The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

'Mr L'

WHILE IN THE CUSTODY OF
THE NORTHERN IRELAND PRISON SERVICE

Date finalised: 16th July 2018

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

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PRISONER OMBUDSMAN INVESTIGATION REPORT

Mr L

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GLOSSARY

AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
AED	Automated External Defibrillator
CCTV	Close Circuit Television
CPR	Cardiopulmonary Resuscitation
ECR	Electronic Care Record
ECR	Emergency Control Room
EMIS	Egton Medical Information System
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
PREPS	Progressive Regimes & Earned Privileges Scheme
PRISM	Prisoner 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
S/O	Senior Officer

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. Two clinical reviews were commissioned in this case. Dr Patrick Quinn, Consultant Forensic Psychiatrist at the Yorkshire Centre for Forensic Psychiatry undertook a clinical review of the healthcare provided to Mr L. A review of the resuscitation attempt was conducted by Ms Laura Walsh who is responsible for the operational delivery of Mental Health services in North Lancashire and has more than 12 years experience within Offender Health.

This report is structured to detail the events leading up to, and the emergency response to Mr L's death.

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 Office spoke with Mr L's family shortly after his death.

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

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

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

BRENDAN MCGUIGAN
Office of the Prisoner Ombudsman for Northern Ireland/Chief Inspector, Criminal Justice Inspection Northern Ireland
16th July 2018

SUMMARY

Mr L died in his cell while in the custody of the Northern Ireland Prison Service. The post mortem investigation found that he died from a haemorrhage due to an incised wound of the right femoral vein.

Mr L had a history of alcohol and substance abuse and had twice been committed to a community psychiatric unit in his teens. He had served time on remand prior to being convicted of a serious offence. At the time of his death he had served approximately four and a half years of his sentence. He had been in prison only once before for non-payment of a fine.

Following his committal, Mr L was accommodated in a unit for assessment due to concerns about his well-being and risk of self harm. During this time his progress was regularly monitored and evaluated by Healthcare staff. He engaged with mental health services including a forensic psychiatrist. After a period Mr L was discharged from healthcare and moved to normal location. He appears to have been reasonably well settled until he was involved in a serious incident in prison around a year before his death. As a consequence of this incident he spent a number of months in the prison's Care and Supervision Unit before returning to normal location.

He was last seen by a forensic psychiatrist (Psychiatrist) approximately a year before his death and had no further reviews by mental health in this period nor reported instances of self- harm.

On the day before his death, some prisoners reported concerns about Mr L's behaving bizarrely to prison staff. These reports prompted a custody prison officer (Officer A) to ring the House Nurse (Nurse A) and ask him to see Mr L. The Nurse saw Mr L that same day and noted that his behaviour was out of character. The Nurse recorded that Mr L was adamant during the consultation that he was neither a risk to himself or to others at present. After the consultation the Nurse discussed Mr L's case with a mental health colleague and the next day made a referral to the mental health team.

On the day Mr L died a number of prisoners again expressed their concerns about his behaviour to landing staff and the Senior Officer (Senior Officer A) on duty in the residential House that day. The Senior Officer spoke to the Nurse who advised that he had made a referral to the Mental Health Team based on his consultation with Mr L the previous day.

The Senior Officer advised landing staff to monitor Mr L.

Given Mr L's previous behaviour it is perhaps understandable that prison staff appeared to consider the risk that Mr L might pose to other prisoners and staff rather than any risk he might pose to himself.

Although the mental health referral had been made, it had not been actioned at the time of Mr L's death. Other than closer monitoring to ensure he did not pose a risk to others, no

other form of intervention was deemed necessary to mitigate any risk of Mr L harming himself.

Mr L was found in a collapsed state in his cell shortly after evening unlock by a fellow prisoner who immediately alerted staff. Prison officers and healthcare staff attempted to resuscitate him but he was pronounced dead by paramedics at 18:30 as short time later.

The clinical reviewer, Dr Patrick Quinn, who undertook the review of healthcare provided to Mr L concluded that Mr L's mental health needs were appropriately managed during his sentence and was satisfied the assessment conducted by the House Nurse the day before he died was probing and his response proportionate to Mr L's presentation. Based on his review of the prison healthcare records, Dr Quinn concluded that Mr L's death was not predictable nor could it likely have been prevented.

The clinical reviewer who assessed the resuscitation attempt commended the incident response by prison staff and nurses and how the nurses documented their individual contributions and attempts to resuscitate Mr L. She said the nurses used good clinical knowledge and skills and their approach was thorough and consistent with National Guidance. She made a number of recommendations to develop future practice.

The SEHSCT's Serious Adverse Incident Level 1 review was not available at the time of writing this report.

This report makes nine recommendations for improvement. Recommendations have previously been made and accepted by the NIPS in respect of journal entries/staff handovers, staff support and debriefs made.

