The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

JOSEPH RAINEY

AGED 20

POST RELEASE FROM HYDEBANK WOOD PRISON &

YOUNG OFFENDER'S CENTRE

ON 19th APRIL 2013

[3rd February 2015]

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Glossary

ASIST	Applied Suicide Intervention Skills Training
CCTV	Close Circuit Television
CJI	Criminal Justice Inspectorate
CPR	Cardiopulmonary Resuscitation
ECR	Emergency Control Room
FMO	Force Medical Officer
HMIP	Her Majesty's Inspectorate of Prisons
NIPS	Northern Ireland Prison Service
PSNI	Police Service of Northern Ireland
RVH	Royal Victoria Hospital
SEHSCT	South Eastern Health and Social Care Trust
STORM	Skills-based Training on Risk Management for suicide prevention

PREFACE

Mr Rainey died on 19th April 2013 as a result of his attempt to hang himself on 9th April 2013.

As Prisoner Ombudsman for Northern Ireland I have responsibility for investigating all deaths in prison custody in Northern Ireland, including deaths post-release. My investigators and I are completely independent of the Northern Ireland Prison Service (NIPS). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications.

I make recommendations for improvement where appropriate; and my investigation reports are published subject to consent of the next of kin, in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

Objectives

The objectives for Prisoner Ombudsman investigations of deaths post-release are to:

- establish the circumstances and events surrounding the death, including the care provided by the NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust (SEHSCT);
- examine whether any changes in NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and

friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. In this case, Dr Seena Fazel, Consultant Forensic Psychiatrist, undertook a clinical review of the healthcare provided to Mr Rainey whilst he was in Hydebank Wood Prison and Young Offender's Centre (YOC).

The report is structured chronologically in relation to the events leading up to, and after Mr Rainey's death, and how the NIPS handled the incident.

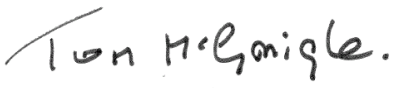
Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death. My predecessor first met with Mr Rainey's next of kin in May 2013, and contact has been maintained with them throughout the investigation. The investigation addresses matters which they raised at the outset, as well as further concerns they raised after reading the first draft of this report.

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

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

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



TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
3rd February 2015

SUMMARY

Joseph Rainey died in Belfast City Hospital on 19th April 2013, ten days after being found hanging in his cell at Hydebank Wood Young Offender's Centre. He was 20 years of age, and had only been in the Centre for a matter of hours.

This was his fourth time in Hydebank Wood, having been released from his most recent incarceration just 18 days previously.

The clinical reviewer considered that although there was evidence of a history of drug use, and possible self-harm, other elements of his background and the fact that he was a bright young man, did not indicate a high risk of suicide in custody.

More recent stressors were felt likely to have been significant. These included a perception that people thought he was a police informer, his belief that his girlfriend was cheating on him, and a sense of hopelessness about the future.

The clinical reviewer found it difficult to say whether possible withdrawal from drugs was a contributory factor in Mr Rainey's suicide. While he did not mention it in his suicide notes, any withdrawal would have destabilized his mental state and possibly made him feel more impulsive.

Mr Rainey had spent 38 hours in police custody before being transferred to Hydebank Wood. Most of this period was unremarkable, but there were sufficient indicators of concern for police to record that he was suicidal, had depression, and told them he self-harmed in the past – details of which were all recorded in the documentation that was passed onto Hydebank Wood Reception.

The prison officer who committed Mr Rainey found him in remarkably good form, quite boisterous and full of energy, similar to previous committals. He gave no impression of being under the influence of drugs, and the officer did not note anything about his presentation that caused him concern. Contrary to Prison Service policy, these observations were solely based on the officer's opinion. Important information supplied by the PSNI via the PACE 16 (Prisoner Escort Record) and PACE 15 (medical form), which included Mr Rainey's suicidal risks was ignored.

Also contrary to Prison Service Policy the reception officer did not provide the committal officer in Beech House, where Mr Rainey was taken, with the PACE 16 form. As a result the committal officer was not aware of the suicide risk that was identified by the PSNI.

The committal officer who admitted Mr Rainey to Beech House found him cheerful, polite and co-operative, with no medical or mental health problems. He said he did not know what to do with the PACE 15 form, and as a result it was not - as required by policy - provided to the nurse who was due to assess Mr Rainey. Had the officer read the PACE 15 he would have noted that Mr Rainey reported having suffered

from depression for six years and taking prescription medications, which conflicted with what Mr Rainey had told him.

A nurse saw Mr Rainey shortly afterwards, and due to conflicting information he provided about his thoughts of suicide, she was ambivalent about his state of mind. Nonetheless she erred on the side of caution and opened a SPAR[1] as a precautionary measure due to his impulsive presentation.

NIPS guidance is ambiguous about how a SPAR handover should be conducted, but in any event the handover - between its initiator (the nurse) and the senior officer responsible for implementing Mr Rainey's Keep Safe Care Plan - was inadequate. Staff concluded Mr Rainey was more tired than at risk of self-harm, and concurred with his request for hourly observations. This was meaningless as such frequency was no more than he would have had as a first night prisoner in any event. Mr Rainey's explanation about being tired was the dominant theme in the handover to night staff when they came on duty. While it was good practice to include Mr Rainey in design and implementation of his personal care plan, the decision should have been balanced against the identified risks and his apparent impulsivity.

Before being locked for the evening Mr Rainey was given an opportunity to speak with the Samaritans, and did so, though another prisoner suggested he treated the conversation as a joke. 26 minutes after finishing his call, Mr Rainey was seen writing a letter in his cell. This later turned out to be his suicide letter, though staff did not realise it at the time. The officer who was checking Mr Rainey did not attach any significance to him writing a letter shortly after phoning the Samaritans, because he had no concerns about him.

The emergency reaction was prompt and professional when Mr Rainey was discovered. However the officers who subsequently accompanied him to hospital felt uncomfortable about having to deal with family queries, and they were not included in the hot or cold debriefs. Nor did the cold debrief follow up on several topics that were raised by staff.

This investigation has identified 15 matters requiring improvement, the majority of which relate to poor communication. Five recommendations, 2, 5, 6, 11 and 14, were previously made and accepted by the NIPS and the SEHSCT: Recommendations 2 and 14 were made and accepted in October 2010, April 2011 and November 2012. Recommendations 5, 6 and 11 were made in November 2008, January 2009 and March 2013 respectively.

Repeated failure to implement recommendations that have previously been accepted is a matter of concern, which I have raised in a variety of forums, most recently in writing to the Minister of Justice and the Minister of Health. They have responded to say the matter is being treated seriously by the NIPS and the SEHSCT.

[1] SPAR – Supporting Prisoners at Risk is a safeguarding procedure utilised when a prisoner is identified as being vulnerable and at risk of suicide or self-harm.

On the basis of the investigation findings, I alerted the Prison Service to my view that there were performance management issues to be addressed in this case. The NIPS accepted this view, and states that relevant staff received performance management and further training.

RECOMMENDATIONS

NIPS -

1. **Prisoner Escort Vehicle Log** – A review of the current Prisoner Escort Vehicle Log should be undertaken to provide officers with the space to document handover information. Any changes to this document should be communicated to all PECCS staff. (Page 15)

2. **Committal Procedures** – Steps should be taken to ensure all Reception and committal staff are fully aware of their responsibilities when completing committal documentation: assessments should be thorough, handovers should be meaningful, and PACE 15 and 16 forms should be properly reviewed. (Pages 16-19)

3. **SPAR "Keep Safe" Procedures** – The Suicide and Self Harm Prevention policy and the SPAR Booklet should be amended to provide consistent and clear instructions on the procedures to be followed when completing a "Keep Safe." (Page 22)

4. **SPAR Observation Intervals on Committal** – Hydebank Wood should cease the practice of applying hourly observation intervals for new committals who are placed on a SPAR. (Page 22)

5. **SPAR Observation Log Entries** – In accordance with NIPS policy, these ought to be meaningful entries which record relevant information on the prisoner's mood, behaviour and circumstances. Staff should be made fully aware of this requirement. (Pages 23-24)

6. **SPAR Handovers** – In accordance with NIPS policy, handovers should be recorded in the class officer's journal and those receiving the handover should familiarise themselves with the content of the SPAR booklet. Staff should be made fully aware of this requirement. (Page 21)

7. **Access to Samaritans Pin Number** – The pin number for prisoners to contact the Samaritans should be accessible by staff at all times. (Pages 23-24)

8. **SPAR Suspensions** –SPAR booklets should be suspended in circumstances where the individual is incapable of posing a risk to themselves. (Page 27)

9. **Staff Welfare** – The welfare needs of staff who accompany prisoners to hospital after an attempted suicide, and are unable to attend the hot debrief, should be addressed at the earliest opportunity. (Page 28)

10. **Guidance for Hospital Watch Officers** – Guidance should be provided for bedwatch officers in relation to dealing with visitor's queries. (Page 28)

11. **Debriefs** – NIPS policy should be amended to require hot and cold debriefs to be undertaken following a serious suicide attempt, within the same timeframes as if the prisoner had died. (Page 28)

12. **Debrief Action Plans** – All steps that are agreed at debrief meetings should be transferred into an action plan that contains clear timeframes and allocates responsibility for implementation. (Page 29)

13. **Staff Communication Sheets** – Clear guidance should be issued to all staff in relation to the use of staff communication sheets, the level of detail required and when they should be written up. (Page 29)

SEHSCT –

14. **NIPS Suicide and Self-Harm Prevention Policy** – The SEHSCT should ensure that all its staff who work in prisons are fully aware of the requirements of this policy. (Page 19)

15. **ASIST/STORM[2] Training** – The SEHSCT should ensure that their Training Needs Analysis for providing ASIST and STORM training is delivered to relevant staff at the earliest opportunity. (Page 19)

[2] ASIST – Applied Suicide and Intervention Skills Training; STORM - Skills-based Training on Risk Management for suicide prevention.

NIPS & SEHSCT RESPONSE

The NIPS responded to this report by saying *"Our sympathy and thoughts go out to Mr Rainey's family. All deaths in custody are tragic and the Prison Service is committed to addressing recommendations made as a result of this investigation by the Prisoner Ombudsman."*

The NIPS recognised the positive actions of some of their staff, but also identified actions – such as failure to communicate the content of the PACE forms - that fell short of the level of professionalism they aim to deliver. Because of this they undertook performance management and provided further training for relevant staff.

The SEHSCT responded to this report by saying that it recognized the importance of staff being aware of NIPS Suicide and Self-Harm Prevention Policy and the importance of relevant staff accessing ASIST and STORM training. In terms of recommendations 14 and 15 they advised that these will be addressed through the continuing implementation of the healthcare training plan.

HYDEBANK WOOD PRISON & YOUNG OFFENDER'S CENTRE

Hydebank Wood Young Offender's Centre is a medium to low security establishment which accommodates young men aged between 18-21 years, who are remanded in custody or serving sentences, mainly of four years or less.

