INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR U
WHILE IN THE CARE OF MAGHABERRY PRISON

Date finalised: **13th January 2022** Date published: **9th February 2022**

The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation of deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

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 Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

By highlighting learning to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

Investigation objectives are set out in the Ombudsman's Terms of Reference and are to:

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

Within the above objectives, the Ombudsman will identify specific matters to be investigated in line with the circumstances of an individual case.

In order that learning from investigations is spread as widely as possible, and in the interests of transparency, investigation reports are published on the Prisoner Ombudsman's website following consultation with the next of kin. Reports are also disseminated to those who provide services in prisons.

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Glossary

BSO	Business Service Organisation
CCTV	Close Circuit Television
CJINI	The Criminal Justice Inspection Northern Ireland
CPO	Custody Prison Officer
CPR	Cardiopulmonary Resuscitation
CT	Computerised Tomography
ECR	Emergency Control Room
EMIS	Egton Medical Information System
FMO	Forensic Medical Officer
GP	General Practitioner
ICU	Intensive Square Unit
IMB	Independent Monitoring Board
NCO	Night Custody Officer
NFA	No Fixed Abode
NICE	National Institute for Health and Care Excellence
PACE	Police and Criminal Evidence (Order) NI
PCO	Prisoner Custody Officer
PDU	Prisoner Development Unit
PECCS	Prisoner Escorting and Court Custody Service
POST	Progressive Short Term Sentenced Team
PRISON SERVICE	Northern Ireland Prison Service
PSNI	Police Service of Northern Ireland
PSST	Prisoner Safety and Support
PRISM	Prisoner Record and Inmate System Management
SPAR	Supporting Prisoners at Risk (Procedure)
SPAR EVO	Supporting Prisoner at Risk (Procedure) Evolution
TRUST	South Eastern Health and Social Care Trust

Foreword from the Ombudsman

The death of a loved one is always difficult. The fact that a death occurs while someone is in prison custody has particular difficulties given the loss families experience when a loved one is taken into custody and the trust they must place in the Prison Service, the Trust, and others, to ensure the safety and wellbeing of their loved one.

All those in custody should expect to be treated decently and with respect, receiving the best care possible for their wellbeing and rehabilitation.

This report will address and inform several interested parties, all of whom will learn from the findings. Where appropriate, recommendations will be made directly to the Prison Service and the Trust. Both organisations will then provide my office with a response indicating if they accept my recommendations and what steps they are going to take, or have taken, to address them.

While these interested parties are important to ensure change to care in custody, this report is written with Mr U's family primarily in mind. It is critical that, as far as I can, I provide explanations and insight to bereaved relatives. I am grateful to them for their contribution to this investigation and I appreciate their patience. I offer my sincere condolences to them on their sad loss and hope this report provides information to address some of the questions they raised and explains events leading up to Mr U's death. The learning, expressed in recommendations, will, I hope, bring some comfort to those who are grieving and bring confidence to those who have family members in custody.

Mr U's custody history

Mr U was committed to Maghaberry Prison in June 2018 on remand. He was found hanging in his cell four days after he was committed. Prison Service and Trust staff successfully resuscitated him at the scene and he was transferred to hospital but he sadly died six days later.

The post mortem report examination found that the cause of death was pneumonia due to cerebral hypoxia due to hanging. An inquest is pending.

Mr U had been in custody 45 times over a 16 year period, mostly for relatively short periods. The longest time he spent out of prison was just over a year and a half. He had been in prison five times in the year before his death and had just been released from Magilligan Prison approximately one month before he returned to Maghaberry Prison.

Following his committal Mr U underwent the normal reception and committal procedures including an initial assessment of his health care needs. A number of issues arose due to Mr U's behaviour, but Dr Grounds, one of the independent

clinical reviewers, was satisfied that Mr U was managed in accordance with procedures and the actions taken in response to his behaviour were reasonable.

On the morning that Mr U was found there had been significant interaction between him and Prison Service staff particularly in the period from 04:30 to 06:00. During this time he was carefully monitored. It appears that all Prison Service staff involved in caring for Mr U that morning did so in his best interests. However, they were unable to provide a clinical assessment of his behaviour and demeanour during this period, as they were not clinically qualified, nor is it a requirement of their role to do so. Only clinically qualified staff would be suitable to do this and a Trust nurse was not asked to see him at that time.

The responses to Mr U's behaviour by Prison Service staff in the hours before he was found were examined in detail. It is not possible to say with certainty that any different course of action could have altered the sad outcome in this case.

Dr Grounds, who examined the records gave his opinion that Mr U probably needed an immediate out-of-hours mental health assessment and potentially medication to make him feel more settled.

There are therefore several learning points which I highlight in the report that may have a bearing on the management of other prisoners in similar circumstances. One relates to the processes in place to ensure that any mental health needs are effectively addressed outside normal working hours. Another is that arrangements are in place at night to facilitate prisoners in crisis to speak to an appropriate person where this may offer a significant protection to them. A third recommendation is made to improve the sharing of clinical information between the healthcare teams in the prison and the receiving hospital in the case of transferred prisoners.

I note that the Prison Service moved quickly to address a number of operational matters identified early in this investigation. This related to making an additional Night Custody Officer (NCO) belt available to facilitate quicker access to keys at night and addressing access to the committal phone over a weekend period.

Wider learning

Mr U's case and others, raise questions about how we might better address the needs of those who are neither in prison or the community long enough to help those caring for them better assess their needs and develop long term care plans with them. This was a question that Mr U's family raised following his death. A striking feature of Mr U's case was how little could be gleaned from the available records to assist those involved in his care. With the benefit of hindsight it could be argued that Mr U's frequent admissions into custody should have informed and alerted those caring for him of the need to delve further into the underlying causes of this.

I discussed Mr U's case with the Prison Service and the Trust and while there are many individuals who like Mr U frequently find themselves within the prison system, there was a strong interest and willingness to reflect on the issues of this report and those raised by Dr Grounds. I appreciate that this work is complex and will require collaboration with others across the justice and health systems. For this reason I had an early meeting, May 2019, with the Director, Reducing Reoffending, Department of Justice and with the Director of Prison Healthcare from the Trust. I then set out my concerns in a letter of August 2020, asking for my concerns to be considered by the joint Departmental Health and Justice Improving Health within Criminal Justice Implementation Group. It is important to note that not all of these issues are the sole responsibility of the Prison Service or the Trust to action. It would require collaboration with a wide range of agencies and organisations involved in providing care and support to people engaging with the criminal justice system and community services.

I would like to see some innovative thinking and proposals developed and tested on how we might engage with people such as Mr U differently to improve their lives, keep them safe and reduce the risk of them reoffending. This is not a matter of failure or apportioning blame in the cases that have raised similar concerns. It is, rather, a matter of doing better for the sake of those in custody with particular sets of needs. A particular aspect of this is connecting custody and community services for those with multiple problems who spend relatively short periods in prison and the community. I look forward to the outcome of this work.

Regulation and Quality Improvement Authority (RQIA)

In October 2021 RQIA published a report of a review it had completed into the service for vulnerable persons detained in prisons.[1] RQIA have brought forward a number of recommendations which should assist in improving the system for individuals like Mr U, in particular recommendations in relation to what information is available to inform how an individual's needs are responded to. One recommendation addresses how an individual's needs are assessed and where information about that individual can be gathered from.[2] This is important as is illustrated by the lack of information available about Mr U. The review recognises that it will take some time to develop a new approach to needs assessment. What is not clear to me is how information about custody history will inform that assessment. In Mr U's case, as referenced above, he was in custody 45 times within 16 years, the

[1] https://www.rqia.org.uk/reviews/review-reports/2021-2022

[2] **Recommendation 2 (Priority 2)**: Commissioners (currently the HSCB) and its provider (SEHSCT) should work together and with the Prison Service to define and agree the metrics needed to inform an ongoing assessment of need. A robust system for regular data collection and analysis, utilising all relevant sources of information, should be developed and implemented as an interim measure ahead of the introduction of Encompass. In the absence of a reliable electronic system, consideration should be given to harvesting data manually. (p19)

longest period of release he experienced during that time was just over 18 months and in the last year of his life he was in and out of custody 5 times. Yet there was little information available to the Prison Service to assist them in supporting him. In my view, his custody history itself would be sufficient to merit a red-flag, leading to questions being asked about his situation and care. I would encourage those working on the new needs assessment approach to take this into consideration. The significance of the needs assessment cannot be overstated and is recognised in RQIA's review as, for example, leading to an integrated model of care for mental health provision.[3] I welcome RQIA's review and its recommendations and look forward to contributing to the implementation of those recommendations where I can.

