The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

DAVID O'DRISCOLL
AGED 30

AT MAGHABERRY PRISON

ON 12TH AUGUST 2016

Date finalised: 14th February 2018

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

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GLOSSARY

ASIST	Applied Suicide Intervention Skills Training
CCTV	Close Circuit Television
ECR	Electronic Care Record
EMIS	Egton Medical Information System
FMO	Forensic Medical Officer
GP	General Practitioner
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence (Order) NI
PECCS	Prisoner Escorting and Court Custody Service
PSNI	Police Service of Northern Ireland
PSST	Prisoner Safety & Support Team
PRISM	Prison Record and Inmate System Management
PTSD	Post-Traumatic Stress Disorder
SPAR	Supporting Prisoners At Risk (procedure)
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure

PREFACE

The previous Prisoner Ombudsman, Tom McGonigle, retired from post on 31 August 2017. His successor will be announced following the appointment of a Justice Minister. In the interim, the important work of the Ombudsman's office must continue. Given the commonality of purpose between that office and the Criminal Justice Inspection Northern Ireland, the Department of Justice has asked me to oversee the Ombudsman's office until a successor to Mr McGonigle can be appointed. It is in that capacity that I publish this report.

The investigators of the Office of the Prisoner Ombudsman for Northern Ireland and I are completely independent of the Northern Ireland Prison Service (NIPS). The Terms of Reference for our investigations are available at www.niprisonerombudsman.com/index.php/publications.

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

Objectives

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

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

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. In this case, Ms Victoria Jenkins, a consultant in pharmacology and toxicology undertook a clinical review of the medication management aspects of this case; and Dr Jane Rees conducted a review of the resuscitation attempt. Ms Jenkins has experience of completing clinical reviews for deaths in custody in Northern Ireland and Great Britain and Dr Rees has over 40 years' experience in Primary Care in England, including 11 years working in prisons there.

This report is structured to detail the events leading up to, and the emergency response to Mr O'Driscoll's death on 12th August 2016.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. The Ombudsman first met with Mr O'Driscoll's mother in September 2016 and contact has been maintained with her throughout the investigation.

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

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

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

BRENDAN MCGUIGAN
Office of the Prisoner Ombudsman for Northern Ireland/Chief Inspector, Criminal Justice Inspection Northern Ireland
14th February 2018

SUMMARY

Mr O'Driscoll was 30 years old when he died in his cell in Bann House, Maghaberry Prison, on 12th August 2016, seven hours after arriving in the prison. The post mortem investigation found that he died by hanging.

Mr O'Driscoll had a long history of mental health problems, as well as alcohol and substance abuse. He had been in prison before, and staff were sufficiently concerned about his risk of self-harm or suicide that he was managed as a vulnerable prisoner on three previous occasions.

On the afternoon of the 12th August, Mr O'Driscoll was remanded from Armagh Court to Maghaberry Prison. The Judge asked that he should see a doctor in Maghaberry as he appeared vulnerable. He was assessed by a prison officer and a nurse, though neither found anything of concern in his demeanor. After leaving Reception around 16:00, Mr O'Driscoll was placed in a single cell on Bann House's committal landing.

At 18.25 Mr O'Driscoll phoned his mother's house and spoke with family members. During the call he threatened to kill himself. This prompted his mother to immediately call the prison and alert staff to his threat. Mrs O'Driscoll's call was passed to the Day Manager who, after making enquires of an officer in Bann House, returned her call at 18:44 to reassure her that her son was okay. Unfortunately however Mr O'Driscoll died by hanging less than three hours later.

The Bann House officer knew Mr O'Driscoll from his previous time in Maghaberry and spent some time with him when he arrived on the landing. The feedback that he provided via the Day Manager to Mrs O'Driscoll was based on their interaction and his observation that her son was settling in well and planning ahead. However nobody checked Mr O'Driscoll after his mother's call; and as in previous death in custody cases, this investigation again identified an inadequate handover from NIPS day staff to the night staff. Recording was also inadequate. The upshot was that there was no verbal or written information provided to night staff to alert them of a need to monitor Mr O'Driscoll more closely.

Our clinical reviewer raised potential concerns about Mr O'Driscoll's prescription and the negative impact of missed doses of certain medicines arising from his time in police custody. This investigation is unable to address either of these matters as they did not involve his time in NIPS custody.

Maghaberry's committal nurse identified Mr O'Driscoll required medication and made arrangements for this to be prescribed. Although Mr O'Driscoll had been prescribed a number of medications in police custody prior to his committal to prison custody, the out of hours GP prescribed two medications. The nurse was in Bann House to administer this medication but the medical unlock in Bann House that evening was delayed by 45 minutes

due to an issue elsewhere in the prison. This was not unusual. At the time of his death, Mr O'Driscoll's medication had not been administered.

A separate clinical review of the resuscitation attempt concluded that it was commenced promptly and carried out in as effective and efficient manner as possible.

The Trust's Serious Adverse Incident Report was not available at the time of writing this report.

This report makes eleven recommendations for improvement. All except one recommendation have been accepted by NIPS and the SEHSCT. It is disappointing that a number of the recommendations again relate to aspects of the committal process, staff handovers and record keeping when similar recommendations have previously been accepted. A number of the recommendations have been actioned by NIPS and the Trust. The one recommendation not accepted by NIPS and the SEHSCT relates to access to prisoners to administer medication. Neither NIPS nor the SEHSCT dispute that an issue exists but rather who has lead responsibility for addressing it. It is my view that both organisations need to work collaboratively to address this matter.

