



The
**Prisoner
Ombudsman**
for Northern Ireland

**REPORT BY THE PRISONER OMBUDSMAN
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH IN
HYDEBANK WOOD PRISON AND YOUNG OFFENDERS CENTRE OF
SAMUEL CARSON
ON 4 MAY 2011
AGED 19**

[8 November 2012]

[Published: 20 November 2012]

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

PRISONER OMBUDSMAN INVESTIGATION REPORT

Samuel Carson

<u>CONTENTS</u>	<u>PAGE</u>
PREFACE	3
SUMMARY	6
ISSUES OF CONCERN REQUIRING ACTION	38
INTRODUCTION TO THE INVESTIGATION	42
FINDINGS	45
<u>Section 1: Background Information</u>	45
Section 1A: Samuel Carson	45
Section 1B: Northern Ireland Prison Service Anti-Bullying Policy	47
<u>Section 2: Samuel's First Time in Hydebank Wood Prison and Young Offenders Centre</u>	49
<u>Section 3: Samuel's Experience From Leaving Prison Up To His Final Committal</u>	56
<u>Section 4: Samuel's Final Committal to Hydebank Wood and Young Offenders Centre</u>	60
Section 4A: Key Event's July to September 2010	60
Section 4B: Key Event's October 2010	68
Section 4C: Key Event's November 2010	76
Section 4D: Key Event's December 2010	78
<u>Section 5: Samuel's Move to Cedar House</u>	80
<u>Section 6: Samuel's Last Few Days</u>	105
<u>Section 7: Management of Security Information at Hydebank Wood</u>	116
<u>Section 8: Other Issues</u>	121
<u>Section 9: Events Following Samuel's Death</u>	124
<u>Section 10: Staff Support and De-brief Meetings</u>	127
<u>Section 11: Autopsy Report</u>	129
<u>Section 12: Findings of the Expert Clinical Reviewer and Samuel's Use of Mirtazapine</u>	130
APPENDICES	139
Appendix 1 – Prisoner Ombudsman Terms of Reference	140
Appendix 2 – Investigation Methodology	146
Appendix 3 – Hydebank Wood Prison and Young Offenders Centre	148
Appendix 4 – Prison Service Policies and Prison Rules	149

PREFACE

Samuel Carson was born on 29 May 1991. He was nineteen years old when he died by suicide¹ whilst in the custody of Hydebank Wood Prison Young Offenders Centre on Wednesday 4 May 2011.

I offer my sincere condolences to Mr Carson's family for their loss. I have met with Mr Carson's family and shared the content of this report with them and responded to the questions and issues they raised. To his family Mr Carson was known as Samuel and with the permission of his mother that is the name used throughout this report.

As part of the investigation into Samuel's death, Ms Gwyneth Ruddlesdin, Head of Integrated Governance and Quality for Kirklees Community Healthcare Service, was commissioned to carry out a clinical review of Samuel's medical treatment whilst in prison. Expert advice was also sought from Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, and Dr Malcolm VandenBurg, a Specialist in General Medicine and Consultant Pharmaceutical Physician. I am grateful to all of the expert advisers for their assistance.

It is not my usual practice when reporting Death in Custody investigations to include information about the offences or alleged offences of the deceased and events outside of prison. In the case of Samuel, however, some information about these matters has been included because I believe them to be relevant to an understanding of the circumstances of his death.

¹ The circumstances surrounding Samuel's death presents as a self inflicted death however, it should be noted that the Coroner's verdict is pending at the time of this report's publication.

PRISONER OMBUDSMAN INVESTIGATION REPORT

Samuel Carson

In the event that anything else comes to light in connection with the matters addressed in this investigation, I shall produce an addendum to my report and notify all concerned of the additions or changes.

A detailed account of the evidence examined during the investigation has been included in the main body of the report. This is particularly to assist Samuel's family; the South Eastern Health and Social Care Trust (SEHSCT); the Prison Service and the Coroner. For other readers who do not wish to consider all of the investigative detail, a comprehensive summary has been included.

It is my practice to make recommendations for action that might lead to improved standards of inmate care and may help to prevent serious incidents or deaths in the future.

In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that *"An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become a barrier rather than a stimulus to progress, with a plethora of action plans at local and central level, and a focus on servicing the plans rather than acting on them. This has led to inspection and monitoring being defined as a problem within the service, rather than a solution and a driver for change."*

The Prison Service and the SEHSCT are currently engaged in two programmes of work with the aim of achieving significant change in the Northern Ireland Prison Service. These

PRISONER OMBUDSMAN INVESTIGATION REPORT

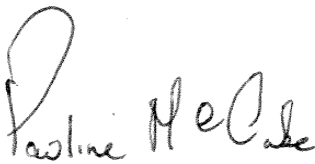
Samuel Carson

are the Strategic Efficiency and Effectiveness (SEE) Programme and the SEHSCT's Service Improvement Boards.

In light of Dame Owers' comments, and in order to support the development of a more strategic and joined up approach to service development, I decided in June 2011, that instead of making recommendations in connection with Death in Custody investigations, I would detail issues of concern that I would expect the Prison Service and SEHSCT to fully address in the context of their programmes of change, with appropriate urgency. I shall keep this approach under review and revert to making recommendations if I am not satisfied that the response of the Prison Service and/or the SEHSCT is adequate.

In the case of Samuel, **28** matters of concern have been identified.

I would like to thank all those from the Northern Ireland Prison Service, the SEHSCT and other agencies who assisted with this investigation.



PAULINE MCCABE

Prisoner Ombudsman for Northern Ireland

8 November 2012

SUMMARY

Samuel Carson was born on 29 May 1991. He was nineteen years old when he died by suicide on 4 May 2011 whilst in the custody of Hydebank Wood Prison and Young Offenders Centre.

Samuel's family described him as a person who was "*happy go lucky*" and always one "*for a good laugh.*" He was their only son and he had four sisters, one of whom was younger than Samuel. As a teenager, he set his heart on joining the army and went through the recruitment process but then met his girlfriend and started a family. Samuel had a son, aged twenty months and a daughter aged eight months, at the time of his death.

Prior to his committal to prison in March 2010, Samuel was known to police in connection with a number of alleged offences, including aggravated burglary, AOABH (Assault Occasioning Actual Bodily Harm) and domestic violence involving his girlfriend. Social Services were also aware, from 2009, that there were domestic violence issues. Samuel's girlfriend said that the domestic violence ceased in 2009 and that Samuel attended behavioural change programmes. Samuel had never been in prison.

A few days after arguing with his girlfriend at the end of February 2010, Samuel rang her. Samuel's girlfriend said that he was crying and that he told her that he had been arrested and charged with rape. He said that he was innocent and that the girl concerned had agreed to sex. The alleged victim was fifteen years and seven months old. Samuel was 18 years old at the time.

Samuel was arrested on the 4 March 2010 and, on 6 March 2010, he was charged with: rape between 1 March and 3 March 2010; sexual activity by an adult with a child between 13 and 16 years; making indecent (pseudo) photographs of a child; and distributing indecent (pseudo) photographs of a child. Samuel had a co-accused.

On 6 March 2010, Samuel was remanded in Hydebank Wood. At committal it was recorded that Samuel informed staff that, approximately two years earlier, he had taken drugs which included Cannabis, Ecstasy, Cocaine, Acid and Speed. He also said that, around the same time, he had self-harmed by cutting himself. He told a

Samuel Carson

nurse officer that this was due to a family break up. It was noted that Samuel was on Propranolol² 40mg twice a day and had taken Diazepam³ twice a day for the last three weeks.

After an initial 24 hour monitoring, it was recorded that *“due to this inmates offence he is considered vulnerable and at risk from other inmates. Therefore a further 24 hour period to settle-in has been agreed...Please make a record of any abuse shouted at the inmate during the night.”*

Samuel was allocated a sentence manager. At interview, the sentence manager said that Samuel was *“scared and apprehensive, basically because of the nature of the offence.”* He said that *“if anyone is in for any sexual offence, rape, underage sex or anything like that, they are sort of shunned by the rest of the (inmates).”* The sentence manager said that Samuel told him that he was innocent, denied that *“it was not consensual”* and gave his account as to why he was saying that other aspects of his alleged offences were untrue.

On 11 March 2010, a senior nurse officer referred Samuel to mental health support following his use of the Samaritans phone over two nights and his admission to his sentence manager that he had a history of depression.

Three days later, Samuel met Opportunity Youth⁴ for the first time and it is recorded that he *“refused any intervention.”*

During Samuel's first week on Elm 2 landing, it is recorded in prison records that he *“...has taken verbal abuse from one inmate because of his alleged crime. He has not caused any problems.”* There is no recorded evidence that any action was taken in response to the verbal abuse noted.

An undated letter from Samuel to his mother around this time said *“I'm here nearly two weeks now and I'm getting it bad in here getting called rapist and getting threatened that I'm gonna get sliced up, I'm feeling really low in here....my head's going worse than it was...if anything happens to me in here I love yous all....”*

² Propranolol: medication known as a “beta blocker” that can be used to treat anxiety which has physical symptoms such as a fast heartbeat and trembling. It tends to slow the heart rate down to relieve these symptoms.

³ Diazepam: a type of medicine called a benzodiazepine which is used for sedative, anxiety relieving and muscle relaxing effect.

⁴ Opportunity Youth: an organisation which provides a comprehensive range of personal development and therapeutic services, including three one to one intervention sessions, to inmates experiencing difficulties during their time in prison.

Samuel Carson

On 19 March 2010, Samuel was moved to Elm 3 (E3) landing. A prison officer told the investigation that Samuel *“should not have been moved to E3 landing. E3 and E4 inmates would have had a tendency to pick on any inmates who would be charged or convicted of sexual offences...and hence would attempt to give verbal abuse to such a prisoner when staff were not about or when it was impossible for them to be identified...for example when all the inmates were in their cells at night. The verbal abuse would normally start at night time.”*

One day later, another prison officer recorded that Samuel was under *“constant danger of attack by other inmates.”* He noted that *“for this reason, he rarely comes out of his room. He has had verbal threats made by other inmates.”* At interview, the officer said that inmates were shouting verbal abuse at Samuel at times when staff would not be able to identify the perpetrator, or at night time. He said that they were shouting *“bullroot (sex offender)... b---rd, f---ng b---rd, d-----d, we’re gonna cut your throat and all sorts of stuff.”* The prison officer said that he had also been approached by inmate orderlies who told him that Samuel was getting verbally abused but that the inmates would never identify the perpetrators.

No evidence was found that landing staff took action to address the bullying which was recorded as occurring at this time.

On 25 March 2010, a SPAR booklet⁵ was opened for Samuel by a member of staff from Opportunity Youth. It is recorded that Samuel had thoughts of suicide and that he had *“coped well on the committal landing but (his mood) deteriorated when moved to Elm 3... Samuel is not coming out of his room...Stated that he had thoughts of suicide last week and had took out his laces from his shoes”*. It is further recorded that *“he stated that night time is the worst and stated he doesn’t know if he will be able to cope until next week.”* Samuel’s bail hearing was due to take place the following week.

That afternoon, as required by Prison Service policy following the opening of a SPAR booklet, a multidisciplinary group met to discuss an Immediate Action Plan for Samuel. It was agreed that Samuel would be moved to Elm 2 and it is recorded that Samuel *“feels much more settled now that he knows he is moving to E2.”*

⁵ Supporting Prisoners at Risk (SPAR) booklets are used at times when staff deem an inmate as vulnerable to self harm and suicide and to provide increased observations and support for inmates.

Samuel Carson

During a further assessment by a senior officer it is recorded that Samuel said that *“thinking about his girlfriend, his children and his mum, stopped him from killing himself.”*

On 30 March 2010, Samuel was involved in a fight with an inmate and it is recorded on an Injury Report Form that Samuel was *“punched twice on the head with a closed fist”* and that he made a statement saying *“he hit me first and I hit him back to defend myself.”* The body chart shows that Samuel had a reddened area to the back of his neck and small lacerations. Both inmates were required to attend adjudications. However, prior to the completion of the adjudications the other inmate was released and both adjudications were withdrawn.

Samuel’s SPAR booklet was closed on 1 April 2010 and he remained on Elm 2 until 4 April when he was then moved to Elm 4.

On 15 April 2010, Samuel was assessed by a mental health nurse officer who said at interview that he *“presented at that time as somebody who had stresses due to his current incarceration in prison. He did not present to me as anybody with sort of like any overt form of mental health.”* The nurse officer said that Samuel’s issues centred on his relationship with his girlfriend and that it appeared that Samuel had not learnt coping strategies for dealing with different situations. It is also recorded that *“although Samuel did state that he feels able to cope with prison life at present we did discuss his ongoing paranoid ideas about his relationship...”*

Samuel agreed to Cognitive Behavioural Therapy⁶ as a means of helping him to learn how to cope. A referral was made to the cognitive behavioural therapist that day but Samuel was released on bail on 24 April 2010, before an appointment was arranged.

On the day of his release, it is recorded on an Injury Report Form that Samuel was involved in a *“fracas”* with an inmate during visits. No injuries were recorded and Samuel *“declined”* to make a statement on the Form. Samuel was released later that day and the planned adjudications were withdrawn.

⁶ Cognitive Behavioural Therapy (CBT) aims to solve problems concerning dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure in the present. CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders.

Samuel Carson

Samuel's solicitor said that, around this time, Samuel told him that he had been struck with *"pool balls placed in a sock"*. The solicitor said that Samuel had told him that he did not want any action taken. The investigation found no evidence in prison records that the prison service were notified of or aware of this alleged incident.

Following his release from prison, Samuel moved into a property on McCandless Street in Belfast, owned by a friend. He stayed at the address for a couple of weeks until he found accommodation in Lemberg Street in Belfast.

At this time, Samuel's girlfriend was three months pregnant with the couple's second child and she was told by the Belfast Health and Social Care Trust that consideration was being given to the commencement of care proceedings in relation to her unborn child, because of their domestic history.

On 4 June 2010, the PSNI attended Samuel's Lemberg Street address and served a PM/1⁷ upon him. The notice stated that; *"Local people believe you raped a 14 year old girl. You may also be the subject of some form of attack in order to force you to leave the area."* Samuel was reluctant to leave his accommodation but, that night, the PSNI assisted him and his girlfriend to move to emergency accommodation. The PSNI advised the couple to contact the Northern Ireland Housing Executive after the weekend, for further assistance.

On the week commencing 7 June 2010, whilst Samuel was in a meeting with a senior housing officer discussing his accommodation needs, he received a telephone call on a mobile phone, which he said was his girlfriend's. One of Samuel's bail conditions was, however, that he was not allowed to be in possession of a mobile phone and when he subsequently presented himself at a police station on 9 June to sign bail, he was arrested for breach of bail conditions. He was again remanded into the custody of Hydebank Wood Prison and Young Offenders Centre until 18 June 2010.

It was recorded at Samuel's committal that *"due to (the) nature of offence he may be targeted by others but no specific threat."*

⁷ PM/1: an official police record of any threat issued against an individual(s). The information can be notified to police via a local community group, paramilitaries or other organisations. When the threat is issued, police are obliged to notify and serve this document upon the person concerned.

Samuel Carson

On the day of his release, Samuel attempted to return to his friend's address in McCandless Street but, when he and his girlfriend were heading to the address, they received a telephone call from the brother of Samuel's friend, who was staying in the house. The friend's brother said that a death threat had been issued against Samuel because of his charges. Samuel rang his mother who advised him to hand himself in to the police. That evening, at around 7pm, Samuel presented himself to Donegall Pass Police Station in Belfast, stating that his bail address was no longer suitable.

As no hostel accommodation could be found, Samuel was kept in the police station overnight. He was recommitted to Hydebank Wood on 19 June 2010 because there was nowhere else that he could go. He remained in prison for three days.

When Samuel was committed on 19 June, he told a nurse officer that he had been threatened by paramilitaries and could not return to his address. During the committal interview he was asked by a prison officer if he had any concerns about his detention and it is recorded that he answered, "Yes." No further explanation is recorded.

It is recorded that, throughout his times in prison, Samuel made applications for hostel accommodation, in the hope of finding somewhere that he could stay. Samuel's sentence manager said that Samuel used to enquire regularly as to whether his applications had been successful. Regrettably, no accommodation was ever found for him.

On 19 June 2010, Samuel was released to his sister's address. On 29 June, after returning from signing bail, Samuel was walking home to this address when he was pursued and assaulted by a group of up to eight youths. It is recorded in Samuel's statement to the PSNI that he was punched and kicked for approximately two minutes.

Samuel's sister, who was pregnant at the time, told the police that she opened the door when she heard someone trying to turn the door handle. She then saw a crowd of youths and Samuel kneeling on the ground. She said that she heard one of the youths threatening Samuel and then someone from the crowd shouted "rapist". Samuel's sister said she brought her brother into the house and told her partner to contact the police, as it wasn't safe for Samuel to live there anymore. Later that day Samuel's sister was verbally abused and physically assaulted by a female who arrived

Samuel Carson

at her house. Samuel returned back to Lemberg Street, even though a threat had previously been issued against him at that address.

On 30 June 2010, Samuel found a property available for rental in Dunluce Avenue in Belfast and, with his girlfriend, met the landlord who agreed that they could have the property for a year. That evening the couple were handed the keys and it was agreed that they would meet again the following day to finalise matters.

The following day, Samuel attended court and, via his solicitor, submitted the Dunluce Avenue address to a police officer as a bail address. The same day, the police officer rang Samuel's new landlord from Laganside Court. The police officer told the landlord that Samuel had been charged with serious sexual offences involving a child and that he had received threats at previous addresses. The officer asked the landlord if he had concerns for the safety of other tenants.

After receiving this information, the landlord "googled" Samuel and decided that he was no longer willing to rent the property to Samuel and his girlfriend. He said that *"this was on the basis that Samuel had failed to be wholly open and honest with me."*

On 1 July 2010, Samuel was remanded into the custody of Hydebank Wood for the last time, having once again been unable to provide a suitable bail address. Following his committal, Samuel was seen by a Healthcare Officer as part of the healthcare screening process and he recorded on EMIS⁸ that he was fit for normal location. His medication was confirmed with his General Practitioner the following day but his medical records were not requested. Samuel was prescribed a reducing dose of Diazepam, but no referral was made to mental health services.

Over the months that followed, he continued to make bail applications but struggled to find a suitable address. Samuel received many visits from his family and girlfriend during his time in prison. They said that, whilst there were times that they found him to be in *"good form"*, they found him often to be anxious and nervous.

On 3 July, Samuel was moved to Elm 2 landing for two days and was then moved to Beech 2 landing on 5 July.

⁸ EMIS: Egton Medical Information System – an electronic medical records system used by the healthcare department of the Northern Ireland Prison Service.

Samuel Carson

An undated note, handed by Samuel to night staff in early July, stated *“Sir, I’m feeling really low at the minute cause next door to me to the left and number 10 and a fella called (name redacted) they’re calling me a rapist and they are organising who’s gonna beat me and who’s gonna hit me first they are calling me a rapist.”* This note was found on Samuel’s medical file.

The investigation established that, contrary to the requirements of the Prison Service Anti-Bullying Policy, the bullying reported in Samuel’s note, and subsequently described to staff, was not referred for a bullying investigation; a Security Information Report (SIR) was not completed and the matter was never reported to the anti-bullying co-ordinator.

On 7 July 2010, Samuel self-harmed with a soft drink can and sustained superficial cuts to his left forearm. He was assessed by a nurse officer who recorded on EMIS that Samuel was *“getting bullied on landing regarding his sexual offence charge... very superficial, however stopped himself as he is getting a bail address and looking forward to the birth of his second child, bitterly regrets cutting himself, but was very wound up and stressed and couldn’t cope...”*

It is recorded that a decision was jointly taken by the nurse officer, a senior officer and a governor to move Samuel to healthcare *“for respite.”* Samuel was noted to be *“very grateful”* for this as it removed him from the *“stress of the landing...”*

The following morning, 8 July 2010, Samuel was assessed by the mental health nurse officer who had seen him previously. The nurse officer recorded on EMIS that Samuel told him that, since moving to Beech 2, *“he has been subject (of) other inmates shouting at him and calling him names. He states that last night the other inmates were planning to attack him today and he stated that he felt that he could not take this anymore and felt that he had no option but to superficially scratch his arm...”*

The mental health nurse officer discussed Samuel’s situation with a senior nurse officer and a principal officer and it was decided that Samuel had self-harmed as a *“reaction to his situation”* and they all agreed that a move out of Beech 2 was necessary. That day Samuel was moved to Elm 2 landing and remained there for two days before being moved to Willow 3 landing because of *“operational requirements.”*

Samuel Carson

On 31 July 2010, Samuel was involved in a fight with an inmate and was seen by a nurse officer who recorded *“no obvious injuries or complaints on assessing.”* It is recorded that Samuel told the nurse officer that he *“was at breakfast...and (name redacted) ran at me...and started fighting with me, he was calling me a rapist.”*

Samuel was adjudicated on 3 August 2010 and pleaded guilty. He was given five days cellular confinement, suspended for three months. The other inmate’s adjudication was withdrawn as he was released, following attendance at Court that day.

On the 20 August 2010, Samuel’s child was born and it is recorded that she was placed on the Child Protection Register *“due to their violent relationship and Mr Carson’s charges.”*

On 24 August 2010, Samuel’s solicitor called the prison and said that Samuel had told his sister that he was going to kill himself. A SPAR booklet was opened and it is recorded that Samuel told staff that *“he is going to hang himself no matter what. He is getting hassle on the landing from other inmates ref his charge. He can’t get a bail address and social services have told him (that) he cannot see his baby daughter (four days old) or his son. States he has had enough.”* Later entries on the SPAR booklet record that Samuel regretted saying that he was going to kill himself, but *“it was the only way to get off the landing.”*

Samuel was also seen by a mental health nurse officer on 24 August 2010 who noted that Samuel was feeling low *“due to his charges.”* The nurse said also that Samuel was complaining that other inmates were making fun of him and that he was not allowed to see his new baby daughter. Samuel was placed in an observation room⁹ on Beech 2 landing and was checked at 15 minutes intervals. A prison officer phoned Samuel’s sister for him and, as he had no phone credit left, staff allowed him to use the office phone.

Samuel had no further contact with mental health services up to his death in May 2011. When asked about this, the nurse who had seen Samuel on 24 August said that Samuel was never referred again.

⁹ Observation rooms are fitted out with a CCTV camera and anti-ligature fittings. The CCTV allows the inmate to be observed 24 hours a day.

Samuel Carson

On 25 August 2010, Samuel was returned back to Willow 3 landing and he named three inmates on the landing who were bullying him.

As required by the Prison Service Anti-Bullying Policy an investigation was commenced, however Samuel subsequently withdrew his complaint saying that *"...individuals concerned would know who had made (the) allegations and things would be worse..."* Notwithstanding the fact that it was known that Samuel had only withdrawn his report because he feared that an investigation might lead to more severe bullying, the investigation was discontinued.

Samuel was reviewed at a case conference on 25 August 2010, a care plan was agreed and a further review was set for 27 August. The care plan included arranging for Samuel to have more *"out of room time (for adhoc) landing duties,"* increased levels of supervision, assistance with bail address, increase in purposeful activity and emotional support. Opportunity Youth, the Offender Management Unit and the Probation Service all assisted with the care plan.

The review planned for 27 August took place on 1 September 2010. It is recorded that there were *"no concerns or issues with (Mr) Carson over (the) past five days"* and that he had *"no thoughts of self harm or suicide."* It was noted that Samuel joined the meeting and was *"positive, talkative and appreciative of the support during a difficult period. He is aware that he should talk to staff if low mood returns."* Samuel's SPAR was closed.

At a further review on 7 September 2010, Samuel told staff that he was coping well since moving back to Willow 3 landing, but that he was still being called names by two inmates on the landing. He said that he did not want a bullying report completed.

On 15 September, Samuel wrote a note to prison staff saying *"Sir can you make a note in the office in the morning not to open my door cause the other inmates are saying there gonna punch the head off me in the morning. (Three inmates names redacted) are calling me a rapist b---rd. If you stayed for a while you can hear them its not nice. Just make a note for in the morning please. (Three inmates - names redacted) said they're gonna get me when the cell door opens."*

Two of the inmates identified by Samuel on this occasion had also been named by Samuel for bullying him in August.

Samuel Carson

The Prison Service conducted an investigation and it is noted that the alleged perpetrators denied the allegation and a potential witness identified by Samuel *“appeared reluctant to make or verify any allegations against other inmates.”* The senior officer who was tasked to investigate the incident concluded that because Samuel was accused of a high profile sex offence he *“will always be a target for verbal abuse whilst in custody.”* He noted also that, as other inmates were reluctant to verify Samuel’s allegations, it was *“...(Samuel’s) word against theirs.”* It is to note that the senior officer also reported the evidence of a prison officer who said that a trusted inmate had confirmed that Samuel was subject to *“an amount of abuse.”* It was the officer’s opinion, however, that the threat of Samuel being assaulted was *“less than the inmate himself perceives.”*

The report concluded that *“either Carson is granted his request to move to another landing or the three individuals are separated and moved to other landings. However, the latter course of action may result in further adverse consequences for Carson.”*

The report was forwarded to the anti-bullying co-ordinator. There was no written record of any action taken; the three inmates remained on the same landing and the reported bullying was not included in the Hydebank Wood monthly statistics detailing bullying reported.

A Security Information Report (SIR) was completed by a senior officer and forwarded to the Security Department. The Security Department recorded in response *“there is no previous information about these particular inmates bullying Carson. It is thought that Carson may be trying to manipulate the system.”* The officer who submitted the form said that at no stage was he ever contacted by security to discuss the SIR he had raised.

On 8 October 2010, Samuel initiated a complaint about the failure of the Prison Service to address his concerns of bullying in September 2010. Samuel wrote, *“I am making a complaint as I am on Willow 3 landing and there are two inmates that are still bullying me, I brought this to the staffs notice which then went to the Senior Officer (SO) notice, SO said that it would be sorted out as it had been a month now there still is no action taken, the two inmates are making me feel low about myself.”*

Samuel Carson

Samuel told a senior officer that the two inmates had called him a “*rapist b---rd*” and said that “*your child will turn out to be a rapist.*” He said the two inmates were also deliberately bumping into him and encouraging others to harass him.

The Prison Service commenced an investigation and the two alleged perpetrators were interviewed and denied the allegations made by Samuel. A potential witness identified by Samuel was also interviewed and it is recorded by the senior officer that “*I believe he (name redacted) had more information than he wanted to share with me, but felt he could not do so for fear of becoming a victim himself.*” The officer also interviewed landing staff and it is recorded that they also “*believed there may be substance to Samuel’s claims, however, again there was no real concrete evidence.*”

On 9 October 2010, one day after Samuel had complained and whilst the investigation was ongoing, Samuel was assaulted. A senior officer went to Samuel’s cell that day and found Samuel to be in a very distressed state. Samuel initially told the officer that he had fallen but eventually said that, whilst he was smoking a cigarette in a room with another inmate, he was assaulted by the inmates who he had previously named.

Samuel was seen by a nurse officer and it is recorded that he had a swelling to his head, a suspected fracture to his nose, cuts and swelling to the inside upper and lower lip and that he was “*agitated and upset*”. The nurse officer recorded that Samuel had said that two inmates had entered his cell and “*...began to punch and kick me. This was a prolonged attack. (Inmate name redacted) lifted a ceramic ashtray and began to hit me around the head (and) the ashtray broke and he held a piece to my throat and (inmate name redacted) pulled (inmate name redacted) away and activated the alarm.*” It is also noted on prison records that one of the assailants had a cut to his hand which Samuel alleged was caused by the broken piece of ashtray.

Samuel declined the offer to inform the police of the incident, however the following day a duty governor informed the PSNI. A police investigation took place however the Public Prosecution Service took a decision that there should be “*no prosecution*” (as detailed in section 4B of this report).

Concluding the Prison Service report into Samuel’s complaint of bullying made on 8 October 2010, the senior officer who carried out the investigation stated that Samuel’s complaint was substantiated and that “*... he had made two complaints of being bullied,*

Samuel Carson

naming the same inmates on both occasions. Now he has suffered an assault by the two alleged bullies...”

After Samuel was assaulted, he indicated that he wished to pursue his complaint of 8 October 2010. Samuel wrote *“I myself Samuel Carson is not happy about the way this was dealt with, I brought the bullying to the staffs notice which something should have been dealt with right away but due to that they were (given) a chance which I ended up with a broken nose and marks in my face and lumps on my head under my hair which was caused by them smashing an ashtray over my head. If action was taken when I brought it to the staff for the second time I would not have been attacked. I am very unhappy.”*

Samuel’s concerns were referred to the anti-bullying co-ordinator and a meeting was arranged to discuss Samuel’s situation; the two perpetrators were moved from the landing and were referred for adjudication pending the police investigation; the Probation Service were asked to engage the perpetrators in a behavioural change programme and support for Samuel was arranged through the Offender Management Unit and Opportunity Youth.