The NIPS accepts the seven recommendations set out in this report and the joint recommendation in respect of post incident debriefs. The SEHSCT accepts the recommendation to develop a policy to address decisions regarding resuscitation where there are signs of irreversible death and partially accepts the joint recommendation.

RECOMMENDATIONS

NIPS:

1. **Journal entries:** The NIPS should highlight to staff the importance of all relevant information being appropriately recorded in journals (Page 20).

2. **Information gathering**: When concerns of the nature raised in this case are evident, a review of the prisoner's history on PRISM should be conducted and/or advice sought from the Personal Development Coordinator or Safer Custody Team (Page 20).

3. **Intervention:** In relevant cases the NIPS should put a care plan in place for prisoners pending a mental health referral being actioned (Page 21).

4. **Code Red and Blue messages:** The NIPS should issue clear definitions and guidance around the use of Code Red and Code Blue messages (Page 23).

5. **Governor's Order:** The Governor should review Governor's Order 1-12 to include the application of CPR in all cases where a prisoner is found unresponsive and make all prison staff aware of this requirement (Page 23).

6. **Checking of Automated External Defibrillators (AEDs**): The NIPS should ensure that AEDS are checked on a daily basis and that a record is made of these checks (Page 23).

7. **Actions arising from debrief meetings:** The NIPS should ensure that learning points identified at debrief meetings are clearly assigned to a named individual or department to implement and include clear timescales for completion (Page 26).

SEHSCT

8. **Resuscitation Policy:** The Trust should develop a policy that includes clear guidance for staff working in prisons who attend incidents of traumatic self-harm. This policy should be in line with national resuscitation guidelines in respect of decisions regarding resuscitation where there are signs of irreversible death (Page 24).

JOINT:

9. **Post incident debriefs and support**: The NIPS and SEHSCT should ensure those staff directly involved in a death in custody attend the initial hot and cold debrief meetings (Page 25).

PRISON BACKGROUND

Delivery of healthcare 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. Joint strategies were agreed in August 2017 and work to develop implementation plans has commenced.

Prisons in Northern Ireland have an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. A recent annual report highlighted a number of concerns relating to healthcare within the prison.

FINDINGS

SECTION 1: BACKGROUND

Mr L was committed to prison charged with a serious offence and was convicted a year later. He had served approximately four and a half years of this sentence at the time of his death.

Mr L was found unresponsive in his cell and was pronounced dead a short time later. The post mortem examination found that he died from haemorrhage due to an incised wound to the femoral vein. There was no alcohol in his system. Low levels of his prescribed medication were detected.

On the day of Mr L's death two in every 100 prisoners in the prison at the night handover were being managed under the prison's SPAR procedures, including two in observations cells. The Operational Status Report for the 24 hour period prior to Mr L's death indicated there were a number of incidents earlier in the day, including an assault on a nurse. While there were significant staffing shortages in the prison at the time there were no regime restrictions on the day of Mr L's death.

Mr L was accommodated on a lower supervision landing which accommodated mainly longer term sentenced prisoners. Over the weekend preceding Mr L's death there had been severe regime restrictions in the residential location, and on one day the landing where he had been accommodated was placed on fire watch due to reduced staffing levels. At morning unlock there were 36 prisoners on Mr L's landing supervised by two prison officers, one of whom was just on his second day of duty. Mr L had been accommodated in this residential House for around a year before his death.

Mr L had a number of previous convictions but had only been in prison once before for non-payment of a fine. He had a history of abusing alcohol and drugs, and had twice been committed to a community psychiatric unit in his teens. On one occasion this was due to a staggered overdose of paracetamol and depression. During his time in prison, he maintained regular contact with his family and friends via telephone calls and visits.

When first committed to prison, Mr L had refused food and fluids for several days and as a consequence he was accommodated in a special unit for assessment. During this time he self-harmed on a number of occasions and at one stage three suicide notes were found in his cell. He explained that these were old notes.

While in the assessment unit his progress was regularly monitored by healthcare staff and evaluated on a weekly basis. He was also seen regularly by the forensic psychiatrist and the mental health team. After eight months Mr L was discharged from healthcare and moved to

normal location, where he appeared to settle. He continued to be seen by the forensic psychiatrist (Psychiatrist A), though less frequently.

He was last seen by the psychiatrist approximately a year before his death and had no further reviews by mental health staff in this period; nor were there any reported instances of self- harm.

He was taking an antidepressant and antipsychotic medication at the time of his death and had been assessed as suitable to administer his own medication.