RECOMMENDATIONS

NIPS:

1. **Record keeping - PECCS** – The NIPS should ensure processes are in place to effectively record and communicate all relevant information about a prisoner's welfare from PECCS to the receiving prison (Pages 13-14).

2. **Reception procedures -** Reception Officers should be reminded of the necessity of using all available, up to date information when assessing new committals; and of not relying on prisoners' self-report or their prior knowledge of the prisoner (Pages 14-15).

3. **Committal officer training** – The NIPS should ensure that Reception and Committal staff are provided with training specific to their role (Page 18).

4. **Performance Issues** - The NIPS should address any performance issues that arise from this case (Page 20).

5. **Staff handovers** – The NIPS should remind staff that all relevant information relating to a prisoner's welfare should be appropriately recorded in the relevant journals/reports; and that thorough verbal and written handovers must be conducted at the start/end of each shift (Pages 20-22).

6. **Response to calls from concerned relatives** - The NIPS should issue guidance for staff on how to respond to calls from concerned relatives (Page 22). This should include consideration of:
    - The prisoner's custodial history and any recent/previous incidents of self-harm;
    - Listening to a recording of any call made by a prisoner where they have threatened to take their life;
    - Speaking directly to the prisoner ;
    - Consulting with healthcare staff; and
    - Comprehensively documenting and sharing the actions taken by all staff involved to safeguard the prisoner.

7. **Resuscitation** - The prison governor should review the time taken for the ambulance to reach Bann House to determine if the process of an ambulance through the prison can be speeded up (Page 25).

SEHSCT:

8. **First night assessment**: The SEHSCT should review the information committal nurses should access as part of the first night in prison assessment (Page 16).

9. **Resuscitation**: The SEHSCT should ensure that adequate supplies of oxygen are available within each residential treatment room (Page 25).

10. **Resuscitation**: The SEHSCT should ensure that the nurses attending a resuscitation attempt record all events comprehensively (Page 25).

Joint:

11. **Medication administration** - The NIPS and SEHSCT should work collaboratively to ensure a system is in place to facilitate timely access to prisoners to administer medication (Page 27).

MAGHABERRY PRISON

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

It has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners. Mr O'Driscoll was not known to the PSST.

Delivery of healthcare at Maghaberry transferred from the NIPS to the SEHSCT in 2008. Following a period of transition all Healthcare staff had become Trust employees by April 2012. The Trust subsequently increased the numbers of staff and the range of services provided. Healthcare is planned and delivered in line with primary care services in the community.

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

An inspection report on the safety of prisoners in Northern Ireland was jointly published by the Criminal Justice Inspectorate and the Regulation & Quality Improvement Authority in October 2014. While inspectors saw evidence of good work in dealing with vulnerable prisoners, they also said joint NIPS/SEHSCT strategies were urgently needed to revise the Suicide & Self Harm policy and the Substance Misuse policy. The joint strategies were agreed in August 2017 and work to develop implementation plans has commenced.

The subsequent report of an inspection of Maghaberry Prison, published in November 2015, found that aspects of healthcare provision had deteriorated, though a follow-up inspection report that was published in February 2016 found some aspects of primary health care had improved again. A further follow-up inspection was conducted in April 2017 and the findings published in August 2017. Inspectors found that while management were continuing to work to improve the prison's performance, shortcomings were found in the care and support provided to the most vulnerable prisoners. The Chief Inspector highlighted concern that despite the critical reports into deaths in custody and serious self-harm, some important lessons had not been learned.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Their 2015-16 annual report highlighted concerns about healthcare within Maghaberry.

Prisoner Escorting and Court Custody Service (PECCS)

PECCS is the prisoner transport and escorting service. PECCS also has responsibility for the safe operation of the cell holding areas in each courthouse in Northern Ireland.

FINDINGS

SECTION 1: BACKGROUND

David O'Driscoll was remanded into NIPS custody following two periods in police custody between 10th-12th August 2016 on a number of charges including contravention of a non-molestation order, assaulting police and criminal damage.

There were 829 prisoners, 25 prison staff and two nurses on duty in Maghaberry on the night of 12 August 2016. There had been only four committals that day, less than the average. Eighteen vulnerable prisoners were being managed, of whom four were in Bann House and two were accommodated in observation cells in other houses. There were 16 medical unlocks during the night.

Mr O'Driscoll's medical records indicated a history of deliberate self-harm and overdoses. He had been most recently hospitalised in July 2016 but left before treatment concluded. Mr O'Driscoll engaged with various community mental health teams but often missed appointments. Nonetheless it is clear that he received good family support, particularly from his mother, to help him cope with his problems.

Mr O'Driscoll had been in prison on six previous occasions prior to his committal on 12th August 2016. During three previous periods in custody he was placed on the SPAR (Supporting Prisoners at Risk) process, which is designed to support prisoners who are at immediate risk of self-harm or suicide. The last SPAR was opened on 12th April 2016 after Mr O'Driscoll had inflicted superficial cuts to his left arm. It was closed on 29th April when medication issues were resolved. Earlier SPARs had been opened for a number of reasons including when Mr O'Driscoll appeared intoxicated, aggressive and unpredictable, was in withdrawal from alcohol/drug abuse, or was in a low mood.

Mr O'Driscoll was arrested at 23:00 on 10th August and was released on bail at 13:30 the following day. He was re-arrested a short time later for breach of his bail conditions. He remained in police custody until the morning of the 12th August when he was taken to Armagh Court.

