The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

'Mr K'

WHILE IN THE CUSTODY OF
THE NORTHERN IRELAND PRISON SERVICE

Date finalised: 3rd May 2018

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

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GLOSSARY

AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
CCTV	Close Circuit Television
CJI	Criminal Justice Inspectorate
CPN	Community Psychiatric Nurse
CPR	Cardiopulmonary Resuscitation
CSU	Care and Supervision Unit
DSH	Deliberate Self Harm
FMO	Forensic Medical Officer
EMIS	Egton Medical Information Systems
IMB	Independent Monitoring Board
PSNI	Police Service Northern Ireland
NIPS	Northern Ireland Prison Service
PACE	Police And Criminal Evidence Act
PECCS	Prisoner Escort and Custodial Service
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust
SO	Senior Officer
SPAR	Supporting Prisoners at Risk
TSH	Thoughts of Self-harm

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 Inspectorate, 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 Northern Ireland Prison Service;
- 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 Prison Service 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 Close Circuit Television footage and phone calls. Where necessary independent clinical reviews of the medical care that was provided to the prisoner are commissioned. In this case Dr Adrian Thomas Grounds, an Honorary Research Fellow at the Institute of Criminology, University of Cambridge, undertook a clinical review of the healthcare provided to Mr K.

The report is structured to detail the events leading up to, and the emergency response to Mr K'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 former Ombudsman first met with Mr K's mother shortly after his death, and contact has been maintained with her throughout the investigation.

Although this report will inform several interested parties, it is written primarily with Mr K's family in mind. They raised concerns about the levels of care provided to Mr K and, in particular, they queried delays in access to medication and seeing a psychiatrist following his initial committal to prison. The family also said they did not understand why he had not been more closely monitored given his self-harm history; and they felt that 15 minute observations should have been continued for a longer period. Although outside the scope of this investigation, the family felt that Mr K should not have been committed to prison at all given his mental health problems and queried whether his mental health issues had been properly diagnosed and treated in both the community and prison. I met Mr K's family recently in order to explain and discuss the findings and recommendations of this report. Many of their initial concerns remain.

I am grateful to Mr K's family, the Northern Ireland Prison Service (NIPS), the South Eastern Health and Social Care Trust (SEHSCT) and the clinical reviewer for their contributions to this investigation.

I offer my sincere condolences to his family for their sad loss.

BRENDAN MCGUIGAN
Office of the Prisoner Ombudsman for Northern Ireland/Chief Inspector, Criminal Justice Inspection Northern Ireland, 3rd May 2018

SUMMARY

Mr K died in his cell while in the custody of the Northern Ireland Prison Service. The post mortem report recorded that he died by hanging.

He had been remanded in custody after having been charged with a serious offence. Mr K had previously been in prison for a number of other offences.

Mr K had a long history of mental health problems and substance abuse. He reported and sought treatment for anxiety and depression over a lengthy period and had a history of self-harm both in the community and prison. He had recently been discharged from a mental health unit.

When he was committed to prison, the committal nurse, on reviewing the available information, initiated the Supporting Prisoners at Risk (SPAR) process. It is notable that the community mental health team alerted prison healthcare staff to Mr K's potential vulnerability in custody. This SPAR was closed seven days later following a case review which was attended by Mr K.

A referral for an initial mental health assessment was generated following the initial mental health screen and Mr K was allocated a mental health key worker. He was seen on four occasions by the mental health nurse and had been seen twice by a prison psychiatrist. At each appointment thoughts of self-harm/suicide were explored with Mr K. However he never gave any indication of suicidal ideation to the various professionals engaged in his care during this period in custody.

Approximately two weeks after committal Mr K moved to a different House where he seemed to settle. He received regular telephone calls and visits from his mother and was in contact with his partner.

On the day of his death Mr K had attempted to contact his partner several times and spoke to his mother. During that call he expressed frustration, despair and feelings of being exploited. However he did not subsequently report any concern to fellow prisoners or prison staff. Several people commented that Mr K was a very private person and did not show outward signs of distress.

At 19:30, during a check, a prison officer looked into Mr K's cell and saw him sitting on the floor with a ligature round his neck. The alarm was raised. Prison officers removed the ligature and commenced chest compressions. Prison healthcare staff arrived at the cell a short time later and took over the attempted resuscitation until paramedics arrived. Mr K was declared dead by paramedics at 19:57.

Our Clinical Reviewer, Dr Grounds, concluded that the attempts to resuscitate Mr K followed accepted procedures.

Overall in relation to whether Mr K's death might have been predicted or prevented, Dr Grounds concluded there were no obvious and proximate indicators of an imminent suicide risk that would have been evident to prison and healthcare staff prior to Mr K's fatal hanging. He said the actions taken by healthcare staff appeared appropriate in light of the information available to them.

Dr Grounds identified a number of learning points for future practice in relation to information transfer, continuity of medication, access to previous medical records, risk assessment and involvement of families in care planning. He also made a number of observations in respect of the SPAR process.

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

This report makes eleven recommendations for improvement. All but one has been accepted by the NIPS and the SEHSCT. The Trust did not accept the recommendation about the use of a single complete record to enhance the transfer of information between custody and community. The Trust would be supportive of such a record being in place but responsibility for the delivery of this initiative is not within the remit of prison healthcare.

A number of the recommendations set out in this report relate to areas highlighted in previous investigation reports including the operation of the NIPS supporting prisoners at risk (SPAR) procedures, contact with families following a death in custody and continuity of medication.

RECOMMENDATIONS

NIPS:

1. **SPAR procedures**: The NIPS should ensure that when a SPAR is opened after an incident of self-harm, the specific issue of suicidal intent should be assessed. When there is evidence of suicidal intent, the relevant parts of the Assessment Interview should be completed, even if the person reports they were not contemplating suicide at the time of the interview (Page 17).

2. **SPAR procedures**: A review of how Mr K's SPAR was managed should be conducted to identify and share learning for future practice (Page 18-19).