Hydebank Wood introduced a Safer Custody Co-ordinator in 2010. At the time of Mr Rainey's death he had not been referred to the Safer Custody Team.

The last CJI / HMI Prisons inspection of Hydebank was conducted in February 2013 and published on 1st October 2013. Several of the 95 recommendations in that report are relevant to the care of new committals and implementation of SPAR procedures.

Hydebank has an Independent Monitoring Board (IMB) whose role is to observe all aspects of the prison regime. The 2012-13 IMB annual report of Hydebank Wood did not make any recommendations that are relevant to Mr Rainey's death.

FINDINGS

SECTION 1: BACKGROUND INFORMATION

Joseph Rainey was 20 years old when he died on 19th April 2013 in Belfast City Hospital, having been found hanging from his TV stand on the evening of 9th April 2013 in his cell in Hydebank Wood Young Offender's Centre.

Mr Rainey had been remanded to Hydebank earlier that day. He had been in Hydebank on three previous occasions since October 2011 – once on a sentence and twice on remand. He had only been released 18 days earlier, on 22nd March 2013, after spending one month on remand.

Mr Rainey had no history of self-harm in prison, though he told police when arrested on 7th April that he had self-harmed "*a few times a couple of years ago.*" His prison medical records showed no diagnosis of mental illness and that he had not previously been on prescription medication (other than an antibiotic and five day course of sleeping tablets due to toothache). He was however argumentative with staff, at times very disruptive, and abused drugs in prison. He generally got along well with other prisoners, though he was involved in a few fights during previous periods in custody.

In August 2012 a Consultant Clinical Psychologist was instructed by Mr Rainey's solicitor to conduct a psychological examination in relation to criminal charges he was facing at that time. His opinion was that Mr Rainey was *"much brighter"* than he expected – *"functioning intellectually better than sixty-three percent of the normal population,"* and that his IQ of 105 was *"a slight underestimation."* The psychologist stated Mr Rainey's numerical ability was exceptional and that he could exceed his stated desire to complete a NVQ Level Two in Catering, or his ambition to own a shop. It was suspected that his intellectual functioning had in the past been clouded by using cannabis.

At the time of his assessment the psychologist was impressed by the references in support of Mr Rainey, and described him as being of a different calibre to many young people who had been brought up in the same environment.

In his clinical review report, Dr Fazel stated *"On the basis of the background history, Mr Rainey did not appear to have many risk factors that would suggest a high risk of suicide in custody. Although there is evidence of a history of drug use problems, and possibly previous self-harm, which are risk factors, these are common in prison populations, particularly in younger persons."*

SECTION 2: MR RAINEY'S ARREST AND TRANSFER TO HYDEBANK

Mr Rainey was arrested in Victoria Square, Belfast at 19.45 on 7th April 2013 and taken into police custody.

On arrival at the police station the custody record highlights that he appeared to be *"under the influence of something,"* and that he felt suicidal. As a result he was placed under constant CCTV observation and was physically checked every 30 minutes.

He was assessed at 21.05 by a Forensic Medical Officer (FMO) who deemed him fit for interview, and instructed his medications should be collected from his home. Mr Rainey told the FMO that he was prescribed pregablin[3], diazepam[4] and quetiapine.[5] This was untrue and when Mr Rainey realised he was not going to be prescribed these medications, he declined the offer of having them collected, and said he would be fine without them.

Mr Rainey slept overnight and the following morning (8th April) awoke requesting medication. When he was reminded that he had declined the offer of having them collected from his home, he commented that he would take them upon release.

Later that morning he was interviewed in the presence of his solicitor, and subsequently charged. During this time, and for the following two hours, Mr Rainey was threatening, aggressive, and destructive. At one stage a "spork" (spoon/fork) provided for eating lunch - had to be removed as he was placing it against his neck. At 14.40 the FMO gave Mr Rainey gabapentin, a medicine that is similar to pregablin. The reason for this is unclear.

Overnight he displayed similar disruptive behaviour for less than an hour, but appeared to have slept for the remaining time. At 08.09 on 9th April he was again given gabapentin and at 09.19 he was taken to court. The court remanded him in custody and he was taken to Hydebank that afternoon.

Other than stating he was suicidal upon arrival at the police station, and two hours 40 minutes (out of the 38 hours) when he was disruptive, Mr Rainey's behaviour for the remainder of his time in police custody was unremarkable.

During the journey from court to Hydebank a prisoner (Prisoner 1) who was being transported along with Mr Rainey stated that he was *"cracking up"* because he had been called a 'tout' (police informer). The officer (Officer 1) who supervised them during the journey could not recall any such abuse. He said that he would routinely inform Reception staff (verbally) if there was any abuse being shouted, so that the

[3] Pregablin can be prescribed for epilepsy, neuropathic pain relief and anxiety disorders.
[4] Diazepam is a diazepam used for anxiety disorders.
[5] Quetiapine is used for depression, mania and bipolar disorder, mood disorders, schizophrenia and psychosis.

prison would be aware of prisoners who did not get along. He advised that no records are made when such concerns are raised because there is no space on the prisoner escort vehicle log to do so.

Analysis of Mr Rainey's phone calls from his previous custodial period indicates an associate outside of prison was referring to him as a "tout" on social media prior to 12th March 2013. His reaction was one of exasperation.

SECTION 3: MR RAINEY'S COMMITTAL TO HYDEBANK

Reception

At 13.20 on 9th April 2013 Mr Rainey, arrived at Hydebank along with four other prisoners.

He was booked in and a Reception officer (Officer 2) interviewed him as part of the committal process. Details of this interview are entered in his 'Committal and First Night Information' booklet.