During these two periods in police custody he was examined twice by the Forensic Medical Officer and attended hospital Accident and Emergency Departments twice. He was first taken to Daisy Hill Hospital A&E just before midnight on 10th August and treated for a cut wrist which the police indicated may have been caused by damaging a window at his mother's home. While there, he reported that he was suicidal and outlined a previous attempt to take his own life. The doctor who examined Mr O'Driscoll recorded that he should be placed on a suicide watch.

When returned to police custody at around 20:00 on 11th August he was examined by a FMO who noted that Mr O'Driscoll *'had been attempting frequent self-harm, required*

restraints in custody and was expressing suicidal intent.' The FMO also noted his recent admission to a mental health ward. While concluding that Mr O'Driscoll was fit to be detained, the FMO said he needed to attend A&E to deal with injuries to his wrist and his mental state.

Mr O'Driscoll was therefore taken to Craigavon Hospital A&E Department at approximately 21:00 on 11th August. His wrist injury was again treated and he was assessed by the mental health team who determined he was at '*moderate risk of self-harm*.' Mr O'Driscoll was given pain killers and left hospital at 23:00 to return to Banbridge Police Station.

After returning from hospital to the police station Mr O'Driscoll was again seen by a FMO, who recorded he had a mental health assessment in hospital for depression and anxiety issues but had *'no current thoughts of self-harm.'*

SECTION 2: COMMITTAL PROCESS

Reception interview in Armagh Court

When Mr O'Driscoll arrived in Armagh Court on 12th August 2016 at around 10:00 responsibility for his care transferred from the PSNI to the NIPS, specifically to the Prisoner Escorting and Court Custody Service (PECCS).

On arrival he was taken through the reception process by the acting Senior Prison Custody Officer (SPCO) (SPCO A). The SPCO completed a PECCS New Committal Form which records a range of details including the court result, documents accompanying the prisoner (usually the PSNI Custody record), risk factors and details of his medication. This form, along with any accompanying documentation, is given to the receiving prison.

The SPCO recorded on the PECCS New Committal Form that Mr O'Driscoll presented a previous risk of self-harm/mental health issues and that he appeared to be under the influence of a substance. The SPCO stated in her staff communication sheet that Mr O'Driscoll had been declared fit for interview by a Police Doctor and that he also had a previous risk of self-harm. She stated she asked Mr O'Driscoll if he had any current thoughts of suicide or self-harm and he had stated, *'No, I'm 100 percent.'* The SPCO said she asked Mr O'Driscoll if there was anything else about his welfare that he wanted her to know but he replied *"No"* and said he wanted to speak to his solicitor.

PECCS Officers do not have access to the Prison Record and Inmate System Management (PRISM) and therefore are unable to check a prisoner's history in relation to any previous SPARs or medical markers. Their assessment is solely based on PSNI documentation and the prisoner's presentation.

Mr O'Driscoll was taken to a cell before being presented to the court at around midday. The court remanded him in custody to appear before Newry Magistrates Court via video link at a later date.

After he was remanded, Mr O'Driscoll's solicitor informed the SPCO that the Judge had asked that he should see a doctor in Maghaberry as he appeared vulnerable. The SPCO said in her staff communication sheet that she explained to the solicitor that he would see a member of Healthcare staff as part of his committal process, and the solicitor appeared content with this.

It is normal PECCS practice to telephone ahead to the receiving prison and advise about the number of new committals. The SPCO said she made this call and informed Maghaberry Reception that there was one new committal - David O'Driscoll - who had a history of self-harm and that the Judge had commented on his vulnerability.

However none of the Reception staff on duty at Maghaberry on 12th August recalled being advised of the Judge's comments. Nor did the PECCS New Committal Form contain any written reference to the Judge's comments.

The NIPS should ensure processes are in place to effectively record and communicate all relevant information about a prisoner's welfare from PECCS to the receiving prison.

Reception Officer Interview and Assessment on 12th August 2016

Mr O'Driscoll arrived in Maghaberry Prison at around 15:00. The documentation that was given to Reception staff by his PECCS escort comprised:

- NIPS New Committal Form, produced by PECCS
- PSNI PACE 15 Detained Person's Medical Form
- PSNI PACE 15/2 Detained Person's Medication Form
- PSNI PACE 16 PER (Prisoner Escort Record) Form (which included vulnerability information and custodial information)

The PACE 15 recorded that Mr O'Driscoll had been to hospital due to his wrist injury and depression and anxiety. The doctor who completed the form also noted that Mr O'Driscoll had *'no current thoughts of self-harm.'* The front page of the Prisoner Escort Record (PER) highlighted:

- *"DP* (detained person) *is of extremely violent nature;"*
- *"DP may have suicidal / self-harm tendencies (current or past) has mental health issues and has self-harmed in the past."*

As a consequence of his previous committals to Maghaberry, Mr O'Driscoll was known to a number of staff who were involved in his committal on 12th August 2016. He was interviewed by Reception Officer (Officer C) who had worked with him as a landing officer during one of his previous sentences. He stated that Mr O'Driscoll was '*just himself*' during the committal process and at no stage did he think he was any different to how he had presented previously. At interview the Reception Officer described Mr O Driscoll as being '*talkative'* and '*chatty.'*

The Reception Officer conducted a vulnerability assessment as part of the reception process and concluded that the opening of a SPAR was not appropriate. He recorded on PRISM that Mr O'Driscoll had been identified as presenting a risk of self-harm but that he had no current thoughts of self-harm. Nonetheless he offered Mr O'Driscoll immediate support from the Samaritans and Listeners[1], both of which were declined.