3. **SPAR procedures:** The NIPS should consider seeking a contribution from the nominated family member in order to inform discussion at SPAR closure/post closure review meetings or at subsequent reviews (Page 18-19).

4. **Family liaison following a death in custody**: The NIPS should ensure that family contact arrangements following a death in custody are as responsive as possible (Page 31).

5. **Lessons learned:** In addition to the debrief meetings, the NIPS should put in place a process to review the broader circumstances surrounding deaths in custody to identify and put in place any immediate learning points (Page 32).

SEHSCT:

6. **Transfer of information:** Once available, the SEHSCT should adopt a single complete record in relevant cases to facilitate the transfer of information between prison and community mental health services upon committal and release (Page 14).

7. **Medication:** The SEHSCT should ensure that currently prescribed critical medicines can be continued during the first night in custody when this is needed to prevent harm from delayed or missed doses (Page 15).

8. **SPAR procedures:** The SEHSCT should ensure that when SPAR reviews are undertaken for prisoners who are under the care of the mental health team, the mental health key worker should be invited to attend the SPAR review and attend where possible. If unable to attend, the mental health key worker should ensure that the view of the mental health team and relevant information is communicated in advance to the review (Page 19).

9. **Access to medical records:** The SEHSCT should ensure that relevant medical records are promptly requested (Page 25).

10. **Mental health assessment:** In the case of a prisoner who has self-harmed shortly before arriving in custody, the SEHSCT should ensure that a comprehensive mental health assessment is offered promptly or acquired by the prison mental health team (Page 25).

11. **Care planning**: The SEHSCT should consider involving families in care planning, and psychological treatment interventions (Page 26).

PRISON BACKGROUND

Responsibility for delivery of healthcare in Northern Ireland prisons transferred from the Northern Ireland Prison Service to the South Eastern Health and Social Care Trust (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. Their 2016-17 annual report highlighted a number of concerns relating to healthcare within the prison.

Prisoner Escorting and Court Custody Service (PECCS)

The PECCS is the Prisoner Transport and Escorting Service. PECCS also has responsibility for the operation of the cell holding areas in each Courthouse in Northern Ireland.

FINDINGS

SECTION 1: BACKGROUND

Mr K was remanded to prison charged with a serious offence. He died six weeks later.

Mr K was found during a routine check at 19:30. He had a ligature round his neck and his ankles and hands were bound with laces. The post mortem found that he died by hanging. There was no alcohol in his system. Prescribed medication was detected at a level consistent with therapeutic use.

He was taking two inhalers, antidepressant and antipsychotic medication at the time of his death and had been assessed as suitable to administer some of his medication, though one prescription was administered by the House nurse.

On the evening of Mr K'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 observation cells. The Operational Status Report for the 24 hour period prior to Mr K's death indicated there were several serious incidents in the prison: one involving a prisoner who had taken his cell mate hostage and another where a staff member was assaulted.

Approximately two weeks after his committal Mr K moved to a different residential location in the prison where he appears to have been settled. The House was subject to weekend routine when Mr K died which meant that prisoners were locked after their evening meal at 17:00 and there was no evening association. There were 44 prisoners on the two landings which were staffed by one officer at the time Mr K was found. This is the normal staffing level for the weekend regime. The Senior Officer's (SO's) journal records that the SO finished duty at 17:00 and that the Day Manager had sent three staff to maintain the regime in the House that afternoon.

Mr K's records indicate that he had a difficult childhood and a history of self harm/attempted suicide and substance abuse. He was known to community mental health services and had received treatment for anxiety and depression. His family reported that he had attempted suicide on several occasions. Some months prior to this committal to prison, Mr K had been admitted to the Mental Health Unit where he was diagnosed with depression.

This voluntary admission followed an impulsive overdose of Lyrica[1]. Mr K was discharged as an inpatient after eight days but continued to attend the day ward for three weeks. Mr K lived alone but had dependents and was in a relationship at the time of his death.

[1] Lyrica also known as Pregablin is a prescription only medication used in the treatment of partial epileptic seizures, to treat neuropathic pain and in the treatment of anxiety disorders. Side effects of this medication include confusion, disorientation, irritability and insomnia, as well as hallucinations, depression and abnormal

Mr K had been in prison on three previous occasions. During a previous period of custody, he attempted to hang himself using laces, and Naloxone, a medication used to block the effects of opioids, was administered. He was placed on a SPAR and moved to an observation cell. He was discharged from prison shortly after this incident.

Mr K reported taking an overdose prior to being arrested. He was treated in hospital and admitted for medical treatment. He was discharged the following day into police custody. A short time later, Mr K was taken by police to hospital for a psychiatric assessment but he withdrew consent and was returned to police custody. He was seen on a daily basis by Forensic Medical Officers (FMOs) when in police custody. They recorded that he suffered from asthma, panic attacks and had mental health problems.

The Clinical Reviewer said the detention records confirmed that while in police custody Mr K was asked about his mental health history each day and there are references to him having no current thoughts of self-harm. The Reviewer noted direct contact between the FMO and the consultant psychiatrist to transfer information; there were several medical reviews and appropriate medication was arranged.

Mr K had completed various prison induction programmes and was on standard regime. No drug tests had been conducted during this period of custody and he had been charged with one offence under prison rules but the matter had been adjourned. As a recently remanded prisoner on a serious charge he was allocated a Personal Development Plan Coordinator in accordance with the NIPS Prisoner Development Model of October 2014. Due to the relatively short time Mr K had been in custody there had been limited engagement with his PDP Coordinator although a resettlement needs profile had been completed.

Mr K had been referred to AD:EPT by healthcare on a short time after his committal but as the waiting list for assessment at that time was 3-4 weeks, he had not been assessed at the time of his death.

dreams. The summary of product characteristics records that suicidal ideation and behaviour has been reported in some patients.

SECTION 2: COMMITTAL

The documentation given to Reception staff when Mr K arrived in prison custody comprised:

- PECCS New Committal Form;
- PACE 15 Detained Person's medical form;
- PACE 16 Prisoner Escort Record and custodial record relating to Mr K's detention in police custody; and
- A handwritten note from the FMO.

