Lloyd-Jones for carrying out this review.

My report contains this preface and a summary followed by an introduction and methodology, leading to my findings and associated recommendations. My findings are presented in five sections:

- Section 1: Events prior to Alan's death on 31 January 2008
- Section 2: Events on 31 January 2008
- Section 3: Events after Alan's death
- Section 4: Other Issues
- Section 5: Overall Findings and Conclusions of the Clinical Review

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

As a result of my investigation, I make **nine recommendations** to the Northern Ireland Prison Service and South Eastern Health and Social Care Trust.



Prisoner Ombudsman for Northern Ireland
18 March 2010

SUMMARY OF INVESTIGATION

Alan Ruddy was committed on remand to Maghaberry Prison on 30 November 2007. On 20 December 2007, Alan was sentenced to an eight month and a four month prison term to run concurrently. Alan's earliest release date, taking into account 50% remission, was 19 April 2008.

Alan was found dead in his cell on the morning of 31 January 2008, eight weeks after his committal to prison.

Following his committal on 30 November 2007, Alan was housed in Roe House where he participated in the Prison Service's induction programme. He remained in Roe House until 4 December 2007.

An initial health committal screening was carried out by a nurse in the medical room in Roe House. This was to ascertain any previous and ongoing medical history.

The nurse identified that Alan was suffering from a number of medical conditions, including epilepsy (usually petit mal type seizures), anxiety and depression. Alan was in possession of a number of medications prescribed by his general practitioner. These were: Rivitril, Cipralex, Amitriptyline, Omeparazole, Tramadol and Temazepam as an 'acute' medication.

The nurse made a referral for Alan to be seen by a prison doctor because of the number of medications he was receiving and the medical conditions, which he had reported.

The next day, 1 December 2007, Alan was seen by a prison doctor and had a further medical screening. The doctor assessed Alan's medication. The doctor prescribed all of Alan's regular medicines, with the exception of Tramadol and Temazepam. The non prescription of Temazepam was consistent with Prison Service policy, as Temazepam has a particular potential for abuse in prison.

After checking Alan's medication history with his GP the prison doctor, on 3 December 2007, prescribed Tramadol and Phenergan for three nights as an alternative to Temazepam.

It was the opinion of the Clinical Reviewer that it was quite clear from the nurse's initial assessment questionnaire and the nature of the drugs that Alan was taking that he had some type of previous/ ongoing medical history. The Clinical Reviewer felt, therefore, that this should have been examined further and that this may then have determined further management.

Alan's medical records were requested from his GP, seven weeks after his committal, when he presented to a Prison Doctor with back pain. It was also the view of the Clinical Reviewer that the notes should have been requested sooner.

Following his committal, Alan was given his medicines on a daily basis until 29 December 2007. On 29 December it is recorded that Alan was assessed as being suitable for, *"self administration"* of his medication. He was then given a weekly supply of his medicine.

Following committal, Alan's time in prison was largely uneventful up until the morning of 5 January 2008, when he reported to a nurse that he had taken an overdose of his prescribed medication. The

nurse assessed the situation and arranged for Alan to be transferred, as an emergency, to the Belfast City Hospital.

At the hospital, Alan was immediately examined and his general health was assessed as *"satisfactory"*. Alan was kept in hospital overnight for observation.

The next day, 6 January 2008, Alan was examined by a duty senior house officer psychiatrist. The psychiatrist noted that Alan had no suicidal thoughts or plans.

Alan explained to the psychiatrist that he *"felt that he can be helped"* by taking Temazepam at night, but that this had been taken away from him and he was greatly annoyed by this. Alan was assessed as having *"no obsessional or delusional thoughts or perceptual disturbance and his cognition was intact"*. The psychiatrist concluded that Alan was not depressed and did not intend to kill himself. He just wanted his usual tablets.

The psychiatrist's impression was, therefore, that this was an impulsive act of self-harm. Her plan was to discharge Alan and recommend that his tablets should be dispensed on a daily basis and taken in front of prison staff. The psychiatrist also recommended that Alan's Temazepam should be recommenced at night and that the duty prison doctor reassess his need for two other prescribed drugs.

Alan was discharged back to Maghaberry Prison on the afternoon of 6 January 2008 and was re-located back to his cell in Roe House.

A handwritten note from Belfast City Hospital, sent with Alan, reads: *"No change to regular meds." "Ensure Temazepam given at night."*

"Your patient was admitted with an Amitriptyline overdose. He was treated conservatively and observed overnight. He was reviewed by psychiatry who felt there was no suicidal intent. They recommend that Temazepam should be given at night as the patient felt he was not getting enough medications. Please review his medications."

A follow up discharge note from the consultant physician who attended to Alan in the Belfast City Hospital was received on 17 January 2008. A typed discharge letter from the duty psychiatrist at Belfast City Hospital was received by the prison on 16 January 2008.

Alan was not re-assessed by a doctor upon his return to prison from Belfast City Hospital. He was not, however, allowed to self administer his medicines until 15 January 2008 and was, from that date, given his medicines on a daily basis until 31 January 2008, the date of his death.

It is the opinion of the Clinical Reviewer that it would have been common and acceptable medical practice for the duty prison doctor to have seen Alan to discuss his recent admission, what had happened, how it had happened and to deal with the care issues as to why he took the impulsive overdose, i.e. the change in his prescribed medication.

When Alan returned to his cell in Roe House at 15.55, a Prisoner at Risk[1] (PAR 1) Booklet was opened by landing staff in response to his overdose of prescribed medication.

[1] PAR 1 definition – is an authorisation and observation booklet which is opened when a prisoner is put under closer observation, usually in his own cell, for his own protection and safety. Observations are carried out and recorded every hour, unless the authorisation requires more frequent checks.

The PAR 1 procedure required hourly observation of Alan. The hourly entries on Alan's daily log over the next 3 days are largely uneventful recording things such as *"watching TV"*, *"appears asleep"*, and *"lying on bed awake"*.

It is, however, recorded that on 7 January 2008 Alan raised three complaints through the Prison Service's internal complaint process.

The first complaint Alan made on 7 January 2008 related to an incident he alleged took place on 4 January 2008. Alan said that he had been slapped on the back of his head by an officer.

Alan's mother was concerned that this complaint had been ignored. She stated that Alan's arm had been *"black and blue"* during a visit she made to Alan on 8 January 2008 and that Alan had mentioned to her that an officer had *"slapped him"*.

Following this complaint being made, a senior officer asked for Alan to be seen by a nurse. A nurse examined Alan on 7 January 2008 and wrote up an injury assessment form saying *"there were no marks or injuries noted."* [It subsequently became evident that the allegation of assault related to 5 January 2008, not 4 January 2008.]

The second complaint made on 7 January 2008 related to the fact that Alan was not happy that he had not been prescribed Temazepam by the prison doctors. The third complaint was in connection with the prison not notifying Alan's family when he was admitted to Belfast City Hospital on 5 January 2008.

Alan did not progress his second and third complaints beyond Stage One of the Prison Service's internal complaint process. A police

investigation into the first complaint was ongoing at the time of Alan's death.

Alan's complaints are examined in the report.

At 15.45 on 8 January 2008, a health care assessment was completed by a nurse, which led to the closure of Alan's PAR 1. The entry made by the nurse on the PAR 1 reads:

"Claims he took a weeks supply of his Amitriptyline and Clonazepam on Saturday because he wasn't getting what he felt was the correct medication i.e. Temazepam. States he has no thoughts of life not worth living. Supervise administration of medication. PAR 1 can be closed as this prisoner was manipulating to get medication".

A case conference also took place at the same time on the landing in Roe House between the nurse and landing staff. A further note written by the nurse on the PAR 1 reads:

"After the weekend's episode it was concluded that Alan Ruddy was attempting to manipulate health care staff in order to get medication. It was explained to him that his medication was not available in this prison. He was basically trying to cause inconvenience. If he had taken anything like the amount of tablets he said he had taken then he would have been at least a bit unwell. In light of this there is no need to keep the PAR 1 open as prisoner has admitted to this..."

Alan was taken off the PAR 1 at 16.00 and remained in his cell in Roe House.

The Clinical Reviewer said that the opening of the PAR 1 booklet demonstrated *"good management of Alan's problem."* He raised concerns, however, about the absence of medical/ psychiatric input and the arrangements for closing the PAR 1.

The Northern Ireland Prison Service Alcohol and Substance Misuse Policy places a strong emphasis on providing rehabilitation and treatment for prisoners with addiction problems. There is no evidence that Alan was offered or accessed any drug counselling services either before or after his drugs overdose on 5 January 2008.

On 10 January 2008, Alan was re-located, due to normal operational moves, to Bann House (Cell 16 Landing 3) to share a cell with another prisoner.

It is recorded that Alan made a further complaint on 10 January 2008 about a visit he attended on 8 January 2008. The visit was terminated by prison staff as they suspected that unauthorised articles had been passed over to him. Alan did not progress this complaint beyond Stage One of the Prison Service's internal complaint process.

The days preceding Alan's death on 31 January 2008 were largely uneventful with Alan's landing reports in Bann House recording that he *"had settled into the wing routine and was causing no problems".*

Alan had further visits on 15, 26 and 29 January 2008, which took place without incident.

Alan consulted with a prison doctor on 23 January 2008 because of back pain and was prescribed Tramadol.

At interview, the prisoner who shared Alan's cell, described the evening of 30 January 2008, the day before Alan died. He explained that, after lock-up time at 19.30, both he and Alan watched TV in their double cell and drank tea for a while before playing cards.

He then said that at about 21.00, Alan produced *"from his jeans pocket, a lump of toilet roll, inside which he had about 8 – 10 small, grey round tablets."* He explained that Alan offered him one tablet which he took and added that "*Alan was always popping drugs, prescription or illegal."*

He observed Alan taking eight or nine tablets before falling asleep on the chair around 22.30. Alan was, he said, asleep and snoring, with his head back. Between 23.00 to 23.30 he tried to raise Alan but he still *"appeared stoned"* so he lifted him onto the bottom bunk bed.

Alan's cell mate said that he also took a single tablet, which Alan had given him, around midnight and eventually became *"quite drowsy"*. He then got into the top bunk bed and watched TV, until he turned it off between 00.30 – 01.00. He remembers Alan was still snoring when he fell asleep.

In line with Prison Service policy prisoners are checked at regular intervals throughout the night. The night custody officer who carried out the checks on Alan's cell on the night of 30 January and morning of 31 January 2008 said, at interview, that checks were carried out at 20.15, 22.20, 01.30 and 05.30 and 07.15. These checks are recorded in the class officer's journal.

Alan's cell mate said that, on the morning of 31 January 2008, their cell door was opened at around 08.40 and he got up, made himself a cup of tea and cleaned the cell as part of his normal routine. Alan was still sleeping and snoring. An officer left a carton of milk to their cell as normal. Alan's cell mate said that he did not suspect anything was wrong at that point.

Alan's cell mate said that he then left their cell to go to another landing in the house and returned 10-15 minutes later. When he returned, he recalled that Alan was "*very pale, hardly breathing.*" He said he tried to check Alan's pulse and when there was no sign of life he went into the corridor to call for help.

Two officers quickly ran to the cell after they heard Alan's cell mate shout *"you better look at this boy".* This was at 09.05.

Both officers entered Alan's cell and saw what they described, at interview, as "*a male lying on the bottom bunk with the sheets down.*"

One officer approached Alan, sat on the end of the bed and checked for signs of life, while the other officer left the cell and sounded the alarm.

Some moments later, a nurse who was on duty in Bann House medical room, arrived at the scene. She later made a note about the incident saying that when she checked Alan, there were *"no signs of life, his pupils were fixed and dilated, no breathing or pulses, hands and face cold and grey in colour, mottling on right side of abdomen".* She added that because of his condition, no medical intervention was carried out.

The prison doctor arrived at the scene and pronounced Alan dead at 09.22.

A post mortem examination carried out on 1 February 2008 gave the cause of Alan's death as:

1 (a) Aspiration pneumonia
due to effects of
(b) morphine, diazepam and amitriptyline.

The metabolite of one of the active constituents of cannabis was also detected, indicating usage in the days prior to death. It could not be stated with certainty, however, that he was under the influence of this when he died.

From the account given by Alan's cell mate, there is no evidence to suggest that, unlike previously, Alan intended to take an overdose of medication.

Dr Neil Lloyd-Jones, in his clinical review of Alan's healthcare and medical treatment whilst in prison, concluded, that in respect of Alan's death:

"If I compare and contrast the drugs found at post mortem with those that I do know that he had been prescribed therapeutically then, beyond reasonable doubt, he was taking illicit drugs that he brought in or had smuggled in to the prison for him."

Telephone calls made by prisoners are recorded routinely. A random sample is monitored by the Prison Service and other calls are monitored where there is information or intelligence to suggest that this is necessary.

Both prisoners, and those to whom they make the calls, are aware of these procedures.

The investigation team listened to the telephone calls made by Alan over the period 24 – 30 January 2008.

There is evidence in the phone calls to suggest that Alan may have been having money transferred into the accounts of other prisoners, to pay for drugs he was accessing in prison. A number of requests are made for money to be transferred and it is confirmed a number of times that money has been paid in as requested. The prisoner account numbers are supplied. No reason for the transfer of the money is ever given.

On another occasion Alan asks the person he has called for £50 to be brought in for him, which the person agrees to. Alan then asks for a further £50 and when asked what it is for, Alan responds *"what do you think."* The person then tells Alan that they wouldn't be able to get the £50 in.

There is evidence also of people Alan speaks to, resisting his requests for money to be brought into prison or paid into other prisoners accounts.

Evidence in prison records also shows that people Alan called had, around the time that the phone calls were made, deposited money into other prisoners' accounts.

As part of this investigation the content of a phone call made by a prisoner, into whose account Alan was arranging for money to be paid, was considered.

There is evidence in this call that, in the days before Alan's death, the prisoner is arranging for drugs to be brought into the prison. These may or may not have subsequently been supplied to Alan.

There is also evidence supplied on a confidential basis that, following Alan's death, a member of healthcare staff notified the Security Department to register their concern about the availability of illegal drugs in Bann House. The person referred specifically to information provided by a prisoner.

In respect of Alan's reasons for taking drugs on 30 January 2008, Dr Lloyd-Jones concluded that, in the absence of any indication that Alan was, on this occasion, taking the drugs to draw attention to something he was angry about, his interpretation of the taking of the drugs that led to his death was, in the absence of an up to date psychiatric assessment that "*in lay terms, it was not an overdose per sé but rather an accidental death as a result of the side effects of taking a cocktail of drugs.*"

A copy of Dr Lloyd-Jones' clinical review report is attached as Appendix 2.

Recommendations

In light of my findings and the observations of the clinical reviewer, I make **nine recommendations** to the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[2] for Northern Ireland, I am responsible for investigating the death of Mr Alan William Viktor Ruddy (known as Alan) in Maghaberry Prison on 31 January 2008. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Appendix 1.

2. I am independent of the Prison Service and 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. As required by law, the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives

4. The objectives for my investigation into Alan's death are:

   - 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;

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

- to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- to ensure that Alan's family have the opportunity to raise any concerns that they may have and that these are taken into account in my investigation; and
- to assist the Coroner's inquest.

INVESTIGATION METHODOLOGY

Notification

5. At 09.45 on 31 January 2008, the Prisoner Ombudsman's Office was notified of Alan's death at Maghaberry Prison in accordance with the Prison Service's policy for dealing with deaths in custody.

6. A member of the Prisoner Ombudsman's investigation team immediately attended Maghaberry Prison to be briefed by prison staff on the circumstances of Alan's death.

7. The Prison Service also contacted the Police Service of Northern Ireland who attended the scene. A member of the prison chaplaincy made contact with Alan's family at approximately 10.30 to notify them of his death.

Notices of Investigation

8. On the morning of 1 February 2008, Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison announcing the investigation, and inviting anyone with information relevant to Alan's death to contact the Prisoner Ombudsman's investigation team.

Family Liaison

9. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the deceased's family.

10. My predecessor, Brian Coulter, first met with Alan's mother and her legal representative on 6 May 2008. Alan's mother was kept informed of the progress of the investigation and I met with her and her legal representative recently to discuss the content of this report.

11. As part of the investigation, a full account was taken of the issues raised by Alan's mother. In particular, she raised the following questions/areas of concern:

- The Chaplain, when notifying the family of Alan's death, indicated that his cellmate had been cleaning the cell floor. She wondered why someone would be cleaning the floor at that time in the morning and whether Alan had been sick.

- When Alan was arrested at Ardmore Police Station and then transferred to Maghaberry on 30 November 2007 why did Alan's prescribed medication not transfer with him?

- The prison healthcare staff were not interested in receiving the list of medications which Alan had been prescribed by his general practitioner, following phone calls to the prison, by his mother. His mother said that she was told that Alan's medical needs would be re-

assessed solely by the prison doctor without taking into account his regular prescribed medication.

- Alan may not have received the proper standard of health care in Maghaberry Prison, given his medical history. In particular, there was a reduction in his medication which he had been prescribed by his general practitioner and other specialists, prior to his committal on 30 November 2007.

- The reduction in Alan's medication may have contributed in some way towards his state of mind and subsequent death, particularly since he had been previously admitted to Belfast City Hospital on 5 January, for two days, following an overdose of his medication.

- Why was Alan's mother not informed by the prison that Alan had been admitted to an outside hospital for two days or that he had taken an overdose?

- Knowing Alan's state of mind following his overdose, why was he not kept in the prison hospital to keep him safe?

- Alan's arm was observed by her, during a visit on 8 January 2008, as being *"black and blue"* and Alan stated that this had been caused by a prison officer hitting him and that he had put in a complaint about this assault to the prison and that they had ignored his complaint.

- It was Alan's mother's understanding that Alan had been observed snoring at 08.00 by his cell mate and by a prison officer who was carrying out early morning cell checks and yet one hour later, at approximately 09.00, he was found dead. Did the prison officer make actual contact with Alan when he carried out his check?

- No word had been received from the Police or the Prison Service about Alan's personal belongings.
  [Note: Shortly after Alan's mother raised this concern, my investigation team contacted the Prison Service to make arrangements for her to receive Alan's personal belongings.]

12. Alan's mother also expressed concern about the way that the family were notified of his death, the fact that they were contacted by phone and the follow up after the original call.

13. The healthcare issues raised by Alan's mother were addressed as part of the clinical review, which was commissioned to examine Alan's healthcare treatment within prison.

14. The other concerns raised by Alan's mother are addressed at the appropriate places in this report.

Prison Records and Interviews

15. The Prisoner Ombudsman's investigation team visited Maghaberry Prison on numerous occasions and interviewed staff and prisoners. All of the prison records relating to Alan's period in custody, including his medical records, were retrieved and analysed.

Telephone Calls

16. The investigation team retrieved and listened to the last seven days of telephone calls made by Alan, in order to establish whether any information in the calls was relevant to the circumstances of Alan's death.

Post Mortem Report

17. My investigation team liaised with the Coroners Service for Northern Ireland to retrieve the post mortem report in order to establish the exact cause of Alan's death.

Clinical Review

18. As part of the investigation into Alan's death, a clinical review was commissioned to examine his healthcare needs and medical treatment whilst he was in custody in Maghaberry. This included an assessment of risk management and the management of Alan's medication.

19. I am grateful to Dr Neil Lloyd-Jones, who carried out the clinical review. The clinical review is attached as Appendix 2.

Working together with interested parties

20. An integral part of any investigation is to work together with all interested parties involved. To that end, the investigation team worked closely with the Police Service of Northern Ireland.

Maghaberry Prison

21. Included at Appendix 3 is some background information describing Maghaberry Prison and the Prison Service policies and procedures relevant to this investigation.

HMCIP and CJINI Inspections/Other Reports

22. The last reported inspection of Maghaberry Prison by Her Majesty's Chief Inspector of Prisons and the Chief Inspector of Criminal Justice in Northern Ireland was carried out in January 2009. The report of this inspection was published in July 2009. I noted the content when preparing this report.

Factual Accuracy Check

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

24. The Prison Service and Trust responded with some comments for consideration. I have now fully considered these comments and made amendments where appropriate. This is, therefore, my final report.

ALAN RUDDY

Background

25. Alan Ruddy had previous short spells in Maghaberry Prison. On this last occasion, he was committed on remand on 30 November 2007. On 20 December 2007, he was sentenced to an eight month and a four month prison term to run concurrently. Alan's earliest release date, taking into account 50% remission, was 19 April 2008.

26. A serious stabbing injury in 2005 resulted in him having major surgery to his abdomen. He was claiming disability living allowance as a result.

27. Alan was a known epileptic and had periodic stomach pains because of the earlier stabbing injury. He also reported periodic back pain because of a road traffic accident.

28. Alan's medical records show that he was known to be a heavy drinker and also took illicit drugs. It is recorded that Alan had ongoing mental health problems in that he had periods of depression and he had relationship problems that culminated in impulsive threats and overdoses.

29. For all of the above medical problems he received a variety of prescribed medications.

FINDINGS

SECTION 1: EVENTS PRIOR TO ALAN'S DEATH ON 31 JANUARY 2008

1. Alan's Committal Health Screening Process

Following his committal on 30 November 2007, Alan was housed in Roe House where he participated in the Prison Service's induction programme. He remained in Roe House until 4 December 2007.

Screening by Nurse

In line with normal practice at Maghaberry, Alan was then seen by a nurse in the medical treatment room in Roe House and an initial health committal screening was carried out.

The screening identified that Alan was suffering from a number of medical conditions, including epilepsy for the last four years (usually petit mal type seizures). Alan's last seizure was reported as occurring two to three weeks earlier. He had undergone abdominal surgery after a stabbing incident 18 months earlier. It is recorded on the committal form that Alan was taking "cipralex for depression".

It is also recorded that Alan said that he had never tried to self harm and had not received treatment from a psychiatrist or psychiatric nurse in the last five years.

In respect of this information, having had an opportunity to look at Alan's previous medical notes, the clinical reviewer Dr Lloyd-Jones, concluded that *"Mr Ruddy had clearly not been truthful to the nurse".*

Alan reported that he was in possession of a number of medications prescribed by his general practitioner. These were: Rivitril, Cipralex, Amitriptyline, Omeparazole, Tramadol and Temazepam. This information was recorded on the Initial Committal Screening Form.

When Alan was in Ardmore Police Station Newry on 29 and 30 November 2008, before being remanded into custody, he was medically assessed by a police doctor and had received his medication.

Because of Alan's medical history, the number of medicines he was receiving and his known medical conditions, the nurse at his prison committal screening on 30 November 2008 referred Alan for a consultation with a prison doctor.

1a. A nurse carried out an initial health screening on Alan's first day in prison, in line with Prison Service policy. Because of his medical history and the medication he was taking she referred him to be seen by a prison doctor.

<u>Screening by Prison Doctor</u>

Alan was seen by a prison doctor on 1 December 2007, the day after his committal.

The doctor carried out a further health screening exercise and reassessed Alan's medications.

Prior to the introduction of EMIS[3] a Prison Doctor would have been required to complete a Medical Officers Committal Assessment Form. Following the introduction of EMIS, it became normal practice to record relevant information electronically.

The doctor recorded on Alan's EMIS medical record that he had *"a history of a road traffic accident with some back pain, he had epilepsy, there was no tenderness to his back or abdomen and his chest was clear."* The doctor also advised that a medication check should be made with his general practitioner.

The doctor prescribed the following medications:

- Clonazepam (substitute for Rivitril/Clonazepam) as a medication for epilepsy;
- Cipralex (substitute for Escitalopram) an anti-depressant medication for anxiety;
- Amitriptyline, a tricycle anti-depressant; and
- Omeparazole as a medication for stomach problems and the treatment of heartburn symptoms associated with acid reflux.

These drugs were administered to Alan on 1 December 2008 and records show that the drugs were then administered to Alan on a daily basis until 29 December 2007.

[3] EMIS definition – Electronic Medical Information System used to keep a computerised record of each prisoner's medical consultations and interventions with a nurse and doctor.

On 29 December 2007, it is recorded that Alan was assessed as being suitable for 'self administration' of his medication. He was then given a weekly supply of his medicines.

Temazepam, which Alan had taken previously, was not prescribed, in line with Prison Service medication policy, due to its potential for abuse and currency value within the prison. Its availability has also been known to lead to bullying and prescribed medication being sold.

1b. A prison doctor carried out a further health screening the day after Alan's committal and prescribed a number of medications.

2. Contact with Alan's General Practitioner

Alan's mother was concerned that the Prison Service were not interested in knowing what medication Alan had been prescribed by his general practitioner. She was also concerned that his medication was reduced and that Alan was not prescribed Temazepam in prison.

On Monday 3 December 2008, the next working day after Alan's committal, a nurse, in line with the prison doctor's request, contacted Alan's general practitioner by telephone to establish what other medications he had previously been prescribed.

The nurse received confirmation that Alan had been prescribed Rivitril, Cipralex, Amitriptyline, Omeparazole and Tramadol. Alan had also been prescribed Temazepam, as an 'acute' medication on two previous occasions, when he described poor sleep in relation to anxiety symptoms. The nurse noted this on Alan's EMIS medical record.

A further entry by the nurse on Alan's EMIS medical record on 3 December 2008 indicates that Alan had been prescribed Tramadol by the prison doctor and that Phenergan had also been prescribed for three nights as a substitute for Temazepam.

2a. Alan was prescribed Tramadol and Phenergan on 3 December 2008, in addition to the other drugs which had already been administered.

In reviewing the committal proceedings, Dr Neil Lloyd-Jones, who carried out the clinical review into Alan's healthcare in prison, made the following points:

- It would have been good practice to have explored further Alan's medical history in respect of his epilepsy and whether this was well controlled.

- It would have been good practice to examine further Alan's psychiatric history, as this may have determined further management.

- It was good practice to contact Alan's general practitioner for verification of Alan's medication. It would have been good practice for the prison doctor, or a nurse instructed by him, to have also asked for a *"potted resume"* of Alan's previous medical history.

In responding to the clinical review, the prison doctor who saw Alan said the following:

- *In retrospect the prison doctor agrees that it would have been helpful for there to have been some questioning (further to that documented by the nurse on the Initial Committal Screening Form) regarding the stability, or otherwise, of Mr Ruddy's epilepsy.*

- *It was clear from the medication that Mr Ruddy was being prescribed that he had had a previous/ongoing psychiatric history. However, it was clear from the Initial Committal Screening Form that Mr Ruddy had reported never having*

been admitted to a psychiatric hospital or received treatment from a psychiatrist/CPN[4] or key worker for a mental health problem in the previous 5 years. Mr Ruddy admitted to being prescribed Cipralex for depression and denied ever having tried to harm himself, or considered harming himself, at that time. The prison doctor comments that, at the time of Mr Ruddy's attendance on him, he must not have appeared agitated and have had normal affect. The prison doctor would comment that, just because a prisoner is on antidepressants (as many prisoners admitted to HMP Maghaberry are), this does not necessarily mean it is necessary for a mental state examination to be performed.

- *The prison doctor explains it would not be customary practice for a brief resume of a prisoner's GP notes to be obtained. The prison doctor did ask a nurse to contact Mr Ruddy's GP, which she did on 3 December 2007. Based on the history given to the nurse and to the doctor, the prison doctor did not consider there was a need to obtain a potted history, although he does see the benefit in having that information easily to hand when assessing each prisoner.*

[4] CPN – Community Psychiatric Nurse

3. Patient Records – Delay in Transfer

Alan's medical records were requested from his general practitioner on 23 January 2008, after he saw a prison doctor complaining of back pain. This was seven weeks after his committal.

Dr Neil Lloyd-Jones said that it was common and acceptable medical practice for the prison to request Alan's previous medical records from his general practitioner but he added that, given the known aspects of Alan's medical history, the request should have been made sooner than seven weeks after committal.

Asked, at interview, about the reason for the delay, the prison healthcare management said that due to the number of prisoners and the quantity of medical records an individual can have, the healthcare centre does not routinely obtain all general practitioner records.

They also said that a prisoner's assessment is based on the examination of the prisoner on the day and the information the prisoner provides. If a clinical history is required for the purpose of diagnosis and treatment, further enquiries will be made with the general practitioner and/or in the medical notes already held on EMIS for that prisoner.

They added that in Alan's case, as recorded, the nurse contacted his general practitioner on 3 December 2007, to ascertain exactly what drugs he had recently been prescribed.

3a. Alan's medical records were requested from his general practitioner on 23 January 2008, seven weeks after his committal.

4. Alan's Overdose on 5 January 2008

Alan's time in prison up until 5 January 2008 was largely uneventful.

A decision had been taken on 29 December 2007 to allow Alan to start self administering his medication and he had been given a seven day supply. On the morning of 5 January 2008, Alan reported to landing staff that he had taken an overdose of his prescribed medication.

A nurse attended Alan, assessed him and arranged for him to be transferred as an emergency to the Belfast City Hospital.

The nurse said, at interview, that Alan had told staff that he had taken an overdose of his own medication. The nurse said that Alan's clinical signs were acceptable apart from a high pulse rate, but because of the alleged overdose and the types of medication which Alan claimed to have taken, she contacted her senior nurse. They both agreed that an emergency ambulance should be organised to take Alan to outside hospital.

A copy of the letter given to the Ambulance crew stated:

"This man, Alan Ruddy, claims to have ingested Amitriptyline 10mg x 14, Clonazepam 0.5mg x 6 and Cipralex 20mg x 7 this morning at approx 11am. On examination, alert and orientated, BP 120/85, pulse 130 regular. He expressed no wish to die but was taking them as a protest to being taken off a sleeping medication. We would appreciate if you could assess and treat accordingly. Thank You."

4a. Alan reported to landing staff on 5 January 2008 that he had taken a drugs overdose.

4b. Alan was assessed by a nurse, an emergency ambulance was called and he was taken to Belfast City Hospital.

5. Alan's Assessment at Belfast City Hospital

Alan was immediately examined on his arrival at Belfast City Hospital on 5 January 2008 and his general health was assessed as *"satisfactory"*. His hospital medical entry records:

"mixed overdose 60 x 0.5mg Clonazepam, He was retained in the hospital overnight for observations. 10 x 10mg (1 sheet and 2 tablets) Amitriptyline, 7 x 20mg Cipralex taken at 11am/11.30am. Taken in protest to being taken off other medications (Tramadol, Omeparazole, Temazepam). Patient says feeling ok apart from very dry mouth/blurry vision. Speech starting to slur. Becoming increasingly drowsy."

Alan remained in hospital overnight.

On 6 January 2008, Alan was examined by a duty senior house officer of psychiatry. An extract of the notes from the psychiatrist's consultation reads:

"Alan said his medications have gradually been withdrawn over the past month.....when he realised that another one of his tablets had been withdrawn he decided to take an overdose as a reaction to this. He did not intend to end his life but "to make screws pay attention".....

Mental State Examination:
Objectively and subjectively he was euthymic. He rated his mood as 6/10. His appetite is good and there is no diurnal mood variation. His sleep can be disturbed by nightmares but this is longstanding. He has no suicidal thoughts or plans. He said he

can be helped by Temazepam at night but this has been taken away from him and he is greatly annoyed by this. He has no obsessional or delusional thoughts or perceptual disturbance and his cognition was intact. In terms of insight he told me he was not depressed and did not intend to kill himself, he just wanted his usual tablets. My impression was that this was an impulsive act of self-harm, he has no clear mental illness and there was no suicidal intent. My plan was to discharge him and I would recommend that his tablets are dispensed on a daily basis and taken in front of prison staff. I would recommend that his Temazepam is recommenced at night and that the duty prison doctor reassess his need for Tramadol and Omeparazole. This gentleman can be referred in future if need be."

5a. A specialist at Belfast City Hospital formed the view that Alan's overdose on 5 January 2008 was an impulsive act of self-harm and that there was no suicidal intent.

5b. The specialist recommended that Alan's tablets should be dispensed daily and taken in front of prison staff.

5c. The specialist also recommended that Temazepam be given at night and the need for two other medicines should be reassessed.

6. Alan's Discharge from Hospital to Maghaberry – 6 January 2008

Alan was discharged back to Maghaberry Prison on the afternoon of 6 January 2008 and was re-located back to his cell in Roe House.

An accompanied handwritten note from the Belfast City Hospital was headed: "*Belfast City Hospital Pharmacy Coding and Discharge Form.*" The note reads as follows: *"No change to regular meds.....Ensure Temazepam given at night....Your patient was admitted with an Amitriptyline overdose. He was treated conservatively and observed overnight. He was reviewed by psychiatry who felt there was no suicidal intent. They recommend that Temazepam should be given at night as the patient felt he was not getting enough medications. Please review his medications."*

The recommendation recorded on the hospital consultation notes that Alan should be prescribed his medication daily and that it should be taken in front of prison staff, was not included in the handwritten note. It was notified later in a typed letter, received on 16 January 2008.

On his return to Maghaberry Alan was not seen by a prison doctor. Alan was not, however, for a period of time allowed to self administer his medicines. His medicine records show that he was supervised swallowing his medicines from the 8 January to 15 January 2008. He was then given his medicines on a daily basis until 31 January 2008, the date of his death.

Dr Neil Lloyd-Jones, the clinical reviewer, commenting on the action taken when Alan returned to prison from Belfast City Hospital on 6 January 2008, said:

"Following Alan's discharge back to the prison, I feel it would have been common and acceptable medical practice for the duty medical officer [prison doctor] to have been informed of his return and for him to have then seen Alan to discuss his recent admission – basically what had happened, how it had happened and to deal with the care issue as to why he took the impulsive overdose i.e. the change in his prescribed medication."

When asked, the healthcare management team said: *"As in all cases, and exactly the same as happens in the community, if any person is discharged from outside hospital, they are generally deemed well enough to care for themselves and go back to normal accommodation, like their own home. The same goes for prisoners in that when they are discharged to return back to prison, i.e. their residential house and cell. There is no requirement for a member of the healthcare team to see the prisoner on their return, unless a specific instruction from the outside hospital would say so."*

In respect of the senior house officer psychiatrist's recommendation to the prison to re-commence Alan on Temazepam, it was Dr Lloyd-Jones opinion that if the recommendations of the duty psychiatrist were not implemented, there should have been a record of the specific criteria from the duty medical officer to justify not implementing the advice.

In response to this concern, the healthcare management team made the following points:

- *"It is unclear from the recommendation made by the senior house officer in psychiatry whether or not this recommendation was purely based on the fact Alan Ruddy wanted to be on Temazepam or whether there was a full clinical assessment made."*

- *"There is too much weight being placed on the recommendations by the senior house officer in psychiatry in Belfast City Hospital when it is not known whether she was acting on the request by Alan Ruddy that he wanted to be on Temazepam or whether this was a clinical based judgement."*

My investigator wrote to the senior house officer psychiatrist asking for further information about her decision to recommend Alan commence Temazepam.

The psychiatrist made, inter alia, the following comment:

"Mr Ruddy had explained that he suffered long term sleep disturbance and thus I felt that the use of Temazepam at night was appropriate to aid sleep but again this was to be given daily."

6a. Alan was discharged from hospital with a handwritten note recommending a review of his medication and that Temazepam should be given at night.

6b. Alan was not seen by a prison doctor on his return to Maghaberry and no action was taken to review his medication.

6c. As a result of his overdose Alan was supervised swallowing his medicines between 8 January and 15 January. He was then given his medicines on a daily basis.

7. Alan's Healthcare after returning to Prison

Alan was re-located back to Roe House when he returned from Belfast City Hospital at 15.00 on 6 January 2008.

Opening PAR 1: 6 January 2008

Alan's mother asked why, as Alan had taken an overdose, he was not taken into the prison hospital to keep him safe.

When Alan returned to Roe House a Prisoner at Risk (PAR 1) Booklet was initiated by landing staff. It was signed by an officer at 15.55.

A PAR 1 Booklet is an observation booklet which is opened when a need is identified for closer observation of a prisoner, for his own protection and safety. Following the opening of a PAR 1, a multi-disciplinary team decides the frequency of observation to be carried out. The default position is the requirement for a recorded observation every hour.

At interview, the prison officers involved in opening the PAR 1 for Alan said that this was a precautionary measure following his recent overdose.

There was, however, no medical or psychiatric input into decisions about how Alan should be managed.

The Period of the PAR 1: 6 - 8 January 2008

The PAR 1 opened for Alan required hourly observations to be carried out. The PAR 1 remained opened for 3 days from 15.55 on 6 January 2008 until 16.00 on 8 January 2008.

The hourly entries in Alan's daily log, recorded as part of the PAR 1 process, were largely uneventful, recording things such as *"watching TV", "appears asleep"* and *"lying on bed awake".*

It is noted, however, that on 7 January 2008, Alan raised three complaints through the prison's internal complaint process.

The first complaint related to an alleged incident on 4 January 2008. Alan said he had been slapped on the back of his head by an officer. Following this complaint being made, a senior officer asked for Alan to be seen by a nurse. A nurse examined Alan on 7 January 2008 and wrote up an injury assessment form saying *"there were no marks or injuries noted."*

The second complaint Alan made that day related to the fact that he was not happy that he had not been prescribed Temazepam by the prison doctors.

The third complaint was in connection with the prison not notifying Alan's next of kin when he was admitted to outside hospital on 5 January 2008 following his overdose.

These complaints are discussed later in this report.

Closing the PAR 1: 8 January 2008

At 15.45 on 8 January 2008, a health care assessment was completed by a nurse. This assessment led to the closure of Alan's PAR 1 at 16.00.

The entry on the PAR 1 by the nurse reads:

"Claims he took a weeks supply of his Amitriptyline and Clonazepam on Saturday because he wasn't getting what he felt was the correct medication i.e. Temazepam. States he has no thoughts of life not worth living. Supervise administration of medication. PAR 1 can be closed as this prisoner was manipulating to get medication."

A case conference was held at the same time between the nurse, a senior officer and a prison officer.

A further entry made on the PAR 1 by the nurse recording the case conference outcome reads:

"After the weekend's episode it was concluded that Alan Ruddy was attempting to manipulate health care staff in order to get medication. It was explained to him that his medication was not available in this prison. He was basically trying to cause inconvenience. If he had taken anything like the amount of tablets he said he had taken then he would have been at least a bit unwell. In light of this there is no need to keep the PAR 1 open as the prisoner has admitted to this…."

The senior officer said, at interview, that Alan had told the nurse that he had taken the overdose because he was refused his usual medication, Temazepam. He explained that they all agreed to close Alan's PAR 1 because he admitted this and the strategy was that he would take his medication under supervision, to prevent him from getting into a position where he could build up a stock of medication.

Alan was taken off the PAR 1 at 16.00 and remained in his cell in Roe House.

Commenting on the use of the word *"manipulative"* in the PAR 1 notes, the healthcare management team explained:

"*In respect of Alan Ruddy's PAR 1, the use of the term "manipulative" used in the notes when closing his PAR 1 is a common phrase used in the practise of describing someone who did something for their own personal gain. It is text book terminology commonly used in medical language to assess a particular situation."*

Dr Lloyd-Jones, the clinical reviewer, commenting on the closure of the PAR 1 process, said that:

"the experience/qualifications (psychiatric wise) of the person who stops the level of supervision (following the implementation of a PAR 1 process) must be considered on a sliding scale basis. In simple lay terms there is no harm in being overcautious and implementing care management. However, de-implementation can, in some cases, be problematic."

PAR 1 Policy

The PAR 1 policy is derived from the Prison Service's Self-Harm and Suicide Prevention Policy. It states that those attending a case conference should include the originator of the form, his/her manager, the Residential Governor, a member of healthcare staff, representatives from probation and psychology, and, where appropriate, the prisoner involved and others as required such as a chaplain and a psychiatrist.

The limited attendance at the case conference at which the decision was taken to close Alan's PAR 1 did, therefore, not fully comply with the requirements of the Prison Service's policy, written to minimise risk. This does not mean that, if more specialist input had been available, the decision or any care plan would necessarily have been different.