Approximately fifteen months before his death, Mr L was involved in a serious incident in the prison and was subsequently removed to the Care and Supervision Unit for a period before returning to the general population. He later said he had been off his medications at the time and put the incident down to a '*moment of madness.'*

Mr L was on an enhanced regime and was employed as a landing orderly. The following security markers were recorded on PRISM for him: Assault on Staff, Prisoner Known to Staff and Violent. He had undertaken seven drug tests while in prison, with one failure six months before his death when tramadol was detected. He was adjudicated on two occasions: one for the failed drug test and the other in connection with the serious incident which took place around fifteen months prior to his death. As Mr L was serving a lengthy sentence he was subject to an annual review of his sentence plan and the last review was completed around three months before he died. He had just finished the last of four scheduled sessions with the prison's drug and alcohol support service on the day of his death. This referral had been generated following the recent failed drug test earlier in the year.

SECTION 2: SOCIAL INTERACTION

Most accounts from prison staff and fellow prisoners describe Mr L as a quiet and reserved person.

As part of their ongoing monitoring of a prisoner's behaviour, landing staff are required to complete PREPS reports on a regular basis. Mr L was generally described as being polite and respectful in these reports and someone who interacted well with others. It was noted that after being demoted in regime level due to a failed drug test, he worked hard to get back to enhanced status.

Mr L was reported as enjoying a more positive relationship with his family in recent years. His parents visited him monthly and he had regular telephone contact with them. Their last visit was around a month before his death.

Analysis of Mr L's telephone calls in the weeks before he died does not reveal anything untoward. He talked about forthcoming visits and explained that ongoing industrial action by prison officers was having very little impact on him. He also recognised the frustrations of prison life and the need to control his temper.

When first committed to prison, Mr L engaged regularly with a prison chaplain and safer custody staff. They worked closely together to support him during his early days in custody. The last record of contact with the safer custody team appears to have been approximately a year before his death.

M L did not appear to be in a relationship at the time of his death.

SECTION 3: EVENTS LEADING UP TO MR L'S DEATH

In the days leading up to Mr L's death several prisoners on his landing said they were concerned about his behaviour and raised their concerns with prison staff and the House Nurse (Nurse A). They reported that he had been hearing voices and was becoming increasingly paranoid and confrontational.

The weekend preceding Mr L's death

Two prisoners (Prisoner A and Prisoner B) said they first raised concerns about Mr L's behaviour with a CPO (Officer A) three days before his death. They said that Officer A made several calls in response to their concerns. However Officer A was not on duty in the residential House that weekend. These prisoners were mistaken as to when they said they first reported concerns to prison staff.

The House Senior Officer (Senior Officer A) on duty over the weekend said she had no previous contact with Mr L and no concerns about his behaviour were reported to her during that time.

A number of prisoners on Mr L's landing said there was a marked change in his behaviour from the start of the weekend. They stated he was convinced that people were talking about him. They tried to reassure him this was not the case. On the Sunday before his death they said he was somewhat calmer.

Due to staff shortages the regime on landings where Mr L was accommodated was reduced on the Sunday prior to his death. Instead of a normal association, Mr L spent the afternoon in another prisoner's cell (Prisoner C). That prisoner said Mr L repeatedly asked him to listen at the door and window during the afternoon as he insisted he could hear voices and people talking about him.

The prisoner said he did not report his concerns to staff over the weekend because when these episodes happened before, he was able to convince Mr L there was no substance to his fears. He also said Mr L had asked him not to speak to prison staff as he feared he might be moved off the landing.

The day before Mr L's death

The day before Mr L's death, Prisoner C said the same pattern of behaviour was repeated again at unlock. At that point he advised Mr L to go and speak to staff because he did not feel able to deal with what was going on. Other prisoners reported hearing Mr L talking to himself during the night. Prisoner C said he followed Mr L down the landing towards the circle to ensure he spoke to staff. Another prisoner (Prisoner D) reported he overheard Mr L telling Officer A that he needed to see the Mental Health team.

During the morning Prisoner C said he was concerned that no one had called for Mr L so he went down and spoke to Officer A on two separate occasions to advise that Mr L was getting worse, and to reinforce the need for someone to see him. Officer A had worked in the residential House for several months and he did not know Mr L prior to working there.

When interviewed Officer A confirmed that up four individual prisoners had spoken to him about Mr L on the morning prior to the day of Mr L's death. He recalls their primary concerns were about his aggression and asking other prisoners if they were talking about him. Officer A queried this with Mr L and said he was not very forthcoming. When Mr L came down to the Class Office and asked to see a medic, Officer A rang the House Nurse twice: the first time to ask the Nurse to see Mr L; and a second follow-up call later in the morning when Mr L had not been called to the treatment room.

Officer A did not consider opening a SPAR as it had been reported to him by prisoners that the main concern was that Mr L was potentially going to 'lash out' at somebody and the risk was not about him harming himself. Officer A spoke to the Nurse after the consultation and was told that a routine referral had been made to the mental health service. He did not however record the concerns raised by others prisoners, nor the actions he took in response, in the Class Office Journal. It was his understanding that only serious incidents should be recorded in the journal. He explained that details such as what had happened in this case would be noted on a Post-it note in the journal to alert other staff. On this occasion there is no evidence that a post-it note was inserted in the journal. During the period he was on duty, Officer A stated he did not observe anything unusual about Mr L's behaviour.

The House Nurse (Nurse A) saw Mr L just before lunch and recorded details of the consultation on EMIS at 11:44. The consultation appears to have lasted several minutes. The Nurse recorded that Mr L described an increase in auditory hallucinations from the preceding weekend and stated that these were the voices of other prisoners. Mr L denied that the voices were destructive but said they were causing him concern. The Nurse noted that other prisoners had offered support over the weekend. He queried if Mr L had taken any illicit substance and whether he posed a risk to anyone, including himself, which he denied. During this consultation Mr L further reported that he had not slept for three nights and that his interest and concentration were lowered. The Nurse recorded that Mr L presented as clean and tidy

In response to Mr L's disclosures, the Nurse recorded that he would liaise with colleagues about a possible Mental Health assessment. He spoke to a Mental Health colleague over lunchtime and the following morning at 10:32 submitted a referral to the Mental Health team. On the referral form the Nurse recorded that staff and prisoners had reported a change in Mr L's presentation over the last 3-4 days. He also highlighted that Mr L had no thoughts of Deliberate Self Harm (DSH) or Life Not Worth Living (LNML) *currently* and that he had vehemently denied illicit drug use. The Nurse also flagged that Mr L had a previous history of self harm, aggression and violence. There is no indication on the form that it had

been reviewed by the Mental Health Team at the time of Mr L's death and it appears that it was only received by them the day after Mr L died.

The Nurse said that he assessed Mr L's behaviour as being '*out of character'* but he did not assess him as being in crisis at that point in time and, therefore, did not consider opening a SPAR.

Dr Patrick Quinn, our clinical reviewer advised that Nurse A's assessment of the prisoner's presentation at the time was probing and that his response to the prisoner's complaints was proportionate. He went on to say that as Nurse A was a primary healthcare nurse, it would be appropriate for him to refer the matter to mental health colleagues in the first instance.

When Mr L returned from seeing the House Nurse he told Prisoner C that the Nurse was sorting out a Mental Health referral. He also appeared to have been upset that he was questioned about using illicit drugs. While the clinical reviewer assessed the Nurse's assessment was probing and proportionate, a number of prisoners commented that the interview with the House Nurse was very short.

According to several prisoners Mr L's behaviour throughout the day continued to steadily deteriorate.

The S/O on duty on the day before Mr L's death (Senior Officer B) said that while she was aware Mr L had been down seeing the House Nurse, she did not know the nature of this appointment and no concerns about his behaviour were raised with her during her shift.

The day of Mr L's death

Mr L called into Prisoner C's cell after unlock on the day of his death and alleged that the House Nurse had been in the yard overnight telling prisoners in the yard about his medical history. Prisoner C describes Mr L as looking '*crazy'* on Tuesday morning, with a '*mad stare, his eyes were black and he was just sitting shaking.*'

A number of prisoners reported that Mr L had covered his TV with a towel because he believed his thoughts were being transmitted from the TV to the tannoy system. After morning unlock Prisoner C reported to the House Senior Officer (Senior Officer A) that Mr L was constantly hearing voices, talking to himself and believed that the announcements on the tannoy were linked to his TV. Prisoner C said he emphasised to the S/O that somebody needed to see Mr L urgently.

The S/O said that she would speak to the House Nurse. Prisoner C said he later spoke to the S/O again. The S/O replied that she had spoken to the Nurse and that Mr L was being referred to Mental Health. Prisoner C recalls replying that somebody needed to see Mr L immediately.

At 11:00 Mr L had an appointment with an AD:EPT caseworker. This was the last of four scheduled sessions following an earlier referral to the service. Mr L reported during these sessions that he had been off substances for five months following his last failed drug test, but was keen to prevent relapse and cope with cravings. During the last consultation the AD:EPT Caseworker did not note anything of concern in Mr L's behaviour. The Caseworker recorded that Mr L stated he did not have issues with drugs at this stage and knew he had to apply what he had learned.

Just before the lunch lock up at 12:30 a prisoner (Prisoner E) said Mr L entered his cell, and he thought Mr L was going to assault him. While he was in the cell, this prisoner said Mr L stood by the window, listening for voices. Immediately after this incident Prisoner E said that he went to the class office and spoke to an Officer (Officer B) who seemed unaware of any concerns about Mr L's behaviour. Given the passage of time Officer B did not recall any discussion with Prisoner E.

Prisoner E had a legal visit scheduled that afternoon and as he was leaving the House he said that he spoke to the Senior Officer about Mr L and also reported his worries to his solicitor during the visit and asked him to intervene. On learning of Mr L's death, the solicitor telephoned this Office the day after Mr L's death and confirmed that his client had raised concerns about Mr L's wellbeing. He advised that he had been unable to intervene.

