The Prisoner Ombudsman for Northern Ireland

SUMMARY INVESTIGATION REPORT
INTO A SERIOUS ADVERSE INCIDENT AT MAGHABERRY PRISON – OCTOBER 2018

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The Head of the Northern Ireland Prison Service (the prison Service) was content for my Office to conduct an investigation into the circumstances surrounding a serious adverse incident which occurred in October 2018. This was in accordance with the Prison Service Suicide and Self-Harm Prevention Policy 2011.[1]

As Prisoner Ombudsman for Northern Ireland, I have discretion to respond to requests from the Prison Service to investigate serious adverse incidents. This is the basis on which this investigation was conducted.

The purpose of the Prisoner Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to the Prison Service and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

At the time when the investigation was initiated, the prisoner was receiving care at hospital having been found in an unresponsive state in their cell at Maghaberry Prison, after their first night in custody. At that stage, the extent of any long term injuries resulting from the incident were not known. The prisoner was later transferred back to Maghaberry Prison after receiving treatment.

Apart from identifying a break in the flow of information in relation to an incident, when they were unwell while in the care of the Prisoner Escorting and Court Custody Service (PECCS), there was nothing unusual about their committal to Maghaberry Prison. Consequently I have made one recommendation to the Prison Service to improve the flow of information from (PECCS) to the receiving prison in relation to incidents which occur at court, while prisoners are in the care of PECCS. This has been accepted.

During their committal, the prisoner received their initial healthcare assessment, and the committal nurse, given the comments they had made while in police custody,

[1] The Prison Service policy states: 'Generally, all cases involving serious self-harm and death in custody will be reviewed internally by NIPS or externally by the Prisoner Ombudsman, as appropriate. However, an investigation by an independent agency or agency may be required where 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 of 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 significant affected'.

decided to open the Supporting Prisoners at Risk (SPAR) process as a precautionary measure. The prisoner then went to the Committal House where they requested to share a cell with another prisoner they knew and this was accommodated. They were subsequently monitored at 30 minute intervals during the night by Prison Service staff and the prisoner gave them no cause for concern. Prison Service staff provided appropriate care during the committal process and the first night in custody. Prison officers monitored the prisoner frequently during the night and they identified no concerns until that early morning in October 2018.

The following morning while conducting a search of the shared cell, initiated by an observation made of their cell mate, the prisoner was found unresponsive. They immediately received medical attention and were transferred to hospital where they were treated for the effects of a drug overdose.

Having thoroughly examined the circumstances of this incident and having commissioned a Clinical Review of the prisoner's clinical care I did not find any action or lack of action by the Prison Service or Trust which directly contributed to this prisoner becoming critically ill.

Truthfully I consider this prisoner very fortunate to have survived. Had it not been for the actions of Prison Service and Trust staff on that early morning in October 2018, the prisoner may have died.

Furthermore, having evaluated the reliable facts surrounding the circumstances of this prisoner being found, I believe, on the balance of probabilities:-

- they came into prison concealing substances internally;
- they either swallowed some of these substances or they leaked inside;

This case highlights the significant challenge in addressing the impact of substance misuse both in terms of reducing the supply of substances but also in working with people to reduce the harm caused by drug misuse.

I reiterate a previous recommendation[2] in relation to scanning technology and would encourage the Prison Service to continue to explore new developments in search technology and equipment, to detect and deter drugs concealed in a person, from being smuggled into prisons.

In the course of my investigation I identified a number of wider learning points, in addition to the recommendation I have made, to enhance Prison Service operational

[2] Previous recommendation – "Reducing the supply of drugs: The Prison Service should continue to explore new developments in the use of search technology and equipment to better detect drugs concealed in prison"

methods, policy, practice or management arrangements which could help if similar circumstances arose in future.

I strongly believe that all those directly involved in serious incidents in prison *must* be involved in post incident meetings unless attendance would be detrimental to their well-being. I reiterate to the Prison Service previous recommendations regarding attendance at these meetings and the need for a formal mechanism to follow-up with any staff who did not attend the debrief.

I also highlight the importance to the Prison Service of timely communication with families.

Additionally, although it did not have a bearing on this case, I make an observation about a gap in the continuity of care when people pass from police custody suites into the care of PECCS or from prisons to PECCS. My concern is for those who might spend quite a lengthy time at court where there is no dedicated healthcare provision – both when health concerns are known and when they arise unexpectedly. I accept that the situation is similar in England and Wales but it raises questions about continuity of medications and their administration, as well as, responses to medical situations when they arise in court holding rooms.

I would also like to take this opportunity to commend all Prison Service and Trust staff on the response taken in relation to this serious adverse incident and am glad it resulted in a prisoner's life being saved.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland