COMMITTEE FOR JUSTICE

OFFICIAL REPORT (Hansard)

Death in Custody of Allyn Baxter

23 June 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Paul Givan (Chairperson)
Mr Raymond McCartney (Deputy Chairperson)
Mr Sydney Anderson
Mr Stewart Dickson
Mr Seán Lynch
Ms Jennifer McCann
Mr Basil McCrea
Mr Alban Maginness
Mr Jim Wells

Witnesses:
Mrs Pauline McCabe) Prisoner Ombudsman for Northern Ireland
Mrs Sinead Simpson) Office of the Prisoner Ombudsman for Northern Ireland

The Chairperson:

The next item on the agenda is a briefing from the Prisoner Ombudsman on her report into the death in custody of Allyn Baxter. I welcome Pauline McCabe, the Prisoner Ombudsman for Northern Ireland, and Sinead Simpson, the director of operations at the Prisoner Ombudsman's office. Pauline, I invite you to take over at this point. I am sure that members will want to put a number of questions to you.

Mrs Pauline McCabe (Prisoner Ombudsman for Northern Ireland):

Thank you very much, Chairman. We were asked to give a brief overview of findings in connection with the investigation into the death of Allyn Baxter. I will provide an overview on the basis that members will ask me for further information afterwards.

Probably the most important issue to draw attention to initially is that the report identified the fact that when Allyn Baxter went into prison, there were a number of factors in his family circumstances and background that increased his vulnerability. Allyn's mother had died when he was around six years of age. Over the years as he grew up, he was with at least 12 different foster families, although he was with his last foster family for four years and had left school with some GCSEs. He had used solvents from an early age. He had misused drugs and alcohol since his early teens. Over the years, he had a history of self-harm and attempted suicides. In fact, before he was committed at the end of July 2010, he had gone into prison at the end of June in connection with non-payment of his television licence fee. In the month between that committal and his final committal, he had been admitted to hospital on three occasions having overdosed.

It is fair to say that the report found that during the period that Allyn was in Hydebank Wood, staff did not, based on their meetings with him, his demeanour and the way in which he presented himself, identify him as being at risk. The CCTV footage that was examined supported the view that, when he was seen in recreation and at visits, Allyn, generally speaking, appeared to be quite well, and that is reflected in the report. However, the report also found that there were a number of issues in connection with Allyn's vulnerability that were not established and properly considered by the Prison Service. A police escort form, which was sent to the prison when Allyn was committed and which identified the fact that he may have had suicidal and self-harming tendencies, was not made available for consideration by the nurse who assessed him. Furthermore, contrary to Prison Service policy, no contact was made with his GP, so the service did not find out that he had been admitted to hospital for three incidents of serious self-harming in the previous month. There were also some breakdowns in communication between landing and healthcare staff, and the different pieces of information that each had about Allyn were not shared. Allyn had told landing staff about his history of self-harm and previous attempted suicides, yet that was not related to healthcare staff. As a result of that and because of Allyn's demeanour, he was not identified as a prisoner at risk during the period that he was in Hydebank Wood.

Another key finding of the report was the fact that there was an issue with an alarm on the night that Allyn was found in his cell. The prisoner in the cell next to Allyn pressed his call bell when he heard strange noises and a low cry for help. There was a five minute delay because a cell light did not illuminate, and the staff who were on duty that night were located in an office in which they were unable to see where the bell had been activated. The report found that, in normal circumstances, such a delay would not have been untoward and that when the staff found Allyn, they had done everything

that they reasonably could to assist him. However, the clinical reviewer found that, in the circumstances, that five-minute delay may have been significant in the final outcome.

Another important finding of the investigation was that Allyn had been locked up for extensive periods during his time in Hydebank Wood. During his last two days, he had been locked up for around 22 hours a day, and the report found that new committals in Hydebank Wood were regularly locked up for long periods. There were a number of reasons for that. Allyn was not exercising and did not use the gym. Gym assessments are carried out one day a week, and, because he had missed it on the Wednesday, he was ineligible for another assessment until the following Wednesday. It is also the case that it takes up to 28 days to put a sentence plan in place, which may identify different areas of purposeful activity that an inmate may become involved in. As that had not happened, Allyn was in his cell for extensive periods. The report drew attention to that, because it is well established that one third of deaths in prisons in England and Wales occur during the first seven days in prison, and there is clear evidence that prisoners who are more engaged in purposeful activity are less likely to self-harm and to dieby suicide.