The prison healthcare management team, when asked about the policy in relation to who attends PAR 1 case conferences and makes the decision to close a PAR 1, said that PAR 1 opening and closure meetings are facilitated and convened by the residential house manager, usually a principal officer, and it is their responsibility as to who sits in on the multi-disciplinary case conferences for PAR 1 closure. However, it is normally an officer from the prisoners landing who knows the prisoner, the house manager and a nurse, who is usually the regular nurse who attends the house.

They also said that opening and closing a PAR 1 is a joint multi-disciplinary decision, which does not rest solely on the healthcare team. Closing a PAR 1, they said, is the

responsibility of all attending the case conference and any decision taken to move towards closure would always err on the side of caution due to the implications of taking someone off a PAR 1 too quickly.

7a. Alan was put on a PAR 1 at 15.55 on 6 January 2008 as a precaution.

7b. The PAR 1 was closed at 16.00 on 8 January 2008, three days later, following a case conference attended by a nurse, a senior officer and an officer.

It is noted that the Prison Service is in the process of introducing a new process for the management of vulnerable prisoners requiring more frequent observation. The new process which is called Supporting Prisoners at Risk (SPAR) replaces the PAR process.

8. Events between 8 January - 30 January 2008

8 January 2008 up to 30 January 2008, the day before Alan died, were largely uneventful. Alan's landing reports record that he *"had settled into the wing routine and was causing no problems".*

On 10 January 2008, Alan was re-located, due to normal operational moves, to Bann House (Cell 16 Landing 3) to share a cell with another prisoner.

It is recorded that Alan made a further complaint on 10 January 2008 about a visit he had attended on 8 January 2008. The visit was terminated by prison staff as they suspected that unauthorised items had been passed over to him. This complaint is examined later in the report.

Alan had further visits on 15, 26 and 29 January 2008, which took place without incident.

The only healthcare intervention during this period was on 23 January 2008, when Alan consulted with a prison doctor with regard to back pain and was prescribed Tramadol. It was following this consultation that Alan's medical notes were requested from his GP.

8a. 8 January to 30 January 2008 were uneventful for Alan.

8b. Alan had a visit terminated on 8 January 2008 because prison staff suspected that unauthorised items had been passed over to him.

8c. On 23 January 2008 Alan was prescribed Tramadol for back pain.

SECTION 2: EVENTS ON 30/31 JANUARY 2008

9. The Evening of 30 January 2008

The prisoner who shared Alan's cell (Cell 16 Landing 3) recalled at interview the events of 30 January 2008, the day before Alan died.

He explained that, after lock-up time at 19.30, both of them watched TV in their double cell and drank tea for a while before playing cards.

He said that at about 21.00, Alan produced *"from his jeans pocket, a lump of toilet roll, inside which he had about 8 – 10 small, grey, round tablets."* He explained that Alan offered him one tablet which he took and added that "*Alan was always popping drugs, prescription or illegal."*

He observed Alan taking eight or nine tablets before falling asleep on the chair around 22.30. Alan was asleep and snoring, with his head back. Between 23.00 to 23.30 he tried to raise Alan but he still *"appeared stoned"* so he lifted him onto the bottom bunk bed.

Alan's cell mate said that he took the single tablet that Alan had given him around midnight and eventually became *"quite drowsy"* himself. He then got into the top bunk bed and watched TV, until he turned it off between 00.30 – 01.00. He remembers Alan was still snoring when he fell asleep.

In line with Prison Service policy prisoners are checked at regular intervals throughout the night. Head count checks are carried out by looking through the flap on each cell door on five occasions throughout the night period. These checks are the responsibility of the night custody officers. The intention of the checks is to confirm that the prisoners are in their cells and that there are no visible concerns for their wellbeing or safety.

The night custody officer who carried out the checks on Alan's cell on the night of 30 January and morning of 31 January 2008 said at interview that checks were carried out at 20.15, 22.20, 01.30 and 05.30. The final check, before unlock, was carried out at 07.15. These checks are recorded in the class officer's evening/night journal.

Alan's cell mate said that, on the morning of 31 January 2008, their cell door was opened at around 08.40 and he got up and made himself a cup of tea. Alan was still sleeping and snoring. An officer left a carton of milk to their cell as normal. Alan's cell mate appears to have cleaned his cell as part of his normal routine. On the evening of Alan's death he told a chaplain that he had cleaned the cell and gone about his business quietly.

Alan's cell mate then left the cell to go to another landing in the house to see a relative. Alan's cell mate said that he did not suspect anything was wrong at that point.

After seeing his relative on another landing, he returned to the cell 10-15 minutes later. Alan's cell mate said that he recalled that Alan was "*very pale, hardly breathing.*" He said he tried to check Alan's pulse and when there was no sign of life he went

into the corridor to call for help. An officer heard him and raised the alarm.

Two officers quickly ran to the cell after they heard Alan's cell mate shout *"you better look at this boy".* This was at 09.05.

Both officers entered Alan's cell and they said, at interview, that they saw Alan "*lying on the bottom bunk with the sheets down.*" One officer approached Alan, sat on the end of the bed and checked for signs of life, whilst the other officer left the cell and sounded the alarm.

Some moments later, a nurse who was on duty in Bann House medical room, arrived at the scene. She later made a note about the incident saying that when she checked Alan, there were *"no signs of life, his pupils were fixed and dilated, no breathing or pulses, hands and face cold and grey in colour, mottling on right side of abdomen".* She added that because of his condition, no medical intervention was carried out.

The prison doctor arrived at the scene and pronounced Alan dead at 09.22.

Alan's mother was concerned that Alan had been observed snoring by his cell mate and by a prison officer who was carrying out early morning cell checks, yet approximately one hour later Alan was found dead. She asked whether the prison officer had made actual contact with Alan when he carried out the check.

The night custody officer who checked Alan's cell at 07.15 on the morning of 31 January 2008 said, at interview:

"On the morning of Thursday 31 January when I checked the cell I opened the flap and knocked the door. There was no movement of either Alan Ruddy or his cellmate. Second time I hit it I'm almost certain the person in the bottom bunk moved and gave a body reaction. I had to tap the door again and the person in the top bunk moved and gave a body reaction. Neither gave any verbal indication but both definitely made body movements. This was the same as usual. They gave no problems during the night. They were just the only ones who were very hard to wake each morning. After we did our checks we did the handover with the day staff."

The night custody officer also said:

"I had one other occasion when I did a check on Cell 16 and prisoner Alan Ruddy wasn't moving at all after a good 5 minutes. This was on Saturday 26 January 2008 about 07.15. I lifted the flap up, finished the landing which was only a couple more cells, then went back to the cell with another officer who was on duty. We literally tried to kick the door to get him to respond and he still didn't. I went back to the class office and phoned our senior officer, told her and exactly at the same time I heard the day staff come on. She was going to come round but we decided to ask the day staff. One officer came round and said "It's not them again" and kicked the door once and then Alan Ruddy responded."

As stated, Alan's cell mate said that Alan was snoring when the cell door was opened at around 08.40.

Alan's mother was also concerned because she said she had been told by the chaplain that Alan's cell mate had cleaned the cell floor on the morning of Alan's death and she wondered if Alan had been sick.

There was no evidence that Alan had been sick that morning.

In the account given by Alan's cell mate, there is also no evidence to suggest that, unlike previously, Alan intended to take an overdose of medication.

9a. Alan spent the evening of 30 January 2008 drinking tea, playing cards and watching TV with the prisoner with whom he shared a cell.

9b. Alan's cell mate says that between 20.00 and 21.00 Alan took eight or nine small grey tablets.

9c. Alan's cell mate reported that Alan *"was always popping drugs, prescription or illegal."*

9d. Alan went to sleep after taking the tablets and appears to have continued sleeping until he died the next morning.

10. Post Mortem Report

A post mortem examination, carried out on 1 February 2008, gave the cause of Alan's death as:

1 (a) Aspiration pneumonia
due to effects of
(b) morphine, diazepam and amitriptyline.

The metabolite of one of the active constituents of cannabis was also detected, indicating usage in the days prior to death. It could not be stated with certainty, however, that he was under the influence of this when he died.

Dr Lloyd-Jones said in his Clinical Review that after comparing the drugs found in Alan's body at post mortem with those that had been prescribed therapeutically, he concluded that, beyond reasonable doubt, Alan was taking illicit drugs.

Alan's family were concerned that the absence of Clonazepam in the toxicology results of the post mortem meant that he was not given this medication for his epilepsy.

In responding to this concern, the attention of Alan's family was drawn to the fact that it is recorded on his medicine administration chart that on the morning of 30 January 2008, along with his other medications, Alan was given his two Clonazepam tablets. Alan should have been taking this medication twice daily, morning and evening, but as he was no longer being supervised when taking his medication, it is unknown whether he took his tablets when they were given to him. It is possible that Alan may have saved the tablets or given

them to another prisoner. However, as Clonazepam has a half life of 18 to 20 hours, it is also possible that Alan may have taken both tablets in the morning and they could still not be evident when the test was performed.

The family were also concerned to know how, if Alan had taken eight or nine tablets the night before he died, the drugs found in his system were shown to be at a therapeutic level.

In considering this concern, the clinical reviewer, Dr Lloyd-Jones advised that without knowing what tablets Alan is alleged to have taken, it would not be possible to answer this question. Different substances remain in the blood for different periods of time. It is also the case that the strengths of the tablets were unknown.

He further explained that it was without doubt the combination of the therapeutic levels of morphine, diazepam and amitriptyline found in Alan's system which caused his central nervous system to depress to such an extent that he did not wake up when he inhaled gastric contents into his lungs.

In relation to 'therapeutic levels', Dr Lloyd-Jones provided the example that if someone was prescribed morphine at therapeutic levels and they had one alcoholic drink, in some cases it could be enough to depress the person's central nervous system to the same extent. In other words, it is the "cocktail" of drugs that is significant.

SECTION 3: EVENTS AFTER ALAN'S DEATH

11. Death in Custody Contingency

As part of my investigation I examined all the policies and guidance relating to procedures to be adhered to following a death in custody, including 'Contingency Plans 45 and 46 – Death of a Prisoner'.

These documents provide guidance to the Emergency Control Room on the actions to take immediately following a death in custody and clearly detail the roles and responsibilities of all members of staff upon notification of a possible death.

