The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR PAUL JOHNSTON
AGED 27
AT MAGILLIGAN PRISON
ON 4th AUGUST 2017

Date finalised: 16th January 2020

Date published: 5th March 2020

Unit 2, Walled Garden, Stormont Estate, Belfast, BT4 3SH
T: 028 9052 7771 E: pa@prisonerombudsman.x.gsi.gov.uk W: www.prisonerombudsman.x.gsi.gov.uk

The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation of deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

The purpose of the Prisoner Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

By highlighting learning to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

The objectives of death in custody investigations are set out in the Ombudsman's terms of reference and are to:

- establish the circumstances and events surrounding the death, including the care provided by the Prison Service;
- examine any relevant health care issues and assess the clinical care provided by the Trust;
- examine whether any changes in Prison Service or Trust 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.

Within the above objectives, the Ombudsman will identify specific matters to be investigated in line with the circumstances of an individual case.

In order that learning from investigations is spread as widely as possible, and in the interests of transparency, investigation reports are published on the Prisoner Ombudsman's website following consultation with the next of kin. Reports are also disseminated to those who provide services in prisons.

Table of contents

Glossary

AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
CCTV	Closed Circuit Television
CIWAA	Clinical Institute Withdrawal Assessment for Alcohol
CNS	Central Nervous System
CJINI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
ECR	Electronic Care Record
EMIS	Egton Medical Information System
GP	General Practitioner
H1	House block 1
IMB	Independent Monitoring Board
MAR	Medical Administration Record
PREPS	Progressive Regimes & Earned Privileges Scheme
RGN	Registered General Nurse
RISE	Regime Index Supervision Easement
RMN	Registered Mental Health Nurse
SPAR	Supporting Prisoners At Risk (procedure)
S/O	Senior Officer

Foreword from the Ombudsman

The death of a loved one is always difficult. The fact that a death occurs in custody, or shortly after someone is released from prison, has particular difficulties given the loss families experience when a loved one is taken into custody and the trust they must place in the Northern Ireland Prison Service (the Prison Service), South Eastern Health and Social Care Trust (The Trust), and others, to ensure the safety and wellbeing of their loved one.

All those in custody should expect to be treated decently and with respect, receiving the best care possible for their wellbeing and rehabilitation.

This report will address and inform several interested parties, all of whom will learn from the findings. Where appropriate, recommendations will be made directly to the Prison Service and the Trust. Both organisations will then provide my office with a response indicating if they accept my recommendations and what steps they are going to take, or have taken, to address them.

While these interested parties are important to ensure change to care in custody, this report is written with Mr Johnston's family primarily in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am grateful to them for their contribution to this investigation and I appreciate their patience. I offer my sincere condolences to them on their sad loss and hope this report provides information to address some of the questions they raised and explains events leading up to Mr Johnston's death. The learning, expressed in recommendations, will, I hope, bring some comfort to families who are grieving and confidence to those who have family members in custody.

I am grateful to the Prison Service, the Trust and the clinical reviewers for their contributions to this investigation. Others have helped in the information gathering process and to them I also extend my gratitude.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
16th January 2020

Section 1: Summary

Mr Johnston was recalled to prison and was transferred to Magilligan prison on 9th March 2017. The decision to recall him to prison was under review at the time of his death. He was found unresponsive in his cell on the morning of 4th August 2017 and although a nurse attempted to resuscitate him he was sadly pronounced dead at the scene.

The post mortem report gave Mr Johnston's cause of death as poisoning by Fentanyl and Alprazolam. Neither drug was prescribed for him.

Mr Johnston had long term mental health and addiction problems. He regularly engaged in both community and prison mental health services and sought help for substance misuse. He had twice been committed to mental health facilities. He had a history of drug overdoses and self-harm both in the community and prison. He was not assessed as being at risk of suicide or self-harm during his most recent custodial period.

I do not believe Mr Johnston intended to take his life. I believe his death was as a result of an accidental overdose. He had acquired prohibited substances which he took and this tragically resulted in his death.

While aspects of the care provided to Mr Johnston could have been better, and there were missed opportunities to better address his needs, it cannot be said with any certainty that his death could have been predicted or prevented.

I am concerned about the devastating impact of substance misuse and poor mental health which resulted in Mr Johnston's untimely death. He was 27 years old. The impact is far reaching, not only among his family but also his peers and those entrusted to care for him in custody and the community. The number of deaths from drugs, as we know, is too high and Mr Johnston's case challenges the Prison Service, the Trust and others who work with young men in prison to identify their vulnerability and develop effective, integrated plans to keep them safe.

Mr Johnston was clearly a vulnerable and troubled young man although he did not appear to have been identified as such in accordance with existing policies and procedures. There is important learning from his case and themes which are apparent in other death and custody investigations I am currently conducting.

I made seven recommendations for improved practice to the Prison Service and Trust. I made a joint recommendation asking the Prison Service and the Trust to consider how to better meet the needs of people like Mr Johnston in custody and I

am pleased that they have committed to doing this. An account of the response to all recommendations is set out later in this report. Other issues were identified in the course of this investigation, which have been accepted in other cases. I note the progress the Prison Service and Trust are making to address these. I will keep these matters under review.

Section 2: Background information – Magilligan prison

2.1 Magilligan prison

Magilligan is a medium security prison which holds male adult sentenced prisoners mainly transferred from Maghaberry prison. The average daily population[1] of Magilligan prison during 2016/17 was 453.

Since 2008 prison health care services have been provided by the South Eastern Health and Social Care Trust (the Trust). There is a 24 hour primary health care service and the Mental Health Team is on site Monday to Friday between 08:00 and 17:00. There are no in-patient beds.

2.2 Criminal Justice Inspection Northern Ireland (CJINI)

The most recent Criminal Justice Inspection for Northern Ireland report of Magilligan prison was published in December 2017. Inspectors found that outcomes for prisoners were good against the healthy prison tests for resettlement and respect and reasonably good for safety and purposeful activity. Inspectors established that there was no integrated drugs and alcohol strategy. The main recommendation was that there should be a prison-wide drug and alcohol strategy with an associated action plan to address both supply reduction and psychosocial support issues.

CJINI found that health services had improved and mental health provision was particularly good for those known to the service.

The CJINI Safety of Prisoners Report, published November 2019, highlighted that one of the most difficult issues facing the Prison Service was the identification of those really vulnerable people in the population and that the Service needed to work to create a therapeutic environment to help stabilise individuals at risk and manage their imprisonment more safely.

2.3 Independent Monitoring Board (IMB)

Magilligan has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners.

[1] Source: Analytical Services Group, The Northern Ireland Prison Population 2016 and 2016/17. Research and Statistical Bulletin 27/2017, September 2017.

The IMB 2017-18 annual report highlighted major concerns about the availability of both prescription and illegal substances. The IMB noted that despite intelligence led interceptions and increased drug testing, considerable quantities of drugs still enter the prison.

2.4 Previous deaths at Magilligan prison

Mr Johnston's death was the first self-inflicted[2] death in Magilligan prison since March 2015. There was a death involving similar circumstances in January 2009 which was investigated by the then Prisoner Ombudsman. Thirty-one recommendations were made to the Prison Service and Trust of which 23 were accepted. Recommendations arising from this report were considered in the course of this investigation, where appropriate.

Magilligan is one of two adult male prisons in Northern Ireland. Since Mr Johnston's death there have been five self-inflicted deaths in custody – four at Maghaberry and one at Magilligan prison. These investigations are ongoing but similar themes are emerging which I will comment on in due course.

[2] A self-inflicted death is defined as the death of a person who has apparently taken his or her own life irrespective of intent.

Section 3: Framework for this investigation

As Mr Johnston died in prison custody I am required to investigate the circumstances surrounding his death and assess the care that he received while he was in custody.

This investigation was conducted in line with my terms of reference and aims to provide explanations, where possible, to Mr Johnston's family.

3.1 Questions raised by Mr Johnston's family

Mr Johnston's family raised a number of areas of concern shortly after his death. In their view the individual who provided the drugs to Mr Johnston was responsible for his death and they wanted to see appropriate action taken against the person. The latter is not within the scope of my investigation. However, the matters of concern that I did take account of during my investigation are summarised below:

a) What were the circumstances leading up to Mr Johnston's death including why he was accommodated in House Block 1 (H1)?
b) Were opportunities missed to keep Mr Johnston safe in the period shortly before his death?
c) If the health care Mr Johnston received in Magilligan was adequate and whether he received medication for his mental health condition?
d) What measures were being taken at that time to reduce the supply of drugs in prisons?
e) Why there was a delay in confirming Mr Johnston's death to his family.

3.2 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. The following information was gathered and analysed by the Investigating Officer:

- NIPS records including closed circuit television (CCTV) footage and telephone calls made by Mr Johnston prior to his death;
- Interviews with prison and health care staff;
- Interviews with prisoners; and
- Prison health care records.

All of this information was carefully examined and I have detailed the relevant matters, which underpin my findings, in this report.

3.3 Independent advice

I commissioned two independent reviews in this case. Ms Jane Mackenzie conducted a clinical review of the health care provided to Mr Johnston, including the attempt to resuscitate him. Ms Mackenzie is a retired registered Mental Health Nurse and (RMN) and General Nurse (RGN) who has extensive experience of working in mental health services in England and Wales. She is a member of the Health Inspectorate Wales Team and has experience of conducting clinical reviews of prison deaths in Wales. Mr Anthony Hewitt, who has extensive experience of work in substance misuse in prisons and in 2016/17 carried out a thematic review for NHS England of all Deaths in Custody in the South of England, examined the addiction support provided to Mr Johnston.

Both clinical reviewers provided me with a report setting out their opinion on the matters they were asked to consider. I have included their opinion, where relevant, in my investigation report.

3.4 Scope and remit of the investigation

The specific objectives of this investigation were to:

1. Establish the circumstances leading up to Mr Johnston's death;
2. Determine if there were opportunities for prison staff or others to intervene to help keep Mr Johnston safe;
3. Assess the clinical care provided to Mr Johnston including whether support to address his substance misuse needs was adequate;
4. Determine if the resuscitation attempt was satisfactory and conducted in line with national guidelines;
5. Examine what steps are taken to disrupt the supply of drugs into the prison;
6. Establish if and why there was a delay in Mr Johnston's family being notified of his death;
7. Examine the post incident arrangements including support for prisoners and staff; and
8. Identify if Mr Johnston's death might have been predicted and/or prevented.

A description of the key events leading up to Mr Johnston's death is set out in Section 4 and my findings are set out Section 5.

Section 4: Description of key events

Mr Johnston was recalled to Maghaberry prison on 4th March 2017 after his licence was revoked.

An initial and comprehensive health care assessment was conducted by a committal nurse (Nurse A) with Mr Johnston following his re-committal to Maghaberry prison. He was prescribed a short course of sertraline – an anti-depressant medication - by the out of hours general practitioner (GP) to maintain continuity of his community prescription. An alcohol withdrawal assessment was commenced. On this date Mr Johnston was assessed as presenting with mild-moderate symptoms of withdrawal.

On 6th March 2017 a member of the mental health team conducted an initial mental health screen[3]. Mr Johnston's contact with the Northern Trust and recent self-harming was noted and he was referred for a routine mental health assessment. The records from the Northern Trust were to be requested. On the same date a prison doctor (Doctor A) continued the prescription for sertraline.

On the 7th March 2017, day 4 of his alcohol withdrawal programme[4], Mr Johnston's withdrawal score was assessed as 8, indicating severe withdrawal symptoms. He was referred for a review the following day but was not seen as the nurse ran out of time.

A decision was taken to transfer Mr Johnston to Magilligan prison on 9th March. A mental health nurse (Nurse B) flagged to the Duty Governor (Governor A) that Mr Johnston was awaiting a mental health assessment but was advised by the Governor that the transfer was to proceed. The nurse alerted her counterparts in Magilligan that Mr Johnston was awaiting a mental health assessment. The health care department at Magilligan was also advised that Mr Johnston was on an alcohol withdrawal programme and that the Day 5 assessment was not completed.

On his arrival at Magilligan prison a nurse (Nurse C) reviewed Mr Johnston's records. She noted that Mr Johnston was being monitored for alcohol withdrawal, that he administered his own medication, had a history of alcoholism but no psychiatric history. The nurse recorded that there were no outstanding referrals relating to Mr

[3] The mental health screen is conducted the next working day after someone is committed. As the mental health team work Monday-Friday, this was the first opportunity to screen Mr Johnston as he returned to Maghaberry on a Saturday. This screen entails a review of the Electronic Care Record (ECR) and information obtained during the initial and comprehensive health care assessment. It is not a face to face consultation.