Following the assault on Samuel, the governing governor requested a *“fact find.”* This concluded that there had been poor communication on the day of the assault; the Security Department had not made a record of the incident despite being involved in taking photographs and that, contrary to Prison Service policy, the duty governor and PSNI were not contacted at the time of incident.

On 16 October 2010, Samuel asked his mother if he could use her address for bail. Samuel’s mother told the investigation that she couldn’t agree to this request because Samuel’s younger sister was living in the house and she knew that the authorities would not permit the return of Samuel whilst this was the case. Samuel did, nevertheless, around 18 October, submit his mother’s address to the police, via his solicitor, saying that his mother had agreed to move his younger sister out of the home if the address was approved for bail.

On 20 October, just days after Samuel requested to use his mother’s address as a bail address; Samuel was visited in prison by the PSNI and was served with a PM/1. The message stated: *“Loyalist paramilitaries linked to both the UDA and UVF have stated*

Samuel Carson

that Samuel Carson is not welcome anywhere in the South East Antrim area, including Carrickfergus. If he returns action will be taken against him by them and also by the community. It is said this will be done, despite who his late uncle was. If he does return and resides at his mother's house his mother would be potential risk also."

Samuel's family told the Prisoner Ombudsman that they were concerned to know how loyalist paramilitaries became so quickly aware that his mother's address had been submitted to secure bail. It is not clear how this was the case and it was explained to Samuel's family that this is a matter outside of the remit of the Prisoner Ombudsman. Samuel's family subsequently referred this and other concerns to the Police Ombudsman.

On 10 November 2010, Samuel told a prison officer that an inmate had called him a "rapist b---rd." The inmate was interviewed and admitted to saying the comment but he also alleged that he made the comment as a result of Samuel threatening to get him "done." Both inmates were warned about their behaviour.

On 27 November 2010, Samuel received three days cellular confinement and 14 days loss of association after failing a drugs test which detected the presence of Cannabis. Samuel was referred to AD:EPT.¹⁰

In November 2010 also, the Public Prosecution Service (PPS) informed Samuel's solicitor that the charges of rape and of making indecent images against Samuel were being withdrawn. The PPS determined that Samuel should be prosecuted for nine offences relating to inciting a child aged 13 – 16 to engage in a sexual act and sexual activity by an adult with a child aged 13-16. On 11 February 2011 at the arraignment, Samuel and his co-accused pleaded not guilty to the charges. The trial of Samuel's co-accused did not take place until 26 March 2012. He was acquitted of all charges as the Public Prosecution Service offered no evidence against him. Samuel's case was never heard.

Samuel's mother said that over the months after the withdrawal of the charges, Samuel continued to be bullied and assaulted. She said that Samuel told her "you get treated better if you come in for murder." Samuel's mother said that she remembered

¹⁰ AD:EPT (Alcohol and Drugs: Empowering People through Therapy): a comprehensive substance misuse service, based in Hydebank Wood, that provides a multi component model of delivery.

Samuel Carson

her son telling her that there was a *“bounty on my head”* and that the first inmate who assaulted him would get extra tobacco.

In December 2010, Samuel told a senior officer that an inmate had offered drugs to anyone who would assault Samuel. The officer recorded the information on a Security Information Report (SIR). When the Security Department assessed the SIR, they recorded that, because Samuel was on remand for a serious sexual offence, it was likely that he would be the subject of threats and abuse from any quarter and *“with regards to location there is little that can be done to ensure Carson’s safety as he is ...suspect to attack anywhere. Inmate (name redacted) is already marked enemy so they should not come into contact.”*

On 31 December 2010, it is recorded that Samuel was moved to Cedar 4 landing which offers superior accommodation and a superior regime. Inmates are normally required to have achieved PREPS¹¹ Enhanced regime status in order to be considered for a move to the landing and involvement in bullying would result in an inmate losing their place in Cedar.

It is recorded on the landing file that Samuel was moved because of *“bullying allegation, inmate is presently Standard (regime).”* It is not, however, clear who instructed that the move to Cedar 4 should take place but the officer who wrote the entry said at interview that *“when the other inmates heard that Samuel, who was on Standard regime, had automatically been moved up to Cedar on Enhanced status, I heard them say at the time that he was a tout.”*

When Samuel arrived on Cedar 4 landing, he had to be moved to Cedar 3 landing as an inmate with whom he had previously had an altercation, was on Cedar 4.

On 21 January 2011, Samuel told a prison officer that an inmate had punched him on the head and neck. It is recorded by a doctor that on assessment, Samuel’s right ear was red and tender and there was no bleeding.

¹¹ Progressive Regimes and Earned Privileges (PREPS): - There are three levels of regime. Basic - for those prisoners who, through their behaviour and attitude, demonstrate their refusal to comply with prison rules generally and/or co-operate with staff. Standard - for those prisoners whose behaviour is generally acceptable but who may have difficulty in adapting their attitude or who may not be actively participating in a Sentence Management Plan. Enhanced - for those prisoners whose behaviour is continuously of a very high standard and who co-operate fully with staff and other professionals in managing their time in custody. Eligibility to this level also depends on full participation in Sentence Management Planning.

Samuel Carson

When the accused inmate was interviewed, it is recorded that he appeared *"bewildered at the accusation."* It is also recorded that staff witnesses stated that they had seen him shaving at the time of the alleged assault. Samuel was offered a move to another landing but then asked for the withdrawal of his allegation. The officer who spoke with Samuel said that he thought that he was *"trying to manipulate a move"*. Samuel was nevertheless moved to Cedar 2 landing later that day.

On 28 January 2011, an application by Samuel to have contact with his daughter was heard at the Belfast Family Proceedings Court and he was granted supervised visits. He met his daughter for the first time on 9 February 2011.

On 2 February 2011, Samuel was punched by an inmate in the holding rooms in the visits area. The inmate told the investigation that he had punched Samuel once because Samuel had said to him that he would *"...rape your ma and your sister."* The inmate said that other inmates had been winding Samuel up beforehand and were calling him a *"rapist b----rd."* An Injury Report Form recorded that Samuel had a slight swelling to his left eye *"after altercation with inmate"* but declined to make a statement. The inmate who had punched Samuel received one day of cellular confinement; the Security Department was informed and the inmates were marked as enemies on the Prison Service information system.

On 20 February, an officer on Cedar 2 landing recorded in the landing log, *"I have stated to (senior officer name redacted) that this inmate will be assaulted on Cedar 2 it is only a matter of time."* On 22 February, the same officer recorded *"once again I have raised my concern that this inmate is going to be assaulted on Cedar 2. I spoke to (the same senior officer) about this matter."* The officer told the investigation that he believed that *"things were getting tense between Samuel Carson and other inmates."* He said that during lockdown, Samuel and the other inmates were shouting abuse at each other. The officer said he was told by his senior officer that his concerns had been raised with the principal officer but that the principal officer had said that he was not going to move Samuel on the *"...word of one officer."* The officer told the investigation that he then told the senior officer *"well you know what, you know what's going to happen. I've done all that I can."*

On 27 February, another officer recorded that Samuel had *"definite issues with other inmates. He tries to keep himself apart but gets aggressive when others comment to"*

Samuel Carson

him.” At interview, the officer said that he recalled three occasions that other inmates had said that Samuel had taken things from them.

It is to note that some officers told the investigation that, during Samuel’s time on Cedar 2 landing, he was involved in bullying behaviour. It is recorded that Samuel was spoken to by an officer about him asking for cigarettes and tobacco from other “vulnerable prisoners.” Samuel was described by one officer as a person who was able to “(give) as good as he gets” and another officer said that Samuel “just wasn’t liked by other inmates because of his personality and that the inmates couldn’t trust him as he could just turn on them with rude comments or he would just spread untrue rumours about them.”

On 1 March 2011, Samuel told a senior officer that two inmates had threatened to assault him. A bullying investigation was commenced and the alleged perpetrators denied the allegation. One of the inmates said that Samuel had taken another inmates’ food and that this led to an argument and name calling. Staff on the landing confirmed that Samuel had stolen the food. It was recorded that Samuel’s complaint was unsubstantiated but the alleged perpetrators were warned about their behaviour.

Some time afterwards, during a different investigation, an officer who was working at the time of the incident said that Samuel had not stolen the food as alleged but had, in fact, eaten a bacon roll that another inmate had said that he did not want.

On 1 March, Samuel was moved from Cedar 2 to Elm 4 landing. It was decided that Samuel should move landings due to the “poor mix on Cedar 2” and it was noted that the move “to some extent catered for his personal wish to be moved from the landing.”

Three days later, the principal officer who had previously said that Samuel should not be moved, became aware that Samuel had been moved. The principal officer told the investigation that it was prison policy to move perpetrators rather than victims and that he, therefore, made enquiries about Samuel’s move. He said that he was informed that staff feared for Samuel’s safety and felt that he was not a suitable inmate for Cedar, but that he was not provided with any proof that Samuel’s safety was at risk.

Samuel Carson

On 6 March 2011, Samuel was moved back to Cedar 2 landing on the instructions of the principal officer, who later said that he also said that the alleged perpetrators should be moved.

In the event, the perpetrators were not moved off Cedar 2 and on 7 March, Samuel was assaulted and said that the assault was carried out by the two inmates he had named on 1 March. Samuel was recorded to have "*multiple bruising to head and face. Bruising to right rib cage and pain on inspiration...*" and was taken to the Royal Victoria Hospital after he started to cough up blood.

The Prison Service commenced a bullying investigation and when questioned, the two perpetrators were aggressive. One of the inmates had red markings on his neck and forehead which he alleged was as a result of the washing powder he was using. It is recorded that he said to the investigating officer "*sure you have no evidence, no CCTV, no forensics nothing.*" The Prison Service investigation eventually concluded that "*on the balance of probabilities (the named inmate) was indeed involved in the incident.*"

The PSNI were notified of the assault on 7 March 2011 and an investigation commenced which was closed on 7 June 2011 due to the absence of "*independent evidence.*" The Prison Service adjudication of the two inmates was "*dismissed*" by a governor because of the lack of independent evidence and because Samuel had died by the time the adjudication took place and could not, therefore, give his account. The Prisoner Ombudsman investigation established that evidence gathered at the scene of the assault was never forensically examined.

On 8 March, the governing governor requested a report from the principal officer who had made the decision to return Samuel to Cedar 2 landing. The officer said in his report that, when the decision was made, there was no evidence to support any risk to Samuel's safety.

On 10 March, Samuel was sent back to Cedar 3 and on 16 March, Samuel saw his daughter for the second time in the presence of his mother and a social worker. Samuel's mother said that she noticed bruising around Samuel's eyes, following the assault. That same day Samuel's solicitor wrote another letter to the prison service raising concerns about "*severe bullying and attacks by inmates*" and the "*inadequate approach taken by the Prison to protect Mr Carson.*" The Prison Service responded saying that they "*take seriously the safe custody of all inmates.*" They said that they

Samuel Carson

would “*continue to monitor all allegations of bullying and endeavour to protect the safety and rights of all inmates.*”

The next day (11 March 2011), Samuel reported to an officer that an inmate had said that he was going to “*batter Carson.*” The officer completed a Security Information Report (SIR) but no bullying investigation was initiated. At interview, the officer said that he thought that this was because Samuel did not want to take the matter any further.

When the Security Department reviewed the report they noted that it was now “*...becoming quite difficult to keep Carson apart, as the list of enemies grow.*”

On 2 April 2011, a SPAR booklet was opened for Samuel. He had self-harmed and cut his right arm several times with a razor blade. He told staff, that he did this as a result of being bullied on Cedar 3 and said that he felt depressed but not suicidal. Samuel said that the abuse he was experiencing was verbal but he would not name the bullies. After he had self-harmed, he told staff that he regretted his actions and felt “*stupid*”.

On 3 April 2011 at 19.05, it is recorded in the observation log of the SPAR document that Samuel was asked how he was by a night custody officer and he replied “*aye alright.*” It is recorded that the officer then “*put note under Carson’s door as it’s difficult to talk through door without others on landing hearing. I said if he wishes to talk he could write it down and pass it out. Carson smiled and nodded after reading note.*”

Another night custody officer who was on duty at the same time, said that Samuel gave her a note saying “*I’m sorry I cut my arms, but in here drives you to this.*” During the course of the evening, a number of further notes were passed between Samuel and the officers, including one from Samuel requesting to speak to the Samaritans.

At interview, one of the officers said that, at one point during the evening, an inmate shouted to ask why notes were being passed and said “*what’s you doing touting? Is he touting on us miss?*” The officer said that when she pretended to walk away she heard an inmate shout “*you scumbag, what did you tell her?*” The officer said that throughout the evening Samuel did not respond to any comments from the inmates.

Samuel Carson

The following day one of the night custody officers completed a staff communication sheet bringing to the attention of her supervisor that she had heard *“verbal taunts directed at Carson...”* and that she believed that Samuel was being bullied. At interview, the officer said that the abuse directed at Samuel was *“severe”*.

On 4 April 2011, a SPAR case conference was held and it is recorded that Samuel *“deeply regretted self harming. He assured the panel that he would not be self harming again...”* It was agreed that the SPAR could be closed and a post SPAR closure interview was set for 11 April 2011. As planned, a SPAR Post Closure Review took place on 11 April 2011 and it is recorded that Samuel *“had no issues since the SPAR was closed. He hoped to be released later that night as he had high court bail and his solicitor had secured a place at a bail hostel.”*

Whilst Samuel was being escorted from healthcare back to Cedar House on 4 April, an inmate called Samuel a *“root”*. The inmate was reduced in regime and it is recorded that *“the victim, inmate Carson, has been the topic for continued abuse and bullying over the past number of weeks and in order to protect him and others, behaviour and comments such as this will not be tolerated.”*

As a result of the concerns recorded by the night custody officer on 3 April, a bullying investigation was commenced by a senior officer. It is recorded that Samuel told the senior officer that *“last night was the worst night of abuse he had endured since he had been in Hydebank”* and that the abuse was of *“an extremely vulgar and sexual nature.”* Samuel also told the senior officer that he was scared on the landing and that after he had self-harmed an unknown inmate had shouted out *“you should have cut your f---ing throat.”* Three inmates were interviewed and denied the allegations of verbal abuse. Two other inmates, however, confirmed that verbal abuse was directed at Samuel. A Security Information Report was not completed.

Whilst the senior officer was conducting this investigation he was informed by a member of staff that a number of inmates on Cedar 3 landing had been acting strangely the night before. The senior officer directed drug testing of all of the inmates and seven tested positively for drugs. Two of these inmates subsequently said that they believed that Samuel had *“touted on them”*, as he had been seen passing notes to staff the evening before.

Samuel Carson

On 5 April 2011, Samuel was assessed by a prison doctor who noted that Samuel had *“depression – poor sleep - not suicidal - refuses (Cognitive Behavioural Therapy) which is the correct option - agreed to trial Mirtazapine 15 nocte. Mirtazapine¹² tablets 15mg 28 tablet. One to be taken at night.”*

That same day, Samuel told a senior officer that an inmate had assaulted him by *“putting the shoulder into him”*. The complaint was investigated and recorded as unsubstantiated. It was recorded that *“there is no way to know if this happened, but Carson has claimed recently that he is being bullied by all and sundry. This may be a move to decide who stays on C3 (Cedar 3).”*

No Security Information Report (SIR) was completed and the anti-bullying co-ordinator was not informed.

On 7 April 2011, following an adjudication, Samuel was found guilty of being in possession of two razors and blades which he had not purchased. The sanction was a deduction of £2.00 per week for five weeks from his earnings and five days loss of association.

On the same day, Samuel was moved from Cedar 3 because it was considered that he was not meeting the standard required from an inmate on Enhanced regime. Samuel was moved to Elm 4 where he spent one day before being moved to Elm 1. He was moved because a senior officer had been made aware that Samuel was not coming out of his room because he was afraid of the other inmates.

As planned, a SPAR Closure Review took place on 11 April 2011 and it is recorded that Samuel *“had no issues since the SPAR was closed. He hoped to be released later that night as he had high court bail and his solicitor had secured a place at a bail hostel.”*

On 12 April, a member of staff completed an SIR after overhearing three inmates talking about Samuel. She said that she heard one inmate say that Samuel had *“touted”* on them and that *“...when I see him, he’ll get it.”* The inmate was seen clenching his fist and punching his other hand as he made the comments. The Security Department noted that Samuel was being blamed for the drug testing of the

¹² Mirtazapine: an anti depressant medication that enhances the effect of naturally occurring chemicals called such as noradrenaline and serotonin, which when released from the brain, act to lighten the mood.

Samuel Carson

seven inmates in Cedar House. It was recorded that *“inmate Carson has now quite a collection of listed enemies and it is difficult to keep him totally safe...”*

The only planned action was that the names of two inmates were to be added to Samuel's list of enemies. There is, however, no evidence that the inmates' names were, as planned, added to the electronic list of Samuel's enemies.

Samuel had his last visit with his daughter on 13 April 2011 with his mother and a social worker present. Samuel's mother said that he was quieter that day than when he had last seen his daughter. She said he appeared withdrawn, nervous and unsettled and appeared to be continuously looking around.

On 13 April 2011, PPANI¹³ arrangements which, due to the nature of his charges had been applied to Samuel, were withdrawn by the PSNI following an amendment to the PPANI Guidance to Agencies, issued by the Department of Justice, restricting the application of PPANI to offenders who had been convicted. It is to note that prison records were never amended to reflect this change and when the Prisoner Ombudsman was notified of Samuel's death in May 2011 she was informed that he was the subject of a PPANI arrangements and a Category 3¹⁴ risk. This was clearly not the case.

On 22 April 2011, Samuel last saw his girlfriend and prior to this she had seen him on 14 April. She said that he was in *“good form”* and that he appeared to have *“no concerns”*.

On 2 May 2011 at 23.30, it is recorded that Samuel was unlocked from his cell having requested to phone the Samaritans. Samuel told the officer, when asked, that nobody was giving him a hard time, and that he was *“..just missing the kids.”* That evening Samuel spoke to the Samaritans for 23 minutes.

On 3 May at 07.59, CCTV footage shows Samuel having breakfast in the association room with other inmates for approximately 10 minutes before leaving. Later that

¹³ PPANI is the Public Protection Arrangements in Northern Ireland which were introduced in October 2008 to manage certain sexual and violent offenders.

¹⁴ Category 3: where previous offending and / or current behaviour and current circumstances present compelling evidence that the offender is likely to cause serious harm through carrying out a contact sexual or violent offence. Such cases are closely monitored by a team of police, social services working as a Public Protection Team (PPT).

Samuel Carson

morning he is seen going in and out of the association room, class office and at lunch time he can be seen eating with other inmates.

That day Samuel made a total of eight telephone calls to his mother, sister and his girlfriend. During the calls, Samuel can be heard to argue with his mother and sister about not letting his girlfriend visit. Samuel's last two telephone calls are to his girlfriend. They argue about who "*finished*" with whom.

A prison officer said that he overheard Samuel speaking to his girlfriend that day and cautioned him as to the inappropriate language he used when addressing his girlfriend. Samuel told him that they were arguing over who had "*dumped*" who first, and sought advice from the officer. At interview, the officer said that he told him "*I think you's will probably be in love again in the next day or two, I said, because you's are all the same. So then he asked me would I phone his visits numbers out to his partner...*" Samuel's telephone credit had been used up in the last phone call.

The officer said he advised Samuel to let the "*dust*" settle to allow everyone to "*calm down*" and he said that he would ring Samuel's girlfriend on his behalf, later on.

At approximately 17.00, the officer said that he rang Samuel's girlfriend and asked her if she was going to come to visit Samuel. At interview, the officer said that Samuel's girlfriend told him that she wanted to see Samuel and would visit "*if she found a baby sitter*". The officer said that he left it on the basis that he would ring Samuel's girlfriend in two day's time to determine if she had found a baby sitter and would also provide her with a reference number to book a visit. Samuel's girlfriend confirmed this account and said that the officer told her that Samuel had said "*he was sorry and that she asked the officer to tell Samuel that she was sorry too*".

The officer said that he relayed this message to Samuel and he was "*very, very happy (and said) thank you very much for doing that for me sir.*"

That evening at 18.31, Samuel can be seen on CCTV playing table tennis, laughing and mixing with other inmates in the association room before leaving at 19.20 to return to his cell.

Samuel Carson

During evening lock up, an inmate said that he heard verbal abuse being directed at Samuel from other inmates in the Care and Supervision Unit (CSU)¹⁵, which is situated immediately below Elm 1 landing. The inmate said that he heard inmates shouting *“you f---ng rapist – go hang yourself.”*

The inmate named four inmates who he believed to have been verbally abusive to Samuel. The Prisoner Ombudsman investigation established that two of the inmates named were present in the CSU on the evening of 3 May 2011 and the other two named inmates were in the CSU in the days before Samuel took his life. These latter two inmates were part of the group of seven inmates who had been drug tested in Cedar House and appeared to think that Samuel had *“touted”* on them.

The inmate on Samuel’s landing also said that weeks before Samuel died; he told him that the abusive comments shouted at him at night annoyed him and, at times, stopped him from sleeping. At interview, the inmate said *“I think he took his life cos of bullying and he missed his family and he didn’t go to the gym or education because he feared he would get sliced.”*

An inmate who was in the CSU on 3 May 2011 confirmed that, on that evening, other inmates from the CSU had directed abuse at Samuel and that when he took his life, they said that *“he deserved it.”*

Undated correspondence, headed *“Parental Contribution to Child Protection Case Conference”* was believed to have been completed by Samuel on 3 May 2011. Samuel was aware that on 5 May, a Case Conference was being held to discuss the welfare of his daughter and the adequacy of parental care for her. The format of the correspondence was a series of questions with a space where Samuel could write his comments. One of the questions was *“Do you believe you need to change anything in your family life?”* Samuel wrote, *“Yes I do, but not as much now since I have been in jail now for over a year. I am more relaxed and I haven’t been on drugs that was my big downfall in the past.”* Samuel also wrote, *“..(Samuel’s girlfriend) is doing a brilliant job bringing (Samuel’s daughter) up on her own and (Samuel’s daughter) has a mum and dad that loves her so much.”*

¹⁵ Care and Supervision Unit (CSU): cells which are also used to house prisoners who have been found guilty of disobeying prison rules.

Samuel Carson

The last question asked was *“Is there anything else you wish to ask?”* Samuel wrote, *“I would like to ask if and when I do the courses that is asked, am I allowed to live with (Samuel’s daughter) in the future as there is nothing more in the world that matters to me. I would do anything to have and be a proper family and also be a good parent to my son and daughter.”*

At interview, Samuel’s sentence manager said that he was aware that Samuel had been told by his girlfriend that if they remained in contact, then Social Services would move to take their daughter into care and that he was *“most distressed... anxious and concerned”* about this. The manager further said that *“in Samuel’s world he had plans set to settle down as a family unit, and such a decision by Social Services certainly impacted on him.”*

On the morning of 4 May 2011, the day of his death, CCTV shows that Samuel did not attend the association room for breakfast but he can be seen at 09.17 ironing a garment.

At 09.46, Samuel is seen seated in the visits area waiting for his sister to arrive and speaking to a prison officer for a number of minutes. The officer said that Samuel had not expressed any concerns to him that day. Samuel talked with his sister for over an hour who said that things were fine and that she *“wasn’t aware he was upset about anything.”* She said that they had arranged that Samuel would telephone her with a visit reference number for her to visit him on Friday (6 May 2011). She said also that she had to get him a shirt for his upcoming court appearance.

At 11.52, Samuel is seen entering the association room for four minutes and is seen carrying a plateful of food out before returning back to his landing.

At 12.15, Elm House is locked up until 13.45. Samuel is not seen on CCTV footage for the remainder of the afternoon.

At 16.10, it is recorded that all the inmates were returned to their cells and locked. An inmate said that Samuel *“seemed pretty down”* that day and told him that he had left his girlfriend and that he believed she was dating someone else and that he had removed photographs of her from the cell wall and left them in reception. The inmate also said that when Samuel was low he would not alert staff. He said that within Elm 1 there was no bullying and *“I don’t think Samuel meant to take his life.”*

Samuel Carson

The investigation established that there was no record of Samuel handing in photographs to reception. An examination of Samuel's cell wall, however, showed that one side of the wall was covered with many pictures and photographs, but there were no pictures of Samuel's girlfriend. There were, however, spaces on the wall where pictures may have been.

A senior officer on the landing said that just before lock up on 4 May 2011, he saw Samuel and he appeared to be in good form that afternoon and he asked him how he was and Samuel told him that he was *"Dead on, I'm grand."*

When Samuel was locked up, a prison officer passed him tobacco that he had ordered from the tuck shop. He said that Samuel thanked him.

Another inmate said that at approximately an hour before Samuel was discovered hanging in his cell he spoke to him about a pink teddy bear that he was making for Samuel's daughter in Liverpool Football Club colours. The inmate said that Samuel told him, *"...I'd give you 25g of tobacco next week in return. He was cheerful as normal. He didn't look upset...I genuinely didn't think Samuel did this intentionally."*

At 16.15, a prison officer checked Elm landing and saw that Samuel was watching television in his cell. He did not speak with Samuel.

At 16.40, a prison officer commenced a headcount of the inmates on Elm 1 landing. He said that when he looked in Samuel's cell, he noticed Samuel sitting on the edge of the top bunk with his legs hanging over the bed. He said Samuel was staring at the cell wall which had pictures on it.

CCTV shows that at 16.47 a prison officer arrived on the landing with another inmate who had just been returned from Court. They are seen entering the association room with food and the inmate is then seen returning to the landing followed by the prison officer at 16.48. The normal routine of the landing on a week day would be that a headcount check would be conducted at approximately 16.45 and then inmate numbers returned to the senior officer. At approximately 16.55 to 17.00 hours an announcement would then be made to allow the unlocking of inmates. The orderlies would be unlocked first to assist with serving the evening meal. A couple of minutes later, the cells would then be unlocked for the remaining inmates.

Samuel Carson

It is recorded that on 4 May 2011, permission was given, via the tannoy, for inmates to be unlocked at 17.00 and that the inmate orderlies were then unlocked to help prepare the food for the other inmates. At approximately 17.05, it is recorded that the prison officer began to unlock the inmates and that the first cell he came to was Samuel's. The officer found Samuel hanging. He activated the alarm and then cut the ligature. The officer recorded, *"once I took the ligature off his neck I brought him backwards to the floor which brought him lying slightly out of his cell. By the time I got him onto the ground, other officers and the nurse officer had arrived."*

An officer who was on the landing on 4 May 2011, suggested that, *"Samuel could have assumed that he was being unlocked at the point (inmate name redacted) was locked in his cell, as the sound of the doors locking and unlocking are very similar. Samuel may have then tied the ligature around his neck for attention and assuming that someone would check upon him shortly after the "unlock" when in effect it was actually someone being locked up."*

It is to note that when the tannoy message is announced at approximately 17.00, prior to the unlocking of orderlies, the message can also be heard by the inmates in their cells. At the time when the other inmate was locked, Samuel would have known, if he was actively listening, that the unlock had not yet been announced. It is possible that he wasn't actively listening. It is also possible that Samuel might have noted that there was no announcement, thought that he had missed the announcement or thought that, on this occasion, unlock had for some reason commenced without the announcement. This might particularly be the case if Samuel heard what he thought was a cell being opened, was waiting to apply a ligature and believed that he had only a short time before his door was opened.

It is not possible to know whether any of these scenarios are correct. It is, however, the case that the actions that led to Samuel's death occurred at a time when he might reasonably have expected to be unlocked very shortly. This might mean that Samuel's actions were a cry for help that were not intended to result in his death.

Samuel used a belt as a ligature and the investigation was told that Samuel had borrowed this belt from another inmate, who had left prison. Attempts were made to contact the inmate concerned to find out when the belt was borrowed but the inmate has currently left Northern Ireland. The investigation confirmed with Samuel's family that the belt that Samuel used on the night of his death did not belong to him. The

Samuel Carson

family also confirmed that, on at least one other occasion, Samuel had borrowed another belt that they saw him wearing in visits. This belt was not in Samuel's cell when he died and had presumably been returned or given to another inmate. It is not possible to say when Samuel borrowed the belt that he used on the night of his death or whether he borrowed it because he was already planning to use it as a ligature. Whilst this is possible it may also be the case that Samuel may have borrowed the belt simply to wear it and subsequently decided to use it as a ligature.

The first nurse officer on the scene after Samuel was found said that when she first saw Samuel she thought he was already dead. She immediately commenced cardiopulmonary resuscitation (CPR) and, with the assistance of others, this continued until the paramedics arrived.

An emergency response bag was requested and was brought to the scene. As a defibrillator could not be found in the bag, one was brought to the scene by a principal officer and it is recorded that a defibrillator was used on Samuel at 17.13. When ambulance staff arrived, they could find no pulse.

Delays in accessing a defibrillator meant that it was eight minutes after Samuel was found that the defibrillator was used. An expert Clinical Reviewer, Mr Edward Brackenbury, was asked to assess whether this was likely to have affected the final outcome for Samuel. Having reviewed all of the prison and ambulance service relevant information, Mr Brackenbury concluded that, in the case of Samuel, the delay was immaterial to Samuel's chances of being resuscitated.

Samuel was pronounced dead at 18.12 on 4 May 2011 by the doctor.

Samuel's family asked why Samuel was bullied throughout his time in Hydebank Wood. The investigation found that much of the bullying to which Samuel was subjected to by other inmates was linked to the nature of the charges that led to him being remanded in custody. There was, however, also evidence that Samuel was bullied because some inmates believed he was a "tout" and had provided information to security about inmates using drugs. This belief was believed to be, in part, because of a misunderstanding resulting from Samuel passing notes back to staff when he was concerned for his safety.

Samuel Carson

The investigation did, however, also find evidence that Samuel did supply information to security staff, that the way in which the contacts were managed was not compliant with strict Prison Service policy that relates to this important area of work and that Samuel was not adequately protected. A full description of the evidence examined and the shortfall in the procedures and practices operated by the Security Department at Hydebank Wood is included in Section 7.

Commenting on Samuel's healthcare at Hydebank Wood, the Clinical Reviewer said that Samuel's physical care following incidents of bullying was adequate but that his mental health support was not. The Clinical Reviewer raised other concerns in respect of: Samuel not being screened for anxiety and depression; his medical records not being requested; inadequate prison healthcare records and poor arrangements for assessing Samuel's suitability for in-possession medication. An account of all of the findings of the Clinical Reviewer is included in Section 12.

Commenting on the decision to prescribe the anti-depressant Mirtazapine for Samuel, the Clinical Reviewer said that *"depression is associated with an increased risk of suicidal thoughts, self-harm, and suicide and it can take two to four weeks for the medication to take effect. It is considered that Mirtazapine should be used with caution in young adults and those with a history of suicidal behaviour or thoughts. There is no indication from the medical records or the statements that any additional observations were implemented."*

User advice for Mirtazapine includes the warning that, during the early weeks, the drug is associated with a greater risk of suicidal thoughts or suicidal attempts, particularly in younger patients. Close supervision in early treatment is, therefore, required.

It is to note that, at the time of Samuel's death, Samuel should have had three Mirtazapine tablets in his possession. When the PSNI searched Samuel's cell, no tablets were found. One tablet was subsequently found by Samuel's family in his clothes when they were returned to them. It was also the case that no Mirtazapine was detected in the blood sample taken at the autopsy. This could mean that Samuel was taking his medicine incorrectly, giving it away, or trading it.

Samuel's family wanted to know why he died.

Samuel Carson

As explained earlier, it is possible that Samuel expected to be found before he died. Whilst it is not possible to conclude this with certainty, the timing of his death might suggest that this was the case. Whether or not Samuel intended to die, the question remains as to what, on the evening of 4 May 2011, resulted in him taking the action he did. As reported, Samuel had been extensively bullied and assaulted during his time in prison. Whilst there was clear evidence that this affected him and, at times, made him frightened to leave his cell, he had never previously made such a serious self-harm or suicide attempt. He had, however, cut himself and had taken the laces out of his shoes to draw attention to his fear and anxiety. He had also made references to dying by suicide in telephone calls to his family.

It did not appear to be the case that Samuel was being bullied on Elm 1 landing at the time of his death. He was, however, subjected to inmates shouting offensive comments from the Care and Supervision Unit (CSU) during the evening and night. He is reported to have said that this *“annoyed him and stopped him from sleeping.”* An inmate reported that on the night before Samuel died he heard inmates in the CSU shouting *“you f---ng rapist – go hang yourself”* to him. It is one possibility that, after months of verbal and physical bullying, Samuel decided that he could not take another night of the same abuse.

It was also the case that Samuel’s own extensive efforts to find a suitable bail address had failed, as had efforts to find him a hostel. As noted earlier, on 24 August 2010, staff noted that Samuel had said *“he is going to hang himself no matter what. He is getting hassle on the landing from other inmates ref his charge. He can’t get a bail address and Social Services have told him (that) he cannot see his baby daughter (four days old) or his son.”*

Family matters may also have affected Samuel’s well being. Samuel had split up with his girlfriend on 3 May 2011. It is to note, however, that he had split up with his girlfriend a number of times previously and then made up. It was also the case that, on 3 May, an officer on Elm 1 had very thoughtfully called Samuel’s girlfriend for him and she had confirmed that she wanted to come up and see Samuel. The officer told this to Samuel who was reported to be *“very, very happy”*. There was, however, evidence that Samuel feared that his girlfriend was seeing other men and that other inmates taunted him saying that this was the case. Samuel’s family tried to assure him this was not the case. It is to note that, over several phone calls, Samuel’s girlfriend is in fact heard to be very caring towards him.

Samuel Carson

On the day of his death, Samuel is alleged to have told another inmate that he had left his girlfriend and it was *“putting his head away.”* When Samuel previously had worries about his girlfriend he would speak with his mother/sister to share his concerns and receive reassurance. On this occasion, Samuel could not do so because he had no available phone credit. This may have made matters worse.

Samuel’s sentence manager said that Samuel was also aware that a case conference was to be heard, on 5 May 2011, in connection with the welfare of his daughter and the adequacy of parental care for her.

The sentence manager said that Samuel’s girlfriend had told him that if she and Samuel remained in contact, then Social Services would move to take their daughter into care. As noted earlier, he said that Samuel was *“most distressed...anxious and concerned”* about this. On 3 May 2011, Samuel also completed a form in connection with the hearing, said that he no longer took drugs and asked, if he completed all of the courses he had been asked to do, *“am I allowed to live with my daughter in the future as there is nothing more in the world that matters to me. I would do anything to have and be a proper family.”*

When Samuel requested the Samaritans telephone two nights before his death, it is reported that he told the officer who gave him the phone that *“nobody was giving him a hard time; he was just missing the kids.”* The last time Samuel was seen alive, he was reported to be sitting on his top bunk staring at the wall opposite which had pictures and family photographs on it.

It was further the case that Samuel knew that he was due in Court on 18 May 2011 in connection with two counts of aggravated burglary and Assault Occasioning Actual Bodily Harm (AOABH). Whilst Samuel had previously said that he expected to be acquitted he was heard, in a telephone conversation, to say that he thought he would be sentenced for up to eight years.

One or more of the factors above may have influenced the decision taken by Samuel on the evening of 4 May 2011. It is possible also that Samuel’s decision on that particular evening may have been affected by his prescription of Mirtazapine. Samuel was prescribed Mirtazapine on 5 April, when he was recorded to have depression and sleep problems, without the recommended measures for additional medical supervision being put in place. As stated earlier, Mirtazapine is known to be

Samuel Carson

associated with an increased incidence of suicidal thoughts and deaths in the early weeks of use. Dr Malcolm VandenBurg advised that if Samuel had only taken Mirtazapine for four weeks at the time of his death, the impact on Samuel's mental health may well have been a contributing factor.

It is also the case that Samuel may have been taking his medicine incorrectly and may have missed doses or stopped taking his tablets abruptly. Dr VandenBurg said that incorrect administration of Mirtazapine would mean that Samuel could "*have repeatedly been subject to changing plasma concentrations, initiation of treatment and abrupt withdrawal.*" Dr VandenBurg confirmed that this could have increased the likelihood of Samuel experiencing suicidal thoughts and said also that Samuel's age would have increased the likelihood of these effects.

As a result of my investigation into Samuel's death, I have identified 28 areas of concern. These concerns have been communicated to Samuel's family and are described in the sections that follow.

Footnote

Whilst there are many aspects of Samuel's story that are deeply regrettable, the investigation did find evidence of a number of staff showing concern for Samuel and trying to help him when this was needed.

I would wish particularly to recognise the thoughtfulness of a night custody officer who did her best to support and reassure Samuel when he was anxious and twice phoned his family on his behalf when she knew this would mean a lot to him. Another night custody officer also showed kindness to Samuel.

I noted also the actions of an officer who lent Samuel tobacco when he had run out and also phoned Samuel's girlfriend, on his behalf, when he had run out of telephone credit after an argument and was upset.

Whilst these were small acts of kindness, it was clearly the case that they were much appreciated by Samuel.

I have drawn this footnote to the attention of these officers.

ISSUES OF CONCERN REQUIRING ACTION

As explained in the preface, the following issues of concern, requiring action by the Northern Ireland Prison Service (NIPS) and South Eastern Health and Social Care Trust (SEHSCT), were identified during the investigation into the death of Samuel Carson. I have asked the Director General of NIPS and Chief Executive of the SEHSCT to confirm to me that these issues will be addressed.

Bullying Related Issues

1. Numerous recorded instances of Samuel being subjected to, at times, very serious, verbal abuse and threats were not investigated and did not lead to any action being taken.
2. Numerous allegations of bullying and noted instances of bullying were not, contrary to the Prison Service Anti-Bullying Policy, referred for investigation; a Security Information Report (SIR) was not completed and required referrals were not made to the anti-bullying co-ordinator.
3. Bullying investigations did not take place or were abandoned when Samuel withdrew bullying allegations, even though it was known to staff that the withdrawal was due to Samuel's concern that he would be subject to more severe bullying.
4. Some reported instances of bullying were not included in the Hydebank Wood monthly bullying statistics.
5. Samuel was assaulted on 9 October 2010 by inmates whom he had previously told staff, a number of times, were bullying him. The duty governor and PSNI were not, as required by Prison Service policy, contacted at the time of the incident.
6. Staff were, at times, reluctant to raise Bullying Incident Reports because they considered that such action might lead to further bullying or assaults.

Samuel Carson

7. Investigations into bullying and resulting action were not effective. On a number of occasions, there was no evidence that recommended action was implemented by the anti-bullying co-ordinator or other staff.
8. On 1 March 2011, inmates whom Samuel alleged were threatening to assault him said at interview that an altercation had occurred because Samuel had taken another inmate's food. A staff member confirmed that this was the case. It was later established that this was not the case and the information provided by Prison Service staff was incorrect.
9. On 7 March 2011, Samuel was kicked and punched by two inmates whom he had previously named as bullying him, after he was returned to the landing where the two inmates were located. He was taken to hospital when he started to cough up blood.
10. Inmates located in the CSU repeatedly verbally abused Samuel and other inmates during the evening/night. There was no evidence that this was addressed.
11. Security staff and some prison staff regarded the bullying of alleged or committed sex offenders as inevitable.

Healthcare

12. There is no evidence that, as required by SEHSCT policy, a summary of Samuel's community GP records was requested.
 13. Samuel was not referred for a mental health review when it was decided to reduce and phase out his prescription for Diazepam.
 14. No mental health assessment took place between August 2010 and Samuel's death in May 2011. SPAR Case Conferences did not adequately consider the need for mental health reviews.
 15. No additional clinical supervision or observation was arranged when Samuel was prescribed Mirtazapine.
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16. A risk assessment for in-possession medication was undated and not recorded on EMIS. The column asking “*Does the prisoner have a history of self harm*” and “*Is the prisoner a target for bullying*” has incorrectly been ticked “no.”
17. EMIS records do not make clear whether a doctor is noting information received or has had a face to face consultation.
18. Entries in EMIS are frequently too brief to enable clinicians to expand upon them if asked.
19. The nurse emergency response bag is reported to be too heavy and to include too much equipment.

Security Arrangements

20. Meetings with Samuel were not noted.
21. No record is kept of all of the “*informal*” meetings that have taken place with any one inmate, so there is no overall picture of contacts with the Security Department.
22. The information supplied to Security by inmates is regularly not recorded. In theory, each contact should result in a Security Information Report being completed.
23. Prior to each occasion that security met Samuel, they created a “*pen picture*” on the basis of the information and intelligence that they had in their possession. The “*pen pictures*” were not recorded and it is entirely unclear how their creation would have been possible when there was no record of all meetings with Samuel and the information that he provided.
24. Even though Security received information from Samuel a number of times, controls that would apply to formalised arrangements for receiving information were not in place.

Samuel Carson

25. The same locations are being used repeatedly to meet inmates providing information and the same “*cover stories*” for requesting the attendance of inmates are regularly used.

Other Issues

26. Samuel’s Public Protection Arrangements in NI (PPANI) status was not updated on prison records to reflect advice received from the PSNI.

27. Some staff felt unsupported after Samuel’s death. This was particularly the case with a staff member known to be vulnerable.

28. Landing records of two periods of Samuel’s time at Hydebank Wood could not be found. No explanation could be provided as to how the notes were lost.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman¹⁶ for Northern Ireland, I have responsibility for investigating the death of Mr Samuel Carson. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached at Appendix 1 to this report.
2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.
3. I am independent of the Prison Service, as are my investigators. As required by law the Police Service of Northern Ireland continues to be notified of all deaths in prison.

Objectives

4. The objectives for the investigation into Samuel's death were:
 - to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;
 - to examine any relevant healthcare issues and assess clinical care afforded by the Prison Service and South Eastern Health and Social Care Trust;
 - to examine whether any change in Prison Service or South Eastern Health and Social Care Trust operational methods, policy, practice or management arrangements could help prevent a similar death in the future;

¹⁶ The Prisoner Ombudsman took over the investigations of deaths in prison custody in Northern Ireland from 1 September 2005.

- to ensure that Samuel's family have an opportunity to raise any concerns that they may have and that these are taken into account in the investigation; and
- to assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising 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 action or practice is identified, and any lessons from the death are learned.

Family Liaison

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the family.
6. It is important for the investigation to learn more about an inmate who dies in prison custody from family members and to listen to any questions or concerns they may have.
7. I first met with Samuel's family on 8 June 2011 and my investigators were grateful for the opportunity to provide them with updates on the progress of the investigation. In November 2012, I again met with Samuel's family to explain and discuss the findings and issues of concerns within this report.
8. It was important for the investigation to learn more about Samuel's background, history and personal circumstances before he died. I would like to thank his family for giving me the opportunity to talk with them about this.
9. Although the report will inform many interested parties, it is written primarily with Samuel's family in mind. It is also written in the trust that it will inform prison policy or practice, which may help to prevent a similar death in the future at Hydebank Wood Prison and Young Offenders Centre or any other Northern Ireland prison establishment.

10. The following questions were raised by Samuel's family:

- What action did the Prison Service take to address the bullying of Samuel?
- Why was Samuel not on suicide watch?
- Why was Samuel treated by other inmates as a sex offender even though the charges against him had been withdrawn?
- Why did the Prison Service notify Samuel's sister of his death instead of his mother, who was the next of kin?

FINDINGS**SECTION 1: BACKGROUND INFORMATION****1A: Samuel Carson**

Samuel was nineteen years old when he died on 4 May 2011, whilst in the custody of Hydebank Wood Prison and Young Offenders Centre.

Samuel's family described him as "*happy go lucky*" and always one "*for a good laugh.*" He was their only son and he had four sisters, one of whom who was younger than Samuel.

Samuel's family said that, as a teenager, Samuel set his heart on joining the army and went through the recruitment process but then met his girlfriend and started a family. Samuel had a son, aged twenty months and a daughter aged eight months, at the time of his death.

Prior to his committal to prison in March 2010, Samuel was known to the police in connection with a number of alleged offences, including domestic violence, which Social Services were also aware of. Samuel's girlfriend said that the domestic violence ceased in 2009 and that Samuel attended behavioural change programmes.

Samuel had never been in prison.

Samuel's girlfriend told the Prisoner Ombudsman's investigator that on a Sunday at the end of February 2010, she and Samuel had an argument and the following day Samuel rang her and said that he now had a new girlfriend. Samuel's girlfriend said that, notwithstanding this, she expected Samuel to keep in contact with her and when she hadn't heard from him by the Wednesday of that week, she kept ringing his mobile, the local hospitals and police stations to attempt to locate his whereabouts.

On the Thursday, Samuel's girlfriend received a telephone call from him. She said that he was crying and told her that he had been arrested and charged with rape. He said that he was "*completely innocent*" as the girl concerned "*had agreed to it.*" The alleged victim was fifteen years and seven months old. Samuel was 18 years old at the time.

Samuel Carson

Samuel was arrested by the PSNI on 4 March 2010 and, on 6 March 2010, was charged with: rape between 1 March and 3 March 2010; sexual activity by an adult with a child between 13 and 16 years; making indecent (pseudo) photo of a child; and distributing indecent (pseudo) photographs of a child. A relative of Samuel was a co-accused.

Due to the nature of the charges, Samuel was the subject of PPANI¹⁷ arrangements and was assessed as being a Potentially Dangerous Person (PDP) with a Category 3¹⁸ risk. Prison Service records confirm that the NIPS were notified of this.

Samuel's girlfriend was pregnant at the time. In April 2010, she received a letter from the Belfast Health and Social Care Trust stating that, due to her and Samuel's domestic history, they were considering starting Care Proceedings in respect of her unborn child. On the 20 August 2010, Samuel's child was born and it is recorded that she was placed on the Child Protection Register "*due to their violent relationship and Mr Carson's charges.*"

On 8 November 2010, Samuel's solicitors were informed that the charges against him of rape and making indecent images had been withdrawn by the Public Prosecution Service (PPS). The charges were then formally withdrawn on 10 January 2011 at a Preliminary Enquiry. The PPS determined that Samuel should be prosecuted for nine offences under article 16 and 17 of the Sexual Offences (NI) Order 2008. Samuel's co-accused was to be prosecuted for five offences under the same order. The charges all related to inciting and carrying out sexual acts with a person under the lawful age.

On 20 January 2011, Samuel was returned for trial in connection with two counts of Aggravated Burglary and three counts of Assault Occasioning Actual Bodily Harm, all of which occurred on 27 January 2009. He pleaded not guilty to these charges on 2 March 2011. The case was listed for trial for 18 May 2011.

On 11 February 2011, at the arraignment, Samuel and his co-accused pleaded not guilty to the charges relating to sexual offences. The trial of Samuel's co-accused did not take place until 26 March 2012. He was acquitted of all charges as the Public Prosecution Service offered no evidence against him. Samuel's case was never heard.

¹⁷ PPANI is the Public Protection Arrangements in Northern Ireland which were introduced in October 2008 to manage certain sexual and violent offenders.

¹⁸ Category 3: where previous offending and / or current behaviour and current circumstances present compelling evidence that the offender is likely to cause serious harm through carrying out a contact sexual or violent offence. Such cases are closely monitored by a team of police, social services working as a Public Protection Team (PPT).

1B: Northern Ireland Prison Service Anti-Bullying Policy

Reference is made throughout this report to the Northern Ireland Prison Service Anti-Bullying Policy. A summary of the prison policy is below.

Aim

The stated aim of the policy is to *“provide for all individuals within our care, a high quality service, with an environment that is free from all forms of bullying, harassment or intimidation.”*

Definition of Bullying

The policy points out that bullying can manifest itself in a number of ways. These include: verbal, non verbal, physical and malicious rumour mongering. It states that bullying may also be overt or covert and that *“young male offenders are more prone to overt bullying i.e. (physical) assault..., making explicit threats of violence...”*

Indicators

A number of indicators of bullying are identified and include, self injuring or threats to self-harm; asking for a cell move; inmates staying in their rooms and behaviour change.

Necessary Action

The policy states that *“staff will respond swiftly and diligently to such reports being made, ensuring as far as possible that the confidence of the victim is not compromised. Inmates must be confident that their complaints are taken seriously and will have no adverse or detrimental effects on them as individuals.”* It further states that *“inmates must be confident that if they feel threatened in any way that staff will listen and act on their behalf.”*

The action taken following an incident is noted to be as follows:

- A Bullying Report (BR1) is completed to include details of the allegations and the incident will be investigated by the residential manager with the assistance

of residential staff and the findings recorded. The aim of the report is “...to ascertain whether there is substance in the allegation and, where the evidence supports it, to lay a charge/s against the perpetrator/s under Prison and Young Offenders Rules. There will be instances where the investigation finds no evidence at this stage to support the claim.” A record must be held for reference purposes.

- In every instance, “a Security Information Report (SIR) must be initiated and filed by security. Information will be analysed to identify any trends in bullying behaviour and to assist in the identification of bullies.”
- When the investigation has been completed, the information must be forwarded to the Director of Custody, who on these occasions is the principal officer, who will “...convene the Anti-Bullying Committee in order to take pro-active measures to deal with the bully. If the allegation has not been proven the Director of Custody will decide if a verbal warning is appropriate in the circumstances.”
- Where there is evidence of bullying the inmate will be charged under Prison and Young Offenders Rules and referred to the Anti-Bullying Committee.

In cases where bullying cannot be proved, the policy states that this may be disposed of as “no further action – where it is clear bullying has not taken place.” Where there is insufficient evidence to substantiate the bullying allegation, the principal officer has the discretion to issue a verbal warning, which will remain in place for a period of six weeks with the inmate’s behaviour being monitored and assessed by residential staff.

SECTION 2: SAMUEL'S FIRST TIME IN HYDEBANK WOOD PRISON AND YOUNG OFFENDERS CENTRE**Committal Process**

On 6 March 2010, Samuel was remanded into the custody of Hydebank Wood Prison and Young Offender's Centre. At the time of his arrest it was recorded in Samuel's police records that the only medical concern was that he was on "*beta blockers*" once a day.

On committal to Hydebank Wood, Samuel was interviewed by a prison officer and it is recorded that Samuel informed him that, approximately two years earlier, he had taken drugs which included Cannabis, Ecstasy, Cocaine, Acid and Speed. Samuel also told the officer that, around the same time, he had self-harmed by cutting himself. During the committal healthcare screening process, the nursing assistant recorded this information on EMIS¹⁹ and noted also that Samuel's self harming episode was due to a family break up and that he had cut his wrists. It is recorded that Samuel was on Propranolol²⁰ 40mg twice a day and had taken Diazepam²¹ twice a day for the last three weeks. Samuel's medication was confirmed with his General Practitioner.

Following a new committal, prison healthcare policy requires that "*all prisoners' GPs are contacted the next working day to request a summary of their medical records.*" There is no indication that there was any attempt to obtain a summary of Samuel's medical records. In her clinical review, Ms Ruddlesdin said that, whilst the previous medical records would not have substantially contributed to the medical care provided for Samuel in Hydebank Wood they might have affected the actions that could have been taken to ensure appropriate mental health support, when Samuel was having difficulties.

Following committal, a new inmate is closely monitored by the Prison Service for a period of up to 24 hours, after which a decision is taken as to whether there is any requirement to extend the monitoring period. A handwritten note with Samuel's committal papers records that "*due to this inmate's offence he is considered vulnerable*

¹⁹ EMIS (Egton Medical Information System): an electronic medical records system used by the healthcare department of the Northern Ireland Prison Service.

²⁰ Propranolol: medication known as "beta blocker" that can be used to treat anxiety which has physical symptoms such as a fast heartbeat and trembling. It tends to slow the heart rate down to relieve these symptoms.

²¹ Diazepam: a type of medicine called a benzodiazepine which is used for sedative, anxiety relieving and muscle relaxing effect.

Samuel Carson

and at risk from other inmates. Therefore a further 24 hour period to settle-in has been agreed...Please make a record of any abuse shouted at the inmate during the night."

Samuel remained on the committal landing for three days, after which he was transferred to Elm 2.

Samuel was also allocated a sentence manager. At interview, the sentence manager said that Samuel was *"scared and apprehensive, basically because of the nature of the offence."* He said that *"if anyone is in for any sexual offence, rape, underage sex or anything like that, they are sort of shunned by the rest of the (inmates)."*

The sentence manager said that Samuel told him that he was innocent and said that he had admitted the act to the police, *"but the bit that he was denying was the fact that it was not consensual and that the person wasn't held in the house, even down to the extent that she was in the next day as well... there was only a Yale lock on the door, no deadlock and she could have walked out."*

Samuel's Time on Elm 2 Landing

Samuel transferred to Elm 2 landing on 9 March 2010.

On 11 March 2010, it is recorded on EMIS by a senior nurse officer that she had referred Samuel for mental health support following his use of the Samaritans phone over two nights. The senior nurse officer had assessed Samuel following receipt of an email from Samuel's sentence manager who had said that, when he was interviewing Samuel's co-accused, the inmate informed him that Samuel had a history of depression and that he (the co-accused) had to talk him out of self-harming.

In the email, the sentence manager stated that Samuel had said that he had considered self harming but decided against this as there were *"...lots of positive factors for not going down this avenue, such as his partner is supportive of him; he has a child and another on the way. His family are supportive of him. He spoke of (his) partner hoping to source another house and hoping to move to the Coleraine area. Samuel has no difficulty with the day time lock ups but finds night time difficult as some inmates are shouting threats. I explained that this was normal in YOC (Young Offenders Centre) given the nature of the charges but if ignored would cease."*

Samuel Carson

On 14 March 2010, Samuel met Opportunity Youth²² for the first time and it is recorded that he *“refused any intervention.”*

Following Samuel’s first week on Elm 2, it is recorded in prison records that he had *“been on the landing for one week and has taken verbal abuse from one inmate because of his alleged crime. He has not caused any problems.”* There is no evidence that any action was taken in response to the recorded verbal abuse.

Samuel’s mother said that, during one phone call, her son said that he was getting a hard time in prison and she started to cry. She said that Samuel then also started crying, passed the telephone to a member of staff and asked them if they could speak to his mother. Mrs Carson said that the officer told her *“not to worry, that Samuel would be okay”* and that the Prison Service *“would look after him.”*

A letter from Samuel to his mother around this time says *“I’m here nearly two weeks now and I’m getting it bad in here getting called rapist and getting threatened that I’m gonna get sliced up, I’m feeling really low in here....my heads going worse than it was...if anything happens to me in here I love yous all...”*

Transfer to Elm 3 Landing

On 19 March 2010, Samuel was transferred to Elm 3 landing and it is recorded that a prison officer explained to him the Elm 3 routine. The prison officer also recorded that he was of the opinion that Samuel *“should not have left Elm 2.”*

At interview the officer said that Samuel *“should not have been moved to E3 (Elm 3) landing. E3 and E4 inmates would have had a tendency to pick on any inmates who would be charged or convicted of sexual offences...and hence would attempt to give verbal abuse to such a prisoner when staff were not about or when it was impossible for them to be identified...for example when all the inmates were in their cells at night. The verbal abuse would normally start at night time.”*

²² Opportunity Youth: an organisation which provides a comprehensive range of personal development and therapeutic services, including three one to one intervention sessions, to inmates experiencing difficulties during their time in prison.

Samuel Carson

On the day that Samuel moved, it is recorded on EMIS that he had fallen and hit his arm on furniture and a “foreign body” approximately 2cm long could be seen below his skin in his right forearm. Samuel was seen by a doctor and referred to hospital.

On 20 March 2010, a prison officer recorded that Samuel was under “constant danger of attack by other inmates.” He noted that “for this reason, he rarely comes out of his room. He has had verbal threats made by other inmates.” At interview the officer repeated that Samuel was “in constant danger.” He said that inmates used to shout verbal abuse at Samuel at times when staff would not be able to identify them, or at night time. The officer said that there were times where a group of inmates would walk pass Samuel’s cell and one of them would shout in and they would say comments such as “bullroot (sex offender)... b---rd, f---ng b---rd, d-----d, we’re gonna cut your throat and all sorts of stuff.”

The prison officer said also that he had also been approached by inmate orderlies who told him that Samuel was getting verbally abused but that the inmates would never identify the perpetrators.

Contrary to the requirements of Prison Service policy, no evidence was found that landing staff took action to address this bullying.

Opening of SPAR Booklet by Opportunity Youth, 25 March 2010

On 25 March 2010, a SPAR booklet²³ was opened for Samuel by a member of staff from Opportunity Youth²⁴. It is recorded that Samuel had thoughts of suicide and that he had “coped well on the committal landing but (his mood) deteriorated when moved to Elm 3... Samuel is not coming out of his room...Stated that he had thoughts of suicide last week and had took out his laces from his shoes. It is further recorded that Samuel “stated that night time is the worst and stated he doesn’t know if he will be able to cope until next week.” Samuel’s bail hearing was due to take place the following week.

That afternoon, as required by Prison Service policy following the opening of a SPAR booklet, a multi-disciplinary group met to discuss an Immediate Action Plan. It was

²³ Supporting Prisoners at Risk (SPAR) booklets are used at times when staff deem an inmate as vulnerable to self harm and suicide and to provide increased observations and support for inmate.

