The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE NEAR DEATH OF MR C (AGED 30) WHILST IN THE CUSTODY OF MAGHABERRY PRISON ON 19 FEBRUARY 2012

[25 April 2013]

[Published, 1 May 2013]

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

Unit 2, Walled Garden, Stormont Estate, Belfast BT4 3SH
T 028 9052 7771 F 028 9052 7752 www.niprisonerombudsman.gov.uk

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PREFACE

Given the particular vulnerability of the person to whom this report refers, he has, throughout this report, been referred to as Mr C.

The Northern Ireland Prison Service's Standard Operating Procedure on Self Harm and Suicide Prevention 2011, states that an internal review or external investigation by the Prisoner Ombudsman will occur when a prisoner self harms to the point where:

- *without immediate intervention the prisoner would have died;*

- *as a result of the incident the prisoner has suffered permanent or long-term serious injury; and*

- *as a consequence of the long-term injuries sustained the individual's ability to know, investigate, assess and /or take action in relation to the circumstances of the incident, has been significantly affected.*

On 24 February 2012, the Prison Service's Director of Operations requested a Prisoner Ombudsman investigation into the near death of Mr C who, following a self-inflicted injury on 19 February 2012, remains under constant care in a nursing home having suffered severe brain damage. At the time of the injury, Mr C was in the custody of Maghaberry Prison.

I met with Mr C's mother following the incident and met with her again to share the content of this report.

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

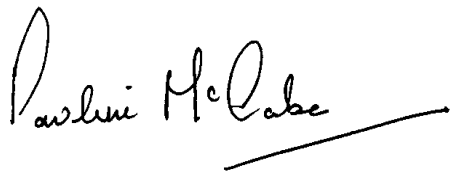
As part of the investigation into this incident, Dr Seena Fazel, a specialist forensic psychiatrist, was commissioned to carry out a medical review of Mr C's healthcare in prison. I am grateful to Dr Fazel for his assistance.

I am also grateful to Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at The Royal Infirmary Edinburgh, who was commissioned to provide an expert opinion on the actions taken by staff when Mr C was found.

In the event that anything else comes to light in connection with the circumstances of this incident, it will be recorded in an addendum to this report and notified to all concerned.

In connection with this investigation, 44 matters of concern are identified.

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
[25 April 2013]

SUMMARY

Mr C was 30 years old when he nearly died on 19 February 2012, after a self-inflicted injury. Mr C was in the custody of Maghaberry Prison.

Mr C's records show that he tried to overdose three times in his late teens, when he was victimised following his conviction for a sexual offence. He then moved to England when he was eighteen and, over the following seven years, received a number of prison sentences.

In 2000, Mr C was diagnosed with alcohol dependence syndrome and in 2008; he had a serious fall which caused multiple fractures of the spine and pelvis. Following his accident Mr C regularly used painkillers.

In December 2009, Mr C's two children were taken into care. Two weeks later, his girlfriend, who was also the mother of his children, died by suicide. On the day of her death, both Mr C and his girlfriend had been drinking heavily and, the following day, Mr C was admitted to a psychiatric hospital for one day, having attempted to cut his throat. He was noted to be *"very depressed,"* with "*suicidal ideation"* and was diagnosed with an adjustment reaction[1]. Mr C had no noted history of psychiatric illness before this time.

Mr C then returned to Northern Ireland and variously lived with his mother and in a hostel. In 2010, he had a further diagnosis of alcohol dependence syndrome and between March 2010 and October 2011 he was committed to prison eight times. His medical records indicate that at the time of these committals, Mr C's mental state was generally considered to be settled.

On 7 October 2011, Mr C was committed on remand to Maghaberry Prison and was later sentenced to two years for a sexual offence. Records show that, during this committal, Mr C was moved from Roe House to Bush House[2] for his own protection, after he had alleged that he was being threatened by other prisoners.

[1] Adjustment reaction is a short-term condition that occurs when a person is unable to cope with, or adjust to, a particular source of stress, such as a major life change, loss, or event.
[2] Bush House has a vulnerable prisoner landing which houses elderly prisoners and prisoners convicted of sexual offences.

On 24 November 2011, Mr C was transferred to Magilligan Prison and on 9 February 2012, he was released on a 'Determinate Custodial Sentence Licence'[3] with a number of conditions. Two days later, Mr C's licence was revoked because it was reported that he had failed to return to his approved accommodation, his behaviour had deteriorated and he had been drinking alcohol. The probation officer who made the recommendation to revoke Mr C's licence reported also that Mr C had said that he was suicidal and *"felt like slitting his wrists or hanging himself".*

On 11 February 2012, Mr C was committed to Bann House in Maghaberry Prison. It was noted that he had a past history of self-harm and that the Prisoner Escort Record indicated that he had *"suicidal tendencies".* The committal officer recorded that Mr C was a *"vulnerable prisoner"* and felt *"at risk being in prison, due to the nature of his offence".* The nurse who carried out Mr C's Committal Healthcare Review recorded that he had had a previous admission to a psychiatric hospital; had a history of self harm outside prison; had attempted to cut his own throat approximately three years earlier and had overdosed at the age of 16/17 years. The nurse recorded that Mr C had no current thoughts of self harm and was calm and co-operative.

At the time of committal, no decision was taken to refer Mr C for a mental health assessment. It was the opinion of the Clinical Reviewer, Dr Fazel, that someone with a history of a previous psychiatric admission, a history of self harm, chronic alcohol problems and experience of recent bereavement, warranted referral for a mental health assessment. Dr Fazel also noted that, *"according to the list of risk factors in the Prison Service's 2011 Suicide and Self Harm Prevention Policy,* (Mr C) *had four (out of a possible nine) risk factors identified during committal namely, a history of suicide attempts, a history of mental ill health, drug or alcohol misuse, and a conviction of a sexual offence"*, which he said, *"indicated an increased risk of suicide in custody".*

Mr C was taken to his cell and locked for the night at the early time of 16.09.

[3] A determinate prison sentence is where the court set a fixed length for the prison sentence and is the most common type of prison sentence. For sentences of a year or more, an offender will serve half their sentence in prison and serve the rest of the sentence in the community on licence.

The following morning, 12 February 2012, when breakfast was being served from a food trolley, Mr C threw liquid and a flask through his cell door after it was opened. A senior officer who was called to Mr C's cell said, *"As I lifted the observation flap of cell 8,* (Mr C) *had commenced damaging the cell furniture. He ignored all attempts to engage or reason with him and continued to methodically smash every piece of cell furniture before pulling the sink from the wall and smashing the toilet with it."* The senior officer said that there was *"no anger...he was very calm... I actually now remember him looking at me as I spoke to him and he just turned and looked at me and just turned his head away again....but no abuse towards me or anything. I didn't exist. He could hear but he couldn't understand. Whatever was going on was much, much greater than anything I was saying."*

Mr C was escorted to the Care and Supervision Unit (CSU) using control and restraint techniques[4] and, as required by Prison Service policy following an incident where control and restraint techniques have been applied, he was assessed by a nurse.

Mr C was again seen by a nurse the next morning, 13 February 2012. The nurse concluded that he was *"fit for adjudication and cellular confinement"*, that his *"mood was relaxed and his behaviour appropriate"*, and that, "*no mental health issues had been raised"*. CCTV shows that the nurse who made this assessment spoke with Mr C from the corridor outside his cell door for approximately one minute.

The same morning, a prison doctor reviewed Mr C's medication requirements. It is recorded that the doctor prescribed diclofenac sodium 50mg (anti-inflammatory medication), co-codamol 30/500 (for pain relief) and varenicline (for smoking cessation). This was consistent with Mr C's prescription when in prison previously.

Later that morning, Mr C phoned a family member and said that he had wrecked his cell because he wanted to "*go to the block*" (Care and Supervision Unit). He said that he was concerned for his safety because "*a prison officer had told other inmates what I am in prison for... I am going to be attacked or killed"*. Mr C said also that he had tried to *"hang myself*" the previous night *"but the rope snapped"*.

[4] Control and restraint techniques are used in situations which require a person to be restrained using Home Office approved techniques.

That afternoon, a probation officer met with Mr C and afterwards opened a SPAR[5] in which she recorded that, *"when discussing emotional wellbeing,* (Mr C) *stated he tried to hang himself last night but the rope broke. Stated he did not inform prison staff. States people have been referring to him as a sex offender. Concerns passed onto prison staff and SPAR opened."* The probation officer noted also that Mr C wanted to move back to Bush House.

Following Mr C's conversation with the probation officer, he was taken to see a senior officer and a SPAR 'Assessment Interview' was carried out. The senior officer noted Mr C's reasons for wanting to die as being: that he was depressed; that he'd had his licence revoked and that he'd only been out of prison for four days (it was actually only two days). The reasons Mr C "*gave for living*" were recorded as *"his mother and his two children".* The senior officer also recorded that Mr C had shown suicidal ideation in the past and that he had been *"sectioned"* two years earlier. He recorded that mental health input would be arranged.

There is no record of any discussion relating to Mr C's allegations that others had been referring to him as a sex offender and that he had been threatened. It was, however, noted on the 'Immediate Action Plan' that Mr C had said that he felt safe when located in Bush House. It was noted also that Mr C was to be observed at 30 minute intervals, have four conversational checks throughout the day and have free access to the phone. The requirement for the mental health assessment was not recorded on the Action Plan.

It is recorded in Mr C's medical records that a SPAR healthcare assessment also took place and that Mr C felt *"depressed about being back in prison"* and that there was *"no evidence of marks or bruising"* around Mr C's neck from his alleged attempt to die by hanging the previous night. The nurse also recorded that Mr C was *"encouraged to speak to staff if feeling low"* and that he "*remained low after a lengthy chat"* with the senior officer. It was noted that Mr C had a *"history of DSH* (deliberate self harm) *and attempted suicide. Will need referral to MHT* (Mental Health Team) *and pr* (prisoner) *happy with same."*

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

Whilst Mr C's SPAR booklet notes that the healthcare assessment took place, none of the information recorded on his medical records was noted on the booklet. It was not, therefore, available to landing staff caring for Mr C.

Around this time, Mr C wrote three letters. In the letters he wrote about how he missed his children and said that he was annoyed that he didn't know where they were. He wrote also of his concern about being labelled a sex offender and his fear of being assaulted by staff and other inmates.

The next morning, 14 February 2012, a nurse noted in Mr C's medical records that a mental health referral marked *"urgent"* had been made. At interview, the nurse said that he placed the written referral in the Mental Health Team's 'pigeon hole' as he understood this to be the referral procedure. The investigation found, however, that the person making the referral is also required to enter the patient's name in the Mental Health Team's diary and that the Team only access referrals recorded in the diary. The nurse who made the urgent referral for Mr C, and other nurses interviewed, had not been made aware of this requirement. It was, therefore, the case that the nurse's referral was not received by the Mental Health Team and was not considered and prioritised at their weekly meeting on 16 February 2012.

Later that morning, Mr C's adjudication, for which he had prepared a written statement, was held. Mr C said that he had told the officer who was serving breakfast in Bann House, before he opened the cell door that he needed to be moved because of *"threats"*. He stated that because the officer said nothing, *"when he opened the door I threw juice over him and a flask and then wrecked the cell. I wanted moved off that wing as I was going to be assaulted if I go back to that wing, Bann, I will be attacked in there, so I would want you to consider that if I go back in there I will assault the officers again. To be moved, I want kept down the block* (Care and Supervision Unit) *or moved to Bush House for my protection. Mostly Bush House or shipped back to Magilligan Prison. I apologise for what happened."*

Mr C read out his statement at the adjudication and pleaded guilty. No questions were asked about the threats that he said he had received in Bann House or his reasons for fearing that he would be assaulted. It was also the case that, following the adjudication, the information in the statement was not communicated to

anyone else or noted on the SPAR (Supporting Prisoner at Risk) booklet that was subsequently opened for Mr C. It was decided that, as a punishment for his actions, Mr C was to remain in the Care and Supervision Unit for five days cellular confinement. In line with Prison Service policy; he was permitted to have a radio and reading and writing materials, but no television.

At interview, the adjudicating governor said that Mr C told him that he did feel suicidal but that he "*had no active plans to take his own life*". The governor said that Mr C felt vulnerable from attack by other prisoners and that he (the governor) felt that *"with* (Mr C) *going to the CSU he would be safe and that there would be a locked cell door in place which would maybe help to settle* (Mr C)*".*

The governor said that Mr C did not say who was threatening him and that he did not take any other action in connection with the statement Mr C made to the adjudication because his *"focus was the adjudication"* and that his role on that day was *"to look at the evidence against the charge".*

Later that day, Mr C was seen by a prison doctor who recorded, *"see yesterday's entry re attempted hanging using towel which snapped. Still feels like self harm i.e. cutting wrists, depressed re losing partner couple yrs ago, also recent deaths of family members, also re return to prison and wants back to Magilligan…..Awaits urgent mhs* (mental health support) + *is on SPAR, wants restart of Prozac* (fluoxetine) + *sleeper."* The doctor prescribed 14 fluoxetine hydrochloride 20 mg capsules (an antidepressant) to be taken once daily and five promethazine hydrochloride 25mg tablets (for sleep problems), one to be taken each night.

Assessment by a nurse is a daily requirement in circumstances where a prisoner is subject to cellular confinement and at 09.45 on 15 February 2012; Mr C was again seen by a nurse. It is recorded in Mr C's medical notes that he was *"relaxed"*, his behavior was appropriate, *"no medical complaints were stated"* and no *"abnormal thoughts or perceptions"* were noted.

Notwithstanding Mr C's reported recent attempt to self harm, the information recorded on his SPAR, the fact that a doctor had noted the previous day that Mr C was depressed and was awaiting an urgent mental health assessment or the

decision to prescribe the antidepressant fluoxetine, the nurse concluded that there was *"no reason for referral to GP or MHT* (mental health team)*"*. It was also the case that Mr C was not issued with the antidepressant medication or medication to help him sleep, which had been prescribed by the doctor the previous day.

The nurse's conclusion on 15 February 2012 that Mr C did not require a mental health assessment was contrary to the conclusion reached by a governor and nurse the previous day and, as stated, noted and recorded by the doctor on 14 February. In the event, a different conclusion was reached at a Case Review shortly afterwards.

Prison Service policy states that a SPAR Case Review must take place within 48 hours of a SPAR being opened. At 11.50 on 15 February 2012, Mr C's Initial Case Review took place and was attended by the nurse who had seen him earlier. It is recorded that, *"*(Mr C) *presented as being very withdrawn… He reported as feeling depressed and still having active suicidal thoughts. He says he has suffered personal loss which weighs heavily on him. Staff report that he has written letters stating he will self harm.* (Mr C) *has seen a doctor for help with his depression and wants a move to Bush or Magilligan. As the prisoner continues to present in such a manner the 30 minutes obs* (observations) *and conversational checks remain unchanged. Referral made to mental health via unit nurse."*

The nurse also recorded in Mr C's medical records, but not in his SPAR, that he was *"asked if actively suicidal – states not when I'm here i.e. CSU* (Care and Supervision Unit) *– was previously in Bann and states was having bother there from other prisoners, no current thoughts of dsh* (deliberate self harm) *at this location, wants to move to Bush and be considered for Magilligan – house S/O* (senior officer) *will action this….advised to request nurse if needed."*

A Care Plan for Mr C was agreed and it is recorded that he was to remain on 30 minute observations, to have conversational checks, to have supervised access to razors and that the nurse who attended the Review was to check that the mental health referral was made. It is recorded that this was actioned the same day. At interview, the nurse said that she checked Mr C's medical record and noted that a

referral had been made. She did not check the mental health team's diary and was not aware that Mr C's referral was not being progressed.

That afternoon, Mr C phoned a family member. During the call, which at times was stilted, Mr C said that he had asked to transfer to Magilligan Prison but had been told that this was not possible. He said that, when asked where he would like to go as an alternative, he had asked to move to Bush House. Mr C said also that staff and prisoners were talking about why he was in prison. The family member told Mr C that he was just being *"paranoid".*

Later that afternoon, Mr C asked for a nurse and, ten minutes later, he was observed to have torn up bed sheets and made ligatures. He was then seen by a nurse who recorded, *"states wishes to kill himself if got* (the) *chance, wishes to go to hospital as feeling down. Plan to increase SPAR to 15 minutes. Move prisoner to safer cell* (observation cell) *where possible."* The nurse also recorded that, following Mr C's assessment with the prison doctor the previous day she would issue his newly prescribed medication that evening. That evening, Mr C was issued his medication to help him sleep but not the antidepressant medication prescribed two days earlier.

Mr C arrived at an observation cell in Lagan House at 18.00 on 15 February 2012 and was provided with his protective clothing. Contrary to Prison Service policy, he was not provided with slippers when his own footwear was removed. CCTV shows that later on that evening, Mr C was pacing up and down his cell on a blanket. Mr C was eventually given slippers 17 ½ hours later.

At 21.56 on 15 February 2012, CCTV shows that Mr C broke a handle off a cup and intermittently slashed at his arms and wrists with the cup before using the handle to slash at his wrists. Staff observed what Mr C was doing and phoned for a nurse. At 22.13, an officer on the landing recorded that Mr C had cut his wrists but that it was *"not that bad, 'minor', medic informed."* The officer later recorded that he had told Mr C that a nurse was coming and that he asked Mr C to give him the *"mug and handle, then after medic sees him he could have a light* (for a cigarette)*".* At 22.38, 42 minutes after the incident commenced, a senior officer and a nurse arrived and Mr C's cell was opened for the nurse to bandage his arms.

Six minutes after the nurse left, Mr C was observed attempting to rip his protective clothing top with his teeth and staff, fearing that he was trying to make a ligature, removed the top. Mr C was later seen to wrap a blanket round his shoulders to keep warm. Early the next morning, at 00.45, Mr C emptied the content of his water bottle and started to chew on it. Staff removed the bottle.

At 08.36 on 16 February 2012, a nurse gave Mr C his medication and recorded in the SPAR booklet that, *"he* (Mr C) *is keen to get out of the safer cell* (observation cell) *and is willing to return to the CSU to finish his cellular confinement – following which he would like to go to Bush House. I advised him that this decision will depend on various factors. He stated that he has no further TSH* (thoughts of self harm) *or SI* (suicidal ideation) *if he can get out of the safer cell."*

Between 11.29 and 11.42 on 16 February 2012, Mr C made two phone calls to a family member. During the first call, a person Mr C asked to speak to did not come to the phone and, after waiting for two minutes and fifty seconds, Mr C ended the call. During his second call Mr C talked of his concern that staff members were going to "*do me in".* He said that he believed that staff were showing pictures of him to *"the Ra*[6]*"* and that he wanted his solicitor to be informed of this.

Following this phone call, a nurse who saw Mr C to administer his medicine, recorded that Mr C had *"poor eye contact, no TSH* (thoughts of self harm) */ suicide"* and noted that he'd just spoken to a family member. The nurse also recorded that Mr C, *"states he has refused meals – advised it is important to eat/drink regularly.* (Mr C) *states he doesn't want to go back to CSU – advised* (Mr C) *I cannot influence where he goes, also advised* (Mr C) *he cannot use threats of DSH* (deliberate self harm) */suicide as a means of obtaining a different location.* (Mr C) *demanded to go to wards - advised him he had no clinical/medical needs to necessitate admission. Very aggressive body language. Took meds."* Mr C's antidepressant medication was not one of the medicines dispensed.

At lunch time on 16 February 2012, Mr C handed his meal back and stated that he was on hunger strike. That afternoon, a further SPAR Case Review took place and it is noted that Mr C had *"stated he wanted to return to the CSU* (Care and

[6] Short for The IRA.

Supervision Unit) *and then Bush* (House)*".* It is also noted that Mr C had subsequently told a nurse that he would self harm if he was moved back to the CSU; that he *"seemed to be somewhat paranoid";* that he thought that *"everyone wants to attack him"*; and that he also thought that *"staff are telling other prisoners about his offences".* It was recorded that, *"low mood is evident and eye contact and engagement in conference were not good".*

It was agreed that it would be *"prudent"* for Mr C to remain in the observation cell for a further 24 hours and was further recorded that Mr C was to be *"encouraged to engage with mental health support as a history of non-engagement existed in the past".* Despite the nurse knowing that Mr C had spoken with a family member and was in a low mood following this, no consideration was given to having his telephone calls monitored.

The need for a mental health review remained on Mr C's Care Plan but it is to note that this was not being actioned.

At 18.43 on 16 February 2012, as required by Prison Service policy, Mr C was seen by the duty governor. It is recorded that Mr C *"explained he had cut his wrists and tried to hang himself because of 'shit' going on in his life".* It was also noted that Mr C felt *"under threat from other prisoners in Lagan because of his offence".*

Between 00.01 and 14.00 on 17 February 2012 Mr C slept for only four hours. He told an officer he *"didn't feel suicidal but was still feeling low"*. Mr C also refused his medication, didn't eat any breakfast or lunch, refused to shower, refused to talk to a member of the prisoner fellowship (but later requested to see a priest), was noted to give *"monosyllabic answers"* and was noted also to have *"poor eye contact".*

At 14.10, Mr C attended a further SPAR Case Review. The Review was chaired by the senior officer of Lagan House, and was attended by a member of staff from Mr C's landing, a member of the probation team, a nurse and Mr C.

A record of the Case Review states that Mr C was "*not suicidal*" but that he admitted being upset about being placed in the Care and Supervision Unit (CSU). It was also recorded that Mr C's SPAR should remain open, that his observations

should be decreased to hourly and that a minimum of four conversational checks within a 24 hour period should occur.

The nurse who attended the review recorded in Mr C's medical records that *"all in attendance"* were in agreement that Mr C was to return to the *"CSU* (Care and Supervision Unit) *on hourly observations to complete CC* (cellular confinement) *then for relocation into main population".* The nurse also recorded that Mr C was *"again adamant"* that he wanted to go to Bush House but was *"advised he must complete his CC first".* It is to note that at the Case Conference on 16 February 2012, it was recorded that Mr C had told the same nurse that if he was returned to the CSU he would self harm.

At interview, the senior officer who attended the Case Review confirmed that it was agreed by all present that Mr C should finish his cellular confinement in the CSU. When asked about the fact that it had been recorded that Mr C had previously been upset about being in the CSU, the senior officer said, *"he had concerns about going to the CSU, because he was upset about getting cellular confinement* (CC), *I think it was the context of it. But again he could see, you know that the CC was there and it was going to be hanging over him anyway. So he was happy to go through that because as he seen it then, if he got that out of the way, then that allowed him then to maybe try and finish off in Bush House where he would be settled and happy."*

The probation officer who attended the Case Review said that, *"*(Mr C's) *mood was much better and I recall that he was more talkative and we discussed how he was going to resolve his situation and how he saw himself getting out of it and he was quite positive about returning to Magilligan at that stage. So we all discussed the possibility of him transferring back to Bush and then getting back to Magilligan. We felt that he would have support within the staff that he was probably used to."*

At interview the nurse who attended the Case Reviews on 16 and 17 February said that she could not recall anything other than what was recorded in Mr C's medical records.

There is no evidence to suggest that consideration was given at the Case Review to the fact that Mr C had: reported low mood; experienced difficulty sleeping; refused

his medication; not been eating his meals; refused to talk to a member of the prisoner fellowship (but later requested to see a priest); was recorded to have being giving *"monosyllabic answers";* and demonstrated *"poor eye contact".*

In all the circumstances, and given that Mr C had been confined in an observation cell for two days, it is unclear why all of those present at the Case Review believed that it was so necessary for Mr C to complete his cellular confinement before he would be permitted to go to Bush House where he felt safe.

It is also the case that Mr C's updated Care Plan noted that he was to engage with mental health and that a referral had been made the day before. There is no record in Mr C's medical notes that a further mental health referral was made on 16 February 2012 or that his earlier referral was followed up.

Commenting in his clinical review report on the appropriateness of Mr C having to complete cellular confinement whilst on a SPAR booklet, Dr Fazel stated, *"in my opinion, some consideration of whether* (Mr C) *should have completed his punishment on a SPAR is warranted. A balance needs to be drawn between not giving the impression to prisoners that any punishments will be moderated if they self harm or threaten suicidality. On the other hand, the mental health consequence of placing someone in cellular confinement needs to be carefully considered, particularly if they have already self harmed in prison recently and have ongoing mental health problems."*

At 14.44 on 17 February 2012, CCTV shows that Mr C was brought into the Care and Supervision Unit and was taken to cell six on landing two, to complete his period of cellular confinement.

At 14.58, Mr C made a phone call to a family member which lasted approximately 17 minutes. Several times during the call, Mr C said that he thought he was going to be attacked or killed whilst in Maghaberry and believed that staff were *"going around the landing"* saying that he'd *"get his throat cut".* He said that if this happened they would *"say that I have self harmed".* Mr C also talked about being *"off suicide watch and back in 'the block'…"* and said that he wanted *"out* (of the observation cell in Lagan House)*"* because he had *"no clothes or nothing".*

That afternoon it was noted that Mr C *"felt a bit low"* but that he had "*no thoughts of self harm*" and was on medication which he said *"seemed to be helping".* It is to note that Mr C had still not been given his antidepressant medication. At 15.41, he made another call to a family member during which he said that he was *"going to get done in tonight"* and that he had heard officers talking about it on the landing. At 16.30, Mr C made a further call and asked for the same family member. He then spent over 11 minutes holding, because the family member was not willing to speak to him again. Mr C's family member did, however, phone Mr C's landing to explain that Mr C was anxious that staff were trying to kill him.

Mr C's bedding and other items were subsequently removed from his cell after an officer talked with him *"at length".* The officer noted that Mr C was *"first threatening to hang himself if he didn't see the governor and then claimed that staff were trying to kill him or planning to kill him".* Mr C's bedding was later returned but had to be removed again when he *"stated he was definitely going to hang himself".* A decision was then taken to return Mr C to Lagan House to an observation cell in protective clothing.

Back in the observation cell, Mr C could be seen on CCTV smoking numerous cigarettes, watching television, pacing his cell, sitting or lying on his bed and looking out of the window. That night he slept for approximately five hours.

On the morning of 18 February 2012, a nurse visited Mr C in his cell because he was complaining of stomach pains and said he thought he ought to go to the prison hospital. The nurse concluded that there was no clinical signs or symptoms to indicate any acute issues and that, *"*(Mr C) *has underpinning anxiety issues and may use vague symptomatic issues to manipulate his way out of the safe cell to avoid returning to the CSU* (Care and Supervision Unit)*".*

Mr C's final Case Review is recorded to have taken place at 10.00 that day. It was attended by a case manager, which in this case was the duty senior officer, a member of staff from Mr C's landing and Mr C. Contrary to the minimum requirement for attendance at a Case Review specified in the Prison Service's Suicide and Self Harm Prevention Policy 2011, a member of healthcare staff was not invited to attend. It was however the case that, contrary to usual practice, the

Review took place in Mr C's cell and at the time when the nurse was assessing Mr C's stomach pains.

At interview the senior officer who chaired the Case Review said that he had not received any training on the SPAR process at the time and, as a result, did not know that a member of healthcare staff must attend and that a Review would not normally be held in a prisoner's cell. The officer said that when he made a phone call to someone in healthcare he *"was asked just about his* (Mr C's) *demeanour and* (was told that) *they had no real concerns about him"*. The senior officer could not recall who he spoke to and there is no record of this phone call taking place in Mr C's SPAR booklet or in his medical records.

CCTV shows that the senior officer entered Mr C's cell and left approximately three minutes later. During this time, the officer spoke to Mr C for approximately two minutes. For the remainder of the time, Mr C was being seen by the nurse in relation to his stomach pains (as detailed above) whilst the senior officer and the member of staff from Mr C's landing talked to one another. At interview, the senior officer confirmed that this was the SPAR Case Review and said that, as a nurse was seeing Mr C about another matter, he took the opportunity to ask the nurse how he thought Mr C was. The senior officer said that he couldn't remember exactly what the nurse said, *"just the general consensus was that he* (the nurse) *was happy with the way he* (Mr C) *was presenting".*

A summary of the Case Review notes that, *"after speaking with* (Mr C) *he appears and presents as calm and pleasant. He is now happy to move back to normal location. Duty Governor consulted and is happy with the situation. Obs* (observations) *changed to hourly as there have been no episodes of DSH* (deliberate self harm). *Review in 1 week."*

It is to note that, over the previous 24 hours, Mr C had displayed a number of possible risk factors listed in the Prison Service Suicide and Self Harm Prevention policy as *"irrational behaviour, anxious appearance, withdrawn or depressive manner, talks about death or suicide, disturbed sleep, unusual, untoward or bizarre behaviour".*

When asked about the threats of suicide that resulted in Mr C being placed in the observation cell, the senior officer said, *"it's hard to define whether when he* (Mr C) *said that, if it's being said as a clear intention of what he intended to do, or whether it was said to try and manipulate".* The senior officer said that he spoke with the duty governor and *"explained how* (Mr C) *was presenting and the possibility of moving him out of the safer cell* (observation cell) *and into…normal location. He* (the duty governor) *said to speak to the security department to see where they're going to put him and I said he needed to finish the committal induction."*

The senior officer updated Mr C's Care Plan to state that his observations were now to take place only hourly. No other actions were recorded and the fact that Mr C had still not been assessed by a mental health nurse was not noted or identified as requiring action.

Prison training records show that the senior officer attended ASIST[7] training on 20 February 2012 and attended training in the SPAR process on 21 February 2012. It was, therefore, the case that, as the officer said, he had not received the necessary training when he made the arrangements for the "Case Review" on 18 February 2012.

At interview, the duty governor to whom the senior officer spoke on 18 February said that he was not aware that the officer was not trained in the SPAR process, but that he had seen the officer in operation before and was *"confident in his ability".*

The duty governor said also that he was not aware that the Case Review took place in the observation cell and was not aware that a member of the healthcare team did not attend the Review. He said also that he did not know that Mr C had been referred for a mental health assessment but that this would not have prevented Mr C from leaving the observation cell as *"it can take weeks"* for a mental health assessment to take place. The governor said that the senior officer had told him that Mr C *"wanted to move on with things"* and that Mr C's cellular confinement had been completed. The governor said that he thought that the Case Review had taken place, the decision had been made and that *"things were positive".*

[7] ASIST – Applied Suicide Intervention Suicide Training.

In relation to Mr C being moved to Bann House to finish his committal induction, the duty governor said that this decision had already been made by the senior officer as far as he was concerned and he was *"rubber stamping"* the decision. It is to note that the duty governor was the same governor who had chaired Mr C's adjudication at which he submitted a statement stating that he feared being attacked and assaulted in Bann House and, if sent there again, he would attack an officer (to ensure that he was again relocated to the CSU).

At 11.15 on 18 February 2012, it is recorded on the SPAR observation log that, the senior officer spoke to Mr C and told him that he was moving to Bann House. At interview, the officer said that the reason Mr C was not returned to the Care and Supervision Unit (CSU) was because he (the officer) contacted someone in the CSU who said that they were *"content that the time spent in the safer cell* (observation cell) *would cover the CC* (cellular confinement)*".*

The senior officer was not aware of the statement that Mr C had prepared for his adjudication because this was not noted on Mr C's SPAR booklet. Whilst it was again not recorded in his SPAR booklet, Mr C's medical records also noted that he was *"previously having bother from other prisoners"* in Bann House. It was, however, recorded that during Mr C's initial SPAR assessment interview, he had said that if he was moved to Bush House, where he had previously felt safe, his thoughts of self harm and suicide would reduce. This was reiterated during the SPAR Case Review on 15 February, when it was recorded that Mr C wanted to move to Bush House or Magilligan and, at the further Case Review on 17 February, where it was agreed that, if Mr C completed his cellular confinement in the CSU, he would then be able to transfer to Bush House.

The officer who escorted Mr C to Bann House said that Mr C was agitated and said that he wasn't happy about moving to Bann House. The officer said that he managed to calm Mr C down by telling him that he would speak to someone on the landing for him and, when they arrived, he sat Mr C down in the circle area and went to explain Mr C's concerns to one of the officers in Bann House.

CCTV shows that at 11.26 on 18 February 2012, Mr C arrived in Bann House and sat on a chair in the circle area[8]. A few minutes later, some prisoners passed Mr C on their way back to the landing from the recreation room / yard and one prisoner can be clearly seen to stand in front of Mr C and glare at him for approximately three seconds. A few minutes later, at 11.33, Mr C walked over to the opposite side of the circle and picked up two metal food containers, one in each hand. CCTV shows that Mr C started to wave one of the containers and two prisoners who were in the circle area looked fearful and quickly left the area. The officer who was processing Mr C's paperwork was standing approximately 10 feet away from Mr C but, due to the angle of the CCTV camera, it is not possible to determine whether this officer spoke to him. CCTV shows that the officer who had escorted Mr C to Bann House then walked purposefully towards Mr C and, using control and restraint techniques took him to the ground and held him there. The incident lasted 17 seconds.

Mr C was held on the ground until 11.38, when the dedicated search team arrived and escorted him to the Care and Supervision Unit under Prison Rule 35 (4)[9] using control and restrain techniques. It was alleged that Mr C was threatening to assault an officer with the metal food container.

One of the questions raised by Mr C's family was why he was not in an observation cell when he attempted to die by suicide.

At interview, the duty governor (the same governor that conducted Mr C's adjudication on 14 February 2012 and authorised Mr C's move to Bann House earlier that morning) said that the reason Mr C was moved to the CSU, rather than back to an observation cell in Lagan House, was because "*the policy on an observation cell is very clear and an observation cell must be used as a last resort and where there is an imminent threat of suicide. What was presented at that time was a serious intention of violence towards staff and maybe prisoners so, on that basis, moving* (Mr C) *to the CSU was the right decision.*"

[8] The circle area of the landing is where the officer's office is located. Telephones for prisoner use are also located in the circle and meals are served there.

[9] Prison Rule 35 (4) states that a prisoner who is to be charged with an offence against discipline may be kept apart from other prisoners pending adjudication, if the governor considers that it is necessary, but may not be held separately for more than 48 hours.

Despite the fact that: Mr C's behaviour when he arrived at Bann House was inconsistent with the assessment made at the Case Review that morning; the duty governor was aware of Mr C's anxiety about being located in Bann House and Mr C was known to be a vulnerable prisoner who had been in and out of an observation cell, no consideration was given to the possibility that either a further Case Review was required or that it might be appropriate to monitor Mr C in an observation cell for a further period.

Having returned to the Care and Supervision Unit Mr C requested and was given the Samaritans phone at 12.25, which he used for ten minutes.

Between 14.01 and 16.04, Mr C made 21 attempts to phone his family. Only three of these calls were answered. During the first call, Mr C asked for a message to be passed to another family member that he was going to be murdered by staff and other prisoners and that they were going to slit his throat. At the start of the second call, which lasted just over 28 minutes, Mr C asked to speak to another family member. The phone handset can be heard to be set down and left. No one came back to the phone and throughout the rest of the time Mr C was heard to repeatedly say things like: *"f**k sake hurry up will you", "f***in b*****d … why did you leave the phone and not come back to it" and "hurry up"*. The third call which lasted almost five minutes was to a different family member. During the conversation the family member, who was clearly frustrated, told Mr C that he was being paranoid about being murdered in prison.

Later that afternoon, Mr C told a nurse who was administering his medication that he felt under threat from other prisoners and was *"demanding to be taken around to the hospital"* in a *"non-aggressive nature"*. The nurse noted that Mr C believed that other prisoners would get into his cell and *"beat him up"* for his past crimes. The nurse tried to reassure him that this wouldn't happen and told him that he would not be taken to the hospital as there was *"no clinical reason"*. The nurse updated the SPAR observation log stating, *"seen in medical room. To remain on 15 minute observations. Medication given."*

An entry made in Mr C's SPAR observation log at 16.43 on 18 February 2012 states, *"checked prs* (prisoner) *said 'I'm not a root*[10]*.' Don't know why."* A further entry by the same officer, at 17.00, states, "(prisoner's name) *is winding him* (Mr C) *up about staff calling him a root. Obviously* [prisoner's name] *is making this up for reasons known only to himself."*

At interview, the officer who made the log entries said that he raised his voice, in order for both Mr C and the prisoner in the cell next to him to hear him, and told Mr C that it was not him (the officer) who had been calling Mr C names but the prisoner in the next cell.

A review of the SPAR observation logs for the period following Mr C's return to the Care and Supervision Unit (CSU) shows that he continued to be observed at 15 minute intervals. CSU staff were responsive to Mr C's needs, made many attempts to engage him in conversation, asked him his first name and helped him to get *"rollies"* (roll-up cigarettes). Mr C also appeared to settle in his bed much earlier than the previous two nights.

On the morning of 19 February 2012, a nurse assessed Mr C to determine whether he was well enough to carry out a period of cellular confinement as a punishment in connection with the most recent incident in Bann House. A record of the nurse's assessment noted that Mr C expressed having a low mood, but denied any feelings of deliberate self harm or suicidal ideation. It was also noted that Mr C's behaviour was *"suspicious and guarded"*, that he *"denied having any hallucinations but talked about seeing shadows at times"*, that he *"stated he wanted to be in a safe cell"* to ensure that he was not harmed and that he had not been sleeping *"due to the perceived threat on him from staff"*.

The nurse also noted a comprehensive background history of Mr C including the fact that he'd been seen by a community psychiatric nurse and a psychiatrist in the past and that he denied any history / current feelings of deliberate self harm or current feelings of suicide.

[10] "Root" is slang for sex offender.

The nurse concluded that Mr C required a *"referral to the mental health team for a further in-depth assessment"*, but determined that, notwithstanding all of the information provided and the recent history in Mr C's SPAR booklet, Mr C was fit for cellular confinement.

At interview, the nurse said that he was not aware of any earlier referrals to mental health.

That morning Mr C was also seen by a governor who recorded in Mr C's SPAR observation log that he said that he was being *"intimidated by staff"* who were *"threatening to cut his throat"* and that he was requesting a transfer to Magilligan Prison.

Between 10.11 and 11.29 on 19 February 2012, Mr C attempted to make 11 calls to the same family member. Only two of these were answered. During the first call Mr C talked about officers putting something into his tea and said that he could *"feel the effects of it"*. He said also that when he died, prison staff would try to make it look like he had died by suicide because he had previously cut his arms and attempted to hang himself. The person Mr C called told him that he was paranoid and they ended up falling out.

Mr C's second and final answered call, which lasted approximately 22 minutes, was to the same person. During the call, Mr C continued to talk of his belief that other prisoners and staff were going to attack him. The person he called appeared to find it difficult to know how to respond to Mr C and became frustrated with him, telling Mr C he needed *"psychiatric help"* because he had been *"coming off with this craziness for the last three days."* He told the family member that he was going to die and that he loved them. Mr C said, *"this will happen tonight"* and made requests relating to his grave before ending the call saying, *"I want buried from your house... Tell* (name redacted) (name redacted) *and* (name redacted) *that I love them."*

Commenting on Mr C's apparent paranoia, the Clinical Reviewer Dr Fazel said: *"These paranoid thoughts probably had some basis in reality, but they seemed to me to have become more intense than his situation would suggest. Specifically, the notion that he would be killed by prison staff is unrealistic, and these paranoid*

thoughts did not seem to moderate with repeated assurances from staff and family. Although I do not think that these are symptoms of an underlying severe mental illness (such as schizophrenia or a psychotic depression), they may be among the stress-related symptoms some individuals experience who are vulnerable because of underlying personality problems. A review by a psychiatrist would have been able to examine these symptoms in more detail, and consider alternative medications, such as a short-term antipsychotic that can help dampen down paranoid symptoms in some individuals, even if they do not have a severe mental illness. We do not know if such medication will have worked in (Mr C)*'s case, but as the paranoia was one of the triggers to* (Mr C)*'s suicidal thoughts, a trial of medication could have been considered. In summary, the combination of the need for a more detailed mental state assessment and the possibility of a trial of a low dose antipsychotic underscores the importance of* (Mr C) *having a psychiatric review."*

At 12.00 on 19 February 2012, the nurse who had seen Mr C earlier that morning recorded on his SPAR observation log that Mr C had declined his medication and that the *"referral to the mental health team will be completed."* Between 12.25 and 15.30, staff recorded on Mr C's SPAR observation log that, at different times, he was pacing in his cell, sitting on his bed, standing at his cell door, reading, or standing looking out of his window and that he had been given writing materials.

At 15.57 the nurse administered Mr C's medication which, on this occasion, he decided to take. Between 16.15 and 17.40, Mr C continued to be observed at 15 minutes intervals.

At 18.00 it is recorded that Mr C was talking to another inmate through the wall. This was the same inmate who was earlier recorded to be "*winding him* (Mr C) *up about staff calling him a root."* At interview, the prisoner denied talking to Mr C that evening. This being the case, it is not possible to assess the impact that of anything the prisoner may have said on Mr C.

At 18.34, CCTV shows that Mr C's cell door was opened for 23 seconds whilst he was seen by a nurse and given his medication. A senior officer and the officer from the Care and Supervision Unit were also in attendance.

Although Mr C was required to be observed at 15 minute intervals, his next observation was twenty nine minutes later, at 19.03. The same officer from the Care and Supervision Unit checked Mr C through his door flap. At interview, the officer said that he could only see Mr C from the knees down and could not get a response from him. The officer also said that he was upstairs in the office catching up on paperwork at the time of the missed observation and hadn't realised that the time had lapsed.