Mr K was initially interviewed by prison Reception Officer (Officer A) who reviewed the police paperwork, conducted a vulnerability assessment and recorded all relevant details on PRISM.

The PACE documentation indicated Mr K had overdosed two days earlier, that he was a drug user and suffered from asthma/depression. It is clear from the entries the Reception Officer made on PRISM that he explored the information recorded on the PACE papers including whether Mr K had any current thoughts of self-harm or suicide. In response Mr K said he had no current thoughts of suicide. The Reception Officer recorded that Mr K was calm and co-operative and had talked openly about his mental health issues. The Reception Officer also recorded there was a letter from the FMO in the committal paperwork. The handwritten note recorded Mr K had a history of depression, his consultant details, that he had reported an addiction to Lyrica and had taken a mixed overdose the day before. The FMO stated that he would appreciate further psychiatric assessment of Mr K. The Reception Officer noted the contents of this letter during the committal interview.

Initial health screen

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

The Initial Health Screen was carried out by Nurse A, the Committal Nurse. Earlier that afternoon, a Senior Manager with a Community Mental Health Team (Senior Manager A) had contacted a Mental Health Nurse in the prison, provided information about Mr K's psychiatric history and forwarded a copy of the Trusts' Risk Screening tool. This information was promptly recorded on EMIS and was available to the Committal Nurse when conducting the initial assessment. The Mental Health Nurse advised the Committal Nurse that a SPAR might be needed.

Based on this and other information gathered and reviewed as part of the health screen, the committal nurse opened a SPAR at 18:00 by completing the referral form. She noted on this document that Mr K appeared low in mood; he was unable to guarantee that he would not attempt to take his own life and could not give her a positive reason to live.

The Clinical Reviewer said the proactive transfer of information from the community mental health team to prison healthcare was notable good practice. He noted that Mr K's previous attempt to harm himself was not recorded on the Risk Screening Tool but was detailed in the EMIS records held by prison healthcare and so the complete known history of self-harm was in the records, albeit in two sources.

He commented: "*Taken together the Risk Screening Tool and the EMIS records provided an adequately detailed history of the nature and circumstances of the past incidents of self-harm, and of Mr K's mental state, varying intent, and protective factors at those times. Thus the clinical staff in the prison had a sufficiently detailed previous history for the purpose of assessing any ongoing suicide risk.*"

Once available the SEHSCT should adopt a single complete record in relevant cases to facilitate the transfer of information between the prison and community mental health services upon committal and release.

The Trust highlighted that once the Encompass (single health record) programme is rolled out in Northern Ireland, this will support transfer of information between prison and community mental health services upon committal and release.

While the notes of the initial healthcare screen recorded on EMIS were comprehensive, the initial healthcare Committal/Transfer Screening Form was not fully completed. Only Mr K's fitness to work and attend the gym was flagged on this form. The information missing on this document related to medical markers which the SEHSCT explained had already been entered on the prison information system during a previous period of custody. As this information was already entered on the electronic system and had not changed it did not need to be recorded on the initial screening document.

The Committal Nurse accessed the Electronic Care Record (ECR) and confirmed Mr K's medication was as recorded on the PACE documentation. A prescription for inhalers and Mirtazapine (15mg) was written by the prison doctor (Doctor A), the day after his committal, without having seen Mr K. The dosage of Mirtazapine was the same as that prescribed in police custody and recorded on Mr K's ECR.

The Clinical Reviewer noted some discontinuity in medication prescription during the initial days in detention and custody. He stated it would have been desirable to ensure continuity of the prescription, particularly at the stressful time of entry to prison, but it is unlikely that the omission of this medication for a day would have had significant adverse clinical consequences.

The SEHSCT should ensure that currently prescribed critical medicines are continued during the first night in custody when this is needed to prevent harm from delayed or missed doses.

SECTION 3: MANAGEMENT OF MR K'S SPAR

The SPAR process is designed to support prisoners who are identified as vulnerable, by putting in place and regularly reviewing an individualised care plan. A SPAR is opened when a referral form is completed, with the aim of triggering an immediate action plan to safeguard the prisoner. Thereafter there will be regular case reviews to monitor progress and ultimately a case closure review. This review is then followed by a post closure review to be completed no later than seven days after closure of the SPAR.

Mr K was managed under the SPAR procedures from his committal until it was closed a week later. A post closure review took place a week after the SPAR was closed. Although the SPAR had been closed around four weeks prior to his death it is appropriate to reflect on the management of Mr K's SPAR in order to identify any learning for future practice.

After Nurse A opened the SPAR an immediate action plan was agreed with Reception Senior Officer (Senior Officer A), the Committal Nurse (Nurse A) and a second Senior Officer (Senior Officer B). Mr K was taken from Reception to a residential House, changed into anti-ligature clothing and placed in an observation cell where he could be closely monitored. The action plan stipulated he should be monitored every 15 minutes and the frequency of conversation checks was specified.

The Referral Form recorded that Mr K had a previous history of overdoses/suicide attempts but it did not include a reference to a previous incident of attempted hanging in prison.

While noting the prompt and appropriate opening of the SPAR, the Clinical Reviewer said the previous hanging attempt should have been recorded on the referral form. He said: "*This would have been pertinent information for the purpose of considering the methods of self-harm or suicide Mr K might consider, and preventive measures, including observation intervals. However, even if hanging was not specifically considered, the placement of Mr K in a safer cell with anti-ligature clothing is likely to have mitigated any risk of this method of suicide*."

The following day an Assessment Interview was conducted between Mr K and the House Senior Officer (Senior Officer C), prior to the initial case review. The purpose of the interview was to address Mr K's perception of the problems which prompted opening of the SPAR. The assessment interview notes record that Mr K said he deserved to die but did not want to.

The instructions for the assessment specify that different parts of the interview form should be completed according to whether there was:

- an act of self-harm with the intention to die;
- whether there was an act of self-harm to cope with living; or
- there was any other reason for opening the SPAR.