On Allyn's last night, he made three phone calls to a friend, which were problematic phone calls. Later that evening, he was found by staff. Shortly before he was found, he had spoken with an inmate in the next cell through the wall, and he had mentioned the fact that he thought that his friend was not speaking to him and that he was "away to write a letter". Even at that stage, the way that Allyn described going away to write a letter did not alert that inmate to a particular concern. Once Allyn was found by staff, the report found that, as I said, they did everything they could to assist him. Unfortunately, however, he was taken to hospital where he subsequently died.

I am aware that I have provided an overview of the report, but I will stop there. We are happy to take any questions on any particular points.

The Chairperson:

I am sure that a number of members will have read the report. I thought that it was particularly tragic that Allyn thought that he only had 21p worth of credit left on his phone when he actually had £2·11.

On the issue of the light that was broken and the five-minute delay, did that light highlight a particular cell, or was it one where the officers would have been based? I know that the officers were unsure where to go to when the alarm was raised.

Mrs McCabe:

The prisoner in the next cell became aware that there may have been a problem and pushed his call bell, which would normally illuminate the light outside his cell. On that night, an officer had gone home because of an injury at work, and two officers were covering a patch that would normally be covered by three officers. Whereas one prison officer might have been located in an office in which there was a panel that would have immediately shown where the light was illuminated, on that night the officer who was covering Allyn's landing was based in an office in which there was no such panel. In fairness, he had located himself in an office that put him in the position nearest to the committal landing. By that stage, Allyn had moved off the committal landing. In all of the circumstances, that was quite a reasonable decision because, when an officer is needed during the night, more often than not, it will be on the committal landing. In that instance, a very unfortunate set of circumstances came together in respect of what happened.

Mr Wells:

Surely the light should be combined with some audible signal. In other words, an officer should not rely on seeing a light. An officer should be able to hear a sound such as a buzzer.

Mrs McCabe:

In many of the newer cells, and indeed on the other landings, there are two lights, one of which is a call bell for all sorts of things, and one is a light that must be used only in an emergency. On that landing, as in some other places, there was only one light that covered everything. The answer is that there is not an audible sound. A light illuminates on the landing, so when the officer got to the right landing, he knew that he was in the right area. He started to go down the landing to look at each cell, and it was only when he realised that he was taking time that he shouted out and someone shouted back to him. The light is not combined with something that makes a noise.

Mr Wells:

Modern computer technology can produce apps and phones that can do umpteen hundred things. There must be some system whereby a panel with lights indicates that there is trouble in a certain cell, rather than having officers running down a corridor saying, "Where is it?"

Mrs McCabe:

Under normal circumstances, had an officer not gone home that night, the officers would have been located in an office with a panel that would have shown where the light was illuminated. It is fair to say that, at busy times, if there were a sound that remained on until officers went to deactivate it,

particularly on a landing on which a bell is being used for absolutely everything, it could be fairly chaotic. You are absolutely right that, if the officers had been in the office where the panel was, they would have known sooner. The records show that the lights had been checked that morning and were functioning, but, obviously, that bulb had blown at some point during that day. As I said, it is extremely unfortunate that those different circumstances came together.

The Chairperson:

In the report, you point out that the family was very appreciative of the officers, particularly of the officer who went to the hospital and helped with the bed watching.

Mrs McCabe:

Absolutely. We found that the officers who went to the hospital did everything that they possibly could to be supportive and caring in their efforts with the family.

Ms J McCann:

Pauline and Sinead, you are very welcome. I have read the report in detail, and it makes very disturbing reading. Those types of deaths in custody seem to be happening more and more frequently. Given the young man's vulnerability and the state of his mental health, I find it very disturbing that that information was not noted and passed on to the prison officers and the people who were looking after Allyn in prison. Your report quotes from Anne Owers's review of the Prison Service:

"it is evident that, in spite of significant financial resources expended … prisons have been unable to run acceptable, consistent and positive regimes."