[4] Alcohol withdrawal was assessed using the Clinical Institute Withdrawal Assessment for Alcohol (CIWAA) AA. This is an evidence-based tool, to support the assessment of the level of reaction and symptoms of withdrawal from alcohol.

Johnston and that no paperwork relating his withdrawal assessments had been sent with him from Maghaberry.

On 14th March Mr Johnston's alcohol withdrawal score was again recorded as 8. This was the last occasion when his withdrawal was monitored until he saw a mental health nurse three weeks later.

On 21st March 2017 Mr Johnston did not attend the treatment room to take his medication despite being called multiple times. He also declined his anti-depressant medication between 22nd March and 31st March 2017.

On 5th April 2017 a mental health nurse (Nurse D), conducted a mental health assessment with Mr Johnston. Following discussion the nurse and Mr Johnston agreed that he required ongoing support to manage withdrawal symptoms and help with his addiction. She concluded that no further action was required from the mental health team at that time but she would update the prison's drug and alcohol support service, Alcohol and Drugs: Empowering People Through Therapy (AD:EPT) and would ask a doctor to prescribe medication to help with drug withdrawal symptoms.

This medication was not prescribed until two days later.

Mr Johnston was initially accommodated in Halward House, one of the prison's residential units, after his transfer from Maghaberry. He regularly attended the gym and worked as a power washer. He maintained contact with family and friends by telephone and through visits. Mr Johnston actively engaged with his probation officer and he was hopeful of being released. On 26th May 2017 he requested a drugs test to prove to the Parole Commissioners that he was drug free but four days later he was told his release was not recommended.

On 1st June 2017 Mr Johnston failed a drug test. At the adjudication hearing and in a follow up appointment with the prisons' drug and alcohol service, AD:EPT, he said he relapsed because he was angry and annoyed that his release from prison had not been recommended. An oral hearing, to review the decision to recall him to prison, was scheduled for 18th July 2017. However this appointment was cancelled and later rescheduled for 4th August 2017. A number of prisoners and Mr Johnston's family reported that he took this delay badly.

On 6th July 2017 prison officers asked health care to see Mr Johnston and a nurse (Nurse E) saw him. He told the nurse that he had stopped all his medications as he hadn't needed them. He also said he had not been sleeping and was feeling stressed in Halward House. The nurse advised Mr Johnston to speak to the Senior Officer

(S/O) and see a doctor to request a short course of night sedation to help him sleep. This medication was prescribed several days later. On 7th July 2017 another nurse (Nurse F) referred Mr Johnston to the mental health team as he reported feeling very stressed, anxious and vulnerable. The mental health team allocated him for a routine mental health pre-assessment contact but this did not take place before Mr Johnston died.

Mr Johnston requested a move from Halward House which was approved and he went to H1 B landing on 10th July 2017.

On 3rd August 2017 Mr Johnston returned from work in the afternoon. He spoke to his father and brother by telephone at 15:51 and they talked about a visit planned for the following Saturday. Mr Johnston then had a haircut and went to his cell at 18:26. The landing was locked at approximately 18:40. CCTV indicated that a prisoner (Prisoner A) appeared to speak to Mr Johnston at his cell door at around 20:50. This was likely the last time he was observed alive.

At 06:46 on 4th August 2017 Mr Johnston was found unresponsive in his cell on H1 B landing by an officer (Officer A) conducting the morning head count[5]. The Officer requested assistance from a colleague (Officer B) and they attempted to get a response from Mr Johnston. They then entered the cell and requested medical assistance.

A nurse (Nurse G) arrived at Mr Johnston's cell at approximately 06:52 and began Cardiopulmonary Resuscitation (CPR). He was joined a short time later by a health care assistant and they continued to perform CPR until paramedics arrived at 07:22. Sadly Mr Johnston could not be resuscitated and he was pronounced dead by paramedics at 07:40.

The post mortem report described Mr Johnston's cause of death as poisoning by Fentanyl and Alprazolam. Neither drug was prescribed for him. The autopsy also found a package containing drugs which had been secreted by Mr Johnston.

[5] Governor's Order S.7 required night guard staff to conduct a full head count and body check (to establish that a prisoner is present and that bodily movement can be observed) at the commencement of duty. It did not require body checks to be conducted during the night at this location. A PEG check is a recorded patrol of landings by night guard officers. The same Order required a PEG to be conducted between 23:00-24:00, 02:00-03:00 and 05:00-06:00. Three PEG checks were conducted at 23:35, 02:45 and 05:45.

Immediately after Mr Johnston's death information came to light that drugs had been brought onto the landing by another prisoner and that Mr Johnston had been given some of those drugs to hide. In the telephone calls made shortly before his death Mr Johnston described having a 'bonus' which possibly referred to plans to profit from selling the substances he had acquired. The police investigated this report but the case was later closed as there was insufficient evidence.

Although Mr Johnston was pronounced dead by paramedics at 07:40 a police Forensic Medical Officer did not attend the prison until 11:40 to formally pronounce life extinct. His death was not confirmed to his father until 12:20 that afternoon.

Section 5: Findings

This section sets out my findings under each investigation objective.

5.1 Establish the circumstances leading up to Mr Johnston's death

The key events leading up to Mr Johnston being found on 4th August were outlined in Section 4 and a timeline is set out in Appendix B. From the information reported to this investigation and listening to Mr Johnston's telephone calls, it appeared another prisoner had a quantity of drugs in his possession on H1. This person gave Mr Johnston some of these drugs to conceal for him. Mr Johnston then told the prisoner he had lost the drugs but it appeared he planned to profit from them. Although the police conducted an enquiry into these reports there was insufficient evidence to pursue this. It is not clear precisely what quantity or type of substances Mr Johnston had in his possession but he estimated he might make £700-£800 from their sale.