The parts of the form that were relevant to the second option were completed. This was because there was no specific information in the SPAR referral Form that indicated suicidal intent at the time of the overdose; and also because Mr K appears to have denied any current thoughts of suicide. As a result the section of the form designed to explore reasons for dying and living was not completed.

The Clinical Reviewer said it was possible there was a missed opportunity here and that selecting the first option for completing the form would have been more appropriate.

The NIPS should ensure when a SPAR is opened after an incident of self-harm, the specific issue of suicidal intent should be assessed. When there is evidence of suicidal intent, the relevant parts of the Assessment Interview should be completed, even if the person reports they were not contemplating suicide at the time of the interview.

An "Agreement to Sharing Information" proforma was completed the day after committal when Mr K gave consent for information to be shared with his mother. The Senior Officer who completed the form explained that he did not consider it was necessary to speak to Mr K's mother at that time.

The Initial Case Review took place on the afternoon of the day after Mr K's committal. The review was chaired by the House Senior Officer (Senior Officer C) and attended by the House Nurse (Nurse B) and a residential officer (Officer B). During this review Mr K reported he had no desire to harm himself. It was recorded that Mr K appeared to be in better form and had no thoughts of self-harm. He reported that a visit with his mother had gone well. The Listener process was explained to Mr K and it was agreed to reduce observation to 30 minutes and move him to a different House. Conversation checks were to continue. Mr K was moved to a shared cell in a different House that same afternoon.

A further SPAR review took place three days later, chaired by the House Senior Officer (Senior Officer D), a residential officer (Officer C) and the House Nurse (Nurse C). Mr K reported no thoughts of self-harm or suicide and expressed a wish to make progress. His observations were reduced to hourly. Although conversation checks were to continue, the Log Book does not record details of conversations over the next three days.

Three days after the first SPAR review, Mr K's Mental Health Key Worker (Nurse D) recorded in the SPAR Log Book (at 12.30) that she had seen Mr K for an appointment; Mr K confirmed that he had no current thoughts of self-harm or suicide, and he would remain on the mental health team caseload for review.

At the final SPAR Review several days later a decision was made to close the SPAR. The requisite number of representatives was present, including a nurse. However they were all different attendees from earlier reviews.

The review was chaired by the House Senior Officer (Senior Officer E) and attended by Nurse E, a residential officer (Officer D) and Mr K. Although Mr K had attended an appointment with his Mental Health Key Worker (Nurse D) the day before for an initial mental health assessment, there is no evidence in the records that any opinion was sought from her about closing the SPAR.

This transpired to be the SPAR closure review and the Senior Officer noted: "*All issues resolved*." Given the nature of the offence for which Mr K had been remanded, his previous self-harm history and ongoing contact with mental health, this could not have been the case.

As required by NIPS policy the Post-Closure Review took place a week later. There is a discrepancy in the dates recorded for this meeting between the record of the meeting and front cover of the SPAR booklet.

This time the meeting was chaired by the Senior Officer (Senior officer F) in the House Mr K was then accommodated in and was attended by a residential officer (Officer E) and Mr K. There was no input from primary or mental healthcare to this review. Mr K reported that he felt good and had no thoughts of self-harm. There was agreement the SPAR should remain closed.

The SPAR logbooks contain records of the observations that were conducted during the SPAR and notes of conversation checks with Mr K. The quality of some entries in the logbook is poor and it is difficult to monitor compliance with the stipulated frequency of conversation checks as there were limited descriptions of conversations with Mr K. The prescribed observation intervals appear to have been adhered to.

In general terms, the SPAR procedures were largely implemented in accordance with the NIPS Suicide and Self Harm Policy 2011 (updated October 2013). However there are shortcomings in some aspects of how the SPAR was managed including the quality of logbook entries – particularly in relation to conversation checks; a reliance on self-report, lack of continuity in terms of those chairing and participation, and lack of contribution either directly or indirectly from people who had more in-depth knowledge of Mr K, including his mother. If Mr K's mother's views had been sought or some of his phone calls monitored, this may have led to more meaningful engagement with Mr K about how he was coping. The SPAR process provides for follow-up interviews after the formal closure review, and this may be worth reflecting on for future cases.

Previous recommendations in Death in Custody and Serious Self Harm investigations have highlighted the importance of meaningful observations and conversation checks taking place and being appropriately documented.

A review of how Mr K's SPAR was managed should be conducted to identify and share learning for future practice.

The NIPS should consider seeking a contribution from the nominated family member in order to inform discussion at SPAR closure/post closure review meetings or at subsequent reviews.

Overall the Clinical Reviewer concluded the decision making in the SPAR process appeared to be reasonable and justified in light of the information available to those involved. The opening of a SPAR was appropriate, and the decisions at the Case Reviews to reduce observations and then close the SPAR were reasonable in response to the improvements in Mr K's presentation.

Some omissions in the initial documentation were of potential importance because they could have influenced assessment and management. In particular the previous incident of hanging was not noted and the question of suicidal intent in relation to the overdose was not clearly assessed.

Dr Grounds further noted that the healthcare representatives who attended case reviews did not appear to have had previous contact with Mr K that was documented in the EMIS records. It would have been desirable for the healthcare representatives to have consulted with their clinical colleagues who had assessed Mr K in order to ensure that this clinical knowledge of his current condition could contribute to decision making.

Furthermore as Mr K continued to be under review by the mental health team when the SPAR was closed, the Clinical Reviewer said it would have been desirable for the records to demonstrate that their opinion was sought in relation to the SPAR closure decision.

The Trust highlighted that the Medical Administration Records (MAR) demonstrated that nurses who attended case reviews had some contact with Mr K for the purpose of supervising the administration of his medication and they would have had access to his mental health records on EMIS.

The SEHSCT should ensure that when SPAR reviews are undertaken for prisoners who are under the care of the mental health team, the mental health key worker should be invited to attend the SPAR review and attend where possible. If unable to attend, the mental health key worker should ensure that the view of the mental health team and relevant information is communicated in advance to the review.

The day after Mr K's SPAR was closed an improvised knife was discovered in his cell during a routine cell search. Mr K was charged under prison rules and attended an adjudication hearing twelve days later. He pleaded "Not Guilty" and the hearing was adjourned as the relevant staff were not available to attend. No further action was taken as Mr K died before the hearing was reconvened.

As is normal practice a member of the Independent Monitoring Board (IMB) (IMBA) attended the hearing. She noted concerns about Mr K's presentation: during a discussion about his prospect of spending a long time in prison, he became upset. She discussed this with the Adjudicating Governor (Governor A) who agreed with her observation.
The Governor queried whether Mr K had been subject to a SPAR. It was confirmed that a SPAR had recently closed but in light of Mr K's presentation the Governor said he would make a referral for support and see if he would be a suitable candidate for a peer support project in the prison. There is no evidence in the available records of either of these actions being followed up.

The IMB member also called with the prison chaplaincy to ask if they had had any contact with Mr K. It was confirmed that the chaplain was planning to contact Mr K, and a review of the records indicate he had a number of visits with a prison chaplain.

The IMB member said that Mr K appeared to be under a lot of stress and may have been having difficulties coping. However she was reassured that both the PSST and the chaplaincy were going to offer support.

SECTION 4: HEALTHCARE & MENTAL HEALTH SUPPORT

The day after his committal, Mr K was seen by a Nurse (Nurse F) who conducted the comprehensive committal assessment. An initial mental health screen was conducted by a Nurse from the Mental Health Team (Nurse D).

The mental health screen entails reviewing the patient's records to identify if they may require any further mental health assessment and support. The Mental Health Nurse noted pertinent details from Mr K's records and reviewed the Risk Screening Tool. She concluded that Mr K should be referred for an urgent Mental Health Assessment. She told this investigation that prison healthcare policy required anyone remanded for the type of offence Mr K was charged with is referred for mental health assessment.

The same Nurse conducted the Initial Mental Health Assessment a week after his committal, the day before the SPAR was closed. The Nurse completed the SEHSCT Initial Mental Health Assessment Form and later summarised the key information on EMIS. She noted that Mr K's SPAR was live and that he had not expressed any current thoughts of self-harm or suicide. She completed a Personalised Recovery Plan which summarised strengths, needs and agreed goals with Mr K. This Plan is a live document aimed at supporting the patient's recovery.

Mr K advised the Mental Health Nurse that he was keen to get work in the prison and that he had completed a work allocation form. He also agreed to self-refer to the prison doctor to have his medication reviewed. Immediately after the assessment the Nurse actioned a referral to AD:EPT, an organisation which provides drug and alcohol support services within the prison, and arranged for the Plan, the Initial Mental Health Assessment form and the updated Risk Screening Tool to be attached to EMIS. This would facilitate other healthcare colleagues access the detail of her assessment and associated documentation.

The Nurse concluded that Mr K should remain under the care of the Mental Health Team and she became his allocated Key Worker.

The Mental Health Nurse advised that primary healthcare staff attend SPAR meetings and if possible, the allocated mental health worker also attends. She did not recollect if she was notified when the SPAR review was taking place or why she did not attend it. She stated it could have been for a variety of reasons including other appointments. She pointed out, however, that the record of her mental health assessment on EMIS would have been available to a healthcare colleague who was attending the SPAR review.

The Clinical Reviewer said that the outcomes of the initial mental health assessment were reasonable in the light of Mr K's presentation in interview at the time.

Repeat prescriptions for Mirtazapine (15mg) and an inhaler were issued on two weeks after Mr K's committal to prison without the patient being seen by a prison doctor.

On the following day Mr K was seen by a House Nurse (Nurse G) and triaged. The nurse noted there were no GP appointments at present but said he would be added to the list as soon as an appointment was available. It is not clear from this EMIS record if Mr K had requested to see a GP or why.

On the same day a different nurse (Nurse H) recorded on EMIS that Mr K had requested (for the second time) to see a dentist. As he was about to move to a different residential location, she entered a slot note for the relevant House Nurse to place Mr K on the dentist's list.

The next day Mr K was triaged by the House Nurse (Nurse I) in his new residential location who recorded that Mr K requested a GP appointment as he wanted his Mirtazapine medication increased and a new inhaler. The first available appointment – just under six weeks later - was allocated.

Twelve days after the initial Mental Health Assessment was conducted Mr K had his next appointment with his Mental Health Key Worker.

At this appointment the Key Worker recorded that Mr K appeared slightly agitated and that his mood was subjectively up and down. He disclosed that he was not sleeping very well and reported paranoia with prison authorities. Mr K also reported that he had self-referred to the prison doctor requesting a medication review and was waiting for an appointment.

The Key Worker queried whether he had any thoughts of self-harm or a suicide plan expressed and he answered in the negative. The Key Worker assessed that his agitation was in response to situational stressors. She gave Mr K a sleep hygiene leaflet and again advised him how to seek support services.

After the meeting the Key Worker contacted the House Nurse to check when the next available GP appointment was and explained Mr K's circumstances. When told this could be three weeks hence she emailed the Practice Manager to request an earlier appointment and this was facilitated around a month earlier than initially allocated. The Key worker concluded that Mr K should remain on their caseload, and a date was set to review him again in two weeks.

Due to Mr K's presentation she also made a routine referral to prison psychiatry; and she made a further entry on EMIS noting that Mr K was awaiting adjudication for possessing a knife.

On the same day as his second appointment with his Mental Health Key Worker Mr K was seen by the prison dentist and afterwards attended the treatment room in the House to request pain relief. The House Nurse gave him eight paracetamol tablets.

Two days later, a Nurse (Nurse J) fitted Mr K for adjudication based on a review of his healthcare records. He recorded that Mr K would need to be seen if cellular confinement was awarded.