There are three pages for the Reception officer to complete in relation to personal information, court details and associated documents received, and whether he had any immediate issues in relation to dependants or his personal affairs - none are noted.

Officer 2 said that Mr Rainey was in remarkably good form and joked about the fact he had only been out of prison for a week (it was in fact 18 days). He described him as *"quite boisterous…full of energy,"* similar to previous committals, giving no impression of being under the influence of drugs. The officer did not note anything about Mr Rainey's presentation that caused him concern.

Officer 2 noted that Mr Rainey's PACE 15 (Police Medical Record) and PACE 16 forms (Prisoner Escort Record) had been received. The front page of the PACE 16 form highlighted that he was suicidal and had depression. The PACE 16 also confirmed he had informed police that he had self-harmed a *"few times, a couple of years ago;"* and that whilst in police custody had held a 'spork' up to his neck.

Hydebank Wood's 'Committal and First Night Information' booklet requires the Reception officer to address any concerns raised by court escort staff or police, by answering 'Yes' or 'No' in response to a specific question. This was not done in Mr Rainey's committal. If 'Yes' had been answered, the booklet reminds the Reception officer to consider opening a SPAR booklet. Given the information provided by police in the PACE 15 and 16 forms, this question should have been answered 'Yes'.

Officer 2 said it was an oversight, because he recalled seeing the information provided by the police. He had been a reception officer for eight months, but despite these markers, and his training in the SPAR process and ASIST[6], he was not concerned and did not discuss them with Mr Rainey. Officer 2 incorrectly tended to rely upon his own observations of a new committal, rather than on written documentation from the police.

[6] ASIST – Applied Suicide and Intervention Skills Training.

Governor's Order 9-2 (10b) (dated 8th August 2011) states *"Where PACE documentation has such entries* (to indicate if the prisoner is at an increased risk of suicide) *the Reception staff must ensure that the documentation is brought to the attention of and a full explanation is given to Healthcare Centre Staff."* In this instance the Reception officer did not bring the PACE forms to the attention of the nurse.

Committal Landing Handover

Mr Rainey was taken to the committal landing in Beech House at 14.27. The PACE 16 form, which highlighted the PSNI concerns, was forwarded to the General Office rather than to the committal landing. Current policy requires a photocopy of the PACE 16 to accompany the prisoner to the committal landing to inform staff, but in Mr Rainey's case this was not done and no handover information was provided. As a result of this failure the suicidal and depression markers highlighted by the police were not passed to staff in Beech House.

Committal Landing Interview

Mr Rainey was then interviewed by a committal landing officer (Officer 3). Topics covered by this interview include medical, physical and mental health problems of which landing staff need to be aware; substance misuse; and a vulnerability assessment which covers risk of self-harm or suicide, anti-social behaviour, potential risk to others, disposition during interview and whether, given all of the information obtained, a SPAR should be considered.

Responses to the questions indicate that Officer 3 found Mr Rainey to be cheerful, polite and co-operative, having no medical or mental health problems and not having recently taken any prescription medication. This is clearly at odds with information provided by the police.

Officer 3, who was not a regular on the landing, said that he had not completed a committal interview for over two years and did not know what PACE 15 or 16 forms were. There was an onus on both Officer 3 and the senior officer to ensure he was fully competent to fulfil his role as committal officer.

Officer 3 confirmed that as a result of his lack of knowledge, any documentation which accompanied Mr Rainey from Reception was placed, unread in the office, and left for regular staff to examine the following day.

Without the PACE 16 form or a proper handover from the Reception Officer (Officer 2), Officer 3 was unaware of the suicidal ideation that Mr Rainey expressed in police custody. Notwithstanding this, if Officer 3 had read the PACE 15 form he would have

seen that Mr Rainey said he suffered from depression for six years, attended mental health services and had been taking prescribed medication.

Given that the PACE 15 information contradicted what Mr Rainey had told him during the committal interview, and the fact that Officer 3 was trained in the SPAR process and ASIST, safeguarding measures should have been considered and discussed with the nurse who was due to assess Mr Rainey.

Not having read the PSNI information on the PACE 15 Officer 3 stated he had no concerns about Mr Rainey's presentation. He did not consider him to be under the influence of drugs; found he presented as he had always done in the past; and therefore signed off the 'Committal and First Night Information' booklet at 14.35, with a recommendation that Mr Rainey be monitored on hourly observations - the maximum interval under which all new committals are observed for a minimum of 24 hours.

Phone Call

Mr Rainey was allowed to make a phone call at 14.55. He was not yet registered to use the phone on the landing, so was allowed to use the staff phone. As this phone is not monitored it is not possible to ascertain details of the conversation, or to whom he spoke.

The officer (Officer 3) who was with Mr Rainey while he made this phone call said he could not recall any details about the phone call due to the passage of time.

Mr Rainey's family were advised by prison staff that the staff phone was broken. However our review of the CCTV footage established that at this time an officer took Mr Rainey to the desk where the staff phone was located. Due to the angle of the camera, CCTV footage did not capture Mr Rainey actually using the phone. CCTV footage did, nonetheless show the staff phone was working at 18.05 when another prisoner was using it.

Healthcare Interview

At 15.55 Mr Rainey left the landing for his healthcare committal interview in the medical room. He returned to the landing at 16.09. The nurse said this interview would usually take 10 to 15 minutes, but she suggested Mr Rainey's lasted slightly longer. The timed medical entry in his record indicates that the assessment started at 15.56, but the exact time it finished is unknown.

A section of the 'Committal and First Night Information' booklet which should be signed off by the nurse was not completed because it had been left in the staff office by Officer 3.

The nurse (Nurse 1) recorded on EMIS[7] that Mr Rainey had thoughts of self-harm; that he had two small healing wounds to his right forearm; that there were no signs of withdrawal; that he was talking fast and needed guidance to concentrate on a single subject; and that his mental state was *"Hyper."* No medications were listed for him, and no mental health referral was made as she felt his behaviour may have been drug-related. Another prisoner said he had heard that Mr Rainey was *"coming off"* methadone (a substitute drug prescribed for heroin addicts), though no further evidence is available to support this.

Nurse 1 surmised that because she had not referred to the police medical record in her EMIS entry, she must not have seen it. This is indeed highly likely since the landing officer (Officer 3) left all the documentation that accompanied Mr Rainey on his desk, and did not know the nurse should have had sight of it. It would have been relevant for the nurse to be aware of the medication that Mr Rainey had received in police custody, the medications he alleged he had been taking in the community, his self-reported six year history of depression, his self-harm attempts in police custody and his attendance at community mental health services. The nurse was also unaware of the contents of the PACE 16 form, which indicated suicidal and depression markers, due to the Reception Officer (Officer 2) not following the correct procedure.

Nurse 1 described Mr Rainey as *"buzzing"* and said he talked rapidly about unrelated topics. She formed the impression that he was under the influence of drugs, but was unconcerned as there was no indication of withdrawal symptoms. She said his demeanour was happy and upbeat, and when she asked him if he was considering self-harm he said *"Yeah yeah, I'm dead on."* However he quickly changed his mind and said *"Actually I might hang myself with my bed sheets."* The nurse said that she questioned him repeatedly about this, and he again changed his message to continually denying any suicidal ideation.

After Mr Rainey left nurse 1 was undecided as to whether SPAR procedures needed to be instigated. She had not received any training in suicide prevention, was unaware of the NIPS Suicide and Self-Harm policy, and had requested, but not received, ASIST[8] training. Nonetheless after some deliberation, and despite being unaware of the information held in the PACE 15 or 16, she opened a SPAR as a precautionary measure due to his impulsive presentation.

The SEHSCT's Primary Care Lead confirmed that primary care staff had identified training needs in relation to suicide risk assessment and the SPAR process. She advised that training in SPAR, ASIST and STORM[9] is included on the primary care team training plan along with a range of other training areas, such as immediate Life Support and Anaphylaxis. SPAR was identified as an initial priority area, and the intention is to continue to arrange SPAR training until all staff have completed it.

[7] EMIS – Egton Medical Information System. The database used to electronically store patients medical records.
[8] ASIST – Applied Suicide and Intervention Skills Training.
[9] STORM - Skills-based Training on Risk Management for suicide prevention.

The Primary Care Lead recognised there remains a need for skills training in relation to suicide risk assessment, which is to be addressed within the content of ASIST and/or STORM training. However, it will take time for all staff to complete this training, which will be prioritised according to the post holders' role.

In relation to the committal process, Dr Fazel emphasised that although the nurse did not query non-availability of a PACE 15 form, she asked appropriate questions in relation to Mr Rainey's mental health history, suicidal thoughts and plans, and recent drug problems.

In summary he stated that *"The committal assessment lacked important elements, in particular the appropriate consideration of the PACE 15 and 16 forms. If this had been done, then I think it would have been of assistance to the committal process for two reasons. First, he was suicidal in police custody and had apparently placed something (a 'spork') on his neck. In my view, this would have important information to inform his potential risk of suicide in that his comments to* (the nurse) *(Nurse 1) were not made in isolation. Second, he made a number of comments in police custody in relation to receiving treatment for mental health problems and for drug problems that would, in my view, led to referrals to both services in prison. In my view, the reception officer and the prison officer completing the committal interview should review police custody records for information on mental health and suicide risk, and this information should be shared with nursing colleagues during the committal process. If nursing staff do not receive the PACE 15 form, then consideration should be given to a process by which this information can be gathered for the purposes of the healthcare committal interview."*

In relation to the appropriateness of care provided to Mr Rainey for possible drug problems, Dr Fazel said that he was *"appropriately investigated for benzodiazepine withdrawal"* by the nurse.

Dr Fazel added, *"As he had been in police custody for two days prior to his committal, then I do not think that his symptoms could be explained by ingestion of illegal substances, but may have been a consequence of withdrawal from other substances. However it would have been difficult to treat as Mr Rainey did not provide any consistent information on other illegal drugs. During his committal, I note that Mr Rainey explained that he was addicted to cannabis, but he told the police surgeon that he was being prescribed pregabalin and diazepam."*

It is possible that some of his symptoms are related to withdrawal from cannabis including restlessness, irritability and insomnia. Sudden withdrawal of pregabalin is not recommended and may lead to sleep problems….In Mr Rainey's case I would have recommended urgent referral to mental health staff in view of the possible withdrawal from illegal drugs."

SECTION 4: OPENING OF THE SPAR BOOKLET

Referral Form

Nurse 1 recorded the following in the initial section of the SPAR booklet:

"Informed me he intends to hang himself with his bed sheets. Shortly after said he might not, he's 'gonna think about it'. Main concern is that he appears to be coming off drugs, but inmate is unfamiliar to me. SPAR opened as precautionary measure as he appears impulsive."

This section of the SPAR booklet contains written instructions on the *'Actions Required by Initiating Member of Staff.'* These explain that the booklet should be given to the person responsible for deciding on the immediate action to be taken to keep the prisoner safe, and that this would usually be the manager of the area where the individual is housed, or is to be located. When a SPAR is opened in Reception, initial decisions about care should be made by Healthcare staff, in conjunction with the manager of the receiving area.

On the basis of these instructions Nurse 1 took the SPAR booklet to the senior officer (Senior Officer 1). She also phoned the landing to inform staff that she had opened a SPAR for Mr Rainey. The officer (Officer 3) who answered informed her that Mr Rainey always presented like this when he arrived into custody.

Nurse 1 said she told senior officer 1 that she was not greatly concerned about the likelihood of Mr Rainey self-harming, and discussed her written observations with him. She also told him that landing staff were not concerned about Mr Rainey self-harming. The senior officer told her he would speak to staff and Mr Rainey promptly. When the nurse left, the SPAR Immediate Action Plan had not been written up. Senior officer1's recollection is that nurse 1 did not discuss the reasons for opening the SPAR, and he felt that she left swiftly because she was already late in finishing her shift.

Dr Fazel's view is that the handover in this case was not conducted *"according to good practice."* However he also felt the lack of a meaningful discussion between the nurse and senior officer was not a contributory factor in Mr Rainey's suicide attempt.

Immediate Action Plan: "KEEP SAFE"

The instructions provided on the SPAR booklet states the purpose of the Immediate Action Plan "Keep Safe" is to consider and record the most appropriate environment and regime to support the prisoner before the first Case Review (which takes place

within 48 hours). It states the Residential Manager (senior officer) will usually be responsible for making these decisions, after consulting with the prisoner / relevant staff, and that the action plan must be completed as soon as possible after the concern has been raised.

The NIPS Suicide and Self-Harm Prevention policy states that the initiator of the SPAR should remain on duty until the Keep Safe is completed. Both the senior officer and nurse said they were unaware of this. This policy guidance differs from the instructions provided on the SPAR booklet which states that initiator should give the SPAR booklet to the person responsible for deciding on the immediate action to be taken to keep the person safe. This creates ambiguity that needs to be addressed. However the ambiguity did not affect the failures to share the suicidal and depression markers that were provided by the PSNI, or the limited meaningful discussion between the nurse and the senior officer, both of which would have prepared the senior officer better for his discussion with Mr Rainey.

In line with Prison Service policy, the senior officer spoke with Mr Rainey about the SPAR process and "Keep Safe" plan between 17.04-17.06 in the Recreation Room. He said he was in a jovial mood, dismissive of the SPAR process and frequently wanted to end the discussion. He told the senior officer that he was not suicidal and said he could not understand why nurse 1 had assessed him as being at risk. Mr Rainey could not explain the comments he had made to the nurse, stating he *"...didn't know where his head was"* because he had been "o*n the go for the past three days,*" and needed some sleep. Two minutes was brief for a conversation that should have explored Mr Rainey's impulsivity, erratic presentation and reasons why he wanted to end the conversation quickly.

The SPAR booklet records that Mr Rainey was *"just a bit tired"* and wanted some sleep. The senior officer said that he gave him the option of hourly, half hourly or 15 minute observation intervals. Mr Rainey requested, and was granted, hourly observations, reiterating that he wanted to get some sleep.

As advocated by the 2005 'Review of Non-Natural Deaths in Northern Ireland Prison Service Establishments', the SPAR policy promotes the involvement of the prisoner in designing their care plan. However, the risks associated with allowing a prisoner to dictate his own monitoring intervals are obvious; and practice on this occasion was further flawed because the senior officer was not in possession of all the facts about Mr Rainey's recent history and presentation. As Mr Rainey would automatically have been on hourly observations (the normal routine for all new committals), the frequency of observations outlined in his SPAR were meaningless.

Mr Rainey was placed in an ordinary cell, rather than an observation cell (which provides anti-ligature furniture and bedding, and CCTV observation) as the senior officer did not assess him as having a serious and immediate intent to self-harm.

Again, this was in keeping with the NIPS Suicide and Self Harm policy, which states that observation cells should not be considered as a first option for a vulnerable prisoner. Rather it states that wherever possible, prisoners should be accommodated and managed in the normal environment, allowing them to retain personal possessions, as observation cells can create a feeling of isolation, which may negatively affect their mental health. This policy is based on the 'Review of Non-Natural Deaths in Northern Ireland Prison Service Establishments (November 2005)' which emphasised the need for a normalised environment to improve a prisoner's mental health.

Mr Rainey's "Keep Safe" plan included an offer of speaking to the Samaritans – which seems somewhat contradictory given that the senior officer felt assured that his comment to nurse 1 was *"off the cuff."* The senior officer said he made this offer because first night committals only have a few minutes to use the staff phone, and the use of it would allow Mr Rainey to have a lengthy conversation with someone outside of the prison, providing additional support and help should he require it.

The senior officer said that the Immediate Action Plan was agreed with Mr Rainey in the first instance, and confirmed by the landing officer (Officer 3) following his discussion with Mr Rainey.

Dr Fazel commented *"The added value of a SPAR would suggest more frequent observations were warranted, such as half hourly."*

SPAR Observations

The following observations were recorded in the SPAR booklet:

17.25 Joe was placed on a SPAR after interview with medical staff. Joe's mood at present is upbeat. Joe at his evening meal.

