The Prisoner Ombudsman for Northern Ireland

SUMMARY INVESTIGATION REPORT INTO A SERIOUS ADVERSE INCIDENT AT MAGHABERRY PRISON – FEBRUARY 2019

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The Head of the Northern Ireland Prison Service (the Prison Service) asked my office to conduct an investigation into the circumstances surrounding a serious adverse incident which occurred in February 2019. 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. The prisoner was later transferred back to Maghaberry after receiving treatment.

There was nothing unusual about the prisoner's committal to Maghaberry Prison. They arrived in the prison's reception after 19:30 and went through the full committal process including an initial health care assessment.

They then went to the Committal House where they were accommodated in a single cell. The prisoner was locked at approximately 21:00 and medication was administered shortly after 23:00. Between 21:00 and 06:00, prison staff checked on the prisoner twelve times. It was only on this last check that it was evident that the prisoner had become unwell. I am content that Prison Service and Trust staff provided appropriate care during the committal process and the first night in 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'.

During checks that an officer was making throughout the whole of the Committal House, around 06.00, they were alerted to a strange noise coming from the prisoner's cell. They lifted the flap to the prisoner's cell to check the prisoner and they observed the prisoner lying on the floor of the cell with laboured breathing. In trying to obtain a response from the prisoner the officer was concerned with the slight responses the prisoner was able to give. The officer immediately advised the officer responsible for the landing, who requested assistance from a Senior Officer and a nurse. A nurse examined the prisoner, helped by two officers and a Senior Officer, and the nurse believed the prisoner may have overdosed. Although the prisoner was slightly responsive throughout their examination and never lost consciousness, their condition was critical and resulted in a transfer to hospital for treatment.

Having thoroughly examined the circumstances of this incident 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. I did not identify any issue, requiring further investigation, with the clinical care provided by the Trust. Consequently, I did not commission an independent review of healthcare.

Truthfully, I consider this prisoner very fortunate to be alive with no long term health impairments due to the vigilance of staff responding to a strange noise that just didn't seem quite right. Had it not been for the actions of Prison Service and Trust Staff on that early morning in February 2019, the prisoner may have died.

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

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

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

Although I do not make any new recommendation on this case, I reiterate a previous recommendation in relation to scanning technology[2] 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.

[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"

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

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland