The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF ALLYN JAMES BAXTER WHO DIED WHILST IN THE CUSTODY OF HYDEBANK WOOD PRISON & YOUNG OFFENDER'S CENTRE ON 3 AUGUST 2010

AGED 19

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PREFACE

Allyn James Baxter was born on 11 October 1990. He was 19 years old when he died by suicide whilst in the custody of Hydebank Wood Prison and Young Offender's Centre on Tuesday 3 August 2010.

Within his family, Mr Baxter was known as 'Allyn' and with the agreement of his family that is the name that I have used throughout my report.

I offer my sincere condolences to Allyn's family for their loss. I have met with Allyn's family and shared the content of this report with them and responded to the questions and issues they raised.

The report contains this preface, the investigation and a summary followed by my issues of concern that require action, an introduction and my findings.

My findings are presented in 11 sections:

- Section 1: Background Information
- Section 2: Allyn's Committal to Hydebank Wood – 28 July 2010
- Section 3: 29 July 2010
- Section 4: 30 July 2010
- Section 5: Events of 31 July 2010 Prior to the Discovery of Allyn
- Section 6: Discovery of Allyn on 31 July 2010 and Subsequent Action
- Section 7: Events Following Allyn's Death
- Section 8: Autopsy Report
- Section 9: Allyn's Detoxification Programme
- Section 10: Other Matters
- Section 11: The Expert Clinical Review

As part of the investigation into Allyn's death, Dr Seena Fazel, Consultant Forensic Psychiatrist and Clinical Senior Lecturer in Forensic Psychiatry at

the University of Oxford, was commissioned to carry out a clinical review of Allyn's medical treatment whilst in prison.

Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, was commissioned to provide his expert opinion of two specific areas of the investigation findings.

I am grateful to Dr Fazel and Mr Brackenbury for their assistance.

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

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.

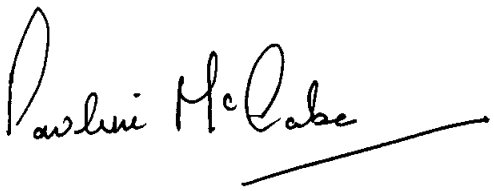
In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that *"An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become 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. There should therefore be an early review of the recommendations, discarding those that are no longer relevant or are time expired, brigading into topic areas those that remain, identifying dependencies within the recommendations and with the change programme, and prioritising and timetabling action over a period of time. Inspectorates and monitors in return will expect real and measurable outcomes."*

The Prison Service and South Eastern Health and Social Care Trust (SEHSCT) are currently engaged in two programmes of work with the aim of achieving significant change in the Northern Ireland Prison Service. These are the Strategic Efficiency and Effectiveness (SEE) Programme and the SEHSCT's Service Improvement Boards.

In light of Anne Owers comments, and in order to support the development of a more strategic and joined up approach to service development, I have decided, on this occasion, not to make recommendations. I am instead detailing 18 issues of concern related to service delivery identified during the course of the investigation. The Prison Service and SEHSCT should address these concerns fully as part of the above programmes for change.

In adopting this approach, I must draw attention to the fact that some of the concerns listed represent failures to deliver existing Prison Service policy or to implement previously accepted recommendations. I must also draw attention to the fact that appropriate action could, in some instances, immediately reduce the likelihood of future serious incidents or deaths. It is, therefore, very important that this is fully considered when action is taken in the context of the current work programmes.

I would like to thank all those from the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and other agencies who assisted with this investigation.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
3 JUNE 2011

SUMMARY

Allyn James Baxter was nineteen years old when he died by suicide on 3 August 2010 whilst in the custody of Hydebank Wood Prison and Young Offender's Centre.

When Allyn was six years old, his mother died of cancer and he then lived with his aunt in Scotland. Because of difficulties arising from his use of solvents, Allyn moved back to Northern Ireland two years later, and, over the following years, stayed with around 12 different foster families. He had a period of residential care when he was aged 13 to 14.

Allyn's family said that he had a history of substance misuse which started when he was very young and that over the years he had seen a number of health professionals including social workers and a child counsellor. He had also worked with CAHMS, a bereavement counselling service.

Allyn stayed with his final foster carers from the age of 14 to 18. He obtained a number of GCSE's, including Science, and then completed an NVQ in Health and Social Care before leaving school at the age of 16. He then worked as a butcher's assistant and a waiter until his employment stopped in 2008.

Allyn's family said that, over the years, his drug and alcohol misuse increased and that it was often a factor in what became a significant history of self harm. Allyn's medical records confirm a past history of solvent, alcohol and polysubstance abuse. They also confirm his history of self harming.

In February 2010, it is recorded that Allyn had debts of around £800.

In 2010 there was an escalation in episodes of Allyn self harming. In April 2010 he was taken to Accident and Emergency when he collapsed and was thought to have overdosed on alcohol. In May, he was taken to Accident and Emergency when he slit his wrist. It was recorded that he was experiencing

"*suicidal ideas as part of a two week history of low mood / thoughts of life not worth living.*"

On 4 June 2010, Allyn had been drinking cider outdoors when he was arrested for failing to pay a fine for having no television licence, and, for the first time, was taken to Hydebank Wood Prison and Young Offender's Centre. It is recorded that, on arrival at the Prison, he was "*in a highly incensed state. Very volatile, frightened and confused……would not let anyone talk to him or touch him.*"

Allyn remained in prison until 10 June 2010 and was cared for, throughout, in the healthcare centre. A nurse said that "*he was hoping never to return to us again.*" When he left prison he visited a family friend who had known him since before the death of his mother. He told her that "*if he ever had to go back to prison he would kill himself.*" She said that Allyn didn't like to be on his own and when he visited her he would follow her around the house.

Allyn again overdosed on 26, 28 and 30 June 2010. He attended an Accident and Emergency Department on each occasion and was admitted to hospital overnight on 30 June 2010.

In the weeks before his death, Allyn was living in a hostel. His family said that on the day that he was committed to Hydebank Wood Prison and Young Offender's Centre he had given up his accommodation with the Simon Community in the hope that he could stay with his friend.

Following an incident on 27 July 2010, Allyn was arrested and spent a night in police custody before he was taken by the Police Service of Northern Ireland to Hydebank Wood Prison and Young Offender's Centre on 28 July 2010.

It is recorded that when escorting Allyn to prison the police provided his 'Prisoner Escort Record.' This includes eight tick box areas of risk which the police can tick if they think a person is *"reasonably suspected of being at exceptional risk."* Two of the boxes were ticked on Allyn's form, noting that

he was of an extremely violent nature and that he may have suicidal/self-harm tendencies (current or past). The reason recorded for highlighting these was *"DP (detained person) is violent will punch [the] wall when aggressive."*

The police medical form that accompanied the 'Prisoner Escort Record' also noted a *"strong smell of alcohol"* from Allyn and that he was *"extremely aggressive"* and *"threatening to jump off bed and hit his head."*

On committal, Allyn was, in line with Prison Service policy, interviewed and assessed by a nurse and then by an officer from the committal landing. The nurse who saw Allyn recorded that he had *"no thoughts of self harm"* and a *"history of alcoholism."* From her examination, the nurse found and recorded that Allyn was shaking and itchy, that he had a headache and anxiety, and that he had been suffering from night sweats – all of which are symptoms of alcohol withdrawal. The nurse was not trained in alcohol detoxification programmes but she contacted a prison doctor who advised her to address Allyn's detoxification by giving him 20 milligrams of Librium[1] three times a day, and Pabrinex, a vitamin B and C injection, three times a day for three days. Dr Seena Fazel, who carried out a clinical review of Allyn's care for the Prisoner Ombudsman, confirmed that this was an appropriate prescription.

A risk assessment for in-possession medication was carried out by the nurse and she recorded that Allyn did not have a history of self harm or overdosing on prescribed medication, but that he did have a history of depression and substance misuse/dependency relating to alcohol. At interview, the nurse said that her note in respect of self harming reflected what Allyn had told her. The nurse said also that she couldn't recall seeing Allyn's police 'Prisoner Escort Record,' which highlighted that he may have suicidal/self harm tendencies.

[1] Librium (Chlordiazepoxide) is a versatile therapeutic agent of proven value for the relief of anxiety commonly used in alcohol detoxification programs.

It is to note that Allyn's prison medical records, from his previous committal, referred to "*issues around self harm and suicide ideation*" and included details of one possible self harm episode in prison.

The nurse made a referral to AD:EPT[2] (who would see Allyn within 20 days of the referral) and put him on the list to be seen by a doctor the following morning. She also completed a 'Healthcare Residential Plan,' to provide the prison officers on Allyn's landing with information that she felt that they should be aware of. A copy of this Plan was not in Allyn's residential file, and, when asked, staff did not know why. Staff said, at interview, that they would not normally know when an inmate was on a detoxification programme. It would appear that where this information is recorded on a Healthcare Residential Plan, it is not communicated at shift handover.

After his healthcare assessment, Allyn was taken to Elm 1 Landing, the committal landing at that time. During his committal interview with an officer on the landing, Allyn said that he had alcohol withdrawal, that he had taken cocaine a couple of months previously, and that he had sniffed gas only a couple of days before. As a result of her conversation with him, the officer recorded that Allyn had a history of self harm, had attempted suicide in the past and had told her (incorrectly) that a SPAR[3] had been opened last time he was in prison. She recorded also that he did not have any current thoughts of self harm or suicide. The information shared with the officer by Allyn was not checked or shared with healthcare staff.

The officer found Allyn co-operative during the interview but said that he was anxious because he wanted to phone his friend. She helpfully allowed him to use the office phone to do this and said that afterwards, he was more content.

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2 AD:EPT Definition – **A**lcohol and **D**rugs: **E**mpowering **P**eople through **T**herapy, is a comprehensive substance misuse service, based in Hydebank Wood, that provide a multi component model of delivery.

3 SPAR – **S**upporting **P**risoners **A**t **R**isk is a process whereby staff can work together to provide care to prisoners/inmates who are in distress in order to help diffuse a potential suicide risk, or help individuals with long term needs (repetitive patterns of self harm and/or injury), to better manage and reduce their distress. Part of this process includes increased observations levels.

Governor's Order 0-13 'Committal to Landing' states that *"All new committals will be risk assessed on committal and a frequency of observation decided. Observations will be at intervals of no more than one hour but may be more frequent if decided. Where a risk assessment has not been carried out, observations will be at intervals of no more than 15 minutes."*

The officer who completed the committal interview with Allyn, recorded *"mood ok"* but noted also that this could change due to his alcohol withdrawal. She recommended that Allyn be observed at 15 minute intervals and this was agreed by a senior officer.

It is recorded in Allyn's observation booklet that 15 minute observations were carried out throughout the night and into the following morning. It is recorded also that Allyn was *"in bed,"* throughout the night and no concerns were noted.

The 'Committal and First Night Observation Support Record[4]' advises that if staff feel it is appropriate, they must open a Supporting Prisoner At Risk (SPAR) booklet *"immediately."* Whilst a decision was taken to observe Allyn at 15 minute intervals, no decision was taken to open a SPAR booklet.

Allyn's family asked whether or not he was on *"suicide watch."*

Commenting on the fact that a SPAR booklet was not opened for Allyn, Dr Fazel said *"it is difficult to know whether it would have been reasonable to open a SPAR document on the basis of Mr Baxter's committal interview."* He noted that Allyn "*denied suicidality*" to healthcare staff. Dr Fazel said, however, that *"If the information of Mr Baxter's escalation of self-harm in the weeks leading up to his committal was known (to prison healthcare,)"* it would have been reasonable to open a SPAR. He said also that *"if the information from police custody was available to prison medical staff, opening a SPAR would have been appropriate."*

[4] Committal and First Night Observation Support Record is contained in the Committal and First Night Observation Booklet which is a booklet that contains the information gathered during the reception process, the committal interview with landing staff, the inmate's vulnerability assessment and the first night observation support record.

The decision to open a SPAR can be taken by any staff member. The information relating to Allyn's recent escalation of self harming was not known to healthcare, but Allyn had told the landing officer of his history of self harming and there was evidence in his prison medical records. Neither the nurse nor the landing officer was aware of the information handed to the Prison by the police.

Because no contact was made with Allyn's GP during this or his earlier period in custody, relevant information relating to mental health, addiction and self-harming incidents from his community medical records, was not accessed and did not, therefore, trigger consideration of the need for a SPAR.

Dr Fazel said that if the above information was known, it would also have been appropriate to admit Allyn into the in-patient healthcare centre in order to manage his detoxification programme. He said that in Allyn's case *"attempts to contact his GP to request a summary of his community medical records could have been considered on the next working day (Thursday morning 29 July 2010.) They do not appear to have been requested. In addition, from the information available to me, they were not apparently requested in his previous prison spell."*

Dr Fazel concluded that *"More robust linking of community medical records with prison health would have been potentially important in Mr Baxter's case, and would likely have led to him being considered as being at suicide risk. The process of assessing and managing this risk in prison may have reduced Mr Baxter's suicide risk, although it is not possible to know if it would have prevented his death."*

It was, however, the view of the South Eastern Health and Social Care Trust that *"even with Allyn's history, taking into account that his presentation and assessment by both healthcare and discipline staff noted no suicidal ideation on committal, it is doubtful that a SPAR would have been opened by healthcare or discipline in the absence of suicidal intent."*

It is to note that on the night of 28 July, even if Allyn had been on an open SPAR, he is unlikely to have been observed more frequently than every 15 minutes, the arrangement put in place by landing staff. A SPAR should, however, have triggered multi-disciplinary case conferencing, the development of a care plan and a careful review of decisions to adjust the frequency of observation of Allyn.

On the morning of 29 July 2010, Allyn was seen by a doctor in relation to his alcohol detoxification programme and, whilst in the healthcare centre he received his Librium and Pabrinex injection.

At 09.15 on 29 July, a decision was taken to move Allyn to hourly observations. An officer recorded in Allyn's committal observation log at this time that he *"Spoke to young Baxter, said he had settled well, moved to hourly obs."*

On the morning of 29 July also, as part of the committal process, Allyn met a probation officer who said that Allyn had told her that his first night in custody had been fine and that he was of the mindset that he was not going to be in prison for very long because he would get bail to stay at his friend's house. The probation officer subsequently contacted Allyn's social worker who advised that she didn't think that Allyn's friend would be prepared to offer their address for bail, because of previous problems.

Allyn was also seen by a governor who said that he noticed that Allyn was wearing numerous tops and that his hands were shaking. The governor asked Allyn if he was cold and Allyn explained that he was "*coming off the drink*." The governor said that *"throughout the interview he (Allyn) was lucid, talked fluently and came across as being in good form. His interaction with me was relaxed and friendly."*

During the afternoon of 29 July, CCTV shows that Allyn ate his lunch in the recreation room whilst talking with other inmates from his landing and later had a visit from his friend. CCTV shows that the visit appeared to go well and Allyn and his friend can be seen laughing together.

Every effort was made to speak with Allyn's friend but unfortunately this was not possible.

After Allyn's visit, Allyn's committal observation log notes; *"16.00 - back in cell good visit"* and *"17.00 - Young Baxter in very good mood, said he has now settled after a visit from (his friend,) no issues or problems."* Hourly observation was then discontinued and Allyn moved on to the standard checks that apply to all inmates.

During evening association on 29 July, CCTV shows that Allyn and the rest of his landing ate their tea meals in the recreation room and, whilst talking with other inmates, Allyn watched inmates play table tennis matches before he returned to his cell.

At 18.09 on 29 July, Allyn made one phone call to his friend to discuss visit arrangements for the following day. Before the call ended, Allyn's friend asked if he was okay and he replied, *"Yeah, I'm fine, just I'll be getting locked up here, I'm just after my dinner and I've just got my injection, now I'm going to my bed."*

CCTV and records show that Allyn attended the healthcare centre during the afternoon and evening of 29 July, and on the morning, afternoon and evening of 30 July, to receive his alcohol detoxification medication.

During the morning of 30 July, CCTV shows that Allyn was in the recreation room between 08.29 and 08.35 for his breakfast and between 11.57 and 12.12 to have his lunch.

Between 13.55 and 14.41, Allyn attended a legal visit. At interview, his solicitor said that he told Allyn that his next court date was scheduled for 3 August 2010, when it was intended that an application for bail would be made. He said that the consultation went well and that Allyn was very pleasant and *"quite upbeat,"* even though he was informed that police would probably oppose the bail address that he was hoping to go to.

Allyn's solicitor told the investigation that even if bail had not been granted, he did not expect Allyn to receive a custodial sentence for the offences committed. He said that this was not discussed with Allyn.

At 17.55 on 30 July 2010, Allyn was moved to Elm 2 Landing, the assessment landing which all new committals progress to. There was no evening association on Elm 2 due to a restricted regime[5] as a result of staffing issues[6] and Allyn and other inmates were, therefore, given their tea meal and evening supper in cell.

On the morning of 31 July 2010, breakfast was served in cell. This was, again, due to a restricted regime as a result of staffing issues.

Between 09.44 and 10.15, Allyn had another visit from his friend. CCTV shows that, although there is less laughter than seen at the visit on 29 July, the visit appears to go well. Allyn's family said that his friend had told them that Allyn had been crying during this visit. Allyn cannot obviously be seen to be crying on CCTV, but it is not possible to say for sure that he wasn't.

During afternoon association on 31 July, CCTV shows that Allyn sat in the recreation room laughing and chatting with another inmate. Both Allyn and the other inmate watched the "winner stays on" table tennis matches that were played and at one point Allyn joined in with one of the games.

At interview, the inmate Allyn had been talking with said that it was the first time that he had spoken with Allyn. He said that Allyn *"was asking me what I was in for and how long I had left, and he was telling me what he was in for….We also talked about football. We are both Liverpool supporters, so we were talking about that for a bit. Allyn then said that he would see me tomorrow and that was the last time I saw him. Allyn seemed okay to me when I was talking to him."*

[5] When a landing has a restricted regime in operation, a minimum of four inmates are permitted to be out of their cell on a rolling basis, consisting of one landing orderly, one inmate using the phone, one inmate getting hot water and one inmate getting showered.

[6] Staffing issues are fully detailed on page 35 of Dame Anne Owers interim 'Review of the Northern Ireland Prison Service', which was published on 28 February 2011.

That afternoon, Allyn visited the healthcare centre to have his final Pabrinex injection. The nurse recorded in Allyn's medical records that *"Inmate appeared well settled, good eye contact and appropriate conversation. Inmate informed me that he was going to a 'dry' hostel and was hoping to address his alcohol issues. Inmate stated his mood was 'ok' at present and felt better after the course of Pabrinex. Advised would continue detox regime, and would see healthcare daily re same. Inmate compliant, and thanked me for everything I had done for him."*

At interview, the nurse said that Allyn *"was hoping to get out and change his life."*

Given that Allyn's solicitor had told him the day before that Allyn's friend had agreed that her address could be given as a bail address, although this was unlikely to be acceptable, it is unclear why Allyn told the nurse that he was going to a dry hostel or when he had decided this. It is possible that this was discussed with his friend during his morning visit. There is some evidence in later phone calls that this may have been the case.

Evening association on 31 July was again restricted as a result of staffing issues.

The investigation found that Allyn was locked from 17.50 on 28 July, following his committal interviews, for 14 hours and 40 minutes. On the following two days, over and above fetching hot water and having a shower, he spent two hours and 34 minutes and two hours and three minutes respectively, out of his cell. The investigation found that no arrangements are in place to provide purposeful activity for newly committed inmates at Hydebank Wood, over and above very limited periods in the recreation room. Use of the gym is permitted after an assessment, but this may take up to seven days. Allyn was not assessed to use the gym.

At interview, a senior officer confirmed that the only time inmates would normally be allowed into the recreation rooms was for the evening association period, where this was not restricted because of staffing issues.

He said that unless an inmate had to use the shower or had a job or appointment to attend in the mornings / afternoons, they would normally be locked. It was established that it takes up to 28 days for a new inmate to attend a Resettlement Board, where a plan for engagement in purposeful activity is developed.

On the evening of 31 July when Allyn was found, he had been out of cell for one hour and 44 minutes during the day. Allyn was locked in his cell from 15.32, other than to shower, get hot water and use the phone. Tea and evening supper were served in-cell.

Between 18.03 and 18.08 on 31 July, Allyn made three short phone calls to his friend.

All three calls were troubled because of problems personal to them and Allyn was upset. It was evident that Allyn did not want to fall out with his friend and during the final call he said "*I'm phoning to talk to you with my last f***g 21p I have on my phone, do you want to spend the 21 seconds I have shouting at me?*" The arguing continued and the final call ended with Allyn saying *"no sweat then, have a good life."*

A review of Allyn's phone credit shows that he had £2.11 left on his phone balance. It appears to be the case that Allyn glanced at the screen and misunderstood how much credit he had left.

At about 20.50 on 31 July, Allyn had a conversation through his cell wall with an inmate in one of the cells next to his. At interview, the inmate said, *"We talked about the fact that there wasn't anything good on TV and he told me that he didn't think that (his friend) was talking to him. He told me that he was away to write a letter, and that was the last I heard from him."* The inmate said that Allyn *"didn't sound depressed in any way"* and that he sounded as though he was just going to go and write a normal letter.

At about 21.10 on 31 July, another inmate on the landing asked a night custody officer to ask the rest of the landing whether they could lend him a

cigarette. In his staff communication sheet[7], the night custody officer said that he shouted the request out to the landing and Allyn offered a cigarette. He said that when the cigarette was retrieved from Allyn, he *"was very pleasant"* and said that the inmate *"could pay him back anytime."*

Approximately 25 minutes later, at around 21.35, an in cell alarm was activated in Elm House. At interview, the inmate on the other side of Allyn said that he heard *"two loud gasps of air and a low cry for help and what sounded like a chair moving across the floor."* He said that he got up straight away and pressed his cell buzzer because *"it sounded like someone in the cell next to me was having an asthma attack."* Having obtained a response from his friend in the cell next to him, the inmate said that he knew that it was Allyn who sounded as though he was in trouble. The inmate said that he stood at his door for approximately five minutes until a member of staff responded to the activated alarm.

During a night shift, there are usually three members of staff supervising the Special Supervision Unit (SSU), Elm Landings 1, 2, 3 and 4 and Willow Landings 1, 2 and 3. On the night of 31 July 2010, a member of staff was injured and went home early, leaving two officers. As a result, the officer who was originally supervising the SSU and Elm 1 Landing, also had the responsibility of supervising Elm Landings 2, 3 and 4. This officer based himself in the office on Elm 1 Landing because it meant he was closer to the new committals on that landing, who require more frequent observations.

When a cell alarm is activated, it could be on any one of the Elm and Willow Landings including the SSU and can be heard across all of them. There are panels in some landing offices to indicate to staff on which landing an alarm has been activated, as well as a light that illuminates outside the cell and a light that illuminates at the end of the landing on which the cell is located.

Both officers on duty on July 31 2010 were in the office on Elm 1 Landing when Allyn's neighbour activated his alarm. The Elm 1 Landing office does

[7] Staff Communication Sheets are written reports/statements completed by officers involved in incidents.

not have a panel to indicate where a cell alarm has been activated and the officers did not, therefore, know immediately to which landing they needed to respond. This led to a short delay in an officer establishing that the alarm had been raised on Elm 2 Landing.

When the officer arrived at Elm 2 Landing he saw the landing light was illuminated confirming that the alarm had been activated on that landing, but that there was no light outside any cell to indicate where he needed to go. It was the case that the bulb in the light on the cell door which illuminates when the alarm is activated, had blown. The officer said that he started to check each cell and, when he was a third of the way down, he shouted to find out who had activated the alarm.

Having been alerted to which cell he needed to check, the officer looked into Allyn's cell and was able to see that Allyn was hanging. The officer immediately radioed for assistance so that an emergency unlock, which requires two officers, could be carried out.

At interview, the officers explained in detail how Allyn had managed to hang himself and the action that they took to remove the ligature.

The officers said that as they were placing Allyn on the floor in preparation for Cardiopulmonary Resuscitation (CPR) to commence, a senior officer and healthcare officer arrived in response to the emergency radio transmission.

At interview, the healthcare officer said that when he looked at Allyn he knew it was a *"very serious situation.....because he (Allyn) was cyanosed[8], he didn't respond to me speaking or anything like that. I opened his airway, checked for his breathing, and checked his carotid artery for his pulse. I found nothing."* He said that he requested an ambulance immediately and, along with the assistance of one of the officers, commenced CPR until the paramedics arrived.

[8] Cyanosed – The healthcare officer described Allyn's lips and ears being blue in colour because of the lack of oxygen in his blood.

It is recorded that at 21.58, the first of three ambulance crews arrived at the prison and at 22.49 Allyn was taken by emergency ambulance to the Royal Victoria Hospital.

The absence of a panel in Elm 1 Landing office to show the location of the activated alarm and the failure of the light to illuminate outside the cell where the alarm was activated, resulted in a delay of approximately five minutes in staff getting to Allyn. Cell alarms are activated for many reasons and, under normal circumstances and particularly when staff are busy, a delay of approximately five minutes would not be significant.

Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh was asked to comment on whether the delay would have been materially relevant to the outcome of the resuscitation efforts.

Mr Brackenbury concluded that the delay, in these circumstances, might have been relevant. He said that *"If the inmate had shut down the circulation to the brain, then a 5-minute delay before restoration of the cerebral circulation would be materially relevant to the outcome of resuscitative efforts. The staff and paramedics did well to restore cardiac output but unfortunately the brain is so sensitive to a lack of oxygen that a few minutes without blood flow to the brain at normal body temperature invariably results in irreversible brain damage."*

Whilst Allyn was being worked on, one of the night custody officers checked his cell for a letter or note indicating that he may have been considering dying by suicide. A note was found on his bench addressed to his family. Allyn wrote that he was sorry for all the heartache that he had caused and that he loved them all.

Commenting on Allyn's death, Dr Fazel said that there were a number of factors that increased his risk of death by suicide in custody. These included a history of severe disruption in childhood including the death of his mother, being fostered around 12 times, a past history of polysubstance abuse and a past and very recent history of deliberate self-harm.

Dr Fazel pointed out that Allyn also had a number of recent stressors that included returning to custody (which he told a close friend would lead to him taking his life), having no accommodation and recent problems in his relationship with his friend.

Dr Fazel said that the combination of all these factors and the trigger of an argument with his friend could explain his death by suicide. He said also that if the argument was a trigger, then his death "*comes across as a relatively impulsive fact.*"

The investigation found that it was clearly the case that Allyn's demeanour when he spoke with staff, during his time in prison, did not lead to concerns about his immediate well being.

It was, nevertheless the case that Allyn was vulnerable and that this was not fully identified. In particular, for the reasons detailed earlier, important information relating to Allyn's history of polysubstance abuse and past and very recent history of deliberate self-harm, was not accessed. Some information that was available was overlooked, or was not shared between those involved in his care. If Allyn's vulnerability had been recognised, his risks might have been managed differently.

One third of suicides in England occur within the first seven days of an inmate being committed. This is the second consecutive Prisoner Ombudsman death in custody report where the death of a vulnerable prisoner/ inmate in Northern Ireland has occurred within five days of committal. In both of these deaths, the prisoners spent excessively long periods alone in their cells.

Research has indicated that time out of cell and higher rates of purposeful activity and human contact are associated with lower levels of self-inflicted deaths. It is not possible to know whether the outcome for Allyn would have been any different if he had spent less time confined to cell. However the fact that any newly committed 19 year-old spends so little time out of cell and has such limited access to purposeful activity, is a matter of concern.

In the case of Allyn, he was also dealing with the symptoms of detoxification and there is some evidence, though staff were not to know this, that he disliked being alone.

It is to note that before and after his last phone call at 18.08, during which he was heard to be upset, Allyn was again locked in his cell. Three hours later he mentioned, through the wall to another inmate that he didn't think his friend was talking to him.

In her interim 'Review of the Northern Ireland Prison Service' (28 February 2011), Dame Anne Owers states that *"it is evident that, in spite of significant financial resources expended, Northern Ireland's prisons have been unable to run acceptable, consistent and positive regimes. This varies between and within the three prisons, but is a fundamental problem in them all."*

It was very unfortunate that a combination of factors led to a delay of approximately five minutes in Allyn being found, after the alarm was raised. I am aware that the two officers who found Allyn were greatly distressed by his death. The investigation found that the two officers did everything they reasonably could to assist Allyn and noted also the efforts made by one of the officers, who accompanied Allyn to hospital, to encourage the removal of bed watch officers from hospital, out of respect and compassion for Allyn and his family.

It is to note that when I met with Allyn's family to share the findings of this investigation, they expressed their gratitude for the efforts of the staff who found Allyn and tried to resuscitate him and also for the kindness and support of the officers who were present at the hospital.

During the investigation, concerns were identified in connection with the immediate support that is provided to staff involved in a very serious incident such as this and these are explained in the report.

ISSUES OF CONCERN REQUIRING ACTION

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

1. The 'Prisoner Escort Record' provided by the PSNI at the time of Allyn's committal to Hydebank Wood was not made available to the nurse officer who carried out Allyn's Healthcare Committal Assessment.

2. Allyn's previous prison medical records were not fully considered at his Healthcare Committal Assessment.

3. The nurse officer, who carried out Allyn's Healthcare Committal Assessment on 28 July 2010, had received no training in detoxification.

4. The healthcare officer, who was the only member of healthcare staff on duty on the night of 31 July 2010, had received no training in the use of Automated External Defibrillators.

5. No contact was made with Allyn's General Practitioner.

6. Information relevant to the assessment of Allyn's vulnerability was not shared with healthcare staff by discipline staff.

7. Allyn's statement that he was previously on a SPAR was not checked.

8. Allyn's Healthcare Residential Plan was not shared at shift handover.

9. On his first night, Allyn was locked for 14 hours and 40 minutes when he had recently been commenced on a detoxification programme

and was experiencing symptoms of detoxification, with checks being carried out by staff who had not received any training in the symptoms of detoxification and the circumstances in which assistance should be sought from healthcare staff.

10. There was a five minute delay from Allyn being found to an ambulance being called.

11. The staff who found Allyn were not adequately supported immediately following the incident. One member of staff was sent to hospital with Allyn and remained on bed watch duties for two nights.

12. Hot de-brief arrangements did not provide staff with 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."*

13. The Cold De-brief was not *"comprehensive"* and did not provide an opportunity for those directly involved to *"share their thoughts with colleagues on the circumstances and their role and involvement."*

14. Apart from accessing the shower and telephone, Allyn was locked for between 21 and 22 ½ hours on each of the three full days he was in Hydebank Wood.

15. There is no programme of purposeful activity for newly committed inmates in Hydebank Wood. Inmates wait up to 28 days to attend a Resettlement Board for a Resettlement Needs Profile to be produced.

16. Gym assessments at Hydebank Wood only take place on a Wednesday. Newly committed inmates may not use the gym until they are assessed.

17. The £1 phone allowance provided for newly committed inmates provides very limited opportunity to talk to family members at a time when they may be very vulnerable.

18. Opportunity Youth did not visit Allyn to carry out an assessment within 48 hours of his committal *"because of staff absences."*

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[9] for Northern Ireland, I have responsibility for investigating the death of Mr Allyn James Baxter. 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 Allyn'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 operational methods, policy, practice or management arrangements could help prevent a similar death in the future;

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

- to ensure that Allyn'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.

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 a prisoner/ 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 Allyn's family on 23 August 2010 and my investigators were grateful for the opportunity to keep in contact with them and to update them on the progress of the investigation. On 1 June 2011, I met with Allyn's family to explain and discuss the findings and recommendations within this report.

8. It was important for the investigation to learn more about Allyn's background history and personal circumstances before he died. I would like to thank Allyn's 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 Allyn's family in mind. It is also written in the trust that it will inform policy or practice, which may help to prevent a similar death in the future at Hydebank Wood Prison and Young Offender's Centre or any other Northern Ireland Prison Establishment.

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

- Was Allyn assessed properly when he was committed to Hydebank Wood?
- Was Allyn given any medication and was this appropriate and adequate?
- Was Allyn on suicide watch and if so were the appropriate checks carried out?
- Was Allyn locked up in a cell on his own?

INVESTIGATION METHODOLOGY AND PRISON RULES

Notification

11. In the early hours of Sunday 1 August 2010, the Prisoner Ombudsman's office was notified by the Northern Ireland Prison Service that Allyn had hung himself and was in the intensive care unit at the Royal Victoria Hospital. On 3 August 2010, the Prisoner Ombudsman's Office was notified that Allyn's life support machine had been turned off and that he had died.

Notices to Prisoners/Inmates

12. On 4 August 2010, Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners/inmates at Hydebank Wood Prison and Young Offender's Centre announcing the Prisoner Ombudsman's investigation and inviting anyone with information relating to Allyn's death to contact the Investigation Team. No responses were received.

Prison Records and Interviews

13. All of the prison records relating to Allyn's period of custody were obtained.

14. Interviews were carried out with prison management, staff and inmates, in order to obtain information about the circumstances surrounding Allyn's death.

Telephone Calls

15. Records show that Allyn made four telephone calls during his custodial period between 28 July and 31 July 2010. Recordings of these calls were obtained.

CCTV Footage

16. CCTV cameras are not situated on the landings where Allyn was located, however, CCTV from the recreation rooms captures a small part of the landing and, therefore, on occasions shows Allyn's movements to and from the landing. When Allyn returns to the landing, other than to make a phone call or use the shower, he is more than likely returning to his cell.

Autopsy & Toxicology Report

17. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy and toxicology report.

Clinical Review

18. As part of the investigation into Allyn's death, a clinical review was commissioned to examine Allyn's healthcare needs and the medical treatment he received in Hydebank Wood.

19. I am grateful to Dr Seena Fazel, Consultant Forensic Psychiatrist and Clinical Senior Lecturer in Forensic Psychiatry at the University of Oxford, who carried out the clinical review.

20. Dr Fazel'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.

21. I am also grateful to Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, who was asked to comment on two specific areas of the investigative findings.

Hydebank Wood Prison and Young Offender's Centre, Prison Rules and Policies

22. Background information on Hydebank Wood Prison and Young Offender's Centre and a summary of Prison Rules and procedures referred to in the report are attached at Appendix 2.

Factual Accuracy Check

23. 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.

24. The Prison Service and Trust responded with a list of comments for my consideration.

25. I have fully considered these comments and made amendments where I felt that this was appropriate.

FINDINGS

SECTION 1: BACKGROUND INFORMATION

1. Allyn Baxter

Allyn Baxter was 19 years old when he died on 3 August 2010 in the Royal Victoria Hospital. The Prisoner Ombudsman is very grateful to Allyn's father, sister and two brothers for sharing information about his life.

When Allyn was six years old, his mother died and he was then cared for by his aunt in Scotland. Because of difficulties arising from his use of solvents, Allyn moved back to Northern Ireland two years later and, over the following years, stayed with approximately 12 different foster families. He had a period of residential care when he was aged 13 to 14.

Allyn's family said that, over the years, he had a number of social workers, a child counsellor and a psychiatrist and had worked with CAHMS, a bereavement counselling service.

Allyn remained with his final foster carers from the age of 14 to18. He obtained a number of GCSE's including Science and then completed an NVQ in Health and Social Care before leaving school at the age of 16, with a good school report.

After school, Allyn worked as a butcher's assistant and a waiter, but his employment stopped in 2008 and he was subsequently in receipt of Jobseeker's Allowance.

Allyn had a history of substance misuse that started when he was very young. Over time, Allyn's family said that he misused a variety of drugs and was drinking increasingly large amounts of alcohol.

Allyn's family also said that Allyn had a significant history of self harm, which often occurred when he was under the influence of alcohol and/or drugs. Examples given of Allyn's self harming included instances of overdosing and an incident in 2008 when Allyn threatened to jump off a bridge and police negotiators were needed to bring him down. Allyn's medical records confirm his past history of solvent abuse, alcohol abuse and polysubstance abuse. They also confirm a significant history of self harm.

In February 2010 it is recorded that Allyn had debts of around £800.

Allyn's medical records demonstrate an escalation in his self harming episodes in 2010. In April 2010, he attended Accident and Emergency having collapsed and was thought to have overdosed on alcohol. On 22 May 2010, he attended Accident and Emergency having cut his wrist. He told the Accident and Emergency nurse that he planned to jump off the balcony of his 14th story flat and it is recorded that he was *"experiencing suicidal ideas as part of a two week history of low mood/thoughts of life not worth living."*

The records also show that Allyn overdosed on drugs and alcohol on 26 June 2010, 28 June 2010 and 30 June 2010, which resulted in him attending Accident and Emergency on each occasion and being admitted to hospital overnight on 30 June 2010. After the incident on 26 June, a mental health assessment concluded that the overdose was impulsive, without planning.

Immediately before his committal to prison, Allyn was living in a hostel. His family said that on the day that he was committed to Hydebank Wood Prison and Young Offender's Centre, Allyn had given up his accommodation with the Simon Community in the hope that he could stay with his friend.

Following an incident on 27 July 2010 Allyn was arrested and spent a night in police custody before he was taken by the Police Service of

Northern Ireland to Hydebank Wood Prison and Young Offender's Centre on 28 July 2010.

At the time of his death Allyn had a three year-old son, from a previous relationship and it is noted on his medical records in June 2008 that Allyn maintained regular contact with him.

2. Allyn's Previous Custodial Period – June 2010

Allyn had one previous custodial period between 4 and 10 June 2010. He had been out drinking cider when he was arrested and taken to Hydebank Wood for failing to pay a fine for having no television licence.

On 4 June, as part of the committal process, Allyn was assessed by a nurse who recorded on his medical notes that he was brought to the healthcare centre *"in a highly incensed state. Very volatile, frightened and confused……This inmate will require an IMR3*[10] *completed in the AM by the GP (as) it was not possible to do this on committal as he would not let anyone talk to him or touch him. His mood was reactive and his actions too volatile. He also head butted the wall in reception and put his fists into the plaster…these will need to be examined and treated."* The nurse recorded that she was *"unable to reason with Allyn at first, but then (he) appeared to respond better to myself as a female. (Allyn) seemed genuinely frightened of male staff (and) calmed down when given time to ventilate and explanations of why he is here."*

The nurse also recorded that Allyn was a moderate drinker, drinking three to six units of alcohol per day, as well as smoking 20 cigarettes daily. She noted that he had no thoughts of self harm and that he had used cannabis in the past month.

The nurse made two referrals, one to the prison doctor regarding Allyn's physical health and one to the mental health team. She also noted that Allyn had a psychiatrist's appointment in Lagan Valley Hospital and that a medical/psychiatric report should be obtained. Records indicate that a medical/psychiatric report was not obtained.

[10] An IMR3 form is filled out on committal when an inmate makes an allegation of ill-treatment against the PSNI. There is no evidence in Prison Records that Allyn subsequently made a complaint about his alleged treatment by the Police Service of Northern Ireland.

Ten milligrams of Librium, which is used to relieve anxiety and to control agitation caused by alcohol withdrawal, was administered. No further Librium was given to Allyn during this committal period. A senior nurse officer said that *"Allyn was in a very agitated state on his first night in custody and for this reason Librium was given. However, he then remained very settled for the remainder of that committal period and required no further intervention of that kind."*

Following Allyn's committal health assessment he was taken to Elm 1 Landing, the committal landing at that time, where a further committal interview was conducted by a prison officer. During this interview the prison officer requested a member of healthcare to speak with Allyn.

Another nurse spoke with Allyn and it is recorded on Allyn's medical records that during his *"committal interview on Elm 1, (Allyn) stated that he had issues around self harm and suicide ideation – he was unsure of whether he would self harm."* Following a conversation with Allyn the nurse noted that Allyn *"obviously had a plethora of issues around broken family relationships and social problems, as well as a history of 'depression' although this is untreated."* She also recorded that she got *"the impression that he was NOT actively suicidal nor indeed (that he) would resort to self harm."* She noted that there was *"no valid reason"* for putting Allyn on a SPAR[11], but despite this he was housed overnight in the healthcare centre *"for observation only"* until he could be seen by a member of the Mental Health Team the next day.

The following day, it is recorded that Allyn was *"very settled overnight (and) a different person"* and that he was appreciative of the help given to him the night before. A doctor assessed Allyn's injuries, which

[11] SPAR – **S**upporting **P**risoners **A**t **R**isk is a process whereby staff can work together to provide care to prisoners who are in distress in order to help diffuse a potential suicide risk, or help individuals with long term needs (repetitive patterns of self harm and/or injury), to better manage and reduce their distress. Part of this process includes increased observations levels.

included *"reddish contusions of the forehead and anterior calves and abrasions of the wrists."* Allyn declined any pain relieving medication. Allyn spent the remainder of this custodial period in the healthcare centre and records note that he was apologetic for his behaviour, remained settled and that no further medical assessments, interventions or medication was provided.

At interview, a nurse said that Allyn *"was so apologetic and we had no problems with him at all and we kept him (in healthcare because) he didn't want to go onto the landings. I felt it was a bit manipulated but he wasn't any big harm to us. He was just new in so we thought, well look, why not just keep him in the hospital and he can do his time here and then out…He was hoping to never to return to us again."*

Following Allyn's release, Allyn visited a close family friend who he had known since before the death of his mother. At interview, the friend said that when talking about his time in Hydebank Wood, Allyn told her that *"if he ever had to go back to prison he would kill himself."* She said that Allyn didn't like change but that if he knew he had to do something the day before, then he could cope with this. She said that when Allyn was arrested in June and taken straight to Hydebank Wood, it really affected him and he couldn't cope.

The friend also said that Allyn didn't like to be on his own and said that when he would visit her he couldn't sit and watch TV, but would instead follow her around the house.

SECTION 2: ALLYN'S COMMITTAL TO HYDEBANK WOOD – 28 JULY 2010

3. Committal Procedures

Reception Process

At approximately 15.20 on 28 July 2010, Allyn was committed to Hydebank Wood Prison and Young Offender's Centre having been arrested the previous night for disorderly behaviour, assault on police and resisting arrest outside his friend's address.

It is recorded that Allyn co-operated fully in providing reception staff with the information they required, including next of kin details, court details, professional contacts and the name and address of his social worker. It is recorded that Allyn said that he did not have any issues in respect of legal matters, prison confinement or cell sharing.

It is also recorded that the police provided Allyn's Prisoner Escort Record, which is a form completed by the police for all detained persons transferred from a place of custody to another location. There are eight tick box areas of risk on the form which the police can tick if they think the person is *"reasonably suspected of being at exceptional risk."* Two of these boxes were ticked on Allyn's form; the first noting that Allyn was of extremely violent nature and the second that he may have suicidal/self-harm tendencies (current or past). The reason given for highlighting these was *"DP (detained person) is violent and will punch the wall when aggressive."*

The police medical form that accompanied the Prisoner Escort Record also noted a *"strong smell of alcohol"* from Allyn and that he was "*extremely aggressive*" and *"threatening to jump off bed and hit his head."*

Healthcare Committal Assessment

Following the reception process, a healthcare assessment takes place in the healthcare centre.

Between 17.00 and 17.33, Allyn had his committal healthcare assessment. The nurse, who knew Allyn from his previous committal, recorded that Allyn had *"no thoughts of self harm"* and a *"history of alcoholism"* from the age of 13, becoming more severe from the age of 17. She noted that Allyn was drinking six litres of cider per day, the week before he was committed. From her examination, the nurse found and recorded that Allyn was shaking and itchy, that he had a headache and anxiety and that he had been suffering from night sweats, all of which are symptoms of alcohol withdrawal. The nurse had no training in detoxification programmes but contacted a prison doctor who advised her to give Allyn 20 milligrams of Librium three times a day and Pabrinex, a vitamin B and C injection, three times a day for three days. In his clinical review report, Dr Seena Fazel confirmed that this was an appropriate prescription.

A risk assessment for in-possession medication was also carried out by the nurse and she recorded that Allyn did not have a history of self harm or overdosing on prescribed medication, but that he did have a history of depression and substance misuse/dependency, relating to alcohol.

The nurse concluded that Allyn was suitable to have his medication as 'daily in-possession.' This meant that each morning, Allyn would visit the healthcare centre to obtain his Librium medication for the day and have the first of his three Pabrinex injections. Allyn would then need to make two further visits to healthcare at lunchtime and in the evening to receive his other two injections.

The committal nurse also recorded that Allyn was issued with his Librium and Pabrinex whilst he was with her and that she advised

him that he should take a light diet and increase his fluid intake. A referral was made to AD:EPT[12] and Allyn was put on the list to be seen by a doctor the following morning.

At interview, the nurse was asked why she had recorded that Allyn did not have a history of self harm or overdosing on prescribed medication. The nurse said that she recorded this because that was what Allyn had told her. She said that she couldn't recall seeing Allyn's police Prisoner Escort Record form which, as stated earlier, highlighted that Allyn may have suicidal/self harm tendencies. The nurse said that it was common for healthcare not to have sight of this form at the time of the healthcare committal interview.

It is to note that Allyn's prison medical records, from his previous committal noted that he had *"head butted the wall in reception and put his fists into the plaster."* It is also recorded in his medical notes that Allyn *"had issues around self-harm and suicide ideation."*

A Healthcare Residential Plan was completed by the nurse. Its purpose is to provide the prison officers in a residential location with information that a nurse feels they should be aware of. The nurse noted that Allyn had a long history of alcohol abuse and that he was on an alcohol detoxification program. The plan instructed prison officers to ensure that fluids were in Allyn's room at all times and to report any change in his mood or behaviour to the healthcare centre. At interview, the nurse officer said that a copy of this plan was handed to prison staff on Elm 1 Landing, the committal landing where Allyn was first located and should have been placed in his residential file. A copy of this Healthcare Residential Plan was not in Allyn's residential file and when asked, staff did not know why. At interview, staff said that they would not normally know when an inmate was on a detoxification programme. It would appear that even where an

[12] AD:EPT Definition – **A**lcohol and **D**rugs: **E**mpowering **P**eople through **T**herapy, is a comprehensive substance misuse service, based in Hydebank Wood, that provide a multi component model of delivery.

officer carrying out a committal interview is aware of the information, it is not routinely communicated during shift handovers.

Residential Committal Interview

Following a healthcare assessment, a committal interview takes place with staff on the committal landing.

At 17.34, CCTV shows that Allyn was brought into the landing office on Elm 1 for his interview. It is recorded in Allyn's 'Committal and First Night Information Booklet[13]' by the interviewing prison officer that Allyn had alcohol withdrawal and that healthcare were aware of this. When asked about his substance misuse, it is recorded that Allyn told the prison officer that he had taken cocaine a couple of months previously, sniffed gas only a couple of days before and considered himself to be addicted to alcohol.

It is to note that Allyn's did not share with the committal nurse the information about his use of drugs.

In connection with Allyn's risk of self harm or suicide, the prison officer recorded that Allyn had been on a SPAR when previously in Hydebank Wood in June 2010. At interview, the officer said that this was recorded because Allyn told her that he had been on a SPAR.

As a result of the conversation with Allyn, the officer also noted that Allyn had a history of self harm and had attempted suicide in the past. This was at odds with the information recorded during the 'Risk of In-Possession Medication Assessment' conducted by the nurse earlier.

The prison officer recorded that Allyn did not have any current thoughts of self harm or suicide but that he had known mental and

[13] Committal and First Night Information Booklet is a booklet that contains the information gathered during the reception process, the committal interview with landing staff, the inmate's vulnerability assessment and the first night observation support record.

physical health problems. No details of these problems were recorded. At interview, the officer said that further details must not have been provided by Allyn and that if he had said more, she would have recorded the information.

The 'Vulnerability Assessment' section of the 'Committal and First Night Information Booklet' records that there were no known recent life experiences that may have increased the risk of Allyn self harming such as bereavement, parental separation or a broken relationship and records that Allyn did not express any concerns about his detention to the officer. The officer recorded that Allyn was co-operative but anxious, during his interview.

At interview, the officer said that Allyn's anxiety was because he wanted to make a phone call to his friend. She said that she permitted Allyn to call his friend from the phone in the office. The officer said that the phone call lasted a couple of minutes and Allyn was anxious to know if his friend was going to visit him. The officer said that it was obvious from what Allyn was saying that his friend was going to visit him, and he seemed more content after the phone call.

Even though Allyn had said that a SPAR had been opened when he was previously in prison, the information obtained by the prison officer about this and about Allyn's use of drugs and history of self harm was not checked or shared with healthcare staff. In the event, it was the case that a SPAR was not opened during Allyn's previous committal.

As noted earlier, during Allyn's previous committal, a prison officer alerted healthcare staff when he identified possible concerns during his committal interview with Allyn. The investigation found that the practice in respect of the communication of relevant information between discipline and healthcare staff, was not consistent.

At 17.50, Allyn left the office with his tea and went to his cell. Allyn's family asked if he was locked in a cell on his own and, unlike in other prisons, it is the case that inmates in Hydebank Wood do not need to share cells because there is the capacity to provide all inmates with their own cell.

Referral to AD:EPT

Information provided by Hydebank Wood's AD:EPT Manager states that the committal nurse's referral was received on 29 July 2010 and that Allyn was placed on their waiting list, with a view to him being seen within 20 days of the referral.

4. Allyn's First Night

First Night Association

The investigation established that, at the time of Allyn's committal, Hydebank Wood had an unwritten policy of keeping all newly committed inmates in their cells for the first 12 hours, or until staff deemed it safe to allow them to associate with others. In the 2008 Criminal Justice Inspection report of Hydebank Wood, it stated that this practice was *"unnecessary."*

Following his committal interview on 28 July 2010, Allyn remained locked in his cell from 17.50 to approximately 08.30 the following morning. It was in fact the case that there was no association for any of the inmates on Elm 1 Landing that night, due to an ongoing problem of inmate lockdowns and regime restrictions resulting from staffing issues[14].

Allyn had a television in his cell and was provided with Hydebank Wood's committal DVD and Information Booklet.

It is to note that the week after Allyn was committed to Hydebank Wood the committal landing was moved to Beech House. Unlike Elm House, Beech House has an office where CCTV can be continuously monitored. Following a risk assessment, newly committed inmates can, therefore, associate as soon as possible with other inmates.

First Night Observation Levels

Governor's Order 10-13 'Committal to Landing' states that *"All new committals will be risk assessed on committal and a frequency of observation decided. Observations will be at intervals of no more than one hour but may be more frequent if decided. Where a risk*

[14] Staffing issues are fully detailed on page 35 of Dame Anne Owers interim 'Review of the Northern Ireland Prison Service', which was published on 28 February 2011.

assessment has not been carried out, observations will be at intervals of no more than 15 minutes."

All staff responsible for committal landings must record all observations and interactions that take place during this initial period and note any concerns.

The officer who completed the committal interview with Allyn, recorded *"mood ok"* but noted also that this could change due to his alcohol withdrawal. She recommended that Allyn be observed at 15 minute intervals and this was agreed by a senior officer.

It is recorded in Allyn's observation booklet that 15 minute observations were carried out throughout the night and into the following morning. No concerns were noted and it is recorded that Allyn was *"in bed"* throughout the night.

Use of SPAR Booklet

Allyn's family asked whether or not he was on *"suicide watch."* It is recorded in the 'Committal & First Night Observation Support Record[15]' that if staff feel it is appropriate, they must open a SPAR booklet *"immediately."* Whilst a decision was taken to observe Allyn at 15 minute intervals, no decision was taken to open a SPAR booklet.

Commenting on the fact that a SPAR booklet was not opened for Allyn, the clinical reviewer, Dr Fazel said *"On the basis of the background history, Mr Baxter had a number of risk factors that indicated an increased risk of suicide in custody. These included a history of attempted suicide and alcohol use problems – which are strong, although not specific, risk factors for suicide in custody*

[15] Committal and First Night Observation Support Record is contained in the Committal and First Night Observation Booklet which is a booklet that contains the information gathered during the reception process, the committal interview with landing staff, the inmate's vulnerability assessment and the first night observation support record.

according to a comprehensive review of the international evidence published in the 'Journal of Clinical Psychiatry' in 2008."

Dr Fazel said that *"it is difficult to know whether it would have been reasonable to open a SPAR document on the basis of Mr Baxter's committal interview and his previous medical records – as they suggest one possible self-harm episode on his previous prison spell (head banging in his cell) and he apparently denied suicidality on committal, to healthcare staff."*

Dr Fazel said that it would have been appropriate to open a SPAR *"if the information of Mr Baxter's escalation of self-harm in the weeks leading up to his committal was known to prison healthcare staff."* (Allyn had, as explained in section 1, overdosed on drugs and alcohol three times in June 2010.) He said also that *"if the information from police custody was available to prison medical staff, opening a SPAR would have been appropriate."*

Whilst healthcare staff could not reasonably have been expected to have accessed information from Allyn's GP on his first night in custody, the information recorded by the doctor who examined Allyn whilst he was in the custody of the Police Service for Northern Ireland, was handed to prison staff. Allyn's previous prison records could also have been accessed. It was also the case, as noted earlier, that Allyn had told the prison officer who carried out his residential committal interview that he had a history of self harm and had attempted suicide in the past

Opening a SPAR booklet would not have changed the frequency of observation of Allyn on his first night, but would have led to a multi-disciplinary case conference, the development of a care plan, the appointment of a case manager and a careful review of decisions to adjust the frequency of observation of Allyn. It should also have emphasised the need for his GP records to be requested at an early opportunity.

It is to note that the SPAR booklet lists features that may impact on the likelihood of self harm. These include:

- Previous history of self harm or suicide ideation
- A history of mental ill health
- Risk identified by police, probation, family or staff

The "Assessment Interview" section of the booklet also identifies drug/alcohol dependence as a risk factor.

SECTION 3: 29 JULY 2010

5. Key Events of 29 July 2010

Consultation with a Prison Doctor

At approximately 08.30 on 29 July, as requested by the nurse the previous day, Allyn was seen by a doctor to review his alcohol detoxification programme. The doctor recorded in Allyn's medical records *"alcohol abuse – longstanding – detox. – TO HAVE PABRINEX DAILY FOR 3 DAYS – explained the use of diazepam[16] – bit shaky but quite calm this morning."*

Records state that Allyn received his Librium and morning Pabrinex injection whilst in the healthcare centre.

Contact with GP

There is no evidence from Allyn's medical records or from interviews that his GP was contacted.

Other information about Allyn's recent self-harming that might have led to consideration of the need for a SPAR was, therefore, never accessed.

In his clinical review report, Dr Fazel stated that *"In Mr Baxter's case, with a known history of alcohol dependence (and one possible self harm episode in prison), attempts to contact his GP to request a summary of his community medical records could have been considered on the next working day (Thursday morning 29 July 2010.) They do not appear to have been requested. In addition, from the information available to me, they were not apparently requested in his previous*

[16] Note: Allyn was not prescribed diazepam and, at interview, the doctor advised that he spoke to Allyn about chlordiazepam, which is not dissimilar to diazepam. Both drugs are used in detoxification.

prison spell. Clear guidelines from the Prison Service about what symptoms (or constellation thereof) should trigger contact with primary healthcare services may assist prison nursing officers in making this decision."

Dr Fazel stated that *"More robust linking of community medical records with prison health would have been potentially important in Mr Baxter's case, and would likely have led to him being considered as being at suicide risk. The process of assessing and managing this risk in prison may have reduced Mr Baxter's suicide risk, although it is not possible to know if it would have prevented his death."*

In November 2009, the Prison Service said, in response to a previous Prisoner Ombudsman Death in Custody investigation recommendation, *"The current position is that if on committal assessment a medical or mental health problem is identified by the committal nurse, the prisoner's GP will be contacted to ascertain all relevant clinical information."*

At interview, the committal nurse said that Allyn did not provide her with his GP details when asked and, she said that she would not know how this information could be ascertained if the inmate did not want to disclose it to her, or if an inmate said they did not have a GP.

The investigation found that Allyn did have a GP and found also that during Allyn's previous custodial period, reference was made in his prison medical notes to a forthcoming psychiatric referral, which would have been requested by his GP.

<u>Opening of a SPAR – Assessment by the South Eastern Health and Social Care Trust</u>

Responding to Dr Fazel's comments about links between the prison and the community, the South Eastern Health and Social Care Trust said, *"Our Primary Care medical opinion is that Dr Fazel's suggested*

preventative measure regarding more robust linking of community medical records with Prison Health, may not have altered Mr Baxter's medical management. Even with his history, taking into account his presentation and assessment by both healthcare and discipline staff noted no suicidal ideation on committal, it is doubtful that a SPAR would have been opened by healthcare or discipline in the absence of suicidal intent."

Decision to Change Observation Frequency

The 'Committal and First Night Information Booklet' incorporates an observation log where staff record all interactions and observations that take place during this initial period and note any concerns.

It is recorded that observations of Allyn at 15 minute intervals, which commenced at 17.50 on 28 July, continued until 09.15 on 29 July, when an officer noted, *"Spoke to young Baxter, said he had settled well, moved to hourly obs."*

At interview, a senior officer said that the officer who made the above entry spoke with him about the fact that Allyn was *"in good form"* and that he had *"settled well"* and that the officer wanted to change Allyn's observation levels to hourly observations. Based on the information provided by the officer, the senior officer said that he was happy for Allyn to be observed hourly.

Meeting with Probation

At 09.36 on 29 July, CCTV shows that Allyn met with a probation officer in the interview room on Elm 1 landing. At interview the probation officer said that her interview with Allyn was *"unremarkable."* She said that on asking Allyn about his first night in custody he said that it had been fine and that he was of the mindset that he was not going to be in Hydebank Wood for very long, because he was going to get bail to stay at his friend's house.

The probation officer said that she then left a message with Allyn's community based probation officer, asking him to contact her so that she could update him on Allyn's new committal. The probation officer also said that she contacted Allyn's social worker to advise her that Allyn had been remanded in custody to Hydebank Wood. She said that during the conversation, Allyn's proposed bail accommodation was discussed as to whether his friend's address would be a realistic option. She said that the social worker advised her that she didn't think that Allyn's friend would be prepared to offer their address for bail, because the relationship between Allyn and his friend had been *"turbulent"* in the past.

Governor's Committal Interview

A governor carries out a committal interview with each new inmate.

Between 11.55 and 12.05, CCTV shows that Allyn met with a governor in the landing office for his interview. It is recorded that Allyn understood his charges and that his next of kin knew that he was in custody. The governor noted that Allyn was satisfied that his money and property were properly itemised when he was committed and that he understood the house regime. Information provided by the governor notes that *"When Allyn came in and sat down, I noticed that he was wearing numerous tops and that his hands were shaking. After introducing myself, I asked if he was cold and he replied that he was 'coming off the drink' or words to that effect. I asked him if he was feeling okay and he replied that he was."* The governor stated that the only thing Allyn mentioned was that he was *"very sore"* in the place where the nurse had administered his Pabrinex injection. The governor said that *"throughout the interview he was lucid, talked fluently and came across as being in good form. His interaction with me was relaxed and friendly."*

Afternoon of 29 July 2010

Following Allyn's interview with the governor, CCTV shows that at 12.05, Allyn went into the recreation room and had his lunch. Having sat talking with other inmates whilst he ate his meal, Allyn returned to Elm 1 Landing at 12.11, along with the rest of the inmates who were in the recreation room.

CCTV shows that Allyn was taken to the healthcare centre for his second Pabrinex injection of the day at 14.25, returning to the landing at 14.39.

The committal observation log entries up to the time that Allyn went for the visit with his friend note that he was in his cell watching TV.

Prison Service policy states that inmates on remand can receive two sixty minute visits per week and between 14.58 and 15.53 on 29 July 2010, Allyn had a visit from his friend. CCTV shows that the visit appeared to go well and Allyn and his friend can be seen laughing together.

Every effort was made to speak with Allyn's friend but unfortunately this was not possible.

After Allyn's visit, the following entries were recorded in the committal observation log:

16.00 *"back in cell good visit."*
17.00 *"Young Baxter in very good mood, said he has now settled after a visit from (his friend,) no issues or problems."*

Hourly observations were then discontinued and Allyn moved on to the standard checks that apply to all inmates. At Hydebank Wood, the policy is that *"standard checks are carried out throughout the day, where inmates are locked, at intervals of no more than two hours.*

Between night guard officers coming on duty at around 19.30 and midnight *"these checks are carried out at intervals of no more than hourly."* Three checks take place between midnight and 07.00.

Evening Association

CCTV shows that the inmates on Elm 1 Landing were unlocked for evening association between 17.05 and 19.20. At 17.08, Allyn entered the recreation room and ate his tea meal. He talked with other inmates and watched table tennis matches. Even though Allyn could have remained in the recreation room, he returned to his cell at 17.35.

At 17.55, CCTV shows that Allyn went to healthcare to receive his last Pabrinex injection of the day, returning to Elm 1 Landing at 18.06.

The only other time that Allyn is seen on CCTV that evening is at 19.00, when he entered the recreation room for approximately three minutes to collect his supper. Again, Allyn could have stayed in the recreation room to eat his supper with other inmates, but he chose to return to his cell.

Although not recorded, the landing would have been locked for the night sometime between 19.20, when all inmates returned to the landing and 19.30 when the night guard carried out their initial head count check.

Telephone Call

Records show that at 18.09 on 29 July, Allyn made a telephone call to his friend that lasted just over one minute. They talked about visiting arrangements for the following day.

Before the call ended, Allyn's friend asked if he was okay and he replied *"Yeah, I'm fine, just I'll be getting locked up here, I'm just after my dinner and I've just got my injection, now I'm going to my bed."*

SECTION 4: 30 JULY 2010

6. Key Events of 30 July 2010

Morning Events

CCTV shows that at 08.08, Allyn went to healthcare for his morning medication. He then talked with other inmates over breakfast in the recreation room, before returning to his cell at 08.35.

From the available CCTV, it appears that Allyn remained in his cell until 11.57 when he went to the recreation room and ate two helpings of lunch whilst chatting to other inmates. He returned to his cell at 12.12.

Legal Consultation

Between 13.55 and 14.41, Allyn attended a video link legal consultation with his solicitor. At interview, Allyn's solicitor said that there were three main purposes of the consultation:

1. To tell Allyn that he was now acting for him, because it was another solicitor who had represented Allyn at the police station.

2. To tell Allyn that his friend had called in to see the solicitor and that his friend had agreed to give her address as a bail address for Allyn. The solicitor said that Allyn was pleased about this.

3. To tell Allyn that his social worker had called the solicitor to find out why Allyn was in Hydebank, but that he had not told her anything about Allyn's case because Allyn hadn't authorised him to do so. The solicitor said that Allyn did not want his social worker to know the reason for his committal and also said that Allyn had a laugh and a joke about this.

The solicitor told Allyn that his next court date was scheduled for 3 August 2010, when it was intended to make a bail application.

Allyn's solicitor said that the consultation went well and that Allyn was very pleasant and *"quite upbeat,"* even though he was informed that the police would probably oppose the bail address that he was hoping to go to.

Allyn's solicitor told the investigation that even if bail had not been granted, he did not expect Allyn to receive a custodial sentence for the offences committed. He said this was not discussed with Allyn.

Tea Meal

At 17.00, inmates were given their tea meal in their rooms due to a restricted regime[17] being operated, because of staffing issues.

Move to Elm 2 Landing

It is recorded at 17.55 that Allyn was moved from the Elm 1 committal landing down the corridor to Elm 2, the assessment landing.

At interview, a senior officer said that *"Elm 1 was purely a committal landing, it's just normally for the first night. The majority of inmates would stay between 24 and 48 hours unless we had a big influx of inmates coming into the centre."* He went on to say that *"Elm 2's an assessment landing. Basically inmates would spend somewhere between four or six weeks on that landing. Staff will get to know them, get to know what they're like and a decision will be made then where they're going to be moved to."*

[17] When a landing has a restricted regime in operation, a minimum of four inmates are permitted to be out of their cell on a rolling basis, consisting of one landing orderly, one inmate using the phone, one inmate getting hot water and one inmate getting showered.

Association Time

There was no evening association on Elm 2 Landing on the evening of 30 July again due a restricted regime resulting from staffing issues, Allyn, therefore, remained in his cell from around 18.00 until the following morning.

Detoxification Medication

It is recorded in Allyn's medical records that he received his lunchtime and evening Pabrinex injections. It is unknown what time these were administered as Allyn's movements to and from healthcare were not recorded by the landing staff and were not captured on CCTV.

SECTION 5: EVENTS OF 31 JULY 2010 PRIOR TO THE DISCOVERY OF ALLYN

7. Morning Key Events

It is recorded in the class officer's journal that at 08.10 on 31 July 2010, breakfast was served in cell. This was, again, because of a restricted regime due to staffing issues. At 09.00, Allyn was taken to healthcare along with six other inmates.

At 09.44, CCTV shows Allyn entering the visits room for a visit with his friend. During the visit, Allyn chatted to his friend and although there is less laughter than seen at the visit on 29 July, the visit appears to have gone well. The visit ended at 10.15, almost 30 minutes earlier than the allocated time. Allyn's family said that the visit ended early because Allyn's friend had been given a lift to the prison and had agreed to leave at that time. Allyn's family also said that Allyn's friend had told them that Allyn had been crying during this visit. Allyn cannot obviously be seen crying on CCTV, but it is not possible to say that he wasn't.

As noted earlier, attempts to speak with Allyn's friend have been unsuccessful.

At 11.56, CCTV shows that Allyn and the other inmates on his landing entered the recreation room to have their lunch. Allyn can be seen eating a full plate of food and extra slices of bread whilst sitting and talking with other inmates. Allyn returned to Elm 2 Landing at 12.08, before the other inmates who left the recreation room at 12.15.

8. Afternoon Key Events and Evening Association

Allyn received his final Pabrinex injection between 13.50 and 14.30, after the landing was unlocked. The nurse who saw Allyn recorded the following in his medical records:

"Inmate appeared well settled, good eye contact and appropriate conversation. Inmate informed me that he was going to a 'dry' hostel and was hoping to address his alcohol issues. Inmate stated his mood was 'ok' at present, and felt better after the course of Pabrinex. Advised would continue detox regime, and would see healthcare daily re same. Inmate compliant, and thanked me for everything I had done for him."

At interview, the nurse confirmed the above and said that Allyn *"was hoping to get out and change his life."*

Allyn's solicitor had told him the day before that Allyn's friend had agreed her address could be given as a bail address for Allyn, although this would probably be opposed by the police. It is unclear why Allyn, therefore, told the nurse that he was going to a dry hostel. It is possible that this was discussed with his friend during his morning visit. There is some evidence, in later phone calls, that this may have been the case.

At 15.11 on 31 July, CCTV shows that Allyn and other inmates entered the recreation room for the afternoon association period. For the majority of the time, Allyn sat with another inmate, laughing and chatting. Both Allyn and the other inmate watched the "winner stays on" table tennis matches that were being played. At one point, Allyn joined in with one of the games until he lost and another inmate took his place. Allyn then continued to talk with the inmate until 15.32 when he returned to Elm 2 Landing.

At interview, the inmate Allyn had been talking to said that it was the first time that he had spoken with Allyn. He said that Allyn *"was asking me what I was in for and how long I had left, and he was telling me what he was in for.....We also talked about football. We are both Liverpool supporters, so we were talking about that for a bit. Allyn then said that he would see me tomorrow and that was the last time I saw him. Allyn seemed okay to me when I was talking to him."*

Evening association was restricted again on Elm 2 due to staffing issues and therefore, other than to use the phone, have a shower, or get hot water, inmates remained locked in their cells until the following morning. As a result, tea meals and evening supper were also served to inmates in their cells. Allyn was, therefore, locked from 15.32.

9. Telephone Calls

Between 18.03 and 18.08 on 31 July, Allyn made three short telephone calls to his friend.

All three calls were troubled because of problems personal to them and Allyn was upset. It was evident that Allyn did not want to fall out with his friend and during the final call he said *"I'm phoning to talk to you with my last f…ing 21p I have on my phone, do you want to spend the 21 seconds I have shouting at me?"* The arguing continued and the call ended with Allyn saying *"no sweat then, have a good life."*

A review of Allyn's phone credit shows that he had £2.11 left on his phone balance. It would appear to be the case that Allyn glanced at the screen and misunderstood how much credit he had remaining when he said to his friend that he only had 21 pence left.

10. Conversations Allyn had with an Inmate and Prison Officer on the Evening of 31 July 2010

Conversation with Inmate

At interview, the inmate who was located in one of the cells next to Allyn said that at about 20.50 on the evening of 31 July, he had been talking to Allyn. He said *"I was speaking to Allyn through the wall. We talked about the fact that there wasn't anything good on TV and he told me that he didn't think that his friend was talking to him. He told me he was away to write a letter, and that was the last I heard from him."* The inmate said that Allyn *"didn't sound depressed in any way"* and that he sounded like he was just going to go and write a normal letter.

The inmate also recalled speaking with Allyn earlier in the day. He said that he hadn't known Allyn long because Allyn had only been on the landing a short time. He said that they had talked about the medication Allyn was taking and that he had a laugh and a joke with him. The inmate said that Allyn *"seemed to be in good form."*

It is recorded that prisoners on the landing were checked at 21.00.

Conversation with Prison Officer

In his staff communication sheet[18], the night custody officer who found Allyn stated that at approximately 21.10, an inmate had asked him whether anyone on the landing would lend him a cigarette. The officer said that he shouted this request out to the landing and Allyn offered a cigarette. The officer said that when the cigarette was retrieved from under Allyn's door, Allyn *"was very pleasant"* and said that the inmate *"could pay him back anytime."*

[18] Staff Communication Sheets are written reports/statements completed by officers involved in incidents.

At interview, the officer said that he recalled, when looking through Allyn's cell door flap, that Allyn was standing at his bench and that he opened his tobacco and rolled the cigarette, before passing it under the door. The officer couldn't recall seeing anything else because, he said, *"I wasn't really looking for anything. I was just looking to see the cigarette."*

SECTION 6: DISCOVERY OF ALLYN ON 31 JULY 2010 AND SUBSEQUENT ACTION

11. Raised Alarm and Staff Response

Reason for Raising the Alarm

At interview, the inmate on the other side of Allyn said that whilst he was lying on his bed watching the television on the evening of 31 July 2010, he heard *"two loud gasps of air and a low cry for help and what sounded like a chair moving across the floor."* He said that he got up straight away and pressed his cell buzzer because *"it sounded like someone in the cell next to me was having an asthma attack."* He said that he banged the wall on one side of his room to see if it was his friend and on hearing that his friend was okay, he banged the other side of the wall, which was Allyn's cell, but got no response. The inmate said that he stood by his door for approximately five minutes, until a member of staff responded to the alarm he raised.

Staff Response to the Alarm

When an inmate presses their in-cell call alarm, an alarm sounds throughout the house and a light illuminates outside the cell where the alarm has been activated. Despite being checked that morning, no light illuminated to identify the cell where the alarm had been activated.

Elm House has four landings, all of which are on one level. There is no CCTV on any landing in Elm House. There is CCTV in the recreation rooms, from which some of the movements of officers on the night of 31 July can be seen.

On Elm 3 Landing, there is an office with a panel which indicates when and where an in-cell call alarm has been triggered anywhere in Elm house, Willow House, where the juvenile inmates are located, and

the Supervised Segregation Unit (SSU). It is normal practice for the night custody officer responsible for Elm House Landings 2, 3 and 4 to be based in this office. On 31 July 2010, however, the night custody officer who was in charge of Elm Landings 2, 3 and 4 was injured on duty and went home early. Because of this, a night custody officer who on the night of 31 July 2010 was responsible for the SSU and Elm 1 Landing was also given landings 2, 3 and 4 to check. The officer based himself in the office on Elm 1 Landing because Landing 1 is the committal landing and more inmates there require more frequent observations. The office on Elm 1 Landing does not, however, have a panel to show where a cell alarm has been triggered, so an officer hearing an alarm depends on looking for the illuminated cell light.

In his staff communication sheet, the officer who responded to the alarm raised by Allyn's neighbour said that at approximately 21.35 *"a cell alarm had been activated but I was unsure of where it was, I looked down E1 Landing then E2 Landing but could not see any outside alarm light on."*

The officer said that whilst he was checking Elm 1 and Elm 2, a colleague, who was supervising the Willow Landings located on the floor above Elm and was also in the office when the alarm was heard, went to check the Willow Landings.

CCTV shows that at 21.37 the two officers came from the direction of the office on Elm 1. The officers stood at the junction of Elm 1 and Elm 2, just outside the office talking for approximately 20 seconds before they both walked in the direction of Elm 1, which is also the direction of the stairs that go to the Willow landings. One of the officers subsequently said in a staff communication sheet that *"during this time we were looking for a cell light on Elm 1 and Elm 2 landings. The conversation between us was about where we were going to check."*

One of the officers can be seen on CCTV coming from the direction of Elm 1 and returning to the office on Elm 1 for approximately 30 seconds, before heading down Elm 2 Landing at 21.38.

The officer said that, as he walked down Elm 2 Landing, he could see the red alarm light flashing at the end of the landing, so he knew that the alarm had been activated somewhere on Elm 2. He said that he checked each cell as he progressed down the landing and, when he was about a third of the way down he shouted out to ask who had pressed their alarm. He said that an inmate called out his name to let the officer know which cell he needed to go to.

The officer said that the inmate then told him that he had heard a strange thudding noise from the next door cell. The officer said that when he checked the cell he saw that Allyn had *"a ligature tied around his neck."* The officer said that he immediately radioed for help and within 20 seconds the second responding officer, who had been checking Willow, arrived to assist with the emergency unlock.

The first responding officer said that it took no more than five minutes for him to respond to the alarm. CCTV shows the second responding officer running at 21.42, in response to the emergency radio transmission.

The radio log records that the emergency message was transmitted at 21.45. It would appear that the timings on the CCTV are not synchronised with the timings of the radio recordings.

It is not known at exactly what time the alarm was activated. It was, however, approximately five minutes from the time when officers left the office on Elm 1, after hearing the alarm, to them entering Allyn's cell.

The delay was due, in part, to the light not illuminating outside the inmate's cell.

Prison Service policy states that all in-cell call alarms, including the light that illuminates outside the cell, must be checked daily. At interview, inmates gave different accounts as to how frequently their alarms are checks. It is, however, recorded in the class officer journal that all in-cell call alarms on Elm 2 were checked at 08.15 on 31 July 2010.

It was later confirmed with the Trades Department in Hydebank Wood that the bulb, outside the cell door of the inmate who had activated the alarm, had blown.

As the frequency of use of cell alarms varies significantly, there is no preventative maintenance programme to replace bulbs at regular intervals.

12. Staff and Paramedics Emergency Response

Emergency Cell Unlock

Prison officers carry a key on their belts that can be used in an emergency to open a cell.

The first responding officer said that he took the key from his belt and dropped it on the floor so that he could stand on the plastic security vial that surrounds it. He said that because he had difficulty in breaking the plastic seal, the second responding officer took the key from him, broke the seal and gained entry to Allyn's cell.

Actions of the Officers after Entering Allyn's Cell

At interview, the two officers who attended to Allyn described in detail how he had managed to hang himself and the action they took to remove the ligature from his neck.

The first responding officer estimated that it took five to six seconds to release Allyn.

Both officers said at interview that they then placed Allyn on the floor and that, by this time, a healthcare officer and a senior officer had arrived. The senior officer and healthcare officer had been notified by the communications room to attend the incident.

It is not possible to confirm what time the healthcare officer and senior officer arrived at the scene, because of the absence of CCTV.

Resuscitation Efforts

At interview, the healthcare officer said that he was in the healthcare office when he got a call over the radio to go immediately to Elm 2

Landing. He said that he *"grabbed the first response bag[19] and the self harm bag[20], ran up the stairs and went through Elm 1 onto Elm 2.....which took less than a minute."* On arrival, he said that he saw staff lying Allyn on the floor, just outside his cell.

The healthcare officer said that when he looked at Allyn he knew it was a *"very serious situation.....because he was cyanosed[21], he didn't respond to me speaking or anything like that. I opened his airway, checked for his breathing, and checked his carotid artery for his pulse. I found nothing."*

The healthcare officer said that he commenced cardiopulmonary resuscitation (CPR) and requested an ambulance immediately. He said that he carried out chest compressions and the second responding officer carried out mouth to mouth resuscitation. The healthcare officer said that he was observing the officer who was doing the mouth to mouth to ensure that Allyn's *"chest was rising and falling and that his airway was open."*

At interview, the healthcare officer said that there was a defibrillator[22] and oxygen bottles available in the healthcare centre, which could have been retrieved by another member of staff, but because he was focused on carrying out basic life support, he did not request these items. The healthcare officer also said that he was not trained in the use of a defibrillator.

A night custody officer who had been on perimeter patrol duty and had responded to the emergency, recorded in her staff communication sheet that the healthcare officer asked her to phone for an ambulance. At interview, she said that she immediately went to the

19 The First Response Bag contains a blood pressure metre, stethoscope, glucometre, finger pulse oximetre, and a variety of items which may be useful in a medical emergency.

20 The Self Harm Bag contains a variety of dressings, steri-strips and bandages.

21 Cyanosed – The healthcare officer described Allyn's lips and ears being blue in colour because of the lack of oxygen in his blood.

22 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.

senior officer's office and phoned the communications room and requested that they call an ambulance. She said that the reason she did not use the quicker option of her radio to do this, was because the radios had been put on talk through[23], which meant the transmission would have been broadcast to all staff in Hydebank Wood. The night custody officer said that sometimes, if this kind of information is transmitted, other inmates may hear that an ambulance is coming to the centre and there may be a *"spate"* of this type of incident.

The communications room incident log shows that at 21.50 five minutes after the first responding officer first requested emergency assistance, an ambulance was requested.

Arrival and Actions of the Ambulance Paramedics

It is recorded that at 21.58, the first of three ambulance crews arrived at the prison. All the staff who were present at the scene said that CPR continued until the paramedics had set up their equipment and were ready to takeover the resuscitation efforts.

At 22.19 a second ambulance crew arrived followed by a third ambulance crew at 22.21.

As a result of the resuscitation efforts of the prison staff and ambulance crews, a cardiac output was restored and it is recorded that at 22.49, Allyn was taken by emergency ambulance to the Royal Victoria Hospital.

Consultant Cardiothoracic Surgeon's Opinion

As explained earlier, because of the injury at work of another officer, the officer who found Allyn had based himself in the office on Elm 1 Landing in order that he was nearer to the newly committed inmates.

[23] Staff radios are placed on talk though in an emergency situation so that all staff in the prison can hear both sides of a conversation between an officer and the communications room. This is to ensure that staff know exactly where they have to respond to.

It was, however, the case that because this office does not have a panel indicating the location of an activated alarm and because the light outside the cell where the alarm was activated did not illuminate, there was a delay of approximately five minutes before the responding officers found Allyn. Cell alarms are activated for many reasons and, under normal circumstances and particularly when staff are busy, a delay of approximately five minutes would not be significant.

Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, was asked to comment on whether the delay of approximately five minutes would have been materially relevant to the outcome of the resuscitation efforts.

Mr Brackenbury concluded that the delay might have been relevant. He said:

"If the inmate had shut down the circulation to the brain, then a 5-minute delay before restoration of the cerebral circulation would be materially relevant to the outcome of resuscitative efforts. The staff and paramedics did well to restore cardiac output but unfortunately the brain is so sensitive to a lack of oxygen that a few minutes without blood flow to the brain at normal body temperature invariably results in irreversible brain damage."

Considering whether the early use of a defibrillator by prison staff could have improved Allyn's chances of survival, Mr Brackenbury made the following comments:

"Standard cardiopulmonary resuscitation (CPR) is an effective method of sustaining the cardiac output for many minutes when performed by trained staff. CPR should be able to maintain enough blood flow to the brain and other vital organs.

Defibrillation often restores the normal cardiac synchrony in situations of cardiac arrest and obviates the necessity for continued external cardiac massage as the heart takes over normal pumping action.

The heart is more robust at withstanding a lack of oxygen when compared to the brain. Restoring cardiac synchrony at the start of external massage or restoring it a few minutes later with the use of a defibrillator is unlikely to have a material effect on the brain damage that has already been sustained by the hypoxic insult. Therefore, I believe that early defibrillation would be immaterial to the final outcome – brain damage occurs very quickly whilst heart function can be salvaged very successfully after many minutes of cardiac massage."

13. Letter Found in Allyn's Cell

Whilst Allyn was being worked on, one of the night custody officers checked his cell for a letter or note that might indicate any intention to die by suicide. A note was on his bench, addressed to his family. Allyn wrote that he was sorry for all the heartache that he had caused and that he loved them all.

14. Outside Hospital Bed Watch Duties

Hospital Bed Watch Duties

Chapter 42 of the Prison Service's Security Manual and Hydebank Wood's Governor's Order 9-17 'Removal of Inmates to Outside Hospital and Bed Watches' provides instructions that staff must adhere to when an inmate has to be moved to an outside hospital. This includes the requirement for two members of staff to be in attendance at all times.

As required by Prison Service policy two staff accompanied Allyn to the hospital and remained with him. One of the officers was the second responding officer.

At interview the officer said that following a second night of bed watch duties he spoke, on the morning of 2 August 2010, with the governing governor of Hydebank Wood. He said that he told the governor that he *"felt there was no place for staff"* to be at the hospital because *"the young lad was dying."* He said that it was the *"most unbelievable scenario"* having staff on bed watch duties, given Allyn's situation. He said also that he was *"no way equipped"* to deal with Allyn's family as well as having to come to terms with what had happened.

The officer said that when he came away from speaking with the governing governor, they were all in agreement that bed watch officers would be removed and the officer said that he felt that he had *"done right for the family."*

Prison Rule 27 (2) provides for a sentenced prisoner to be temporarily released to enable him to have healthcare. The same provision does not extend to remand prisoners like Allyn. However, when asked, the Governor said that he felt that, as Allyn was not at any risk of escape and represented no risk to the public, he considered that dignity and humanity were paramount.

Notwithstanding the discussion on 2 August 2010, bed watch officers remained at the hospital until the afternoon of 3 August 2010 when Allyn died, after his life support machine was turned off.

It was evident, at interview, that the second responding officer was deeply concerned about the decision to keep officers on bed watch duties.

An entry in the officer's Bed Watch Journal, notes that at 18.20 on 2 August 2010 an officer at the hospital *"Informed the Establishment that life support would be switched off lunchtime tomorrow."*

The governing governor informed the investigation that, based on the information provided by the second responding officer and clarification sought on Allyn's condition, he decided to remove staff from the hospital. He stated that he could not recall the specific sequence of conversations or the dates that they took place, but he remembered that he spoke to another governor and asked him to attend the hospital to instruct the officers on bed watch to return to Hydebank Wood. Five minutes after the governor arrived at the hospital, Allyn's life support machine was switched off and he died.

It is recorded in the bed watch officer's journal that at 15.45 on 3 August 2010, five minutes after the governor arrived Allyn died and hospital cover was withdrawn.

The notes of a de-brief meeting on 12 August, to review the events surrounding Allyn, record that *"at the time of Allyn's death, one person present made it known to the staff that perhaps it was time for them to leave. The staff accepted that grief was heightened and took their leave of the site."*

SECTION 7: EVENTS FOLLOWING ALLYN'S DEATH

15. Death in Custody Contingency

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.

Using the contingency plans, the communications room, which controls and records all movements around the prison, immediately notified the appropriate personnel of the seriousness of Allyn's situation when he was taken to the Royal Victoria Hospital. Those notified included the Police Service for Northern Ireland and the Prisoner Ombudsman.

16. Inmates/ Staff Communication and De-Brief Meetings

Inmate/Staff Communication

A Notice to Inmates was issued by Hydebank Wood Prison and Young Offender's Centre on 2 August 2010, advising inmates of the incident and the services available to them via landing staff, Samaritans, Opportunity Youth, AD:EPT, Cruse, Chaplaincy and Offender Management staff.

A Notice to Staff was also issued on 2 August 2010 advising them of the incident and the services available to inmates.

A Notice to Inmates was issued on 3 August 2010 advising inmates that Allyn had died and reminding them of the assistance available via staff.

The Governor of Hydebank Wood advised that he held an impromptu full staff meeting on 2 August 2010 to advise staff of the incident and offer support. There was no record of who attended the meeting or what was discussed.

Hot De-Brief

The Prison Service's 2009 addendum to their Revised Self Harm and Suicide Prevention policy issued in September 2006 states:

"In the immediate period following a death in custody, it is important that there is a hot de-brief, including ECR (emergency control room/communications room) *staff if available. This should take place immediately, but will obviously depend on the circumstances of the individual case. However, 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. A brief note should be taken of those attending, and matters raised."

The requirement for a hot de-brief to take place when staff have been involved in a serious self harm incident, not resulting in a death at the prison, is not included in the 2006 policy or its 2009 addendum. It is to note, however, that the requirement to hold a hot and cold de-brief following any serious self harm injury event or a death by suicide has been included in the 2011 edition of this policy, which was published on 10 February 2011.

The senior officer who was involved in this emergency said at interview that, not withstanding that there was no policy requirement because Allyn did not die in custody, he spoke individually with each member of staff who was in the prison that night. He said that he did this to check how they were and to ensure that they knew of the support services available to them. He said that no note of this was made but that an email was sent to the Director of Operations, Governing Governor and Duty Governor, which detailed that he had spoken with all the staff in the prison. A copy of this email was not retained.

At interview the first responding officer said that no offer of support was provided to him on the night of 31 July 2010 which, he said, made him feel *"terrible."* He said that he still had to work on the same landing where Allyn had been found and was asked *"to tape up the room and actually stood over the area where we cut him down."*

The second responding officer also said that no one asked him whether he was okay or offered support. The second responding officer was sent to the hospital with Allyn and was also on hospital bed watch duty the following night.

The perimeter patrol night custody officer and healthcare officer who responded to the emergency, both said that they were spoken to on a

one to one basis, asked if they were okay and were informed of the support available to them.

Meeting Held by the Governing Governor

A record of a meeting held on 5 August 2010, by the governing governor is titled *"Hot De-brief of Prisoner Baxter Suicide."* The record notes that there were 26 people in attendance at the meeting. A large proportion of those in attendance were not involved in the incident. It is recorded that the governing governor thanked all those who attended and gave a *"corporate overview of the incident,"* which included: history of Allyn's family background; the reason for Allyn being in custody, including his previous custodial period; and a chronology of events, including what happened when Allyn was taken to hospital. An explanation of the role of the Police Service for Northern Ireland and Prisoner Ombudsman was given and it is also recorded that the support mechanisms available *"for any staff that feel they require help or support,"* was explained.

Another governor who attended the meeting and a representative from Care Call[24], spoke to staff about setting up group sessions for those who were directly involved at the scene of the incident.

A number of the night custody officer's who attended the meeting said, at interview, that *"it was the governing governor talking and we all listened."* They said that they had understood that the meeting would be a chance to discuss whether anything could have been done differently and how people felt, and that this was not the case. One officer said they felt *"left in limbo"* and a number of officers said also that they felt that it would have been much better for the meeting to have been attended only by those directly involved in the incident. Another officer said that he felt that he didn't get the opportunity to discuss the fact that there are three or four items on the night

[24] Care Call – Provide phone and face to face counselling, mediation, training, critical incident management and specialist therapies for employees.

custody belts which, he said meant that he had to *"fiddle"* with his belt to obtain what he needed, so instead, he said he removed it and placed it on the floor.

The governing governor said that the reason he held a hot de-brief for all of the night custody officers was for "*an information and learning/mentoring perspective."*

All staff interviewed said that the one to one and group sessions that were subsequently set up with Care Call and the Prison Service's Occupational Support Branch (welfare) were excellent. Some of the staff who were involved and emotionally affected by Allyn's death said that they would have liked more support from management at Hydebank Wood.

In connection with the concerns raised about the night custody belt, responding to the Prisoner Ombudsman's draft report, the Prison Service said:

"The night custody belts have a number of items with specific purposes. An emergency cell key/fob to enable emergency access to a room without having to go to another location to retrieve a cell key or fob; a Hoffman knife to cut through ligatures in the event of finding someone hanging or with a ligature around their neck (the Hoffman knife has recently replaced the "Big Fish knife" which was found to have limitations in use); a resuscitation mask to enable the user to administer mouth to mouth resuscitation at minimal risk to either person; a T Bar and isolation key to isolate sprinklers that have accomplished their task so that undue damage is prevented from happening to surrounding areas;

In addition night guard staff will carry a torch to illuminate an inmate sleeping in the darkness of his room causing him minimal interference without having to switch on his room light; and a pegging wand to record when checks on inmates have been carried out."

They also said that *"All items are there for a specific purpose and are located in separate pouches or retainers. There is no requirement to remove one in order to gain access to another and there will be no delay in gaining access to any item that may be required."*

It was nevertheless the case that the officer felt that this was an issue which he wasn't given the opportunity to discuss. He said although it only took seconds to remove his belt and obtain what he needed he said *"seconds are seconds".*

Cold De-Brief

Section 6.11 of the Self Harm and Suicide Prevention policy requires that *"a more comprehensive [cold] de-brief should take place within 14 days."*

In the 2009 addendum to this policy it states that *"The comprehensive de-brief is intended to provide opportunities for staff to further reflect on the events surrounding the death in custody and to identify any immediate learning from the events. The cold de-brief is not intended to be a comprehensive investigation into the circumstances. It is an opportunity, however, for staff to express their views and share their thoughts with colleagues on the circumstances and their role and involvement."*

A cold de-brief was held on Thursday 12 August 2010 and was attended by the senior officer who was present the night Allyn was found and an officer who carried out bed watch duties whilst Allyn was in hospital. Also in attendance was the safer custody manager and head of custody branch for the Northern Ireland Prison Service, as well as a governor, safer custody manager and suicide prevention co-ordinator from Hydebank Wood. The two officers who found Allyn were not present and did not, therefore, have an opportunity to express their views and thoughts.

The efforts of the staff who found Allyn were noted and recognised and problems associated with the availability of *"solid ligature points"* were discussed and possible action considered.

It is to note that the record states that *"follow up support for staff and prisoners was quick and effective,"* and *"there were no obstacles in gaining access to the cell."* These were not the findings of this investigation.

SECTION 8: AUTOPSY REPORT

17. Findings of the Autopsy Report

An autopsy examination was carried out on 4 August 2010 and gave the cause of Allyn's death as:

I(a) Hanging.

The report states:

"Analysis of a sample of blood taken on 1 August 2010, whilst Allyn was in hospital, found chlordiazepoxide and metabolite (Librium) and evidence of drugs with similar properties to thiopentone and lidocaine which the state pathologists notes, were presumably administered whilst in hospital."

SECTION 9: ALLYN'S DETOXIFICATION PROGRAMME

18. Detoxification Policy and Procedure

Allyn's family asked whether Allyn was given any medication and was this appropriate and adequate.

In July 2010, Hydebank Wood did not have an agreed Alcohol Detoxification Policy. Without a formal policy, the healthcare team used the 'Drug Misuse and Dependence – UK guidelines on clinical management (Department of Health publication 2007)' to manage alcohol detoxification programmes, through clinical observation and judgements. Use was made of 'An Improved Alcohol Withdrawal Scale-1357' which is a research based scale that provides a score to indicate if treatment is required. The treatment administered by the healthcare team included Chlordiazepoxide (Librium) and Thiamine/ Pabrinex (a vitamin B and C complex.)

In September 2010, the South Eastern Health and Social Care Trust introduced a policy on the management of alcohol withdrawal, to be applied throughout the Prison Service.

Allyn's Detoxification Programme and Medication

Allyn received a fixed dose of 20mgs of chlordiazepoxide (Librium) three times per day from the day of his committal on 28 July 2010 until 31 July 2010. He also received a three day course of three intramuscular vitamin B and C injections (Pabrinex) per day.

Commenting on the medication Allyn received for detoxification, the clinical reviewer, Dr Fazel stated *"In my opinion, Mr Baxter's medication was appropriately prescribed"* and the administering of Pabrinex injections was *"in line with clinical guidelines."*

Dr Fazel concluded that *"I do not believe that any improvements in the management of detoxification, on their own, would have prevented Mr Baxter's death."*

Location of Allyn During Detoxification

The investigation considered whether the detoxification programme should have been administered with Allyn as an inpatient in healthcare. In his clinical review report, Dr Fazel made the following comment:

"It is generally accepted that mild or moderate alcohol dependence can be managed as an outpatient. If there is a high risk of complicated withdrawal, then an inpatient setting should be considered. Factors that may indicate a complicated withdrawal include previous delirium tremens, previous alcohol withdrawal seizures, cognitive impairment, or severe dependence. These factors were not apparently present in Mr Baxter's case apart from arguably the severity of his dependence. However, it is my impression that he had a moderate dependence.

Other considerations for inpatient treatment include physical illnesses, or acute or chronic mental health problems (such as suicidality,) malnutrition, self neglect, and older age. Although Mr Baxter had a history of suicidality in the weeks leading up to his imprisonment, he denied it on committal to health staff (but not to prison staff). If the information of Mr Baxter's escalation of self-harm in the weeks leading up to his committal was known, I think that it would have been appropriate to consider admission to healthcare."

The policy on the management of alcohol withdrawal introduced in September 2010 states that *"if there are any difficulties with withdrawal, the patient should be referred to the Addictions Team for advice on specific care planning if being managed in the normal prison location."*

It is to note, however, that prison officers working on committal and other landings have received no training in the symptoms of detoxification or when medical intervention should be sought, and some staff did not know Allyn was on a detoxification programme. It is also the case that once locked at 17.50 on 28 July 2010, Allyn, who was reported to have withdrawal symptoms, remained locked in his cell for the next 14 hours and 40 minutes, albeit checked very regularly by staff. The extent of the monitoring was, therefore, limited to observation through the door flap.

SECTION 10: OTHER MATTERS

19. Medical Emergency Training

First Aid Training

Healthcare officers are not qualified nurses. All healthcare officers were originally employed as prison officers but were given the opportunity to train as healthcare officers. The roles and duties of the nurses and healthcare officers are similar, but a healthcare officer is excluded from administering controlled drugs, operating under patient group directives and conducting a medical assessment to determine if an inmate is suitable for cellular confinement or adjudication.

On 31 July 2010, of all the staff on duty, only the healthcare officer was trained in first aid. The officer who administered mouth to mouth resuscitation was not trained.

Information provided by Hydebank Wood's personnel manager, states that the Prison Service takes guidance from the Health and Safety Executive, and in particular 'The Health and Safety (First Aid) Regulations 1981 Approved Code of Practice and guidance' when setting the level of staff required to be trained in first aid.

The codes of practice and guidance state that *"How much first-aid provision an employer has to make depends on the circumstances of each workplace. There is no fixed level, but each employer needs to assess what equipment, facilities and personnel are appropriate."*

The guidance suggests that for every 50 members of staff at work, there is at least one first-aider trained in First Aid at Work.

The number of staff currently trained in first aid at Hydebank Wood is 19, which equates to a ratio of approximately 1:20 and, therefore, more than meets the guidance.

The personnel manager stated that in respect of the numbers of trained staff on duty on a shift by shift basis, there is no specific criterion. He stated, however, that he believes the following should be taken into account:

- Hydebank Wood has 24/7 healthcare cover
- 22 Night Custody Officer's at Hydebank Wood have been trained in the use of defibrillation equipment
- 11 Night Custody Officer's have been First Aid trained in 2011

Notwithstanding the efforts made by Hydebank Wood to provide first aid training for staff, it was, as stated, the case that the officer who administered mouth to mouth was not trained. He was, however, supervised by a healthcare officer who was trained in first aid.

Commenting on whether it was materially relevant that the officer who carried out mouth to mouth resuscitation was not first aid trained, Mr Brackenbury said that "*I am confident that the Healthcare Officer, performing external cardiac compressions on the patient, in combination with the Prison Officer performing artificial ventilation, provided a satisfactory degree of cardio-respiratory support. Although the Prison Officer was not formally trained in providing artificial ventilation, he was appropriately supervised by the Healthcare Officer to ensure that artificial ventilation was performed effectively. Both Officers' efforts were rewarded by restoration of the circulation though, regrettably, damage to the brain precluded a satisfactory final outcome. The fact that the Prison Officer had not had formal training in CPR was immaterial to the final outcome of resuscitation.*"

Defibrillator Training

At interview, the healthcare officer said he was not trained to use the defibrillators that are available in Hydebank Wood.

At interview, the perimeter patrol night custody officer said that she had received training on the use of a defibrillator in readiness for the prison purchasing them. She was unaware that there was a defibrillator in the healthcare centre that could have been used.

Hydebank Wood has two defibrillators, one in the healthcare centre and one in Ash House. Information provided by the training manager stated that there is no specific requirement to have staff trained in the use of defibrillators but that Hydebank Wood is planning to train its entire staff. He stated that 33 staff have already been trained but that no future training dates have yet been set.

As stated previously, considering whether the early use of a defibrillator by prison staff could have improved Allyn's chances of survival, Mr Brackenbury said *"I believe that early defibrillation would be immaterial"* to Allyn's final outcome.

20. Allyn's Time Out of Cell

In his review into Non-natural Deaths in Custody in Northern Ireland Prisons[25], Professor Roy McClelland stated that:

"The regime content and activity levels were also examined as literature points to a correlation between poor regimes and adverse effects on the mental well being of Offender's. This can contribute to self-harm and an increase in suicidal ideation."

Professor McClelland also made reference to the Howard League for Penal Reform[26] which criticised the long periods of time spent in 'enforced' idleness.

HM Prison Service Order 2700 which applies to prisons in England and Wales states:

"Independent research has indicated that at prison level, lower rates of self-inflicted death are associated with higher rates of purposeful activity, even when the type of prison is taken into account."

In October 2005, 'An Ecological Study of Factors Associated with Rates of Self-inflicted Death in Prisons in England and Wales' concluded the following:

"The provision of purposeful activity is recognised as important in preserving prisoners' well being. The 1998 WHO Consensus statement on mental health promotion in prisons states that 'activities should be available to enable prisoners to make the best use of their time in prison', and also states in particular that 'workplaces and classrooms

[25] Professor Roy McClelland, Professor of Mental Health at Queens University Belfast chaired the group who published, "A review of Non–natural Deaths in Northern Ireland Prison Service Establishments (June 2002–March 2004.)"

[26] The Howard League for Penal Reform is the oldest penal reform charity in the UK. It was established in 1866 and is named after John Howard, one of the first prison reformers.

can offer an environment in which prisoners can be kept busy or diverted enough to achieve a temporary mental "escape" from the pressures of imprisonment.' The current study suggests that increasing purposeful activity may be particularly important for reducing one of the most pressing mental health problems in prisons, namely self-inflicted death."

It is also the case that in England, one third of suicides in prison occur within the first seven days of a prisoner being committed[27].

Unlock Schedules

Hydebank Wood's locally revised Progressive Regime and Earned Privileges Scheme (PREPS)[28] provides information about when inmates will be unlocked for set periods each morning, afternoon and evening as follows:

	Monday-Saturday	Sunday
Morning	07.45-12.15	08.30-12.15
Afternoon	13.45-16.00	13.45-17.00
Evening	16.45-19.45	-

It is recorded in the PREPS policy that during the above periods of unlock, inmates may avail of the following facilities according to their regime level, subject to location and any operational restrictions applicable at the time:

- Access to the exercise areas
- Access to dining hall

[27] Taken from the 25 November 2010 'Committee for Justice Official Report (Hansard)' - Briefing by the Prison Review Team, chaired by Dame Anne Owers.

[28] The purpose of PREPS is to encourage and reward inmates' commitment to completion of their Resettlement plan. To encourage pro-social behaviour within the prison and to contribute to a better controlled, safer, and healthier environment for inmates and staff based on mutual respect. To prepare inmates for release on license or otherwise by developing improved citizenship qualities and self worth for effective and safe integration into community and to reduce the potential for further offending.

- Access to laundry/ironing
- Access to landing kitchens
- Access to healthcare
- Access to landing recreation rooms and equipment (table tennis, table football in Elm 1 & 2 where Allyn was located)
- Access to shower areas
- In-cell association
- Access to gymnasium (assessments for suitability to use the gymnasium are carried out each Wednesday, therefore Allyn did not have an opportunity to have an assessment)
- Access to telephones

Inmates may also attend education, training and work experience sessions, depending upon availability and their sentence plan.

Governor's Order 82/10 issued on 20 May 2010 states that normal staffing levels required to operate a full regime on the landings in Hydebank Wood is two members of staff. When staff are not available and only one member of staff is on a landing, a restricted regime will operate.

In the interim 'Review of the Northern Ireland Prison Service' chaired by Dame Anne Owers and published on 28 February 2010, it was noted that *"Despite considerable expense, all three prisons, and Maghaberry in particular, have unacceptably poor regimes, which waste resources and do not allow prisoners access to the activities and interventions they need to support change and reduce reoffending."*

The report also states that one of the issues underlying this is:

"Restrictive working practices and excessive and inflexible agreed staffing levels, together with a recruitment freeze, mean that it is in practice impossible to run agreed regimes."

Consequences of Restricted Regimes at Hydebank Wood

When a landing has a restricted regime in operation, a minimum of four inmates are permitted to be out of their cells at any one time; one landing orderly, one inmate using the phone, one inmate getting hot water and one inmate getting showered. The number of inmates unlocked will be dependant upon a number of factors including the landing numbers, whether or not the inmates are considered to be *"compliant"* and the overall situation in the prison.

It is recorded in Hydebank Wood's 'Restricted Regime Log' that Elm 1 and Elm 2 had periods of restricted association as follows, during the period that Allyn was located on each of them:

Date	**Morning**	**Afternoon**	**Evening**
28 July	-	15.20 – Allyn committed	Elm 1 Restricted
29 July	Elm 1 No restrictions	Elm 1 No restrictions	Elm 1 No restrictions
30 July	Elm 1 No restrictions	Elm 1 No restrictions	Elm 2 Restricted
31 July	Elm 2 No restrictions (NB: Landing Journal states restricted)	Elm 2 No restrictions	Elm 2 Restricted

It was, however, the case that CCTV showed no evidence of inmates being allowed to use the recreation rooms, irrespective of whether restrictions were recorded as applying, on any morning or afternoon, with the exception of the afternoon of 31 July 2010.

Allyn was, therefore, subject to a restricted regime for all of the mornings, two of the three afternoons and three of the four evenings that he was in prison.

At interview, a senior officer said that the only time inmates would usually be permitted into the recreation rooms would be for the evening association period. He said that unless the inmate had to use the shower, phone or had a job/appointment to attend to in the mornings and afternoons, they would usually remain locked in their cells.

It is also to note that as a result of the restrictions, Allyn ate the following meals in his room:

Breakfast	-	29 and 31 July 2010
Dinner	-	28, 30 and 31 July 2010

From Prison Records and the available CCTV, the amount of time Allyn appears to have spent out of his cell (not including any time spent showering or cleaning his cell) is as follows:

28 July 2010 **Committal interviews between 15.20 and 17.50**. (Allyn was locked from 17.50 until 08.30.)

29 July 2010 **Two hours 34 minutes (approx)**

- Healthcare for Injections (x three) including a Dr's Appointment - 45 minutes
- Meeting with Probation – seven minutes
- Governor's Committal Interview – ten minutes
- Lunch – six minutes
- Visit – 55 minutes
- Tea meal and association – 27 minutes
- Telephone – one minute
- Collect supper – three minutes

(NB: Allyn spent one hour 58 minutes in his cell during the evening when he could have gone to the recreation room.)

30 July 2010 Two hours three minutes (approx)

- Breakfast and morning medication – 27 minutes
- Lunch – 15 minutes
- Legal consultation via video link – 46 minutes
- Move to Elm 2 Landing – five minutes
- Afternoon and Evening trip to Healthcare for medication – 30 minutes

31 July 2010 One hour 44 minutes (approx)

- Morning medication in healthcare – 15 minutes
- Visit – 31 minutes
- Lunch - 12 minutes
- Final dose of Pabrinex – 20 minutes
- Afternoon association – 21 minutes
- Telephone Calls – five minutes

(NB: Allyn spent 14 minutes in his cell when he could have been in the recreation room during the afternoon association.)

Purposeful Activity

The Prison Service PREPS policy records that, depending on their particular situation, inmates can partake in different types of constructive activity, as follows:

- Education programmes (including arts and crafts)
- Vocational training programmes
- Work opportunities throughout the prison establishment
- Job search and preparation for release advice and training
- Computer based training
- Support and treatment for addictions
- Offending behaviour programmes

- Sport and recreation

Information provided by the sentence manager states that in order for inmates to avail of the above activities they must attend a Resettlement Board within 28 days of committal. He stated that a Resettlement Needs Profile is completed at the board and a plan drawn up with the inmate, to meet their particular needs.

It would appear to be the case that no arrangements are in place to provide purposeful activity for newly committed inmates at Hydebank Wood, over and above very limited association periods in the recreation room.

Cell Sharing

Allyn's family asked if Allyn was locked up in a cell on his own.

All inmates at Hydebank Wood have single cells. Allyn was, therefore, alone for the periods he was locked. Consideration as to whether cell sharing may be appropriate is at times relevant to the care of inmates identified as vulnerable. As discussed earlier, Allyn was not identified as vulnerable.

In his clinical review, Dr Fazel noted that *"all cells in Hydebank Wood Prison are single ones, and research has demonstrated that occupancy of a single cell is associated with suicide. It is possible that were Mr Baxter housed in a shared cell, his ability to carry out his suicide would have been curtailed. Part of the reason for this is that if the trigger was in fact the phone calls with his friend on the evening of 31 July, his suicide comes across as a relatively impulsive act."*

21. Phone Money

Making contact by phone with family and friends may be very important for newly committed inmates, especially those who are particularly vulnerable.

During Allyn's phone calls on 29 and 31 July 2010, it appeared to be the case that his calls were rushed due to him worrying about his phone credit running out.

In the 'New Committals – First Night Procedure' check sheet, it states that on committal, an inmates phone account will be credited with £1 in order to facilitate a phone call. As required by Prison Service policy, Allyn had £1 credited to his phone account on the morning of 29 July 2010.

Once a week, inmates can purchase phone credit from the tuck shop. On committal, Allyn did not have any money and, whilst waiting for his weekly regime allowance of £4/week to be credited to his account, a donation of £5.71 was made by St. Vincent De Paul on 30 July 2010.

With this donation, Allyn purchased £2 of phone credit on 30 July.

As noted earlier, following Allyn's final call, he still had £2.11 of phone credit but seems to have thought that he only had 21 pence left. It would appear that he glanced at the screen and misunderstood his balance.

22. Opportunity Youth

Opportunity Youth provide a comprehensive range of personal development and therapeutic services dedicated to meet the needs of young people. The organisation has a small team based in Hydebank Wood to deliver the following services:

- Committal Assessment and Brief Intervention
- Advocacy
- Safer Lives
- Services specific to Juvenile Landing
- Safer Custody Support
- Crisis Intervention (Positive Behavioural and Emotional Support)
- Goals Mentoring
- Officer Training

It is to note that whilst the substance misuse service provided by AD:EPT comes under Opportunity Youth, it is delivered by a separate team.

All inmates should have a committal assessment completed by Opportunity Youth. The committal assessment focuses on an assessment of vulnerability. If an inmate tells an Opportunity Youth staff member that they are finding it difficult in Hydebank Wood, then they will be offered a maximum of three, one to one, intervention sessions within their first week in prison. Opportunity Youth have a service level agreement with the Northern Ireland Prison Service to conduct 85% of committal assessments within 48 hours of an inmate's committal. Allyn was not seen by Opportunity Youth during his three days in Hydebank Wood.

The manager of Opportunity Youth in Hydebank Wood said that Allyn was on the list to be seen on 1 August 2010, but because of staff

absences it was not possible to see him within the first 48hrs of his committal.

The manager said that if staff on the landing had concerns about Allyn they could have requested someone from Opportunity Youth to see him under the 'Rapid Response' referral system which operates. This would have meant that Opportunity Youth would have prioritised seeing Allyn within 24hrs from the receipt of the referral. No such referral was made.

SECTION 11: THE EXPERT CLINICAL REVIEW

23. Clinical Review Findings

Findings of the Clinical Review have been included at the appropriate places throughout the report.

Considering Allyn's death, Dr Fazel also made the following observations.

Risk of Suicide in Prison

Taking into consideration Allyn's background history and personal circumstances and whether these could have increased his risk of suicide in prison, the clinical reviewer, Dr Fazel, made the following comment:

"On the basis of the background history, Mr Baxter had a number of risk factors that indicated an increased risk of suicide in custody. These included a history of attempted suicide and alcohol use problems – which are strong, although not specific, risk factors for suicide in custody according to a comprehensive review of the international evidence published in the 'Journal of Clinical Psychiatry' in 2008. In addition, other factors associated with suicide were present including that he had recently lost his accommodation, had apparent ongoing relationship problems, was on remand, and had a previous prison sentence."

Allyn's Death by Suicide

Dr Fazel stated that *"Any formulation of why Mr Baxter died from suicide would take into account the following issues. First, Mr Baxter had a number of background factors that increased his risk, which included a history of severe disruption in childhood including the death of his mother, being fostered around 12 times……a past history of*

polysubstance abuse from the age of 8, and a past and very recent history of deliberate self-harm. In addition, he had a number of recent stressors that included returning to custody (which he told a close friend would lead to him taking his life), losing his accommodation, and recent problems in his relationship with his friend. Dr Fazel stated that *"the accumulation of these various factors together, and which in isolation or in part were not sufficient to lead Mr Baxter to take his own life, would be one possible formulation to explain his death. In other words, the combination of background factors that increased his vulnerability with recent life events and the trigger of an argument with his friend could explain his suicide."*

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 and the Secretary of State for Northern Ireland (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 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 Secretary of State for Northern Ireland. 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 Secretary of State for Northern Ireland.

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.

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 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 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 Secretary of State (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 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 Secretary of State for Northern Ireland. 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 Secretary of State for Northern Ireland. 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.

APPENDIX 2

HYDEBANK WOOD PRISON AND YOUNG OFFENDER'S 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 Offender's aged between 17 and 21 years on conviction, serving a period of 4 years or less in custody and all female prisoners including young Offender's.

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 focuses on a balance between appropriate levels of security and the Healthy Prisons Agenda[29] – 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.

POLICIES AND PRISON RULES

The following is a summary of Prison Service policies and procedures relevant to my investigation. They are available from the Prisoner Ombudsman's Office on request.

Prison Rules

Rule 85(2) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – In the absence of the medical officer, his duties shall be performed by a registered medical practitioner approved by the chief medical officer and the Secretary of State.

Rule 85(2A) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – In the absence of the medical officer a registered nurse may perform the duties of the medical officer set out In rules 17(4) (medicine in possession on reception)m 21(1) and (2) (medical examination on reception), 26(2) and (3) (transfer), 28(2) (discharge), 41(2) (award cellular confinement), 47(5) (daily visit in cellular confinement), 51(3) (fitness for work), 55(3) (fitness for recreation) and 86(4) (prisoners who complain of illness).

Rule 85(2B) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – If a prisoner is examined, seen, considered or visited by a

[29] Healthy Prisons Agenda-The concept of a healthy prison is one that was first set out by the World Health Organization, 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.

registered nurse under the rules set out in (2A) and the registered nurse is of the view that it is necessary for the prisoner to be examined, seen, considered or visited by the medical officer he shall make arrangements for that to occur as soon as reasonably practicable.

Rule 85(3) of The Prison and Young Offender's Centres Rules (Northern Ireland) 1995 – Arrangements shall be made at every prison to ensure that at all times a registered medical officer is either present at the prison or is able to attend the prison without delay in cases of emergency.

Standard Operating Procedures

Notice to Staff 82/10 'Restricted Regime Standard Operating Procedures': Sets out guidance to staff which must be followed whenever there is a need to implement a restricted regime in areas of the centre where normal staffing levels are set at two.

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 and Hydebank Wood's Policies

Self Harm and Suicide Prevention Policy (2006)

In a desire to improve its arrangements for dealing with vulnerable prisoners, the Prison Service revised its Self-Harm and Suicide Prevention policy in September 2006. The revised policy 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."*

Progressive Regimes and Earned Privileges (PREPS) Policy

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.

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.

Governor's Order 9-17 'Removal of Inmates to Outside Hospital and Bed Watches': Sets out guidance and instruction to staff on what their responsibilities are when escorting inmates to outside hospital and when an inmate is on bed watch.

Governor's Order 10-13 'Committal's to Landings': Sets out guidance and instructions to staff on what they should do when carrying out an inmate committal.