17.40 Asked for Samaritans phone. Used Samaritans PIN number.

18.40 Sitting at desk writing a letter.

19.30 Checked. Lying on top of bed. No issues / concerns.

20.30 Watching TV

21.30 Lying in bed watching TV

CCTV shows Mr Rainey using the phone booth on the landing to contact the Samaritans between 18.05 and 18.14. The difference between the SPAR entry time of his request to use the Samaritan phone, and the call taking place was due to

difficulty in finding an officer who knew the access PIN number. An officer (Officer 4) from another location arrived on the landing and assisted in facilitating this call. The landing officer (Officer 3) recalled Mr Rainey shouting to him in a jovial manner that there was £49 of credit left. Another prisoner (Prisoner 1) said that while Mr Rainey was on the phone to the Samaritans he called him over and said *"Come and hear this, I'm gonna talk S**t to these, am gonna wind these people up."* CCTV footage confirms this prisoner was using the staff phone at the time and appears to look in the direction of Mr Rainey for a short time and laugh. As calls to the Samaritans are confidential, details of his conversation are not available.

There was no association that evening due to staff shortages and a disruptive prisoner. Mr Rainey therefore remained locked in his cell from 18.14.

Officer 3 recorded the entries at 17.25, 17.40, 18.40 and 19.30. He said he did not consider engaging in conversation with Mr Rainey or asking what he was writing after his call with the Samaritans, because *"At no time did he seem distressed."* On reflection the officer agreed his entries were not sufficiently detailed.

The prisoner (Prisoner 3) in the cell adjoining Mr Rainey said he had been calling staff to see if his toilet could be unblocked. He said Mr Rainey heard him and called *"You're worried about your toilet and I'm in here writing suicide notes."* The prisoner did not think that Mr Rainey was serious. A night guard officer (Officer 7) who had been on the landing to conduct 15 minute observations on another prisoner said he did not hear any conversations between Mr Rainey and anyone else.

Night staff started their shift shortly after 19.30, and took responsibility for managing Mr Rainey's SPAR. The landing officer (Officer 3) said that during his handover he told night staff that Mr Rainey was on a SPAR, but that he had no concerns about him. No record of the handover was made in the Class Officer's Journal, which is contrary to Prison Service policy.

The officer (Officer 5) who received the handover said he was told that Mr Rainey was on a SPAR, but that he was tired and just wanted to sleep. He also advised that he did not read the referral page which outlines the reason for the SPAR, because from the start of his shift he was assisting with a vulnerable prisoner from another landing who had been disruptive for most of the evening.

CCTV footage confirms staff were on Mr Rainey's landing at 20.30 and 21.30. The officer recorded the following observations in Mr Rainey's SPAR booklet:

20:30	*Watching TV*
21:30	*Lying in bed watching TV*

Dr Fazel described the quality of the SPAR observations and recordings as *"Lacking"* and *"Not consistent with SPAR guidelines,"* as little or no conversations were conducted.

SECTION 5: DISCOVERY OF MR RAINEY

At 22.15 after the disruptive prisoner on an adjacent landing was relocated elsewhere, the senior officer (Senior Officer 2) requested staff to carry out a routine supervised check of Mr Rainey's landing, and an officer (Officer 5) walked onto the landing to commence the checks. Officer 5 said Mr Rainey's television was on and the room was illuminated, but because he could not see Mr Rainey he shouted to the senior officer to get his cell unlocked. This message was heard by the officer in the bubble (Officer 6) who immediately unlocked the cell electronically.

Another officer (Officer 7) ran towards Mr Rainey's cell at 22.16 and he said the door was unlocked very quickly after his arrival. He found Mr Rainey hanging from the television shelf (which is approximately four and a half feet off the ground) by his bed sheets, and quickly lifted him up to relieve the pressure around his neck. Both officers said the Hoffman knife[10] could not be used because of the thickness of the sheets, and Officer 5 had to unravel the sheets in order to free Mr Rainey. Mr Rainey had also tightly wrapped both hands into the sheets, which added to the pressure of releasing him. As soon as he was extricated from the bed sheets the officers brought him out onto the landing. No signs of life were observed, and Officer 7 commenced chest compressions straight away.

Emergency procedures were instigated as soon as Senior Officer 2 was asked to get the cell unlocked.

A nurse (Nurse 2), who was just leaving Beech House after attending the disruptive prisoner, quickly turned back to respond to the emergency unlock. On route to Mr Rainey's location she instructed another prison officer to retrieve her emergency medical bags from the Healthcare Department in order to not delay her arrival at the scene.

She arrived on the landing at 22.19 and began to give breaths while Officer 7 continued to give administer chest compressions. Her medical bags arrived at 22.25 and 22.28, and shortly afterwards she attached the Laerdal Mask and Ventilation Bag[11]. Officer 7 and nurse 2 continued CPR until paramedics and a doctor arrived. The nurse described how the colour began to return to Mr Rainey, and that he was less blue. The defibrillator was used but it instructed *"No Shock,"* and a faint pulse was felt.

Nurse 2 continued to support the paramedics and doctor. A tube was inserted which allowed Mr Rainey's lungs to be filled with air, and he began to breathe intermittently on his own. When his breathing became shallow, air was pumped into his lungs again.

[10] A Hoffman knife is specifically designed to reduce the risk of further injury when cutting a ligature.
[11] Laerdal Mask and Ventilation Bags facilitate assisted ventilation of a patient.

Mr Rainey was prepared for transportation, and left the prison at 23.22 for the Royal Victoria Hospital (RVH).

Letters Written by Mr Rainey

Mr Rainey had written letters to his mother and a friend, which provide some insight into his thinking and actions. They suggest that relationship difficulties, feeling that he had nothing to look forward to (because he was homeless, had no money or job), and the fact that acquaintances in the community had been spreading rumours that he was a *'tout,'* were significant.

Mr Rainey also wrote that spending time in jail was easy and that he was not worried about it.