Samuel Carson

agreed that Samuel would be moved to Elm 2 (E2) and it is recorded that Samuel *"feels much more settled now that he knows he is moving to E2."* During a further assessment the following day with a senior officer it is recorded that Samuel said that *"...thinking about his girlfriend, his children and his mum, stopped him from killing himself."*

Reviewing the notes of the multi-disciplinary group, the Clinical Reviewer expressed concern that *"although nursing staff are listed as being involved in the discussions, at no point was a referral considered for a formal mental health assessment."*

Inmate Fight 30 March 2010

On 30 March 2010, Samuel was involved in a fight with an inmate and it is recorded on an Injury Report Form that Samuel was *"punched twice on the head with a closed fist"* and that he made a statement saying *"he hit me first and I hit him back to defend myself."* Both inmates were required to attend adjudications but the other inmate was then released and both adjudications were withdrawn.

Samuel's SPAR booklet was closed on 1 April 2010 and it is recorded that Samuel *"...had no current thoughts of self-harm...feels comfortable on E2 and that a move to E3 or E4 would upset him as he is getting abuse from inmates there due to the nature of his charges."*

Samuel remained on Elm 2 until 4 April when, despite it being recorded three days earlier that a move to Elm 4 was not in his best interest, he was moved to Elm 4. It was recorded that this was for *"operational requirements."*

9 to 15 April 2010

Prison records appear to indicate that Samuel initially settled well on Elm 4. On 9 April, it is recorded by a prison officer that Samuel was in *"great form at present. He is mixing well on the landing..."*

On 15 April, Samuel had his assessment with a mental health nurse officer. At interview, the nurse officer said that Samuel *"presented at that time as somebody who had stresses due to his current incarceration in prison. He did not present to me as anybody with sort of like any overt form of mental health."* The nurse officer said that

Samuel Carson

Samuel's issues centred on his relationship with his girlfriend. He said also that Samuel appeared not to have ever learnt coping strategies and how to deal with different situations.

The EMIS entry recording the consultation, notes that Samuel had harmed himself in the past for *"...several reasons, these being his parents had split up, he split up from an ex-girlfriend and he had been having paranoid ideas that his current girlfriend was cheating on him. He did go on to admit that he does have paranoid ideas about his relationship with his girlfriend with whom he has had a child. He states that when he is in the cell he constantly thinks that his girlfriend is cheating on him...despite him also stating that she is supportive of him and has left clothes and money for him regularly. We explored his past behaviours and he did admit to being volatile in the past at the least of things..."* The nurse officer also recorded that *"although Samuel did state that he feels able to cope with prison life at present we did discuss his ongoing paranoid ideas about his relationship. We discussed CBT²⁵ (Cognitive Behavioural Therapy) as a means of him developing better coping strategies. He agreed that this may be of benefit to him and agreed to engage with this service."*

A referral was made to the cognitive behavioural therapist that day but Samuel was released before an appointment was arranged and the referral was never progressed when he returned to prison.

Incident 24 April 2010

On 24 April, it is recorded on an Injury Report Form that Samuel was involved in a *"fracas"* with an inmate during visits. No injuries were recorded and Samuel *"declined"* to make a statement on the form.

Samuel's solicitor said that, around this time also, Samuel told him that he had been struck with *"pool balls placed in a sock"*. The solicitor said that Samuel had said that he did not want anything done about it. The investigation found no evidence in prison records that the prison service were notified of or aware of this alleged incident.

²⁵ CBT (Cognitive Behavioural Therapy) aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure in the present. CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders.

Samuel Carson

Samuel was released on 24 April and adjudications planned in connection with the incident with an inmate that day, were withdrawn.

Applications for Hostel Places

It is recorded that, during his time in prison Samuel, with the assistance of his solicitor, began to make applications for hostel accommodation through the Probation Service, in the hope of finding somewhere that he could stay. On one occasion, Samuel temporarily withdrew one of these applications because he said he was concerned that his release to the hostel would result in Social Services seeking a full care order on his child.

Samuel's sentence manager said that Samuel used to enquire regularly as to whether he had been successful in obtaining a placement in a hostel.

SECTION 3: SAMUEL'S EXPERIENCE FROM LEAVING PRISON UP TO HIS FINAL COMMITTAL**Release into the Community**

Samuel was released on bail on 24 April 2010 and moved into accommodation in McCandless Street in Belfast, which was owned by a friend who allowed him to use this address until he could find suitable accommodation. Two to three weeks later, Samuel moved to accommodation in Lemberg Street in Belfast.

On 4 June, the PSNI attended Samuel's Lemberg Street address and served him with a PM/1.²⁶ The notice stated that *"Local people believe you raped a 14 year old girl. You may also be the subject of some form of attack in order to force you to leave the area."*

Notwithstanding the notified threat, Samuel was reluctant to leave his accommodation. That night, however, the PSNI assisted him and his girlfriend to move to emergency accommodation and advised them to contact the Northern Ireland Housing Executive after the weekend, for further assistance. The PSNI also informed the Housing Executive and Social Services of their situation.

Breach of Bail Conditions

On the week commencing 7 June 2010, whilst Samuel was in a meeting with a housing officer discussing his accommodation needs, he received a telephone call on his girlfriend's mobile phone. It was a condition of Samuel's bail that he was not permitted to have a mobile phone.

Social Services subsequently became aware of this incident and, when Samuel presented himself at a police station on 9 June in connection with his bail, he was arrested for breach of bail conditions.

On 10 June 2010, Samuel was again remanded in Hydebank Wood and it was recorded at the time of committal that *"due to (the) nature of offence he may be targeted by others but no specific threat."* Samuel remained on Elm 1 landing until 14

²⁶ PM/1: an official police record of any threat issued against an individual(s). The information can be notified to police via a local community group, paramilitaries or other organisations. When the threat is issued, police are obliged to notify and serve this document upon the person concerned.

Samuel Carson

June and was then moved to Elm 2. He remained on Elm 2 until his release on bail on 18 June 2010.

Samuel's landing records were sought for this period of custody from the Northern Ireland Prison Service but the investigation was informed that these could not be found. No explanation could be provided as to how these notes were lost.

Release and Return to Custody on 18 June 2010

On the day of his release, Samuel attempted to return to his address in McCandless Street but that evening, at approximately 19.00, he presented himself to Donegall Pass Police Station in Belfast stating that the address was no longer suitable. Samuel's girlfriend told the investigation that, on the day of Samuel's release from prison, they were travelling on the bus to the bail address when Samuel received a phone call from the occupier, who was the brother of the inmate who owned the property. The occupier told him not to come to the address because a death threat had been issued against Samuel, because of his charge. Samuel's girlfriend said that he rang his mother and she told him to hand himself into the police.

Samuel's girlfriend said that when Samuel went to the police, two police officers tried to find a hostel for him but there were no vacancies, so he was kept in the police station overnight. Samuel's girlfriend returned to a women's hostel where she had been staying previously.

Samuel was recommitted to Hydebank Wood on 19 June 2010, because there was nowhere else that he could go. He was then released on 22 June 2010.

On the day of Samuel's committal, an entry recorded on EMIS by a nurse officer states "*was released on Friday and was threatened by paramilitaries and therefore could not go to the address that had been arranged for him. He had to go to the police station and subsequently arrived back at Hydebank Wood as he has no safe address at present. He states that his mother has arranged for a new house for him and should be released on Monday when all is finalised. No change in his health status.*" During the committal interview he was asked if he had any concerns about his detention and it is recorded that he answered, "yes." No further explanation is recorded.

Samuel Carson

Samuel's landing records were requested for this period in Hydebank Wood but, again, the investigation was informed that these could not be found. No explanation could be provided as to how the notes were lost.

On 22 June 2010, Samuel was released to his sister's address and one of his bail conditions was that he would have to sign bail at Tennent Street Police Station.

Assault in the Community

On 29 June 2010, after returning from signing bail, Samuel had disembarked from a bus and was walking home to his sister's address, when he was pursued and assaulted by a group of up to eight youths, just outside of her property. It is recorded in Samuel's statement to the PSNI, that he was punched and kicked for approximately two minutes.

In her statement to the police, Samuel's sister, who was pregnant at the time, said that she opened the door when she heard someone trying to turn the door handle. She said that she saw a crowd of youths and her brother kneeling on the ground, trying to get up. She said that she heard one of the youths threatening Samuel and then someone from the crowd shouted "*rapist*". Samuel's sister said she brought her brother into the house and told her partner to contact the police, as it wasn't safe for Samuel to live there anymore.

Before the PSNI arrived, there was a knock at the door and Samuel's sister was confronted by a female, who was related to one of Samuel's assailants. This female was verbally abusive to Samuel's sister and then punched her twice.

Samuel's Further Attempts to Find Accommodation

After this incident Samuel returned to Lemberg Street, even though a threat had been previously issued against him in connection with this address.

On 30 June 2010, Samuel identified property available for rental in Dunluce Avenue in Belfast and, with his girlfriend, met the landlord. The landlord agreed to let the couple rent the property for a year and, that evening, handed them the keys. It was agreed that they would meet again the following day to finalise matters. Samuel and his girlfriend stayed at the Dunluce Avenue address that night.

Samuel Carson

The next day, 1 July, Samuel attended court and, via his solicitor, submitted the Dunluce Avenue address to the police as a bail address. The same day, the police officer who received the information rang Samuel's new landlord from Laganside Court. The officer stated that *"The landlord was advised that the charges related to serious sexual offences involving a child and enquiries (were) made around children living in the apartment. He was also advised there had been threats made at the previous addresses and enquiries made if he had any concerns for the safety of other tenants and/or property."*

At interview, the landlord said *"I received a telephone call from a police officer whom I believe was part of the prosecuting team. The officer explained that the reason why he was ringing was due to child safety and he was concerned about whether Samuel would be in the presence of children... He further said that Samuel Carson was accused of serious charges relating to child abuse. Lastly, he also informed me that my address was (to be) used as a bail address."* The landlord said that after he heard about Samuel he *"googled"* him to find out more details of his offence and said that *"based on the information from the police officer and the information that I found on him, I decided not to rent the property to him. This was on the basis that Samuel had failed to be wholly open and honest with me."*

It is to note that the family of Samuel Carson raised concerns in connection with police conduct in relation to the disclosure of information and bail addresses. It was explained to them that this issue is outside the remit of the Prisoner Ombudsman's investigation. The family subsequently advised that they had taken a complaint to the Office of the Police Ombudsman for Northern Ireland.

SECTION 4: SAMUEL'S FINAL COMMITTAL TO HYDEBANK WOOD PRISON AND YOUNG OFFENDER'S CENTRE**4A: Key Events July to September 2010****Prison Committal Process**

On 1 July 2010, Samuel was remanded into the custody of Hydebank Wood Prison and Young Offenders Centre having again been unable to provide a suitable bail address. He continued to apply for bail over the months that followed but had difficulty finding an acceptable address.

During the committal process an inmate is asked questions which form part of a Vulnerability Assessment Record. One of the questions is, *"Has the inmate got a history of being bullied/victimised?"* In answer to the question, the officer who interviewed Samuel has marked "No". Another prison officer recorded that Samuel was *"very confident of getting bail on Tuesday (the following week). Appears to be in good form."*

During the healthcare screening process, a nursing assistant recorded on EMIS that Samuel was fit for normal location and that his medication was Diazepam 5mg twice a day. This was confirmed with Samuel's GP the following day who said that Samuel was currently prescribed 5mg of Diazepam as and when required, with a maximum of 10mg a day. The nurse officer recorded that the plan was to provide Samuel with 5mg of Diazepam daily for four days followed by 2mg for three days, prior to withdrawing the medication. Samuel's medical notes were not requested and, even though he was prescribed a reducing course of Diazepam, no referral to the mental health team was made.

Samuel was seen by the Probation Service the following day and it is recorded that *"paramilitary attended his sister's address and he was expelled from this house... remanded due to no bail address."*

Samuel remained on the committal landing in Elm 1 until 3 July 2010, when he was moved to Elm 2 landing for two days, before moving to Beech 2 landing on 5 July 2010.

Samuel Carson

On 5 July 2010, Samuel met Opportunity Youth and said that he was going to get bail to his father's address, once his father signed the bail application. It is to note that Samuel's father told the investigation that, when Samuel asked to use his address, he told him that the address wouldn't be suitable, due to the paramilitary presence in the area.

Allegation of Bullying

An undated note, believed to have been written by Samuel in early July, stated "*Sir, I'm feeling really low at the minute cause next door to me to the left and number 10 and a fella called (inmate name redacted) they're calling me a rapist and they are organising who's gonna beat me and who's gonna hit me first.*" Samuel's note was found on his medical file with a note stating that it was given by Samuel to night staff.

The investigation established that, contrary to the requirements of the Prison Service Anti-Bullying Policy, Samuel's note was not referred for a bullying investigation; a Security Information Report (SIR) was not completed and the matter was never reported to the anti-bullying co-ordinator.

Self Harming Incident - 7 July 2010

On 7 July 2010, Samuel self-harmed with a soft-drink can and sustained superficial cuts to his left forearm. He was assessed by a nurse officer who recorded on EMIS that Samuel was "*getting bullied on landing regarding his sexual offence charge... very superficial, however stopped himself as he is getting a bail address and looking forward to the birth of his second child, bitterly regrets cutting himself, but was very wound up and stressed and couldn't cope...*" The nurse officer recorded "*superficial cuts to left forearm. Cleaned and dressed with Mepore and Steri-strips.*"

It is recorded that a decision was jointly taken by the nurse officer, a senior officer and a governor to move Samuel to healthcare "*for respite.*" Samuel was noted to be "*very grateful*" for this as it removed him from the "*stress of the landing...*"

It is recorded that "*a SPAR document did not need to be generated at this stage as Samuel is away from the stress and has given assurances that he does not intend to harm himself further. Will be monitored in a healthcare room overnight under nursing camera observation and hourly physical checks.*"

Samuel Carson

The following morning, 8 July 2010, Samuel was assessed by the mental health nurse officer who had seen him previously. The nurse officer recorded on EMIS that Samuel told him that, since moving to Beech 2, *“he has been subject (of) other inmates shouting at him and calling him names. He states that last night the other inmates were planning to attack him today and he stated that he felt that he could not take this anymore and felt that he had no option but to superficially scratch his arm...”*

The mental health nurse officer discussed Samuel’s situation with a senior officer and a principal officer and it was decided that Samuel had self-harmed as a *“reaction to his situation”* and they all agreed that a move out of Beech was necessary. On 8 July, Samuel, therefore, moved to Elm 2 landing.

On 10 July, Samuel was moved to Willow 3 landing. It is recorded that this was because of *“operational requirements,”* Samuel remained on Willow 3 until 14 December apart from two short periods discussed later.

Allegation Against Samuel – 17 July 2010

It is recorded on a SIR that on 17 July, an inmate told a senior officer that he feared Samuel was going to attack him and that this was due to a clash of personality. The Security Department recorded that *“Carson is at present a Category A due to the nature of his offence. He may be subject to attack from others.”*

Fight with Another Inmate

On 31 July, Samuel was involved in a fight with another inmate. Samuel was seen by a nurse officer who recorded *“no obvious injuries or complaints on assessing.”* It is recorded that Samuel told the nurse officer that he *“was at breakfast...and (inmate name redacted) ran at me...and started fighting with me, he was calling me a rapist.”*

Samuel alleged that the inmate concerned was aware of his charge of rape and had approached him and said he would rape Samuel’s partner. Samuel said that he reacted to this and started fighting. CCTV footage was viewed at the adjudication.

Samuel was adjudicated on 3 August 2010 and was found guilty and was given an award of five days cellular confinement, suspended for three months. The other

inmate's adjudication was withdrawn as he was released following attendance at Court that day.

Opening of Second SPAR

On 24 August 2010, a SPAR booklet was opened, following a telephone call from Samuel's solicitor. The solicitor informed the prison service that Samuel had told his sister that he was going to kill himself. It is recorded on the SPAR booklet that Samuel told staff that *"he is going to hang himself no matter what. He is getting hassle on the landing from other inmates ref his charge. He can't get a bail address and social services have told him (that) he cannot see his baby daughter (four days old) or his son. States he has had enough."*

A multidisciplinary group, which included a nurse officer, met to discuss Samuel. Further entries on the SPAR booklet record that Samuel regretted saying that he was going to kill himself, but *"it was the only way to get off the landing."* The same day Samuel was seen by the mental health nurse officer who recorded on EMIS an entry consistent with the account above and noted that Samuel was *"also feeling low due to his charges."*

Samuel was also seen by the mental health nurse officer on 24 August 2010 who noted that Samuel was feeling low *"due to his charges."* The nurse said also that Samuel was complaining that the other inmates were making fun of him and that he was not allowed to see his new baby daughter. Samuel was placed in an observation room²⁷ on Beech 2 landing and was checked at 15 minutes intervals. A prison officer phoned Samuel's sister for him and, as he had no phone credit, staff allowed him to use the office phone.

Samuel had no further contact with mental health services up to his death in May 2011. When asked about this, the nurse who had seen Samuel on 24 August said that Samuel was never referred again.

Samuel was placed in an observation room on Beech 2 landing and he was checked at 15 minutes intervals. On the night of 24 August, it is recorded that Samuel asked a

²⁷ Observation rooms are fitted out with a CCTV camera and anti-ligature fittings. The CCTV allows the inmate to be observed 24 hours a day.

Samuel Carson

prison officer, to ring his sister to let her know that he was fine. The officer rang his sister and when he was told that she had done so, "*Samuel was happy with this.*" The following morning Samuel asked to use the phone to ring his sister and was permitted to use the office phone as he had no phone credit.

On 25 August 2010, Samuel returned back to Willow 3 landing and he named three inmates on the landing whom he said were bullying him and a case conference was held to develop a Care Plan for Samuel. The Care Plan included arranging for Samuel to have more "*out of room time (for adhoc) landing duties,*" increased levels of supervision, assistance with his bail address, increase in purposeful activity and emotional support.

Shortly afterwards Samuel met with Opportunity Youth, the Probation Service and the Offender Management Unit in connection with his Care Plan.

Bullying Investigation – 25 August 2010

In line with the requirements of the Prison Service Anti-Bullying Policy and procedures, an investigation was commenced after Samuel named the three inmates whom he said were bullying him. It is, however, recorded that Samuel subsequently withdrew his allegation citing that "*...individuals concerned would know who had made (the) allegations and things would be worse. Samuel was adamant he did not wish to proceed despite assurances that we would do what we said. Allegation withdrawn.*"

Notwithstanding the fact that it was known that Samuel had only withdrawn his allegation because he was concerned that he would be subject to more severe bullying, no SIR was completed and the bullying investigation was discontinued. The report marked "*allegation withdrawn*" was not forwarded to the anti-bullying co-ordinator.

It is to note that the Anti-Bullying Policy states that "*inmates must be confident that their complaints are taken seriously and will have no adverse or detrimental effects on them as individuals.*"

SPAR Review and Closure

A SPAR review planned for 27 August took place on 1 September and it is recorded that there were *“no concerns or issues with (Mr) Carson over (the) past five days”* and that he had *“no thoughts of self harm or suicide.”* It was noted that Samuel joined the meeting and was *“positive, talkative and appreciative of the support during a difficult period. He is aware that he should talk to staff if low mood returns.”* The SPAR was closed on this date with a post closure review set for 7 September 2010.

When the post closure review took place on 7 September, it is recorded that *“Samuel has been coping ok since moving back to W3 (Willow 3 landing). He says he is still being called names by 2 people on the landing but does not want to have a bullying report done. He says he does not feel suicidal as his mum is bringing his baby daughter up to visit next week. He said if he feels things getting to him he will speak to staff.”*

Bullying Investigation – 15 September 2010

Eight days later, on 15 September, Samuel wrote a note to prison staff saying *“Sir can you make a note in the office in the morning not to open my door cause the other inmates are saying there gonna punch the head off me in the morning. Three inmates are calling me a rapist b---rd. If you stayed for a while you can hear them its not nice. Just make a note for in the morning please. (Three inmates names redacted) said they’re gonna get me when the cell door opens.”*

On 16 September, Samuel told a prison officer that those bullying him had said that *“if his new born child was male, it would (become) a rapist.”*

Two of the inmates named on this occasion were two of those identified by Samuel in August 2010 as bullying him.

On this occasion, the Prison Service conducted an investigation and the alleged perpetrators were interviewed. All of them denied the allegations. It is recorded that a potential witness whom Samuel had identified was interviewed and he *“appeared reluctant to make or verify any allegations against other inmates.”*

The senior officer who was tasked to investigate the incident concluded that because Samuel was accused of a high profile sex offence he *“will always be a target for verbal*

Samuel Carson

abuse whilst in custody.” The senior officer noted that, as other inmates were reluctant to verify his allegations, it was currently “... (Samuel’s) word against theirs.”

In the senior officer’s report it is, however, recorded that a prison officer had made discrete enquiries with *“a trusted inmate on the landing who confirmed that there was an amount of abuse going on over the lock up periods but could not name any inmates involved. However, (the prison officer) is of the opinion that the actual threat of Carson being physically attacked is less than the inmate himself perceives.”*

The report concluded that *“either Carson is granted his request to move to another landing or the three individuals are separated and moved to other landings. However, the latter course of action may result in further adverse consequences for Carson.”*

The senior officer’s report was forwarded to the anti-bullying co-ordinator and the officer had no further dealings with the case. At interview, the officer said that the comments in his report *“reflect that Samuel’s specific allegations against the identified perpetrators were unsubstantiated, however the allegations of verbal abuse were substantiated i.e. verbal abuse was taking place, which is recorded in my report where I have stated that (officer name redacted) had spoken to a trusted inmate who was able to confirm that verbal abuse was taking place by unnamed inmates.”*

Each month Hydebank Wood compiles statistics detailing the number of bullying cases reported. The statistics are then considered at management meetings. The bullying alleged by Samuel in September 2010 was not included in the month’s statistics and, when asked, the anti-bullying co-ordinator suggested that this may have been as a result of a filing error.

At interview, the anti-bullying co-ordinator could not recall what action was taken when the report was forwarded to him. He said *“I would probably have been speaking to the residential manager as well to see as to what we could have done regarding any moves or whatever, but because of the fact it was unsubstantiated that’s possibly why that didn’t happen. I don’t honestly know, as I say.”*

There is no written record of any action being taken as a result of the investigation report. Samuel and the alleged perpetrators remained on the same landing, apart from several days where two of the three inmates were placed in the Care and

Samuel Carson

Supervision Unit (CSU)²⁸ for cellular confinement, following adjudication for an unrelated matter.

A SIR naming the three inmates allegedly involved in the bullying was completed by the senior officer conducting the investigation and forwarded to the Security Department. The officer also recorded on the SIR that Samuel had informed the senior officer that one of the alleged bullies would be bringing drugs into prison when he returned from compassionate bail.

When the Security Department considered the SIR, a security officer recorded *“there is no previous information about these particular inmates bullying Carson. It is thought that Carson may be trying to manipulate the system.”*

At interview, the senior officer who completed the SIR said that Samuel did not negotiate or seek anything in return for the information he supplied in connection with drugs. The officer said also that, after he submitted the form, the Security Department did not contact him to discuss the content. The officer said *“it was not my impression having spoken to Samuel on that day that he was manipulating the system in any way.”*

It is recorded by the Security Department that when the inmate named by Samuel returned from home leave he was searched with negative results. It is however also recorded that, because of rostering arrangements, the Passive Drug Dogs were unavailable that day.

²⁸ Care and Supervision Unit (CSU): cells which are also used to house prisoners who have been found guilty of disobeying prison rules.

4B: Key Events October 2010**Complaint Raised by Samuel – 8 October 2010**

Samuel made a complaint on the 8 October 2010, regarding the failure of the prison service to act upon his concerns of bullying, reported in September. Samuel wrote *"I am making a complaint as I am on Willow 3 landing and there are two inmates that are still bullying me, I brought this to the staffs notice which then went to the SO's (Senior Officer) notice, the SO said that it would be sorted out as it had been a month now there still is no action taken, the two inmates are making me feel low about myself."*

Samuel alleged that two inmates that he had identified as bullying him in September, had called him a *"rapist b---rd"* had again said that *"your child will turn out to be a rapist"* and were deliberately bumping or nudging him out of the way when he was on the landing. A potential witness was identified by Samuel. Samuel said also that the two inmates were encouraging other inmates to harass him.

A senior officer was appointed to investigate the complaint. The two alleged perpetrators were interviewed, as was the witness named by Samuel. The alleged perpetrators denied the allegations made by Samuel and the investigating officer recorded that *"I believe he (the named witness) had more information than he wanted to share with me, but felt he could not do so for fear of becoming a victim himself."* The officer also interviewed landing staff and it is recorded that they also *"believed there may be substance to Samuel's claims, however, again there was no real concrete evidence."* During this investigation, the senior officer became aware of the previous investigation conducted in September.

Before the investigation was completed, Samuel was assaulted on 9 October by those that he had identified as bullying him.

Assault of Samuel 9 October 2010

It is recorded in a statement to the PSNI that on 9 October that a prison officer was on the landing at 15.30 when he came across a group of inmates in a cell. The officer stated that he ordered the inmates out of the cell and discovered Samuel with blood on his t-shirt. The officer reported this to a senior prison officer.

Samuel Carson

It is recorded in the senior officer's staff communication sheet that he attended Samuel's cell and found him in a very distressed state. The senior officer recorded that Samuel's first account of what had happened was that he had fallen. The officer said that he had to *"coax young Carson to attempt to ascertain the true facts."* Eventually Samuel said that whilst he was in a room with another inmate smoking a cigarette, he was assaulted by two of the inmates that he had named in September and further complained about on 8 October.

Samuel was seen by a nurse officer and it is recorded on the Injury Report Form that he had a swelling to his head, a suspected fracture to his nose, cuts and swelling to the inside upper and lower lip and that he was agitated and upset. The nurse officer recorded that Samuel had said that two inmates had entered his cell and *"...began to punch and kick me. This was a prolonged attack. An inmate lifted a ceramic ashtray and began to hit me around the head (and) the ashtray broke and he held a piece to my throat and (the other named inmate with Samuel) pulled (inmate name redacted) away and activated the alarm."* It is recorded on an Incident Report Form completed by a prison officer that one of the assailants, had a cut to his hand which Samuel alleged was caused by the broken piece of ashtray.

It is recorded on EMIS that *"On examination, (Samuel had) slight swelling to head on (left) side and on top of head (small bump) nose mis-shaped. Appeared agitated and upset. No other injuries noted."*

A day after the assault, Samuel told a nurse officer that he had difficulty breathing *"via (his) nasal airways"* and he was referred to the general practitioner who saw him on 11 October and referred him for an X-ray at Maghaberry Prison. The medical facilities in Maghaberry Prison do not, however, provide a service for the x-ray of injuries of the type sustained by Samuel.

A letter referring Samuel to a hospital ENT (Ears, Nose and Throat) Department was finally issued by the doctor on 2 November 2010, three weeks after Samuel had sustained his injuries.

It is recorded that, following the assault, Samuel was offered the assistance of the PSNI but that he declined this. The following day a duty governor informed the police

about the incident. Both of the perpetrators were moved from the landing and placed on report, pending the police investigation. No SIR was completed.

Outcome of the Bullying Investigation

The senior officer tasked to carry out the investigation of the complaint about bullying made by Samuel on 8 October, said that *"...during the course of my investigation I discovered that (another senior officer) had also submitted a bullying report on behalf of Samuel Carson. When all is considered, I believe Samuel's complaint to be substantiated. He had made two complaints of being bullied, naming the same inmates on both occasions. Now he has suffered an assault by the two alleged bullies. I have informed Samuel of the outcome of my investigation..."*

All the related records were forwarded to the anti-bullying co-ordinator on 10 October 2010.

PSNI Investigation

On 10 October 2010, the PSNI interviewed Samuel. In a statement to the police, Samuel said that on 9 October 2010, between 14.30 and 14.45, he was in a friend's cell with three inmates when two inmates entered the cell and began to punch him around the face and head for approximately one and a half minutes. Samuel said that, during the assault, he was held in a chair by one of the inmates who used his foot to pin him in the seat. He said that he was then repeatedly punched around the face and head and then struck over the head three times with an ashtray, which then shattered into pieces. Samuel said that he was threatened with one of the broken pieces by one of the assailants and he was told *"I'll f---ng stiff you."* Samuel said the assailant threw the broken ashtray in the bin and he took some toilet roll, as he (the assailant) appeared to be bleeding.

The PSNI seized the ashtray and Samuel's T-shirt which had blood stains on it. The police recorded that the offences under consideration were Assault Occasioning Actual Bodily Harm (AOABH) in connection with both suspects and, against one suspect, an additional offence of threats to kill.

Samuel Carson

On 26 February 2011, four months later, the PSNI interviewed one of the suspects who denied any involvement in the assault. It is recorded that the police investigating officer had been attempting to confirm the address of the suspects after the incident and that both inmates were now *“again resident on remand.”* Prison records confirmed, however, that between the date when the assault on Samuel took place and the date when one of the suspects was eventually interviewed, both suspects remained in prison. It is not known why the PSNI were unaware of this.

The second suspect, who was accused of AOABH and threats to kill, was never interviewed by the PSNI, apparently due to his refusal to assist police. It is recorded in the PSNI record that *“numerous attempts were made to speak with (the assailant) both through the prison and his solicitor and he refused to speak with Police.”*

A police file was submitted to the Public Prosecution Service (PPS) in June 2011 and the PPS directed *“no prosecution”* due to the absence of any evidence other than Samuel’s account. By this time, Samuel had died.

It is not known why the PSNI did not arrest and interview the second suspect. The Prisoner Ombudsman asked for the results of forensic examination of the seized exhibits, in order to establish whether the action subsequently taken by the Prison Service was appropriate. She was advised that the items were never submitted for further forensic examination.

Fact Find

Following the assault on Samuel on 9 October 2010, a *“fact find”* was requested by the governing governor on 11 October 2010. A principal officer was appointed to conduct this.

The principal officer’s findings were that:

- There was poor communication on 9 October 2010 because the communications room were not informed that Samuel had been assaulted. It is to note that, whenever an assault occurs, the Hydebank Wood communication room would normally be notified of the incident and would then co-ordinate the necessary action, which would include notifying the Security Department.

Samuel Carson

- The Security Department did not record any incident despite being involved in taking photographs. It would have been normal practice for the Security Department, particularly when they attended the scene, to make a record of the incident.
- The duty governor was not informed of the incident or the PSNI contacted at the actual time of the incident. It is recorded by the principal officer that should the *“Standard Operating Procedure (SOP) contained in notice 106/09 been followed, then this would not have happened and PSNI would have been informed.”*

Samuel’s Response Following his Assault

Samuel’s assault on 9 October 2010 appears to have been the result of him complaining on 8 October 2010 about being bullied. After the assault, Samuel pursued his complaint in writing, *“I myself Samuel Carson is not happy about the way this was dealt with, I brought the bullying to the staffs notice which something should have been dealt with right away but due to that they were (given) a chance which I ended up with a broken nose and marks in my face and lumps on my head under my hair which was caused by them smashing an ashtray over my head. If action was taken when I brought it to the staff for the second time I would not have been attacked. I am very unhappy.”*

Samuel’s complaint was referred to a principal officer who on this occasion was also the anti bullying co-ordinator. The anti-bullying co-ordinator recorded that *“The Anti-Bullying Committee met on Thurs 14 Oct ref this incident. The background building up to this event was discussed and it was noted that when you first made staff aware of verbal abuse from three inmates in particular, no evidence could be found as to substantiate your claims at that time. An inmate whom it was thought would be able to supply information and give evidence on your behalf was unable to do so when interviewed, the three inmates identified by you as bullies denied any such behaviour and staff on the landing felt that you were in no danger. Staff were told to keep an eye on things anyway just in case. Approx three weeks later you submitted this complaint and (a named senior officer) was in the middle of investigating it whenever you were assaulted.”*

Samuel Carson

The action then instigated by the anti-bullying co-ordinator included the removal of the two perpetrators from the landing and staff monitoring of their behaviour; referral of the two perpetrators for adjudication and to probation for a behavioural change programme and support to be provided to Samuel by the Offender Management Unit and Opportunity Youth.

The adjudication of the two alleged perpetrators was adjourned pending the outcome of the “*PSNI investigation*”.

It is recorded on Samuel’s complaint form that, following the implementation of the above actions, he was now “*happier*” because the perpetrators had been removed from the landing.

At interview, it was pointed out to the anti-bullying co-ordinator that his comment that no evidence could be found to substantiate Samuel’s allegation of verbal abuse in September 2010, was not accurate because a trusted inmate had told staff that Samuel was being subjected to verbal abuse. The co-ordinator accepted that this was the case.

Concerns Raised by Samuel’s Solicitor

On 14 October 2010, Samuel’s solicitor wrote to the Prison Service raising concerns about the number of assaults that Samuel had been subjected to by other inmates and requesting information about what measures were put in place to ensure Samuel’s safety. The solicitor also submitted a request for the transfer of Samuel to another landing.

The investigation established that the letter was received and forwarded to a governor, but the governor was unable to recall receiving the letter. The letter was not acknowledged by the Prison Service and Samuel’s solicitor was not informed of any action taken to ensure Samuel’s safety.

Adjudication of Samuel for Needlessly Activating the Emergency Cell Alarm

On 16 October 2010, Samuel was adjudicated and lost five days of association due to “*endangering health and safety by needlessly activating your emergency cell alarm.*” Samuel had been released from his cell to have a shower at 15.20 but was relocked at

Samuel Carson

15.40, before he had his shower. This was because the officer had to leave to collect other inmates from education. Within one minute of being locked Samuel pressed his emergency alarm and informed the staff member that he wanted a shower. Samuel pleaded guilty to this.

Samuel's Request to Use his Mother's Address for Bail

On 16 October, Samuel had a visit from his mother and sister. During the visit he asked if he could use his mother's address as a bail address. Samuel's mother told the investigation that she couldn't agree to this request because Samuel's younger sister was living in the house and she knew that the authorities would not, therefore, permit it.

The PSNI said, however, that Mrs Carson's address was subsequently submitted for their approval as a bail address. They said that Samuel's solicitor informed them that Samuel had told him that his mother had agreed that she would move his younger sister out of the home if Samuel was to move back to her address.

Samuel's solicitor informed the Prisoner Ombudsman investigation team that (Samuel's mother's) address was submitted to the PSNI as a bail address sometime around 18 October, on the instructions of Samuel.

Threats from Paramilitaries

On 20 October 2010, just days after Samuel requested to use his mother's address as a bail address; Samuel was visited by the PSNI and was served with a PM/1.

The message stated:

"Loyalist paramilitaries linked to both the UDA and UVF have stated that Samuel Carson is not welcome anywhere in the south east Antrim area, including Carrickfergus. If he returns action will be taken against him by them and also by the community. It is said this will be done, despite who his late uncle was. If he does return and resides at his mother's house his mother would be potential risk also."

Samuel Carson

Samuel's family were concerned that loyalist paramilitaries became so quickly aware that Samuel's solicitor had offered his mother's address to secure bail, particularly as Samuel's mother said that she had not, in fact, agreed to this. It is not clear how this was the case and the Prisoner Ombudsman had to explain that this matter was outside of the remit of her investigation.

It is, however a matter of concern to the Prisoner Ombudsman investigation that the difficulty Samuel experienced in securing a bail address in order to leave prison, appeared to impact upon his overall well being, particularly in light of the difficulties he was experiencing inside Hydebank Wood. It was clearly the case that Samuel made strenuous efforts to find an address where he and his girlfriend could live.

On 28 October, a further PM/1 was served. It stated:

"Loyalist paramilitaries linked to both the UVF and Red Hand Commando have stated that Samuel Carson is not welcome anywhere in the Whitehill area or any other loyalist estate in Bangor area. If he moves to the area, action will be taken against him by the community. It is said this will be done, despite his family connections. Because of the nature of the offences he will not be protected in any loyalist estate."

Samuel had previously submitted a number of bail addresses in the Bangor area to the PSNI in 2010.

4C: Key Events November 2010**Abusive Comment to Staff**

It is recorded by an officer that on 8 November 2010, Samuel used *“foul and abusive language, called me a specky c--t (and) kicked the door of his room several times.”* At the time of the investigation, the officer concerned was on long term sick leave and subsequently left the Prison Service. It was therefore, not possible to establish what lead to this incident.

Withdrawal of the “Rape and Making Indecent Image” Charges

On 8 November 2010, Samuel’s solicitors were informed that the charges against him of rape and making indecent images had been withdrawn by the Public Prosecution Service (PPS). The PPS determined that Samuel should be prosecuted for nine offences under article 16 and 17 of the Sexual Offences (NI) Order 2008 and that his co-accused should be prosecuted for five offences under the same order. The charges all related to inciting and carrying out sexual acts with a person under the lawful age.

On 11 February 2011 at the arraignment, Samuel and his co-accused pleaded not guilty and on 26 March 2011, Samuel’s co accused was acquitted of all charges as the PPS offered no evidence against him. Samuel’s case was never heard.

Bullying Investigation – 10 November 2010

On 10 November 2010, Samuel informed a prison officer that an inmate called him a *“rapist b----rd”* and threatened to *“jump all over his head”*. An investigation was commenced and it is recorded that an officer had heard the inmate shout *“rapist b----rd”* whilst Samuel was locked in his cell. No reply from Samuel was heard. The officer challenged the inmate who had made the comment and warned him that he would be charged if it continued.

It is recorded that the inmate was interviewed and admitted that he had called Samuel a rapist but said that this was after Samuel threatened him by saying that he would get him *“done”*. When Samuel was interviewed, he admitted to making this comment but said that this was only in response to verbal abuse. The Prison Service

Samuel Carson

investigation was unable to establish who started the altercation and both inmates were warned about their behaviour.

The anti-bullying co-ordinator was informed of the incident but a SIR was not completed.

Opportunity Youth

On 16 November 2010, Samuel had his last session with Opportunity Youth, having met them a number of times since his initial committal. He told the member of staff that his solicitor had told him that the charges would be dropped and that he may be released soon. It is recorded that he *“says it’s a significant relief and weight off his mind. Sam thought it was about time and he can now shed the label of the allegation.”*

Drug Test Failure

On 27 November 2010, Samuel was adjudicated after failing a drugs test which detected Cannabis. Samuel received three days cellular confinement and 14 days loss of association. In an EMIS entry, a nurse officer recorded that Samuel was referred to AD:EPT.²⁹

²⁹ AD:EPT (Alcohol and Drugs: Empowering People through Therapy): a comprehensive substance misuse service, based in Hydebank Wood, that provides a multi component model of delivery.

4D: Key Events December 2010**Landing Log Record Following Withdrawal of Charges**

It is recorded on the landing log dated 5 December 2010, that Samuel *“mixes and interacts well with staff and all other inmates. Initial charges have been withdrawn but not fully accepted by all inmates due to their nature...”*

Samuel’s mother said, however, that over the months after the withdrawal of the charges, Samuel continued to be bullied and assaulted. She said that she asked Samuel if the other inmates knew that the charges had been withdrawn and that he said *“mummy, you don’t understand. (When) you come in here labelled, that’s what you’re in for and he went as far as saying to me... ‘cos I remember it distinctly, he says to me you get treated better if you come in for murder. ‘Cos that kind of took me aback as well, you know, him saying that to me.”*

Movement of Samuel to Elm 3

On 14 December 2010, Samuel was moved from Willow 3 landing to Elm 3 for 17 days. The reason recorded was *“operational requirements.”*

Security Information Report – 30 December 2010

On 30 December, Samuel informed a senior officer that an inmate had offered drugs to anyone who would assault Samuel and that he was also being excluded by others from playing pool. The senior officer recorded that *“I should at this stage be raising a BR1 (Bullying Report) however the last time one was raised resulted in Carson getting badly assaulted. Carson also stated that he will be in court on the 10 January where it was highly likely the charges against him would be dropped (no other charges outstanding).”*

Samuel’s mother said that she remembered her son telling her that there was a *“bounty on my head”* and that the first inmate who assaulted him would get extra tobacco.

The senior officer said that he offered Samuel the opportunity for a bullying investigation to be conducted but that this was declined. The officer suggested that this may have been due to Samuel’s fear of being assaulted and his previous

Samuel Carson

experience of being assaulted after he complained about being bullied. The officer further stated that Samuel did not want to be assaulted before he went to Court on 10 January and was hoping to be released.

The Security Department assessed this information and recorded that *“with regards to location there is little that can be done to ensure Carson’s safety as he is ...suspect to attack anywhere. Inmate (name redacted) is already marked enemy so they should not come into contact.”*

Smuggling of SIM Card

One of Samuel’s visitors told the investigation that they visited Samuel sometime between December and February and, at his request, smuggled a *“pay as you go”* mobile phone SIM card into prison. They said that Samuel had said that this would *“help to keep the other inmates off his back.”* A SIM card can be used as “currency” in prison.

The SIM card was found following a search of Samuel’s cell after his death.

SECTION 5: SAMUEL'S MOVE TO CEDAR HOUSE**Samuel's Move to Cedar House**

On 31 December 2010, it is recorded that Samuel was moved to Cedar 4. On the landing file the reason why Samuel was moved was recorded as *"bullying allegation, inmate is presently Standard (regime)."* Cedar landing offers a superior regime and better accommodation. In order to be eligible to be located in Cedar House, inmates must normally have achieved Enhanced regime.

There are three levels of privilege regime that can apply to an inmate, Basic, Standard and Enhanced. Enhanced regime offers the greatest benefits and includes the potential to receive higher earnings, more telephone credit to spend and more money for tuck shop purchases. Inmates achieve improved regime status as a reward for appropriate behaviour and co-operation with all aspects of their sentence plan.

At interview, the officer who recorded the reason for Samuel's move from Elm to Cedar said that the reason for his recollection was that he was informed that Samuel was to be moved by a senior officer. He said also that when he asked a senior officer why Samuel was going to Cedar, he was told that the governing governor *"ordered for Mr Carson to be moved"*. He said also that *"when the other inmates heard that Samuel, who was on Standard regime, had automatically been moved up to Cedar on Enhanced status, I heard them say at the time that he was a tout."* The senior officer who was alleged to have given the instruction was asked about Samuel's move but was unable to recall what happened.

On the day that Samuel arrived on Cedar 4 (C4) at 15.00 it is recorded that he had a *"previous altercation with a C4 inmate, therefore may not stay."*

Samuel was moved to Cedar 3 the same day.

Allegation of Assault

On the morning of 21 January 2011, Samuel informed a senior officer that an inmate entered his cell after unlock and punched him on his head and neck. Samuel was seen by a doctor and it is recorded on the Injury Report Form that his *"R pinna (visible part of outer ear) red and tender... no bleeding."*

Samuel Carson

It is recorded by medical staff that head injury observations were implemented, advice given and ice provided.

Bullying Investigation – 21 January 2011

A senior officer was appointed to conduct a bullying investigation. He interviewed the alleged perpetrator and it is recorded that when he was informed of the allegation, the inmate *“vehemently denies any contact...and seemed bewildered at the accusation.”* It is recorded that staff said they had also witnessed the accused in his cell shaving at the alleged time of the assault.

Samuel was offered a move to another landing within Cedar and it is recorded by the officer that, *“Strangely when the cell move was suggested he wanted to retract his allegation which may cynically lead one to believe that he was trying to manipulate a move...”* The officer was unavailable for interview due to long term sickness.

The anti-bullying co-ordinator was informed of the incident but a SIR was not completed. It was decided that Samuel should be moved anyway. Prior to him moving, it is recorded in Samuel’s landing file, that he had been *“giving backchat to (a named officer). Not Acceptable.”*

Samuel was moved to Cedar 2 landing that day.

Samuel’s Application to See his Daughter

On 28 January 2011, an application for Samuel to have contact with his daughter was heard at the Belfast Family Proceedings Court. The application was opposed by the Health Trust and the Guardian Ad Litem, however the Court directed that Samuel should have a supervised visit.

Assault 2 February 2011

On 2 February, it is recorded that Samuel was involved in an incident with an inmate. The incident occurred in the holding room in the visits area.

An Injury Report Form completed by healthcare staff, recorded that Samuel had a *“slight swelling to (left) eye after altercation with (an) inmate...”* and that he declined to

Samuel Carson

make a statement. At interview, the inmate who assaulted Samuel said that it had all started when he was on Elm 3 landing with Samuel and *“a couple of the inmates were winding him up calling him a rapist b---rd... next thing he shouts out my name and says I’ll rape your ma and your sister. I kept telling him it wasn’t me but he kept saying it. So when we were in visits, I punched him once and that was it. It was caught on CCTV but he didn’t take it further to the police or anything.”*

The inmate was adjudicated and received one day of cellular confinement. A SIR was completed and the Security Department recorded their intelligence assessment that *“There is no previous information about past history between these two inmates.”* The action taken by security was recorded as *“inmates marked as enemies on PRISM (the prison computer system). Landing staff contacted to update security cards.”* The PSNI were not notified of the assault.

Telephone Call – 7 February 2011

On 7 February 2011, Samuel and his girlfriend can be heard during a phone call to finish their relationship because Samuel has been corresponding with a female prisoner. Samuel and his girlfriend end up back together three days later.

Samuel’s First Visit with his Daughter

On 9 February 2011, Samuel had his first visit with his daughter in the presence of his mother and a social worker. At interview, Mrs Carson said that she remembers Samuel saying to her *“mummy, you’re right, she’s beautiful, you know... I’ve been up from 7 o’clock this morning getting ready and having a shower and all and a shave... you’re right, she’s gorgeous...”* At interview, Samuel’s mother said that her son was so pleased to see his daughter and that he was on the floor smiling and playing with her.

Observations of Prison Officers on Cedar Landing

Samuel remained on Cedar landing for just over three months. A prison officer, described Samuel, during this time, as someone who *“always wanted to be your friend but (for example) would over step the mark and would become intrusive in his dealings with you...while (I was discussing something with a prison officer) Samuel would immediately interrupt or come in between us and then talk over (us). He was always around about the (staff) desk on the landing unnecessarily.”*

Samuel Carson

In relation to other inmates, the same prison officer said that Samuel *“used to be friendly with other inmates but the next minute he would make up a story or rumour immediately in front of this inmate and it would just set them off and upset them no end. He just wasn’t liked by other inmates because of his personality and that the inmates couldn’t trust him as he could just turn on them with rude comments or he would just spread untrue rumours about them.”*

On 20 February 2011, the same officer recorded in the landing log *“I have stated to (named senior officer) that this inmate will be assaulted on Cedar 2 it is only a matter of time.”*

Two days later the same officer recorded, *“once again I have raised my concern that this inmate is going to be assaulted on Cedar 2. I spoke to (the same named senior officer) about this matter.”*

At interview, the officer said that he wrote this entry because *“...I could see things were getting tense on Cedar 2 between Samuel Carson and other inmates. During lock up times in the daytime I would hear Carson and other inmates calling each other names. They would start off shouting abuse at each other. Sometimes I think it would be the other inmates who would start on Samuel and other times Samuel would start off being abusive to them. When I would go to the landing, it would just stop. I made the record as I predicted that Samuel was going to get assaulted by other inmates. When I made the record I also voiced my opinion to other colleagues that an assault was imminent.”*

The officer said that in February 2011, after he had raised his concerns, he saw his senior officer gathering Samuel’s file and said that the senior officer told him that he was going to raise the concerns with the principal officer. When the senior officer returned, the officer said that he told him that the principal officer had said that he *“is not moving him (Samuel) on the word of one officer.”* The officer said that he replied to the senior officer *“Well you know what’s going to happen. I’ve done all that I can.”*

At interview, the senior officer was asked to give his account of the action he took after being informed by the prison officer of his concerns about Samuel’s safety. He said that he could not recall, given the lapse in time.

Samuel Carson

On 27 February 2011, another prison officer recorded that Samuel had *“definite issues with other inmates. He tries to keep himself apart but gets aggressive when others comment to him.”*

The prison officer told the investigation that he got to know Samuel for several months and found his personality to be *“good at times and at other times he would be angry for no reason. I recall approximately three inmates approaching me on separate occasions and making allegations that Samuel took things from them. One of the inmates alleged that Samuel took tobacco from him. On each occasion the inmates refused to raise the issue of bullying for fear of repercussions for them if Samuel found out that they had approached the authorities.”*

No evidence was found of the officer ever recording that he had been approached by inmates in connection with these allegations. It is, however, recorded on 10 and 20 March 2011, by another officer that Samuel was spoken to *“about asking other vulnerable inmates for tobacco.”* A further record made by the same officer noted that Samuel *“needs to learn how to get on with people. Sailing close to the wind. A spell in Beech/Elm may cool his heels...”*

The officer said that he wanted to remind Samuel in writing that he was an Enhanced³⁰ inmate and, should he be dropped in regime, he may be moved to another landing without as many privileges. The officer told the investigation that Samuel’s behaviour needed to improve and that the comments were written for his attention as he would have to *“sign off”* that he had seen them. The officer also said that Samuel did not question or challenge any of the comments that he had written.

At interview, a senior officer in Cedar said also that, on one occasion, he found Samuel in possession of a radio that did not belong to him. The senior officer said that he chose to verbally warn Samuel rather than refer him for adjudication.

Samuel’s Contact with his Mother

Samuel’s mother said that during the month of February 2011 he rang her and named a number of inmates who had threatened him and he asked her to speak to a governor

³⁰ Enhanced prisoner: a prisoner whose behaviour is continuously of a very high standard and who co-operates fully with staff and other professionals in managing their time in custody. Eligibility to this level also depends on full participation in Sentence Management Planning.

about this. Mrs Carson said that she spoke to a member of the landing staff who said that he would keep an eye on Samuel.

Bullying Investigation – 1 March 2011

On 1 March 2011, whilst Samuel was still in Cedar 2, a bullying investigation was commenced by a senior officer after Samuel alleged that two inmates had threatened to assault him. Samuel said that the threat was due to the nature of his offence. It is recorded that, during an interview, Samuel said that he was in fear for his personal safety and that he said *“I have no problems with inmate(s) on C3 (Cedar 3)”*. The senior officer who spoke to Samuel said that when Samuel made the comment he thought that he was attempting to *“secure a move to Cedar 3 and therefore dictating his residential location within the centre.”*

The two inmates, whom Samuel alleged had threatened to assault him, were interviewed by the senior officer and one of them told the officer that inmates had been involved in an altercation with Samuel over an evening meal. It was alleged that Samuel had taken another inmate’s food and that this led to an argument and name calling between Samuel and the inmate concerned.

It is recorded that the alleged perpetrators were warned about their behaviour and that the senior officer also spoke with regular landing staff and the class officer who was working at the time when the alleged incident took place. The officer recorded that it was the impression of staff that Samuel was *“giving as good as he gets”* and that he brought *“attention to himself due to a very poor attitude towards other inmates on the landing.”* The staff said also that it was the case that Samuel had *“...indeed stole another inmate’s food.”*

It was recorded, that Samuel’s allegation was unsubstantiated. Nevertheless, moving Samuel was considered to be the best option due to the *“poor mix on Cedar 2”* and *“to some extent catered for his personal wish to be moved from the landing.”* The anti-bullying co-ordinator was informed of the incident, however a SIR was not completed.

It is to note that, sometime afterwards, it was established, during another investigation by the Prison Service that, contrary to what other inmates had said at the time, Samuel had not in fact stolen the item of food as alleged. It is recorded that an officer who was working at the time of the incident, stated that Samuel had not

Samuel Carson

stolen the food. He stated that another inmate had a bacon roll and that Samuel ate it because the inmate did not want it. It is to note that staff had wrongly supported the incorrect account of Samuel's behaviour given by inmates.

On 1 March 2011, Samuel was moved from Cedar 2 to Elm 4 landing. It is recorded in the landing log that Samuel was "*moved to Elm 4 for his own safety.*"

Events after Samuel was Moved

On 4 March, the principal officer who was reported to have said in February that Samuel should not be moved, became aware that Samuel had been moved from Cedar 2. At interview, the principal officer said that it was Prison Service policy to move perpetrators rather than victims and he made enquiries about Samuel's move. The principal officer said that he was informed that staff feared for Samuel's safety and felt that he was not a suitable inmate for Cedar 2. The principal officer said that he was not provided with any proof that Samuel's safety was at risk.

The principal officer said that, the same day, before he went off duty, he left verbal instructions that Samuel was to return to Cedar 2 and that the two inmates who were alleged to have been bullying Samuel, were to be removed from the landing. When the principal officer returned from duty on 6 March 2011 he found that his instructions had not been followed and he reiterated them.

On 6 March, it is recorded that Samuel was "*moved back to C2 (Cedar 2) on (redacted principal officer's name) instructions.*" The perpetrators were not, however, moved from the landing as the principal officer said afterwards he had instructed they should be. At interview, another principal officer said that, at the time, he recalled the principal officer telling him that when Samuel was moved back to Cedar, the other two inmates were supposed to have been moved out. The principal officer, who gave the instruction, identified the senior officer he believed he had spoken with. The senior officer was unavailable for interview due to long term sick leave.

Assault 7 March 2011

On 7 March 2011, one day after Samuel was moved back to Cedar 2, it is recorded that a senior officer arrived at Samuel's cell and found numerous items strewn across the cell. Samuel was sitting in his cell in a "*distressed state with numerous areas of*

Samuel Carson

redness on his face.” Samuel said that he had been kicked and punched by the two inmates he had named on 1 March. He said also that he had been head butted by one of the inmates. The officer immediately commenced a bullying investigation.

Samuel was seen by a nurse officer who recorded that he had *“multiple bruising to head and face. Bruising to right rib cage and pain on inspiration. States no loss of consciousness but felt light headed. States he was set on by 2 other inmates. B/P 122/70, P100 RESP 14. Paracetamol x 2 given. For review.”* Samuel declined to make a statement in the section provided on the Injury Report Form.

That day Samuel was taken to the Royal Victoria Hospital after he started to cough up blood. He returned to Hydebank Wood later that afternoon.

When asked at interview, the principal officer who gave the instruction on 6 March that Samuel was to be returned to Cedar 2, said that he had not been made aware in February, as stated by a senior officer, or at any other time of a concern that Samuel would be assaulted on Cedar 2. The principal officer was unable to say whether he would have taken a different decision if he had been aware of this information.

Bullying Investigation – 7 March 2011

The two alleged perpetrators were interviewed by prison staff. It is recorded that both were aggressive when questioned and that one of the inmates had red markings on his neck and forehead. It is noted also that the inmate, when questioned as to why he appeared breathless, denied that this was the case and said that the red marks on his body were as a result of the washing powder that he was using. It is recorded in the Bullying Investigation Report that, when the inmate was informed that he was being questioned in connection with a recent incident, he replied *“sure you have no evidence, no CCTV, no forensics, nothing.”*

At interview, the officer who conducted the investigation and interviews said that the red marks on the inmate’s forehead were *“consistent with a head butt, which is what Carson had told me.”* In his Bullying Investigation Report he recorded that *“on the balance of probabilities (the named inmate) was indeed involved in the incident.”*

The adjudication of the two alleged perpetrators was adjourned pending a *“Police Enquiry.”*

Samuel Carson

At interview, the anti-bullying co-ordinator stated that even though the investigation, in this instance, substantiated the allegation, the Anti-Bullying Committee was not called together for a number of reasons. He said that a “*Challenging Anti-Bullying*” programme was due to be launched imminently, to replace the arrangements operating at that time, and a decision was made to hold no further Committee meetings. He said that this was because the Committee had been ineffective in the past and was only “*rubber stamping*” incidents that had occurred.

The assault on Samuel on 7 March 2011 was also not included in the Hydebank Wood bullying statistics. The anti-bullying co-ordinator said that this may have been as a result of a filing error. No SIR was completed.

Referral for Police Investigation

The PSNI were notified of the 7 March 2011 assault incident and an investigation was commenced.

The Prisoner Ombudsman investigation was advised by the PSNI that on 4 April 2011 the PSNI contacted Hydebank Wood to arrange interviews with the two alleged perpetrators and a governor then contacted them to make arrangements for the interview of one of the inmates with his solicitor. The other inmate had, at this stage, been discharged from prison.

In the event, neither of the two were interviewed.

On 7 June 2011, the PSNI advised that the investigation was closed due to “*no independent evidence.*” The PSNI stated that this was because there was no CCTV footage of the incident and no member of staff had witnessed the alleged assault. The PSNI said that, prior to any interviews taking place with the suspects, they discussed the incident with the Public Prosecution Service (PPS) on 7 June and it was then decided not to submit a file to the PPS.

Enquiries were made with the PPS and the prosecutor stated that he was unable to recall the conversation with the PSNI but that he may have spoken to the police and given advice. Any advice given was not recorded.

The prison officer who interviewed Samuel and the alleged perpetrators and recorded that he saw markings on one of them which appeared to be consistent with a head butt as alleged by Samuel, was also never interviewed by the PSNI.

No Security Information Report (SIR) form was completed by the Prison Service and the adjudication of the two inmates who were alleged to have assaulted Samuel was “dismissed” by a governor on 14 December 2011. The governor stated that he dismissed the charges on the basis that “*we had no CCTV evidence or staff witness reports to corroborate his allegations (and) that tragically Samuel had died and was therefore unable to take part in the adjudication process...*”

Governing Governor Report Request

On 8 March 2011, the principal officer who made the decision to return Samuel to Cedar 2 on 6 March was tasked by the governing governor to report on the circumstances of the alleged assault of Samuel. In the principal officer’s investigation report he stated that on 4 March, he became aware that Samuel had been moved to Elm 4 after he made a complaint which was unsubstantiated. The principal officer stated that, as it was not the prison’s policy to move victims, he instructed that Samuel should be returned to Cedar 2 landing. He said that staff and management objected to this because there was a fear for Samuel’s safety and they felt that he was not a suitable inmate for Cedar.

The principal officer stated that he made enquiries about Samuel and there was “*no evidence*” to support any risk to Samuel’s safety. He said he, therefore, left instructions that Samuel was to return to Cedar 2 landing. With regard to staff comments about Samuel “*being an unsuitable inmate*” the principal officer stated that Samuel had every right to be on Cedar 2 as he was an Enhanced inmate.

The principal officer further reported that, on 6 March 2011, he returned to work to discover that Samuel had not been moved. He said that this was because the house manager had concerns for Samuel’s safety. It is recorded that the principal officer said that he spoke to the house manager and that no new evidence was provided to him that caused him to be concerned for Samuel’s safety. Samuel was, therefore, moved back to Cedar 2. The principal officer recorded that he explained to the house manager that the perpetrators, not the victim, should be moved. He noted that the

Samuel Carson

manager stated that the perpetrators *“had not been proven as bullies so no action could be taken against them and (he) couldn’t see any harm in moving the probable victim.”*

Whilst the principal officer said at interview that, when he had instructed staff to move Samuel back to Cedar, he had also instructed a senior officer to move the two perpetrators off Cedar 2 landing at the same time, it is to note that the report to the governing governor does not explain that there had been a failure to follow his instructions.

At interview, the principal officer said that after he submitted his report a meeting, attended by himself, the governing governor and two senior officers was held. He said that, at the meeting, one of the senior officers admitted that he failed to move the two perpetrators as instructed.

Samuel remained on Cedar 2 until 10 March when he moved to Cedar 3.

Telephone Calls Made on 14 March 2011

Samuel made three phone calls on 14 March 2011, one to his sister, one to his girlfriend and the last to his mother. In the call to his sister Samuel said that he was upset that his girlfriend spoke to *“two fellas”* while she out with his other sister and another girl. Samuel told his sister that he was *“cracking up about this”* and that she should not have let his girlfriend go out with his other sister. Samuel’s sister can be heard to try and calm him down. She tells him that she will ring their other sister. Samuel then says that he *“feels like going back to the cell and putting a belt around his neck attached to a pipe.”* He says that his girlfriend has *“broken his heart”* and he *“doesn’t want any fella near her”* until he gets out.

Approximately four minutes later, Samuel rings his girlfriend and asks for the names of the men she spoke to, because, he says, he would *“put one in them”*.

Fifteen minutes later, Samuel rings his mother and questions her as to what she knew about his girlfriend speaking to other men. During this call Samuel’s mother tells him that his girlfriend had been on the phone booking visits, but has since texted her to cancel them. Samuel’s mother tells him that this may be because he has upset her.

Samuel Carson

Samuel then continues talking about his girlfriend's night out and his mother reiterates that Samuel's girlfriend can be trusted. She tells Samuel that it is "*all in his head*" and that he needs to "*settle himself*".

That day Samuel made 38 phone calls, 12 of which resulted in conversations and by the end of the day his relationship with his girlfriend is re-established.

Samuel's Second Visit With his Daughter

On 16 March 2011, Samuel saw his daughter again in the presence of his mother and a social worker. Mrs Carson said that Samuel's girlfriend had told her that when she last visited Samuel he had two black eyes. Samuel's mother said that, at the visit on 16 March, she noticed that Samuel's black eyes had turned yellow, in colour.

At interview, Mrs Carson said that when she asked her son what was happening about the injuries, he told her that nothing was happening and she responded "*Samuel, surely if that was on... you know, outside, them boys would be arrested and charged or something.*"

Solicitor Second Letter to the Prison Service

On 16 March, Samuel's solicitor wrote another letter to the prison service raising concerns about "*severe bullying and attacks by inmates and (Samuel) has reported and lodged reports of numerous incidents and threats to staff before and after these incidents and has sustained numerous and significant injuries. We understand that Mr Carson has been taken to hospital on at least two occasions following these incidents. We believe the inadequate approach taken by the Prison to protect Mr Carson is unreasonable and clearly unlawful and in breach of our client's rights pursuant to Articles 2, 3, 5, and 8 of the European Convention on Human Rights. Please accept this correspondence as notice that should Mr Carson be subject to another attack whilst in custody we shall have no alternative but to issue proceedings immediately and pre action protocol shall not be followed.*"

The letter was forwarded to a governor who replied saying: "*the staff and management of Hydebank Wood take seriously the safe custody of all inmates. I am aware of an assault on Mr Carson and this was investigated and those believed to be involved were*

moved away from Mr Carson's housing unit. We will continue to monitor all allegations of bullying and endeavour to protect the safety and rights of all inmates."

Security Information Report

On 17 March 2011, a Security Information Report (SIR) was completed by a senior officer after Samuel told an officer that an inmate had said to Samuel in the Care and Supervision Unit (CSU) that he was going to *"batter Carson when I get back to the landing."* It is not known for what reason Samuel went into the CSU as this is not recorded anywhere in prison records.

The allegation was not investigated and, when asked why, the officer said that, from his recollection, Samuel did not want to proceed with the allegation. The officer did not know why this was the case but said that, at this time, the alleged perpetrator was not in the same location as Samuel and Samuel was not, therefore, at risk of assault. The officer said that he felt that the only option he had was to complete an SIR.

Following the SIR being raised, the Security Department recorded that *"inmate Carson is housed in Cedar and is being kept apart from named enemies and (the named inmate) will not be returning to Cedar and is time served in 4 weeks. It is becoming quite difficult to keep Carson apart as the list of enemies grow."*

Medical Review

On 21 March 2011, Samuel was seen by a nurse officer and it is recorded that Samuel had *"hurt his shoulder/neck when he hit it off a sink as he was bending down"*. A doctor was contacted and Samuel was given Diazepam 5mg, Ibuprofen 400mg and Paracetamol. The following day, he was seen by a doctor and he was diagnosed with a *"wry"* neck.

Acquittal of Samuel's Co-accused

On 26 March 2011, Samuel's co-accused was acquitted of all charges as the Public Prosecution Service offered no evidence against him.

SPAR Booklet – 2 April to 4 April 2011

On 2 April 2011 at 23.15, a SPAR booklet was opened by a prison officer after Samuel informed staff that he had cut his right arm several times with a razor blade. He told staff that he did this as a result of being bullied on Cedar 3 landing and that he felt depressed, but not suicidal. Samuel said that he wanted to be moved off the landing.

It is recorded in medical records that Samuel had *“10 x incisions to (right) inner forearm (and his wounds were) cleaned and Steri-strip and dressing applied.”* The lacerations were redressed two days later. No consideration was given to a mental health referral.

After he had self-harmed, Samuel said *“he felt stupid and regrets his actions.”* Samuel was placed on 30 minute observations. The following morning he spoke to a senior officer and told him that the abuse he had been experiencing was verbal but that he would not name the bullies.

On 3 April at 19.05, it is recorded in the observation log of the SPAR booklet that Samuel was asked how he was by the night custody officer and he replied *“aye alright.”*

At 19.30, the same night custody officer pushed a note below Samuel’s cell door. It is recorded that she *“put note under Carson’s door as it’s difficult to talk through door without others on landing hearing. I said if he wishes to talk he could write it down and pass it out. Carson smiled and nodded after reading note.”* At interview, the night custody officer was unable to recall why she had chosen to communicate with Samuel in writing but said that, on occasions, she would do this with certain inmates to respect their privacy.

At interview, another night custody officer on duty at the same time said that Samuel gave her a note saying: *“I’m sorry I had cut my arms, but in here drives you to this.”*

The night custody officer said at interview that she thought that Samuel had self-harmed for a number of reasons. She said that Samuel didn’t want to be in prison, that he had had a difficult visit with his partner and that he was getting verbal abuse. When interviewed, Samuel’s girlfriend, who had visited him a few days earlier said that

Samuel Carson

their visit had gone well. It is unclear, therefore, why the officer had a different impression.

The following day the night custody officer completed a staff communication sheet bringing to the attention of her supervisor that Samuel was being verbally bullied. She said that this included him being called words such as “*rapist*” and “*scumbag*.” The night custody officer said also that, in one of his notes, Samuel asked them to contact his girlfriend to apologise for his self harming and to ask her to bring the children up when next visiting. The night custody officer said that she assumed that Samuel’s girlfriend had told him that she was refusing to bring the children in to see him if he continued to self harm.

It is recorded that at 20.25, Samuel passed out another note to the night officer who had first encouraged him to use notes to communicate. Samuel was requesting to use the Samaritan’s phone but wrote that he was worried others would hear. It is recorded that the night custody officer wrote back saying that if Samuel “*kept his voice down others shouldn’t hear*” and that “*Carson smiled and nodded*”.

At 20.55 it is recorded that Samuel was seen using the Samaritans phone and gave the “*thumbs up*” to the night custody officer as she checked on him.

At 21.28 the officer passed Samuel a note to ask how he was feeling and he nodded and whispered “*sweet*”.

It is recorded at 22.59 that, when Samuel was in bed, the night custody officer “... *called him over to door as Samuel had requested earlier in evening if we could phone his girlfriend and assure her he’s ok as he was finding it hard to settle. Asked (senior officer) who okayed it. Informed Samuel that I’d phoned his girlfriend and she was fine and would speak to him tomorrow. Samuel was fine with this and said thank you.*”

The other night custody officer also said that she also wrote a note to Samuel saying, “*hopefully (the telephone call will) stop you self harming again and we are always there to talk to you and do press the cell alarm if you need us, ok.*”

At interview, the same officer said that when Samuel was passing notes back and forth an inmate shouted out and asked why we were passing notes back and forth to Samuel. She said that she shouted out that it was on a “*need to know basis.*” She

Samuel Carson

said that at one point the same inmate shouted *“What’s you doing touting? Is he touting on us Miss?”* The officer said that she said *“right lads, that’s enough.”* The officer said that she then walked away and pretended to leave the landing and, when inmates thought that there were no staff present, she heard an inmate shout, *“you scumbag, what did you tell her.”*

The night custody officer said that throughout the evening Samuel did not respond to any comments from the other inmates.

Incident of Verbal Abuse

On 4 April 2011 at 14.43, while Samuel was being escorted from healthcare back to Cedar House, an inmate shouted *“root”* at Samuel. It is recorded by a principal officer that this inmate was reduced in regime and that his behaviour was *“totally unacceptable.”* The officer also recorded that *“the victim, inmate Carson, has been the topic for continued abuse and bullying over the past number of weeks and in order to protect him and others, behaviour and comments such as this will not be tolerated.”*

SPAR Case Conference

On 4 April at 16.00, a SPAR case conference was held and it is recorded that Samuel *“deeply regretted self harming. He assured the panel that he would not be self harming again...”* It was agreed that the SPAR could be closed that day and a post closure interview was planned for 11 April 2011.

Bullying Investigation – 4 April 2011

The night custody officer who was concerned about Samuel on the night of 3 April 2011, forwarded a communication sheet she had written to her supervisor stating that she believed that Samuel was the subject of bullying. At interview, the night custody officer said that the abuse directed at Samuel was *“severe.”*

An investigation was commenced on 4 April 2011 by a senior officer and it is recorded in his bullying report that Samuel named three inmates as the perpetrators. It is recorded in the report that Samuel told the senior officer that *“last night was the worst night of abuse he had endured since he had been in Hydebank”* and the abuse was of *“an extremely vulgar and sexual nature.”*

Samuel Carson

Samuel told the senior officer that he was scared on the landing and that after he had self-harmed an unknown inmate had shouted out "*you should have cut your f---ing throat.*"

The three inmates were interviewed by the senior officer and denied the allegations. The other inmates on the landing were interviewed and two inmates did confirm that verbal abuse was directed at Samuel on 3 April 2011.

It is recorded that the senior officer stated that "*it is clear that there is a bullying problem on C3 (Cedar 3) landing.*" The senior officer recommended that a warning should be delivered to inmates on the landing advising them that bullying and verbal abuse was unacceptable and that this should be followed by a period of increased staff vigilance.

The report was then submitted to the anti-bullying co-ordinator. At interview, the co-ordinator said that his role would have been to collate the data, check if any further action was necessary and, if there were any issues outstanding, he would have communicated with the appointed member of staff, but normally the senior officer would have addressed and resolved the issues. The co-ordinator was unable to recall what specific action was taken in relation to the investigation relating to the alleged bullying on 3 April 2011.

No Security Information Report (SIR) was completed.

The senior officer who conducted the investigation on 4 April was informed by a staff member that a number of inmates on Cedar 3 had been "*acting strangely*" the night before. The officer directed a search of the inmates' cells with negative results. Seven inmates were, however, drug tested and the results of all seven were positive for drugs.

At interview, two of the inmates who had tested positive for drugs said that they believed that the reason why they were found out was because Samuel had "*touted*" on them. They said that they drew this conclusion because they had observed him passing notes back and forth to landing staff on the night of 3 April.

Review by Prison Doctor

On 5 April 2011, Samuel was assessed by a prison doctor. It is recorded on EMIS that Samuel was found to have *“depression - poor sleep - not suicidal - refuses (Cognitive Behavioural Therapy) which is the correct option - agreed to trial Mirtazapine 15 nocte. Mirtazapine tablets 15mg 28 tablet. One to be taken at night.”*

At interview, the doctor said that Samuel refused Cognitive Behavioural Therapy (CBT) which would have helped him. The doctor said that it was his intention to trial Mirtazapine³¹ for three months to determine its effectiveness. A further prescription for the medication was issued on 27 April by another doctor.

At no point was a referral for a formal mental health assessment made.

Commenting on the decision to prescribe Mirtazapine, the Clinical Reviewer said that this was correct. She said that *“depression is associated with an increased risk of suicidal thoughts, self-harm, and suicide and it can take two to four weeks for the medication to take effect.”* She pointed out, however, that *“Mirtazapine should be used with caution in young adults and those with a history of suicidal behaviour or thoughts.”* She noted that there is no indication from the medical records or the staff statements that any additional observation of Samuel was implemented.

Bullying Investigation - 5 April 2011

On 5 April, a bullying investigation was commenced by a senior officer following an allegation from Samuel that an inmate had assaulted him by *“putting the shoulder into him”*. The inmate was interviewed and denied the allegation. A witness identified by Samuel told the senior officer that he was unsure as to what happened and that it was *“nothing”*.

During this investigation a prison officer, informed the senior officer that an inmate had been bullied by Samuel. The officer also said that *“there was indeed two or three other vulnerable inmates who Samuel did spend time with on the landing and I learned through watching his behaviour that he was maybe gleaning goods, tuck shop goods off them, i.e. tobacco. I actually spoke to Samuel on several occasions’ reference his*

³¹ Mirtazapine: an antidepressant medication that enhances the effect of naturally occurring chemicals called such as noradrenaline and serotonin, which when released from the brain, act to lighten the mood.

Samuel Carson

behaviour and warned him of such.” It is recorded that the officer spoke to Samuel and established that Samuel had asked the inmate to order tobacco for him in return for lending shampoo to the vulnerable inmate but tobacco was more expensive than the shampoo.

The Prison Service investigation concluded that Samuel’s complaint of assault was unsubstantiated. It is recorded that *“there is no way to know if this happened, but Carson has claimed recently that he is being bullied by all and sundry. This may be a move to decide who stays on C3 (Cedar 3).”*

No SIR was submitted to the Security Department and the anti-bullying co-ordinator was not informed.

Samuel Charged 6 April 2011

On 6 April, Samuel was charged with *“possession (of) two Mach 3 razors and razor blades which there was no record of you having purchased.”*

The reporting officer recorded that, following a report by an inmate that his razor and blades were missing, he conducted a search and found the missing items in Samuel’s cell. When Samuel was asked to account for the items he said that he had bought them from the tuck shop. The officer made enquiries and found that there was no record of Samuel buying a razor or blades from the tuck shop.

On 7 April 2011, Samuel was found guilty of the offence and the outcome of the adjudication was a deduction of £2.00 per week for five weeks from his earnings and five days loss of association.

Alleged Bullying by Samuel 7 April 2011

On 7 April an employee of Opportunity Youth completed a Bullying Report stating that the same inmate, whom Samuel had asked to buy tobacco from him, had alleged that Samuel had been bullying him. In connection with the incident mentioned above, the inmate had said that Samuel had been aggressive towards him, had been bullying him for tobacco and was trying to influence him to bring drugs back from home leave.

Samuel Carson

A Bullying Investigation was conducted and it is recorded that the alleged victim did present as timid and vulnerable but *“...when questioned further ref the specifics of the alleged incidents of bullying he was very vague in his answers. It appeared to both of us that he was attempting to make it up as he went along.”*

It is recorded that when Samuel was interviewed he, *“...presented as somewhat cocky but denied all knowledge of bullying. When questioned ref tuck shop items he explained that he had loaned (the inmate) some shower gel and was merely attempting to have that repaid to him. He further claimed that the allegation of asking to have drugs brought into the centre was false claiming that he was morally against the use of drugs and that he had never failed a drugs test. He further explained that he felt these allegations had been made on the back of an incident which had happened on the landing earlier in the week, i.e. several inmates being back housed after failed drugs test. He felt that some of those inmates were under the impression (falsely) that he (Samuel) had brought the drug taking to the attention of staff; he felt that (the inmate) may have been put under pressure by these inmates to make the allegations as a means of revenge.”*

It was recorded that the allegations against Samuel were unsubstantiated and that this was because *“...the sketchy information given by (the inmate) compared to the logical explanation given by inmate Carson. We believe that indeed there may have been an element of revenge being sought for the earlier incident. However Carson has been reminded in no uncertain terms of the prison rules governing the lending & borrowing of personal property and of his attitude and future behaviour which at this point in time was not that of an Enhanced inmate.”*

The anti-bullying co-ordinator was informed of the incident but a SIR was not completed.

Samuel Backhoused

On 7 April 2011, a meeting took place between a principal officer, two senior officers and a prison officer. It is recorded that Samuel's behaviour was discussed at the meeting and it was concluded that Samuel was not meeting the standard required from an Enhanced inmate and that he should be reduced in regime to Standard and moved out of Cedar House. It was noted that Samuel had informed them that he

Samuel Carson

would feel unsafe moving to another house, but that he had said also that he felt unsafe in Cedar House.

Further notes by a senior officer made the general comment that there were other occasions where Samuel should have been disciplined. It is recorded that an officer had been threatened by Samuel during lock up and that “...*there should have been a full report about the incident, a SIR submitted to security and the inmate charged.*” The full circumstances of the alleged incident are not recorded. Samuel was moved to Elm 4 the same day and remained there for one day.

Drug Testing

Samuel’s last drug test was on 4 April 2011 which he passed. Prior to this he was asked to take drugs tests on 20 April 2010, 4 September 2010, 31 October 2010, 9 November 2010, 24 January 2011 and 17 March 2011. Records indicate that Samuel passed all the tests except on 9 November when he refused to take the test, and on 27 November 2010 when he failed.

Movement to Elm 1

On 8 April 2011, Samuel was moved from Elm 4 landing to Elm 1 landing. At interview, a senior officer on Elm 4 said that an officer had told him that “...*Samuel wasn’t coming out of his room as he was afraid of the other inmates.*” The senior officer then decided to move Samuel to Elm 1 where he said he found him to be much happier. At interview, he said that he witnessed him mixing and integrating with other inmates.

The senior officer said that when he moved Samuel, he was aware that another inmate, noted on Samuel’s security card as his enemy, also resided on Elm 1. The senior officer said that he got both Samuel and this inmate together and they shook hands. The officer said there was no further issue between them.

SPAR Closure Review

As planned, a SPAR Closure Review took place on 11 April 2011 and it is recorded that Samuel “had no issues since the SPAR was closed. He hoped to be released later that night as he had high court bail and his solicitor had secured a place at a bail hostel.”

Samuel Carson

Telephone Calls – 11 April 2011

Samuel made three calls on 11 April, two to his girlfriend and one to his sister. In both telephone conversations with Samuel's girlfriend there are comments relating to their relationship and in the last one, they argue and Samuel tells his girlfriend that it is over between them because she has been in contact with an ex boyfriend in order to see her other daughter.

In his telephone call to his sister he tells her that his head is "nearly away" and tells her that he does not want to live anymore and that no one is helping him or doing anything for him.

Security Information Report – 12 April 2011

On 12 April, two members of staff said that after delivering a training awareness course in bullying, two inmates entered their class and spoke with another inmate about Samuel. One of the staff members completed and submitted a Security Information Report (SIR) stating that one of the inmates said "*someone touted...who it was...Carson...and when I see him he'll get it.*" It is also noted that the inmate clenched his fist and punched his other hand as he made the comment.

It is recorded that following receipt of the SIR, a member of the security staff carried out an intelligence assessment and noted that "*seven inmates were drug tested from C3 (Cedar 3) as staff reported that they seemed to be acting strange. They all failed and were back housed and they seem to think that inmate Carson informed (Security) which is not the case.*"

It is not clear why the name of the staff member who received this information was not, in line with normal practice, recorded by the security officer. The member of staff from Security who completed the report has since left the Prison Service and has not responded to a request to assist the investigation.

The only action planned by security in response to the SIR was to add two inmates' names to the list of enemies on Samuel's security card and to the electronic list of inmate enemies on the prison database. This is used in the management of individual inmate security.

Samuel Carson

Despite the security officer's stated intention, Samuel's security card and the electronic prison records were not updated with the additional names. The seven inmates who believed Samuel had "touted" on them were also not included on the electronic prison records.

At interview, Samuel's sentence manager said that Samuel told him that being called a "tout...coupled with the alleged offences made him feel more vulnerable regarding attack from peers..." The manager stated that Samuel was unable to identify the persons who made the comments and he discussed the bullying policy with Samuel but "he did not want to go down this route as he felt it would make matters worse for him." The manager said that he then "focused on promoting positives in Samuel's life, and encouraged him in terms of positive affirmations, to which he responded well."

Review of PPANI Arrangements

On 13 April 2011, a police officer contacted the Probation Department in Hydebank Wood to inform them that Samuel would no longer be subject to Public Protection Arrangements Northern Ireland (PPANI)³². Those assessed under the arrangements are recorded as a Potentially Dangerous Person (PDP) and placed into one of three categories. Category 3, which is the most serious of the three categories, was applied to Samuel when he was charged. The definition of Category 3 is: "where previous offending, and/or current behaviour and/or current circumstances present compelling evidence that the offender is highly likely to cause serious harm through carrying out a contact sexual or violent offence."

From April 2011, PPANI arrangements ceased to be applicable to those charged but not convicted.

When, however, enquiries were made with the Prison Service in April 2012, Samuel was still recorded as being the subject of PPANI arrangements Category 3. It is not known why his status was never amended following the information being provided by the PSNI.

³²PPANI: Public Protection Arrangements in Northern Ireland which were introduced in October 2008 to manage certain sexual and violent offenders.

Samuel's Visit 13 April 2011

On 13 April 2011, Samuel had his last visit with his daughter. Samuel's mother and a social worker were also in attendance. Mrs Carson told the investigation that her son was quieter that day than when he had seen his daughter previously. She said that he appeared "*withdrawn, nervous and unsettled*" and he "*appeared to be continuously looking around*". She said that Samuel also requested to have a photograph taken with his daughter.

The following day, 14 April 2011, Samuel had a visit from his girlfriend. Samuel's girlfriend said that he was in "*good form*" that day and was telling her about their daughter and how she was crawling and had waved to him. She said also that Samuel felt frustrated about the length of time he was in prison. Two days later, Samuel's girlfriend visited him again and she said that he "*appeared fine*".

Samuel's Girlfriend's Final Visit

On 22 April, Samuel saw his girlfriend for the last time and she said that he was in "*good form*" and that he appeared to have "*no concerns*". Samuel's girlfriend had visited him 14 times between March 2011 and 4 May 2011.

Medical Referral 27 April 2011

On 27 April, it is recorded that Samuel was seen by a nurse officer after Samuel said that he had fallen out of bed and hurt his neck. Samuel was given two Paracetamol and was to see the general practitioner the same day. There is no record of Samuel being seen by a doctor.

Telephone Calls – 29 April 2011

Samuel made three calls on 29 April to his mother, sister and girlfriend. A fourth call to his girlfriend was unanswered.

In his telephone calls to his mother and sister, Samuel told them that his trial was on 18 May 2011 and that he could get between six to eight years for two counts of aggravated burglary and three counts of AOABH (Assault Occasioning Actual Bodily Harm).

Samuel's Concern about Being Labelled a "Tout"

Samuel's sentence manager told the investigation that during April, whilst he was on Elm 1 landing, Samuel told him that he had concerns that other inmates in the prison had labelled him a "tout." He told the manager that other inmates thought that he had identified the inmates who were taking drugs in Cedar House. Samuel also told the manager that, in December 2010, when Samuel was moved to the privileged landing in Cedar house, an inmate was found to have a mobile phone or a SIM card and other inmates believed that Samuel had been moved because he had given this information to the authorities.

The manager stated that at no stage did Samuel admit to him that he had provided this information.

Samuel's Role in Providing Information to Staff

There was some evidence that Samuel passing notes to staff, when he feared for his safety, did contribute to a belief by inmates that he was "a tout."

The investigation also found, however, that Samuel had in fact given information to prison security on a number of occasions and that he may not have been adequately protected by the Prison Service in connection with this.

This is discussed in Section 7.

SECTION 6: SAMUEL'S LAST FEW DAYS**2 May 2011**

CCTV cameras are not situated on the landings where Samuel was located. CCTV in the association room located on the landing does, however, cover a small part of the corridor leading onto the landing where Samuel's cell was located. Samuel's movements in this area can, therefore, be seen.

On 2 May 2011, CCTV footage shows Samuel going in and out of the association room at 17.31 and 17.50.

At 23.30, it is recorded in the class officer's evening/night journal that Samuel was unlocked to receive the Samaritans phone. At interview the senior officer said that when he opened Samuel's cell door, Samuel asked him to come in and sit down. The senior officer, who had dealt with a previous complaint of bullying concerning Samuel, said that he asked Samuel if he was being bullied again. He said that Samuel replied *"no, no, nobody's giving me a hard time; I'm just missing the kids."*

The investigation established that Samuel rang the Samaritans at 23.32 and spoke to them for 23 minutes.

3 May 2011

On 3 May at 07.59, CCTV footage shows Samuel in the association room sitting with other inmates eating his breakfast for approximately 10 minutes.

At 09.34, Samuel can be seen going in and out of the class office and the association room on several occasions. He is also seen to iron a garment.

At 11.59, Samuel eats lunch with other inmates for approximately 13 minutes.

During the day, Samuel made a total of eight telephone calls to his mother, sister and his girlfriend. Samuel can be heard to argue with his mum about her telling his girlfriend that he didn't want her to visit him. It appears from other telephone calls at the end of April, that Samuel had wanted his girlfriend to *"sweat a bit."* Samuel's last two telephone calls on 3 May are with his girlfriend and they argue about who has *"finished"* with whom. As noted earlier, Samuel and his girlfriend had split up and got

Samuel Carson

back together three times during his time in prison. It is to note that, throughout many calls, Samuel's girlfriend is heard to be very caring towards him.

A prison officer on Samuel's landing, told the investigation that he was in the class office when he overheard Samuel speaking to his girlfriend on 3 May and, after the call, he cautioned Samuel about the inappropriate language that he had used when he spoke to her. The officer said that Samuel told him that his partner had said that she had *"dumped me"* but that he had actually *"dumped her two weeks"* earlier. The officer said that Samuel then asked him what he thought of the situation. At interview, the officer said that he replied *"I think you's will probably be in love again in the next day or two, I said, because you's are all the same. So then he asked me would I phone his visits numbers out to his partner..."* Samuel's telephone credit had been used up on the last phone call.

The officer told Samuel that he thought it would not be a good idea to telephone his girlfriend so soon after that phone call and he advised Samuel to *"let the dust settle"* to allow everyone to *"calm down"*. The officer said that he told Samuel that he would phone his girlfriend for him later on.

The officer said that he rang Samuel's girlfriend sometime in the evening after 17.00 and *"half expected her to say that she wasn't going to come near him"*. He said that she was, however, very pleasant and said that if she could get a child minder, she would come and see Samuel. The officer said that an arrangement was made that the officer would ring Samuel's girlfriend in two days time to determine if she had found a baby sitter and would also provide her with a reference number to book a visit.

The officer said that he relayed this message to Samuel and he was *"very, very happy (and said) thank you very much for doing that for me sir."*

Samuel's girlfriend told the investigation that she was sorry that she and Samuel had argued and wanted them to be together. She said that the officer told her that Samuel was *"sorry"* and that she asked the officer to tell Samuel that she was sorry too. She said that she would visit Samuel and confirmed that the prison officer had said he would ring her with the visit number.

At 18.31 on 3 May 2011, CCTV shows Samuel entering the association room, interacting with other inmates and playing table tennis for approximately seven

Samuel Carson

minutes. Samuel is seen laughing with a group of inmates before leaving at 19.20 to return to his cell.

During that evening, an inmate on Samuel's landing said that he heard inmates from the Care and Supervision Unit (CSU), which is immediately below Elm 1 landing, shouting at Samuel *"you f---ng rapist – go hang yourself."* The inmate named four inmates whom he believed had shouted the comments. He said that after Samuel's death, the same inmates said that he *"deserved it."*

The inmate said that weeks before Samuel died, Samuel told him that the abusive comments shouted at him at night *"annoyed him"* and that it stopped him at times from sleeping. The inmate said *"I think he took his life cos of bullying and missed his family and he didn't go to the gym or education as he feared he would get sliced."*

The investigation confirmed that two of the named inmates were in the CSU on the 3 May and also on the days after Samuel's death. The other two named inmates were in the CSU up until a number of days before Samuel died and were two of the seven inmates who were moved in April 2011 following the failed drug tests in Cedar House. As noted earlier, these inmates appeared to believe that Samuel had given information about them to prison staff.

An inmate who was in the CSU around the time of Samuel's death, and a second inmate, who had been in the CSU since 1 May 2011, told the investigation that on 3 May, abuse was shouted at Samuel by unnamed inmates from the CSU and that after he took his life, inmates in the CSU did comment that Samuel *"deserved it."* Other inmates in the CSU denied that there had been shouting.

The investigation also spoke with three other inmates who were located on Elm 1 landing in February 2011 and were believed by inmates to be sex offenders. The three inmates told the investigation that, when they were located on Elm1, from about 19.30 onwards each evening, inmates in the CSU shouted abuse at them and would tell them to take their own lives. One of the inmates said at interview that *"when I hear the shouting, it depresses me and sometimes it makes me want to take my life but then I think about getting out and there's hope for me to live."* Another of the inmates said that inmates would shout up *"rapist b---rd or they would hit us when they see us...I have been on SPARS a few times cos of the abuse they have given me. It makes me feel depressed and I don't want to live anymore."*

Samuel Carson

Child Protection Case Conference

Undated correspondence headed "*Parental Contribution to Child Protection Case Conference*" is believed to have been completed on 3 May 2011, by Samuel. Samuel was aware that on 5 May 2011, a Case Conference was being held to discuss the welfare of his daughter and the adequacy of parental care for her. The format of the correspondence was a series of questions with a space where Samuel could write his comments. One of the questions was: "*Do you believe you need to change anything in your family life?*" Samuel wrote, "*Yes I do, but not as much now since I have been in jail now for over a year. I am more relaxed and I haven't been on drugs that was my big downfall in the past.*"

Answering other questions, Samuel said: "*...(Samuel's girlfriend) is doing a brilliant job bringing (Samuel's daughter) up on her own and (Samuel's daughter) has a mum and dad that loves her so much.*"

The last question asked was "*Is there anything else you wish to ask?*" Samuel wrote, "*I would like to ask if and when I do the courses that is asked, am I allowed to live with (Samuel's daughter) in the future as there is nothing more in the world that matters to me. I would do anything to have and be a proper family and also be a good parent to my son and daughter.*"

Samuel's sentence manager said that he was aware that Samuel had been told by his girlfriend that, if they remained in contact, then Social Services would move to take their daughter into care and that he was "*most distressed... anxious and concerned*" about this. The manager further said that "*in Samuel's world he had plans set to settle down as a family unit, and such a decision by Social Services certainly impacted on him.*"

4 May 2011

On the morning of 4 May 2011, CCTV footage shows that Samuel did not go to the association room for breakfast. He is first seen on CCTV at 09.17 when he enters the association room and irons for four minutes.

Samuel Carson

CCTV shows that at 09.39 Samuel was in the visits area and he was placed in a holding room with another inmate before being escorted to a seated area in visits. The inmate said that he did not speak to Samuel that day.

At 09.46, Samuel is seen sitting in the visits area waiting for his sister to arrive. Prior to her arrival Samuel is seen speaking to a prison officer for a number of minutes. The officer said that, from what he could recall, it was a normal day for Samuel and he had not expressed any concerns.

At 09.57, CCTV footage shows the arrival of Samuel's sister and they are seen greeting each other. They talk for over an hour. Samuel's sister said that Samuel was *"...laughing and things seemed okay that day... you know he had planned that I (would) go up on the Friday because he was (up) for Court and I had to get him a shirt and he hugged me on the visit and says right I'll phone you with the (visit reference) numbers and you can come and see me that Friday"* She said that she *"wasn't aware that he was upset about anything."*

Samuel left the visits area at 11.03.

At 11.52, Samuel is seen entering the association room for four minutes and is then seen carrying a plateful of food out and returning back to his landing.

At 12.15, Elm House is locked up until 13.45. Samuel is not seen on CCTV for the remainder of the afternoon.

Samuel's Last Hours

It is recorded that at 16.10 on 4 May 2011, all inmates were returned to their cells and locked.

A senior officer on Elm 1 landing said that he saw Samuel just before he was locked up and remembered asking him *"how are you son?"* He said that Samuel smiled back at him and replied *"dead on. I'm grand."* The senior officer said that this was the last time he saw Samuel alive. He said that when he learnt Samuel had died, he was shocked, particularly because Samuel appeared to be in such good form that afternoon.

Samuel Carson

An inmate on Elm 1, said that Samuel *“seemed pretty down”* that day and had told him that he had left his girlfriend, that it was putting his *“head away”* and that he believed she was dating someone else. The inmate said that the day before, Samuel had removed pictures of his girlfriend and left them in reception.

The inmate also said that in the past when Samuel was low, he would not inform staff. He described Samuel as someone who always wanted to be liked and a person who found it difficult when others didn't like him. The inmate described Samuel as *“anxious, fearful and depressed”* from February 2011 onwards and said that he remembered, on one occasion, Samuel telling him that the *“boys are going to kill me.”* The inmate said that he told Samuel not to be paranoid and told him also that *“...he'll get a digging and to take it and move on.”* The inmate said that on Elm 1 there was no bullying and he said that *“I don't think Samuel meant to take his life.”*

There was no record of any pictures having been left at reception by Samuel. An examination of Samuel's cell wall, however, showed that one side of the wall was covered with many pictures and photographs, but that there were no pictures of Samuel's girlfriend. There were, however, spaces on the wall where pictures may have been.

At interview, an officer who was on the landing on 4 May 2011 said that he gave Samuel tobacco which he had ordered from the tuck shop. He said that, when he passed the tobacco to Samuel through the cell door, Samuel thanked him and said to the officer that he owed him tobacco. The officer explained that he had previously lent Samuel some tobacco, when Samuel had run out. The officer told Samuel not to bother and said *“I trust you, I will see you in the morning. His last words to me was thanks very much for getting that sir.”*

Another inmate said at interview that, approximately an hour before Samuel was discovered, he remembered speaking to him about a teddy bear that Samuel had asked him to make. Samuel had asked the inmate to make a pink teddy bear in Liverpool Football Club colours, for his daughter's birthday. The inmate said that Samuel said he'd *“...give me 25g of tobacco next week in return. He was cheerful as normal. He didn't look upset. I also know that Samuel had got his tobacco which staff had already given to him. There was nothing else that day as it appeared quite normal as we were checked at about 16.45... I genuinely didn't think Samuel did this intentionally.”*

Samuel Carson

At 16.15, a prison officer carried out a check on Elm 1 landing. At interview, the officer said that when he looked in to Samuel's cell everything appeared to be normal. He said that Samuel was watching television and they did not say anything to one another.

At 16.40, a prison officer commenced his duty with a headcount of the inmates on Elm 1 landing. The officer said that when he looked in on Samuel, he noticed he was sitting on the edge of the top bunk with his legs hanging over the bed. He said that Samuel was staring at the cell wall which had a pin board with pictures.

CCTV shows that at 16.47 a prison officer arrived on the landing with another inmate who had just been returned from court. They are seen entering the association room with food and the inmate is then seen returning to the landing followed by the prison officer at 16.48.

At interview, an officer who was on the landing at the time, stated that the normal routine of the prison on a week day, would be that a headcount check would be conducted at approximately 16.45 and then the numbers returned to the senior officer. At approximately 16.55 to 17.00 hours an announcement would then be made to allow the unlocking of inmates. The orderlies would be unlocked first to assist with serving the tea meal. A couple of minutes later, the cells would then be unlocked for the remaining inmates.

It is recorded that on 4 May 2011, permission was given, via the tannoy, for inmates to be unlocked at 17.00 and that the inmate orderlies were then unlocked to help prepare the food for the other inmates.

The officer suggested that, on 4 May, "*Samuel could have assumed that he was being unlocked at the point (inmate name redacted) was locked in his cell, as the sound of the doors locking and unlocking are very similar. Samuel may have then tied the ligature around his neck for attention and assuming that someone would check upon him shortly after the "unlock" when in effect it was actually someone being locked up.*"

It is to note that when the tannoy message is announced at approximately 17.00, prior to the unlocking of orderlies, the message can also be heard by the inmates within their cells. At the time when the inmate was locked, Samuel would know, if he was paying attention, that the unlock had not yet been announced over the tannoy. It is

Samuel Carson

possible that Samuel may have thought that he had missed the announcement or that, on this occasion, unlock had for some reason commenced without the announcement. This might particularly be the case if Samuel heard what he thought was a cell being opened, was waiting to apply a ligature and believed that he had only a short time before his door was opened.

It is not possible to know whether any of these scenarios are correct. It is, however, the case that the actions that led to Samuel's death occurred at a time when he might reasonably have expected to be unlocked very shortly. This may or may not mean that his actions were a cry for help that were not intended to result in his death.

Discovery of Samuel

At 17.05, a prison officer began to unlock the inmates on Elm 1 landing and the first cell he unlocked was Samuel's. He later recorded on a staff communication sheet the detail of how he found Samuel hanging. The officer said that, after he discovered Samuel: *"...I left the cell and activated the alarm. Whilst returning to the cell after activating the alarm I took out my Hoffman knife and cut the ligature from prisoner Carson's neck. Once I took the ligature off his neck I brought him backwards to the floor which brought him lying slightly out of his cell. By the time I got him onto the ground, other officers and the nurse officer had arrived."*

Actions of Staff

CCTV shows staff moving towards Elm 1 landing at 17.03 from the office, following the activation of the alarm on the same landing. The office is situated approximately 30 feet away from Samuel's cell. A SPAR conference was taking place in the office and three staff were present. One of the members of staff was a nurse officer and the other two were senior officers.

The nurse officer stated that when she heard the alarm and a tannoy message and realised that the emergency was on Elm 1, she immediately ran down the landing with the senior officers. She stated that she saw an officer pulling an inmate from room 3 out onto the corridor. The nurse officer said *"I did not know at this time who the inmate was... I noted his complexion colour was blue and there was no movement. At this time I thought Samuel was dead. I immediately commenced CPR (Cardio Pulmonary Resuscitation). Initially I applied both compressions and breaths to Samuel, however*

Samuel Carson

there was no response from him. I continued CPR for approximately 10 minutes. I applied eight cycles of CPR on my own and then (a prison officer) took over the compressions. During this time I requested an ambulance for a non breathing unconscious patient and I requested a colleague to bring up the emergency equipment. I continued doing the breaths – approximately another 10.”

Other officers arrived and took turns to assist with the CPR. It is recorded that another nurse officer, attended and was instructed by the first nurse officer at the scene to get the emergency equipment. She then left, returning with the “*equipment and oxygen.*”

One of the senior officers present requested an ambulance and the other radioed that the incident was a “*code blue*”³³. This officer then went downstairs to the CSU to locate a defibrillator³⁴ but couldn’t find one and returned to the scene.

A governor said that he arrived on the scene within one and a half minutes of the alarm going off and was told that someone had requested a defibrillator. He said that he immediately fetched a defibrillator from the administration department and returned two to three minutes later. The handwritten log recorded at the time, shows that after the alarm was triggered at 17.05, an ambulance was requested within three minutes and a defibrillator was used on Samuel at 17.13 and a “*shock advised by machine.*”

An officer, who is an instructor in CPR and in the use of a defibrillator, stated that he was in the CSU at the time of the emergency and arrived on the landing within seconds of the alarm going off. He said that when he arrived, he immediately assisted with CPR and continued to do so until the defibrillator arrived. The officer stated that he then applied pads to Samuel’s chest and the device instructed him to shock Samuel which was followed by instructions to continue with CPR. It then instructed another shock and shortly afterwards, the paramedics arrived.

It is recorded that at 17.15 the ambulance crew arrived and “*applied ECG leads + Defib – no pulse. Pupils fixed + dilated – pronounced flat lined – following examination (by paramedic).*”

³³ Code blue means that there is a medical emergency to alert medical staff to the type of response required. There are a number of reasons why a code blue would be announced including when the casualty is unresponsive to voice or has a ligature.

³⁴ Defibrillators are designed to analyze the heart rhythm itself, and then advise the user whether a shock is required. They are designed to be used by lay persons, who require little training to operate them correctly.

A prison doctor pronounced Samuel dead at 18.12 on 4 May 2011.

Significance of Delay in Accessing Defibrillator

At the request of the Prisoner Ombudsman, an expert Clinical Reviewer Mr Edward Brackenbury was asked to assess whether the delay in accessing a defibrillator affected Samuel's final outcome.

Mr Brackenbury noted that:

- Cardio Pulmonary Resuscitation was commenced immediately by the prison staff and the defibrillator demonstrated the requirement for a direct current shock. It can be assumed that the heart was in ventricular fibrillation³⁵ or pulseless ventricular tachycardia³⁶ both of which would warrant electrical cardioversion.
- Despite resuscitative efforts, it was clear that Mr Carson could not be saved.

In his conclusion, Mr Brackenbury said that:

"The process of hanging effectively cuts off the supply of blood and oxygen to the brain so that, within a few minutes, irreversible brain damage occurs. In this cardiac arrest situation, the question of whether the eight minute delay in applying the defibrillator could have affected the success of resuscitation is an important one as, with each passing minute, the chances of successfully defibrillating a patient out of a ventricular arrhythmia (heart rhythm) decrease by 7-10%."

"It is known that the heart can continue to beat for some 20 minutes or so after judicial hangings. My own observations of hearts removed during cardiac transplantation surgery suggest that even these diseased hearts can continue to beat intermittently for many minutes after removal from the body. It is likely, therefore, that enough time had elapsed from the initiation of Mr Carson's hanging for the heart rhythm to have deteriorated from a regular rhythm to a ventricular dysrhythmia (disturbed rhythm) and subsequent asystole (no rhythm or heart beat). This period of time would have been of

³⁵ Ventricular fibrillation is a severely life threatening heart rhythm (arrhythmia).

³⁶ Pulseless ventricular tachycardia is associated with no effective cardiac output.

Samuel Carson

such duration that Mr Carson would have already suffered profound and irreversible damage to his brain. Therefore, I can confirm that, even if Mr Carson had received immediate cardioversion from the defibrillator, it is likely that the final, fatal outcome would have been the same. The eight minute delay in obtaining the defibrillator was therefore immaterial to Mr Carson's chances of being resuscitated."

Samuel Carson

SECTION 7: MANAGEMENT OF SECURITY INFORMATION AT HYDEBANK WOOD

Much of the bullying to which Samuel was subjected by other inmates was linked to the nature of the charges that led to him being remanded in custody. This appeared to be the case even after the charges of rape and making indecent images were withdrawn on 10 January 2011. The Prisoner Ombudsman investigator who attended Hydebank Wood immediately following his death was informed that Samuel was the subject of PPANI arrangements and was Category 3 status (highly likely to cause serious harm through carrying out a contact sexual or violent offence.) This was not correct.

As discussed earlier, however, there was also evidence that Samuel was bullied because some inmates believed that he was a “tout” and that he had provided information to staff at Hydebank Wood about inmates using drugs. Samuel also told a member of staff that inmates thought he had provided information about a mobile phone / SIM card.

When seven inmates were moved off the Cedar Enhanced regime landing following a failed drugs test, it appears to have been widely believed that Samuel had provided information in respect of their use of drugs. The investigation was told and it was recorded in security records that it was, in fact, the case that an officer was reported to have raised concerns that led to the drugs tests being administered. At interview, the senior officer, who was given this information when carrying out a bullying investigation, said that a night custody officer had been concerned that the behaviour of the inmates was “*worse than normal and they had concerns that it was due to drug use.*” The senior officer said that the member of staff, speaking about one of the inmates, said “*...his eyes seemed to be jumping up and down in his head.*”

The senior officer did however say also, that during the bullying investigation, he spoke to Samuel and it was the case that Samuel had named several of the inmates who were taking drugs on the landing.

When asked, the officer, who was alleged to have supplied the information to the senior officer, stated that she did not do so.

It is not, therefore, entirely clear who said what and how significant the information provided by Samuel was. It is the case that, after the results of the drugs tests were

Samuel Carson

known, the senior officer said that he had given a verbal report to security and believes that he told them that the alleged bullies were amongst the ones that Samuel had identified as taking drugs.

At interview, two of the inmates who had tested positive for drugs said that they believed that the reason why they were found out was because Samuel had “*touted on them*”. They said that they drew this conclusion because they had deserved him passing notes back and forth to landing staff, the night before. They did not appear to have any knowledge of Samuel’s conversation with the senior officer, during which he provided the names of inmates using drugs.

As reported in Section 5, on the night of 3 April 2011, Samuel was invited by a prison officer, who was concerned for his welfare, to write notes if he wanted to communicate with staff, so that other inmates could not hear him. Samuel did so and it would appear to be the case that this exchange of notes may have been misunderstood and contributed to a belief that Samuel was supplying information.

The investigation did, however find that, as well as the matter of the drug related incident in Cedar House, Samuel did meet with security and supply other information. He also gave information, on occasions, to other staff. It is not clear what motivated Samuel to provide information and, importantly, evidence was found that the manner in which contacts with Samuel by the Security Department were managed was not compliant with the strict Prison Service policy that relates to this important area of work. Samuel was not, therefore, adequately protected.

Contacts with Security/Information Given

Evidence found of Samuel supplying information and/or meeting with security officer(s), over and above the information provided in connection with drugs in Cedar House, is as follows:

- On 16 September 2010, it is recorded that Samuel told a senior officer that an inmate “*was due to bring back 1 oz of blow (Cannabis) and 100 tablets from his compassionate bail this afternoon.*” It is recorded by the Security Department that when the inmate was returned from home leave he was searched with negative results. It is, however, recorded that the Passive Drug Dogs were unavailable that day.
-

- A principal officer stated that on 6 January 2011 he met with Samuel in the landing recreation room to discuss whether Samuel wished to have contact with his children during his time in custody. During this discussion Samuel provided information about the whereabouts of an inmate who was unlawfully at large. The officer who was given this information was unable to remember to whom he forwarded this information, but recalled that he went to the Security Department and it was either a police officer who was there, or a member of Security, that he told. There is no evidence of a written record made by Security.
- At interview, a prison officer from Cedar House said that Samuel asked him on four to five separate occasions over a period of weeks to speak to a member of Security. The officer said that he asked Samuel, on each occasion, if he could assist and that Samuel replied “*I can’t tell you.*” The officer said that he contacted security every time that Samuel requested their assistance and that was the end of his dealings with it.
- A different prison officer informed the investigation that he saw Samuel meeting with a member of Security in the video link room in Cedar House on at least two occasions.
- A senior officer said that he witnessed Samuel in a video link room with Security on approximately three occasions in Cedar House.
- Another officer said that he recalled on at least one occasion seeing Samuel meeting Security staff in the video room in Cedar House.

Evidence from Security Officer

A member of the Security Department at Hydebank Wood, who was reported to have met with Samuel, was asked about his contacts with him.

The officer said that he had met with Samuel on 7 January 2011 at Samuel’s request; 10 January 2011 at Samuel’s request and had also had “*a long conversation*” with Samuel on 15 February 2011 when he was walking around the landings talking to

inmates. At both of the meetings, the information provided by Samuel related to the location of mobile phones/SIM cards.

Security Management Issues

At interview, the security officer was asked about the implications for Samuel's safety of the meetings that took place, the way in which they were arranged and the number of people who observed them. During the discussion, the officer said the following:

- Security was contacted on two occasions following a request from Samuel, to meet a member of Security. On both occasions he supplied information and this was discussed with the Security principal officer but no written record of this information or the decision making was recorded.
- The security officer accepted that Samuel may have had meetings with other members of Security that he was unaware of. He was only able to confirm the number of times that he personally met Samuel in his capacity as a security officer. Other meetings with Samuel and Security could have taken place and also not have been recorded. It was established that no record is kept of all of the "informal" meetings that have taken place with any one inmate, so there is no overall picture of how any contacts with Security they are having.
- Whilst there is a requirement for each contact to result in the completion of a SIR, in practice the information supplied by inmates is regularly not recorded.
- Prior to each occasion that he met Samuel, a "pen picture" was created on the basis of the information and intelligence that the Security Department had in their possession. The "pen pictures" were not recorded and it is entirely unclear how useful the picture would have been when there was no record of all meetings with Samuel and the information that he provided.
- The security officer stated that a meeting took place where consideration was given to whether it would be appropriate to apply one of the various methods of formalising Samuel's role as an inmate providing information. Samuel was not deemed suitable due to the information he supplied not being reliable and there was too "great a risk to the inmate...(and it)..would be refused at headquarters by

the gatekeepers.” Controls that would apply to formalised arrangements were not, therefore, in place.

- The officer accepted that it was possible that a situation could arise where an inmate was, on a regular basis, requesting to meet security officers to provide information, in the absence of a formal arrangement. He said that if this occurred, it would need to be addressed as it could compromise the safety of the inmate and consideration would be given to providing a point of contact other than a member of Security. When asked whether the security officer had, on any occasion, ever implemented this alternative arrangement, he said that he hadn't.
- In relation to the number of people who saw Samuel meeting with security officers, the officer said that there is no other place that he could have taken Samuel without others knowing that a meeting was taking place. He said he was reliant on *“staff to keep their mouths shut and other inmates.”* He further said that *“At the end of the day if an inmate asks to speak to security they are mature enough or should be mature enough to realise you know...”*. It was established that the same locations are being used repeatedly to meet inmates providing information and the same *“cover stories”* for requesting the attendance of inmates are regularly used.

Meeting with Security Governor

The governor with overall responsibility for security at Hydebank Wood was asked about contacts with Samuel and arrangements for managing inmates who provide information. The governor also has a number of other areas of management responsibility and is not, therefore, dedicated to security matters.

The governor said that he is not involved in the day to day running of the Security Department, which he said was well established when he was moved to Hydebank Wood. He said that he is concerned mainly with high priority security issues that affect or could affect the security of the prison. The governor had no knowledge of, or involvement in, any contacts Samuel had with the Security Department.

SECTION 8: OTHER ISSUES**Complaint Against Police**

At the beginning of July 2010, when Samuel met his sentence manager he made specific allegations about a named police officer and told the manager that he believed the police officer had “*blocked*” his possible bail addresses and, in order to do so, had co-operated with paramilitaries. It is recorded by the sentence manager in his rough notes that Samuel alleged that the police officer “*informed local paramilitaries, informed landlord (and) no police called to check address – Limavady.*”

The sentence manager told the investigation, that Samuel alleged that the police officer had informed “*local paramilitaries and what he meant was that the officer had in fact informed a community restorative group of his charges (and his) whereabouts and in this instance it was...Whitewell Road which might have been one of the addresses that he was at, prior to being committed in July 2010.*”

Samuel’s family raised this matter with the Prisoner Ombudsman and were advised that such a concern fell outside of her remit. This being the case, the family took their concern to the Office of the Police Ombudsman for Northern Ireland. The Prisoner Ombudsman’s office has shared all of the evidence examined in connection with Samuel’s bail applications with the Police Ombudsman’s office, to assist them with their enquiries.

Ligature

Samuel used a belt as a ligature and during the investigation, staff informed the Prisoner Ombudsman investigators that they had heard that Samuel had borrowed this belt from another inmate. Attempts were made to contact the inmate concerned, but the inmate has currently left Northern Ireland. Samuel’s own belt was taken from him at committal because the design did not conform to Prison Service Regulation.

The investigation confirmed with Samuel’s family that the belt that Samuel used on the night of his death did not belong to Samuel. The family also confirmed that, on at least one other occasion, Samuel had borrowed another belt that they saw him wearing in visits. This belt was not in Samuel’s cell when he died and had presumably been returned or given to another inmate.

It is not possible to say when Samuel borrowed the belt that he used on the night of his death or whether he borrowed it because he was already planning to use it as a ligature. Whilst this is possible it may also be the case that Samuel may have borrowed the belt simply to wear it and subsequently decided to use it as a ligature.

Samuel's Role in Bullying Others

As reported, a small number of officers alleged at interview that Samuel, at times, particularly later in his committal, bullied vulnerable inmates, for items that he wanted such as tobacco. A few members of staff said that they believed that Samuel could “*give as good as he got.*” There is some evidence of this behaviour in prison records.

It is to note that the investigation found significant research evidence to show that inmates who are bullied, as Samuel was, will bully others. Evidence was also found of a relationship between bullying and self harm. One example is below.

In 2003, the HM Prison Service Safer Custody Group undertook a project on perceptions of safety based on visits and surveys with young people and staff in nine establishments, including specialised prison service units, a Secure Training Centre and Local Authority Secure Children's Home. While there needs to be some caution with the findings due to the small sample size the conclusions identified included:

- An apparent association between experiences of bullying and thinking about self-harm. All those surveyed who had thought about self-harming and who had actually self-harmed said they had been the victims of negative behaviours from others;
- An apparent overlap between victim and victimiser roles. Those who had reported being victims of negative behaviour such as bullying by others were considerably more likely to have used the behaviour against others themselves than those who had never been a victim.

Crucially, the role and influence of staff was identified as vitally important. It was identified that the most successful regimes were those where young people could expect consistent treatment by staff. The report also noted that the majority of young

people appreciate it when staff show genuine concern or interest in them and take time to talk or following follow through with things they said they would do.

The HM Prison Service study considered 'negative behaviours' which could include threats, theft, assault, and other forms of victimisation: "*Of those who reported being victims of negative behaviours, considerably more were likely to have used these behaviours against others (78%) compared with those who had never been a victim (44%).*"

SECTION 9: EVENTS FOLLOWING SAMUEL'S DEATH**Death in Custody Contingency**

In the event of an inmate dying, Hydebank Wood's Governor's Order 1-12 'Death of an Inmate' details the actions that are required by the Communications Room, Duty Governor, Prison and Healthcare Staff.

The Prison Service policy documents, "Contingency Plans Forty Four and Forty Five – Death of a Prisoner" clearly detail the roles and responsibilities of all members of staff upon notification of a possible death.

In line with the requirements of the contingency plans, the communications room, which controls and records all movements around the prison, immediately notified the appropriate personnel at the time and carried out a preliminary assessment of the cause of Samuel's death. Those notified included the Police and the Prisoner Ombudsman.

Family Notification of Samuel's Death

One of the concerns raised by Samuel's family was that Samuel's sister was informed of the death rather than his mother who was the next of kin.

As part of the committal process, inmates are requested to provide next of kin details in the event of an emergency.

In the event of a death, the protocol to be adopted is outlined in Prison Service Governor Orders. These state that on instruction from the governor, consideration should be given as to the best method of contacting the next of kin.

In the case of Samuel, a governor and a chaplain were tasked to contact the family after Samuel was pronounced dead.

The governor said that it was the intention to contact the next of kin who was Mrs Carson and to establish that she was at home in order to arrange to visit the home. The governor said that the prison had two telephone numbers for Mrs Carson, one a

Samuel Carson

landline number and the other a mobile number and a telephone number also for Samuel's sister. It was agreed that the chaplain would contact Mrs Carson.

At interview, the chaplain said that from his recollection, there was only one landline telephone number for Mrs Carson and he rang the landline telephone number twice and there was no answer and then they decided to contact Samuel's sister to determine the whereabouts of his mother. Records show that there were two telephone numbers for Mrs Carson, a mobile number and a landline telephone number. The chaplain stated that he was concerned that the news of Samuel's death would reach the family before they could make contact with his mother.

When the chaplain contacted Samuel's sister he recalled introducing himself and explained that he had been attempting to contact Samuel's mother and that he needed *"to speak to her as a matter of urgency concerning her brother."* The chaplain stated that she asked *"what was wrong, has something happened to Samuel?"* and he told her that there had been a tragic situation.

In the difficult discussion that followed it was not possible for the chaplain to withhold from Samuel's sister the information that Samuel had died and she became very distressed and terminated the call.