On the same day, Mr K's Mental Health Key Worker contacted the Mental Health Unit at the hospital where Mr K had received treatment to request further information and details about his diagnosis. She spoke to the community psychiatrist who gave her a short patient history and advised that the notes should be formally requested. The Key Worker recorded that Mr K's next Psychiatry review at the hospital would have been due in several months.

Also on the same day a Nurse (Nurse K) took a phone call from Mr K's mother enquiring about his medication. The Nurse contacted the House Nurse and noted that he was receiving his prescribed medication by supervised swallow from the House Nurse.

The prison doctor (Doctor A) issued a repeat prescription for Mirtazapine tablets (15mg) four days later without seeing Mr K. The doctor does not appear to have been aware that Mr K had earlier requested a GP appointment to have his Mirtazapine dose increased.

The first of two appointments with a psychiatrist (Doctor B) took place around four weeks after his committal to prison. The psychiatrist conducted a comprehensive assessment of Mr K's personal history, mental health and how he was coping in prison. In the EMIS record, the psychiatrist noted Mr K's low mood and some paranoid ideation. Mr K denied any thoughts of self-harm. The psychiatrist recorded in her record of the interview that psychiatric notes from the hospital where he had been a patient were awaited.

As a result of her assessment the psychiatrist increased Mr K's dose of Mirtazapine to 30mg.

The Clinical Reviewer said that the psychiatrist's decision to increase Mr K's dose of Mirtazapine and to ensure he was aware of sources of support, was appropriate in relation to the interview findings. Dr Grounds noted that the incident of attempted hanging was not referenced in the psychiatrist's assessment although the suicide incidents recorded in the Trust's Risk Screening Tool were.

He also observed there was no specific reference in the psychiatric assessment to Mr K's thoughts and feelings about the nature of the offence he was alleged to have committed. He said, "*…the potential psychological impact of the offence does not appear to be a matter that the mental health team explored with Mr K. The enormity of what he allegedly did, his suicidal reaction, and the troubled past relationship with the victim, were potentially important for assessing his vulnerability but were not a focus of attention in this or the other mental health assessments.*"
The Clinical Reviewer added that it was of note that in the initial mental health assessment and the assessment with Doctor B, Mr K is recorded as saying that he wished he had succeeded in the attempt to kill himself after the homicide.

The following day Mr K was due to have a further appointment with the dentist but declined to attend. He had earlier attended a GP appointment (with Doctor C) and reported that the psychiatrist had increased his Mirtazapine to 30mg the day before, which pleased him. During this appointment Mr K asked for his inhaler to be changed and a prescription for this was issued.

A follow up review with the psychiatrist was scheduled for the following day but Mr K refused to attend. A further appointment with the psychiatrist was arranged for four days later.

At this appointment Mr K reported that he was sleeping better than previously but continued to complain of low mood and ongoing paranoid ideation. Mr K reported some thoughts of life was not worth living though he denied thoughts of self-harm or suicidal intent. He reported that he had been under a lot of stress during the week and was troubled by hearing voices. The psychiatrist prescribed anti-psychotic medication. She also recorded she would discuss Mr K's problems with his Key Worker.

The Clinical Reviewer again noted that a thorough assessment had been made of Mr K's current mood and symptoms. He said that the decision to commence anti-psychotic medication was an appropriate measure in view of the account given by Mr K during interview.

Two days after the consultation with the psychiatrist Mr K had a further appointment with his Key Worker. The Key Worker did not recall if she had had time to review the notes of the psychiatric appointments in advance of this appointment. Mr K discussed issues with his prescribed medication and the Key Worker advised him to discuss this with the psychiatrist at their next review.

Mr K's care plan and safety measures were also reviewed. The Key Worker recorded his mood as being varied and explored whether he had thoughts of self-harm or suicide. She outlined two programmes that could provide him with support and coping mechanisms, and he agreed to attend. She made the referrals immediately after this appointment and arranged to see Mr K again in three weeks. The Key Worker said that Mr K engaged well with her and she felt they had developed a therapeutic relationship.

The Clinical Reviewer concluded: "*On this occasion, as on the previous mental health team reviews, the actions taken after the interview appeared to be appropriate in light of the interview findings*."

Learning for future practice

In considering the overall management of Mr K's Mental Health Care, the Clinical Reviewer made a number of observations in relation to:

- the clinical documentation;
- the timing of specialists assessments; and
- the clinical management of self-harm.

Clinical documentation

While noting the initial proactive transfer of information from the community to prison, which was promptly actioned, further information from the hospital had not arrived by the day of the last appointment with his Mental Health Key Worker even though it was formally requested two weeks earlier. The Clinical Reviewer said this information should have been sought and provided earlier.

The SEHSCT should ensure that relevant medical records are promptly requested.

The timing of specialist assessments

The Clinical Reviewer highlighted that the National Institute for Clinical Excellence (NICE) clinical guideline for the mental health care of adults in contact with the criminal justice system (NG66) was not in place at the time of Mr K's death. For the future, the Reviewer highlights the value of this guideline, which includes reference to the need to obtain, evaluate and integrate all available and reliable information about the person, and the need to ensure continuity of treatment including prescribed medication.

In relation to mental health assessments, the Reviewer notes that when committed to prison, a comprehensive clinical assessment of Mr K's needs and risks after the incident of self-harm was absent and ought to have been offered promptly by the specialist mental health team.

As the initial mental health assessment was not conducted until a week after Mr K's committal, and the subsequent psychiatric assessment did not take place until a month later, the Clinical Reviewer stated: "*It cannot be said that a comprehensive specialist mental health assessment following the self-harm was conducted by, or was available, to the prison mental health team as quickly as it should have been when assessed against the NICE clinical guideline cg16 for the short term management of self-harm*."

In the case of a prisoner who has self-harmed shortly before arriving in custody, the SEHSCT should ensure that a comprehensive mental health assessment is offered promptly or acquired by the prison mental health team.