Finally, I want to express my gratitude to the Prison Service, the Trust and the clinical reviewers for their contributions to this investigation. Others have helped in the information gathering process and to them I also extend my gratitude.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland

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[3] **Recommendation 6 (Priority 2):** Commissioners (currently the HSCB) and providers (SEHSCT) should work together to develop a service specification for an integrated model of care for mental health provision within the prison service; this should be informed by a robust needs assessment taking into account the needs of vulnerable people in custody. Underpinned by the right to health, there should be equitable seven-day provision across all prison sites. (p26)

Section 1: Background information – Maghaberry Prison

1.1 Maghaberry Prison

Maghaberry Prison is a high security prison, which holds male adult sentenced and remand prisoners. The population in the prison at the time of the incident involving Mr U was 865.

This prison has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners.

Since 2008, the Trust have provided prison healthcare services. There is a 24 hour primary healthcare service and there are no in-patient beds. At the time of Mr U's death the Mental Health Team was on site Monday to Friday between 08:00 and 17:00. However, from 30th October 2020, this service is now available seven days a week between the hours of 08:00 and 17:00. Additionally, all mental health committal triage has been carried out face to face from October 2020.

At the time of Mr U's death, the Prison Service was operating its Supporting Prisoners at Risk (SPAR) procedure. However, a new enhanced SPAR Evolution (SPAR EVO) procedure was later introduced on 11th February 2019 and was fully rolled out across Maghaberry Prison by August 2020. The updated procedures aimed to take account of shortcomings identified by the Criminal Justice Inspection Northern Ireland and the Prisoner Ombudsman. SPAR EVO introduced a person centred approach, giving staff much more flexibility in creating a more bespoke plan to suit individual needs.

1.2 Criminal Justice Inspection

The most recent inspection of Maghaberry Prison was in April 2018 and the report was published in November 2018. Inspectors reported that the prison had settled considerably since the last full inspection in May 2015 and was now a much safer prison.

The overall picture of safety had progressed hugely and levels of violence and disorder had reduced. However, Inspectors remained concerned that work to support the most vulnerable men at Maghaberry Prison had not developed to the same level as other aspects of safety.

The Criminal Justice Inspection Northern Ireland (CJINI) Safety of Prisoners Report, published November 2019, highlighted that one of the most difficult issues facing the Prison Service was the identification of those really vulnerable people in the population and that the Prison Service needed to work to create a therapeutic

environment to help stabilise individuals at risk and manage their imprisonment more safely.

1.3 Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB whose role is to satisfy themselves regarding the treatment of prisoners.

The 2018-19 IMB annual report described continued improvement in the prison and attributed this to the introduction of a core day and a sustained focus on reducing the amount of drugs coming into the prison.

The IMB commented that the prison was now a safer and more stable environment. The board also reported significant changes in the field of safer custody including the introduction of updated operating procedures for supporting prisoners at risk of suicide or self-harm.

1.4 Prisoner Escorting and Court Custody Service (PECCS)

PECCS is the prisoner transport and escorting service. PECCS is responsible for the safe operation of the cell holding areas in each courthouse in Northern Ireland and were responsible for Mr U's care at court and transferring him safely to Maghaberry Prison.

1.5 Regional and Quality Improvement Authority (RQIA)

RQIA is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. Following events in 2016 when my Office carried out an investigation into a serious adverse incident and a number of suicides in prison, a review was commissioned by the Departments of Health and Justice to consider provision for particularly vulnerable persons in prison. The purpose of RQIA reviews is to identify best practice, highlight gaps or shortfalls in services where improvement is required and to protect the public interest. A long awaited report of the Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons was published on 05 October 2021. All recommendations are to be delivered within 18 months of publication of the report.

1.6 Previous incidents at Maghaberry Prison

Mr U's death was one of three self-inflicted deaths at Maghaberry Prison during 2018. Although the three men who died were located in different residential units and the circumstances of their deaths do not appear to be related, a number of shared learning points have emerged from my investigations of these deaths, which I will comment on in Section 4.

Section 2: Framework for this investigation

Mr U died at hospital as a consequence of injuries he sustained when he was found hanging in his cell at Maghaberry Prison. As his death resulted from events which occurred while he was in custody, I am required to investigate and report on the circumstances surrounding his death.

This investigation was conducted in line with the objectives set out on page 2, which include providing explanations, where possible, to Mr U's family.

2.1 Questions raised by Mr U's family

Mr U's family raised a number of questions relevant to my investigation when they met with my predecessor. These are summarised below:

- What was the precise timeline of events leading to Mr U's death?
- How was Mr U's withdrawal from alcohol and drugs managed after he arrived in prison?
- What interaction did staff have with Mr U on the night and hours before he was found?
- Was there a process for escalating concerns about Mr U's behaviour and/or an emergency response for people in crisis?
- Why a telephone call was not facilitated shortly before Mr U was found?
- Why Mr U was located in a single cell which was not close to the staff office?
- How long Mr U was hanging before he was found?
- If Mr U had been prescribed medication and if he received support from mental health services?
- If it was possible that Mr U had pneumonia prior to arriving in prison as he had told a prison chaplain that he was not feeling well?
- What rehabilitation services Mr U was offered in prison?
- Why Mr U's next of kin was not informed of what happened until several hours after the incident?
- If there was any validity of reports given to the family by prisoners that Mr U made calls for help which went unanswered?
- They were concerned that the system did not appear to pick up on people who were repeatedly in and out of prison and were keen that learning from Mr U's case might help others who find themselves in similar circumstances.

2.2 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. The following information was gathered and analysed by the Investigating Officer:

- Prison Service records including Closed Circuit Television (CCTV) footage;
- Interviews with relevant staff from the Prison Service and the Trust; and
- Medical records.

All of this information was carefully examined and I have detailed the relevant matters, which underpin my findings, in this report.

2.3 Independent advice

When appropriate, I commission an independent clinical review of specific aspects of healthcare. A clinical reviewer is commissioned from an agreed list, usually to provide peer review of healthcare provision, and they provide a report with recommendations. My office provides relevant documentation and reviewers receive a terms of reference specific to each case. They provide an independent, expert opinion about care provided. A clinical reviewer may, for example, assess delivery of care in relation to current clinically approved guidelines, local and national. They will keep in mind whether or not care has equivalency with that provided in the community and any learning to improve care in the future.

I commissioned two independent clinical reviews of the healthcare provided to Mr U. The first was conducted by Dr Adrian Thomas Grounds, an Honorary Research Fellow at the Institute of Criminology, University of Cambridge. The second reviewer, Dr Jane Rees, reviewed the resuscitation of Mr U. Dr Rees is a registered medical practitioner who has over forty years' experience in primary care including working in prisons since 2004.

The clinical reviewers each provided me with a report setting out their opinion on the matters they were asked to consider. I have included their opinion on relevant matters in my investigation report, particularly Dr Grounds which considered wider learning arising from Mr U's death.

2.4 Scope and remit of the investigation

The specific objectives of this investigation were to:

Arrival and initial assessments

i. assess the provision of primary and secondary healthcare services provided to Mr U, the management of medication and whether those services were at least equivalent to those he might have received in the community;

ii. consider the adequacy of the initial committal healthcare assessment and management of Mr U's alcohol withdrawal and the decision not to prescribe Librium or other medication;
iii. consider the impact, if any, of Mr U being committed at the weekend in terms of his healthcare assessment and treatment;
iv. establish the reason Mr U did not receive a committal phone call;

Events prior to the evening of the incident

v. determine the reason Mr U was in a cell on his own which was not close to the staff office;
vi. assess the possibility that Mr U already had pneumonia when he came into prison;

Events leading up to Mr U being found

vii. establish the precise circumstances leading up to Mr U's death;
viii. consider the adequacy of action taken by staff in their interactions with Mr U during the night before, through to the morning of the incident;
ix. determine if staff should have managed Mr U under Supporting Prisoners at Risk (SPAR) procedures when they interacted with him during the early hours, before he was found;
x. Consider what opportunities Mr U had to engage in rehabilitative services and with Mental Health;

Response to the incident

xi. establish the time between Mr U last being checked and him being found;
xii. consider if Prison Service staff were properly equipped to respond to this incident;
xiii. assess if the attempt to resuscitate Mr U was conducted in line with national guidelines;
xiv. determine if there were any other issues which impacted on the resuscitation effort, for example space to provide first aid, access by emergency services or with the procedures for taking Mr U from his cell to the ambulance;
xv. establish whether there is any validity of reports given to the family by prisoners on the landing;

Post Incident

xvi. consider the impact on staff, prisoners and others arising from this incident and whether appropriate actions are in hand to follow up with those staff who were unable to attend the hot and cold debriefs.

A description of the key events leading up to Mr U's death is set out in Section 3 and my findings are set out Section 4.

Section 3: Description of key events

Over a 16 year period Mr U had been in prison 45 times mostly for relatively short periods although at one point he served an 11 month sentence. The longest time he spent out of prison in the 16 year period was just over a year and a half. In the year before his death Mr U had been in prison five times and had just been released from Magilligan Prison approximately one month before he was returned to Maghaberry Prison on new charges.

3.1 Arrival at Maghaberry Prison and initial assessments

Mr U was arrested in June 2018 and spent two days in police custody before appearing in court from where he was remanded to Maghaberry Prison. He saw a Forensic Medical Officer (FMO) whilst at the police station and records of this consultation, and those relating to his general detention, were provided to the staff who were responsible for his care at court and prison reception.

When he arrived at Maghaberry Prison, Mr U went through the normal committal process which involved an interview with a Prison Service Reception Officer (Custody Prison Officer (CPO) A) and a series of activities including the recording of his details on the Prisoner Record and Inmate System Management (PRISM)[4], a search and a log taken of his property. Mr U told the Prison Service Reception Officer (CPO A):

- he had no history of self-harm or suicide;
- nothing had happened in his life recently to increase thoughts of self-harm and suicide;
- he was not involved with mental health services and did not need any immediate support; and
- that he was withdrawing from the use of alcohol and drugs.

The Prison Service reception officer (CPO A) reviewed the information provided by PSNI and recorded details of the committal interview and personal search on PRISM.

The committal process also involved an initial and comprehensive healthcare assessment.[5] Mr U saw a Trust nurse (Nurse A) who carried out the initial healthcare

[4] The prison information system is a computerised electronic recording system known as Prisoner Record and Inmate System Management (PRISM).

[5] These assessments are conducted in line with NICE Guideline 57 Physical health of people in prison. The initial healthcare assessment is conducted in the prison reception within four hours of committal. The purpose of this screen is to gather information to keep a prisoner safe during the early stages of their time in custody. The assessment focusses particularly on medication, alcohol and drugs misuse, immediate mental health issues (including risk of suicide and self-harm) and any conditions that fall under the critical medications list. This is followed by a comprehensive health screen within 72 hours of committal. This is usually conducted the day after committal.

assessment in reception shortly after Mr U arrived at Maghaberry Prison. The Trust nurse (Nurse A) checked the Electronic Care Record for details of current medications and appointments. This check confirmed that Mr U was not taking any medication prior to coming into prison. As a result no medication was requested. The Trust nurse (Nurse A) took a history from Mr U and did a number of clinical observations including an alcohol withdrawal assessment. The score from this assessment was four indicating mild withdrawal symptoms which did not require treatment with medication. The Trust nurse (Nurse A) asked if Mr U had thoughts of self-harm and he said he did not. The Trust Nurse (Nurse A) did, however, note the information in the PSNI records that Mr U may have previously attempted to hang himself but Mr U disputed this with her.

Based on their respective assessments, the Prison Service Reception Officer (CPO A), the Trust nurse (Nurse A) and others Mr U had interacted with in the prison reception, considered that he did not need to be managed under the prison's SPAR arrangements and was suitable to share a cell.

He left the prison reception and went to Bann House, the residential house where new committals are generally accommodated for a period of induction and assessment before they are dispersed to other residential units.

Mr U was placed in Cell 13 on Bann 2 landing with another prisoner (Prisoner A) approximately 90 minutes after arriving in the prison reception.

3.2 The day following Mr U's arrival at Maghaberry Prison

The following day after Mr U arrived at Maghaberry Prison, the same Trust nurse (Nurse A) saw him to complete the second part of the healthcare assessment. The alcohol withdrawal assessment was repeated and Mr U's score increased to nine. This score was just below the threshold for treatment with medication. During this assessment Mr U demanded Librium, a medication used to treat withdrawal symptoms from alcohol and/or drugs. When the Trust nurse (Nurse A) explained that a prescription for this medication was not going to be requested because of the assessment score, Mr U 'stormed' out of the room. This meant that the Trust nurse (Nurse A) was unable to complete the assessment. Instead, notes of the consultation were recorded with a further plan to review Mr U again the following day.

3.3 The second day after Mr U's arrival at Maghaberry Prison

On the second day after arriving in Maghaberry Prison, a Trust mental health nurse (Nurse B) conducted a mental health screen[6]. Based on available information this

[6] The mental health screen is conducted the next working day after someone is committed. As the mental health team, at this time worked Monday-Friday, this was the first opportunity to screen Mr U as he came into prison during the weekend. This screen, at this time, entailed a review of the ECR and

nurse concluded that Mr U did not need to be referred to the mental health team for support at that time but that this could be revisited if any further information became available.

Also, a Trust nurse (Nurse C) planned to complete the comprehensive healthcare assessment which Mr U had stormed out of the day before. Prison Service staff told the Trust nurse (Nurse C) that Mr U had been volatile and aggressive that morning. The Trust nurse (Nurse C) was in the Treatment Room on Landing 2 at the time and recorded that Mr U could be heard banging and shouting from there. The assessment did not proceed as planned and was, therefore, incomplete.

Mr U's volatile behaviour appeared to stem from issues he was having with his cell mate (Prisoner A). To resolve this Mr U was moved from Landing 2 in Bann House to a single cell (Cell 18) on Landing 3 later in the morning.

CCTV footage of the remainder of the day showed Mr U having routine interactions with Prison Service officers and a number of prisoners. He activated his cell alarm several times and Prison Service officers responded. They did not recollect specifically what Mr U requested but said it was most likely routine.

The landing was locked at 19:30 and the day staff were replaced by night staff (Night Custody Officers (NCOs)). No issues about Mr U were noted in the staff handover from day to night staff. An additional NCO was also on duty in Bann House because 14 other prisoners were being managed under the SPAR arrangements.

3.4 Events leading up to Mr U being found

Prior to midnight, apart from the routine NCO checks, there was only one additional occasion when a NCO (NCO A) went to Mr U's cell. This NCO recollected this was because a prisoner in an adjacent cell mentioned that Mr U had promised them a roll-up earlier in the day. The NCO (NCO A) checked with Mr U but he did not want to provide a roll-up to the other prisoner.

After midnight Mr U had a number of interactions with NCOs which are summarised below:

Time[7]	Interaction with Mr U
01.01	Mr U told the NCO (NCO A) during a supervised check that he had a shank in his cell. The officer later recalled that Mr U was acting 'strangely' but not unusually. This was reported to the NCO's Senior Officer (SO) (SO A) who was supervising the check.

information obtained during the initial and comprehensive healthcare assessment. It was not a face to face consultation.

[7] Unless otherwise indicated these timings relate to those taken from the CCTV footage.

Time[7]	Interaction with Mr U
01:07	The Senior Officer (SO A) informed the prison's Emergency Control Room (ECR) that Mr U had advised that no-one was to come into his cell because he had a shank. This was done so that this information would be relayed to the Security Department the following morning and a cell search carried out prior to Mr U being unlocked.
02:31	The NCO (NCO A) lifted the flap on Mr U's cell door and observed him for approximately 10 seconds.
04:29	A different NCO (NCO B) checked on Mr U during an unsupervised check of all prisoners on the landing. This NCO remained at the cell for approximately 26 seconds.
04:53	Mr U activated his cell bell alarm. Two NCOs (NCO B and NCO C) initially responded. NCO (NCO B) remained at the cell door and appeared to be talking to Mr U for approximately four and a half minutes.
05:08	Mr U again activated his cell alarm. The same NCO who responded to the earlier alarm (NCO B) went to the cell and spent just over six minutes speaking to Mr U.
05:18	This NCO (NCO B) returned to the cell again and spoke to Mr U for almost five minutes. The NCO then reported Mr U's behaviour to their Senior Officer (SO A).
05:23	The NCO's Senior Officer (SO A) spoke to Mr U whilst accompanied by the NCO's on duty on the landings at that time (NCO A, B and C). They partially unlocked the door about a minute later to allow Mr U to safely pass out his cup so that they could get him a cup of tea. The door was only partially unlocked given the earlier notification made by Mr U that he had a shank in his cell.
05:29	Mr U was given a cup of tea and then his cell was relocked. The Senior Officer (SO A) continued to speak to Mr U at the cell door. Several NCOs (NCO A and NCO B) remained on the landing outside Mr U's cell. The Senior Officer (SO A) closed the flap on the cell door at 05:30 but remained outside the cell.
05.31	The Senior Officer (SO A) checked on Mr U by lifting the flap on the cell door for approximately 8 seconds before then closing it and walking away.

Time[7]	Interaction with Mr U
05.33	The Senior Officer (SO A) again checked on Mr U and appeared to talk to him briefly for approximately 30 seconds through the flap in the cell door. He walked away but left the flap on the cell door open.
05:38	The Senior Officer (SO A) conducted a further check at the cell door by looking into the cell for approximately 32 seconds. The Senior Officer (SO A) made a journal record (05:40) that Mr U had requested a sleeping tablet but was advised that he could not get medication unless it had been prescribed by a doctor. It was also recorded that Mr U had been given a cup of tea and that the Senior Officer (SO A) had asked the landing staff to check Mr U regularly.
05:47	A Reception Officer[8] (CPO A) checked Mr U and recalled that Mr U was sitting on top of his bed looking relaxed and drinking tea.
06:01	Mr U activated his cell alarm and the NCO (NCO A) responded at 06:02. The NCO (NCO A) spent approximately 45 seconds at the cell before walking away. NCO (NCO A) recalled that Mr U had requested to make a telephone call. It was explained to Mr U that his request could not be facilitated at that time but that he should ask day staff to organise this. This was the last interaction with Mr U.

3.5 Response to Mr U being found

At 06:16:21, a NCO (NCO A) looked into Mr U's cell and saw that Mr U was hanging from the end of the bed. This was 13 minutes and 4 seconds after the same NCO (NCO A) had last left Mr U's cell door. This NCO (NCO A) was the additional officer on duty in Bann House that night and did not have a NCO belt[9] and therefore had no access to emergency keys to open the cell door. The NCO (NCO A) alerted a colleague (NCO C), who was nearby, and together they accessed keys, sent an urgent message to the ECR and entered the cell at 06:17:26. They were joined by a third NCO (NCO D). The three NCO's (NCO A, NCO C and NCO D) therefore entered the cell just over a minute after Mr U was first observed hanging.

As an urgent message had been sent, healthcare staff were requested to go to the landing. The NCO's who first entered the cell were assisted by a Senior Officer (SO B)

[8] A reception officer was on the landing to escort a prisoner who was being transferred to England that day.
[9] NCO's carry emergency keys on a belt, along with a Hoffman knife and radio. The keys are secured by a seal which officers must break to access the keys should they need to enter a cell. NCO's are not permitted to unlock cells except in the event of an emergency.

and two members of PECCS staff (Prisoner Custody Officer (PCO) A and PCO B) who were on the landing to facilitate the early transfer of a prisoner to England.

There were six officers in total on hand to assist with resuscitation. Officers attempted to cut the ligature as soon as they entered the cell. They supported Mr U's weight while doing this. They had some difficulty cutting the ligature because of how tightly it was twisted.

Within minutes two Trust nurses (Nurse D and Nurse E) arrived at the cell and coordinated the resuscitation efforts. An emergency ambulance had been requested as soon as the first Trust nurse (Nurse D) arrived on the landing (06:19). The Prison Service officers rotated chest compressions and although a defibrillator was applied it did not advise a shock at any stage. Shortly before paramedics arrived on the landing a Trust nurse (Nurse E) reported at 6:34:22 that Mr U was trying to breathe and had a cardiac output. Chest compressions were no longer necessary at that point.

Four paramedics worked with Mr U before he was moved to the ambulance and transferred to hospital. The ambulance left the prison at 07:07 and arrived at hospital at 07:24.

3.6 Post incident Response

At 11:45, the Deputy Governor (Governor A) informed Mr U's next of kin what had happened and that her son was receiving treatment at hospital. Arrangements were made for the family to spend as much time as possible with Mr U while he was at hospital.

Mr U's condition worsened after he arrived at hospital and he died six days later. A post mortem was conducted and the cause of death was recorded as Pneumonia due to Cerebral Hypoxia due to hanging. Samples were not retained for toxicology testing due to the length of time Mr U was treated in hospital. An inquest is pending.

A hot debrief[10] meeting was conducted at 07:30 shortly after Mr U had been taken to hospital. It was chaired by the Governor of Maghaberry Prison (Governor B). The meeting was attended by the majority of staff who were directly involved in resuscitating Mr U, including Trust nurses. The PECCS staff were unable to attend as they had escorted Mr U to hospital. The initial timeline of events was established and staff were signposted to support services.

[10] Standard 25 of the Prison Service's Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody. The hot debrief should take place as soon after the incident as possible and involve all staff who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

The cold debrief[11] meeting took place two weeks after the incident and was again chaired by the same Governor (Governor B). It was attended by most of the NCO's on duty on the night of the incident and the Trust nursing staff. There was also representation from the Prisoner Safety and Support Team (PSST). The PECCS officers and Prison Service Reception staff involved in responding to the incident did not attend.

[11] The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning.

Section 4: Findings

The findings in this section have been structured to address the questions which arose following Mr U's committal to custody, events prior to Mr U being found, the response to the incident and the post incident response.

4.1 Committal and initial assessments

The PECCS staff who escorted Mr U from court to Maghaberry Prison gave the prison reception staff the following documentation:

- NIPS New Committal Form, produced by PECCS;
- PSNI PACE 15 Detained Person's Medical Form;
- PSNI PACE 15/2 Detained Person's Medication Form;
- PSNI PACE 16 PER (Prisoner Escort Record) Form (which included vulnerability information and custodial information).

Maghaberry Prison Notice to Staff 156/16 (Committal Documentation) advises staff to ensure accurate records are maintained on PRISM, and where Police and Criminal Evidence Order NI (PACE) 15 and 16 forms are received, they must be accurately documented and their content transcribed onto the relevant committal screen. The Notice goes on to state that Prison Service reception staff and Trust committal nurses must ensure that the information contained on PACE forms is given adequate weight and actioned accordingly.

In this instance the Reception Officer (CPO A) noted that the PACE documents had been received and I am satisfied that the information was accurately recorded on PRISM and that relevant matters were discussed with Mr U including if he had any thoughts of suicide or self-harm.

Committal telephone call

As part of the committal process, individuals are offered the opportunity to make a telephone call either from the prisoner Reception area or shortly after they arrive in Bann House. This is primarily so that the individual can let a family member or friend know where they are. This is known as a committal telephone call. Prison Service staff record if someone has made a committal telephone call on a committal checklist. If the call is not made in Reception the check box is left unticked so that staff in Bann House, or whatever location the prisoner moves to following committal, can follow this up. In Mr U's case Prison Service records indicated that a call was not made in Reception or Bann House. Prison Service Officers said that some prisoners refuse the offer to make a committal call when they first arrive in prison.

The PSNI records indicated that Mr U did not want to alert family members that he was in prison so this may still have been a factor after he arrived in prison.

Even if Mr U had wanted to make a call on the day he arrived in Maghaberry Prison, this would not have been possible after he left the Reception area because the committal telephone in Bann House had been locked.[12] The telephone remained locked until the arrival of administrative staff the next working day as these staff were the only ones at that time who could reset the computer system to unlock the telephone.

Mr U's cell mate (Prisoner A) would have been in the same position as him and when the telephone was unlocked he was offered and availed of his committal telephone call. By that time Mr U had moved off the induction landing (Landing 2) to Landing 3 and it appears the opportunity to follow up with him and offer a telephone call was missed.

The Prison Service clearly recognises the importance of making a telephone call available to individuals when they are first committed to prison but the system which was in place at the time of Mr U's death, whereby the system could only be unlocked during the normal working week, was flawed and potentially resulted in people who wanted to make calls not being able to. This was raised with the Prison Service in the course of this investigation and a new process, which enables Prison Service staff to reset the system at weekends, is now in place.

I am pleased that the Prison Service moved quickly to change this process as it was not fit for purpose and potentially impacted detrimentally not only on those in custody but also their families. As the new process is already operational I do not make a recommendation on this matter.

The reason the issue of the committal call is of some significance is that Mr U asked to make a telephone call shortly before he was found hanging in his cell. This is discussed in further detail on page 29.

Initial healthcare assessments

Dr Grounds considered the initial healthcare assessments and concluded:

- The initial healthcare assessment carried out appeared to have been adequate when compared with previous assessments;
- The information from PSNI and the FMO was noted and Electronic Care Record accessed;
- There was nothing which suggested that the plan to reschedule the reviews because of Mr U's behaviour was insufficient;

[12] At the time of Mr U's committal the committal telephone was locked rendering it unavailable. This can happen if it is used beyond its permitted limits or an incorrect PIN is entered. Administrative staff who work Mondays to Fridays were then the only people who could unlock the system.

- The decisions not to prescribe medication to Mr U were appropriate and were in line with the level of symptoms measures in the structured Alcohol Withdrawal scale[13];
- There was no clear indication that Mr U needed any other form of medication;
- Mr U did not appear to suffer any disadvantage in terms of the level of nursing assessments received over the weekend of his committal;
- Mr U waited two days for his Mental Health Screening, because, as previously alluded to, the Mental Health team only worked weekdays at that time.

Mr U's family asked how his withdrawal from alcohol and drugs was managed, if he had been prescribed medication and if he had received support from mental health services in the prison. The examination of the records and review of those records by Dr Grounds confirmed that Mr U:

- was assessed for withdrawal but the scores of this assessment did not warrant medication being prescribed;
- was not receiving any other medication; and
- had a mental health screen done but this did not find that he needed onward referral to mental health services in the prison.

4.1 Events prior to Mr U being found

Cell location

Mr U's family asked why he was in a cell on his own which was not close to the staff office on the landing.

Although Mr U initially shared a cell on Landing 2 in Bann House it appeared that he and his cell mate (Prisoner A) did not get on well together. Mr U had requested to move cells as a means of resolving the issue between himself and his cell mate. A Prison Service Officer (CPO B) made enquiries to see if there was another free cell so that they could be separated. At that time, the Prison Service Officer (CPO B) said that Mr U's body language was aggressive when asking for a cell move but once the other prisoner (Prisoner A) had left the cell to go to an appointment and Mr U knew that he was being moved, he calmed down.

[13] Alcohol withdrawal symptoms are assessed using a structured Alcohol Withdrawal Scale. The range of possible scores on the scale is 0-67. Scores in the range 0-9 are in the 'mild' category and require observation (and a repeat assessment) only. Scores in the range 10-20 indicate medication is required.

The Prison Service Officer (CPO B) rang the upstairs Class Office[14] for landings 3 and 4 and established that Cell 18 on Landing 3 was vacant. Mr U was then moved to occupy that cell.

There was no other consideration as to the physical location of the cell other than that it was vacant. There was no risk flagged in relation to Mr U which would have had a bearing on which cell he occupied.

Mr U's report of feeling unwell

Mr U's family had been told that a Prison Chaplain saw Mr U lying on his bed on the morning before he was found and that he had told the Chaplain he was not well. Given the cause of death, they asked if it was possible that Mr U already had pneumonia when he first arrived in prison.

There were no records to indicate there was any interaction between Mr U and a Prison Chaplain after he arrived into custody. Prison Service Officer (CPO B) who managed Mr U's move to Landing 3, specifically recalled asking Mr U if he wanted to speak to a Chaplain and he declined. However, that is not to say that a Chaplain did not look in on him when they were on the landing. It is possible that Mr U was feeling unwell as he was withdrawing.

Dr Grounds was asked to address the family's query. He said that while the available records do not exclude the possibility that Mr U had pneumonia when committed to prison, as it was not specifically investigated, there were no indications that Mr U had respiratory symptoms, a raised temperature or any other pointers to indicate an infection.

4.2 Events leading up to Mr U being found

It is evident from the actions of Prison Service staff prior to Mr U being found and particularly in the period from 04:30 to approximately 06:00, that Mr U's behaviour and presentation was a cause of concern for the NCOs (NCOs A, B, C and D) on the landing and their Senior Officer (SO A). There had also been the report of Mr U having a shank in his cell at 01:01.

Mr U's family were concerned that he had been calling for help but that these calls had gone unanswered. It is evident that Mr U's behaviour was causing concern but it is also clear, from the CCTV footage that all cell alarms were responded to and that Prison Service staff spent a considerable period of time interacting with him.

In addition to fully understanding what interaction Prison Service staff had with Mr U prior to his death, his family specifically wanted to know if there was a process for

[14] The Class Office is located on landings. It is where the computer and phone to each landing is located and the office that the Officers work out of.

escalating concerns about his behaviour before he died and what the emergency response was to people in crisis.

The detail included in one of the NCO's account of events and the level of monitoring and checking conducted by Prison Service staff from 04:30, prompted the following questions: -

- whether the opening of a SPAR might have been considered,
- whether there was the potential for this to have altered the outcome, and
- if any other course of action might have been available to prevent the incident of self-harm which resulted in Mr U's death.

At the time Mr U was found the Operating Procedures[15] as set out in the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated October 2013) applied. This policy aimed to identify vulnerable prisoners at risk of self-harm or suicide, and provide the necessary support and care to minimise the harm an individual may cause himself throughout their time in custody. Within the Prison Service policy a vulnerable prisoner was defined (page 4) as:

'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."

The policy document highlighted the initial period following committal to custody as being a vulnerable time and provides guidance on risk factors (pages 10-14). There is no set formula for assessing risk. Anyone opening a SPAR exercised their own professional judgment as to whether it was necessary to manage a person under this process.

The SPAR policy provided for NCOs to raise concerns with their Senior Officer (SO A) and for that Officer to respond to these. Even though the events involving Mr U unfolded in the early hours of the morning, the option of moving him to an observation cell and opening a SPAR were available to the Senior Officer (SO A) subject to getting authority to do so from the on call Duty Governor (page 19).

The possibility that Mr U may have had a shank in his cell would have had to have been factored in to any decision to relocate him to an observation cell. This would have required the Senior Officer (SO A) to assemble staff to conduct a cell search before a move was contemplated in order to ensure the safety of Mr U and Prison Service staff. At interview, the Senior Officer (SO A) said that this was a factor in how the situation was managed that night.

[15] The operating arrangements were revised and introduced to Maghaberry Prison in December 2018.

Given the account provided by one NCO (NCO B), the reports made to the Senior Officer (SO A) and the actions of staff thereafter to keep Mr U safe, it appeared that there might have been grounds to open a SPAR. However, Prison Service Officers reported that they had calmed Mr U and he had reassured them that he did not have suicidal thoughts.

On this matter Dr Grounds concluded that while Mr U's behaviour and demeanour were probably sufficient to trigger the opening of a SPAR, he did not think this was a necessity for two reasons:

i) There was no clear evidence of suicidal thoughts or plans; and
ii) Individual staff used their discretion to provide him with personal support.

He further identified two other relevant issues:

i) Whether a SPAR would have, in practice, kept Mr U safe; and
ii) If the SPAR would have resulted in any additional monitoring.

Dr Grounds was content that a SPAR could have been opened if Prison Service staff had deemed it necessary but that it seemed unlikely it would have resulted in any additional personal contact or more frequent monitoring.

As was required by the Prison Service policy, one of the NCO's (NCO B) reported concerns to the Senior Officer (SO A) and they attended the landing together. Mr U was closely observed by Prison Service Officers – possibly more closely than he might have been if a SPAR had been opened. CCTV indicated he was observed and/or interacted with Prison Service officers 11 times in a 90 minute period. Even if Mr U had moved to an observation cell, the monitoring intervals would still have left the opportunity for him to harm himself. We also do not know how he would have responded had he been relocated to an observation cell.