[1] Listeners are prisoners who have undertaken training with the Samaritans to provide peer support to those experiencing crisis. Arrangements for Listeners or other suitable peer support scheme is set out in Standards 14 and 15 of the NIPS Suicide and Self Harm Prevention Policy.

Part of the vulnerability assessment includes a question to establish if any events (such as a relationship breakdown) might increase thoughts of self-harm or suicide. Mr O'Driscoll replied in the negative to this question, even though his warrant showed he had damaged his mother's property. The Reception Officer did not explore this matter with Mr O'Driscoll.

The committal form, a sheet which is attached to the front cover of the prisoner's file, recorded that the Reception Officer found '*no issues*' in relation to Mr O'Driscoll's arrival into Maghaberry.

The Reception Officer confirmed at interview that he was unaware of the Judge's concern about Mr O'Driscoll's vulnerability. He was adamant that, at no stage during the reception process, did Mr O'Driscoll give him any cause for concern or show any signs of distress. He went on to explain there could be occasions when NIPS Reception officers will speak to Healthcare staff if they had any doubts about a prisoner's presentation, but in the case of Mr O'Driscoll he did not have those concerns.

The Reception Officer also confirmed that Mr O'Driscoll's previous SPAR history was visible to him during the committal interview. He elaborated that, despite this knowledge, he could only assess Mr O'Driscoll on how he presented that day. He went on to explain that a large proportion of committals may have a SPAR history, and that it would neither be practical nor reasonable to open a SPAR solely based on this information.

Reception Officers should be reminded of the necessity of using all available, up to date information when assessing new committals; and of not relying on prisoners' self-report or their prior knowledge of the prisoner.

The Reception Officer also printed the healthcare cover sheet which is passed to the Committal Nurse. This document summarises the outcome of the vulnerability assessments and responses to questions about substance/alcohol misuse. If applicable, a copy of the individual's previous SPAR history is attached to the healthcare cover sheet. In Mr O'Driscoll's case, this listed that three previous SPARs had been opened.

Initial Health screen

The healthcare committal process comprises an initial screen, undertaken within four hours of committal, followed by a comprehensive health screen within 72 hours. As Mr O'Driscoll died on the evening of his committal only the initial health screen had been conducted.
The purpose of this screen is to gather information to keep a prisoner safe during the early stages of their time in custody. The assessment focusses particularly on medication, alcohol and drugs misuse, immediate mental health issues (including risk of suicide and self-harm) and any conditions that fall under the critical medications list.

The Committal Nurse (Nurse A) conducted the initial health screen in Maghaberry reception and completed an Initial Committal Screening Form. This is used to gather initial information

about the prisoner's health, obtain consent to share information and identify medical markers for PRISM.

Mr O'Driscoll agreed that his information could be shared. He provided details of an outstanding hospital appointment and informed the Committal Nurse that he had been an inpatient in the Bluestone Unit (a mental health unit) at Craigavon Area Hospital earlier in the year. The Committal Nurse recorded both addictions and self-harm markers for PRISM in relation to Mr O'Driscoll, even though he denied both when she asked.

The Committal Nurse did not identify any immediate concerns about Mr O'Driscoll's wellbeing. She said his presentation was not particularly anxious, nor did his demeanour suggest he had any thoughts of self-harm or suicidal ideation. She said there was nothing that indicated to her that he needed to be placed on a SPAR. The Committal Nurse went on to explain that she was not aware of Mr O'Driscoll's previous SPAR history. She said she did not routinely check previous medical records during the healthcare committal process as there was not enough time to do this.

It cannot be established if the Committal Nurse received or reviewed the healthcare cover sheet documenting Mr O'Driscoll's previous SPAR history.

The Committal Nurse also said she knew Mr O'Driscoll from his previous periods in custody and that his presentation during the committal interview on 12th August 2016 was no different from previously.

The SEHSCT should review the information committal nurses should access as part of the first night in prison assessment.

During the committal screen, the nurse asks the prisoner to outline any medication they have been prescribed. However the nurse cannot administer medication until the prescription has been confirmed on the Electronic Care Record (ECR) and prescribed.

After accessing the ECR, the Committal Nurse put a note on EMIS requesting the prison doctor to prescribe the medication. The prison doctor (Doctor A) noted on the ECR that the last prescription had been made a year before and therefore did not prescribe medications. While the ECR indicated Mr O'Driscoll had not been prescribed medication, empty medication boxes that he brought into custody indicated he had a daily issue prescription. On noting the doctor's decision, and taking into account the discrepancy between the ECR and empty medication containers in Mr O'Driscoll's possession, the Committal Nurse then contacted the GP Out of Hours service and arranged for a prescription to be created. The Out of Hours GP prescribed two medications that evening for Olanzapine and Pregablin – medications used for the treatment of anxiety disorders and schizophrenia.

The Committal Nurse also completed an In-possession Risk Assessment for Mr O'Driscoll and concluded he was not suitable to manage his medication due to his lengthy history of abusing medication.

Mr O'Driscoll's medication was to be given to him during the evening medication round. The Nurse (Nurse B), who was administering medications that evening in Bann House, was in the House waiting for the Night Guard Manager (Senior Officer A) to arrive to complete the medical unlocks when Mr O'Driscoll was found hanging in his cell.