It was the case that Mr C's observation checks in the CSU had, prior to his final check, consistently been carried out at regular intervals, as required. The evidence also suggests that the care and consideration shown to Mr C by staff in the CSU was the most thoughtful that he received during the period of his final time in prison. This being the case, the mistake made by the sole officer in the CSU who missed Mr C's final observation was most unfortunate.

From the time the officer found Mr C and called for assistance, it took five minutes for an emergency unlock to be carried out with a senior officer. Mr C was found to be suspended by a ligature made from the bottom of his vest. The senior officer cut Mr C down using a Hoffman Knife[11] and placed him on the floor of the cell to *"carry out a primary survey to establish his condition".* The senior officer established that Mr C's airway was clear but that he was not breathing. Cardiopulmonary resuscitation (CPR) commenced with the assistance of the two nurses. An automated external defibrillator and a pulse oximeter were used and it was established that Mr C had a pulse and was still alive. It was recorded that CPR continued for further 10-15 minutes until Mr C started to breathe himself. The senior officer noted that *"it wasn't normal breathing in the proper sense of the word so we continued on the oxygen and we constantly monitored him".* This continued until paramedics arrived at 19.31 and entered Mr C's cell.

It is to note that in his clinical review report, Mr Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh said that, *"resuscitation of someone who is near to death is often a catastrophic, disruptive, shocking and distressing event; especially distressing if the final outcome is not good. The prison staff involved in* (Mr C)*'s CPR should be commended for their efforts."*

[11] Hoffman knives are used to quickly and safely cut a ligature without any hazard to the officer or prisoner.

At 19.47, Mr C was taken away by the paramedics to the Royal Victoria Hospital, Belfast. There was a four and a half minute delay in requesting the ambulance due to an unfortunate misunderstanding of one of the radio messages sent by the senior officer at the scene.

In light of the missed observation check and the delay before staff entered Mr C's cell after he was found, Mr Edward Brackenbury, was asked to provide his expert opinion on the significance of these findings to Mr C's outcome.

Mr Brackenbury concluded that:

"The delay in the quarter-hourly SPAR checks and the five-minute delay in opening the cell door and commencing CPR could, in theory, be relevant to the final outcome of the resuscitation attempt. The brain is a highly oxygen-dependant organ and can become severely damaged after only three or four minutes of hypoxia at normal body temperature. Even the smallest delay in rescue will be important in determining the success, or otherwise, of resuscitation following hanging. The delayed SPAR check and the delay inherent in unlocking the cell, undoing the ligature, man-handling (Mr C) *into an appropriate area where resuscitation could be effectively performed and taking time to assess his clinical status would be relevant to a condition where every passing minute without the circulation of oxygenated blood counts towards an increasing likelihood of a bad outcome. However, given the brain's high degree of oxygen-dependency, prisoners who self-harm by hanging, even when discovered early, are at a real risk of sustaining significant brain damage. Not surprisingly, quarter-hourly checks, even when delayed by a few minutes, may still miss the opportunity to prevent the harm resulting from hanging."*

In considering the reasons why Mr C made an attempt to die by suicide on 19 February 2012, Dr Fazel said that Mr C had a number of background factors that increased his risk, which included a past psychiatric history and alcohol abuse, a past and recent history of deliberate self harm, and suicidal ideas and episodes of self harm in prison. In addition, he had a number of psychosocial stressors including the bereavement of his girlfriend around two years before, and his two young children being in care.

Dr Fazel noted that there may have also been some important triggers, including Mr C's fear that prison officers and/or other prisoners would attack him. He said also that Mr Cs difficult phone calls with family members may be relevant.

Comments made by the inmate in the cell next to Mr C on the evening of his attempt to die by suicide may or may not have contributed to his anxiety and concerns.

It is also the case that the medication varenicline which Mr C was prescribed in prison to help him stop smoking, and subsequently stopped taking, can contribute to feelings of depression and cause insomnia. It is not possible to say whether varenicline contributed in any way to Mr C's state of mind on 19 February 2012.

Noting that Mr C did not have a mental health review, Dr Fazel said that, *"it is not possible to determine whether in themselves any measures arising from such an assessment would have prevented* (Mr C)*'s serious attempt but it would have been good practice in my opinion. The other issue relevant to prevention relates to* (Mr C)*'s various location moves, and an individually-tailored Care Plan in high risk prisoners that is mindful of their concerns would be helpful."*

The investigation found that the implementation of SPAR observations and the organisation and attendance at Case Reviews was, in general, to a higher standard than has been observed in other investigations, excepting the specific (important) shortfalls described earlier. This reflects the efforts that have undoubtedly been made by the Northern Ireland Prison Service and South Eastern Health and Social Care Trust (SEHSCT) to improve the arrangements for protecting prisoners at risk of self harm.

Nevertheless, the fact that someone with Mr C's history who had a significant number of self harm risk factors; was known to be suffering from depression and paranoia and to be experiencing considerable anxiety about his personal safety, was confined to cell for long periods with very limited human contact and with no television (whilst in the Care and Supervision Unit), raises fundamental questions about the effectiveness of the Prison Service and SEHSCT's approach to managing vulnerable prisoners. In particular, it raises questions about the extent to which

current SPAR and Case Review procedures, even where conscientiously applied, actually deliver an appropriate level of care.

It was very evident that Case Reviews did not properly consider the underlying causes of Mr C's self harming / threats to self harm and Care Plans were not adequately responsive to his individual circumstances, needs and vulnerability. There were also significant communication breakdowns resulting in a failure to properly consider important risk management related information. The effects of these breakdowns were, once again, exacerbated by the fact that adequate arrangements for the overall coordination of Mr C's care package, were not in place.

As a result of his attempt to die by suicide on 19 February 2012, Mr C has complex physical and cognitive disability resulting from injury to his brain. Mr C can use gestures at times but is unable to communicate his basic needs and is not able to speak. When Mr C is not fighting infections in hospital, or undergoing operations, he is cared for in a nursing home.

The section that follows details 44 areas of concern identified as a result of this investigation.

ISSUES OF CONCERN REQUIRING ACTION

The following issues of concern, requiring action by the Northern Ireland Prison Service and South Eastern Health and Social Care Trust [SEHSCT], were identified during the investigation into the near death of Mr C. I have asked the Director General of the Prison Service and Chief Executive of the SEHSCT to confirm to me that these issues will be addressed.

It is regrettably the case that many of these issues have been reported in connection with previous Prisoner Ombudsman investigations.

SPAR Process

1. SPAR Case Review summaries did not, at times, adequately reflect the discussions that had taken place or the actions agreed.

2. No information was recorded in Mr C's SPAR 'Initial Healthcare Assessment' other than the name of the nurse who completed the assessment. Important information was not, therefore, available to landing staff caring for Mr C.

3. There is evidence that some staff considered that Mr C may have been threatening self harm in order to manipulate a move and that this may have inappropriately influenced their approach to assessing his needs and developing a Care Plan.

4. SPAR Case Reviews and case managers themselves did not adequately consider the reason(s) for Mr C's self harming.

5. Some decisions made at SPAR Case Reviews were based solely on how Mr C presented at the Review, without consideration being given to important information relating to his actions and demeanour over the previous 12 to 24 hours.

6. No consideration was given to monitoring Mr C's telephone calls or to offering him support through the Listener Scheme.

7. Important conversations and written information were not documented in Mr C's SPAR Booklet.

8. Mr C's final SPAR Case Review was conducted without the required attendance of a nurse; was conducted in the observation cell; lasted only two minutes; failed to identify the need to follow up Mr C's outstanding mental health assessment and was chaired by a senior officer/case manager who was not trained in the SPAR process.

9. A SPAR Case Review was held at a weekend, when the availability of staff to attend the multi-disciplinary meeting was limited.

10. On a number of occasions, SPAR Care Plans failed to reflect actions agreed at SPAR Case Reviews.

11. Only one out of five of Mr C's SPAR Care Plans was entered on PRISM[12]. It is a policy requirement that each Care Plan is entered on PRISM so that Reviews may be undertaken by the Safer Custody Coordinator.

12. When Mr C was found hanging, he had not been checked for 29 minutes. He was required to be checked at 15 minute intervals.

13. Despite numerous previously accepted recommendations, adequate arrangements for care coordination were not in place to ensure appropriate monitoring and continuity of the delivery of Mr C's Care Plan.

14. Mr C was not provided with slippers when his clothes were removed following his transfer to an observation cell.

15. Mr C was moved to Bann House even though he had said that he had been threatened and believed he would be assaulted there.

16. No thought was given to the full circumstances of Mr C's unacceptable behaviour after he was moved to Bann House for the second time. As a

[12] PRISM – Prison Service's prisoner information management system.

result, the possibility that a further Case Review was required or that Mr C may need to be monitored in an observation cell for a further period, were not considered.

Threats to Mr C's Safety

17. Mr C's assertion in an adjudication statement that he had been threatened in Bann House were not questioned by the adjudicating governor or investigated, as required by the Prison Service Anti–bullying Policy.

18. Mr C's assertion to various members of staff that he had been threatened in Bann House was not investigated, as required by the Prison Service Anti–bullying Policy.

19. Bullying behaviour by a prisoner in the CSU was not reported and investigated as required by the Prison Service Anti–bullying Policy.

Prison System Issues

20. Appropriate handovers were not provided to staff when Mr C was moved to an observation cell.

21. Prisoners committed for sexual offences are being marked on the board in the class office of the committal house with a red line by their name. This could lead to their identification by other prisoners.

22. The committal form has limited space for officers to include additional comments or concerns expressed by vulnerable prisoners.

23. The first information prison staff received in connection with the concerns expressed by a community probation officer about Mr C's possible suicidal ideation was on 13 February 2013, by which time Mr C had, allegedly, made an attempt to self harm or die.

24. No proper consideration was given to the appropriateness of Mr C being made to complete his punishment of cellular confinement whilst on a SPAR. No consideration is given to alternative methods of punishment for prisoners on a SPAR or who have underlying and active mental health problems.

25. Notwithstanding his risk factors, Mr C was assessed for a further period of cellular confinement on the day of his attempt to die by suicide.

26. Important paperwork was missing from Mr C's CSU file and the file of another prisoner.

27. There is only one emergency belt[13] issued to the CSU each day and it is located in the senior officer's office downstairs in the CSU. The ability of staff to effectively and efficiently respond to an emergency situation is compromised because of this.

28. There is no automatic 'grill override' for the main gate into the CSU which means that a member of staff has to leave the emergency situation to facilitate other responding staff in gaining access to the CSU.

29. There was only one officer on duty in the CSU at the time of Mr C's attempt to die by suicide, which limited the officer's ability to respond to the emergency situation effectively.

30. It took five minutes from the time that Mr C was found unresponsive by an officer to the time that his cell was unlocked.

31. No hot de-brief took place.

32. No follow-up check was made on the well-being of the officer who found Mr C, during a period of subsequent absence.

[13] An emergency belt has on it items such as a radio, Hoffman Knife (safety knife), an emergency key and a face shield for the use of mouth to mouth resuscitation.

Healthcare Concerns

33. Current healthcare committal forms do not positively signpost committal nurses to circumstances where an immediate mental health referral should be undertaken.

34. The mental health referral process was not known to all staff and resulted in Mr C's emergency referral not being actioned.

35. Nurses referred only to Mr C's medical records when checking whether Mr C had been referred to the mental health team. As a result, they believed that an urgent referral was being actioned when this was not the case.

36. The requirements for a healthcare assessment for fitness to undergo cellular confinement are not adequately specified.

37. An assessment of fitness to undergo cellular confinement was, in one instance, completed in one minute.

38. A nurse who carried out a detailed healthcare assessment and concluded that an in-depth mental health assessment was required, still considered Mr C to be fit for cellular confinement.

39. It took four days, from the date of prescription, before Mr C was issued his fluoxetine (antidepressant) medication.

40. A nurse recorded in Mr C's medical file that he did not require a mental health assessment or referral to a GP, when a prison doctor and SPAR case manager had already determined that an assessment was required.

41. Mr C was issued with varenicline (smoking cessation medication) without the need for adequate risk monitoring arrangements being put in place.

42. A nurse recorded in Mr C's medical records that she could not influence the location that Mr C was moved to. In a multi-disciplinary care plan approach, this should not be the case.

43. Some nurses made limited entries in Mr C's SPAR observation log, which meant that landing staff did not have access to important information. It is to note that the Prison Service's Suicide and Self Harm Prevention policy states: *"The record should include information that can be shared without breaching medical confidentiality."*

44. In the absence of a mental health assessment, Mr C was not considered for a psychiatric assessment or for a trial of a low dose antipsychotic medication which may have helped to address his symptoms of paranoia.

RESPONSE TO AREAS OF CONCERN

Northern Ireland Prison Service

The Director General indicated that she was considering all of the Issues of Concern and would issue a response in due course.

South Eastern Health and Social Care Trust

The Trust Chief Executive responded as follows:

Responding to the report into the circumstances surrounding the near death of Mr C, the South Eastern Health and Social Care Trust (SET) said*: "I do not have any amendments in relation to factual accuracy and believe that the analysis of the contextual circumstances and factors associated with this incident have taken place in a fair and well considered manner. Pleasingly, credit has been given to practitioners having demonstrated evidence of "Professional good practice" in respect of their care into this case.*

I would also like to make the following comments:

- *The Mental Health pathway now includes a mental health triage nurse who, based on information provided by the committal nurse, will assess all new committals with mental health issues within 72 hours of committal to jail. This facilitates all patients with mental health issues to be managed in a timely and appropriate way throughout their stay in jail.*

- *The SET in-house pharmacy is due to open on 1st May 2013. One of the benefits of this new model of care is that patients will have more timely access to prescribed and repeat medication."*

- *Clearly, it is important that all staff understand the purpose and importance of the SPAR documentation. This is a dynamic document and its utility is dependent on the quality, completeness, accuracy and relevance of the information contained therein. The comments of this report are therefore worthy of consideration and will be taken forward by SET, in collaboration with NIPS through the appropriate governance structures."*

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. The Northern Ireland Prison Service's Standard Operating Procedure on Self Harm and Suicide Prevention 2011, states that an internal review or external investigation by the Prisoner Ombudsman will occur when a prisoner self harms to the point where:

    - *without immediate intervention the prisoner would have died;*

    - *as a result of the incident the prisoner has suffered permanent or long-term serious injury; and*

    - *as a consequence of the long-term injuries sustained the individual's ability to know, investigate, assess and/or take action in relation to the circumstances of the incident has been significantly affected.*

2. On 24 February 2012, the Prison Service's Director of Operations requested a Prisoner Ombudsman investigation into the near death of Mr C who, following a self-inflicted injury on 19 February 2012 whilst in the custody of Maghaberry Prison, remains under constant care in a nursing home having suffered severe brain damage.

Objectives

3. The objectives for my investigation into Mr C's near death are:

    - To establish the circumstances and events surrounding the serious incident, including the care provided by the Prison Service and relevant outside factors.

    - To review Mr C's location movements within Maghaberry Prison and, in particular, his time in the Care and Supervision Unit and in an observation cell.

- To examine any relevant health and clinical care issues.

- To examine whether any change in operational methods, policy, practice management arrangements would help prevent a similar incident in future.

- To ensure that Mr C's family have the opportunity to raise any concerns that they may have and that these are taken into account in the investigation and report.

Family Liaison

4. An important aspect of the role of Prisoner Ombudsman dealing with any near death incident investigation is to liaise with the family.

5. It is important for the investigation to learn more about the person at the centre of the investigation from family members and to listen to any questions or concerns they may have.

6. I first met with Mr C's mother on 16 March 2012 and my investigators were grateful for the opportunity to keep in contact with her solicitor to provide updates on the progress of the investigation. I met with Mr C's mother again on 23 April 2013 to explain and discuss the Findings and Issues of Concern within this report. I would like to thank Mr C's mother for giving me the opportunity to talk with her.

7. Although my report will inform many interested parties, I write it primarily with Mr C's family in mind. I also write it in the trust that it will inform policy or practice which may make a contribution to the prevention of a similar serious incident in future within the Northern Ireland Prison Service.

8. Mr C's mother asked the following questions:

- How was Mr C able to do what he did whilst on a Supporting Prisoners At Risk (SPAR) Booklet?

- Why was Mr C not in an observation cell and what consideration was given to this?

- What level of care did Mr C receive?

FINDINGS

SECTION 1: BACKGROUND HISTORY

Mr C

Mr C was 30 years old when he nearly died on 19 February 2012, as a result of a self-inflicted injury. Mr C was in the custody of Maghaberry Prison.

The investigation examined Mr C's community medical records, prison records and prison medical records and noted the following background information.

During his teenage years, Mr C was victimised following his conviction for a sexual offence. It is recorded that this led him to overdose three times during his late teens and was the reason for him moving to England when he was around 18 years of age. Mr C lived in England for seven years and, during this time, received a number of prison sentences.

In 2000, Mr C was diagnosed with alcohol dependence syndrome.

In 2008, a serious fall led to multiple fractures of the lumbar region of Mr C's spine and pelvis and he started to take pain killers.

In December 2009, Mr C's children, who at the time were aged one and four, were taken into care. Two weeks later, Mr C's girlfriend, who was also the mother of his two children, died by suicide. On the day of her death, both Mr C and his girlfriend had been drinking heavily. The following day, Mr C was admitted to a psychiatric hospital for one day, having attempted to cut his throat and was noted to be *"very depressed"* with *"suicidal ideation"*. He was diagnosed with an adjustment reaction[14]. Mr C had no recorded history of psychiatric illness before this time. The death of Mr C's girlfriend led to her family threatening Mr C as they felt he was to blame for what had happened and, as a consequence, he returned to Northern Ireland.

[14] Adjustment reaction is a short-term condition that occurs when a person is unable to cope with, or adjust to, a particular source of stress, such as a major life change, loss, or event.

Following his return, Mr C had periods of homelessness and variously lived with his mother and in a hostel. In 2010, he had a further diagnosis of alcohol dependence syndrome.

Between March 2010 and October 2011, the date of Mr C's last sentence, he had eight prison committals. Mr C's prison medical records indicate that at the time of these committals, his mental state was generally assessed to be settled.

SECTION 2: MR C'S RECALL TO PRISON ON 11 FEBRUARY 2012

The Circumstances Surrounding Mr C's Recall to Prison

On 7 October 2011, Mr C was committed on remand to Maghaberry Prison and subsequently convicted of a sexual offence on 24 October. He was given a sentence of two years.

During his time in Maghaberry, records show that Mr C was moved from Roe House to Bush House for his own protection, due to concerns that he was being threatened by other prisoners. On 24 November 2011, Mr C was transferred to Magilligan Prison.

In January 2012, Mr C made an application for compassionate temporary release to attend his grandmother's funeral. The application was, however, turned down by Magilligan Prison, after information was received from a family member saying that, *"*(Mr C) *will be murdered if he attends his grandmother's funeral."*

On 5 February 2012, Mr C threw a computer at a wall and was given seven days cellular confinement. It is recorded that the reason that he did this was because *"he was not happy in his residential area"* and *"was not getting on with people".* Other than this incident, prison records indicate that Mr C worked at Magilligan as an orderly and *"was finishing his time off quietly…Nothing adverse to report".*

On 8 February 2012, it is recorded in Mr C's medical records that he was *"anxious about being released home tomorrow, going to hostel, transpires that he's worried he'll be in reception with other prisoners."*

On 9 February 2012, Mr C was released on a 'Determinate Custodial Sentence Licence'[15] with a number of conditions. Two days later, on 11 February 2012, his licence was revoked following a recommendation from a probation officer. In a letter to Mr C from the Department of Justice, it is stated that Mr C had failed to

[15] A determinate prison sentence is where the court set a fixed length for the prison sentence and is the most common type of prison sentence. For sentences of a year or more, an offender will serve half their sentence in prison and serve the rest of the sentence in the community on licence.

return to his approved accommodation, his behaviour had deteriorated and he had been drinking alcohol. The probation officer who made the recommendation reported also that Mr C had said that he was *"suicidal"* and that he *"felt like slitting his wrists or hanging himself".*

This information was provided to the Police Service of Northern Ireland (PSNI), along with the papers required to authorise Mr C's arrest.

Mr C's Committal to Maghaberry on 11 February 2012

At 15.24 on 11 February 2012, Mr C was committed to Bann House where all new committals are located in order for them to take part in an induction program.

As part of the committal process, an officer spoke with Mr C and completed his "First Night in Prison" paperwork. The officer recorded that he had received the PSNI paperwork that accompanied Mr C, and noted that he had a *"past history"* of self harm *"see PACE forms"*[16].

It is to note that the Prisoner Escort Record and accompanying PACE forms note, *"DP* (detained person) *reports back pain and depression. DP reports suicidal tendencies. DP has displayed aggression towards officers."*

The committal officer also recorded that Mr C was a vulnerable prisoner and felt at risk when in prison, due to the nature of his offence. The officer recorded on the Cell Sharing Risk Assessment that Mr C did not have any concerns about sharing a cell and did not know any other prisoner that presented as a risk to him. It is not clear why Mr C said that he had no concerns about sharing a cell when he had said that he felt at risk from others in prison and had difficulties during his previous committal to Maghaberry.

At interview, the officer said that it was Mr C's, not the officer's, perception that he was vulnerable. The officer also said that, because of the nature of Mr C's offence, he recorded it on the paperwork and *"flagged it up to staff on the landing to make sure he wasn't doubled up in a cell with specific type of people, basically for his own*

[16] PACE (**P**olice **A**nd **C**riminal **E**vidence) forms are custody forms used upon arrest.

protection". The officer said that a red diagonal line would have been placed beside Mr C's name on the board in the officer's office to identify Mr C as a sex offender. He said that this was because staff would *"need to be careful"* when deciding prisoners who they *"doubled* (Mr C) *up with".* The officer said that it was *"not something set down for us to do, but we always did it".*

At interview, the officer also raised concerns about a lack of training, in connection with the identification of vulnerable prisoners, for those staff involved in the committal process. He expressed concern also about the time available to properly assess new committals and the lack of space on the Committal Form to detail the reasons why a prisoner may feel at risk. The investigation confirmed that the space for additional comments on the Committal Form is limited.

The nurse who conducted the required Committal Healthcare Review recorded that Mr C had a previous admission to a psychiatric hospital approximately three years earlier; had a history of self harm outside prison; had attempted to cut his own throat approximately three years previously and had overdosed at the age of 16/17 years. The nurse also recorded that Mr C had no current thoughts of self harm, but that he had had thoughts of self harm *"the day he got out of Magilligan because he didn't want to be in a hostel under probation. Didn't do anything, just took a drink instead."* The nurse noted Mr C's behaviour as *"calm and co-operative"* and, in connection with Mr C's medication on committal recorded *"see EMIS[17], as just released from Magilligan 2 days ago".* Mr C's last prescription in Magilligan was for diclofenac sodium (a non steroidal anti-inflammatory drug), co-codamol (a pain killer) and varenicline (for smoking cessation).

It was the case, however, that, on 5 February 2012, when Mr C threw a computer at a wall in Magilligan, his cell was searched and he was found to have stock piled 49 diclofenac tablets. These tablets were handed in to healthcare and it is recorded in Mr C's medical records that *"it would appear that he has no need for them, tablets disposed of".* Attention was not drawn to this matter in the notes made in connection with the new committal.

[17] EMIS – Egton Medical Information System – the electronic database for recording a person's medical record.

CCTV shows that at 15.52, Mr C was taken to his cell and locked for the night at 16.09.

In his clinical review report, Dr Fazel noted that, *"according to the list of risk factors in the Prison Service's 2011 Suicide and Self Harm Prevention Policy, Mr C had four (out of a possible nine) risk factors identified during committal: namely, a history of suicide attempts, a history of mental ill health, drug or alcohol misuse, and a conviction of a sexual offence"*, which he said, *"indicated an increased risk of suicide in custody".*

SECTION 3: EVENTS OF 12 FEBRUARY 2012

Incident During the Breakfast Round

At 09.02 on 12 February 2012, CCTV shows that whilst officers were serving Mr C from the breakfast trolley, liquid and a flask was thrown from Mr C's cell.

In the officers Staff Communication Sheet (a written account completed following an incident) it states that:

"On Sunday 12 February 2012 at 09.30 in Bann House wing 1, I opened (Mr C)*'s cell door. He threw water around me and threw his flask at me. The wing alarm was hit and the prisoner relocked."*

The senior officer in charge of Bann House, who responded to the alarm, recorded in his Staff Communication Sheet:

"As I lifted the observation flap of cell 8, prisoner (Mr C) *had commenced damaging the cell furniture. He ignored all attempts to engage or reason with him and continued to methodically smash every piece of cell furniture before pulling the sink from the wall and smashing the toilet with it."*

At interview, the senior officer said that the manner in which Mr C was damaging his cell was *"very methodical"*. He said that there was *"no anger... no effin and blinding, no shouting, he was very calm"*. The senior officer said also that *"it was very rare for someone with those offences to behave in that manner.....most of them are very timid and shy... they wouldn't bring much attention to themselves... I actually now remember him looking at me as I spoke to him and he just turned and looked at me and just turned his head away again... but no abuse towards me or anything. I didn't exist. He could hear but he couldn't understand. Whatever was going on was much, much greater than anything I was saying."*

When asked whether he was aware of anything that had happened to trigger the incident, the senior officer said that when he talked to the officer who raised the alarm the officer said that *"it came totally out of the blue.....totally unexpected"*.

After the alarm was raised, the Dedicated Search Team (DST) arrived on the landing and escorted Mr C to the Care and Supervision Unit (CSU) using control and restraint techniques[18].

Care and Supervision Unit (CSU)

At 09.37 on 12 February 2012, Mr C arrived in the CSU and, as required by Prison Service policy, following an incident where control and restraint techniques have been used, he was medically assessed. The nurse who assessed Mr C recorded in his medical records that handcuffs had been used and that blood was noted on both of his wrists. The nurse recorded, however, that these injuries were sustained when Mr C was wrecking his cell. The nurse also recorded that, *"no other injuries noted, declined to make a statement, no allegations made".*

Later that afternoon, at 15.29, Mr C was seen again by the same nurse. It is recorded in Mr C's medical records that an area between his thumb and index finger on his left hand was cleaned and dressed and that he had other superficial wounds which did not require treatment. The nurse also noted that the earlier record stating that Mr C had blood on both wrists when he arrived in the CSU was incorrect and should have stated that the blood was noted on his hands.

During the rest of the afternoon / evening, CCTV shows that Mr C was provided with his evening meal, given a newspaper to read and checks were carried out during the evening and night, as required by Prison Service policy. Mr C was permitted to have a radio in his cell but no television.

[18] Control and restraint techniques are used in situations which require a person to be restrained using Home Office approved techniques.

SECTION 4: EVENTS OF 13 FEBRUARY 2012

Nurse Assessment

Prison Rule 41 (2) states that cellular confinement is not permitted *"……unless **an appropriate healthcare professional** has certified that the prisoner is in a fit state of health to undergo it."*

At 08.58 on 13 February 2012, CCTV shows that Mr C's cell door was open and a nurse spoke with him from the corridor, for approximately one minute. It is noted in Mr C's medical records that he was assessed to be "*fit for adjudication and cellular confinement*", his mood was *"relaxed"*, his *"behaviour appropriate"* and that no mental health issues had been raised.

Medication Prescription

At 11.44, a prison doctor reviewed Mr C's medication requirements without seeing him. It is recorded that the doctor prescribed diclofenac sodium 50mg (a non steroidal anti-inflammatory drug), co-codamol 30/500 (a pain killer) and varenicline (for smoking cessation). It is to note, that this is consistent with Mr C's prescription when in prison previously but, as discussed earlier, it was also the case that on 5 February 2012, when Mr C's cell at Magilligan Prison was searched, he was found to have stock piled 49 diclofenac tablets.

At interview, the doctor said that, before prescribing Mr C's medication, he checked his medication record to confirm his prescription and when it was last issued. The doctor said that there was no information on Mr C's electronic medical record (EMIS[19]) to alert him to the fact that Mr C had stockpiled tablets but said also, that he would not have been particularly concerned about this in any case, because diclofenac does not *"hold the currency"* for trading in prison in the way that some other prescribed medicines do.

[19] EMIS – Egton Medical Information System

It is also the case that the medication varenicline, which Mr C was prescribed in prison to help him stop smoking, can contribute to feelings of depression, irritability, agitation and can be associated with suicidal behaviour.

A review of EMIS showed that the system will provide an alert to flag up the misuse of medication, provided the member of staff entering the relevant data activates this facility. It would appear to be the case that this function was not used.

Telephone Call to Family Member

At 11.47, Mr C phoned a family member and said that the reason he had wrecked his cell and thrown water over an officer was because he wanted to go to *"the block"* (the Care and Supervision Unit). Mr C told the family member that he was concerned for his safety because a prison officer had told other inmates what he was in prison for and he was going to be *"attacked or killed".*

Mr C then asked for his solicitor to be contacted and asked to submit a request for Mr C to remain in *"the block"* or be moved to Bush House (where he had been housed during his previous committal). Mr C said that he had been told by an officer that he would be returned to Bann House and that he had told the officer *"I can't go back there".* Mr C also told the family member that he had tried to hang himself the previous night *"but the rope snapped".*

There is no evidence that Maghaberry Prison was made aware of the content of this telephone conversation and Mr C's solicitor told the investigation that he was never contacted in connection with these concerns or asked to make any request to the Prison Service on Mr C's behalf.

Meeting with Probation

At 14.00, a probation officer met with Mr C. It is recorded on the probation contact sheet that, *"when discussing emotional wellbeing, Mr C stated he tried to hang himself last night but the rope broke. Stated he did not inform prison staff. States*

people have been referring to him as a sex offender. Concerns passed onto prison staff and SPAR[20] opened."

Opening of the Support Prisoners at Risk (SPAR) Booklet

The probation officer, who opened the SPAR booklet, recorded the following:

"Met with (Mr C) *at 2pm for the purpose of probation committal interview. He is subject to a DCS* (Determinate Custodial Sentence) *and the licence element has been revoked. Community PO* (probation officer who revoked Mr C's license) *advised of some concerns in relation to suicidal ideation. When discussing this with* (Mr C)*, he informed me that he attempted to hang himself last night but the rope broke. He stated that he did not inform any prison staff about this. Encouraged* (Mr C) *to talk to people if mood deteriorates, or if he is considering self harm. Stated that would be 'attention seeking' and if he wished to kill himself he won't be discussing it with anyone. Stated other prisoners have referred to him being a sex offender and he wants to move to Bush."*

It is to note that this is the first communication to prison staff of concerns expressed by Mr C's community probation officer about his possible suicidal ideation. It is also to note that, by the time this was recorded, Mr C had, allegedly, already made an attempt to self harm or die.

Following Mr C's conversation with the probation officer, he was taken to see a senior officer and a SPAR Assessment Interview was carried out. The senior officer noted Mr C's reasons for wanting to die as being that he was depressed and that he'd had his licence revoked having only been out of prison for four days (it was actually only two days). It is recorded that the reasons Mr C gave for living, were his mother and his two children. The senior officer also recorded that Mr C had displayed suicidal ideation in the past and that he had been *"sectioned"* two years ago. He also noted that arrangements would be made for mental health support to be put in place as a support mechanism.

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

It is not clear whether the senior officer discussed Mr C's allegation that others had been referring to him as a sex offender with him as this is not recorded. There is also no evidence that any consideration was given to Mr C's earlier statement that he had been threatened and was concerned about being assaulted. This senior officer is no longer employed by the Prison Service and, therefore, is no longer available for interview.

It was, however, noted on the Immediate Action Plan that Mr C said that he felt safe when located in Bush House. It was noted also that he was to be placed on 30 minute observations, have four conversational checks throughout the day and have free access to the phone. Whilst the need for mental health intervention as a support mechanism had been identified at the assessment interview, this was not recorded as part on the Immediate Action Plan.

There is nothing noted in Mr C's SPAR booklet with regards to the required SPAR Initial Healthcare Assessment, which took place at 16.21, other than *"Nursing Officer* (name redacted)*"*. It is, however, recorded in Mr C's medical records (EMIS) that the assessment took place, that Mr C felt *"depressed about being back in prison"* and that there was *"no evidence of marks or bruising"* around Mr C's neck from his alleged attempt to hang himself the previous night. The nurse also recorded that Mr C was *"encouraged to speak to staff if feeling low"* and that he remained *"low after a lengthy chat"* with the senior officer. It was noted that Mr C had a *"history of DSH* (deliberate self harm) *and attempted suicide. Will need referral to MHT* (mental health team) *and pr.* (prisoner) *happy with same."*

Mr C was placed on the doctors list to be seen the following morning.

Summary of SPAR Observation Log

A review of the SPAR observation log and CCTV for the period between 16.30 and 23.40 shows that observations were carried out within the specified 30 minute intervals and that, at various times, Mr C was observed walking around his cell, lying in his bed and writing.

Mr C's Letters

A review of the post book showed that, at some point, Mr C wrote three letters one of which was posted on 14 February and two on 16 February. One letter was to a family member, another was to a woman in England and the third was to a woman in Hydebank Wood Prison. At interview, the woman in Hydebank Wood said that Mr C wrote about how he missed his children and said that he was annoyed that he didn't know where they were. He wrote also of how his concern about being labelled a sex offender and said he would like to meet up with her when they were both out of prison.

At interview, the family member said that Mr C wrote about his concerns that he was going to be attacked by prisoners and staff, saying much the same as he had said in the earlier telephone conversation.

SECTION 5: EVENTS OF 14 FEBRUARY 2012

Prisoner Request Form

As part of the prison morning unlock regime, prisoners are asked whether they have any requests. On the morning of 14 February, Mr C made a formal written request to receive emergency phone credit and to receive postal orders because, he said, he wouldn't be receiving any visits. Mr C's request for emergency phone credit was granted and he was advised that, as required by Prison Service policy, he would have to wait a period of time to demonstrate that he did not receive any visits before his request to receive postal orders would be approved.

Initial Mental Health Referral

At 10.44 on 14 February 2012, the nurse, who had conducted Mr C's Initial Healthcare Assessment in connection with the SPAR opening process, recorded in his prison medical records that a mental health referral was *"made this a.m. Marked Urgent"*. A copy of this referral is also in Mr C's medical file.

Commenting on the urgent mental health referral, the Clinical Reviewer, Dr Fazel said: *"I think this was appropriate considering his* (Mr C's) *psychiatric history and his recent suicidal threats."*

At interview, the nurse said that he placed the written referral in the mental health team's pigeon hole as he understood that to be the correct procedure at the time. The investigation found, however, that the person making the referral was also required to enter the prisoner's name in the mental health team's diary. The investigation also found that the nurse who made the urgent referral for Mr C did not write his name in the mental health team's diary, because he, and other nurses, had not been made aware of the need to do so.

The nurse did, however, also say that he spoke with a member of the mental health team in connection with the urgent referral of Mr C. The nurse could not remember who he had spoken to.

Maghaberry's mental health lead stated that, at the time, only the mental health team's diary would have been reviewed to ascertain which prisoners needed to be seen. She said that now, the referral is sent electronically to the team but the referring nurse still needs to enter the prisoner's name in the mental health team's diary. It was, therefore, the case that the nurse's referral was not actioned by the mental health team and Mr C was not considered during the mental health team multi-disciplinary meeting on 16 February 2012.

Adjudication (Disciplinary) Hearing

On 14 February 2012, Mr C attended an adjudication hearing, in connection with the incident on the morning of 12 February 2012 whilst Mr C was in Bann House. It was the decision of the adjudicating governor that Mr C was to remain in the Care and Supervision Unit (CSU) for five days cellular confinement, as a punishment for his actions.

Mr C's statement, prepared for the adjudication process, states that he had told the officer who was serving breakfast through the closed door of the cell that he needed to be moved because of *"threats"*. Mr C stated that, as the officer did not respond, *"when he opened the door I threw juice over him and a flask and then wrecked the cell. I wanted moved off that wing as I was going to be assaulted if I go back to that wing, Bann, I will be attacked in there, so I would want you to consider that if I go back in there I will assault the officers again. To be moved, I want kept down the block* (CSU) *or moved to Bush House for my protection. Mostly Bush House or shipped back to Magilligan Prison. I apologise for what happened."*

The investigation found that, whilst Mr C read out his statement at the adjudication hearing, his assertion that he had been threatened and his belief that he would be assaulted if he remained in Bann House were not questioned or probed by the adjudicating governor, to determine whether any action was required. It is to note that it is not unusual for convicted sex offenders to experience bullying, which often involves threats being shouted during the night. The Prison Service Anti-Bullying policy requires all allegations of bullying to be fully investigated.

At interview, the adjudicating governor said that Mr C was quiet at the adjudication hearing and he stopped the proceedings twice, once for the SPAR booklet to be fetched and once *"to discuss how* (Mr C) *felt".* The governor said that Mr C told him that he did feel suicidal but that he *"had no active plans to take his own life".* The governor said also that Mr C felt vulnerable from attack by other prisoners and that he felt that *"with* (Mr C) *going to the CSU he would be safe and that there would be a locked cell door in place which would maybe help to settle* (Mr C)*".* He said that, in the CSU, Mr C would be seen every day by a governor and by healthcare staff.

The governor said that Mr C did not say who was threatening him and that he did not take any other action in connection with the statement Mr C made to the adjudication because his *"focus was the adjudication"* and his role on that day *"was to look at the evidence against the charge".* He pointed out that Mr C's statement had been through a number of hands before the adjudication including, *"Bann House staff, the SO* (senior officer in) *Bann etc."* It is to note that, whilst Mr C had informed other staff about his concerns, landing staff in Bann House would not have seen the adjudication statement.

Adjudications are recorded and a review of the tape of Mr C's adjudication on 14 February 2012 indicates that the adjudication was stopped twice. There is no evidence on the tape of any of the conversation reported by the governor above, but the governor did say that the conversation took place off tape. It is, however, to note that when the tape was restarted for the first time, the first question the governor asked Mr C was *"are you on a SPAR or anything like that?"* The Governor then asked, "if a SPAR came over with the prisoner". The Governor then asked for the tape to be stopped for a second time. When the tape was re-started the Governor asked Mr C *"do you still have thoughts of suicide"* to which he replied *"yes".* The matter of Mr C's suicidal ideation was not discussed again. It is to note that there is no indication as to how long each of the two breaks lasted.

Medication and Nurse Assessment

At 12.22, it is recorded in his SPAR booklet that Mr C received his medication. The issuing nurse recorded in Mr C's medical records that he had no current thoughts of self harm or suicide and that he appeared relaxed and his behaviour was

appropriate. The nurse also noted that a mental health referral was being completed by her colleague and that he was to see the doctor later that afternoon.

Prison Doctor's Assessment

At 14.34, Mr C was seen by a prison doctor who recorded, *"see yesterday's entry re attempted hanging using towel which snapped. Still feels like self harm i.e. cutting wrists, depressed re losing partner couple yrs ago, also recent deaths of family members, also re return to prison and wants back to Magilligan.....Awaits urgent mhs* (mental health support) + *is on SPAR, wants restart of Prozac* (fluoxetine) + *sleeper* (sleeping tablet)*."*

The doctor prescribed 14 fluoxetine hydrochloride[21] 20mg capsules to be taken once daily day and five promethazine hydrochloride[22] 25mg tablets, one to be taken each night. At interview, the doctor said that he met Mr C for the first time on 14 February 2012 and "*prescribed fluoxetine to assist with his mood*". The doctor said that Mr C had said that he was in low mood due to recent family deaths, loss of his partner and his return to prison. The doctor said that he "*also prescribed promethazine as* (Mr C) *had difficulty sleeping".* The doctor explained that, once he has prescribed medication, it is up to the nursing staff to ensure that the medication is issued.

Summary of SPAR Observation Log

A review of the SPAR observation log and CCTV for this 24 hour period shows that observations were carried out within the specified 30 minute intervals. It is recorded that, at various times, Mr C was lying in his bed, talking to staff (including senior officers, governors and health professionals) and *"seemed in good form".* There is no evidence that Mr C took the exercise period to which he was entitled each day. Later entries suggest, however, that even if Mr C was offered exercise, he would probably have refused it because inmates would be able to shout at him in the exercise yard, through their windows.

[21] Fluoxetine (Prozac) is an antidepressant.
[22] Promethazine hydrochloride is a medicine which is used in allergic disorders, nausea and vomiting and problems with sleep.

SECTION 6: EVENTS OF 15 FEBRUARY 2012 IN THE CARE AND SUPERVISION UNIT

Nurse Assessment for Continued Cellular Confinement

Assessment by a nurse is a daily requirement in circumstances where a prisoner is subject to cellular confinement and at 09.45 on 15 February 2012, Mr C was seen by a nurse. It is recorded in Mr C's medical notes that he was *"relaxed"*, his behavior was appropriate, *"no medical complaints were stated"* and no *"abnormal thoughts / perceptions"* were noted. The nurse concluded that there was *"no reason for referral to GP or MHT* (mental health team)*"*. It was also the case that Mr C was not issued with his fluoxetine medication which had been prescribed by the doctor the previous day.

At interview, the nurse said that she *"couldn't say 100%"* whether she would have reviewed Mr C's SPAR booklet or medical records before the assessment for cellular confinement took place. The nurse said also that the reason for not issuing Mr C with his fluoxetine medication could have been because *"the medication maybe had not arrived with me yet"*. The nurse said that, alternatively, it might have been that Mr C's prescription wasn't *"flagged up on a written report"* that she would have received before she attended the CSU, to indicate the prisoners who received their medication as 'supervised swallow[23]'. In relation to her conclusion that Mr C did not require a referral to the mental health team, the nurse said she recorded this because that was how Mr C had presented to her at that time and he *"obviously didn't request anything of me at the time* (such as) *'Could you get a doctor to see me?...Could you bring a mental health nurse to see me?'..."*

The nurse's conclusion on 15 February 2012 that Mr C did not require a mental health assessment was contrary to the conclusion reached by a governor and nurse the previous day and noted and recorded by the doctor during his consultation on the morning of 14 February. In any event, however, the later decision had no impact because, as explained earlier, the investigation found that Mr C's referral on 14 February was not completed properly and would not be picked up by the mental

[23] Supervised swallow is when the prisoner has to take their medication in front of the nurse.

health team because it had not been written in their diary. The investigation also found that even if the referral had been completed properly, the nurse's entry in Mr C's medical record stating *"no reason for referral to GP or MHT* (mental health team)*"* would not necessarily have cancelled the earlier referral because the mental health team relied on their diary to ascertain who needed to be seen.

SPAR Review and Care Plan

Prison Service policy states that a SPAR Case Review: *"brings together the multi-disciplinary team in order to consider the needs of the individual and the care required. The Care Plan sets out how the support and care to address those needs is to be delivered. An Initial Case Review must take place within 48 hours of the concern being raised. Subsequent Case Reviews will be set during the Initial Case Review. There must be no longer than 7 days between any further Case Reviews."*

At 11.50 on 15 February 2012, Mr C's Initial Case Review took place. The review was attended by Mr C, the Care and Supervision Unit (CSU) senior officer, a probation officer, a chaplain and the nurse that had assessed Mr C that morning.

The record of the Initial Case Review states that, *"*(Mr C) *presented as being very withdrawn. He reported as feeling depressed and still having active suicidal thoughts. He says he has suffered personal loss which weighs heavily on him. Staff report that he has written letters stating he will self harm.* (Mr C) *has seen a doctor for help with his depression and wants a move to Bush or Magilligan. As the prisoner continues to present in such a manner the 30 minutes obs* (observations) *and conversational checks remain unchanged. Referral made to mental health via unit nurse."* The next Review was scheduled for 17 February at 11.30.

The probation officer who attended the Case Review noted in Mr C's file, *"still have a feeling that there's something, something that we're certainly not party to".* At interview, the probation officer said, *"we wondered were there drugs involved as well? There was alcohol taken when he was in the community and could that be the cause of his behaviour or related to it, but at that stage it was suggested that a drug test wouldn't be that reliable."* The probation officer said the reason he had written the entry above was because he was *"baffled as to what had happened because I*

had recollection of him, okay some time ago, but he was a very alert, pushy, slightly aggressive in presentation character and his presentation at this time was, I think it was totally the opposite of that and then, from discussion with (a fellow colleague),*... there's nothing really that you could pinpoint that would cause such a collapse and I was wondering had something else gone on."*

The nurse who attended the Case Review recorded in Mr C's medical records that he had *"low mood, states this is normal for him – normally has thoughts of dsh* (deliberate self harm) *on his mind – went to Mater* (hospital) *before coming to prison to be 'committed' but states didn't stay as there were people there who he didn't get on with – was to go to RVH* (Royal Victoria Hospital) *but didn't bother. Asked if actively suicidal – states 'not when I'm here' i.e. CSU – was previously in Bann and states was having bother there from other prisoners, no current thoughts of dsh at this location, wants to move to Bush and be considered for Magilligan – house S/O* (senior officer) *will action this....advised to request nurse if needed."*

There is no evidence in any of the notes of the Case Review that Mr C was questioned about the nature or circumstances of the *"bother"* he was receiving from prisoners in Bann House.

A further Care Plan for Mr C was agreed at the Case Review and it is recorded that he was to remain on 30 minute observations, to have conversational checks, to have supervised access to razors and that the nurse who attended the Review was to now check that the mental health referral had been made.

Prison Service policy states that: *"It is the case manager's responsibility to ensure that details of the Case Review and all action points to be followed up are input onto PRISM*[24]*."* This policy is intended to ensure that the Suicide and Self Harm Prevention Co-ordinator can monitor Case Reviews and report accurately on the data captured. In this instance, Mr C's Care Plan was not updated on PRISM.

At interview, the nurse said that when checking to see whether a mental health referral had been made she checked Mr C's electronic medical record (EMIS), which noted that a referral had been submitted on 13 February. The nurse did not,

[24] PRISM - Prison Records and Information Management System.

therefore, check whether Mr C's name had been placed in the mental health team's diary. The investigation found that, had Mr C's name been placed in the diary, the mental health multi-disciplinary team would have reviewed his case on Thursday 16 February.

Telephone Call

At 14.35 on 15 February 2012, Mr C phoned a family member. During the call, which at times was stilted, Mr C said that he had asked to transfer to Magilligan Prison but that he had been told that this was not possible because he was in the CSU and because he had to be in prison for two months before he would be allowed to transfer. Mr C went on to say that, when asked where he would like to go as an alternative, he had asked to move to Bush House. Mr C said also that staff and prisoners were talking about why he was in prison. The family member he was talking to told Mr C that he was *"just being paranoid"*.

Self Harm Attempt

At 16.25 on 15 February 2012, it is recorded that, *"*(Mr C) *asked for a medic. Told medic on later with meds, replied 'ok', mood appears to have lowered. SO* (senior officer) *and also staff informed."*

At 16.35, Mr C was observed to have torn up bed sheets and made ligatures. He was removed from the cell and placed into a dry cell (an empty cell) until he could be assessed by a nurse.

At 16.50, a nurse assessed Mr C and recorded on the SPAR, *"Seen in cell. States wishes to kill himself if got* (the) *chance, wishes to go to hospital as "feeling down". Plan to increase SPAR to 15 minutes. Move prisoner to safer cell* (observation cell) [25] *where possible."* The nurse also recorded in Mr C's medical notes that *"he would have tied a noose with bed sheets if he got chance and wishes to commit suicide and has tried same in past. Asked why he had not informed nurse of this today, he replied, I was OK then, when I asked prisoner why he felt this way he did not reply*

[25] An observation cell has a camera in it which allows a member of staff in the secure POD (the control room of the house) to observe the prisoner 24/7 and record their observations every 15 minutes.

instead sat with head down and did not make eye contact throughout conversation." The nurse also recorded that, following Mr C's assessment with the prison doctor the previous day, he was to commence on fluoxetine and medication to aid his sleep which, she noted, she would issue that evening.

A review of Mr C's medication administration record shows that Mr C was given his sleeping tablet but did not receive his fluoxetine medication until 18 February 2012.

Mr C remained in the dry cell until 18.00 when he was taken to an observation cell in Lagan House.

Summary of SPAR Observation Log

A review of the SPAR observation log and CCTV for between 00.00 and 18.00 on 15 February 2012 shows that observations were carried out within the stipulated 30 minute and, latterly, 15 minute intervals. Records also show that Mr C was given a book and newspaper to read, was provided with cigarettes, was encouraged to use the yard instead of staying in his cell and, prior to his phone call that afternoon, appeared to be upbeat and *"feeling much better".* In the event, Mr C did not use the yard because he would not come out of his cell. He had no television.

SECTION 7: TRANSFER TO LAGAN HOUSE OBSERVATION CELL ON 15 FEBRUARY 2012

Process on Arrival

As required by Prison Service policy, authorisation to place Mr C in an observation cell wearing special protective clothing (clothing that cannot easily be used to make ligatures), was given by a governor. The governor agreed that Mr C should be placed in the observation cell because *"*(Mr C) *had prepared a ligature and threatened to take his own life".* The governor also recorded, *"I spoke with him but he would not engage in conversation or make eye contact".*

Mr C arrived at the observation cell in Lagan House at 18.00 on 15 February 2012. He was searched and provided with his protective clothing. It is recorded that Mr C was shown how to use the cell television, emergency call button, staff intercom and Samaritans phone.

Asked whether he had been briefed about Mr C's history and the reason for locating him in an observation cell, the officer who received Mr C in Lagan House said that once he'd finished giving Mr C his introduction to the observation cell he would have been *"able to suss out why or where he came from and whatever, from whatever* (was) *in his SPAR".*

Availability of Footwear

Standard 18 of the 2011 Prison Service's standard operational procedures on suicide and self harm prevention states that: *"Shoe laces and belts* ***will*** *be removed as a matter of course and, if necessary, personal shoes will be removed and slippers provided."* CCTV shows that no slippers were provided to Mr C when his own footwear was removed. CCTV also shows that later on that evening, whilst Mr C was pacing up and down his cell, he placed blankets on the floor, possibly because his feet were cold.

Talking about why Mr C was not provided with slippers, the officer who provided Mr C with the anti-ligature clothing said at interview that, *"that was a big issue*

with us, it is just if (we) *have them they get them, if they don't, they don't. There was no constant supply of them and it was, it was just an ongoing thing that was going on in Lagan".*

Issues connected with prisoners in protective clothing being cold have been highlighted in a previous Prisoner Ombudsman death in custody report.

Self Harm Episode with Broken Cup

Observation cells have in-cell CCTV and this shows that at 21.56 on 15 February 2012, Mr C emptied the contents of his mug into the sink in his cell and wrestled with it until the handle broke off. Mr C then slashed at his arms and wrists periodically with the cup before using the handle to slash at his wrists.

The POD[26] officer's log[27] notes that at 21.50 Mr C *"phoned requesting medic".* CCTV of the POD shows that, following this request, the POD officer contacted the staff on the landing. A few moments later, it would appear from the CCTV in Mr C's cell that an officer spoke to Mr C through his cell door. There is no evidence in the SPAR log book, POD log book or ECR occurrence log[28] that a nurse was requested at this time. At interview, the POD officer could not recall why Mr C was asking for a nurse.

At 22.00, it is noted that Mr C was *"trying to cut wrists with cup"* and CCTV shows the POD officer using the intercom. At interview, the officer said that this would have been to notify the landing staff of Mr C's actions. It is to note that at 22.00, an officer on the landing recorded *"prisoner trying to self harm. Broken handle on mug. Trying to cut wrists. SO* (senior officer) (name redacted) *informed."*

At 22.13, a further entry by the officer on the landing notes that Mr C had cut his wrists but that it was *"not that bad, 'minor', medic informed."*

[26] The POD is a secure room in the accommodation block. The officer in the POD has responsibility for allowing access to and from the building as well as controlled movement within the building. They also have monitors to review all CCTV available in the building.
[27] The POD officer is responsible for viewing the CCTV of inside the observation cell every 15 minutes and for a record of the observations to be kept in a log.
[28] ECR Occurrence Log notes all requests via the radio to the Emergency Control Room. One of the responsibilities for staff in the Emergency Control Room at night is to co-ordinate medical unlocks.

Another entry by the same officer records that he had told Mr C about the nurse being on his / her way and that he *"asked for mug and handle, then after medic see's him he could have a light* (for a cigarette)*."* Shortly after this, at 22.38, the nurse arrived and entered Mr C's cell to see to his arms. Bandages were applied to both arms and the cup and handle were removed.

CCTV shows that there was 42 minutes between the commencement of this incident and the broken cup and handle being removed from Mr C's cell.

Governor's Order 8-2 'Medical Attention for Prisoners After Lock-Up' states that, *"if it is necessary to unlock a prisoner….ensure that sufficient numbers of officers are available to deal safely with the situation… the SO* (senior officer) *will supervise and be present in the wing before the cell door is unlocked."* The same Order also states that in and emergency situation *"when the life of a prisoner is at risk"* two landing officers will be present before the cell is unlocked.

At interview, the officer who was on the landing at the time of the incident said that he could not recall or advise why it took the length of time it did to respond. He said that, on the basis of what he had recorded at the time, it would appear to be the case that, although Mr C had self harmed, it was not an emergency situation. The officer also said that because he and the POD officer continued to check on Mr C, it was the case that, if Mr C had cut himself further and it was *"an extreme case where there's a load of blood",* he would have given Mr C instructions to elevate his arm and put pressure on the wound whilst he called in an emergency message for assistance. The officer said that, in that scenario, his colleague would have heard the message and assisted him in carrying out an emergency unlock, providing it was safe for them to do so.

The officer also said that he did not know why the senior officer and nurse took the time they did to attend to Mr C, but suggested that it could have been the case that they were attending to another incident(s) elsewhere in the prison.

At interview, the POD officer said that once he had notified the landing staff about his observations and was aware that the nurse and senior officer had been

requested to attend, there was little else he could do other than continue to monitor Mr C on the camera.

The nurse who dressed Mr C's arm recorded in his medical record, *"asked to see pr* (prisoner) *as he had cut both arms and broken plastic cup. Seen in safer cell* (observation cell) *multiple superficial scratches to both arms and wrists. Minimal intervention needed dry dressing applied...."*

Tearing of Anti-ligature Suit & Covering of the Observation Cell Camera

Approximately six minutes after the nurse had left Mr C's cell, the POD officer contacted the landing staff to inform them that Mr C was attempting to rip his protective clothing top with his teeth. A couple of minute's later, staff entered Mr C's cell and removed his top. CCTV shows that the senior officer, nurse and two night custody officers were present. At interview, one of the officers said that he couldn't recall whether he was instructed by his senior officer to remove Mr C's top or if it was a decision made by him and his colleague. He said that whilst it should not be possible to tear an anti-ligature top, it could have been the case that they wanted to reduce the risk of Mr C being able to do so.

Less than ten minutes later, Mr C covered the camera in his cell with wet toilet tissue and it is recorded by the landing officer that Mr C refused to uncover the camera. Three minutes later, the toilet paper was removed. An entry in the log notes *"made trade to uncover camera for a light* (for a cigarette)*"*.

Summary of SPAR and POD Observation Logs

A review of the SPAR observation log, cell CCTV and POD observation log for the period between 18.00 and 23.59 on 15 February 2012, shows that observations were carried out within the specified 15 minute intervals. Over and above the events detailed above, records also show that Mr C was facilitated in lighting numerous cigarettes, used a blanket to cover his shoulders after his top was removed and was frequently seen to be pacing up and down the observation cell.

SECTION 8: EVENTS OF 16 FEBRUARY 2012

Removal of Mr C's Water Bottle

CCTV shows that at 00.45 on 16 February 2012, Mr C emptied the content of his water bottle and started to chew on it. This was observed by staff and within five minutes staff entered Mr C's cell and removed it. It is not known why Mr C was doing this, but it may have been a further attempt to create a sharp edge in order for him to cut himself.

Nurse Assessment

At 08.36 on 16 February 2012, a nurse issued Mr C with his medication and, at the request of staff, spoke with him. It is recorded in the SPAR booklet that the nurse, *"had a discussion with* (Mr C) *around his present circumstances and state of mind".* The nurse recorded that: *"He* (Mr C) *is keen to get out of the safer cell* (observation cell) *and is willing to return to the CSU to finish his cell confinement – following which he would like to go to Bush House. I advised him that this decision will depend on various factors. He stated that he has no further TSH* (thoughts of self harm) *or SI* (suicidal ideation) *if he can get out of the safer cell. I also advised him that a SPAR meeting would be held today to determine next course of action.* (Mr C) *stated that he understood all that was explained to him."*

At interview, the nurse could not recall anything landing staff said to him about the circumstances of him being asked to talk to Mr C.

Provision of Slippers

At 11.25, Mr C left his cell to use the telephone. On his return, CCTV shows that, 17½ hours after his shoes were removed, Mr C had been provided with a pair of slippers.

Telephone Calls

Between 11.29 and 11.42 on 16 February 2012, Mr C made two phone calls to a family member. During the first call, the person Mr C had asked to speak to did not come to the phone and after waiting for two minutes and fifty seconds, Mr C ended the call.

During his second call to the same person Mr C talked of his concerns that staff members were going to *"do me in"*. Mr C said that he thought that one of the staff members in Maghaberry was the father of a victim of a previous offence for which he was convicted.

Mr C said also that he believed that staff were showing pictures of him to *"the Ra*[29]*"* and that he wanted his solicitor informed of this. The person that Mr C was talking to told him that he should inform his probation officer of his concerns and Mr C replied, *"they are all in it together"*.

Mr C's solicitor told the investigation that he was never made aware of Mr C's concerns.

The investigation established that it was not the case that a member of staff is the father of a victim of an offence committed by Mr C.

Further Conversation with Nurse

At 11.42 on 16 February 2012, when Mr C returned to his cell following his phone calls, a nurse entered his cell to give him his medication. It is recorded in the SPAR observation log that Mr C had *"poor eye contact, no TSH* (thoughts of self harm) */ suicide"* and noted that he had just spoken to a family member. The nurse also recorded that Mr C *"states he has refused meals – advised it is important to eat/drink regularly.* (Mr C) *states he doesn't want to go back to CSU – advised* (Mr C) *I cannot influence where he goes, also advised* (Mr C) *he cannot use threats of DSH* (deliberate self harm) */suicide as a means of obtaining a different location.* (Mr

[29] Short for 'The IRA'.

C) *demanded to go to wards - advised him he had no clinical/medical needs to necessitate admission. Very aggressive body language. Took meds."*

Following Mr C's conversation with the nurse, CCTV and SPAR observations show that Mr C handed his lunch back and stated that he was on hunger strike.

SPAR Case Review

At 14.15 on 16 February 2012, as required by Prison Service policy, a SPAR Case Review was conducted. The Review was chaired by the senior officer of Lagan House, and was attended by a member of staff from Mr C's landing, a senior officer from the prisoner safety and support team, a member of the probation team, a nurse and Mr C.

A summary of the Case Review was recorded and notes that Mr C was in an observation cell and, when spoken with that morning by a nurse, had *"stated he wanted to return to the CSU* (Care and Supervision Unit) *and then Bush".* It is also noted that Mr C had subsequently told the same nurse that he would self harm if he was moved back to the CSU. It was also noted that Mr C *"seemed to be somewhat paranoid"* thinking that *"everyone wants to attack him"* and that *"staff are telling other prisoners about his offences".* Whilst Mr C had claimed to have had no further thoughts of self harm since the previous night, it was recorded that *"low mood is evident and eye contact and engagement in conference were not good"* and that it would be *"prudent"* for Mr C to remain in the observation cell for a further 24 hours.

It was further recorded that Mr C was *"encouraged to engage with mental health support as a history of non-engagement existed in the past".* A review of Mr C's medical records shows only one previous referral to mental health in July 2006 which he attended. It is unclear, therefore, why this comment was recorded. It is to note that no consideration was given to monitoring Mr C's phone calls in light of the fact that the nurse had picked up that Mr C's mood was low that morning after he had spoken to a family member.

Mr C's Care Plan was updated to note that he was to remain on 15 minute observations, that conversational checks were to be maintained and that he was to be encouraged to engage with staff more. Once again, Mr C's Care Plan was not updated on PRISM, as required by Prison Service policy.

Mr C's "*Mental Health*" remained on his Care Plan, but it is to note that next to this is recorded, *"Review has been made – to be seen A.S.A.P"*. It is more than likely the case that this entry meant that a referral (not a Review) had been made as there is no indication in Mr C's medical records that a mental health review had taken place. It is regrettable that, despite Mr C's SPAR case plans consistently noting that he needed mental health support, the case manager who completed the Care Plan was unaware that the mental health referral on 14 February was not completed properly and, therefore, the mental health team were not aware of any requirement to assess Mr C.

Governor's Review

It is a requirement of Prison Service policy that a prisoner located in an observation cell must be seen each day by a governor. At 18.43 on 16 February 2012, Mr C was seen by the duty governor. It is recorded in the SPAR observation log that when the duty governor spoke with Mr C, *"he was quiet but did talk"*. The governor recorded that Mr C had *"explained he had cut his wrists and tried to hang himself because of "shit" going on in his life"*. The governor noted that Mr C would not elaborate on this any further but that he did say that he was hoping to move out of Lagan House the following day. The duty governor ended his entry by noting that Mr C felt *"under threat from other prisoners in Lagan because of his offence."*

Summary of SPAR and POD Observation Logs

A review of the SPAR/POD observation logs and cell CCTV during this 24 hour period shows that observations were carried out within the specified 15 minute intervals. Over and above the events detailed above, the records show that Mr C: was facilitated with lighting numerous cigarettes; refused the offer of a shower and use of the phone; was seen by the prison fellowship who prayed with him and left him reading material; covered the camera lens in his cell on a couple of occasions

for very short periods of time; lay in bed; and, on occasions, watched television. It is also recorded that, when Mr C raised concerns with staff, they tried to reassure him that he was safe.

SECTION 9: EVENTS OF 17 FEBRUARY 2012

Overview of Observations Leading up to Further SPAR Case Review

A review of staff observations and CCTV evidence between 00.01 and 14.00 on 17 February 2012 indicate that Mr C only slept for approximately four hours because he *"couldn't sleep"* and appeared to be low in mood. During this period Mr C can be seen pacing in his cell, he told an officer that *"he didn't feel suicidal but was still feeling low"*. He also refused his medication and didn't eat any breakfast or lunch. It is also recorded that Mr C refused to shower or talk to a member of the prisoner fellowship (but later requested to see a priest), gave *"monosyllabic answers"* and had *"poor eye contact"*.

In the event, Mr C did not get to see a priest. At interview, the prison officer who made the entry said that, whilst she couldn't recall the specific occasion, *"if a prisoner asked me for a priest or a chaplain I would go and phone the chaplaincy, so all I can say is that I did."*

The chaplaincy informed the investigation that the records for this period are no longer available.

SPAR Case Review

At 14.10 on 17 February, Mr C was taken to the senior officer's office to attend a further SPAR Case Review. Also in attendance was, a senior officer, a member of staff from Mr C's landing, a nurse and Mr C's probation officer.

A record of the Case Review states that Mr C was *"not suicidal"*, that he *"admits"* to being *"upset"* about being placed in the Care and Supervision Unit (CSU) and that he said he just wanted to *"get his cc* (cellular confinement) *done and move to a normal residential location"*. It was also recorded that the SPAR should remain open; that Mr C's observations should be decreased to hourly and that a minimum of four conversational checks within a 24 hour period should occur. The next review was recorded to be scheduled for 24 February 2012.

Mr C's Care Plan noted the above actions and that he was to *"engage with mental health"* and that a referral had been made the day before. Mr C's Care Plan was again not updated on PRISM as required by Prison Service policy.

As discussed earlier, the only referral to the mental health team was made on 14 February and because of misunderstandings about the referral process, the team was unaware of the request to review Mr C.

Whilst there is no record on the SPAR Case Review that Mr C was to be moved to the Care and Supervision Unit (CSU) to finish the remainder of his cellular confinement (CC), it is recorded in his medical records, by the nurse who attended the review, that Mr C was *"again adamant"* that he wanted to go to Bush House but was *"advised he must complete his CC first".* The nurse also recorded: *"all in agreement* (Mr C) *can return to CSU on hourly observations to complete CC, then for relocation into main population."* She noted also that he had no thoughts of self harm or suicide.

It is to note that the same nurse had informed the Case Review on the previous day that Mr C had told her that he would self harm if he was returned to the CSU. There is no evidence in the SPAR booklet or Mr C's medical records that this was considered as part of the Review on 17 February. There is also no evidence that consideration was given to the fact that Mr C: reported low mood; experienced difficulty sleeping; refused his medication; was not eating his meals; refused to talk to a member of the prisoner fellowship (but later requested to see a priest); was recorded to have given *"monosyllabic answers"* and had demonstrated *"poor eye contact".*

In all the circumstances, and given that Mr C had been confined in an observation cell for almost two days, it is entirely unclear why all of those present at the Case Review believed that it was so necessary for Mr C to complete his cellular confinement before he would be permitted to go to Bush House where he felt safe.

At interview, the senior officer who attended the Case Review confirmed that it was agreed by all present that Mr C should finish his cellular confinement in the CSU. The officer said that, normally, he would have documented the decision on the

summary of the Case Review. When asked about the fact that it had been recorded that Mr C had previously been upset about being in the CSU, the senior officer commented: *"He had concerns about going to the CSU, because he was upset about getting cellular confinement* (CC), *I think it was the context of it. But again he could see, you know that the CC was there and it was going to be hanging over him anyway. So he was happy to go through that because as he seen it then, if he got that out of the way, then that allowed him then to maybe try and finish off in Bush House where he would be settled and happy."*

At interview, the probation officer said that during the Case Review on 17 February, Mr C's state of mind was more *"encouraging".* He said that Mr C's *"mood was much better and I recall that he was more talkative and we discussed how he was going to resolve his situation and how he saw himself getting out of it and he was quite positive about returning to Magilligan at that stage. So we all discussed the possibility of transferring back to Bush and then getting back to Magilligan. We felt that he would have support within the staff that he was probably used to."*

At interview, the nurse who attended the Case Reviews on 16 and 17 February said that she could not recall anything other than what was recorded in Mr C's medical records.

Commenting in his clinical review report on the appropriateness of Mr C having to complete cellular confinement whilst on a SPAR booklet, Dr Fazel stated: *"in my opinion, some consideration of whether* (Mr C) *should have completed his punishment on a SPAR is warranted. A balance needs to be drawn between not giving the impression to prisoners that any punishments will be moderated if they self harm or threaten suicidality. On the other hand, the mental health consequences of placing someone in cellular confinement need to be carefully considered, particularly if they have already self harmed in prison recently and have ongoing mental health problems."*

Noting also that a nursing assessment is made to consider fitness to carry out cellular confinement, Dr Fazel said that it was his view that *"guidance on the preferential use of other punishment options in those on a SPAR or who have*

underlying and active mental health problems should be considered by the Prison Service."

Mr C's Return to the Care and Supervision Unit (CSU)

At 14.44 on 17 February 2012, CCTV shows that Mr C was brought into the CSU and was taken to cell six on landing two, to complete his period of cellular confinement.

At 14.58, Mr C made a phone call to a family member which lasted approximately 17 minutes. Several times during the call, Mr C said that he thought he was going to be attacked or killed whilst in Maghaberry and believed that staff were *"going around the landing"* saying that he would *"get his throat cut"*. He said that, if this happened, staff would *"say that I have self harmed"*. Mr C also talked about being *"off suicide watch and back in 'the block'..."* and said that he wanted *"out"* (of the observation cell in Lagan House) because he had *"no clothes or nothing"*. Mr C also said, *"I was wearing a thing like a straight jacket, a pair of shorts and slippers and I was being watched 24/7."*

At 15.25, an officer recorded in the SPAR observation log that he had spoken with Mr C to ask him how he was after being in Lagan House. The officer recorded that Mr C said that *"he felt a bit low"* but that he had no thoughts of self harm and was on medication which he said *"seemed to be helping"*.

At 15.41, Mr C made another call to a family member which lasted approximately five minutes. During this call, Mr C said that he was *"going to get done in tonight"* and that he had heard officers talking about it on the landing. Mr C asked the person he had phoned to inform the governor, which they said they would do. Mr C also said that an officer had put something on his door which, he said, probably said that he was a *"paedo"* (paedophile). The person phoned advised Mr C to take this off the door and show it to the governor. Mr C said that he couldn't because he was "*doing cellular confinement*".

CCTV shows that at 14.48, an officer placed an A4 size piece of paper on Mr C's door. Enquiries have established that this was information in relation to the awards given to Mr C at his recent adjudication.

At 16.30, Mr C made a further call to a family member which lasted approximately 13 minutes. Mr C asked the receiver of the call to ask another person to come to the phone and speak with him. The other person can be heard in the background saying that they are not going to come to the phone to speak to Mr C again. One minute and 35 seconds into the call the person who received the call made a final attempt to get the other person to come to the phone, without success. Mr C remained on the line for a further 11 ½ minutes before he ended the call.

At 16.50, it is recorded on the SPAR observation log that an officer spoke with Mr C *"at length".* The same officer recorded that Mr C was *"first threatening to hang himself if he didn't see the governor and then claimed that staff were trying to kill him or planning to kill him".* Following this conversation, Mr C's bedding and other items were removed from his cell. The officer recorded that when Mr C's bedding and other items were being removed, Mr C *"claimed he wasn't going to hurt himself at all".* At interview, the officer said that shortly before he spoke to Mr C, he had received a phone call from a member of Mr C's family to tell him what Mr C had said about staff trying to kill him. The officer said *"at that point….alarm bells started ringing"* that something was not right with Mr C.

At 17.05, the same officer recorded that he talked to Mr C again and that Mr C requested to see a nurse. The officer recorded that he actioned this request.

At 17.20, the officer recorded that whilst he was talking to Mr C he noticed that Mr C had *"poor eye contact* (was) *not communicating and under these conditions and previous threats of self harm I feel Mr C should revert to 15 minute observations".*

At 18.00, it is recorded that Mr C was offered the use of the telephone but refused, stating that *"it didn't matter and that he would phone tomorrow".*

At 18.40, Mr C was moved to a 'dry cell'. Ten minutes earlier he had been handed back his bedding. It is recorded that the bedding *"had to be removed again as the*

prisoner stated he was definitely going to hang himself". As a result, the decision was made to return Mr C to Lagan House to an observation room.

Mr C's Return to the Observation Cell in Lagan House

At 19.03 on 17 February 2012, Mr C was placed in an observation cell in Lagan House in protective clothing. As required by Prison Service policy, authorisation was sought from a governor. The reason recorded by the governor was, *"CSU staff were concerned that* (Mr C) *would attempt to hang himself after telling staff that he was going to kill himself".*

The senior officer in Lagan House, who had chaired the SPAR Case Review earlier that day said at interview that he was surprised to see Mr C back in an observation cell and that he was *"a bit disappointed"* in himself to see Mr C back because *"I thought I had turned a corner with him, but obviously I hadn't".*

The officer who took Mr C to his observation cell recorded that Mr C had told him that he was *"fine now"* and that he wanted to return to the Care and Supervision Unit. The officer also recorded that he explained to Mr C that he had been *"authorised for the obs* (observation) *cell overnight and the SO* (senior officer) *would reassess this in the morning. He* (Mr C) *said this was okay and asked for a cup of tea, which was provided."*

At 19.15, Mr C asked to use the phone but was refused. It is recorded that it was explained to Mr C that, because his landing and another were on *"fire watch,"*[30] none of the prisoners on his landing were being allowed out to use the phone. It is also recorded that Mr C then asked to see a nurse, but wouldn't give a reason why. There are no further entries in the SPAR or POD observation logs to indicate that a nurse was, as requested by Mr C, asked to attend.

A review of the SPAR / POD observations logs and CCTV for the remainder of the night show that Mr C had numerous cigarettes, watched television, paced his cell, sat or lay on his bed and looked out of the window.

[30] The term "fire watch" is used when there is no association for prisoners and the landing is locked down and effectively goes into the night time routine for head count checks.

SECTION 10: EVENTS OF 18 FEBRUARY 2012

It would appear from the observations recorded in the SPAR/ POD logs, as well as from CCTV, that Mr C slept for approximately five hours on the night of 17/18 February 2012. Unlike the previous night, staff did not try to find out why Mr C was not sleeping. Similarly, between 19.30 on 17 February and 09.07 on 18 February 2012, staff observations note only what Mr C was doing. There is no information recorded to indicate that staff had checked how Mr C was feeling.

Nurse Assessment

At 09.07 on 18 February 2012, CCTV shows that a nurse entered Mr C's cell. It is recorded in Mr C's medical records that it was a "*non urgent call out*" as Mr C was complaining of stomach pains and thought he ought to go to the prison hospital. Following the nurse's assessment he concluded that there was no clinical signs or symptoms to indicate any acute issues and that Mr C's stomach pains were more than likely attributable to constipation caused by the medication that he was taking. The nurse concluded that: *"*(Mr C) *has underpinning anxiety issues and may use vague symptomatic issues to manipulate his way out of the safe cell to avoid returning to the CSU. Will continue to monitor the situation and advised staff to contact healthcare if symptoms deteriorate."*

Mr C's Last SPAR Case Review

It is recorded in Mr C's SPAR booklet that his last Case Review took place at 10.00 on 18 February 2012 and was attended by a case manager, which in this case was the duty senior officer, a member of staff from Mr C's landing, and Mr C.

The Prison Service's Suicide and Self Harm Prevention Policy 2011 states: *"If it is considered that a prisoner should be moved out of an observation cell, a Case Conference must be held to ratify that decision. As a minimum, the Case Conference should consist of the Residential Manager with responsibility for the observation cell, an officer with responsibility for monitoring the person in the observation cell, a Residential Manager or Class Officer with responsibility for the prisoner in normal residential accommodation and a Healthcare Officer."*

A member of healthcare staff did not attend the Case Review on 18 February 2012. It was also the case that Mr C had not yet been assigned to a *"normal residential location"* and did not, therefore, have a regular residential manager or class officer.

At interview the senior officer who did attend the Case Review said that he had not received any training on the SPAR process at the time and, as a result, did not know that a member of healthcare staff must attend. The officer said that he made a phone call to someone in healthcare and *"I was asked just about his demeanour and they had no real concerns about him"*. The senior officer could not recall who he spoke to and there is no record of this phone call taking place in Mr C's SPAR booklet or in his medical records.

It was also recorded that the Case Review took place in Mr C's observational cell at Lagan House. Whilst not stipulated in Prison Service policy, it would usually be the case that SPAR Case Reviews take place in the senior officer's office or the medical room. At interview, the senior officer said that he has since been trained on the SPAR process and is now aware that Case Reviews should not take place in the prisoner's cell.

At 09.07 on 18 February 2012, CCTV shows that the senior officer entered Mr C's cell and left approximately three minutes later. During this time, the senior officer can be seen talking to Mr C for approximately two minutes and for the remainder of the time, Mr C is seen by a nurse in relation to his stomach pains, as detailed above. CCTV shows that whilst the nurse talked to Mr C, the senior officer and the member of staff from Mr C's landing who is recorded as having attended the Case Review, are talking to one another.

At interview, the senior officer confirmed that this interaction comprised the SPAR Case Review. He said also that as a nurse was seeing Mr C about another matter, he took the opportunity to ask him how he thought Mr C was. The senior officer said that he couldn't remember exactly what the nurse said, however *"the general consensus was that he* (the nurse) *was happy with the way he* (Mr C) *was presenting"*. At interview, the nurse said that he couldn't recall if he was asked to make a contribution to the Case Review. There is nothing recorded in Mr C's medical records in connection with this.

At interview, the senior officer also said that it is not always possible to have 'policy compliant' attendees at a Case Review over a weekend (18 February 2012 was a Saturday). He said that, since his training on the SPAR process, he was now aware that he should have asked Mr C *"more in-depth questioning, more direct questioning".*

At interview, the officer present at the Case Review said that, from what he could remember, the senior officer *"probably asked me how he* (Mr C) *was getting on that day".* The officer said that, from what he could recall, Mr C's *"major gripe was the CC* (cellular confinement)*, there was no way he was going back to the CSU* (Care and Supervision Unit)*....As long as that was sorted, the prisoner was quite happy, you know, as far as I could make out."*

A summary of the Case Review notes: *"After speaking with* (Mr C) *he appears and presents as calm and pleasant. He is now happy to move back to normal location. Duty Governor consulted and is happy with the situation. Obs* (observations) *changed to hourly as there have been no episodes of DSH* (deliberate self harm)*. Review in 1 week."*

It is to note that Appendix 1: Recognising Risk of the Suicide and Self Harm Prevention policy warns that: *"some people may be adept at concealing their intent to self harm so staff should be aware of a prisoners body language, what they say, how they say it, their reaction or response to questions and how they respond to the environment."* It was the case that, over the previous 24 hours, Mr C had displayed a number of possible risk factors identified in the policy, including *"irrational behaviour, anxious appearance, withdrawn or depressive manner, talks about death or suicide, disturbed sleep, unusual, untoward or bizarre behaviour".*

At interview the senior officer said that he read the SPAR booklet before talking to Mr C. There is, however, no evidence that he considered how Mr C had presented over the previous 24 hours or throughout his time on the SPAR.

In relation to Mr C's threats of suicide, which led him being placed in the observation cell, the senior officer said: *"it's hard to define whether when he* (Mr C)

said that, if it's being said as a clear intention of what he intended to do, or whether it was said to try and manipulate."

The senior officer said that he spoke with the duty governor and *"explained how* (Mr C) *was presenting and* (of) *the possibility of moving him out of the safer cell* (observation cell) *and into…normal location. He* (the duty governor) *said to speak to the security department to see where they're going to put him and I said he needed to finish the committal induction."*

There is no indication that the senior officer was informed about, or considered, any information relating to Mr C's anxieties or preferences in connection with his location, or of decisions made at previous Case Reviews.

Prison training records show that the senior officer attended ASIST[31] training on 20 February 2012 and attended training in the SPAR process on 21 February 2012. It was, therefore, the case that, as the officer said, he had not received the necessary training when he made the arrangements for the Case Review on 18 February 2012.

At interview, the duty governor to whom the senior officer spoke on 18 February said that he was not aware that the officer was not trained in the SPAR process, but that he had seen the officer interviewing a SPAR prisoner before and *"on the basis of knowing how he operates, I would have had no concerns".*

The duty governor said also that he was not aware that the Case Review took place in the observation cell and was not aware that a member of the healthcare team did not attend the Review. The duty governor did not know that Mr C had been referred for a mental health assessment but said that this would not have prevented Mr C from leaving the observation cell as it *"can take weeks"* for a mental health assessment to take place. He said that the senior officer had told him that Mr C *"wanted to move on with things"* and that Mr C's cellular confinement had been completed. The governor said that he thought that the Case Review had taken place, the decision had been made and that "*things were positive".*

[31] ASIST – Applied Suicide Intervention Skills Training

In relation to Mr C being moved to Bann House, the duty governor said that this decision had already been made by the senior officer and, as far as he was concerned, he was *"rubber stamping"* the decision. It is to note that the duty governor was the same governor who had chaired Mr C's adjudication at which he submitted a statement stating that he feared being attacked and assaulted in Bann House and, if sent there again, he would attack an officer (to ensure that he was again relocated to the CSU).

When a SPAR Case Review takes place, consideration must be given as to whether the prisoner's Care Plan requires updating with any new actions. The record of the Case Review on 18 February 2012 was ticked by the senior officer to state that the Care Plan was not updated as there were no new actions. It was, however, the case that the senior officer had in fact updated Mr C's Care Plan to state that the frequency of his observations had been reduced to hourly.

There was no reference in the Care Plan to Mr C's move to normal location or to the fact that he had still not been seen by the mental health team.

At interview, the senior officer said that he would have looked through the SPAR before the Review, to ascertain what had happened at previous Case Reviews but said that he could not remember whether he spoke to healthcare about Mr C's outstanding referral to the mental health team. The senior officer said also that he did not record the issues from Mr C's previous Care Plans on his new Care Plan and thought he didn't have to, as there was no change.

In his clinical review report, Dr Fazel stated *"as these were ongoing issues, it is unclear why they are not mentioned"* in Mr C's updated Care Plan.

Mr C's Care Plan was, again, not updated on PRISM as required by Prison Service policy.

Prison Service policy states that one of the responsibilities of residential managers, *"at all levels"* is to *"ensure that all Healthcare stipulations on preventative measures for prisoners in their area of responsibility are recorded and carried out."* It was therefore the case that, as the most senior operational representative at the Case

Review, responsibility for ensuring that the mental health referral was being actioned would have resided, on that day, with the senior officer.

The manner in which the Case Review was conducted and the absence of a healthcare representative, combined with the inexperience and inadequate training of the senior officer, undoubtedly contributed to these oversights.

It is recorded on the observation log that, at 11.15 on 18 February 2012, the senior officer spoke to Mr C and told him that he was moving to Bann House. At interview, the officer said that the reason Mr C was not returned to the Care and Supervision Unit (CSU) was because the person he contacted in the CSU had said that they were *"content that the time spent in the safer cell* (observation cell) *would cover the CC* (cellular confinement)*"*. He also said that Mr C was *"happy to be coming out of the safer cell* (observation cell)*....there was no fear.....just content that he wasn't going back to the CSU"*. The senior officer could not recall who he spoke to in the CSU and it was not recorded on the SPAR booklet.

As well as Mr C detailing his concern that he would be assaulted if he was sent back to Bann House in his adjudication statement, it was also recorded in Mr C's medical records that he was *"previously having bother from other prisoners"* in Bann House. Neither piece of information was ever recorded in Mr C's SPAR booklet, nor is there any evidence that it was ever considered or discussed at a Case Review. It was, therefore, never noted on Mr C's Care Plan and was not known to the senior officer who made the decision to move Mr C to Bann House on 18 February 2012. As stated, Mr C's concerns were made known to the duty governor at the adjudication hearing.

It was recorded that, during Mr C's initial SPAR assessment interview on 13 February, he stated that if he was moved to Bush House, where he had previously felt safe, his thoughts of self harm and suicide would reduce. This was reiterated during a SPAR Case Review on 15 February, when it was recorded that Mr C wanted to move to Bush House or Magilligan. At a further Review on 17 February, it was determined that, if Mr C completed his cellular confinement in the CSU, he would then be able to transfer to Bush House.

At interview, the senior officer said that even though he wasn't aware of the earlier incident which resulted in Mr C being moved from Bann House, or the fact that Mr C had said he would assault an officer if he was to return there, *"didn't bring into question where else he could be placed."*

At interview, the duty governor said that he did not take into consideration Mr C's statement at adjudication when talking to the senior officer about Mr C's move to Bann House.