In Dr Grounds' opinion, Mr U's behaviour, based on the account given by one of the NCOs (NCO B), was sufficient to trigger a referral for an urgent (i.e. emergency / immediate) specialist mental health assessment, if such a service existed out of hours. He was satisfied that if this incident had occurred in the community such an assessment would have been considered by a primary care clinician. Dr Grounds said that Mr U probably needed an immediate out-of-hours mental health assessment and to be given a short acting sedative to make him feel more settled until he could be reviewed the following morning.

Based on his review, Dr Grounds reported that the clinical records did not show clear indicators of imminent suicide risk during the period Mr U was in Maghaberry Prison. There was, however, a possibility, that Mr U's death could have been prevented if an immediate out-of-hours mental health assessment had been provided when an NCO

(NCO B) became concerned about Mr U's condition. In Dr Grounds' view, a specialist mental health clinician would also have been able to make an expert assessment of Mr U's mental state, the intensity of his beliefs, and the clinical monitoring and care he needed.

In light of Dr Grounds' opinion, I consider it is very important for the Prison Service and the Trust to reflect on how urgent mental health assessments and medication might be arranged out of hours. I accept that Prison Service Officers, in this instance, acted with good intention but they were not in a position to clinically assess Mr U's needs in the same way as if he had suffered a significant physical illness. It is also important to factor in that due to Mr U's behaviour his healthcare assessment following his committal to custody had not been completed and he could have still have been experiencing withdrawal symptoms.

The Trust advised that where there are immediate concerns, patients can be transferred to hospital for assessment and treatment. The Trust noted, however, that there can be limitations when a patient is aggressive and agitated and said that the normal process is to manage a person on a SPAR until it is decided if an assessment is required. The Trust highlighted that it is not commissioned to provide 24 hour specialist mental health access but agreed it should be available and that the Trust mental health services have now moved to a 7 day working pattern. Furthermore, the Trust advised that Trust staff can access an out-of-hours general practitioner (GP) service for advice and medication and this can be promptly administered from stock medications.

I fully appreciate the challenges of safely managing people in crisis out of hours. In this instance a SPAR was not opened, and apart from a conversation about the issue of sleeping medication, it does not appear that Trust staff were consulted about Mr U's behaviour and demeanour particularly in the period from 04:30 onwards.

In order to make a determination that someone required an urgent mental health assessment either within the prison or at an outside hospital, a member of Trust staff would have had to have clinically assessed Mr U. I go back to what might have happened if, for example, Mr U had collapsed or inflicted a serious injury to himself. A Trust nurse would have attended and decided how best to proceed. That may have resulted in assessment and treatment within the prison or the person may have been taken to hospital. Again, in this instance whether Mr U had a shank in his cell would have had to be taken account of in terms of any relocation.

In prisons, as in the community, acute psychiatric emergencies can occur at any time and staff need to be aware of the range of options available to them to care for someone in this situation.

Recommendation 1:
The Prison Service and the Trust should review their out-of-hours procedures/protocols to ensure there is a common understanding of how to access specialist services out-of-hours. Additionally they should develop a checklist to assist prison staff in recognising deteriorating mental health that may require clinical assessment. Where an immediate specialist mental assessment is required, provision should be made to rapidly prescribe and administer medication if needed.

One further observation made by Dr Grounds relates to Mr U's request to make a telephone call in the early hours shortly before he was found. Mr U's family also asked why a telephone call was not facilitated at that time.

It appears an assumption made by a NCO (NCO A) was that this could not happen at night, when prisoners are locked. It is not clear who Mr U wanted to call or why but Dr Grounds said while he understood the operational reasons, this could have been a protective factor. We also know that Mr U had not received a committal call. I am satisfied this is an important consideration and I make the following recommendation:

Recommendation 2:
The Prison Service should ensure that arrangements are in place at night to facilitate prisoners in crisis being able to speak to an appropriate person where this may be a significant protection for them.

Record keeping

Apart from the entries made by the Senior Officer (SO A) in their journal and in the Night Manager's report about the incident when Mr U reported he had a shank in his cell, there were no records of Mr U's behaviour or of the interactions staff had with him for the period prior to midnight and the early hours of the morning before he was found. It is not clear to me how the requests made by Mr U for a phone call and medication and concerns about his behaviour would have been followed up. The additional NCO (NCO A) in Bann House that night understood that as they were not a regular member of staff, they were not responsible for completing the journal and another NCO (NCO B) said it was their intention to leave a post-it note for the day staff coming on duty. Neither are satisfactory and I reiterate to the Prison Service the need for all appropriate and relevant information to be recorded in journals.

4.3 Response to the incident

Access to the cell

There was a short delay of just over a minute in gaining access to the cell because the NCO (NCO A) who observed Mr U hanging did not have keys to unlock the cell. As this officer was an additional member of staff on duty in Bann House no other NCO belt, with keys, was available for that officer to wear. This has since been rectified and an additional NCO belt is now available in Bann House. This ensures that all officers patrolling landings at night have access to the equipment they require to fulfil their duties.

I commend Maghaberry Prison for addressing this issue in the course of the investigation. I am satisfied that the short delay did not have any material impact on the time taken to access the cell in this instance but it might have done in a different set of circumstances.

Estimated time between the time Mr U was last checked until he was found hanging

An examination of the CCTV footage established that the time between Mr U last being checked when a NCO (NCO A) responded to a cell alarm until he was found, was 13 minutes and 4 seconds.

Mr U's family reported that they had been told at the time that he had not been hanging for any longer than 5 minutes. This was also the timeframe referred to in medical records. The paramedics who responded to the incident recorded that the reported time between Mr U last being seen and being found unresponsive was 7.5 minutes.

As there is no CCTV in normal cells, it is not possible to say for certain how long Mr U had been hanging before he was found. Dr Grounds reported that intervention would probably have been needed almost immediately if Mr U were to have been saved. His understanding from medical literature was that lethal brain damage can result very quickly from hanging, and that the degree of brain damage Mr U sustained did not imply that he must have been hanging for longer than five minutes; it could also have resulted from hanging for a shorter period.

The resuscitation of Mr U

All those involved in resuscitating Mr U reported no issues with the resuscitation response.

Dr Rees was invited to examine the records and advise if the resuscitation effort was conducted in line with national guidelines.

Dr Rees was satisfied that the resuscitation of Mr U was carried out promptly and efficiently in accordance with Resuscitation Council Guidelines 2015. She was content that Mr U received cardiopulmonary resuscitation (CPR) in accordance with guidelines to the point that a pulse was detected and she commended the staff involved for their efforts.

4.5 Post incident

Notification to Mr U's family

Although Mr U arrived at hospital at 07:24, it was not until 11:45 that his next of kin were informed of what had happened. It is important to note that when he left the prison, staff involved were hopeful that they had revived Mr U.

Paragraph 9.4 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated October 2013) provides guidance on contacting the next of kin in the event of a serious injury or death. This states that the Governor in charge or Duty Governor must inform, as a matter of urgency, the immediate family or next of kin or arrange for another appropriate person to do so. The policy also provides for the Governor to arrange for a family chaplain or local PSNI officer to inform the next of kin. Paragraph 9 of Maghaberry Prison's Death in Custody Contingency Plan Number 51 (Reviewed October 2013) which gives effect to the Prison Service Suicide and Self Harm Prevention Policy, states that if a prisoner has been moved to outside hospital and the medical opinion is that death is imminent or likely the Duty Governor should inform the next of kin as soon as possible.

Mr U had been resuscitated at Maghaberry Prison before he was taken by ambulance to hospital. Ambulance Service records indicated Mr U arrived at hospital at 07:24 and his care was transferred to hospital staff at 07:50. At 11:19, PECCS staff who accompanied Mr U to hospital, contacted the prison and advised that Mr U had been placed in an induced coma and that the results of scans were awaited. At this point, given the seriousness of the incident, the Deputy Governor (Governor A) decided to notify Mr U's next of kin.

Prison staff escorting Mr U at hospital informed the ECR at 11:19 that Mr U was in the Intensive Care Unit (ICU), that he had been placed in an induced coma and that medical staff were awaiting the results of Computerised Tomography (CT) scans. On learning this information the Deputy Governor (Governor A), rather than waiting on medical advice to contact the next of kin, decided to notify them and they were informed at 11:45. I believe this was the most compassionate action to take in the circumstances.