Two other prisoners (Prisoner B and Prisoner F) said that they had also raised concerns with the S/O at around 14:15 when they were leaving the residential House. CCTV footage of the circle area that afternoon shows the Senior Officer talking to three prisoners for several minutes while they were waiting at the grille. When interviewed Prisoner B said that he was worried about the danger Mr L posed to other prisoners and to himself. Both reported that the S/O said she was aware of the situation and staff were doing everything they could to help Mr L.

The S/O recollected the encounter with Prisoner E but not Prisoners B or F. Her discussion with Prisoner E prompted her to have a second conversation with the House Nurse. The S/O said she was assured after speaking to the Nurse that Mr L did not present any concern in terms of suicide or self-harm.

That afternoon, at around 14:30, Prisoner C said that he and another prisoner (Prisoner D) were working in the stores close to the medical treatment room and took the opportunity to speak to the House Nurse directly about Mr L. Prisoner C said he told the Nurse that he was really worried about Mr L and the Nurse explained he had made a referral to the Mental Health team. Both prisoners stated that they told the Nurse Mr L needed to be seen right away.

The Nurse recollects the House Senior Officer and several prisoners speaking with him on that day and said he relied on his meeting with Mr L the day before when deciding what action to take. The Nurse said that he did not detect any further deterioration in Mr L's

behaviour from these reports. If this had been conveyed, he may have decided to see Mr L again.

Prisoner C also reported that he had spoken to Mr L about the possibility of him taking his own life, but that he (Mr L) had said that he would not attempt to do so again.

Around 16:00**,** Prisoner G said that he spoke to Officer C who came on duty at 13:45 that afternoon. Officer C had not observed anything untoward with Mr L but undertook to observe him for a period. Officer C said that she had only worked on the particular landing few times before and she did not know the prisoners particularly well. Officer D recalls a prisoner (but did not recollect who exactly) raising concerns with Officer C.

After the conversation with Prisoner G, Officer C observed Mr L more closely and noted he was more withdrawn than usual and had spent some time lying in his bed. Prisoner F also recalled speaking to Officer C and being advised that the concerns had been noted. Officer C did not recall this conversation. It was shortly after this that S/O rang the landing and spoke to Officer C in response to what had been reported to her.

The House S/O advised she spoke to Officer C and asked her to confirm the reports about Mr L's behaviour. After the landings were locked at 16:30 Officer C went to the S/O's office and they had a discussion, after which Officer C made the following entry in the Class Office Journal: '16:45: *Spoke to S/O regarding the low mood and strange behaviour of PR D76 L, walking up and own landing not speaking to anyone and spent 60 mins in bed staring at the ceiling*.'

This entry does not record any action to be taken by staff to speak to or monitor Mr L. However Officer C said that she had offered to keep an eye on Mr L. The House S/O did not make an entry in her journal. She explained this was one of many conversations she might have with individuals in the course of her normal duties and in this specific case, the exchanges did not raise sufficient concern to warrant her making a record in the journal.

Both the S/O and Officer C said they did not know Mr L well but they were aware of the serious incident he had previously been involved in. They confirmed their concern that afternoon was for the safety of staff and other prisoners on the landing. Senior Officer A said she did not make any decision to intervene, such as locking Mr L in his cell because she did not want to isolate him and exacerbate the situation. Nor did she consider opening a SPAR as no concerns had been raised by anyone that Mr L posed a risk of harm to himself. She said she advised staff to be vigilant and to inform her of any change of behaviour.

In the event Mr L was found unresponsive in his cell shortly after unlock. At that point no mitigating actions, other than to monitor his behaviour, had been put in place by prison staff.

Potential learning from this case

Although there are some inconsistencies in the prisoners' accounts, several of them raised concerns with prison staff and the House Nurse on a number of different occasions in the two days leading up to Mr L's death. Individual officers and the House Nurse responded by making a referral to Mental Health and a decision had been taken to monitor Mr L.

In hindsight there are factors which potentially had a bearing on staff recognition and acceptance of the deterioration in Mr L's behaviour, and therefore possible options to provide support. Ultimately however it is not possible to say whether any intervention might have averted Mr L's death, but there may be learning for other cases.

Communication

The main route for prison officers to highlight concerns is via written journal entries and verbal handovers between staff when going off and on duty. Although prisoners had concerns about Mr L over the weekend, these were not reported to prison staff at the weekend. The officers detailed to the landing on the day of Mr L's death had no knowledge of the previous day's events; and those relieving them at 13:45 did not know that concerns had been raised earlier that day. As concerns had not been reported to the S/O on duty the previous day nor over the preceding weekend, the House S/O was also not aware there was any issue until a number of prisoners spoke to her directly on the day Mr L died.