Mr Johnston's family asked why he was accommodated in H1 at the time of his death. When Mr Johnston transferred to Magilligan prison on 9th March 2017 he shared a cell with another prisoner in Halward House and then moved into a single cell on 15th March 2017. He requested to be moved to a single cell on H1 on 3rd April but remained in Halward House at that time. On 24th May 2017 he asked to be placed on the waiting list for A landing in H1. H1 A landing was an enhanced landing (known as the Regime Index Supervision Easement (RISE) landing) and B wing held those who were deemed to be vulnerable or those awaiting a place on the RISE landing. On 7th July Mr Johnston again requested a move out of Halward House for mental health reasons. This was approved subject to him being added to the waiting list for the RISE landing. At the time of his death Mr Johnston was, therefore, accommodated on B landing because he was hoping to be moved onto the RISE landing. He was not being managed as a vulnerable person even though he had requested a move out of Halward House due to mental health issues and did meet a number of criteria set out in the Magilligan Prison Vulnerable Person policy (2017-2019).

5.2 Determine if there were opportunities for prison staff or others to intervene to help keep Mr Johnston safe

Mr Johnston's family were concerned that there may have been opportunities for prison staff or others to intervene to keep him safe in the days before his death. Sadly it was only after Mr Johnston's death that information came to light from prisoners on the landing that he misused substances.

Prison staff said this was not reported to them at the time nor had they observed Mr Johnston being under the influence of drugs or other substances. As a result of the meeting with Mr Johnston's family, additional CCTV footage was requested and viewed to see if there were any differences in Mr Johnston's demeanour over a longer time period. In this footage he seemed to engage in routine landing activities and did not appear to fall, stumble or stagger. It is possible that he may have been under the influence and attempted to hide this from prison staff in order to avoid detection.

Prison staff said that if they had concerns that someone may be under the influence, the course of action is to lock someone in their cell and monitor them more closely. There is evidence in the landing journals for this same period of this being done with another prisoner. Such action would also usually be reported to the prison's security department in the form of a security information report and to prison health care. These measures were ones which were highlighted in a previous death in custody investigation.

I encourage prisoners who have knowledge of prohibited substances being available on a landing, or concern about the level of drug taking of a friend, to provide that information to prison staff, a nurse or representative of other organisations who work in the prison so that steps can be taken to reduce the harm caused by illicit drug taking. I acknowledge the challenge of providing such information but nevertheless such information regarding prisoners is about their safety and that should be paramount.

5.3 Assess the clinical care provided to Mr Johnston including whether support to address his substance misuse needs was adequate

Two independent reviews were commissioned in this case and although each reviewer considered Mr Johnston's case independently they arrived at similar conclusions on a number of matters. Ms Mackenzie commented on the overall health care and mental health support and Mr Hewitt focussed on addiction support.

Both reviewers agreed Mr Johnston was a vulnerable, troubled young man who led a chaotic and unstable lifestyle. He had numerous convictions and as time progressed the period between sentences became shorter. They noted how his mental ill-health and substance misuse interacted problematically and that this was linked to his offending. They further noted that Mr Johnston attributed many of his problems to the death of his baby brother.

Although Mr Johnston's community history is outside the scope of this investigation it is worthy of note that since his discharge in December 2016 and recall in March, he was admitted to Accident and Emergency on five separate occasions. Three of those incidents were overdose related.

The reviewers found that Mr Johnston had many interactions with services in both the community and prison to address his difficulties as was indicated in the short period when he was released on licence. Ms Mackenzie described his engagement as '*unpredictable and inconsistent*' and that follow up was difficult due to him being in and out of prison on relatively short sentences.

In terms of substance misuse Mr Hewitt stated that Mr Johnston appeared to primarily use Central Nervous System (CNS) depressants rather than stimulants and that his levels of reported substance use were '*often high-risk and potentially fatal to someone who had not developed a tolerance*.' Mr Hewitt said Mr Johnston also had a tendency to combine substance use with alcohol which only increased his risk.

<u>Issues identified by the clinical reviewers</u>

(i) Responsiveness of services and information flow/communication

The clinical reviewers identified that:

- interventions offered to Mr Johnston were mostly prompted by referrals;
- he was often referred to substance misuse and mental health services in prison;
- he was difficult to engage in those services;
- despite the high level of contact these referrals did not seem to lead to anything further;
- the documentation reflects a reactive approach of trying to address presenting risks only, as opposed to including an overview of life and experience with regard to mental health and related issues, and overly relied on self-reporting;
- with a dual diagnosis of mental health and substance misuse he seemed to fall between two stools;
- he was not typical as he did not fit into what was available;
- it was unclear to what extent prison staff, mental health and substance misuse services understood Mr Johnston's risk history;
- there did not appear to be a clear and systematic communications link between prison and community mental health and specialist addictions teams and prison teams so information was often not shared or considered;

- several issues indicated his ongoing difficulties in coping with prison life: and information about his self-harming history; refusal of medication; still presenting as 'withdrawing' a month after committal appeared not to be shared between prison and health care staff;
- although he met several criteria for him to be considered a vulnerable person and a number of interventions described in the NIPS policy[6] were in place, he was not managed under the prison's safer custody/vulnerable prison procedures;
- it would have been difficult for health care teams to extract key information from the available records to support his continuity or consistency of approach to his health care and management; and
- there was no cohesive health care summary, no systematic framework for assessment, care planning or review process and nothing similar to a case formulation documenting his health care and custodial history.

Although describing it differently both reviewers recommended that a coordinated multi-disciplinary, multi-agency approach should be central to working with people with complex multiple needs who fail to fit, or engage well, with existing provision. They felt emphasis should be placed on managing risk rather than presenting need and the individual actively monitored rather than in response to referrals. The issue of engagement should also be explicitly considered.

It was noted shortly after his committal that records from the Northern Trust were to be requested but these did not appear to have been provided at the time of Mr Johnston's death.

There are a range of procedures in place in prisons to assess and manage risk and needs including:

- the prisoner development model;
- supporting prisoner at risk procedures[7] (SPAR);
- Safer Custody forum;
- Substance Misuse Forum;
- security monitoring;
- progressive regime and earned privileges scheme (PREPS); and
- primary health care and mental health support.

[6] NIPS Vulnerable Person Policy 2017-2019

[7] At the time of Mr Johnston's death the Northern Ireland Prison Service Suicide and Self-Harm Prevention Policy 2011 (updated October 2013) and associated operating procedures were in place. New SPAR operating procedures – SPAR Evolution- were introduced at Magilligan prison on 30th April 2018.

At different times and in response to risk and needs care plans will be developed, delivered and monitored in custody. There is often input from different organisations provided to these plans but what appears to be lacking is an overarching assessment of risk and need which the respective organisations can work towards, particularly when someone is difficult to engage or refuses to engage in what is being offered. Some prisoners, for whatever reason, don't manage to engage or may not have the emotional capacity to make good choices. Developing capacity for engagement is critical.