Your report refers to the length of time that the young man was locked up, and it seems to be the case that there were lock-ups and lack of access to educational activities and the type of activities that would help vulnerable people in that situation.

I do not know what Allyn was in prison for the second time, but I know that the first time he was in prison was for a very minor offence: the non-payment of a fine. It is an issue that people should sometimes not be in prison at all for the non-payment of a fine.

Are you confident that some headway is being made to ensure that we have a prison regime that is fit for purpose and that looks out for vulnerable people? Are you confident that we are moving towards a situation in which people are not left in their cells for that length of time for whatever

reason?

Mrs McCabe:

The interviews given by the deputy director of the Prison Service in the days following the publication of the report probably answer that question better than I can. He said that he could not guarantee to anybody that there would not be a situation in which vulnerable prisoners were locked up for 22 hours. I have talked about this a little today, because we presented our annual report in which we draw attention to the fact that complaints have gone up very significantly this year. The factor that accounts for most of that increase by far relates to your points. It is the case, and has become more the case in the past few years, partly because of some of the efficiency savings and cuts, that prisoners are often locked up for long periods and that association time is cancelled. I know that the Committee has had a number of briefings on the Anne Owers report. She draws attention to the fact that, across the prison estate, what is being offered as a purposeful regime, and the availability of activities that we know can impact on reoffending behaviour, is significantly constrained. Part of that relates to how money is being spent in the Prison Service.

Many of the complaints relate to the implementation of the progressive regimes and earned privileges scheme (PREPS). The Prison Service organises an incentive scheme to encourage the right kind of behaviours so that, if prisoners do all the right things, remain drug free and behave in a way that is appropriate and respectful, they are entitled to certain privileges, including additional association time. Given all the problems, very often it is not possible to deliver the association time that prisoners have earned.

There are ongoing problems. Anne Owers has comprehensively drawn attention to those. Can I say that I am confident about the issues that the member raised? At the moment, I absolutely cannot say that. However, we completely support the findings of Anne Owers and the significant package of measures that she recommends. That is the way in which we can make a difference and move forward in a fashion that is much more focused on delivering the issues that we know can impact on offending behaviour and change the attitudes and behaviours of people in prison.

Mr Dickson:

Thank you, Pauline, for your presentation on this particularly sad case. I have read the report in detail. I wish to comment on Mr Wells's point. The use of technology is important, and I appreciate the fact that that should form part of the recommendations that you have. For example, a press button should perhaps also send a text alert to the officers on duty identifying the cell number. All those

things are possible in today's modern age.

I want to turn to the chapter in your report on issues of concern requiring action, which is very comprehensive. As a layperson, they just scream common sense to me, which is why some aspects of the issue are so disappointing. You say that you have asked the director general to confirm that those issues will be addressed. Has he done so? Has he accepted the fact that those issues need to be addressed? Has he put in place an effective action programme to ensure that they have been addressed?

Mrs McCabe:

The director general accepted that all the areas of concern need to be addressed. As has been well publicised, the Prison Service has a huge backlog of recommendations. The risk with that, notwithstanding the fact that they have not been dealt with before, is that people put a lot of time and energy into working through recommendations. Anne Owers and others believe — certainly the director general believes — that a much more comprehensive and strategic approach is needed. Members will have read the report and will be aware that, this time around, rather than make recommendations, we listed complaints. We were trying to feed into that and to give an opportunity for those to be addressed in that way. The director general is appearing before the Committee later today. He has started a programme of work called the SEE programme. The intention is that that will have several work strands, and the types of issues that I identified in the report will be addressed through those work strands.