Mr U's family reported that Prison Service staff they met at the hospital were respectful and discrete. They appreciated the Governor (Governor B) attending the hospital to express his condolences following Mr U's death.

An issue of concern at this point was the conflicting accounts about the length of time Mr U had been hanging before he was found. At such a distressing time, the family found this difficult to process and this is where Prison Service plans to introduce a Family Liaison Officer would greatly assist.

Incident response

The incident response was reviewed at the hot and cold debrief meetings.

Standard 25 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody.

The hot debrief should take place as soon after the incident as possible and involve all the staff who were closely involved with the incident, where they are available to attend. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning. This also provides a further opportunity to check in with staff involved in an incident.

There was representation at both meetings by Prison Service staff and Trust nurses who were directly involved in this incident. The PECCS staff involved in the incident were unable to attend the hot debrief as they had accompanied Mr U to hospital. Although PECCS staff operate from Maghaberry Prison, they were not invited to attend the cold debrief as they are separately managed. As a consequence PECCS management, while having some awareness of the involvement of their staff in an incident, did not appreciate the role they played in assisting with resuscitation and incident response. There was no formal follow-up with these staff at the time nor recognition of their role although that was addressed later. Maghaberry Prison's management have noted that if a similar situation arises again then all relevant staff, including those outside the direct management of the Governor will be invited to participate in debrief meetings. Prison and PECCS staff who responded to the incident were commended for their efforts to resuscitate Mr U.

During both debrief meetings, events prior to midnight and the morning before Mr U was found were reviewed in detail and a number of issues discussed. These included; the removal of patients on stretchers from the scene of an incident to an ambulance, the potential impact of staffing levels at night on how incidents can be safely managed, the provision of emergency NCO additional belts and communication with the hospital about Mr U's condition once he had left Maghaberry Prison. Staff support services were also addressed.

All actions raised at the cold debrief meeting were completed.

From interviews with Prison Service staff, it was evident that each person responded differently to the situation and had different experiences and knowledge of the available staff support systems and how to access them. This was discussed with a Senior Governor (Governor C) at Maghaberry Prison in connection with this and another investigation. The Senior Governor (Governor C) advised that action points from debrief meetings would be assigned to specific individuals (most likely Functional Heads or Unit Managers) and this work would include follow-ups/regular contact with those involved in an incident. The Prison Service also pointed to its Prisons Well Programme and work to develop a full Wellbeing Programme for staff. I look forward to learning more about this work.

In June 2020 the Justice Minister Naomi Long, commissioned a review of the measures in place to support prison officers experiencing work related stress. The review report was published in January 2021[16] with recommendations for improvement and action plans to deliver the recommendations. I welcome this work which extends to both operational prison staff and those who have retired. I hope that it will inform how hot and cold debriefs can more effectively support staff present at the time of a death in custody.

Updated information on prisoners transferred to hospital

Dr Grounds reported that the issue of Trust Staff being unable to obtain updated information on a patient's condition in these circumstances is one that may need to be jointly agreed in future. He found that the hospital records indicated the reason for this was because of concerns about confidentiality and not conveying information by phone to non-identifiable persons. He recommended that there was an agreed protocol for appropriate information sharing between healthcare Trusts in prison and the receiving hospital. I endorse this recommendation and add that appropriate information should be shared by the Trust with Prison Service managers and staff in such circumstances to ensure that there is no miscommunication with staff and families.

Recommendation 3:
The Trust should work with other Trusts to develop and agree a protocol for appropriate sharing of clinical information between the healthcare teams in the prison and the receiving hospital in the case of transferred prisoners. Appropriate information should also be shared with prison managers and staff.

[16] https://www.justice-ni.gov.uk/publications/statement-and-reports-review-support-services-serving-and-retired-prison-officers

4.6 Wider learning arising from Mr U's case

Dr Grounds examined Mr U's prison healthcare records for one year prior to his most recent committal to provide a broader commentary on aspects of Mr U's care and to set his most recent committal in the context of what had happened in his recent past. During this time Mr U had been in prison on five separate occasions for relatively short periods.

During the one year period looked at, Mr U received primary rather than secondary healthcare services in prison custody. As with his last committal, although Mr U was screened, he was assessed as not requiring further assessment by primary mental health services while in prison or onward referral to secondary mental health services. Overall Dr Grounds found that the primary healthcare services provided in custody were generally satisfactory and equivalent to standards that would be expected in the community.

Dr Grounds found that Mr U's reported long and serious history of alcohol and substance misuse and dependence was recognised and considered at each reception to prison custody. While on each occasion the appropriate investigations were done, it was not clear that there was any considered assessment of Mr U's developing and potentially worsening history in relation to substance misuse.

Dr Grounds commented on the absence of any descriptive account of Mr U's personal history and circumstances in the prison healthcare records he reviewed. In brief, he said that the records did not convey an impression of who Mr U was or how he experienced his world.

This he said had two consequences:

- It was difficult to assess Mr U's clinical problems fully in an individual context; and
- The records did not convey an understanding of Mr U's subjective psychological life.

In Dr Grounds' view the fact that someone serves multiple, relatively short periods in custody should not preclude initiating and establishing long term and integrated programmes of clinical treatment and support to address substance misuse.

Mr U's case presented challenges for those who were responsible for his care both in prison and the community. Sadly Mr U spent much of his adult life inside prison yet there is relatively little of his personal history and circumstances documented in either his Prison Service or Trust records. Discussions my Office had with Mr U's family shortly after his death provided more insight into Mr U's experience of the world around him and something of the trauma he experienced. Access to this

information would have assisted those caring for Mr U, particularly with regard to his safety.

Individualised care approaches, in terms of custodial and healthcare management remains a significant challenge. I accept Dr Grounds' findings that on each and every occasion Mr U was committed to custody that the necessary screening and other assessments were done but I would suggest that additional approaches be considered also.

Mr U's family raised concern that the system did not appear to pick up on people who were repeatedly in and out of prison. This is a valid concern. In my view there is a broader discussion required around how continuity of care is provided, particularly for people who are neither in prison or the community long enough to engage in services or have services wrapped around their individual needs. The Prison Service and the Trust are important parties to that conversation but so too are those responsible for delivery of community services. At the most basic level, Mr U's frequent admissions into custody should have informed and alerted those caring for him.

A starting point for this discussion might be a study of cases where, like Mr U, there have been multiple committals to custody. My Office examined an extract taken from PRISM for one day in November 2019. This showed that only 2% of the prison population on that date had been committed more than twenty times. Of concern is that three quarters of these people had previously been committed to Hydebank Wood College, as had Mr U.

The small number of people committed to custody more than 20 times provides a manageable number of cases to examine in detail and potentially, to establish ways to intervene and guide individuals in custody to effective interventions, perhaps altering the course of their lives. Assessing and managing such needs on a longitudinal basis, joining up information, appointments and support between custody and community might be possible. Potentially the number of committals could act as a red flag with particular attention paid to those coming into the system as young offenders.

Additionally, prisoner examination would benefit from the observations and recommendations made by Dr Grounds in terms of his review of Mr U's records for the period prior to his most recent committal.

These included:

Issue	Potential action
Inability to transfer care to a GP Continuity of health care was not maintained as there was an inability to	Review what further steps can be taken to arrange GP registration for prisoners who

Issue	Potential action
transfer care to a GP. This meant that information could not be passed on to a GP or received from a GP during the multiple times Mr U was in and out of prison. This was not an uncommon occurrence given the unstable nature of where people might have lived prior to coming into prison and that they may not know in advance where they are going to be living on their release. Dr Grounds reported that the current process whereby discharge letters[17] are sent to the Business Services Organisation (BSO)[18] if a patient is not registered with a GP is not effective.	are not registered with a community GP before they are released from prison. Avoid the use of No Fixed Abode (NFA) where possible. Examine records for details of temporary accommodation such as stays in hostels and record this on Egton Medical Information System (EMIS) rather than use of NFA and liaise with hostel support staff to facilitate GP registration. Explore details of where a patient might reside on release and record this in the patient's record so GP registration could be explored. Liaise with the Prisoner Development Unit (PDU)[19] to examine arrangements being made by housing on release and be provided with details of any through care case worker who could act as a point of contact for referrals to community services.
Assessment of developing history of substance misuse Mr U's history of alcohol and substance misuse was recognised and considered at each committal. If a trajectory of increasing severity had been confirmed there could have been consideration of referring Mr U to a specialist drug and alcohol team either in prison or the community.	Consider assessing the longitudinal history and conducting a full specialist substance misuse assessment if there is a deteriorating course.