He had also written on the walls of his cell *"TOOTH* (his nickname) *RIP 9th APRIL 2013"* and *"TOOTH – ALL TOUTS ARE SCUM."*

Dr Fazel advised that *"Any formulation of why Mr Rainey died from suicide would take into account the following issues. First, although we do not have extensive information on Mr Rainey's background, he had a number of factors that increased his risk, which included polysubstance abuse and previous self-harm. However more recent stressors are likely to been significant. These included Mr Rainey's perception that people thought he was a police informer, his belief that his girlfriend was cheating on him, and a sense of hopelessness about the future. My view is that the accumulation of these various factors together, and which in isolation or in part were not sufficient to lead Mr Rainey 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 could explain his suicide.*

The assessment of suicide risk, even in high risk groups such as hospital inpatients, remains an inexact science. Part of the problem is that many of the identified risk factors in high risk groups are also present in individuals who do not die from suicide..."

"…I find it difficult to say one way or the other whether Mr Rainey's possible withdrawal was a contributory factor in his suicide attempt. I note that he did not mention it in his suicide notes, but at the same time, any withdrawal would have destabilized his mental state and possibly made him feel more impulsive."

SECTION 6: MR RAINEY'S HOSPITILISATION & DEATH

Mr Rainey arrived at the Royal Victoria Hospital (RVH) at 23.30 on 9th April 2013 accompanied by two night guard officers (Officer 6 and Officer 8).

He immediately underwent a number of tests, and the next day he was transferred to the City Hospital where further tests were conducted. These revealed that he had severe brain damage, from which he would not recover.

On 17th April Mr Rainey was granted bail by the courts and prison staff were stood down. His family were concerned about this as they had advised police they would not support a bail application. Although this matter is not within the Prisoner Ombudsman's remit to determine, enquiries with the NIPS and Court indicate that Mr Rainey's then solicitor may have instigated this application.

At 01.19 on 19th April Mr Rainey passed away. The autopsy recorded the cause of his death as pneumonia due to cerebral hypoxia (brain damage caused by reduced supply of oxygen to the brain) due to hanging.

Continuation of SPAR

The SPAR booklet remained open and bedwatch staff continued to record events in the SPAR observation log. Given that a hospital bedwatch log records everything that takes place, and Mr Rainey's circumstances, the SPAR should have been suspended earlier to reduce unnecessary work.

SECTION 7: POST INCIDENT FOLLOW-UP & ISSUES

Hot Debrief

NIPS policy requires a hot debrief for staff who were involved, following a death in custody. The purpose is to allow staff to discuss the events that took place, highlight any learning from it, and to be informed of the support that is available.

A hot debrief took place that night (on 9th April) with all staff involved, with the exception of the two officers (Officer 6 and 8) who accompanied Mr Rainey to the hospital. No effort was made by the chair to contact these officers.

The minutes of this meeting contain a summary of the discussion, including the fact that as an additional welfare measure all staff involved were relocated to other areas of the prison. The minutes conclude there was no further information or action required as a result of that meeting.

Both officers who accompanied Mr Rainey to hospital were uncomfortable when they were asked to speak to his family and inform them what had happened. They were informed by Hydebank Wood Communications Room (their point of contact when escorting a prisoner offsite) that they were not allowed to share any information with the family, and felt awful about this. The officers considered they were not trained to handle that type of situation, and that a governor should have attended the hospital to deal with family queries.

Cold Debrief

A Cold Debrief, which affords staff the time to reflect on the incident, share what went well and identify any learning that could be achieved, should be held within 14 days of a death in custody.

The Cold Debrief in this case took place on 1st May 2013, 21 days after the incident, and 11 days after Mr Rainey passed away. While technically compliant with the policy, this could have been more beneficial (as participants' recall would have been fresher) if it had been conducted by 23rd April 2013.

Minutes of the meeting demonstrated the following positive actions:

- Aftercare was provided for prisoners who were affected by Mr Rainey's death;
- Support for staff who participated was highly praised (though the officers who accompanied Mr Rainey to hospital were again not in attendance at this Cold Debrief);

The following concerns and suggestions were noted at the Cold Debrief:

- Oxygen cylinders being located exclusively in the Healthcare Department; and a query about how often their oxygen levels are checked, and by whom. This raised a specific action for the NIPS Health and Safety Department in conjunction with the SEHSCT;
- It would have been beneficial to offer some staff the opportunity to go off-duty immediately after the incident. It was suggested that an emergency list of staff willing to come in on such occasions could be compiled. There was no action point against this despite it clearly being a matter that merited exploration;
- Prison staff had difficulty in gaining access to Mr Rainey when he was first admitted to the hospital, due to the medical attention he was receiving. Again there is no action point against this issue despite it being a matter that needed to be addressed;
- A hospital ward door was found to be unsecured, only after a friend of Mr Rainey's gained access without prior knowledge of bedwatch staff. Again there is no action point against this security breach, and there is no record of it in the hospital bed watch log;
- As new committals do not always admit to using illicit drugs it was suggested that a buddy system could be introduced as an additional safeguard measure. No action point accompanies this suggestion;
- It was recommended that vulnerable prisoners on SPARs should not be concentrated in one location as this places increased pressure on NIPS and SEHSCT resources. There is no indication of what action was going to be taken in relation to this suggestion.

It is clear that this meeting facilitated thought-provoking discussion, with some measured and useful considerations that should have been explored further. However an action plan was not produced as a result of this debrief.

Staff Communication Sheets

Staff communication sheets are written by each member of staff who deals with an incident. They should be compiled without conferring, as soon as practicable after the event, and preferably before the end of the shift. The time span in which staff communication sheets were completed in this instance was 22nd April - 4th July 2013. This defeats the spirit of the policy, because important details are forgotten with the passage of time.