Commenting on the effectiveness of Mr C's final Case Review in his clinical review report, Dr Fazel stated that he *"would have expected that more details about his specific location preferences would be included."* He also said that is was not sufficiently clear as to why the senior officer noted that Mr C had *"no episode of DSH* (deliberate self harm)*"* as *"*(Mr C) *had been threatening self harm the previous evening, and had apparently cut his arms on the day before that (16/2/12)".*

Mr C's Move to Bann House

At interview, the officer who escorted Mr C to Bann House said that, whilst they were walking from Lagan House, Mr C was agitated and said that he wasn't happy about moving to Bann House. The officer said that he couldn't fully remember the conversation but said that he managed to calm Mr C down by telling him that he would speak to someone on the landing for him. The officer said that, when they arrived, he sat Mr C down in the circle area and went down the landing to explain Mr C's concerns to one of the officers in Bann House. The officer said that he had only been down the landing for a couple of minutes when the discipline alarm[32] sounded.

CCTV shows that at 11.26 on 18 February 2012, Mr C arrived in Bann House and sat on a chair in the circle area[33]. A few minutes later, some prisoners passed Mr C on their way back to the landing from the recreation room / yard and one prisoner can be clearly seen to stand in front of Mr C and to glare at him for approximately

[32] The discipline alarm is raised by staff when an incident with a prisoner is occurring and the officers require extra assistance from their colleagues.
[33] The circle area of the landing is where the officer's office is located, phones for the prisoners to use and where meals would be served.

three seconds. A few minutes later, at 11.33, Mr C walked over to the opposite side of the circle and picked up two metal food containers, one in each hand. CCTV shows that Mr C started to wave one of the containers and two prisoners who were in the circle area looked fearful and quickly left the area. The officer who was processing Mr C's paperwork was standing approximately 10 feet away from Mr C but, due to the angle of the CCTV camera, it is not possible to determine whether this officer spoke to Mr C. CCTV then shows the officer who had escorted Mr C to Bann House walking purposefully towards Mr C and, using control and restraint techniques, took him to the ground and held him there. The incident lasted 17 seconds.

Mr C was held on the ground until 11.38, when the dedicated search team arrived and escorted him to the Care and Supervision Unit using control and restrain techniques under Prison Rule 35 (4)[34]. It was alleged that Mr C was threatening to assault an officer with the metal food container.

At interview, the officer who was processing Mr C's paperwork said that when Mr C arrived at Bann House he was *"fidgety /restless"* and, in the short time that Mr C was there before the incident occurred, the only thing Mr C said was that he didn't want to be in Bann House. The officer couldn't recall whether the other prisoners had said anything to Mr C to trigger his subsequent behaviour.

Mr C's Removal to the Care and Supervision Unit (CSU)

One of the questions raised by Mr C's family was why he was not in an observation cell when he attempted to die by suicide. It would appear that Mr C was moved to the CSU following the incident at Bann House, rather than being returned to the observation cell in Lagan House because the "Case Review" that morning had determined that he was suitable for return to a normal cell/location.

At interview, the duty governor (the same governor that conducted Mr C's adjudication on 14 February 2012 and authorised Mr C's move to Bann House earlier that morning) said that the reason Mr C was moved to the CSU, rather than

[34] Prison Rule 35 (4) states that a prisoner who is to be charged with an offence against discipline may be kept apart from other prisoners pending adjudication, if the governor considers that it is necessary, but may not be held separately for more than 48 hours.

back to an observation cell in Lagan House, was because *"the policy on an observation cell is very clear and an observation cell must be used as a last resort and where there is an imminent threat of suicide. What was presented at that time was a serious intention of violence towards staff and maybe prisoners so, on that basis, moving* (Mr C) *to the CSU was the right decision."*

Despite Mr C's behaviour being inconsistent with the assessment made at the earlier "Case Review", the fact that the duty governor was aware of Mr C's anxiety about being located in Bann House and that Mr C was known to be vulnerable and have spent time in an observation cell, no consideration was given to the possibility that either a further Case Review was required or that it may be appropriate to monitor Mr C in an observation cell for a further period of time.

At 11.45 on 18 February, it is recorded that Mr C arrived in the CSU and was seen by a nurse, as required by Prison Service policy when 'use of force' has been applied to a prisoner. The nurse recorded in Mr C's medical records that he was complaining of pain in his hands and right shoulder but that there were *"no obvious deformities/swelling or bruising noted".*

Samaritans / Telephone Calls

At 12.25 on 18 February 2012, Mr C requested and was given the Samaritans phone which he handed back approximately ten minutes later. Due to the Samaritans code of confidentiality the content of this conversation could not be disclosed to the investigation and Mr C did not mention the call during any of his conversations with his family.

Between 14.01 and 16.04, Mr C made 21 attempts to phone his family. Only three of these calls were answered. During the first call, at 15.18, Mr C asked for a message to be passed on to another family member. The message given was that he was going to be murdered by staff and other prisoners and that they were going to *"slit my throat"*.

At the start of the second call, at 15.29, which lasted just over 28 minutes, Mr C asked to speak to another family member. The phone can be heard to be placed on

a table and left there. No one came back to the phone and throughout the rest of the time Mr C was heard to repeatedly say things like: *"f**k sake hurry up will you"*, *"f***in b*****d … why did you leave the phone and not come back to it"* and *"hurry up"*.

The third call, at 15.58, which lasted almost five minutes, was to a different family member. During the conversation the family member told Mr C that he was being *"paranoid"* about being murdered in prison, that he sounded tired and that he should try to get some sleep. Mr C continued to say that staff were going to let other prisoners into his cell to kill him. The family member tried to reassure Mr C that prison staff were not allowed to do that, but Mr C was not reassured. After the call ended, Mr C made one further attempt to speak to the family member he had previously been trying to speak to during his second call, but was then asked by an officer to see the nurse and receive his medication.

Medical Review

At 16.12 on 18 February 2012, it is recorded in Mr C's medical records that whilst Mr C was being given his medication, he informed the nurse that he felt under threat from other prisoners and was described by the nurse as *"demanding to be taken around to the hospital"* in a *"non-aggressive nature"*. The nurse also noted that Mr C had poor eye contact, was communicating clearly and concisely but that he believed that other prisoners would get into his cell and *"beat him up"* for past crimes. The nurse noted that he tried to reassure him that this wouldn't happen but told him that he would not be taken to the hospital as there was *"no clinical reason"*.

The nurse updated the SPAR observation log stating: *"Seen in medical room. To remain on 15 minute observations. Medication given."* It would appear that no consideration was given to the need to follow-up the outstanding mental health referral that was noted in Mr C's medical records on 14 February 2012. At interview, the nurse said that he did not follow up on his referral because, *"I thought I'd gone down all the correct channels of referral"*.

Taunting by Other Prisoners

An entry made in Mr C's SPAR observation log at 16.43 on 18 February 2012 states: *"checked pr* (Mr C)*, said 'I'm not a root*[35]*.' Don't know why."* A further entry by the same officer, at 17.00, states: *"*[prisoner's name] *is winding him* (Mr C) *up about staff calling him a root. Obviously* [prisoner's name] *is making this up for reasons known only to himself."*

At interview, the officer who made the log entries said that he raised his voice, in order for Mr C and the prisoner in the cell next to him to hear him and told Mr C that it was not him (the officer) who had been calling Mr C names but the prisoner in the cell next to him. He said that *"I was very annoyed with* (prisoner's name) *saying this as I knew that* (Mr C) *was not in a good place at that time".* The officer also said that, over and above the SPAR entries he wrote at 16.43 and 17.00, he said he *"was convinced that I recorded this matter with* (prisoner's name) *either on an SIR* (security information report)*, Journal or daily log at the time".* The investigation examined all of the documents where this information could have been recorded but was unable to find any further note by the officer. It is, however, to note that a page of CSU log entries was found to be missing from both Mr C's file and the other prisoner's file. This may or may not simply be the result of a failure to re-file the sheets. In the event, it is unacceptable that the pages are missing and the Prisoner Ombudsman has commented on this before. It is to note that Mr C's family were concerned that the pages could have been deliberately removed to prevent the discovery of relevant information and this added to their distress. It is not possible to say that this was not the case but it is to further note that the officer who was interviewed willingly volunteered the information that he had written the additional note. Whatever the explanation, the entry in the SPAR makes it clear that Mr C was being taunted by another prisoner and was being told that staff were calling him a "*root.*"

It is to note that there is no evidence that any consideration was given to dealing with this incident under the Prison Service Anti-bullying Policy.

[35] "Root" is slang for sex offender.

At interview the prisoner said that he could not remember hearing Mr C arrive in the CSU on 18 February 2012 and with regards to using the word *"root"*, he said, *"I may have called the officer a root but not* (Mr C)*"*.

Summary of SPAR Observation Log

A review of the SPAR observation logs for the period following Mr C's return to the CSU shows that, despite the recommendation at the earlier "Case Review" to reduce his observations to hourly, he continued to be observed at 15 minute intervals.

At interview the duty governor said that "*the CSU had changed* (Mr C)*'s observations to 15 minutes"*. It is also to note that the nurse who saw Mr C that afternoon recorded on his SPAR *"to remain on 15 minute observations"*.

Over and above the events detailed above, records show that CSU staff were responsive to Mr C's needs, chatted with him and helped him to get *"rollies"* (roll-up cigarettes). Mr C also appeared to settle into bed a lot earlier than the previous two nights.

SECTION 11: EVENTS OF 19 FEBRUARY 2012 BEFORE MR C WAS FOUND HANGING

Nurse Assessment

At 09.50 on 19 February 2012, a nurse assessed Mr C for the purpose of determining whether he was well enough to carry out a period of cellular confinement as punishment for his actions the previous day. The nurse recorded that Mr C expressed having a low mood, but denied any feelings of deliberate self harm or suicidal ideation. It was also noted that Mr C's behaviour was *"suspicious and guarded"*, that he *"denied having any hallucinations but talked about seeing shadows at times"*, that he *"stated he wanted to be in a safe cell"* to ensure that he was not harmed and that he had not been sleeping *"due to the perceived threat on him from staff"*.

The nurse also took a comprehensive history and noted that Mr C had been seen by a community psychiatric nurse and a psychiatrist in the past and that he denied any history / current feelings of deliberate self harm or current feelings of suicide. The nurse concluded that Mr C was fit for cellular confinement but that he required a *"referral to the mental health team for a further in-depth assessment"*.

In contrast to the above entry in medical records, the entry that the nurse made in Mr C's SPAR observation log (the only entry which prison staff could access) noted only that Mr C had *"no issues or concerns"* and that he had requested to speak with the governor.

At interview, the nurse said that he only works at weekends in Maghaberry and not every weekend. He said that, whilst he is a mental health trained nurse, the purpose of this particular assessment was only to ensure that Mr C was fit for cellular confinement. The nurse said that he had never met Mr C before the assessment but decided to complete a more comprehensive assessment because of his experience as a mental health nurse and the way in which Mr C was presenting. He said that prior to meeting Mr C, he looked through Mr C's SPAR booklet, spoke with landing staff and looked at Mr C's medical records on the computer. The nurse also said that the reason he decided to refer Mr C for a more

in-depth mental health assessment was because a full mental health assessment would take about an hour and he only had twenty minutes to spend with Mr C. He said that he was not aware of any earlier referrals to the mental health team.

When asked about Mr C saying that he *"wanted to be in a safe cell* (observation cell)*"*, the nurse said that Mr C *"wanted to be in a safe cell to ensure that he is not harmed.' The concern of harm that* (Mr C) *was expressing was specifically from prison staff and other prisoners not harm or risk to himself. I reassured him that other prisoners would not have access to him and that the prison officers were there to help him. If I had any concerns about him being a risk to himself on that particular day, I would have had no hesitation to have him placed in a safe cell or transferred to the Healthcare wing."*

Governor's Review

Prison Rule 41 (3) states that: *"The governor shall visit every prisoner undergoing cellular confinement at least once a day..."* At 10.45, CCTV shows that a governor visited Mr C in his cell. This was the same governor who conducted Mr C's adjudication on 14 February 2012, who agreed to move Mr C to Bann House on 18 February and who responded to the alarm that was raised when Mr C was subsequently considered to have threatened staff with food containers. It is recorded in Mr C's SPAR observation log that Mr C told the governor that he was being *"intimidated by staff"* who were *"threatening to cut his throat".* The governor also recorded that Mr C declined the chance to see CCTV of the wing in connection with his anxieties. It is further noted that when Mr C requested a transfer to Magilligan Prison, the governor instructed staff to issue Mr C with a request form. The governor concluded his entry in the log book by writing that Mr C *"seemed angry and withdrawn".*

At interview, the governor said that Mr C had said that staff had opened his door during the night in order to let prisoners in to cut his throat. The governor said that the reason he offered Mr C to view the CCTV was to try and prove to him that there was nothing going on outside his cell the night before. He said that Mr C's response to the offer was that he thought the CCTV would be edited so there would

have been no point in him viewing it. He said that when he tried to reassure Mr C that CCTV would not be edited, Mr C *"basically stormed off".*

Mr C's Request to Transfer to Magilligan Prison

As instructed by the governor, Mr C was provided with a request form on which he wrote *"can I request a transfer to HMP Magilligan Prison".* It is to note that, four days later, Mr C's request for a transfer to Magilligan was accepted. Regrettably, Mr C was by this time in intensive care at the Royal Victoria Hospital.

Telephone Calls

Between 10.11 and 11.29 on 19 February 2012, Mr C attempted to make 11 calls to the same family member. Only two of these were answered.

The first call lasted just under seven minutes. Mr C talked of officers putting something into his tea and said that he could feel the effects of it. He said also that, when he died, prison staff would try to make it look like he had died by suicide because he had previously cut his arms and attempted to hang himself. The person Mr C called told him that he was *"paranoid"* and they ended up arguing and falling out.

Mr C's second and final call, which lasted approximately 22 minutes, was to the same person. During the call, Mr C continued to talk of his belief that other prisoners and staff were going to attack him. The person he called appeared to be frustrated with what he was saying. They told him that the things that he was anxious about were *"in your head",* that they thought he was paranoid and that he needed *"psychiatric help"* because he had been *"coming off with this craziness for the last three days".* Mr C told the family member that he was going to die and that he loved them. He said that *"this will happen tonight"* and made requests about his grave before ending the call saying, *"I want buried from your house, I don't want any of them at the funeral – right. Tell* (name redacted) (name redacted) *and* (name redacted) *that I love them."*

At 11.52, Mr C returned to his cell.

At the time of considering the Prisoner Ombudsman investigation into the near death of Mr C, the family member to whom Mr C had been talking said that a couple of hours after receiving this call, they once again contacted Maghaberry and asked to be put through to the wing where Mr C was located. They said that they spoke to an officer, told him about the phone call and said that they thought Mr C was being paranoid but wanted to make staff aware of what he was saying because they were concerned. The family member said that the officer told them not to worry about Mr C and said that he would be looked after. Unlike the earlier phone call by the same family member, there is no record of this call.

Events on the Afternoon of 19 February 2012

At 12.00 on 19 February 2012 the nurse who had seen Mr C earlier that morning recorded on his SPAR observation log that Mr C had declined his medication, that he had spoken with a governor regarding his transfer to Magilligan and that the *"referral to the mental health team will be completed".*

Between 12.25 and 15.30, staff recorded on Mr C's SPAR observation log that at different times he was pacing in his cell, sitting on his bed, standing at his cell door, reading, standing looking out of his window and had been given writing materials.

At 15.57 the nurse administered Mr C's medication which, on this occasion, he agreed to take.

Between 16.15 and 17.40, Mr C was observed at 15 minutes intervals and it was recorded that, at different times, he was standing in his cell, taking a wash, using the toilet and staring out of the cell window.

At 18.00 it is recorded that Mr C was talking to another inmate through the wall and at 18.20 it is recorded that he was *"walking around the cell in a circle".*

At interview, the officer who was carrying out the observations said that he couldn't hear what was being said between Mr C and the prisoner who was in the cell next to him.

At interview, the prisoner concerned denied talking to Mr C that evening. It is to note, however, that this is the prisoner that was recorded to have earlier taunted Mr C.

As the prisoner denied talking to Mr C, it is not possible to assess what the impact of anything he may have said, had on Mr C.

It is to note that, at interview, the prisoner alleged that he heard staff threatening and swearing at Mr C. Other prisoners located in the CSU were interviewed in connection with this and no evidence was found to support this allegation.

At 18.34, CCTV shows that Mr C's cell door was opened for 23 seconds whilst he was seen by a nurse in order for him to receive his medication. Also in attendance was the officer who had been carrying out Mr C's observations and a senior officer. At interview, the officer said that Mr C passed a tablet back to the nurse. He said that he did not know what the tablet was. This matter is not recorded in Mr C's medical records. During the cold de-brief[36] meeting, it is recorded that the tablet was an anti-inflammatory medication and *"did not give any 'red flag' concern about his* (Mr C's) *mental state".*

At 19.03, CCTV shows the same officer kicking Mr C's cell door, apparently unable to gain a response. It was 29 minutes since Mr C had been checked and, at the time, he was required to be observed at 15 minute intervals.

Reason Why Mr C's Last 15 Minute Observation was Missed

At 16.30 on Sunday 19 February 2012, 'fire watch'[37] had commenced in Maghaberry Prison and, as required, only one officer remained on duty in the Care and Supervision Unit (CSU). The officer left in charge had been on duty since 08.00 that morning, but had, up until 16.30, been looking after the prisoners on landings three and four in the CSU, with other colleagues. That evening there were

[36] A 'cold de-brief' meeting is a de-brief meeting for the staff involved in the incident to discuss whether there was any learning/ concerns they had following an incident. This meeting should take place within 14 days of the incident.
[37] The term 'fire watch' is used when there is no association for prisoners and the landing is locked down and effectively goes into the night time routine for head count checks.

16 prisoners in total in the CSU, 12 upstairs and four downstairs (one of which was Mr C).

At interview, the officer said that, prior to his commencement of 'fire watch' duties he went downstairs to landing two and received a handover from the officer who had been responsible for that landing. He said that the officer told him that Mr C was the only prisoner on landing two that was on a SPAR, that he required 15 minute observations and that no other concerns had been raised about him.

The officer said that, in order to ensure that prisoner observations are not missed, staff use a clockwork egg timer which is kept in their office upstairs. He said that he wasn't sure who had brought in the egg timer, but that at times it could be unreliable and go off earlier or later than set. The officer said he could not recall whether he was using the egg timer on 19 February 2012.

At the time of the missed observation the officer said that he was upstairs in the office catching up on paperwork and hadn't realised that the time had lapsed.

The officer also said that, after the incident, he had been concerned that he had missed or been late on his last observation. The officer said that he was, however, contacted by the security department and provided with evidence to show that Mr C should have been on hourly observations. He said that if he had, in fact, been carrying out observations at hourly intervals, Mr C would not have been found when he was and resuscitated.

The evidence provided to the officer by the Security Department was Mr C's last SPAR care review, which, as previously stated, was not policy compliant and had recommended Mr C's observations be reduced to hourly intervals.

It was the case, however, that 15 minute observations continued from the time that Mr C arrived in the CSU and the duty governor said that the CSU had *"changed his* (Mr C's) *obs to 15 minutes"*. It was also the case that a nurse had recorded on the SPAR the need for observation at this frequency to be continued and the officer was correctly informed at handover that he was to observe Mr C at 15 minute intervals. Notwithstanding the information provided by the Security Department, it was

clearly the officers own understanding at the time of the incident that he should be observing Mr C every 15 minutes.

SECTION 12: EVENTS AFTER MR C WAS FOUND HANGING

At interview, the officer who found Mr C said that, when he checked through the door flap at 19.03, he could only see Mr C from his knees down. He said that as a result of a previous incident where articles were thrown at staff through the door flap, a secondary flap, with more restricted views, had been located on the doors to reduce the risk of injury to staff.

CCTV shows that, after the officer first looked through the door flap of Mr C's cell, he walked away from the cell and entered the office closest to him. At interview, the officer said that he then contacted the emergency control room (ECR) to notify them that Mr C was unresponsive. CCTV shows that the officer then left the office and walked to the senior officer's office just around the corner, where he picked up the emergency belt which has items such as a radio, a Hoffman knife[38], an emergency key and a face shield for use in mouth to mouth resuscitation. At interview, the officer said that there is only one belt issued to the CSU each day and that it is located in the senior officer's office.

At 19.03:23 the emergency control room then made contact by radio to Oscar 2 (duty Senior Officer). At interview, the senior officer said that he was in Foyle House when he received the urgent message via his radio regarding the CSU and, as he was close to a phone, called the ECR to ascertain further details.

At 19.04, the officer returned to Mr C's cell and can be seen to repeatedly kick his door in an attempt to get a response.

At 19.05, the officer walked away from Mr C's door and again entered the senior officer's office where he answered a phone call.

At 19.06, CCTV shows that the officer returned to Mr C's cell and continued to attempt to get a response from Mr C.

[38] Hoffman knives are used to quickly and safely cut a ligature without any hazard to the officer or the prisoner.

At interview, the officer said that, in the recent past, there had been an inmate in the CSU who had faked unconsciousness in order to get his cell door opened for him to overpower staff who genuinely thought he needed assistance. The officer said that, for that reason, he felt he had to be careful not to compromise the safety of the unit or himself. The officer, therefore, waited for the senior officer to arrive to assist in an emergency unlock of Mr C's cell.

At 19.08 on 19 February 2012, CCTV shows that the officer walked away from Mr C's cell to let the senior officer into the CSU because, unlike all other houses in Maghaberry, there is no 'automatic grill override' to allow staff in the Emergency Control Room to carry out the unlock. Seconds later CCTV shows that the senior officer unlocked and entered Mr C's cell, while the officer ran down the landing to let a nurse into the unit.

At interview the officer said that when the senior officer arrived he relocked the grill to the unit in the interest of safety because, at that time, he wasn't sure what type of incident they were dealing with. The officer said that when he went to unlock the grill and let the nurse in, he then knew what Mr C had done and decided to leave the grill unlocked so that others responding could access the unit straight away.

At 19.10, another nurse arrived with medical equipment and entered Mr C's cell.

The senior officer recorded in his staff communication sheet that when he opened the cell, he found Mr C suspended by a ligature made from the bottom of his vest. He noted that he immediately cut Mr C down using a Hoffman Knife and placed him on the floor of the cell to *"carry out a primary survey to establish his condition"*.

The senior officer established that Mr C's airway was clear but that he was not breathing.

Cardiopulmonary resuscitation (CPR) commenced with the assistance of the two nurses. An automated external defibrillator and a pulse oximeter were used and it was established that Mr C had a pulse and was still alive. It was recorded that CPR continued for further 10-15 minutes until Mr C started to breathe himself.

The senior officer noted that *"it wasn't normal breathing in the proper sense of the word so we continued on the oxygen and we constantly monitored him".* This continued until paramedics arrived. The senior officer recorded that at no time did Mr C regain consciousness.

CCTV shows that, at 19.31, the paramedics arrived and entered Mr C's cell. At 19.47, Mr C was taken by the paramedics to the Royal Victoria Hospital, Belfast.

There was a four and a half minute delay in requesting the ambulance due to a misunderstanding in connection with the radio messages sent by the senior officer at the scene. On arrival at the scene the senior officer requested an emergency ambulance via his radio. One minute later the senior officer can be heard on his radio to say *"Oscar 2* (the senior officer) *to Control: disregard my last."* This was interpreted by the officer in the emergency control room as the need to cancel the ambulance. At interview, the senior officer said that when he said "Oscar 2 to Control" he was about to ask for further medical assistance but as he was about to pass the message, additional medical staff had arrived. He said *"the disregard* (my) *last* (was) *in relation to the message that I was about to send".* It was, however, the case that this was interpreted by the officer in the emergency control room as the requirement to "disregard" the initial ambulance request. Four and a half minutes later, the senior officer can be heard to say *"Oscar 2 to Control: regarding my last, CPR is being carried out on the prisoner and he is unresponsive at this time".* The officer in the control room then says *"do you require an ambulance"*? The senior officer responds on his radio by saying *"I have requested that initially over",* to which the control officer responds *"received and understood".* An emergency ambulance was then requested.

It is clearly the case that the delay that resulted was the result of human error and a genuine misunderstanding.

In light of the missed observation check and delays occurring before staff entered Mr C's cell after he was found, Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, was asked to provide his expert opinion on the significance of these findings to Mr C's outcome.

Mr Brackenbury concluded the following:

"The delay in the quarter-hourly SPAR checks and the five-minute delay in opening the cell door and commencing CPR could, in theory, be relevant to the final outcome of the resuscitation attempt. The brain is a highly oxygen-dependant organ and can become severely damaged after only three or four minutes of hypoxia at normal body temperature. Even the smallest delay in rescue will be important in determining the success, or otherwise, of resuscitation following hanging. The delayed SPAR check and the delay inherent in unlocking the cell, undoing the ligature, man-handling (Mr C) *into an appropriate area where resuscitation could be effectively performed and taking time to assess his clinical status would be relevant to a condition where every passing minute without the circulation of oxygenated blood counts towards an increasing likelihood of a bad outcome. However, given the brain's high degree of oxygen-dependency, prisoners who self-harm by hanging, even when discovered early, are at a real risk of sustaining significant brain damage. Not surprisingly, quarter-hourly checks, even when delayed by a few minutes, may still miss the opportunity to prevent the harm resulting from hanging.*

Any delay in checking, gaining access to, and resuscitating, a prisoner who attempts to take his/her life by hanging can have an impact on the final outcome. Nearly-constant surveillance and a mechanism to ensure easy access to the cell (both of which may be impractical or undesirable in a prison setting) by those who could provide rescue would be important in situations where a delay of a few minutes is critical."

It is to note that Mr Brackenbury also said that, "*resuscitation of someone who is near death is often a catastrophic, disruptive, shocking and distressing event; especially distressing if the final outcome is not good. The prison staff involved in* (Mr C)*'s CPR should be commended for their efforts."*

Staff Support and De-brief Meetings

The Prison Service Self-Harm and Suicide Prevention policy provides guidance on when de-brief meetings should take place following a serious self harm incident or death in custody.

It states: *"in all cases involving a serious incident of self harm or death in custody, hot de-briefing will take place and will involve all of the staff (where possible) who were closely involved with the incident… and will take place as soon after the incident has been brought under control as possible."* A hot de-brief[39] meeting did not take place. The reason given for this, by the governor who chaired the meeting, was *"there had not been a hot de-brief on the night in question, because at that time, we were not aware of the underlying seriousness of* (Mr C)*'s condition and indeed, it had taken some days for PSHQ* (Prison Service Headquarters) *to consider referral of the case to the Prisoner Ombudsman".* It is, however, to note that the Ombudsman's 'Death in Custody' on-call investigator was called on the night of Mr C's attempted death by suicide due to the perceived seriousness of the incident.

The Prison Service Self-Harm and Suicide Prevention policy also states: *"a cold de-brief will take place within 14 days of the incident to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional learning from the events."*

The cold de-brief did not take place until 13 March 2012. One of the issues raised by the officer who found Mr C was in relation to being able to respond to this type of emergency situation quickly. It was noted that the officer *"did not unlock the prisoner initially because he had been the only member of staff on the landing and had feared a key compromise…* (The officer) *felt that there was a significant learning point in relation to keys and staffing. Because being the only member of staff on duty, he had to carry both the cell and grill keys. This meant that if he had opened the cell door he would have had to leave the prisoner unattended in order to open the grill for incoming staff. This would have left the prisoner unattended and a potential for a* (security) *compromise."*

At interview, the officer who found Mr C also said that he was offered the support of Care Call[40], but due to a bad experience of speaking to them in the past, he declined the offer. He said that it *"might have been beneficial to get a phone call from work, certainly within the next 24 hours"* to see if he was *"alright".* The officer

[39] The purpose of a hot de-brief meeting is to talk about the incident and ensure the welfare of the staff involved.
[40] Care Call is an independent organisation which can provide well being support to civil service staff.

said that he was not contacted by management until two weeks later when he received a letter inviting him for interview as he was on sick leave.

Royal Victoria Hospital

Mr C was taken to the Accident and Emergency Department of the Royal Victoria Hospital, Belfast where a CT scan was performed. He was then transferred to the Intensive Care Unit (ICU) and put into a medically induced coma. Officers were not permitted to guard Mr C whilst he was in the ICU, but nurses advised officers *"(Mr C) would remain sedated"* and updates about condition would be provided.

Family members visited Mr C and officers were provided with updates on Mr C's condition of *"no change."*

On 23 February 2012, Mr C's SPAR was suspended and staff were removed from their hospital guard duties after it was confirmed that Mr C had substantial brain damage.

Mr C's Release by the Parole Commissioners

On 21 August 2012, the Prison Service advised that the Parole Commissioners had directed that Mr C could be released from custody, because he did not pose as a risk to the public or of an unaided escape.

Mr C's Current Circumstances

Mr C has complex physical and cognitive disability as a result of the injury to his brain. Mr C can communicate through gestures at times but is unable to communicate his basic needs and cannot speak. When Mr C is not fighting infections in hospital, or undergoing operations, he is cared for in a nursing home.

SECTION 13: FINDINGS OF DR FAZEL'S CLINICAL REVIEW REPORT

Mr C's Paranoia

Dr Fazel noted that:

- From 16 February, Mr C made a number of comments to nursing staff which suggest that he was *"becoming increasingly paranoid".*

- On 18 February a nurse recorded that Mr C was concerned that *"other inmates will get into his cell and beat him for past crimes"* and, on 19 February, Mr C reported to another nurse that *"officers are going to either kill him or let the other prisoners kill him".*

- This evidence is corroborated in Mr C's phone calls with his family. On 18 February, Mr C said in a phone call that he *"was going to be murdered by staff or inmates".* On 19 February, a few hours before Mr C's suicide attempt, he said in a phone call that the prison officers were poisoning his tea.

Dr Fazel concluded that:

"These paranoid thoughts probably had some basis in reality, but they seemed to me to have become more intense than his situation would suggest. Specifically, the notion that he would be killed by prison staff is unrealistic, and these paranoid thoughts did not seem to moderate with repeated assurances from staff and family. Although I do not think that these are symptoms of an underlying severe mental illness (such as schizophrenia or a psychotic depression), they may be among the stress-related symptoms some individuals experience who are vulnerable because of underlying personality problems. A review by a psychiatrist would have been able to examine these symptoms in more detail, and consider alternative medications, such as a short-term antipsychotic that can help dampen down paranoid symptoms in some individuals, even if they do not have a severe mental illness. We do not know if such medication will have worked in (Mr C)*'s case, but as the paranoia was*

one of the triggers to (Mr C)*'s suicidal thoughts, a trial of medication could have been considered. In summary, the combination of the need for a more detailed mental state assessment and the possibility of a trial of a low dose antipsychotic underscores the importance of* (Mr C) *having a psychiatric review."*

It is to note that there was further evidence that Mr C was paranoid, a few days before to his return to Maghaberry when he was in Magilligan Prison. Just prior to Mr C's release from Magilligan Prison, he was known to be concerned about being in the reception area with other prisoners, who were not sex offenders. A similar concern resulted in him refusing to attend the Mater Hospital following the threats of suicide that he made to his community probation officer. Mr C said that this was because there were allegedly people in the hospital that he would not get on with.

Mental Health Support

It was Dr Fazel's opinion that someone like Mr C, who has a history of a previous psychiatric admission, a history of self harm, chronic alcohol problems and recent bereavements should be referred for further mental health assessment. Dr Fazel stated: *"I accept that some factors, on their own, such as alcohol abuse, are too unspecific to indicate a need for referral, but a referral is warranted, in my opinion, when a combination of factors is present."*

Dr Fazel also commented on the Initial Committal Health Screening Forms and suggested that the current form should be improved *"so that positive screening for a certain number of items should lead to consideration for referral could be examined"*, as was the case with the forms that were previously used. The new form, unlike the form used previously, does not signpost the circumstances in which a newly committed prisoner should be referred for a mental health assessment.

Mr C's Location Concerns

Mr C had moved to England as a teenager due to apparent victimisation following his conviction of a sexual offence. Commenting on this, Dr Fazel said:

"With this in mind, it is possible to see that (Mr C) *was particularly sensitive to being identified as a sex offender and that it was concerning that he believed that prison officers and / or other prisoners were telling others about this. As he felt that this was a risk in Bann House and expressed this concern in his adjudication on 14 February 2012, it is possible to see that this was a legitimate concern for him.....I think that his concerns about location moves should have been given a more considered response.....Furthermore, in view of* (Mr C)*'s recent difficulties with certain locations, then it was arguably in the interests of his mental health to move to Bush House or Magilligan, and this could have been considered as part of Case Reviews when any move was deemed possible (i.e. when his cellular confinement was completed)."*

In connection with this, Dr Fazel noted the content of the statement Mr C prepared for his adjudication which referred to *"threats"* he received in Bann House and his belief that he would be assaulted if he returned there. Noting that this information wasn't shared, Dr Fazel said that *"such comments would have been relevant to his future care in prison...consideration of how such information can be routinely shared is worthy of examination in my opinion."*

SPAR Case Reviews & Care Plans

It was clearly the case that Mr C's Case Reviews did not adequately consider the underlying causes of his self harming and, in particular, his fear of being bullied and attacked (which appeared to have some basis in fact) and his perception that staff were going to kill him, which was evidence of his developing paranoia. Dr Fazel concluded that the failure of Care Plans to *"not identify his concerns about his personal safety"* was *"an omission as he had expressed them on many occasions".*

Reasons why Mr C attempted to Die by Suicide

In considering the reasons why Mr C made an attempt to die by suicide on 19 February 2012, Dr Fazel said that Mr C had a number of background factors that increased his risk, which included a past psychiatric history and alcohol abuse, a past and recent history of deliberate self harm, and suicidal ideas and episodes of self harm in prison. In addition, he had a number of psychosocial stressors

including a bereavement of his girlfriend around two years ago, and his two young children being in care.

Dr Fazel noted that there may have also been some important triggers, including Mr C's paranoid thoughts that prison officers and/or other prisoners would attack him as he believed that other prisoners were being told that he was a sexual offender.

Dr Fazel suggested that Mr C's difficult phone calls with family members may also be relevant. He noted that Mr C *"appears to have perceived* (a family member) *not to be supportive in a phone call at 10.57 on the day of his attempt"* related to his belief that officers have put something into his tea and he can feel the effect that it is having on him. Dr Fazel said *"*(The family member) *tells* (Mr C) *that he is paranoid which* (Mr C) *disagrees with. He ends up appearing to be frustrated with* (the family member) *saying 'thanks for your support'…"*

Dr Fazel said: *"It would have been appropriate, in my view, for* (the family member) *to phone prison staff to let them know about these conversations as it would have alerted them to a short-term increase in suicide risk (and a possible need to enhance observations)."* As stated previously, a family member had phoned the Prison Service just days before to tell landing staff about Mr C's anxieties as expressed in a phone call. (Prisoner Ombudsman Note: subsequent to the Clinical Reviewer recording this comment, the family member concerned told the investigation that they had relayed the content of Mr Cs last phone call to staff.)

Considering the role of staff in preventing the incident, Dr Fazel said: *"a number of factors suggest that the suicide attempt was difficult to predict for the prison staff. On the day before the attempt, he* (Mr C) *was assessed as part of a SPAR Case Review not to be suicidal, and he was not expressing suicidal thoughts for the two days before his attempt. There appeared to be nothing particularly abnormal in his behaviour on the day of the incident. In relation to preventive measures, my view is that a mental health assessment should have been considered as part of* (Mr C)*'s most recent committal, which may have provided advice on medication, suicide risk, and location moves. It is not possible to determine whether in themselves any measures arising from such an assessment would have prevented* (Mr C)*'s serious*

attempt but it would have been good practice in my opinion. The other issue relevant to prevention relates to (Mr C)*'s various location moves, and an individually-tailored Care Plan in high risk prisoners that is mindful of their concerns would be helpful."*

APPENDICES

APPENDIX 1

INVESTIGATION METHODOLOGY

Notification

1. On 19 February 2012, the Prisoner Ombudsman's office was notified by the Prison Service about Mr C's serious attempt to die by suicide.

2. On 24 February 2012, the acting Director of Operations for the Northern Ireland Prison Service contacted the Prisoner Ombudsman and requested an investigation into the Near Death of Mr C be carried out by the Ombudsman's office.

3. On 29 February 2012, Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison, inviting anyone with information relevant to the incident to contact the investigation team.

Prison Records and Interviews

4. All prison records relating to Mr C's period of custody were obtained.

5. Interviews were carried out with prison management, staff and prisoners in order to obtain information about Mr C and the circumstances surrounding this serious incident.

Telephone Calls

6. Between 11 and 19 February 2012, the length of Mr C's most recent committal period, he made 16 telephone calls. All 16 telephone calls were obtained and listened to.

CCTV Footage

7. CCTV from each of the various landings that Mr C had been located during his most recent committal period was obtained and reviewed.

Maghaberry Prison

8. Background information on Maghaberry Prison is attached at Appendix 2.

Clinical Review

9. 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.

10. I am also grateful to Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, who was commissioned to provide his expert opinion of the actions taken by the staff who found Mr C and the medical care he received after he was found.

Criminal Justice Inspectorate/Other Reports

11. Previous recommendations made to the Northern Ireland Prison Service by the Prisoner Ombudsman and the Criminal Justice Inspectorate which are relevant to the circumstances surrounding Mr C's death have been considered as part of this investigation.

Factual Accuracy Check

19. I submitted my draft report to the Director of the Northern Ireland Prison Service and the Chief Executive of the SEHSCT for a factual accuracy check.

20. The Prison Service and SEHSCT responded with comments for my consideration. I have fully considered these comments and made amendments or included them where appropriate.

APPENDIX 2

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[41] and integrated[42] conditions.

Maghaberry Prison is one of three Prison establishments managed by the Northern Ireland Prison Service, the others being Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. Four Square Houses - Bann, Erne, Foyle and Lagan, and the new purpose built accommodation of Quoille house, which has a landing used for housing poor coping prisoners who attend the Donard Unit[43]. There is also the purpose built separated accommodation houses of Roe and Bush, make up the present residential house accommodation.

There are three lower risk houses within the Mourne Complex of Maghaberry Prison, called Braid, Wilson and Martin Houses. These are usually used to house lifer prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU).

There is also a Landing within Maghaberry Prison called Glen House which is used to accommodate vulnerable prisoners.

There is also a Care and Supervision Unit[44] (CSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.

[41] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.
[42] Integrated – general residential accommodation houses accommodating all prisoners.
[43] The Donard Unit has been specifically designed to facilitate purposeful activity for poor coping prisoners.
[44] Care and Supervision Unit (CSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and resettlement of which addressing offending behaviour is an element.

Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[45] (PREPS).

The last reported inspection of Maghaberry Prison by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[46] in Northern Ireland was conducted in March 2012 and published on 17 December 2012.

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

[46] Website link - http://inspectorates.homeoffice.gov.uk/hmiprisons/inspect_reports/547939/551446/maghaberry.pdf?view=Binary

APPENDIX 3

PRISON POLICIES AND PROCEDURES

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 21(1) and (2) (medical examination on reception), 41(2) (award cellular confinement), 47(5) (daily visit in cellular confinement), 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 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 32 Restriction of Association - Where it is necessary for the maintenance of good order or discipline, or in the Governor's own interests that the association permitted to a prisoner should be restricted, either generally or for particular purposes, the Governor may arrange for the restriction of his association

Prison Service and Maghaberry's Policies

Maghaberry Prison – Care and Supervision Unit (CSU) Management Guidance sets out the procedures and actions that must be followed in relation to the accommodation, care, discipline and control of prisoners while in the Unit and their subsequent relocation to normal accommodation. It also details when prisoners will be subjected to closed visits.

Self Harm and Suicide Prevention Policy (February 2011)
The Prison Service Self-Harm and Suicide Prevention policy updated and re-issued in February 2011 states that it:

"aims to identify prisoners at risk of suicide or self harm and provide the necessary support and care to minimise the harm an individual may cause to him or herself. The Service recognises that this is an important priority and one that demands a holistic approach. Prisoners become vulnerable for many reasons. Vulnerability is often presented as an inability to cope with personal situations and/or the prison environment and where, without some form of intervention the likelihood of self-harm or loss of life is imminent. The Service's definition of a vulnerable prisoner is;

An individual whose inability to cope with personal situations within the prison environment may lead them to self harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication."

Governor's Orders

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners. The following orders have been considered as part of this investigation:

Governor's Order 5-1 'Special Supervision Unit (SSU)' (28 June 2010) details the regime of the SSU.

Governor's Order 5-2 'Prisoner Misconduct and Adjudication' (28 June 2010) explains when the Governor can place a prisoner on Prison Rule 35 (4) for the purpose of adjudication.

Governor's Order 5-3 'Rule 32 Authorisation and Regime' (28 June 2010) details the authorisations procedures for placing a prisoner on Rule 32. It also details the regime that the prisoner will follow whilst in the Care and Supervision Unit (SSU).

Governor's Order 8-2 'Medical Attention for Prisoners After Lock-Up' details the actions to be taken of staff when a prisoner requires medical attention during lock-up periods in emergency and non-emergency situations.