From the information gathered as part of this investigation it is evident that the Duty Governor and two other Governors, following Alan's death on 31 January 2008, adhered to all the necessary procedures in dealing with the incident.

11a. The procedures specified in Prison Service policy were implemented following Alan's death.

12. Preservation of Evidence

When any prisoner dies it is important that the Prison Service takes all necessary steps to ensure the preservation of a scene and evidence. Governors Order 3-12 sets out what procedures should be followed in the event of such an emergency.

From examination of events following the alarm being raised and consultation with the PSNI, it is clear that prison and healthcare staff carried out their duties in line with Prison Service policy and procedures.

12a. Prison Service policy and procedures for managing the scene of an incident were adhered to.

13. De-Brief Meetings

The Prison Service's Revised Self Harm and Suicide Prevention Policy issued in September 2006 states:

"A Hot De-Brief meeting is vital following the death of a prisoner as it enables all who took part to comment, while it is fresh in their minds, in respect of what went right or what could have been done better. Hot De-Brief meetings make a positive contribution to the implementation of better practice locally, and sometimes, across the Prison Service. It also gives staff the opportunity to discuss their feeling and reactions and calm down or seek help before going home."

The Duty Governor and two other Governors held an immediate hot de-brief meeting following Alan's death. It was not a requirement of Prison Service policy at the time that the de-brief be recorded.

Page 20 of the Addendum to the September 2006 Self Harm and Suicide Prevention Policy issued in January 2009 now states that *"a brief note should be taken of those attending, and matters raised."* This amendment resulted from a recommendation following earlier death in custody investigations.

Section 6.11 of the Self Harm and Suicide Prevention Policy requires that *"a more comprehensive [cold] de-brief should take place within 14 days*". There is no evidence that this cold de-brief took place.

13a. In line with the Prison Service policy in place at that time, the Duty Governor and two other Governors carried out a verbal hot de-brief immediately following the incident of Alan's death.

13b. There is no evidence that a more comprehensive cold debrief, as required by Prison Service Policy, took place within 14 days of Alan's death.

14. Drugs Amnesty

Prison records show that at 16.48 on 31 January 2008, the same day that Alan died, another prisoner, who was also located in Bann House, was taken by emergency ambulance to Lagan Valley Hospital suffering from a drugs overdose. He was returned to the prison later that evening at 19.52, after assessment and treatment.

My investigation team offered the prisoner the opportunity to meet in order that he may provide any information which may have been relevant to the circumstances around Alan's death. He did not wish to be interviewed.

Following receipt of information on 31 January 2008, about 'bad drugs' being circulated within Maghaberry Prison, the Governing Governor issued a Notice to Prisoners at 10.16 on 1 February 2008, to be displayed on the landings across the prison.

The Notice to Prisoners stated:

"Prison authorities here at Maghaberry have received information that a 'bad batch' of drugs is being used by prisoners within Maghaberry at the present time. We are concerned in relation to the severe consequences (serious injury or death) that may potentially occur from this usage. Any prisoners engaging in this activity are urged to stop and consider the outcome of their actions. To help in this instance the Governor has granted an amnesty for a period of 48 hours, effective immediately. During this time prisoners may hand over any drugs to members of staff

without fear of disciplinary action. This amnesty will cease at 17.00hrs on Saturday 2 February 2008. Signed – Governor Maghaberry Prison."

No drugs were handed in as a result of the amnesty notice.

14a. Another prisoner was taken to hospital as a result of a drugs overdose, on the day that Alan died.

14b. Management at Maghaberry Prison had reason to believe that "bad drugs" were being passed around the prison. A notice was issued on 1 February 2008 warning prisoners not to take drugs and a 48 hour amnesty was implemented to encourage prisoners to hand in drugs.

14c. No drugs were handed in as a result of the amnesty.

15. Internal Investigation of Alan's Overdose on 5 January 2008

Section 7.5 of the Self-Harm and Suicide Prevention Policy, revised September 2006, states that:

"formal investigations should be conducted into incidents of serious self-harm to establish what, if anything, the prison can do to prevent a recurrence. Self-Harm/Attempted Suicide Summary Forms must be countersigned by a Governor grade who will be responsible for determining and recording whether a formal investigation is required."

An internal investigation might have considered:

- Issues related to the availability of drugs in Bann House.
- Issues related to the way in which Alan was accessing drugs.
- Issues related to the provision and arrangements for accessing support services for prisoners known to abuse drugs.
- Issues related to the Prison service response to Alan's previous psychiatric history.

15a. There is no evidence that any formal investigation was considered or conducted following Alan's drugs overdose on 5 January 2008.

SECTION 4: OTHER ISSUES

16. Alan's Access to Drugs

Telephone calls made by prisoners are recorded routinely. A random sample is monitored by the Prison Service and other calls are monitored where there is information or intelligence to suggest that this is necessary.

Both prisoners, and those to whom they make the calls, are aware of these procedures.

The investigation team listened to the telephone calls made by Alan over the period 24 – 30 January 2008.

There is evidence in the phone calls to suggest that Alan may have been having money transferred into the accounts of other prisoners, to pay for drugs he was accessing in prison. A number of requests are made for money to be transferred and it is confirmed a number of times that money has been paid in as requested. The prisoner account numbers are supplied. No reason for the transfer of the money is ever given.

On another occasion Alan asks the person he has called for £50 to be brought in for him, which the person agrees to. Alan then asks for a further £50 and when asked what it is for, Alan responds *"what do you think."* The person then tells Alan that they wouldn't be able to get the £50 in.

There is evidence also of people Alan speaks to, resisting his requests for money to be brought into prison or paid into other prisoners accounts.

It is recorded on 8 January 2008, that prison staff in the visits area suspected unauthorised items were being passed to Alan at a visit. This led to his visit being terminated. Alan subsequently made a complaint about the termination of his visit.

Evidence in prison records also shows that people Alan telephoned had, around the time that the calls were made, deposited money into other prisoners' accounts.

As part of this investigation the content of a phone call made by a prisoner, into whose account Alan was arranging for money to be paid, was considered. There is evidence in this call that, in the days before Alan's death, this prisoner was arranging for drugs to be brought into prison. These may or may not have subsequently been supplied to Alan.

There is also evidence, supplied on a confidential basis, that following Alan's death, a member of healthcare staff notified their concern to the Security Department about illegal drugs which they said appeared to be available in Bann House. The person referred specifically to information provided by a prisoner.

17. Complaints made by Alan using the Internal Complaint Process

Alan raised four complaints through the Prison Service's internal complaint process, three on 7 January 2008 and a further one on 10 January 2008.

First Complaint

On 7 January 2008, Alan made a complaint that on 4 January 2008 he had been slapped on the back of his head by an officer. It is not clear why Alan waited until 7 January 2008 to report this incident.

Alan's mother was concerned that this complaint had been ignored. She stated that Alan's arm had been *"black and blue"* during a visit she made to Alan on 8 January 2008 and that Alan had mentioned to her that an officer had *"slapped him"*.

Alan's complaint reads: *"On the 4 January 2008 an officer hit me a slap on the back of the head. I do not know his name or number. It's about two and a half months that I had a scan of my cervical spine for epilepsy, is it normal for an officer to slap or hit a prisoner?"*

On the day that Alan made this complaint, a senior officer asked for Alan to be seen by a nurse. A nurse examined Alan and wrote up an injury assessment form saying *"there were no marks or injuries noted."*

When interviewed, the nurse, who completed the injury report, confirmed that she was asked to see Alan and assess him.

The nurse explained that she completed an IMR 12 [injury report] stating that Alan had told her *"he had been hit or slapped on the back of the head by an officer on 4 January".* The nurse said it was not unusual to record no marks or injuries because lots of prisoners tended to delay reporting alleged assaults. In Alan's case, there was a three day delay.

She pointed out that Alan was seen on 5 January 2008 by another nurse after he was reported to have taken an overdose and he was also seen in Belfast City Hospital by doctors on 5 and 6 January 2008 and at no time did he mention the assault. He also declined to mention to her on 7 January 2008 any more detail about the incident or to make his own statement.

She added that the EMIS medical record entry for 7 January 2008 in Alan's medical records noted the fact that Alan was unhappy about not getting Temazepam.

The nurse said that she allowed him to "*ventilate*" about that issue but explained to him that it was prison medication policy. The nurse also explained that as Alan had reported an assault, he was to be seen that day by the Duty Governor.

The senior officer who had referred Alan to the nurse responded to him on 7 January 2008 in respect of Stage One of his complaint, saying:

"This has been referred to the Duty Governor who has subsequently interviewed the prisoner. This allegation is now

being dealt with by PSNI at the prisoner's request. The prison is unable, therefore, to progress this complaint until the police have concluded their investigation".

The nurse, who had attended to Alan on 5 January 2008, was asked if he had mentioned any assault on 4 January 2008 when he reported taking the drugs overdose. The nurse said that if Alan had told her anything about this incident she would have recorded it. [As noted below, it subsequently became evident that the allegation of assault related to 5 January 2008, not 4 January 2008.]

The papers in respect of the PSNI investigation into Alan's complaint were reviewed.

A summary of the incident in the PSNI papers states, that on 5 January 2008 at approximately 11.00, Alan alleged that he was the subject of common assault. The outline of the case states that Alan had taken an overdose that morning and an ambulance had been called to take him to Belfast City Hospital. Prior to the ambulance arriving, Alan alleged that an officer punched him in the arm and slapped him on the back of the head. The papers record that the officer was interviewed by police and had denied the assault.

The papers also record that *"no prosecution is recommended due to the lack of any independent evidence and there was no CCTV or witnesses to the allegation."*

It would appear that Alan had mixed up the date that he was alleging the assault took place. In his internal complaint, Alan

said that it happened on 4 January 2008, however, all the police statements and circumstances described relate to events of 5 January 2008.

A statement made by Alan to the PSNI, dated 16 January 2008, reads:

"On Saturday 5 January 2008 at approximately 11am two prison officers entered my cell, which is Cell 6 Landing 2 Roe House. An officer instructed me to put out my cigarette. I informed him that I didn't have an ashtray. This officer immediately struck out at me with a closed fist and struck my right lower arm. He then knocked the cigarette out of my hand onto the floor. The officer then informed me that I was going into the cell across the landing. The officer told me to walk over to the cell and I did this by walking with the officers behind me. I entered the cell and it was empty except for a bed, TV and chair. I turned the TV on and watched the darts. The cell door had been closed and locked once I entered it. The officer was banging on my locked cell door. I believe he was trying to get me started. A short time later the cell door opened and two ambulance crew members were standing there and the officer was behind them. The officer told the ambulance crew that he would walk me down, and for them to go on. At this time he was inside my cell and the next thing, after the ambulance crew had left, he lifted his hand and slapped me on the back of my head and said "get out of the cell." The officer and another officer I did not know escorted me to the ambulance and then left. I do not know why the officer assaulted me. For your information an ambulance was called for me because I had taken an overdose of approximately 60 prescribed tablets. I was taken to Belfast City Hospital for treatment and stayed in hospital two

nights. I wish to make a formal complaint against the officer. The second officer did not assault me at any time."

A question and answer statement, dated 14 April 2008, in the PSNI papers records an interview with the officer who Alan alleged assaulted him.

It states: *"Q - Alan Ruddy alleges that on 5 January 2008 at approximately 11am that you instructed him to put out his cigarette, prisoner Ruddy states that he replied "I don't have an ashtray". He alleges that you immediately struck him with a closed fist on the lower right arm. Prisoner Ruddy also alleges that you slapped him on the back of his head while he was in the cell waiting to go to the ambulance. Did you assault prisoner Ruddy as he alleged?"*

The officer's response reads: *"A - On the date in question Prisoner Ruddy was suspected of having taken an overdose of prescribed tablets and an ambulance was tasked to the jail. I escorted him to the ambulance. At no time did I assault prisoner Ruddy. My dealings with him at all times were professional. Prisoner Ruddy was detained at Belfast City Hospital for two days due to having taken an overdose of prescribed drugs. I can only suggest that on this date and time the substantial overdose of tablets had affected his mind."*

As the PSNI did not interview the second officer and members of the ambulance crew, it is not possible to determine which elements of the accounts offered could have been corroborated.

Second Complaint

Alan's second complaint, made on 7 January 2008, related to the fact he was not happy that he had not been prescribed Temazepam by the prison doctors. His complaint reads:

"I came into prison on 30 November 2007, seen the doctor on that day for all of 5-10 minutes, since that he has taken me off my tablets. I even came in with my own tablets. The doctor does not know my medical history, so why? All I want is my medication."

A nurse answered Alan's complaint at Stage One saying:

"The doctor prescribed your medication according to your clinical need and in line with NIPS guidelines."

Alan did not pursue this complaint to the next stage of the Prison Service's internal complaint process.

Third Complaint

The third complaint concerned the reason why the prison had not notified Alan's next of kin when he was admitted to outside hospital on 5 January 2008 following an overdose.

Alan said in his complaint: *"On 4 January (sic) I was took to Belfast City Hospital and got discharged on 6 January – no-one informed my next of kin – why?. What is the policy when someone goes to hospital – the thing is to phone the next of kin is it not?"*

A senior officer responded to Alan at Stage One saying: *"If you were to be kept in hospital for any length of time or your life was in immediate danger then your next of kin would be informed at the most prudent time. Someone took the decision not to inform them."*

Alan did not pursue this complaint to the next stage of the Prison Service's internal complaint process.

Fourth Complaint

Alan's fourth complaint, made on 10 January 2008, was about a visit he had on 8 January 2008. The visit was terminated by prison staff as they suspected that unauthorised articles had been passed over to him.

At Stage One of the complaint, Alan said that he had a visit on 8 January 2008 *"for all of 10 minutes"* and that a few officers came to his table and said that his visit was terminated. Alan

said that he was not given a proper reason and that when he was talking to his visitors on the phone they told him that they were locked in a room. Alan said he *"would like the prison to keep a recording of the visit for his solicitor and a reason why it happened."*

A senior officer from the visits area responded to Alan at Stage One, saying:

"Officers observing the visits area suspected that your visitors had passed unauthorised articles to you. It is procedure to terminate a visit when this happens and a return search is carried out on the prisoner. Visitors are held in a room until this happens. This is the procedure and all staff must adhere to this. All visitors whether domestic or legal are subjected to the same procedures. All visits are recorded and access to these records would have to be requested through the appropriate channels. However as you have now received an explanation you can appreciate why this happened."

Alan did not pursue this complaint to the next stage of the Prison Service's internal complaint process.

18. Other Concerns Raised by Alan's Family

Alan's Transfer to Outside Hospital

Alan's mother was concerned that she was not informed by the Prison Service that Alan had been admitted to an outside hospital on 5 January 2008 and remained there for two nights because he had taken a drugs overdose.

The healthcare management team at Maghaberry were asked what the practice was at that time, when a prisoner is admitted to an outside hospital, in respect of notifying next of kin.

They explained that when a prisoner is admitted to outside hospital, officers are designated to provide continuous supervision at the hospital and feedback to the prison as to whether a prisoner's condition is improving or deteriorating. Based on the information provided, prison management then make a decision as to whether or not to contact next of kin.

In Alan's case it was not deemed necessary to contact his family.

Notification of Next of Kin when a Prisoner is in Outside Hospital – Previous Recommendation

As a result of other complaints arising since Alan's death in connection with families not being notified of serious illness or the hospitalisation of a prisoner, I made the following recommendation to the Prison Service in March 2009:

"I recommend that the Northern Ireland Prison Service ensures that all reasonable steps are taken to notify the next of kin of a prisoner as soon as practicable in all cases of serious

injury/illness or removal to hospital. This should include situations involving a serious life threatening attempt at self harm or suicide. In circumstances where a prisoner states that they do not wish their family to be contacted, or the Prison Service knows that a prisoner has no contact with their family, this should be respected. All associated policies and guidance documentation should be updated to reflect this change in policy".

The Prison Service accepted my recommendation.

18a. The Prison Service did not notify Alan's family that he had been admitted to Belfast City Hospital on 5 January 2008 as a result of a drugs overdose.

18b. In March 2009, the Prison Service accepted a recommendation by the Prisoner Ombudsman that families should be notified in all cases where a prisoner is seriously ill/injured or is taken to hospital.

Notification to Alan's Family of his Death

A member of the prison chaplaincy contacted Alan's family by telephone at approximately 10.30 to advise them of his death.

Alan's mother raised the way in which the family were notified of his death, the fact that notification was by phone and the follow up after the original call.

In response to the family concerns, my investigation team spoke with the prison chaplain who had contacted Alan's family about

the points they made. The Chaplain wrote explaining the action that he had taken. He made the following points:

- *"I was contacted to conduct the 'Last Rites,' these are only administered to a dying person, never to one who is already dead and therefore there was no necessity to approach and anoint the person. Therefore I simply said the prayers for the dead from the corridor with the cell door ajar, and asked an officer to stay to witness that I did not enter the cell."*

- *"I spoke with Alan's cell mate who was deeply shocked and disturbed and described how he had thought Alan was asleep and had left him undisturbed, but had cleaned the cell and gone about his business quietly. He thought he remembered Alan even snoring in the early morning."*

- *"Later on the morning of the death I discussed with a Governor about contacting the family to let them know the tragic news."*

- *"I offered to contact the family and let them know. I believe we discussed how I might best go about this. I thought of driving directly to Newry or telephoning them. After weighing up the pros and cons I decided to telephone the family. I cannot recollect how I obtained the telephone numbers, perhaps from prison records or perhaps the Governor."*

- *"My recollection is that the telephone was answered by either the mother of the deceased or the mother-in-law. I*

think it was the latter and I was momentarily relieved because I felt then there was someone present with Alan's wife. Naturally, in my life as a priest, I have had the onerous task of telling people sad news and though there is no way to soften the loss I spoke as kindly, sensitively and pastorally as I could in this regrettable situation."

- *"I then spoke to Alan's wife in the same manner. The response naturally was again shock and horror only this time accompanied with some hysteria, not surprisingly. I did not go into any details whatsoever and simply said that Alan had died and that it appeared he had done so quietly during his sleep. I had no other details to impart except that I had prayed with him and said the prayers for the dead. The two women were inconsolable of course and the conversation ended quite quickly."*

- *"I offered to be of assistance should they require it and promised to ring later at a better time."*

- *"I do remember only getting through a couple of days later when the phone was answered I think by a sister of the deceased. Again I offered my condolences and sympathy and offered to be of assistance thinking that they might find consolation in my having prayed and seen the remains of the deceased. The telephone call was short and curt, I received an assurance that the family were dealing with the prison authorities."*

Family Liaison

Alan's mother felt that there was a lack of contact with the family after Alan's death, and in particular his mother said:

"That no word had been received from the Police or the Prison Service about Alan's personal belongings."

This issue has arisen a number of times in other deaths which the Prisoner Ombudsman has investigated. In this case, the investigation found there was no family liaison officer appointed by the Prison Service to deal with Alan's family after his death.

Shortly after Alan's mother expressed her concern, the investigation team contacted the Prison Service to make arrangements for her to receive Alan's personal belongings.

19. Drug and Alcohol Rehabilitation Services

Within the Northern Ireland Prison Service Alcohol and Substance Misuse Policy a strong emphasis has been placed on adopting a multi-agency approach to re-educate and provide rehabilitation and treatment for prisoners with addictions, as well as through-care when a prisoner's time is served.

At the time of Alan's death, the addictions counselling services in Maghaberry Prison were provided by Dunlewey. Dunlewey is a community based independent alcohol and drug treatment centre which set up a joint partnership with Maghaberry to provide a range of programmes to work alongside people with alcohol and substance misuse and addiction, to help them achieve a good recovery.

There is no evidence that Alan was offered or accessed any drug counselling services either before or after his drugs overdose on 5 January 2008.

The prison's healthcare management team were asked about the monitoring or assistance programmes in place for prisoners, like Alan, who had a history of drug and alcohol abuse. They made the following points:

- From a clinical point of view a newly committed prisoner would be checked for any symptoms of withdrawal and action would be taken to alleviate any reported symptoms.