The Night Guard Manager explained that he had been delayed by approximately 45 minutes in returning to Bann House to complete the medical unlocks[2] due to a Listener call out in another house.

[2] A medical unlock is the name given to the process whereby prisoners are unlocked for the purpose of receiving medical attention, including the administration of medication at any time when a cell is locked. This is normally through the night guard period but can also occur at times when the prison is locked during the day (for example on a Saturday or Sunday evening, over lunchtime periods, over the 16-45 headcount period and at times when a residential unit has been locked or restricted). At night medical unlocks usually take place under the supervision of the Night Guard Manager and two prison officers.

SECTION 3: BANN HOUSE

Transfer to Bann House

Just before 16:00 Mr O'Driscoll was taken from the prison Reception to the committal landing in Bann House where he was accommodated in a single cell.

When new prisoners arrive in Bann they are given information about a range of practical aspects of prison life. Written information advises that if they need any further assistance, they should ask landing staff for help. New arrivals may also be provided with a free five minute phone call.

There were two officers working on the Committal Landing when Mr O'Driscoll first arrived. There had been regime restrictions that day in Bann House due to staffing shortages but staffing levels on Bann 1 & 2 went back up to three during the association period when Officer A, who was working a long day, was joined by Officers B and C. These officers had around four years experience with the NIPS. All had completed induction training though two of them indicated that they had not received specific training for working with newly-committed prisoners.

The NIPS Training Department advised that all staff receive training in the SPAR process, Mental Health Awareness, First Night in Custody, Safe Talk or Asist (depending on when induction training was undertaken) and Behaviours in Prison.

In response to a recommendation in a separate investigation, the NIPS undertook a training needs analysis for Reception and committal staff and intends to deliver a programme of training for all committal and Reception staff.

The NIPS should ensure that Reception and committal staff are provided with training specific to their role.

CCTV footage shows a number of interactions between Mr O'Driscoll and other prisoners, and with Officer A, between 16.00-18.22. Officer A provided Mr O'Driscoll with his evening tea and breakfast pack and made arrangements for tuck shop purchases and for Mr O'Driscoll arranging to borrow tea and coffee from another prisoner. Officer A reported he and another officer were supervising prisoners coming back in from the yards around this time and he was able to talk to Mr O'Driscoll while he was doing this. He reported that he would generally review the committal summary sheet on the cover of a new committal's file when a new prisoner first comes onto the landing.

Officer A had worked with Mr O'Driscoll in the past and described his behaviour as no different to previous periods in custody. He recalled that Mr O'Driscoll was anxious to get his committal phone call and at 18.22 he took him from his cell to the phone.

The committal phone call

Mr O'Driscoll called his mother's home telephone number and his younger sister answered. Officer A introduced the call and checked that the recipient was content to take it.

Mr O'Driscoll's family did not appear to realise that he was in prison. He asked to speak to his partner but his sister told him that she did not think his partner would ever talk to him again.

Mr O'Driscoll became upset and said to his sister *'Just look after yourselves. I love you and I'll talk to you another day …… go away from me, go away from me, go away from around me the whole f…ing lot of you.'*

His sister asked her father to speak to him and Mr O'Driscoll said *'Look I won't be around you no more, get a space up to* [name of Mr O'Driscoll's brother who had died a number of years earlier in an accident] *ready cause I'm not pulling through this no more and that's straight true. I'm not pulling through this no more.'* Mr O'Driscoll ended the call after telling his father that he would talk to him some other time.

CCTV footage shows that Mr O'Driscoll did not appear to be distressed, either on his way to the phone or when returning to his cell. Immediately after making the call he got hot water to make a cup of tea.

Officer A stated that he did not recollect Mr O'Driscoll's demeanour following the phone call nor when they spoke for approximately ten seconds before he was relocked in his cell. Officer B had no contact with Mr O'Driscoll on the landing but she saw him going to and coming from his phone call. She did not see anything that raised concerns for her.

Mrs O'Driscoll's telephone call to the prison and management of this call

Less than five minutes after the committal call concluded, Mrs O'Driscoll phoned Maghaberry Prison to express concern about her son's welfare. Her call was answered by Officer D in the Emergency Control Room (ECR). The ECR log records the time of her call as 18:35. The Control Room Officer confirmed Mrs O'Driscoll had informed him that her son had called home and '*was threatening to kill himself and to get the plot open.*' The Control Room Officer recorded details of the call on the ECR Register of Safer Custody Calls and contacted the Day Manager, Senior Officer (SO) (Senior Officer B). The Control Room Officer said he informed the Day Manager of the nature of the call and passed on Mrs O'Driscoll's telephone number. Once the details of the call had been passed on to the Day Manager, ECR staff had no further role in the matter.

The Day Manager immediately phoned Bann House to obtain background information about Mr O'Driscoll. He spoke to Officer A and told him Mr O'Driscoll's mother had phoned the prison to express concern about her son. Officer A had spoken to Mr O'Driscoll just minutes

before receiving the call from the Day Manager. He informed the Day Manager that he had no concerns for Mr O'Driscoll's wellbeing on the basis of his interaction with him since he had come onto the committal landing.

Officer A gave the Day Manager an account of Mr O'Driscoll's time on the landing since he arrived. As far as he was concerned there were no signs that Mr O'Driscoll was suicidal. He reported to the Day Manager that Mr O'Driscoll had made a phone call to his sister but that, in his view, no issues had arisen from this call.