Apart from the entry made on EMIS (which prison staff are unable to access) by the House Nurse and the journal entry made by Officer C shortly before Mr L was discovered unresponsive, there were no other records of concerns. This resulted in the various concerns that were raised being considered in a piecemeal fashion by prison staff.

NIPS staff gave various explanations for not making journal entries. Governor's Orders 2-12 (Journals and Record Keeping) and 7-25 (Handovers) require staff to record in journals and, include at handovers, details of SPARs and incidents of self-harm or attempted suicide. When considered against these requirements Mr L's situation did not meet this threshold.

However as staff on duty on the day of Mr L's death (both morning and afternoon) were relatively new to the landing and did not know Mr L, they could not be aware that his behaviour was out of character.

As Mr L was accommodated on a low supervision landing where prisoners are expected to take greater personal responsibility for managing their daily routines and activity, prison staff stated that the landing accommodated a 'tight knit group of prisoners' and they 'sort of let them get on with it.' If this was the case the fact that at least seven prisoners said they came forward to speak to different members of staff on several occasions is of itself significant and potentially warranted a record being made. This would have presented an opportunity for staff to more closely monitor the situation, explore the accounts with the

prisoners who raised concerns and initiate steps that might have better managed the risk at an earlier stage.

The importance of ensuring that all relevant information is recorded in prison journals has been raised in other investigations. Subsequent notices to staff were recirculated to highlight this issue. The NIPS must continue to emphasise to staff the importance of all relevant information being appropriately recorded in journals.

The NIPS should emphasise to staff the importance of all relevant information being appropriately recorded in journals.

Potential opportunities to further explore Mr L's behaviour

There are differing accounts of the concerns reported to prison staff. A number of prisoners said they highlighted the risk of Mr L harming himself, as well as concerns about possible aggression towards others. Prison staff said only the risk to others was highlighted. The House Nurse though had asked him directly if he had any thoughts of suicide and self-harm, and he denied any such ideation.

None of the prison staff knew Mr L particularly well but they were all aware that he had previously been involved in a serious incident in the prison. They did not appear to be aware of his previous self-harm history. It may be understandable that the risk to other prisoners and staff was uppermost in their minds. Other than the assessment conducted by the Nurse and referral to mental health, no regard was paid to Mr L's own wellbeing despite his previous safer custody history other than the Nurse.

One potential learning point is that when concerns of this nature are raised in future, then a review of the prisoner's history on PRISM should be undertaken and/or advice sought from the prisoner's Personal Development Coordinator or the prison's Safer Custody Team.

When concerns of the nature raised in this case are evident, a review of the prisoner's history on PRISM should be undertaken and/or advice sought from the prisoner's Personal Development Coordinator or the Safer Custody Team.

Consideration of actions to mitigate risks pending the mental health referral

The SEHSCT advise that timescales for mental health referrals are in line with community mental health services, with urgent referrals being actioned within ten days and routine referrals within nine weeks. Prison staff were aware that a mental health referral had been made and because of this were satisfied that no other action as required. Given the timescales associated with a mental health referral and fact that concerns continued to be raised after Mr L had seen the Nurse, it may have helped if alternative interventions had been considered pending the mental health referral being actioned.

However since prison staff believed Mr L posed a greater risk to others than to himself, one possible course of action would have been to lock him in his cell in order to mitigate the risk. The S/O's rational for not doing so - that could have prompted Mr L to harm himself earlier than he did - was considerate and appropriate. A possible learning point may be for prison staff to put a care plan in place pending a mental health referral being actioned.

In relevant cases, the NIPS should put a care plan in place for prisoners pending a mental health referral being actioned.

SECTION 4: EVENTS AFTER MR L WAS FOUND

At 17:05 on the day of Mr L's death Officer C began to unlock the landing. As ten prisoners were due to go to the gym she unlocked them first and then proceeded to unlock the remainder of the landing. She then called the kitchen as the landing was four meals short and began giving out breakfast packs for the following morning. As Mr L was accommodated on a low supervision landing, it was not uncommon to unlock the cells without routinely taking requests at the door.

At approximately 17:30 Prisoner H entered Mr L's cell as he had not come out for his tea. He discovered Mr L in a collapsed state and immediately shouted for Officer C to activate the alarm to summon help.

On entering the cell Officer C noted a lot of blood and ran from the cell to alert other staff. She sent a Code Red message and requested the Emergency Control Room to call an ambulance.

Officer C then returned to the cell and along with Officer E, who had responded to the alarm from another landing in the residential House, attempted to get a pulse. Within minutes a number of other NIPS staff arrived at the House including a Senior Officer from Security (Senior Officer C) who applied the Automated External Defibrillator (AED). It did not advise a shock.

Nurses B, C and D initially responded to the radio message and were the first Healthcare staff to arrive in the House at 17:37. Nurse B and Nurse C went straight to Mr L's cell and Nurse D went to the treatment room to collect the emergency bag. Nurse C recorded catastrophic blood loss and that the injury was not actively bleeding.

Healthcare staff commenced CPR. Mr L's airway was maintained using an I-gel airway and oxygen was applied. They attempted to gain intravenous access, but without success. CPR was maintained by Healthcare staff in rotation until the arrival of paramedics. Other healthcare staff also responded and took part in the resuscitation attempt (Nurses E, F and G).

Paramedics arrived at the prison at 17:59 and were at the scene by 18:05. Paramedics obtained Intraosseous (IO) access, a technique which prison healthcare staff are not trained to undertake, and administered three doses of adrenalin. The AED was in place throughout the resuscitation and at no time did it indicate a shockable rhythm.

Despite all attempts to resuscitate Mr L, he was pronounced dead at 18:30 and his death was certified by the Forensic Medical Examiner at 22:10.

Clinical review of the resuscitation attempt

Ms Laura Walsh conducted a review of the resuscitation attempt. She said that prison staff and nurses reacted professionally and quickly to the incident and the nurses applied good clinical skills and knowledge. She said the resuscitation attempt was thorough and consistent with the UK Resuscitation Council Guidelines. She also found the documentation completed by nurses was of a high standard and clearly described the resuscitation attempt and their individual contributions.

The Clinical Reviewer concluded that that there was evidence to suggest that Mr L received clinical care which was equivalent to that which could have been expected in the community.

In the course of conducting her review the Clinical Reviewer identified a number of areas for improvement.

She noted that the NIPS had no standard definition of Code Red/Blue messages and there were gaps in the Governor's Order providing advice to staff in the prison on when to commence CPR. As the response to the incident was so swift the Clinical Reviewer was satisfied neither would have made a difference in this particular case, but might do so in a different set of circumstances. She suggested the NIPS should issue clear definitions and guidance around the use of Code Red and Code Blue messages, review Governor's Order 1-12 to include the application of CPR in all cases where a prisoner is found unresponsive, and make all prison staff aware of this requirement.

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The Governor should review Governor's Order 1-12 to include the application of CPR in all cases where a prisoner is found unresponsive and make all prison staff aware of this requirement.

The NIPS advised that both of these actions have now been implemented.

Ms Walsh noted that AEDs should be checked on a daily basis and a record made in the S/O's journal, with a weekly check undertaken by Unit Managers. Although the AED in this case was operating correctly, the records showed that over a 32 day period there were records of only 13 checks being completed. The NIPS should ensure that AEDS are checked on a daily basis and that a record is made of these checks.

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The reviewer said that the decision to commence CPR was appropriate and referenced joint National Midwifery Council, Royal College of Nursing and British Medical Association guidance which states that a decision not to commence CPR should be supported when there 'are signs of irreversible death ie rigor mortis'.

Ms Walsh was satisfied that there were no signs of rigor mortis documented and that paramedics had also attempted to resuscitate Mr L. She noted that the Trust did not have a specific resuscitation policy for prison healthcare. She recommended the Trust should develop a policy that includes clear guidance for staff working in prisons who attend incidents of traumatic self-harm. This policy should be in line with national resuscitation guidelines in respect of decisions regarding resuscitation where there are signs of irreversible death.

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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 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 reflect on events and identify any additional learning.

Both meetings took place within the required timescales.

The Deputy Governor (Governor A) chaired the hot debrief meeting which took place at 19:40 on the day of Mr L's death. It was attended by 21 staff who were involved in the incident and addressed all areas identified in the template set out in the operating procedure. It was noted by the clinical reviewer that five of the six nurses who attended the hot debrief left the meeting before it concluded to attend another emergency in the prison.

The House Senior Officer (Senior Officer A) reported that there had been no concerns or issues raised about Mr L until that day when another prisoner had reported that he was behaving strangely. She advised of her conversation(s) with the House Nurse who had also

spoken with other prisoners. This may have been the S/O's understanding but in fact concerns were first raised with staff the day before and prisoners were concerned about him over the weekend. No follow-up actions arising from the hot debrief were identified.

The cold debrief meeting took place nine days later and was chaired by the Duty Governor, (Governor B). This meeting was attended by a number of staff who responded to the incident but not the first and second NIPS responders. Healthcare staff did not attend this meeting, nor make apologies at the time. The Trust later explained that unfortunately due to staffing pressures and to other meetings, no-one was available to attend this meeting. No representative of the Independent Monitoring Board was present. While the NIPS Suicide and Self Harm Prevention Policy 2011 (updated October 2013) does not stipulate who should attend a cold debrief meeting, it is beneficial for a range of disciplines to be present, and particularly Healthcare representatives.

The events of the day of Mr L's death were reviewed and those attending concluded there was nothing more staff could have done that evening. The events that led up to Mr L's death – which were referenced to an extent at the hot debrief - were not explored. This was a significant omission as there may have been some learning points for future practice.

Officers who responded to the incident were invited to outline how they had been managing. A Governor (Governor C) said that he had held a meeting with a SEHSCT representative (Mr A) who had been advising the NIPS how to support prisoners and staff in the aftermath of deaths in custody. A follow-up meeting was to be conducted four weeks later in order to monitor developments.

Commenting on the initial hot and cold debrief meetings, the Clinical Reviewer, Ms Walsh said: *'Considering that a significant part of any debrief will include the emergency response and resuscitation attempt, the non-attendance of the people who attended the incident brings into question the effectiveness of the debrief.'* She therefore recommended that staff involved in serious incidents of this nature are supported to attend debriefs and receive support.

The NIPS and SEHSCT should ensure those staff directly involved in a death in custody attend the initial hot and cold debrief meetings.

The Trust partially accepted this recommendation pointing out that the initial hot and cold debrief meetings were among a range of measures put in place to support nursing staff directly involved in this incident.

As discussed at the initial cold debrief meeting, a follow up meeting, chaired by the then Deputy Governor (Governor A) took place around nine weeks later. The Governor explained that this further meeting was convened to ascertain how staff were coping and whether anything else could be done to support them. Four officers who were on duty on the evening Mr L died were present although not the officers who first responded to the

incident. The Operational Nurse Manager and a Nurse – both of whom were involved in the attempt to resuscitate Mr L - were also present.

Staff were clearly given the opportunity to talk about the impact of Mr L's death and there was wider discussion about the appropriate timing of debrief meetings and the need to follow-up with staff who had been unable to attend the initial cold debrief and the follow-up meeting. This discussion resulted in two action points being identified to address these points. Neither action point was directly assigned to an individual or department to implement nor was a timescale for implementation identified, and neither appear to have been implemented.

Both action points would clearly enhance staff support mechanisms and are in line with recommendations made in previous death in custody investigation reports but it is important that where improvements for practice are identified, these are implemented.

The NIPS should ensure that learning points identified at debrief meetings are clearly assigned to a named individual or department to implement and include clear timescales for completion.

In addition to the debrief meetings, the NIPS invited the Police Reform and Rehabilitation Trust (PRRT) to provide a therapy session for the staff who responded to Mr L's death. This session was attended by staff who were directly involved in the incident, with the exception of one officer who was on sick leave as a result of the incident.

The NIPS staff interviewed acknowledged they were supported by line managers and advised to use the Carecall service. The CPO who had only been on his second shift had been visited at home by a manager, which he appreciated. These follow-up steps are positive developments.

Two Community Response Plan meetings took place shortly after Mr L's death. The record of the first meeting indicates this meeting was attended by representatives from NIPS, SEHSCT and a number of partner organisations. A record of the second meeting could not be located. The purpose of the meetings was to review any potential connection between the two recent deaths, identify any other prisoners who might be at risk and review support mechanism for both prisoners and NIPS/SET staff. Again this was commendable.

Notwithstanding the good practice outlined above – the holding of a follow up debrief, the involvement of PRRT and community response plan meetings - all those directly involved in responding to Mr L's death did not appear to have the opportunity to attend the scheduled debrief meetings and/or received ongoing support. As the impact of deaths in custody may have a lasting effect on both staff and prisoners, the NIPS, as identified at the follow up cold debrief meeting, should offer further formal check-ins with those directly involved to see how they are doing and signpost opportunities for support.

The former Prisoner Ombudsman met Mr L's parents after they had an opportunity to meet with three of his friends in prison. This meeting was arranged by the lead Chaplain and the family reported that they valued the interaction it provided. His parents did not raise any concerns about the circumstances surrounding Mr L's death.

SECTION 5: CLINICAL REVIEW (HEALTHCARE)

Dr Patrick Quinn, a Consultant Forensic Psychiatrist, was invited to conduct a review of Mr L's medical and custody records and advise if his healthcare needs were appropriately managed.

Dr Quinn noted that Mr L had a number of interactions with a range of healthcare staff in custody and in the community including mental health nurses, general practitioners and a consultant forensic psychiatrist. During all engagements with these professionals Mr L expressed thoughts of low mood and self-harm.

The reviewer identified this as a recurring theme throughout Mr L's contact with the NI Prison Service and when in contact with psychiatric services in the community ie thoughts of self-harm, periods of instability and an appropriate/proportionate response from professionals involved at that time.

Dr Quinn concluded:

- Mr L's mental health needs were appropriately managed;
- The response to Mr L's behaviour before his death was appropriate;
- Mr L's death was not predictable nor could it have likely been prevented;
- The medication prescribed to Mr L was appropriate.

He stated:

"The interventions by different [healthcare] staff at different times both in the community and when on remand/sentenced, were appropriate and that which would be ordinarily expected when caring for, advising, supporting a prisoner in similar circumstances to Mr L."