- It can be difficult to determine whether a drug is really needed or is being abused.

- There is a community based addiction team, for Maghaberry, who insist on self referrals. This means that healthcare staff cannot refer prisoners directly.

- In respect of the self administering of drugs by prisoners who receive a weekly or monthly supply, a history of drug abuse will not preclude self administration.

19a. Alan was not offered and did not access any addiction counselling services whilst in Maghaberry.

20. Report on Minimising the Supply of Drugs in Northern Ireland Prisons

As a response to concerns about the increase in drug related incidents and evidence of increased misuse of drugs in each of the Northern Ireland prisons, the Prison Service in July 2008, developed a project to research areas of concern.

As a result of the findings of the Project Group, 28 recommendations were produced. These included recommendations relating to:

- Staff Training
- Entry and Exit Points
- Visits
- Searches
- Passive Drugs Dogs
- Use of Intelligence
- Drug Testing
- Search Facilities
- Detection Equipment.

An action plan was produced by the Prison Service in respect of the recommendations made. An audit of the implementation of the plan has not yet taken place.

This Report is referred to in the Recommendations following sub Section 21.

SECTION 5: THE CLINICAL REVIEW

21. Overall Findings and Conclusions of the Clinical Review

Dr Neil Lloyd-Jones, the clinical reviewer whom I commissioned to carry out a clinical review into Alan's healthcare treatment in prison, made the following points in respect of Alan's overall care.

It should be noted that responses to points made in the clinical review received from a prison doctor and from the prison healthcare management team at Maghaberry, have been included at the relevant places throughout this report.

Previous Medical History

Dr Lloyd-Jones summarised Alan's history as follows:

"He was a known epileptic and possibly had periodic back pain. He also had an ongoing psychiatric history in that he had periods of depression. However, he also, at times, threatened to harm himself and/or impulsively take overdoses of paracetamol. Importantly with his psychiatric history at no time did he have the conviction or desire to actually end his life. I would emphasise that the overdoses were very much 'spur of the moment acts' as a reaction to life events. For all of the above medical problems he received a variety of prescribed medication. He was also known to be a heavy drinker and to take illicit drugs."

Initial Medical Screenings

In respect of Alan's initial medical screening by a nurse when he was committed to prison on 30 November 2008, Dr Lloyd-Jones said that it would have been good practice to *"tease out"* his medical history regarding his epilepsy, establishing for example, was his epilepsy normally well controlled or was his epilepsy becoming unstable and if so why?

Dr Lloyd-Jones said that further questioning around this area would then determine further possible management. Therefore, on this aspect, it was his opinion that Alan's standard of medical care had fallen below common and acceptable medical practice.

In respect of the doctor's assessment of Alan on 1 December 2008, Dr Lloyd-Jones said that from the nurse's initial assessment questionnaire and the nature of the drugs that Mr Ruddy was taking, it is quite clear that he had 'some type' of previous/ongoing psychiatric history.

Dr Lloyd-Jones said that faced with this, he feels that it would have been common and acceptable medical practice to have used these facts as a *"launching pad"* to have examined his psychiatric history further and the questions and answers to that may have then determined further management.

Dr Lloyd-Jones also noted that the doctor had requested verification of some of Mr Ruddy's medication and regarded this as good and acceptable medical practice.

However, faced with this type of medical history, Dr Lloyd-Jones feels that it would have been common and acceptable medical practice for the doctor personally or for him to have instructed the nurse to gain a *"very brief 'potted' résumé"* from his general practitioner vis-à-vis his ongoing/previous medical history.

Contact with Alan's General Practitioner

Dr Lloyd-Jones noted that on 24 January 2008, over seven weeks after entering the prison medical service, a request was made to Alan's general practitioner for his previous medical records.

The fact that the request was made, he said, was common and acceptable medical practice, however, in light of the known aspects of Alan's assessment, Dr Lloyd-Jones said that on the balance of probability it is his opinion that the request for his medical records should have been made sooner rather than later.

Admission to Outside Hospital Following Overdose

In respect of the decision by a nurse to request an emergency ambulance after Alan took an overdose on 5 January 2008, Dr Lloyd-Jones said that this was, in his opinion, common and good acceptable medical practice.

Alan's Overdose

In respect of Alan's overdose, Dr Lloyd-Jones concluded that Alan had taken the overdose as a reaction to not receiving all the medication that *"he felt"* he should have had.

Dr Lloyd-Jones said that this was very much in common and followed the 'theme' of Alan's life in general. In Alan's own words, *"he did not intend to end his life, but to make the screws pay attention."*

Medical Intervention when Alan returned from Outside Hospital

Dr Lloyd-Jones commented on the action taken when Alan returned to prison from Belfast City Hospital on 6 January 2008.

He said that following Alan's discharge back to the prison, it would have been common and acceptable medical practice for the duty prison doctor to have been informed of his return and for him to have then seen Alan to discuss his recent admission – basically what had happened, how it had happened and to deal with the care issue as to why he took the impulsive overdose i.e. the change in his prescribed medication.

PAR 1 Process

Commenting on the opening of the PAR 1 after Alan returned from outside hospital, Dr Lloyd-Jones said that the fact that this assessment was initiated did demonstrate good management of Alan's problem, however, he added that

"importantly I note the absence to any reference to his management from the medical and psychiatric teams i.e. they may not have known of the recommendations vis-à-vis his drug management, supervision and use of Temazepam."

Dr Lloyd-Jones made further observations about the de-escalation and closure of the PAR 1 process. He noted that the *"health care assessment"* was done to enable staff to be made aware and manage his problem and that equally the decision to step down the level of supervision was made by the nursing staff/or administrative staff. He said that whilst he would accept that the heightened care can easily be initiated by one of the nursing staff/or prison officer, he puts forward the suggestion that, in some cases, consideration should be given as to the nature of the person who stops it.

He added that each case must be taken on its merits, but he would have thought, and possibly this is/was the case, that the experience/qualifications (psychiatric wise) of the person who stops the level of supervision must be considered on a sliding scale basis. He said *"in simple lay terms there is no harm in being overcautious and implementing care management. However, de-implementation can, in some cases, be problematic."*

Doctor's Consultation on 23 January 2008

Dr Lloyd-Jones commented on the doctor's consultation on 23 January 2008, when Alan was prescribed Tramadol.

He said, as a general practitioner, caution is needed in prescribing this drug for a known epileptic. He said that the

doctor may have exercised that caution but he was not clear as to whether or not the doctor knew/had knowledge of the degree of supervision or not of Alan's other medications.

Dr Lloyd-Jones also added *"be that as it may the level of supervision of Tramadol and some of his other drugs is irrelevant to the final scenario that took place."*

Alan's Death

Commenting on Alan's death, Dr Lloyd-Jones said that after comparing and contrasting the drugs found in Alan's body at post mortem with those that he had been prescribed therapeutically then, he concluded that, beyond reasonable doubt, Alan was taking illicit drugs that he brought in or had smuggled in to the prison for him.

Dr Lloyd-Jones said that he noted Alan had taken an impulsive overdose of prescribed medication on 5 January 2008 and that, in his opinion, this was very much in common and followed the 'theme' of his life in general. Dr Lloyd-Jones concluded that, on 31 January 2008, Alan had died as a consequence of taking a number of drugs some of which had not been prescribed.

Referring to the account, given by Alan's cellmate, of 30 January 2008, Dr Lloyd-Jones noted the reference to the ease with which Alan had in his possession 8-10 tablets and Alan's cell mate's comments that *"Alan was always popping drugs, prescription or illegal."*

Dr Lloyd-Jones concluded his clinical review by saying:

"Importantly I note the absence in the prisoner's account of any apparent anger/rebellion etc on the part of Mr Ruddy towards the prison authority. In other words he had not said that Mr Ruddy had given any indication that he intended to take any medication in overdose form as an impulsive reaction to some other event."

Dr Lloyd-Jones said that it was, therefore, his view in the absence of an up to date psychiatric report that Alan's death *"in lay terms, was not an overdose per sé but rather an accidental death as a result of the side affects of taking a cocktail of drugs."*

RECOMMENDATIONS

I make **nine recommendations** to the Prison Service and its South Eastern Health and Social Care Trust partners. I shall request updates on the implementation of these recommendations in line with the action plan provided by the Prison Service.

Recommendation 1

I recommend that the Prison Service and the South Eastern Health and Social Care Trust (SEHSCT) review the arrangements for contacting prisoners' community General Practitioners. This should include a review of the adequacy of the information requested and timeliness of requests being made in circumstances where prisoners present at committal with medical or mental health problems.

Recommendation 2

I further recommend that the Prison Service and the SEHSCT ensure that it is a specific requirement of every committal review that consideration is given to the need for a further comprehensive healthcare assessment to establish a clinical baseline for healthcare management and that an appropriate plan for any review is put in place.

Recommendation 3

I recommend to the Prison Service and the SEHSCT that, where a prisoner returns from hospital after an incident of

self-harm, he/she should be seen and assessed by the duty doctor as soon as practicable.

Recommendation 4

I recommend that the Prison Service and the SEHSCT review the arrangements for deciding who should be in attendance at a case conference where the option of closing a PAR 1/SPAR booklet is being considered. In particular, the need for a medical and/or psychiatric input should always be considered.

Recommendation 5

I recommend that all senior staff, should be made aware of the need to carry out a more comprehensive cold de-brief, with the staff on duty at the time of a death in custody, within 14 days.

Recommendation 6

I recommend that the Prison Service adheres to Section 7.5 of the Self Harm and Suicide Prevention Policy and ensures that internal investigation is always conducted following an incident of serious self-harm. Where a formal investigation is considered not to be required, the reasons should be recorded.

Recommendation 7

I recommend that the Prison Service appoints a family liaison officer to advise and provide appropriate support for bereaved families following the death of any prisoner in custody.

Recommendation 8

I recommend that the Prison Service comprehensively audits the implementation of the Prison Service Action Plan produced in response to the recommendations of the Report on Minimising the Supply of Drugs in Northern Ireland Prisons July 2008.

Recommendation 9

I recommend that the Prison Service and Trust further review the arrangements for monitoring, supporting and referring to specialist services, prisoners with drug addiction problems.