I will make one point that concerns us. Two and a half years ago, I was reporting on the death of Colin Bell. When I last reported on the death of John Deery, I was reporting pretty much the same areas of concern that we had reported on two and half years earlier. It is not the case, where we have made recommendations over the past three years, that the Prison Service ignored them. Many people in the Prison Service have worked hard. There have been projects, strategies and initiatives to try to make a difference. However, the reality, which Anne Owers addressed well, is that they have not delivered on making that difference. She argues that there are fundamental issues that we need to address, and if we do not address them — if we keep looking at things as topics, such as vulnerable prisoners or other issues — regardless of whatever time, energy and money we invest in them, we do not get the changes on the ground that we need. That is why she said that her report absolutely has to be taken as a package, a view which we fully support.

Mr Dickson:

Thank you. That is helpful.

Mr B McCrea:

There are a number of concerns about this issue. Generally, suicide is unpredictable in nature. People seem to lose control in a minute. However, the inability to get medical records, the failure to phone the GP and the acknowledgement in the committal interviews that those were problems makes me think that this must be a pervasive and general problem in the Prison Service.

Mrs McCabe:

Again, I can do no better than return to what Anne Owers said in her report, which was that the problems are too deep and too long-standing, which is why she recommends a fundamental review. As I said, the Prison Service has made efforts; it has looked at the safer custody policy and the care of vulnerable prisoners policy. It has implemented all sorts of checks, balances and arrangements, but, as you point out, the service has not delivered the changes that we need.

Anne Owers talks about problems of culture, approach, management and leadership, which all impact on the service delivered. It is important to say that many good officers are trying hard to deliver a good service. I think that the package that Anne Owers recommends is that the best service that we can provide to those officers trying to do a good job is to have that programme of change that will enable them to be effective. It is frustrating for officers who try to deliver a good service to find that it does not produce the outputs, because, as Mr McCrea said, the failure to address fundamental issues undermines the ability of any one initiative or project to make a difference.

Mr B McCrea:

I support and am glad to hear of the great efforts that the prison officer went to after the event. I am not an expert, but the problem is that self-harming seems to be endemic. There seems to be a lot of self-harming that is routinely dealt with by prison officers, but no real understanding of how that represents, almost self-evidently, mental health issues. The report has been published, but do prison officers and the authorities understand that self-harm means a mental problem. What is your assessment?

Mrs McCabe:

There are, perhaps, two strands to that. First, an awful lot of people come into prison with mental health problems, addiction problems and learning difficulties. It is a massive challenge to the Prison

Service to deal with such problems. Therefore, how we spend money looking after prisoners — how much of it is invested in mental health services, addiction services, and so on — is an important question.

I referred to the second element earlier. All the evidence shows that people who are locked up longer self-harm more, and every day there is evidence of that in situation reports from our prisons. The evidence is that those who are more engaged in purposeful activity, human contact and mixing with others are less likely to self-harm. Given the way in which staff are deployed, one difficulty is that the ability to invest in purposeful activity — to get prisoners out of their cells and involved in such activity — is greatly limited by the way in which things are currently organised. Anne Owers referred to those issues in some detail.

There is also a third strand, which is to question why some people are in prison who could be looked after much more effectively in a different place. For those who are in prison, it is about the specialist services to support and look after them. However, a joined-up holistic approach is also about organisation, regime, purposeful activity and how prisoners spend their days.

Mr B McCrea:

I accept the medium- and longer-term solution that you talk about; that is fine. However, I have a specific issue. The report states:

"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."

That is not part of the generic restructuring that we need to look at. This is a fundamental failure. Had medical records been asked for, a different conclusion would have been reached. That is also brought up in the committal proceedings, when the nurse looked at the agitated state in which he came in. This is not the long-term solution, and I want you to find the long-term solution. However, I also want to know that when people come in in that state, their GP records are automatically looked for.

Mrs McCabe:

What you say is absolutely right. Based on the recommendation that I made two years ago, which was accepted by the Prison Service, the GP should have been contacted in those circumstances. If the

GP had been contacted, and the Prison Service had been aware that there had been three episodes of self-harm in the previous month, officers should certainly have considered opening a SPAR (supporting prisoners at risk) so that he was looked after as a vulnerable prisoner and, particularly as he was undergoing detoxification at the time, they should have seriously considered locating him in healthcare. The relationship with the generic issue is that sometimes officers think that there is a danger that when the emphasis is on policies, practices and boxes and ticking, the underpinning issues of the culture of care and how we look after people in those circumstances may be put to one side, and things that should happen do not happen because the focus is on procedures and ticking the right boxes.