Although Mr Johnston had significant addiction issues and these were documented in prison, probation and health care reports, he was not identified by residential officers who worked with him on a day to day basis as being vulnerable or at high risk of overdose. Neither had he come to the attention of the prison's security department in terms of drug related activity.

I accept that care plans will often be developed in response to particular events or problems. The challenge, however, as the clinical reviewers have both highlighted, is to develop a more integrated approach and effective ways of collating and communicating key, understandable information which everyone contributes to and works from. I agree with the reviewers that this should be actively coordinated and monitored but I would caution against an over medicalised model.

Recommendation 1
Managing vulnerable prisoners: The Prison Service and the Trust, together with their partner agencies, should review the assessment of risk and management of those presenting with complex case histories and are difficult to engage in services to ascertain if a case formulation model is workable in a prison environment or can be built into existing models.

Despite being on a landing which accommodated vulnerable prisoners, and meeting some of the criteria outlined in the prison's Vulnerable Persons' Policy, Mr Johnston was not identified as being vulnerable even with his history. He was therefore not managed as such.

The prison's Vulnerable Person's policy does not adequately describe the purpose for which it was intended and should be reviewed or its application changed.

Recommendation 2
The Governor should review Magilligan's Vulnerable Persons' Policy to ensure it meets the purpose for which it is intended.

(ii) Treatment of withdrawal, addiction support and medication management

Mr Johnston did not complete an alcohol withdrawal monitoring programme and he was not prescribed medication to treat his withdrawal symptoms until almost a month after he had been returned to prison. Ms Mackenzie queried why a nurse had run out of time to complete the assessment on Day 5.

The Trust explained that the nurse could not complete the assessment due to the number of patients she had to see on that day and highlighted that it was good practice that she recorded that Mr Johnston was not seen. There was, however, no follow up review arranged.

The Trust raised concern that Mr Johnston was transferred before his clinical assessments were completed and highlighted the potential risk associated with someone being transferred in a cellular van between Maghaberry and Magilligan while still experiencing withdrawal symptoms. Although a nurse requested that Mr Johnston stay in Maghaberry this was on the basis of an outstanding mental health assessment rather than ongoing monitoring of withdrawal symptoms.

Recommendation 3
Inter-prison transfers: The Prison Service and Trust should discuss and agree the approach to transferring prisoners who are being monitored for withdrawal when a transfer to another prison is being considered so that any clinical risks can be appropriately managed.

Mr Hewitt said it was not clear why Mr Johnston would have been withdrawing a month after being recalled but it was his view that this should have been explored. In Mr Hewitt's experience where someone has a long established dependency, it is good practice to commence treatment for withdrawal at the earliest point. He would also have expected Mr Johnston to be referred for an early specialist substance misuse assessment to inform a more developed treatment plan.

Mr Hewitt noted, however, that Mr Johnston declined a referral to AD:EPT at committal. He said that Mr Johnston's risk history may also have suggested a need for a specialist clinical substance misuse assessment separate to or together with that provided by AD:EPT. AD:EPT did conduct a comprehensive assessment at a later point and saw him after he failed a drug test.

In his report, Mr Hewitt said that while assessments were made in a timely way a number of opportunities are likely to have been missed to provide treatment and assistance to Mr Johnston. His conclusion was that despite Mr Johnston's mixed feelings about engaging with services, which made it more difficult to help him, it should have been clear that Mr Johnston was a high risk to himself. He felt that most involved with Mr Johnston only had part of a picture and more effort should have

been taken to gather a clear and accurate history to enhance understanding of Mr Johnston's situation and respond effectively by actively monitoring and managing his risk. This links to the earlier discussion on Page 16-17 about the possibility of developing a case formulation and management plan approach.

Recommendation 4
Withdrawal monitoring: The Trust should ensure that alcohol withdrawal monitoring is completed once commenced.

Mr Johnston stopped taking his anti-depressant medication several weeks after his committal but this was not followed up at the time and an assessment of the effect this may have had on him was not done.

Recommendation 5
Medication: The Trust should ensure that if it is identified that a patient is not taking their prescribed medication, they will be offered an appointment with a GP to discuss this and the outcome documented in the patient's record. The Trust should ensure that any unused medication is disposed of.

(iii) Records and record keeping
Ms Mackenzie found that some of the health care records were of a good standard and others were not. She identified a number of issues with inaccurate and inconsistent record keeping. Some records had not transferred from Maghaberry to Magilligan (the alcohol withdrawal monitoring charts) and between community mental health services and the prisons.

Nurses and doctors are required to adhere by their respective professional guidelines for record keeping. The quality of record-keeping has been highlighted in other death in custody investigations and learning is underpinned through training events and advice given to staff. While hard copy records such as Medication Administration Record (MAR) Cards are audited there is not currently an audit conducted of Egton Medical Information System (EMIS) patient records.

Recommendation 6
Record-keeping: The Trust should put in place arrangements to audit health care records to monitor compliance with national and local standards.

Despite Mr Johnston's engagement with community health and addiction services, these records were not requested. The flow of information between prison and community services was not as effective as it could have been.

Ms Mackenzie also commented that the design of the 'In-Possession' medication assessment flowchart was confusing for those having to use it as a decision making tool. Issues with the in-possession documentation were identified as a lesson learned in another case and the Trust undertook to develop a new form. The Trust have updated the policy and accompanying flowchart but this has not been implemented for operational reasons. I have not made a further recommendation on this matter but encourage the Trust to progress this work.

5.4 Determine if the resuscitation attempt was satisfactory and conducted in line with national guidelines

Although the two officers first on the scene had both recently been trained in Basic Life Support neither commenced CPR with one officer saying that he had never come across anything like this before and froze. The nurse who responded to the incident commenced CPR although he believed Mr Johnston was already dead. The nurse said that he wanted to do everything he could to attempt to resuscitate Mr Johnston given his age.

Ms Mackenzie was satisfied that an earlier intervention by prison officers would not have changed the sad outcome. In her view, however, it raised an issue about what is expected of prison officers in these circumstances and the role of nurses taking decisions about when to resuscitate. Ms Mackenzie suggested that the Prison Service should consider incorporating scenario based simulations into its emergency response training so that prison officers are better prepared and more able to effectively put their training into practice when faced with the trauma of finding someone.