Clinical management of self-harm

Dr Grounds highlights that important aspects of the NICE guideline for the longer term management of self-harm were implemented in Mr K's case. For future practice, while recognising possible difficulties in including family members in care planning for prisoners, he draws attention to the benefits of developing the Personalised Care Plan in conjunction with family members. He suggests this may have been relevant in this case given that contact with Mr K's mother had been deemed a protective factor, she had telephoned the prison to enquire about his medication and he had given consent for information to be shared with his mother.

The SEHSCT should consider involving families in care planning, and psychological treatment interventions.

The Clinical Reviewer made two further points for improved practice in respect of the clinical management of self-harm. The first was in relation to the dose of anti-depressant medication not being reviewed for four weeks after Mr K's committal. Dr Grounds said that as it appears Mr K, "*was not experiencing the dose as sufficient and, in view of his presenting history it would have been preferable to have undertaken the review he was requesting more quickly."*

The final point made by the Clinical Reviewer relates to whether psychological interventions with a trained therapist are available in the prison where Mr K died and if they were considered in this case. He said: "*If it is the case that such treatment is not available within the mental health team this would be a significant omission in the range of mental health treatment interventions that can be provided for a population at heightened risk of suicide and self-harm.*"

Overall, in relation to the question of whether Mr K's death might have been predictable and preventable, the Clinical Reviewer assessed that available records did not show obvious and proximate indicators of imminent suicide risk that would have been evident to prison and healthcare staff prior to his fatal hanging.

SECTION 5: SOCIAL INTERACTION

Mr K was generally described as being quiet and likeable, and by some, as inscrutable.

Prison officers reported that he was polite and compliant with prison routines and procedures. They said that he did not engage much with them nor ask for help. His demeanour did not suggest that he was particularly anxious and he gave no cause for concern. One officer said that Mr K appeared happy to do his time and that he would encourage younger prisoners to conform.

Fellow prisoners in the House reported that Mr K regularly played pool, attended the gym and exercised in the yard. He did not appear to have any close friends on the landing but generally mixed well with others. Apart from a conversation with one prisoner about his medication, there were no indications that he shared any of his problems prior to the day he died.

Although Mr K's alleged offence caused significant division within his family he received regular visits from his mother and was in frequent telephone contact with her. He also spoke to his partner and a friend on the telephone.

Mr K made almost seventy telephone calls mainly, to his mother, partner and a friend. The calls reflected anxieties around his financial affairs including the disposal of his assets, organising visits and a bail application. On a number of occasions he expressed frustration and stress about the prison regime, his medication and mental health support. In a call to a friend several weeks after he was committed to prison, he asked for his remaining money to be split between his mother and a dependent, just in case something happened.

Mr K had a number of meetings with a prison chaplain and attended some church services. He was not known to the prison's safer custody team during this custodial period.

SECTION 6: EVENTS ON THE DAY MR K DIED AND AFTER HE WAS FOUND

The residential House where Mr K was accommodated was on weekend regime when he died. The landing was unlocked at 08:35 with the landing Mr K was on offered exercise in the yard in the morning and the other landing in the afternoon. Two prison staff were on duty on Landings 1 and 2 until lunchtime (Officer F and Officer G) when they were relieved by two others (Officer H and Officer I). Of the four officers on duty during the day, two were regularly in the residential House and, although a third officer had come from a different House he had previously met Mr K.

The officers reported that Mr K's demeanour and behaviour that day gave them no cause for concern and they had routine interaction with him. They did not detect any difference in his behaviour from previous encounters. One officer (Officer G) recollected Mr K conversing, laughing and joking with other prisoners in the yard that morning. The fourth officer, who was not a regular on the landing, did not recall any interaction with Mr K that day.

Several prisoners reported that Mr K was in good form on the day he died although one said he seemed different, quieter that day. Another said he heard third hand that Mr K had a bad telephone call which lowered his mood. Another said he was not sure whether it was a bad phone call or inability to contact someone which caused him frustration. Mr K did not speak directly to anyone about the nature of the calls he made. At around 16:00 a prisoner on another landing, who said he knew Mr K and a relative well, recalled having a brief conversation with him. He reported Mr K did not seem to be in a good place and in the course of the conversation had said he just felt like '*pulling the plug*'. The prisoner did not report this concern as he thought that Mr K would be the last person to harm himself.

Mr K used the telephone five times on the day he died between 9:05 and 15:04. Two of the calls were made to his partner's number but they were not answered. The last call to his friend at 15:04 followed up on an earlier conversation about getting in touch with his partner.

A call to Mr K's mother lasted several minutes. During it he expressed feelings of despair and frustration. At one point he talked about being at the end of his rope and said that he had no purpose anymore. He finished the call by telling his mother that he was going to get a cup of coffee and would call her the following Monday. In hindsight Mr K's mother said she regrets not alerting the prison to the detail of this call but she had not because he had frequently said similar things.

The evening meal was served at 16:00 and the landing locked at 17:00. The landings are locked early on weekends when, unlike weekdays, there is no evening association.

At 19.32 a prison officer (Officer J) who had just come on duty on the landing Mr K died commenced a head count. Mr K was accommodated in the first cell she checked. Officer J lifted the cell door flap and initially did not see Mr K because the cell was in darkness. She then saw him sitting on the floor. She called out several times but Mr K did not respond.

The officer immediately contacted the Emergency Control Room by radio to report that Mr K was unresponsive. On hearing the transmission a Night Custody Officer (Officer K) who had been working on a different landing went to Mr K's cell and tried to rouse him. At 19:33 the officers transmitted a Code Blue message, requested urgent medical assistance and permission to enter the cell. Officer K said he entered the cell first and took Mr K's weight while the other officer (Officer J) cut the ligature using a Hoffman knife. They placed Mr K on the floor and commenced CPR.

The ECR tasked an emergency ambulance at 19:36.

The Code Blue message was picked up by Nursing staff in the Healthcare Department and immediately actioned. A Senior Nurse (Nurse L) and two other nurses initially responded. Nurse M and Nurse N went directly to the House while the Senior Nurse followed after collecting emergency equipment. Two other nurses (Nurse O and Nurse P) who had arrived at the prison to commence their night shift were told about the Code Blue by staff at the main gate. They went directly to the House and assisted with the resuscitation. The defibrillator was applied but registered that no shock was advisable at any point. The nurses continued to rotate compressions until the ambulance staff arrived. After assessing Mr K, a paramedic pronounced death at 19:57.