[17] A discharge letter notifies an individual's GP of their imminent release and provides details of their medication regime at the time of discharge, a list of current problems requiring active consideration or outstanding out-patient dates.
[18] When a person is not registered with a GP a discharge letter is issued to the BSO. When BSO receive a letter, they will check if a person has since registered with a GP and if yes, forward the letter to them. If the individual does not register with a GP, they retain the letter on file. If an individual attempts to register with a GP and the practice does not accept that registration, the individual can ask BSO to place their details on a GP's list.
[19] To help address the needs of resettling short term sentenced prisoners, Maghaberry Prison established a Progressive Short Term Sentenced Team (POST) team within its PDU to coordinate resettlement activities, including housing, with this group of people. POST staff and partner agencies aim to assist prisoners find accommodation whether on a temporary or permanent basis.

Issue	Potential action
Absence of any descriptive account in the clinical records of Mr U's personal history and circumstances. This absence makes it difficult to assess individual clinical needs fully and presents a difficulty in understanding his subjective psychological life.	Enhance prison clinical records by inclusion of a summary of the person's family and personal history, and social circumstances. Consider undertaking a mental health assessment especially where there is an absence of records. Access and include all relevant past medical history in prison medical records in accordance with NICE guidance. Pay attention to implementing the National Institute for Health and Care Excellence (NICE) Guideline on 'Patient experience in adult NHS services' (CG138).[20]
Impact of short sentences Mr U had six relatively short periods in custody within a year. He was not registered with a GP. Timescales for interventions were too short for any substantive programmes to be completed.	Consider doing a full assessment of substance misuse with aim of setting up a longer term programme of support that would be continued in the community. Potentially consider a full mental health assessment.
Lack of information available for mental health screening It was good that a mental health screen was in place but it was less clear how comprehensive the information available to the person conducting the screen was.	Carry out a specialist mental health assessment if there is a past history of a potentially life-threatening and planned suicidal act. Examine the potential for any psychiatric problems associated with substance misuse.

I shared Dr Grounds' report and my draft investigation report with the Prison Service and the Trust and discussed the important observations it contained. Similar matters have been raised in a number of other investigations and I have written to the Department of Justice asking that these issues are considered by the joint Departmental (Justice and Health) Improving Health in Criminal Justice Implementation Group.

[20] https://pathways.nice.or.uk/pathways/patient-experience-in-adult-nhs-services

Section 5: Conclusions

With regard to my responsibilities to investigate Mr U's death and specifically considering the objectives of my investigation, I draw the following conclusions:

i) My investigation established the circumstances and events leading up to Mr U being found in his cell. These are set out in Section 3. They cover events from Mr U's committal through to the post incident response. The findings at Section 4 address the specific objectives of this investigation as documented on pages 13 and 14 of this report.

ii) Mr U appears to have died as a result of the injuries he sustained having been found hanging in his cell in Maghaberry Prison. An inquest into the circumstances surrounding his death is pending.

iii) I accept the opinion of Dr Grounds that the records did not show clear indicators of immediate suicide risk during the period Mr U was in police and prison custody. I further note that Dr Grounds commented that if an urgent specialist mental health assessment had been available there was a possibility that Mr U's death could have been prevented although, it is difficult to say this with a high degree of certainty. We cannot know this for sure for a number of reasons: the challenge for prison staff of judging that an assessment might be required and summoning healthcare support, whether Mr U would still have been presenting as he had done earlier that morning when a Trust nurse attended and how a transfer to hospital, if needed, might have been affected given the earlier report of Mr U having a shank in his cell.

iv) I endorse Dr Rees opinion of the resuscitation effort and commend all staff involved for their efforts.

v) There is potential for important learning for those who may experience a crisis during the night. It was very clear to me that all Prison Service staff involved in caring for Mr U that morning were doing so in Mr U's best interests but they could not provide a clinical assessment of his behaviour and demeanour as they were not medically qualified to do so. It

is important that the Prison Service and the Trust work through their respective out-of-hours processes to ensure that mental health needs are addressed in a similar way to physical health needs. It is very important in this discussion that no-one makes assumptions about what can and cannot happen because of the time of day but rather consider the individual needs of the person in crisis.

vi) A significant wider learning point emerging from this investigation concerns the identification of people who are at risk of suicide and self-harm. Mr U served many short sentences and he was neither in prison nor the community long enough for any meaningful engagement around how best to address his needs. Indeed there was little available information about him documented in the Prison Service and Trust records which gave much insight into how he experienced his life. However, the frequency of committal over a relatively short space of time, could have provided insight.

vii) The potential to consider and assess people in similar situations on a longitudinal basis should be further explored. I have written to the Department of Justice to ask that the wider observations made in this case, including the recommendations made by Dr Grounds in his report, are considered by the joint Departmental Health and Justice Improving Health within Criminal Justice Implementation Group. I plan to keep this work under review.

viii) I have addressed, as far as possible, the questions raised by Mr U's family and provided an explanation of the circumstances leading to his death. The questions they posed at the beginning of this investigation were insightful and went to the heart of the learning which I hope emerges from this investigation. Central to this is how the system responds to people who are repeatedly committed to custody for relatively short periods and the limitations this places on the continuity of care they receive.

ix) Another question the family asked was about the process for escalating concerns about Mr U's behaviour and what the emergency response is to people in crisis. It is evident that

Prison Service staff escalated their concerns to the NCO's Senior Officer (SO A) and actions were taken to engage and calm Mr U but there is learning in terms of responding to deteriorating mental health outside normal working hours.

x) I deeply regret the time it has taken to conclude my investigation and share my report with Mr U's family.

xi) In order to assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, I will provide the Coroner with the materials underlying to my investigation.

xii) I welcome and endorse the recommendations in the Review of Support Services for Operational Prison Staff, commissioned by Naomi Long, Minister of Justice. I hope that Critical Incident procedures will improve debriefs and staff can be more effectively supported, especially when they are involved in such a critical incident that results in my office completing an investigation.

Section 6: Recommendations

A list of the recommendations made in this report follows:

Recommendation 1:

The Prison Service and the Trust should review their out-of-hours procedures/protocols to ensure there is a common understanding of how to access specialist out-of-hours and develop a checklist to assist prison staff recognise deteriorating mental health which may require clinical assessment. Where an immediate specialist mental assessment is required, provision should be made to rapidly prescribe and administer medication if needed.

This recommendation was not accepted.

In their responses the Prison Service and the Trust said that the SPAR process is the usual method of ensuring the safety of people in prisons who are at risk of self-harm/suicide, followed up by mental health staff where necessary. Additionally there was 24 hour nursing cover, access to out-of-hours GP and, if needed, a transfer to an Emergency Department would be considered. The Prison Service and Trust stated it was important to note that Mr U was not deemed to be suicidal. In the two years since Mr U's death the Prison Service and the Trust highlighted that they had jointly developed and implemented the SPAR evolution approach which had provided a fundamental change in how prisoners, about whom there is a concern, are responded to and supported. They also said that there were established mechanisms in place to raise a concern or alert a member of Trust staff where a member of Prison Service staff identified a change in someone's behaviour.

Recommendation 2:

The Prison Service should ensure that arrangements are in place at night to facilitate prisoners in crisis to speak to an appropriate person where this may be a significant protection for them.

This recommendation was accepted.

Recommendation 3:

The Trust should work with other Trusts to develop and agree a protocol for appropriate sharing of clinical information between the healthcare teams in the prison and the receiving hospital in the case of transferred prisoners. Appropriate information should also be shared with Prison Service managers and staff.

This recommendation was not accepted.

The Trust advised that since Mr U's death a memorandum of understanding for data sharing for direct care purposes between Northern Ireland Health and Social Care Trusts was approved in early 2020. The Trust also pointed out that Trust staff have

access to the NI Electronic Care Record and is included in the scope of Encompass development which will replace current information systems with one Health and Social Care digital integrated care record for Northern Ireland.

Areas raised in previous reports which will be kept under review

- All appropriate and relevant information should be recorded in prison journals.