Prison Service training in this area is already scenario based and both officers had relatively recently completed first aid training. It is difficult to account for how anyone might respond in the same circumstances. Increasing an understanding of reactions to stressful and traumatic situations, including the freeze response, could be helpful in providing officers information to assist one another in such circumstances.

Ms Mackenzie noted that in light of other death in custody investigations, the Trust planned to develop guidance for its staff relating to making decisions to commence CPR when there is a total absence of life signs and the person is likely to have been dead for some time. This work is ongoing.

5.5 Examine what steps are taken to disrupt the supply of drugs into the prison

There had not been drug related death at Magilligan prison since 2009. However, since Mr Johnston's death there have been a number of serious self-harm incidents relating to the taking or concealment of drugs both at Magilligan and Maghaberry prisons. This is a matter of concern. Drug related deaths in the community in Northern Ireland have increased significantly. The number of males dying from drug related causes[8] has almost doubled in Northern Ireland in the last 10 years with the largest numbers of deaths occurring in those aged between 25 and 34 years. The Prisons and Probation Ombudsman,[9] my counterpart in England and Wales, earlier in 2019, also reported an increasing concern about the number of deaths in which drugs has played a key part.

Local guidance for the management of substance misuse in custody was issued to staff in Magilligan prison on 6th April 2017 and a joint strategy between the Prison Service and the Trust for the management of substance misuse in custody was agreed in August 2017.

The guiding principles of Magilligan's approach are to:

1) eliminate the supply of drugs into prisons; and
2) reduce demand for drugs by providing prisoners with a range of opportunities to encourage them to adopt a drug-free lifestyle, before and after release.

The prison deploys a familiar range of techniques to reduce supply including:

- intelligence gathering, monitoring and staff vigilance;
- mandatory drug testing;
- passive drug dogs;
- controls in visits areas;
- searching; and
- seizure analysis.

Data for a six month period prior to Mr Johnston's death was requested to examine the range of measures adopted by the prison to reduce the supply of drugs into the prison. This found:

- 531 prisoners were drug tested. The average population at that time was 437;
- 77% of the tests results were passes and 23% were either fails or refusals;
- just over 60% of the test results were completed to inform risk assessments relating to home leave, regime progression and work, approximately 30% were

[8] Source: Northern Ireland Statistics and Research Agency Statistics Press Notice – Drug related and drug-misuse deaths registered in Northern Ireland (2007-2017).

[9] https://www.ppo.gov.uk/blog/the-worrying-increase-of-drug-related-deaths-in-custody/

on the grounds of reasonable suspicion and 9% were due to random drug testing;

- 120 adjudications were held related to failed drug tests of which 80% resulted in guilty awards with most charges relating to substances either tested or believed to be consistent with cannabis followed by buprenorphine (an opioid substitute);
- 574 supervised searches resulting in 98 drug and 27 mobile phone finds;
- One third of the drugs detected in confirmation results[10] related to cannabinoid substances, 18% buprenorphine, 15% benzodiazepines and 10% opiates;
- Passive drug dogs were deployed on all prisoners to the prison from Wednesday to Sunday and 790 searches were conducted of prisoners at other locations in the prison – mainly reception; and
- The level of telephone and mail monitoring was dependent on staffing levels with the time allocated to the censoring of correspondence decreasing over recent years.

Mr Hewitt examined the measures adopted by Magilligan to address the misuse of substances and made the following observations:

- The prison's substance misuse document covered both supply and demand reduction but could usefully have had more of a focus on alcohol, throughcare support, on psychoactive substances and on reducing diversion of prescribed medication.
- More weight should be given to risk in terms of where treatment options are focussed;
- The Substance Misuse forum was also focused on both demand and supply and its activities should be reflected in an action plan to drive developments;
- The security measures (as listed above) appeared to be usual but he noted that most of the intelligence reports were generated by the security department themselves which suggested there may be missed opportunities to gather and make use of a wide range of intelligence from other sources in the prison;
- There was no clear overview of the substance misuse treatment system in the prison and what the main pathways were. He felt there was an unhelpful degree of separation between the clinical addiction service and AD:EPT although the Trust advise that AD:EPT now attended weekly clinical meetings;

[10] A confirmation test is undertaken after a positive screening test. The confirmation test details the type and level of drug detected in the test. Northern Ireland Prison Service Guidance on the Mandatory Drug Testing of Prisoners, September 2010.

- It was not clear what the priorities are for the substance misuse services other than the traditional ones of managing risk; dependencies and withdrawals. He felt that priorities should be primarily based on risk, not on willingness to engage, or historical patterns of drug use and services provided.

After Mr Johnston's death prison staff reported that drugs, including the trading in prescription medication, presented a significant challenge in the prison and despite measures aimed at reducing supply, they were available, as is evident from the above statistics. A number of staff were frustrated that there was not a higher level of telephone call monitoring and more robust measures to detect drugs coming in through visits and on prisoners returning from home leave. The majority of those interviewed mentioned the need for enhanced scanning technology to detect concealed packages given the limitations of existing searching techniques.

I acknowledge that Magilligan, like other prisons, deploys a range of approaches to reduce the supply of drugs into prison. However, given how drugs are being concealed and how prevalent this problem appears to be, I encourage the Prison Service to continue to explore new developments in search technology and equipment to detect and deter drugs concealed in a person from being smuggled into prisons.

Recommendation 7
Reducing the supply of drugs: The Prison Service should continue to explore new developments in the use of search technology and equipment to better detect drugs concealed in a person.

I endorse Mr Hewitt's comments that policies and strategies only go so far in driving developments. More importantly, an active and effective partnership between the Prison Service, the Trust and its partner agencies, through the prison's Substance Misuse Forum to consider both supply and harm reduction, is required.

5.6 Establish if and why there was a delay in Mr Johnston's family being notified of his death

Mr Johnston's family was notified of his death several hours before being contacted by a prison Governor (Governor B) to confirm this. This was deeply distressing for them and it is important that the Prison Service understand the impact this can have on the grieving process. The family raised this matter directly with the then Governor of Magilligan prison (C) and Governor (B) at a meeting shortly after Mr Johnston's death.

Mr Johnston appreciated the opportunity to meet with the Governors and they had discussed how the family was notified of Mr Johnston's death. The Governor explained that he had followed protocol and added that if the same scenario arose again he would likely respond differently. He apologised for the distress caused to the family due to the delay in confirming Mr Johnston's death.

The Prison Service is currently developing new arrangements to improve the communication with families following a death in custody and these are due to be introduced in the winter.

The issue of how families are notified of the death of a relative in custody and how their immediate needs are met in the aftermath of a death has been raised in other recent death in custody investigations. I commend plans to introduce a Family Liaison role which will provide a single point of contact for families and I will keep this under review once introduced.

5.7 Examine the post incident arrangements including support for prisoners and staff

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 the staff, where possible, 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 reflect on events and identify any additional learning. This also provides a further opportunity to check in with staff involved in an incident.

A Governor (Governor D) completed the hot debrief on 4th August 2017 at 12:00 hours. Three officers who were involved in responding to the incident attended. The record of this meeting was inadequate and did not cover the detail recommended in the prison service policy.

A cold debrief was not conducted.

In direct response to the circumstances surrounding Mr Johnston's death, however, a series of searches were initiated in different locations in the prison, including H1 A&B landing, to recover illicit substances and mobile phones and there was increased ad-hoc monitoring of telephone calls made by prisoners aimed at disrupting the supply of drugs in the prison. Mental health staff, AD:EPT, chaplains and others attended H1 A&B to provide support to Mr Johnston's friends.

Recommendations relating to various aspects of these debrief meetings have been made to and accepted by the Prison Service in previous investigation reports.

Debrief meetings are an important mechanism to review the circumstances surrounding a serious incident and present an opportunity to reflect on opportunities for potential learning. Despite the actions taken by Prison Service in response to previous recommendations, the records provided in this instance do not provide sufficient assurance that the opportunity for learning from this case was optimised in accordance with the NIPS policy intention.

I reiterate to the Prison Service the importance of conducting debrief meetings in accordance with its own policy. Adequately recording those meetings so that procedures can be monitored and improved is also critical.

The health care staff interviewed said they were unclear what support was available to them. They were unaware of the hot and cold debrief process, although a cold debrief meeting did not take place in this case, and apart from peer support from health care colleagues, they reported that no additional support was offered. Prison staff acknowledged they were signposted to staff support services immediately after the incident. Ms Mackenzie noted that months after the incident those who directly responded, including the experienced nurse, still understandably had it on their minds. Ms Mackenzie said that it should be recognised that a wide range of support services should be made available and easily accessible to all staff.

The issue of post incident support for both prison and health care staff has been raised in previous death in custody investigations. The Prison Service and Trust have a range of support mechanisms available but in the course of our investigations there continue to be issues raised about access to these services. If a cold debrief had been held this would have provided a further opportunity to check in with those directly involved in the incident.

The Trust advised that they continue to expand their staff care programme to include a trauma informed approach and the Prison Service is developing a Staff Wellbeing Strategy.

I recognise that individuals experience traumatic and stressful situations differently and aftercare should be tailored to their needs. I encourage the Prison Service and Trust to continue to develop their staff care services to not only be trauma-informed but also resiliency-informed. This will support staff focus not only on prisoners but also on themselves so that they can build on their strengths to recover, as well as, becoming more aware of their needs as a result of experiencing traumatic and stressful events.

5.8 Identify if Mr Johnston's death might have been predicted and/or prevented

Given their respective areas of expertise both clinical reviewers were asked to comment on whether Mr Johnston's death might have been predicted and/or prevented.

Ms Mackenzie concluded: 'Taking all available information into consideration and although more could have been done to limit the risks for this vulnerable young man, it cannot be concluded with any certainty, that Mr Johnston's death was intended, or that it could have been foreseen or prevented.'

Mr Hewitt said it appeared Mr Johnston's death was accidental, 'specifically a misjudgement on his part of the likely effect of the drugs he had taken. It is probable that he was not fully aware of the amounts he had taken, and it is quite possible that he was also not aware of exactly what it was that he actually took, either because he was misinformed or because he didn't know.'

Section 6: Response to recommendations

A list of the recommendations made in this report and the Prison Service and Trust response to them follows:

Recommendation 1

Managing vulnerable prisoners: The Prison Service and the Trust, together with their partner agencies, should review the assessment of risk and management of those presenting with complex case histories and are difficult to engage in services to ascertain if a case formulation model is workable in a prison environment or can be built into existing models (p20).

The Trust accepted this recommendation and it was partially accepted by the Prison Service. In its response the Prison Service highlighted the changes made to its supporting prisoners at risk process which is an important change and a welcome one. However, this recommendation focusses on a wider brief and encourages an all-encompassing approach to complex histories that requires systemic change. I encourage the Service to work collaboratively with the Trust to explore if a case formulation model is workable.

Recommendation 2

The Governor should review Magilligan's Vulnerable Persons' Policy to ensure it meets the purpose for which it is intended (p21).

This Prison Service accepted this recommendation.

Recommendation 3

Inter-prison transfers: The Prison Service and Trust should discuss and agree the approach to transferring prisoners who are being monitored for withdrawal when a transfer to another prison is being considered so that any clinical risks can be appropriately managed (p21).

The Prison Service accepted this recommendation but it was not accepted by the Trust. The Trust said that the Prison Service should always seek the Trust's opinion on the transfer of prisoners and pointed out that on occasions prisoners may be transferred despite their advice or they may not know that someone has transferred until after the event. I accept ownership of the transfer policy rests with the Prison Service, however, I want to ensure that the Trust contribute to the review which the Prison Service plans to undertake.

Recommendation 4

Withdrawal monitoring: The Trust should ensure that alcohol withdrawal monitoring is completed once commenced (p22).

The Trust accepted this recommendation.

Recommendation 5

Medication: The Trust should ensure that if it is identified that a patient is not taking their prescribed medication, they will be offered an appointment with a GP to discuss this and the outcome documented in the patient's record. The Trust should ensure that any unused medication is disposed of (p22).

The Trust partially accepted this recommendation.

Recommendation 6

Record-keeping: The Trust should put in place arrangements to audit health care records to monitor compliance with national and local standards (p23).

The Trust accepted this recommendation and in its response explained that an arrangement is in place to audit clinical records annually and that an audit had recently been completed of GP records.