Mr B McCrea:

So —

The Chairperson:

I want to move on as other members wish to speak. Are you OK with that, Mr McCrea?

Mr B McCrea:

You are in the Chair.

Mr A Maginness:

I do not think that we can wait for the full implementation of Anne Owers's reports on prison reform. Some action must be taken immediately to cope with the situation. It seems to be a repetition of previous events — not quite the same but similar — and action must be taken. In your annual report today, you talk about an increase in complaints about lockdown. Was this a form of lockdown?

Mrs McCabe:

There were a couple of factors. Certainly, the amount of time that Allyn spent in his cell was affected by lockdowns that the Prison Service would describe as being the result of staff shortages. We would argue a different case. It was partly that, and it was partly the arrangements that are in place anyway at Hydebank Wood about what is available to anybody during their first 28 days of committal.

Mr A Maginness:

However, it is self-evident in your report that lockdown complaints have increased, and that seems to suggest that there is a problem. I do not want to stray into your annual report, but is it not relevant to this situation?

Mrs McCabe:

The problem is that we have a range of agreements in place that were made a long time ago and that influence how officers are deployed and how flexibly they can be deployed. Those agreements were made for particular reasons at a time, and they served their function well. There were fixed arrangements about the number of officers on landings at particular times, and so on, arrangements around overtime, holidays, starting and finishing times, shift arrangements, and so on. Anne Owers's report drew attention to the fact that officers work a notional 39-hour week, but that delivers 28 hours on front-line duties. There are all sorts of issues about how they are deployed, and that has a consequence. It means that a huge amount of money is tied up in paying officers' salaries, but there are limitations resulting from how the officers are used and what it is possible to deliver during the normal regime. Clearly, Prison Service policies should not be breached. However, after three years of making recommendations, I am absolutely convinced that the Anne Owers approach, which is that we need a package, is the only thing that will really deliver the difference. We need to do this as a fundamental review and a package. We have tried lots of quick-fix policies, and huge credit must go to the people who have made incredible efforts to do that, but those policies are not delivering change on the ground. In fact, things are getting worse.

Mr Lynch:

Thank you for the report, which is very comprehensive. Having read it, I am saddened like everybody else. The case is not just a prison issue but a major indictment of the way in which our justice system decides who to send to prison and for what offence. Even members of the public have said how trivial that man's offence was. He went to prison for the non-payment of his TV licence. That is true. There needs to be a list. You mentioned Anne Owers's comments, but this case is an indictment of the whole criminal justice system.

Mrs McCabe:

I completely agree with you. I return to what Anne Owers said and draw your attention to two issues. When she spoke about the package, she included two fundamental issues that, if dealt with, could make a huge difference to the challenges facing the Prison Service. The first of those is the percentage of remand prisoners. Fifty per cent of the prison population at Maghaberry is on remand, which makes a very difficult situation a whole lot harder for the staff and management. The second issue is about how we treat what we call "finers". Last year, one third of all committals were for fine default. Moreover, 52% of female committals last year were for fine default. One of those, as Anne Owers reported, was for the non-payment of a dog licence. The average stay in prison for somebody

who defaults on a fine is four days. The average cost of committal procedures is well in excess of £3,000 per prisoner, and there is no repayment of the fine that actually got the person into prison in the first place. If, as part of the package, we were to deal with finers and remand prisoners — Anne Owers talked about introducing a 12-month cap — that alone would make a colossal difference to the task and challenges that face management in the Prison Service and would give them a much better chance of investing in things that are really a challenge for officers, such as mental health and addiction problems. In addition, if we are really serious about making sure that those leaving prison do not come back, dealing with finers and remand prisoners would give us an opportunity to deal with those other issues while we have them in prison.

The Chairperson:

Thank you very much. That concludes the session, and you have brought us nicely on to a fine default consultation.