The Clinical Reviewer reviewed records of the resuscitation and concluded that the response of healthcare staff was quick, they were present in sufficient numbers, and the methods they used were appropriate.

The post incident interviews by the Prisoner Ombudsman of those involved indicate that it was judged that Mr K had died before their arrival. Nonetheless they followed resuscitation procedures as required until the ambulance staff arrived. Interviewees raised the question of whether qualified nurses in the prison should have the authority to end resuscitation when there is clear clinical evidence to do so, but noted this would require a change of policy.

This same issue was raised in relation to another case when the SEHSCT accepted the need to have a Do Not Resuscitate (DNR)/Verification of Life Extinct policy and procedures specific to prison healthcare.

Concerns raised by prisoners

Two prisoners interviewed for this investigation referred to hearing staff laughing after Mr K was pronounced dead and while his body remained on the landing. One felt that this was a nervous laugh while the other interpreted the noise in a mocking way. He said that he and other prisoners had been upset by the behaviour of prison staff and had banged their cell doors and shouted in disgust. He also stated that they submitted complaints about this matter. A search of the complaints registered on the NIPS database did not identify any complaints submitted about this issue. There were a number of complaints raised several days later when one of the prisoners had become unwell during the night.

When this Office is notified of a death in custody, an Investigator promptly attends the scene. The Investigator heard prisoners banging their cell doors when she arrived on the landing and was told the prisoners were trying to attract attention as they wanted to give statements to the police.

Family notification and ongoing liaison

Mr K's next of kin – his mother - was notified by telephone of her son's death at 23:40 on the night he died by the Duty Governor (Governor B).

At the initial family meeting Mr K's mother raised concerns about the four hour delay in being notified of her son's death and asked for clarification of the normal process for notifying families. In particular she wanted to know why a priest had not informed her of the death.

She also highlighted recent difficulty in contacting the nominated NIPS liaison officer (the Duty Governor) for several weeks after Mr K's death, and complained about his cold tone during initial telephone calls with her. Mrs K also wanted to know why a priest did not attend at the time of her son's death to administer the last rites and, why the family had not been given an opportunity to formally identify the body.

Paragraph 9.4 of the NIPS Suicide and Self Harm Prevention Policy 2011 (updated October 2013) provides guidance on contacting next of kin in the event of a death in custody. This states that the Governor in charge or Duty Governor must inform, as a matter of urgency, the immediate family or next of kin or arrange for another appropriate person to do so. The policy also provides for the Governor to arrange for a family chaplain or local PSNI officer to inform the next of kin. The policy goes on to provide for a nominated contact to address immediate queries on the day of the incident and thereafter establishing a contact person to liaise with the family.

At 20:00 the Duty Governor (Governor B) was informed of a death in custody and he arrived at the prison approximately an hour later. Prior to his arrival the Emergency Control Room Occurrences Log recorded the Night Guard Manager (Senior Officer G) unsuccessfully attempted to contact three separate prison chaplains between 20:39 and 20:42. The Night Guard Manager informed the ECR at 20:45 that he was unable to contact a chaplain.

The FMO attended the prison at 22:26 and left at 23:12.

At 23:04 a female contacted the prison to express concern about a friend of Mr K's who was also in the same prison and whom she said may be vulnerable on learning of his death. Having checked that the DiC protocols had been followed, the Duty Governor telephoned Mr K's mother directly at 23:40 to inform her of her son's death. He also conducted the formal identification.

The same governor was the nominated family liaison contact for enquiries in the days after Mr K's death. He acknowledges some initial communication difficulties with Mr K's next of kin, but he later facilitated them to visit Mr K's cell and arranged a meeting with the prison chaplain which he said was well received.

The NIPS policy recognises that families will have immediate and ongoing questions about the death of a loved one in custody and should ensure that it is as responsive as possible to the families in this situation.

NIPS should ensure that family contact arrangements following a death in custody are as responsive as possible.

Hot and cold debriefs

The NIPS Suicide and Self Harm Prevention Policy 2011 (updated October 2013) states that the hot debrief should take place as soon after the incident as possible and involve all of the staff who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

The hot debrief was chaired by the Duty Governor (Governor B) and followed the NIPS recommended template. It was attended by most of the staff who initially responded to the incident. A brief synopsis of events earlier in the evening was given and details of aftercare for staff were noted. There was no record of a discussion about aftercare for prisoners. No remedial actions were identified.

In accordance with NIPS policy the cold debrief took place within 14 days of Mr K's death. It was chaired by a Governor (Governor A). The purpose of this meeting is to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional learning from events. There was representation from safer custody, SEHSCT, IMB and one of the officers who initially entered Mr K's cell.

The events of the day Mr K died were briefly reviewed and attendees were asked to comment on any potential learning points. The Senior Nurse on duty that day said, on reflection, it may have been helpful to brief the NIPS officer who found Mr K that attempts to revive him were unlikely to be successful. Aftercare for NIPS and SEHSCT staff was discussed, with the IMB expressing concern that prison staff were not sent home when an assurance had been given that this would be the case following a death in the prison some months earlier. The NIPS said during this investigation that staff detailing after an incident depends on availability of other staff and individual wishes.

The Governor who chaired the meeting said that the (then) Justice Minister was reviewing the possibility of offering therapy to staff involved in traumatic events.

Records of the hot and cold debriefs follow along similar lines to previous events. The emphasis at both debrief meetings, in line with the NIPS policy, is generally focussed on the response to the incident and support for staff and prisoners. As a consequence the learning for future practice gained from a broader review of the individual's circumstances leading up to the time of death is limited.

In addition to the debrief meetings, the NIPS should put in place a process to review the broader circumstances surrounding deaths in custody to identify and put in place any immediate learning points.