The chaplain said that he attempted again to contact Samuel's sister and then rang the first telephone number and the phone was answered immediately by a male who told him that Samuel's sister had informed them that her brother had died.

The chaplain said that he offered to visit the family and invited them up to the prison but this was declined and he provided the family with his contact details.

The governor concerned, said that *"it was decided to make contact firstly with (Samuel's sister) who had visited that morning, this was to establish if their mother was at home to enable (the chaplain and the governor) to visit her to break the tragic news."* This written account is at variance with the chaplain's recollection. It does, however, appear to be the case that the overriding wish was to try and see Mrs Carson and break the news to her at home. This was a very appropriate decision if it had been possible to deliver it.

Samuel Carson

In the event, it is very unfortunate that the sequence of events meant that Samuel's sister was the first to hear of his death and that his mother then heard the news from her daughter who was very distressed.

Later that evening, a telephone message from the family was relayed to the governor and the chaplain that all contact with the family was to be made through their solicitors.

SECTION 10: STAFF SUPPORT AND DE-BRIEF MEETINGS**Hot De-Brief**

The Prison Service's Self-Harm and Suicide Prevention policy, issued February 2011 states:

"In all cases involving a serious incident of self-harm or death in custody, hot de-briefing will take place and will involve all of the staff (where possible) who were closely involved with the incident.

The hot de-brief will be held by the Duty Governor or the most senior manager at the time (depending on the circumstances of the case) and will take place as soon after the incident has been brought under control as possible. During the hot de-brief staff should have the opportunity to express their views in relation to how the situation was discovered, managed and any additional support or learning that could have assisted. In addition, the hot de-brief is an opportunity to identify if staff themselves require specific support."

The policy also requires that a record of the hot de-brief will be completed and a copy made available to the Head of Custody Branch and to the Prisoner Ombudsman.

A hot de-brief was completed on the evening of Samuel's death with staff involved in the incident and those who assisted in managing the scene afterwards.

Cold De-Brief

The Self-Harm and Suicide Prevention policy also states that *"a cold de-brief will take place within 14 days of the incident to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional learning from the events. The cold de-brief is not intended to be a comprehensive investigation into the circumstances. Rather, it is an opportunity for staff to express their views and share their thoughts about the incident and their role and involvement in it. A member from Prison Service Headquarters (PSHQ) Custody Branch will attend the cold de-brief to support the Governor conducting it."* It is also a requirement of the policy that a record of the cold de-brief is made.

Samuel Carson

On the day that Samuel died, a female inmate also died by suicide later that evening.

It is recorded that a cold de-brief, *“touching on”* the deaths of Samuel and the female inmate, took place on 17 May 2011. The meeting was chaired by the Head of Safer Custody who was supported by two of his colleagues from Prison Service Headquarters. It is recorded that *“the objective of the meeting was to give the staff involved in both incidents an opportunity to air their views and concerns around the reaction of colleagues and other relevant agencies to these events.”* The record of the meeting does not note who attended.

It is recorded that issues of concern arising from the events of 4 May 2011 were raised by staff involved in each of the deaths. These included:

- *“the lack of support services available to staff following a critical incident”;*
- *“information available at the time regarding support services was scant”;*
- *“medical response bags contain too much equipment, some of which is not necessary”;* and
- *“defibrillators being more readily available throughout the prison...and sited in more accessible places”.*

In relation to the presence of the defibrillators, it is recorded that the nurse officer who attended at the scene with the emergency response bag said that, whilst the defibrillator was in the emergency bag, it could not be found. She said that there was too much equipment in the bag which was unnecessary. Since this incident a defibrillator has been installed on Elm 1 landing, though not on other landings.

It should be noted that some staff interviewed did state that they were offered help and support in coping with the incident.

SECTION 11: AUTOPSY REPORT

An autopsy examination was carried out on 5 May 2011 and gave the cause of Mr Carson's death as:

I (a) Hanging

The report states:

"This young man was physically healthy. There was no natural disease to cause or accelerate death. He had his appendix removed in the past but this was merely an incidental finding.

Other than the ligature mark there were no other recent marks of violence. There were however the scars of self-inflicted wounds on both forearms.

The report of Forensic Science Northern Ireland shows that at the time of his death there was no alcohol in the body. The blood was further analysed for a range of pharmaceutical drugs and drugs abuse but none was detected."

Absence of Mirtazapine in the Blood Sample Analysis

The investigation confirmed that Samuel's blood was tested for Mirtazapine and that none was detected. At the time of his death Samuel was prescribed Mirtazapine 15mgs to be taken at night. The half-life³⁷ of Mirtazapine is prolonged and Dr Malcolm VandenBurg confirmed that he would have expected it to have been found in Samuel's blood if he was taking it correctly. Dr VandenBurg pointed out that the mean half-life of elimination is 20-40 hours and that longer half-lives of up to 65 hours have occasionally been recorded. Shorter half-lives have been seen in younger men. The half-life is sufficient to justify once a day dosing.

Samuel had been issued with seven Mirtazapine tablets on 30 April 2011 and should, therefore, have had three left at the time of his death. During the PSNI search of the cell, no tablets were found. Samuel's family subsequently found one tablet in his clothing that was returned to them.

³⁷ The time it takes for half of the drug to be eliminated from the bloodstream.

SECTION 12: FINDINGS OF THE EXPERT CLINICAL REVIEWER AND SAMUEL'S USE OF MIRTAZAPINE

Having reviewed the Healthcare provided to Samuel at Hydebank Wood, the Clinical Reviewer, Ms Gwyneth Ruddlesdin said that:

1. The EMIS clinical records show that, between 6 March 2010 and 4 May 2011, Samuel had a total of 39 contacts with the nursing staff, seven consultations with the medical staff and six contacts with the mental health nurse in addition to the clinical contacts following IMR12 (Injury Report Form) incidents.
2. Thirteen "immediate medical reviews" took place. On six of the thirteen occasions that Samuel received immediate medical assessment by a nurse, he was not referred for medical follow-up. The paucity of the medical records do not enable an assessment to be made as to whether this was appropriate on each occasion. It is, however, of concern that following the alleged assault on 9 October 2010, the medical and nursing staff at Hydebank Wood did not know that nasal x-rays could not be undertaken at Maghaberry Prison and it was not until 2 November 2010 (three weeks later) that Samuel was referred to the ENT (Ear Nose and Throat) specialist at the hospital.
3. Two of the healthcare assessments refer to self-harming incidents (7 July 2010 and 2 April 2011). Whilst Samuel was seen for mental health support on 8 July 2010, there does not appear to have been any similar consideration of the need for additional support following the 2 April 2011 incident.
4. There is no indication that there was any attempt to obtain a summary of Samuel's medical records from his General Practitioner. Whilst the previous medical records would not have substantially contributed to the medical care provided for Samuel in Hydebank Wood, consideration of them might have affected the actions that could have been taken to ensure appropriate mental health support.
5. Samuel had a new committal consultation on 6 March 2010. At this time Samuel stated that he had deliberately self-harmed two years previously by cutting his wrists (this is not noted within the previous GPs records) but that he had no thoughts of self-harm at that time. He was subsequently seen by a nurse on 11 March 2010, having made a number of telephone calls to the Samaritans. The EMIS records show that the nurse made a referral for mental

- health support. There is no subsequent indication within the medical records that this referral was pursued or followed up.
6. The last recorded mental health contact with Samuel was on 25 August 2010. A referral for Cognitive Behavioural Therapy (CBT) was made on 15 April 2010. There is no indication that Samuel was seen by a therapist at any time or that this referral was pursued by any of the clinical staff at Hydebank Wood.
 7. In addition, whilst the physical care provided to Samuel following self-inflicted injuries was acceptable, at no point after August 2010 does it appear that a further mental health assessment was undertaken. It is noted that, on 5 April 2011, the doctor recommended CBT to Samuel but this was refused so that a trial of Mirtazapine 15mgs was initiated. Whilst a mental health therapeutic relationship depends on the co-operation of the individual, it is noted that the extent of follow-up by all clinical staff was limited.
 8. Three Self-Harm and Suicide Prevention (SPAR) documents have been provided dated 25 March to 1 April 2010, 24 August to 1 September 2010 and 2 April to 4 April 2011. Although nursing staff are listed as being involved in the discussions, at no point was a referral considered for a formal mental health assessment.
 9. At the new committal interview on admission to Hydebank Wood on 6 March 2010, Samuel did tell the nurse that he had deliberately self-harmed two years previously by cutting his wrists. This was repeated to the mental health nurse on 15 April 2010. However, on 4 April 2011, Samuel told the nurse that he had never self-harmed before.
 10. It is noted that the Inspector of Criminal Justice in Northern Ireland undertook an unannounced follow-up inspection of Hydebank Wood in March 2011 subsequent to a full inspection in 2007. Recommendations had been made regarding mental health services in 2007 but the 2011 review found that less psychiatric input was available for the young prisoners (2.137).
 11. There is also no evidence of any screening for anxiety or depression being undertaken.
 12. Samuel underwent an initial committal consultation at Hydebank Wood on 5 March 2010 when his medication was noted and a doctor provided a repeat

prescription of Propranolol 40mg twice per day (14 tablets). There is no indication within the medical records that this prescription was reviewed.

13. Samuel was prescribed a reducing course of Diazepam. In interview on 17 January 2012, a prison doctor stated that it was common to prescribe a reducing course of Diazepam if someone was anxious on committal to prison and that the individual would normally also be seen by the mental health team. There is no indication within the medical records that such a referral was made.
14. On 4 April 2011 Samuel was seen by a nurse. He was stating that he was depressed and could not sleep. It was planned for him to be seen by the General Practitioner the following day. On 5 April 2011 a prison doctor was asked to see Samuel; it is documented that he was not suicidal but had a poor sleep pattern. The doctor believed that Samuel could benefit from CBT but this was refused. Samuel did agree to a trial of Mirtazapine 15 mgs (28 tablets). At interview on 17 January 2012 the doctor explained that this was consistent with someone not badly depressed, which is why he had prescribed 15 mgs rather than 30 mgs to be taken at night as it can help sleep. The doctor said that, if it was not helping, he would expect nurses to feedback any concerns and he would then have reviewed Samuel. If it were proving effective he would have hoped Samuel would have stayed on this medication for at least three months.
15. On 27 April 2011 the doctor issued a repeat prescription with the assumption that it was making an improvement. There is no entry within the EMIS record to support or refute this assumption.
16. A risk assessment for in-possession medication has been made available, although it is undated and its completion is not recorded within the main EMIS record. It is also unclear who actually completed the form. However, the 'no' column has been ticked for "*Does the prisoner have a history of self-harm' and 'is the prisoner a target for bullying*". Samuel stated that he had self-harmed at his initial committal screening on 6 March 2010 and, although there is no indication that this had occurred from his previous medical records, it could have been expected that this would have been noted on the risk assessment form. Similarly, there is evidence from the IMR12s (Injury Report Forms) and the SPARs that Samuel was subject to antagonism and bullying from other inmates which should have led to the risk assessment being updated. Whilst

there is no indication that Samuel had any intention of taking an overdose at any point, it indicates weaknesses within his medical supervision. The clinical decision of the General Practitioner to prescribe Mirtazapine was appropriate. However, no system was implemented to review Samuel's progress on the medication.

The Inspector of Criminal Justice in Northern Ireland review in March 2011 noted that the in possession policy was not being complied with and that a revised risk assessment had not been implemented. In particular, "*documentation was often incomplete and there was little evidence of review*".

17. The consultation section of the EMIS records is not always clear as to if the clinician was noting information received or if they had had face-to-face contact with Samuel. The entries are also frequently very brief and, at interview in January 2012, the clinicians were not able to expand on their records. A prison doctor reported that the General Practitioners were reliant on the nursing staff observing inmates and referring anyone about whom they had concern. It is unclear how well this communication functioned. It is noted that referrals to mental health services were not followed up and that there was no robust system of review. In particular, all clinical staff should be reminded that good record keeping is paramount and all clinical staff should complete clinical records training annually as part of their mandatory training requirement. In addition, the annual records audit should be focussed on a qualitative evaluation of the completeness of the record.

Actions of Medical Staff after Samuel was Found on 4 May 2011

Commenting on the actions of medical staff on the evening of Samuel's death, the Clinical Reviewer said:

It is apparent from the interviews held with clinical staff that a nurse arrived at Samuel's cell very quickly, having already been on the landing. The cold de-brief, held on 17 May 2011, recorded that there have been concerns regarding defibrillator availability and associated staff training both to use the defibrillator and in First Aid. It is noted that the majority of trained prison staff work on night duty. The cold de-brief recorded a number of learning points but it is unclear of the status of these or if they have been converted into an action plan.

Mirtazapine

The Clinical Reviewer noted the following in respect of the anti-depressant Mirtazapine that was prescribed to Samuel:

“Mirtazapine works in the brain, where it enhances the effect of naturally occurring chemicals called neurotransmitters. These are chemical compounds that act as chemical messengers between nerve cells. Noradrenaline and serotonin are two such neurotransmitters. When noradrenaline and serotonin are released from nerve cells in the brain they act to lighten mood. When they are bound to nerve cells in the brain, they no longer have an effect on mood. It is thought that when depression occurs, there may be a decreased amount of noradrenaline and serotonin released from nerve cells in the brain.

Mirtazapine works by blocking receptors called alpha-2 receptors that are found on nerve cells in the brain. Noradrenaline and serotonin would normally bind to these receptors. By blocking them, Mirtazapine prevents noradrenaline and serotonin from becoming bound to the nerve cells. This enhances the mood-lightening effect of free noradrenaline and serotonin that is released from nerve cells, and helps relieve depression.

Depression is associated with an increased risk of suicidal thoughts, self-harm, and suicide and it can take two to four weeks for the medication to take effect. It is considered that Mirtazapine should be used with caution in young adults and those with a history of suicidal behaviour or thoughts.”

The investigation found that the US Library of Medicine offers the following “important warning” to users of Mirtazapine:

“A small number of children, teenagers, and young adults (up to 24 years of age) who took anti-depressants (mood elevator) such as Mirtazapine during clinical studies became suicidal (thinking about harming or killing oneself or planning or trying to do so). Children, teenagers, and young adults who take anti-depressants to treat depression or other mental illnesses may be more likely to become suicidal than children, teenagers, and young adults who do not take anti-depressants to treat these conditions.

You should know that your mental health may change in unexpected ways when you take Mirtazapine or other anti-depressants even if you are an adult over 24 years of age.

Samuel Carson

You may become suicidal, especially at the beginning of your treatment and any time that your dose is increased or decreased. You, your family, or your caregiver should call your doctor right away if you experience any of the following symptoms: new or worsening depression; thinking about harming or killing yourself, or planning or trying to do so; extreme worry; agitation; panic attacks; difficulty falling asleep or staying asleep; aggressive behavior; irritability; acting without thinking; severe restlessness; and frenzied abnormal excitement. Be sure that your family or caregiver knows which symptoms may be serious so they can call the doctor if you are unable to seek treatment on your own.

Your healthcare provider will want to see you often while you are taking Mirtazapine, especially at the beginning of your treatment. Be sure to keep all appointments for office visits with your doctor.”

Dr Malcolm VandenBurg advised that if Samuel had only taken Mirtazapine for four weeks at the time of his death, the impact on Samuel’s mental health may well have been a contributing factor.

It is also the case that Samuel may have been taking his medicine incorrectly and may have missed doses or stopped taking his tablets abruptly. Dr VandenBurg said that incorrect administration of Mirtazapine would mean that Samuel could “*have repeatedly been subject to changing plasma concentrations, initiation of treatment and abrupt withdrawal.*” Dr VandenBurg confirmed that this could have increased the likelihood of Samuel experiencing suicidal thoughts and said also that Samuel’s age would have increased the likelihood of these effects.

South Eastern Health and Social Care Trust Response

The SEHSCT Prison Healthcare Team responded to the Prisoner Ombudsman and Clinical Reviewer assessments of Samuel’s healthcare and areas of concern, making the following points:

- There are a number of helpful learning points for the service with regard to access to GP medical records, use of the EMIS system and the availability of emergency equipment which will be addressed going forward albeit that it is not clear that these issues directly contributed to the unhappy outcome in this case.

- With regard to the issue of special observation when Mirtazapine is prescribed, the Associate Clinical Director of Prison Health Care has considered the British National Formulary (BNF)³⁸ recommendations for this drug in young people; *The balance of risks and benefits for the treatment of depressive illness in individuals under 18 years is considered unfavourable for the SSRIs Citalopram, Escitalopram, Paroxetine, and Sertraline, and for Mirtazapine and Venlafaxine. Clinical trials have failed to show efficacy and have shown an increase in harmful outcomes. However, it is recognised that specialists may sometimes decide to use these drugs in response to individual clinical need; children and adolescents should be monitored carefully for suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment.*
- The observations about Samuel's mood and behaviour recorded in the Prisoner Ombudsman report indicates a greater level of monitoring than would normally be available to a GP in the community. The observations in the report are variable in their accounts of his mood. On the 3 May 2011 he was reported as being "*very, very happy*", whereas on the following day he said that the dispute with his girlfriend was "*putting his head away*". Whether more formal monitoring arrangements would have been beneficial is debatable.
- The Trust's Medical Director suggested that further advice should be sought from the Prison Consultant Forensic Psychiatrist about the issue of the monitoring of Samuel after he was prescribed Mirtazapine. The Forensic Psychiatrist reviewed the National Institute for Health and Clinical Excellence (NICE)³⁹ guidance and did conclude that the concern about the apparent sub-optimal level of monitoring of Samuel once treatment with Mirtazapine commenced is fair in light of the guidance.
- This does pose some difficulty for the Trust in providing an appropriate level of healthcare to people in custody. The Trust is required to provide a similar level of care to that which would be available to others in the community whilst also having due regard to the particular difficulties experienced by prisoners as they pass through custody. There is no doubt that in Samuel's case the known

³⁸ The British National Formulary (BNF) is a medical and pharmaceutical reference book that provides a wide spectrum of information and advice on prescribing, dispensing and administration of medicines.

³⁹ National Institute for Health and Clinical Excellence (NICE) develop evidence based guidelines on the most effective ways to diagnose, treat and prevent disease and ill health. It was set up to reduce variation in the availability and quality of NHS treatment and care.

“Psychosocial Stressors” as set out in the Prisoner Ombudsman report will have impacted significantly on him. These include his detention; his inability to secure a bail address; relationships with his family, particularly his girlfriend; the threats he experienced from Paramilitaries; the bullying and assaults that he endured; the experience of being in custody in relation to the nature of the offence he was charged with; and the experience of being perceived by other prisoners to have provided information to prison staff.

- It is intended that a Prison Service Protocol will be drawn up regarding treatment of depression in young adults in keeping with current accepted good practice but at the same time having regard to the vicissitudes of prison life. Such a protocol will need to include a comprehensive Risk Assessment of known psychosocial stressors. This would require clinical staff in prison healthcare to be provided in a timely manner with definitive views/information from multiple sources including the patients’ family, legal representative, the Probation Service, Police, Prison Security Department and Sentence Manager.
- Clearly the coordination and collating of such information is a major task and a matter for all agencies involved rather than the healthcare team in isolation. It is unfair to expect clinical staff to treat depressive symptoms in isolation from the knowledge of the world that the patient/prisoner inhabits. It would then be the responsibility of the antidepressant prescriber to ensure that routine monitoring occurs prospectively at time intervals defined in an agreed Care Plan.
- The Prisoner Ombudsman report also raises an issue of concern requiring action in relation to there being no evidence that, as required by SEHSCT policy, a summary of Samuel’s community GP records was requested. This is a recommendation that the SEHSCT had implemented as the result of a recommendation in a previous Death in Custody report. However, the practicalities of requesting a summary of records has meant that prison healthcare staff can wait for up to five days before the Community GP returns the summary template. Consequently a decision has been made to revert to the former practice of phoning the GP for a list of medication only. This at least gives a sound base line which informs the Prison Healthcare GP’s first consultation. We understand that the Electronic Care Record (ECR) will be

Samuel Carson

available for prison use on or before 31st March 2013. This will resolve the issues around accessing community records but in the meantime the Trust will be using the medication list as the base line for care.

- The Trust's Medical Director agrees with Mr Brackenbury's conclusions that any delay of eight minutes in applying the defibrillator would not have made any material difference in the outcome of this case. The cardiac arrest, once it was established at 17:05 on 4 May 2011, was conducted in an appropriate manner by the staff who attended.
- With regard to the nasal injury and referral to Maghaberry after assault on 9 October 2010, the Medical Director points out that x-rays of the nasal bones are not indicated to make a diagnosis of nasal fracture... *"From what I can see in this report, no specific treatment was required for the nasal injury thereafter. This event did not in any way, in my opinion, contribute to the events of 4 May 2011"*.
- The Medical Director agrees with Dr VandenBurg, that the physical care provided to Samuel following self-inflicted injuries was acceptable.
- The Medical Director notes also that, in the immediate days/hours up to Mr Carson's death, he could not see overt signs of depression or suicidal ideation on reading the report provided. He says that it is his view that the suicide has more likely been impulsive.

APPENDICES

APPENDIX 1

PRISONER OMBUDSMAN FOR NORTHERN IRELAND
TERMS OF REFERENCE FOR INVESTIGATION OF
DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence;
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care;
- Provide explanations and insight for the bereaved relatives;
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising 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 action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set Terms of Reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.
7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.
10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons the Minister of Justice (or appropriate

representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Prison Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Minister of Justice. The Ombudsman may also publish material from published reports in other reports.
15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Minister of Justice.
16. Annex 'A' contains a more detailed description of the usual reporting procedure.

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.
 2. The Ombudsman sends a draft report (including background documents) to the Prison Service.
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3. The Service responds within 28 days. The response:
 - (a) draws attention to any factual inaccuracies or omissions;
 - (b) draws attention to any material the Prison Service consider should not be disclosed;
 - (c) includes any comments from identifiable staff criticised in the draft; and
 - (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe).
 4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Prison Service first may make a consecutive process preferable).
 5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.
 6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.
 7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.
 8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Minister of Justice (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of
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establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request). If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.
10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.
11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Minister of Justice. The Ombudsman may also publish material from published reports in other reports.
12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Minister of Justice. In that case, steps 8 to 11 may be modified.
13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.
14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

INVESTIGATION METHODOLOGY

Notification

1. On the evening of Wednesday 4 May 2011, the Prisoner Ombudsman's office was notified by the Northern Ireland Prison Service about Mr Carson's death in Hydebank Wood Prison.
2. A member of the Ombudsman's investigation team attended Hydebank Wood Prison that evening to be briefed about the series of events leading up to Samuel's death.

Notices to Prisoners/Inmates

3. On 5 May 2011, Notices of Investigation were issued to Prison Service Headquarters and to staff and inmates at Hydebank Wood Prison and Young Offender's Centre announcing the Prisoner Ombudsman's investigation and inviting anyone with information relating to Mr Carson's death to contact the Investigation Team.

Prison Records and Interviews

4. All of the prison and prison healthcare records relating to Mr Carson's period of custody were obtained.
5. Interviews were carried out with prison management, staff and inmates, in order to obtain information about the circumstances surrounding Mr Carson's death.

Telephone Calls

6. Records show that Mr Carson made 347 telephone calls however 138 were not answered between 7 February 2011 and 4 May 2011. Recordings of these 209 calls were obtained and listened to.

CCTV Footage

7. CCTV cameras are not situated on the landing where Mr Carson was located at the time of his death; however, CCTV from the recreation/dining room, on occasions shows Mr Carson's movements to and from the landing.

Autopsy & Toxicology Report

8. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy and toxicology report.

Clinical Review

9. As part of the investigation into Mr Carson's death, a clinical review was commissioned to examine Mr Carson's healthcare needs and the medical treatment she received in Hydebank Wood.
10. I am grateful to Ms Gwen Ruddlesdin, who carried out the clinical review.
11. Ms Ruddlesdin's clinical review report was forwarded to the South Eastern Health and Social Care Trust for comment. The Trust responded and I have included the comments made at the appropriate places in this report.

Factual Accuracy Check

12. Before completing the investigation I submitted the draft report to the Director General of the Northern Ireland Prison Service and the Director of Adult Services and Prison Health for the South Eastern Health and Social Care Trust for a factual accuracy check.
13. The Prison Service and Trust responded with a list of comments for my consideration.
14. I have fully considered these comments and made amendments where I felt that this was appropriate.

HYDEBANK WOOD PRISON AND YOUNG OFFENDERS CENTRE**Background Information**

Hydebank Wood Prison and Young Offender Centre is a medium to low security establishment located in South Belfast which accommodates all young male offenders aged between 17 and 21 years on conviction, serving a period of four years or less in custody and all female prisoners including young offenders.

The Centre was opened in 1979, and has the capacity to hold up to 306 inmates (both remand and sentenced.) It comprises five self-contained houses – Elm, Willow, Cedar, Beech and Ash. Although some services are shared, Ash House has been designated, since 2004, as the women’s prison, and it has a distinct and separate identity. Each of the five houses can accommodate approximately 60 inmates in single cell accommodation.

Arrangements can be made to accommodate younger people at Hydebank Wood. Legislation also permits inmates of 15 years old to be held in Hydebank Wood if their crime is deemed to be of a very serious nature. Male juvenile inmates are accommodated separately on two landings within Willow house (Hydebank Wood does not accommodate female juveniles, who are, instead, held at the Juvenile Justice Centre in Bangor.)

There is approximately 355 staff in post at Hydebank Wood, which includes approximately 304 prison/governor grades and 51 civilian and support grades.

It is one of three detention establishments managed by the Northern Ireland Prison Service, the others being Maghaberry Prison and Magilligan Prison.

The regime in Hydebank Wood aims to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda⁴⁰ – safety, respect, constructive activity and addressing offending behaviour. Purposeful activity and offending behaviour programmes are a critical part of the resettlement process. In seeking to bring about positive change, staff develop prisoners/inmates through a Progressive Regimes and Earned Privileges Scheme (PREPS) as in other prisons.

⁴⁰ Healthy Prisons Agenda: The concept of a healthy prison is one that was first set out by the World Health Organisation, but it has been developed by the HM Inspectorate of Prisons. It is now widely accepted as a definition of what ought to be provided in any custodial environment.

POLICIES AND PRISON RULES

The following is a summary of Prison Service policies and procedures relevant to this investigation. They are available from the Prisoner Ombudsman's Office on request.

Prison Rules

Rule 80 of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 states that at every prison a separate building or a suitable part of the prison shall be equipped, furnished and staffed in a way appropriate to the health care and treatment of sick prisoners.

Rule 85 (2A) TO 85 (2C) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 sets out the provisions of certain functions of the medical officer to be carried out by a registered nurse.

Rule 88A (1) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 states that a governor may require that a prisoner whom he considers to be at risk of suicide or self-harm be accommodated in a cell or room designated for the management of that prisoner's risk of suicide or self-harm.

Rule 88A (2) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 Where the cell or room designated under paragraph (1) is an observation cell the prisoner shall be accommodated in that cell for such period as is consistent with the management of his risk of suicide or self-harm.

Death in Custody Contingency Plan

The Death in Custody Contingency Plan provides step by step guidance for all staff in how to deal with and manage the death of a prisoner in custody.

Prison Service Policies

Self Harm and Suicide Prevention Policy (February 2011) The Prison Service Self-Harm and Suicide Prevention policy updated and re-issued in February 2011 states that it:

“aims to identify prisoners at risk of suicide or self harm and provide the necessary support and care to minimise the harm an individual may cause to him or herself. The Service recognises that this is an important priority and one that demands a holistic approach. Prisoners become vulnerable for many reasons. Vulnerability is often presented as an inability to cope with personal situations and/or the prison environment and where, without some form of intervention the likelihood of self-harm or loss of life is imminent. The Service’s definition of a vulnerable prisoner is;

‘An individual whose inability to cope with personal situations within the prison environment may lead them to self harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication.’

Governor’s Orders

Governor’s Orders are specific to each prison establishment. They are issued by the governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners. The following orders have been considered as part of this investigation:

Governor’s Order 1-12 ‘Death of an Inmate’ details to the actions required by staff in the Communication Room, the duty governor, staff at the scene and of healthcare staff.

Governor’s Order 11-15 ‘Attendance at Safer Custody Case Conference Reviews’, which details representatives required to attend the case review.

Governor’s Order 11-17 ‘Referrals to Safer custody’ details to how staff should refer an inmate to the Safer Custody Team.

Samuel Carson

Governor's Order 11-15 'SPAR Process' advises staff of the SPAR process, how and when this should be implemented and the responsibilities of staff who have the duty of care for inmates with an open SPAR booklet.

Governor's Order 11-24 'Closing a SPAR Booklet', which details the actions required before a SPAR booklet can be closed.