Recommendation 7

Reducing the supply of drugs: The Prison Service reviews and evaluates the use of search technology to better detect drugs concealed on a person to reduce the supply of drugs into prisons (p26).

The Prison Service accepted this recommendation. The Service said it was exploring new developments in the use of search technology and is continuing to work with other Departments to secure the necessary approvals to introduce new equipment to prisons.

Areas of care raised in previous reports which will be kept under review

I do not repeat the recommendations made in previous reports but note the progress made and plan to keep these matters under review.

- Development by the Trust of the medication 'In-Possession' risk assessment chart (p23).

- Guidance for Trust staff to assist with making decisions to commence CPR where there is a total absence of signs of life (p24).
- The development of the Family Liaison role by Prison Service (p27).
- Conduct of debrief meetings by Prison Service (p28).

Section 7: Conclusions

With regard to my responsibilities to investigate Mr Johnston's death and specifically considering the objectives of my investigation, I draw the following conclusions:

i) My investigation established the circumstances and events leading up to Mr Johnston's death on 4th August 2017. These are set out in Section 4 and at Appendix A.

ii) I accept and endorse the opinion of the clinical reviewers that, on the balance of probabilities, Mr Johnston did not intend to take his own life and that his death was likely accidental. I note, however, it is a matter for the Coroner to determine the cause of Mr Johnston's death.

iii) I further accept and endorse that although aspects of the care and treatment Mr Johnston received could have been better, I do not believe these directly contributed to his death. Sadly if Mr Johnston had not ingested substances which were not prescribed for him, he would not have died. I agree with Mr Hewitt that he may not have been aware of the quantity or precise type of the substance he had taken.

iv) I am very concerned about the impact of substance misuse both in the community and in prisons and the devastating impact this has on individuals, their families and those engaged in providing care and support for them. This is an extensive societal problem with many underlying contributory factors. The Prison Service and the Trust cannot address challenges presented by substance misuse without the wider societal problems being effectively addressed. They do, however, have an important part of play when someone comes into custody and later returns to the community.

v) Mr Johnston was typical of many young men who come in and out of prison. He led a chaotic lifestyle, struggled with substance misuse and mental ill-health, and was difficult to engage in services. Mr Johnston, like many others, presents an enormous challenge to those entrusted with their care particularly where no one agency has a complete picture or insight into the risk they present to themselves. Although it will be of little comfort to the Johnston family, my Office is aware of a number of instances, and is investigating several incidents, when prison and health care staff were able to intervene to prevent a death. Mr Johnston's death

emphasises the need for collaborative, inter-agency cooperation, especially the need for sharing information to enable effective risk assessments and responses.

vi) I have highlighted the need for the Prison Service and the Trust, together with their partner agencies, to work closely together to consider how they might enhance existing processes or consider alternative approaches to accurately assess and capture the risks and treatment needs presented by individuals who are difficult to engage, and actively monitor and manage them in custody. I have also recommended that the Trust and Prison Service discuss and agree an approach to transferring people between prisons who are withdrawing from substances.

vii) I have identified a need for the Prison Service to review its Vulnerable Person's policy at Magilligan prison and enhance ways of detecting the supply of drugs coming into prison. I have not repeated previous recommendations to the Prison Service on how families are notified of the death in custody of a relative, the conduct of debrief meetings and staff support. I will continue to monitor progress in each of these areas.

viii) I have identified a number of learning points for the Trust to address for improvement:

- Withdrawal monitoring and treatment;
- Follow up action when an individual reports they are not taking their medication
- The quality of patient notes and records.

ix) I have not repeated recommendations to the Trust in respect of staff care, the development of guidance for its staff relating to making decisions to commence CPR, the improvement of the possession medication flowchart and the requesting of community records. I will continue to keep these matters under review.

x) I acknowledge and welcome the response of the Prison Service and the Trust to the recommendations arising from this investigation. I will keep these matters under review.

xi) Where possible, I have addressed the questions posed by Mr Johnston's family during this investigation. My findings on these are set out in the body of this report and reflected in the recommendations which have emerged from my

investigation. The circumstances in which Mr Johnston's family were informed of his death were not satisfactory and I trust with the introduction of the Family Liaison role by the Prison Service, this will not be repeated.

xii) In order to assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, I will provide the Coroner with the materials underlying my investigation.

Appendix A

Summary of key events

Date	Event
21/01/16	Committed to Maghaberry - 3 year determinate custodial sentence (18mths custody 18mths supervised licence).
05/12/16	Released on licence.
03/03/17	Notified of licence revocation.
04/03/17	**Recalled to prison and committed to Maghaberry prison.** Prison committal and initial health care assessment.
05/03/17	Comprehensive health care committal assessment.
06/03/17	Mental health screen and referred for pre-mental health assessment, anti-depressant prescribed.
09/03/17	Issue raised by mental health team concerning transfer.
09/03/17	Transferred to Magilligan.
14/03/17	Alcohol withdrawal score attached to EMIS (not assessed).
15/03/17	Moved to a single cell in Halward House.
21/03/17	Did not attend treatment room to take medication.
22/03/17 & 31/03/17	Anti-depressant medication declined.
03/04/17	Requested to be moved to a single cell on H1.
05/04/17	Pre mental health assessment conducted.
07/04/17	Prescribed medication for withdrawal.
04/05/17	Completed AD:EPT assessment for support on release.
15/05/17	Saw House nurse – feeling unwell.
24/05/17	Promoted to Enhanced regime and requested to be put on the waiting list of the RISE landing.
26/05/17	Requested drug test to prove he was clean.
30/05/17	Received single Parole Commissioner decision not recommending release.
01/06/17	Failed drugs test for Tramadol abuse.
02/06/17	Family visit.
09/06/17	Adjudication for failed drug test (Tramadol abuse).
16/06/17	Family visit.
06/07/17	Prison staff asked a nurse to see Mr Johnston as he was feeling vulnerable. Saw nurse and advised to speak to House Senior Officer and Doctor.
07/07/17	Referred to mental health. Submitted request to be moved out of Halward House.

10/07/17	Allocated for mental health pre-assessment contact. Prescribed sleep medication.
10/07/17	Moved to H1 B wing.
14/07/17	Family visit.
18/07/17	Date of cancelled oral hearing.
24/07/17	Demoted to standard regime for failed drug test.
03/08/17	Telephoned father and brother.
04/08/17	Found unresponsive and pronounced dead at the scene.