However Officer A had not heard what Mr O'Driscoll said on the phone; nor did he have the facility to listen to the call. His report to the Day Manager was based solely on his assessment of Mr O'Driscoll's demeanour and their interactions since his arrival on the landing.

Officer A said this was the first time he had encountered such a call during a year working with new committals in Bann House. An examination of Emergency Control Room records between August-October 2016 indicates 37 calls expressing concern about a relative in prison: 14 of these suggested concern about possible self-harm or suicide. This is a comparatively small number, so it should be possible for the NIPS to attend to such calls more thoroughly.

The Day Manager said he asked Officer A to keep an eye on Mr O'Driscoll and inform him if anything in his demeanour changed; and to inform the night guard that there were concerns about Mr O'Driscoll so that a watch could be kept on him during the night. When interviewed Officer A did not have a clear recollection of being asked to complete any instruction by the Day Manager. Officer A later said that if he had been told to complete a task he would have recorded and completed it. As internal telephone calls are not recorded, it is not possible to evidence if or what instruction was issued to Officer A.

There is no evidence from an examination of CCTV footage, interviews with nightguard staff and a review of relevant journals to indicate that the Day Manager's requests were acted on.

Details of the telephone call from the Day Manager were not recorded in the class office journal. Officer A suggested this was due to a shortage of staff on the landing, though he also acknowledged there had been a low number of committals that day.

The NIPS should address any performance issues that arise from this case.

With hindsight the Day Manager stated that it may have also been appropriate for him to ask Officer A to speak with Mr O'Driscoll directly following his phone call, in order to confirm that he was okay.

After receiving assurances from Officer A, the Day Manager called Mrs O'Driscoll at 18:44 to say her son was okay. During this call Mrs O'Driscoll said she told the Day Manager that her son suffered from mental health problems for which he received medication.

They discussed Mr O'Driscoll's reference to his deceased brother, and there appears to have been a subtle misunderstanding about this aspect of the conversation: whereas Mrs O'Driscoll said she had reported his verbatim comment to *'open the plot'* in a reference to his intent to end his own life, the Day Manager thought Mrs O'Driscoll said her son had *'lost the plot'* – which had a less sinister implication.

The Day Manager told Mrs O'Driscoll that her son had seen a nurse in Reception and that his medication would have been sorted out. He went on to say that, as her son was on a committal landing he would be checked every two hours. He explained the landing staff had assured him Mr O'Driscoll was in good form and had filled out a tuck-shop order for Saturday. The Day Manager told Mrs O'Driscoll the landing staff would continually assess her son's mood and behaviour and if anything appeared wrong they would speak with him and follow prison procedures to safeguard him. He also told Mrs O'Driscoll that the night staff would be informed that concerns had been raised about her son's wellbeing.

Following his feedback to Mrs O'Driscoll, the Day Manager obviously did not consider any further actions were necessary in addition to those he had already asked the Officer A to carry out.

Mrs O'Driscoll said she felt much better following her conversation with the Day Manager and that her fears had been allayed. Unfortunately however, none of the preventive measures that he outlined were put in place.

The Day Manager recorded the details of the call to and from Mrs O'Driscoll on the Duty Manager's "24 Hour Operational Status Report." This electronic report records all operational incidents over a 24 hour period. It includes a section for telephone messages which the Duty Manager decides need to be documented. The Day Manager made the following entry under the telephone messages section of the report, *'18:44 – Made a phone call to the mother of Prs D3660 O'Driscoll. She had called previously with concerns over her sons wellbeing. I spoke with her and allayed any fears she had for her son.'*

The Night Guard Manager (Senior officer A) who came on duty said he did not have time to read the Status Report when commencing his shift. Nor were the concerns raised by Mrs O'Driscoll included in the verbal handover from the Day Manager to him. However in light of the steps already taken by the Day Manager to address Mrs O'Driscoll's concerns, and given the nature of the entry in the status report, even if the Night Guard Manager had read the report, it was highly unlikely to have prompted him to take any further action in respect of Mr O'Driscoll.

If the Day Manager's entry in the Status Report or his verbal handover had included more detail about the nature of the call, the Judge's comment about his vulnerability, Mr

O'Driscoll's previous SPAR history and the detail of his requests to Officer A, this should have alerted the Night Guard Manager that Mr O'Driscoll required further attention during the night.

At 19:35 David O'Driscoll activated his cell alarm and Night Custody Officer (Officer E) responded. Officer E recorded in the class office journal that Mr O'Driscoll had requested his medication and had been advised the medic would be round later, to which he replied *'Okay.'* Officer E was unaware of the concerns that had been raised earlier in the evening by Mrs O'Driscoll.

The NIPS should remind staff that all relevant information relating to a prisoner's welfare should be appropriately recorded in the relevant journals/reports; and that thorough verbal and written handovers must be conducted at the start/end of each shift.

Previous recommendations have been made by this office in relation to recording details of incoming phone calls and the handling of Mrs O'Driscoll's call suggests those lessons have been learned to an extent. However it is clear that some aspects of Mrs O'Driscoll's call should have been managed better. It is impossible to conclude whether a discussion with Mr O'Driscoll about his mother's call, or more effective communication during the staff handover would have resulted in a better outcome. However there were clear deficiencies that must be remedied in order to minimise any future risks.

The NIPS should issue guidance for staff on how to respond to calls from concerned relatives. This should include consideration of:

- ***The prisoner's custodial history and any recent/previous incidents of self-harm;***
- ***Listening to a recording of any call made by a prisoner where they have threatened to take their life;***
- ***Speaking directly to the prisoner;***
- ***Consulting with healthcare staff; and***
- ***Comprehensively documenting and sharing the actions taken by all staff involved to safeguard the prisoner.***

SECTION 4: CLINICAL REVIEW - MEDICATION

Mr O'Driscoll was only in the custody of the Northern Ireland Prison Service for seven hours prior to his death. Given his history of abusing alcohol and prescription drugs and concerns raised by his family about how his medication was managed during that time, Ms Victoria Jenkins, a consultant in pharmacology and toxicology, was invited to conduct a review of Mr O'Driscoll's medical and custody records and comment whether his medication was prescribed/managed appropriately while in custody, given his history of alcohol and substance abuse. Ms Jenkins is qualified to comment on the effect of missed doses of medication comparing what an individual should have been prescribed to what they were actually prescribed. In Ms Jenkin's opinion it would not be appropriate to consider Mr O'Driscoll's prison medication alone but the combined period in custody from his arrest.

Ms Jenkins was provided with copies of Mr O'Driscoll's police custody and other records from which she established that he was prescribed and administered the following medications while in PSNI custody at Banbridge Police Station:

Name of Medication	Dose	Frequency (no. times a day)	Date Given	Time Given
Diazepam	5mg (1 tablet)	2	11/08/2016	20.15
Lyrica (pregabalin)	150mg (2 tablets)	2	11/08/2016	20.15
Co – Amoxiclav	500/125 (1 tablet)	3	11/08/2016	20.15
Zopiclone	7.5 mg (1 tablet)	1 (at night)	12/08/2016	00.46
Trazodone	150 mg (2 tablet)	1 (at night)	12/08/2016	00.46
Olanzapine	5 mg (1 tablet)	2	12/08/2016	00.46

In her report Ms Jenkins commented on each individual medication given to Mr O'Driscoll and the effects of missed or delayed dosages. She concluded that as Co-Amoxiclav (penicillin) was given to prevent infection of his cut arm, missed doses would not have had a significant effect on his mental health or have caused suicidal thoughts. Similarly Ms Jenkins concluded that both Zopiclone and Trazodone were due to be taken only once at night and as such were administered correctly on the 12th of August.

Ms Jenkins established that Mr O'Driscoll did not appear to have been given any further doses of Diazepam and Lyrica (Pregablin) on the 12th August while in police custody nor, as

his medication had not been administered at the time of his death following his committal to Maghaberry that afternoon. She commented:

'Mr O'Driscoll takes a number of regular medications for conditions such as pain, anxiety, depression and schizophrenia. If not correctly prescribed, he is therefore likely to have inadequate control of these conditions. The symptoms of the conditions themselves if untreated (particularly in the setting of a prison which is likely to result in a greater degree of anxiety and depression) could in my opinion have contributed to Mr O'Driscoll's decision to take his life on the day in question.

'Given the nature of Mr O'Driscoll's medications, the fact that he has previously self-harmed, his history of mental health problems and comments made by individuals who saw him whilst in custody, it would have been vital that his medication was administered as prescribed.

'Although withdrawal symptoms would not always be expected to be seen this soon after missed doses of a drug, earlier missed doses will have significantly reduced the levels of these drugs in Mr O'Driscoll's blood (as supported by only trace levels of olanzapine, diazepam and trazodone and no zopiclone being detected in his Post Mortem blood samples). Withdrawal symptoms of the drugs include anxiety, depression, psychosis and hallucinations. Trazodone both during and after cessation of treatment has been known to cause suicidal thoughts. I cannot rule out the possibility that under prescribing of Mr O'Driscoll's medications has contributed to his death'.

The adequacy of Mr O'Driscoll's prescription in the time leading up to his committal to Maghaberry is not a matter for this investigation as the prescription was not done while he was in NIPS custody. Nor can we comment upon how his medications were administered while he was in PSNI custody. It is unclear from the police custody records if all Mr O'Driscoll's medication was administered on the morning of 12th August before he was brought to Armagh Court, and this may have had a bearing on the interval between dosages.

In relation to his time in the NIPS custody the committal nurse correctly accessed ECR and made appropriate arrangements for a prescription to be written. Whereas Mr O'Driscoll had been prescribed six medications during his detention in police custody, the out of hours GP prescribed two medications. The medical records do not show what information was passed to the out of hours GP nor the reason why the GP prescribed two medications. This type of anomaly would normally be addressed during a medicines reconciliation process completed the following working day. The committal nurse arranged for the medication to be administered as prescribed during the evening medication round on 12th August.

Unfortunately Mr O'Driscoll died before his medication was administered.

SECTION 5: EVENTS AFTER MR O'DRISCOLL WAS FOUND HANGING

Officer E commenced the PEG[3] check on Bann 2 landing at 21.29 on 12th August 2016.

On lifting the flap of Cell 10, Officer E saw David O'Driscoll sitting at the back of the cell with a ligature around his neck. He immediately sent an urgent message over the radio to the ECR. On hearing the Code Blue message, Officer F ran from an upstairs landing down to Bann 2. Officers E and F entered the cell at 21:30. Officer E supported Mr O'Driscoll's body while Officer F cut the ligature. Together they lowered Mr O'Driscoll onto the floor and commenced cardiopulmonary resuscitation (CPR). Officer E noted in his Staff Communication Sheet that Mr O'Driscoll's body was cold to the touch.

Several minutes after Mr O'Driscoll was found, Nurse B, who was already in Bann House to administer medication, arrived at his cell, having collected emergency equipment from the treatment room en route. Nurse B applied the defibrillator. She was joined by a second nurse (Nurse C) who had run to Bann House to assist when the call came over the radio. The two nurses and two officers continued CPR for 37 minutes, rotating compressions between them until paramedics arrived. Nurse B recorded that Mr O'Driscoll's pupils remained fixed and dilated throughout the resuscitation attempt. She had attempted to gain intravenous access in order to administer adrenalin, but was unsuccessful.

The ambulance crew arrived at the cell at 21.54. The monitor was changed to the ambulance service defibrillator and adrenaline was administered by paramedics by another technique which prison nurses are not trained in. All efforts to resuscitate Mr O'Driscoll were unsuccessful and he was pronounced dead at 22.08.

Dr Jane Rees conducted a review of the resuscitation attempt with Mr O'Driscoll. She identified a number of learning points for future practice relating to the provision of oxygen supply, recording keeping by nurses and how quickly ambulances can access residential houses, all of which have been addressed.

The prison governor should review the time taken for the ambulance to reach Bann House to determine if the process of an ambulance through the prison can be speeded up.

The SEHSCT should ensure that adequate supplies of oxygen are available within each residential treatment room.

The SEHSCT should ensure that the nurses attending a resuscitation attempt record all events comprehensively.

[3] A PEG check is a recorded patrol of landings by night guard officers. The patrols are recorded on a pegging system at appropriate locations during patrols. Maghaberry's Governor's Order 8-1 advises that patrols will be made and recorded at intervals of no more than one hour or more frequently as directed by the Governor.

Overall Dr Rees concluded: *"I am satisfied that the attempt to resuscitate David O'Driscoll was commenced promptly and carried out in as effective and efficient manner as possible in the circumstances. It is clear from the nursing notes that Mr O'Driscoll's brain and circulation were seriously compromised before the resuscitation started."*

Hot and cold debriefs

Standard 25 of the NIPS Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody.

The hot debrief should take place as soon after the incident as possible and involve all of the staff who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to further reflect on events and identify any additional learning.

The hot debrief meeting following Mr O'Driscoll's death was chaired by a senior Governor (Governor A). It was attended by all staff who were involved in the incident and addressed all areas identified in the template set out in the operating procedure. It noted there were no delays in accessing the cell or with the availability of necessary equipment; and that Care Call and support services were offered to the staff involved. The Night Guard Manager reported a concern about staffing levels.

The cold debrief took place on 25 August 2016. It was less well attended by staff involved in the incident, though there was representation from the PSST, Healthcare and Independent Monitoring Board.

The notes of the hot debrief meeting were not available to those attending the cold debrief. The record of the cold debrief was extensive and included background information about Mr O'Driscoll, events of 12th August and detail of the resuscitation efforts.

At the cold debrief there was discussion about the provision of oxygen supply in Maghaberry's residential houses. Although it was noted that Mr O'Driscoll had not been without oxygen supply at any stage, the nurses asked a member of NIPS staff to get a replacement cylinder from another House in case the first expired. This was done and the oxygen replaced. It was suggested and actioned that two oxygen cylinders are made available in treatment rooms.

The Night Guard Manager stated during the cold debrief that he had been delayed returning to Bann to complete medical unlocks[4] that evening. He stated it was not uncommon for medication rounds to be held up because of operational issues in the prison and that it was often after midnight before the nurses finished their rounds.

Concerns about medical unlocks were also raised during staff interviews in this and other death in custody investigations, as well as, prison inspections. Although the number of medical unlocks on this particular evening was relatively low, and the delay of 45 minutes is unlikely to have been material in this case, there does appear to be a wider issue around access to prisoners to administer medication during periods of lock up which requires consideration. The issue of medication was raised by Mrs O'Driscoll in her call to the prison and Mr O'Driscoll himself had used the cell bell alarm to ask when he was getting his medication earlier in the evening.

The NIPS and SEHSCT should work collaboratively to ensure a system is in place to facilitate timely access to prisoners to administer medication.

The record also shows that concerns were raised about communication between day and night staff, staff detailing after Mr O'Driscoll's death - the Bann night guard staff remained on duty that night and for the following three nights.

Specific responses to these matters were not outlined in the record. The Governor who chaired the cold debrief (Governor B) was able to outline clear NIPS responses to staff detailing and handovers. For example staff detailing after an incident depends on availability of other staff and individual wishes; advice and guidance in respect of Night Guard patrol duties and keeping and checking of journals were subsequently updated and re-issued on 3 April 2017. Governor's Orders 7-25 and 8-1, and Notice to Staff 69/17, also reissued on 3 April 2017, highlight the requirement for proper handovers to be conducted and what should be entailed in such handovers.

Minutes of any meeting, including hot and cold debriefs, will always be more useful if they reflect outcomes and responsibilities, rather than merely outline who said what.

[4] A medical unlock is the name given to the process whereby prisoners are unlocked for the purpose of receiving medical attention, including the administration of medication at any time when a cell is locked. This is normally through the night guard period but can also occur at times when the prison is locked during the day (for example on a Saturday or Sunday evening, over lunchtime periods, over the 16-45 headcount period and at times when a residential unit has been locked or restricted). At night medical unlocks usually take place under the supervision of the Night Guard Manager and two prison officers.