The Prisoner Ombudsman for Northern Ireland

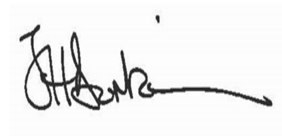
INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

KENNETH RAMAGE

AGED 47 WHILE IN THE CUSTODY OF MAGHABERRY PRISON ON 18 SEPTEMBER 2020

Note from the Interim Prisoner Ombudsman

This report, including the foreword, was at an advanced stage before the former Prisoner Ombudsman, Dr. Lesley Carroll, left office on 29 February 2024. Dr. Carroll was fully engaged with the investigation and report concerning Mr Ramage's death in custody and I believe it is appropriate that her foreword is included in this published report. I also appreciate how difficult and lengthy the investigation and reporting process has been and wish to express my condolences to the Ramage family on the loss of Kenneth.



JACQUI DURKIN
INTERIM PRISONER OMBUDSMAN
21 June 2024

The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland (the Ombudsman) 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 custody and incidents of serious self-harm.

The purpose of the 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 learnings to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of people in custody.

The Ombudsman's investigation has an important role in the Coroner's Inquest at which cause of death is established. Together with other independent investigations, the Ombudsman's investigation provides information to assist the Coroner to reach a conclusion regarding the cause of death. It is not for the Ombudsman to draw a conclusion as to cause of death but rather to consider what happened and identify any administrative shortcomings, errors and malpractice. Standards applied to all investigations help safeguard the Ombudsman's independent investigations. At times, the Ombudsman will co-operate with other parties where such co-operation will inform an investigation.

The remit for Ombudsman investigations is set out in the Terms of Reference included at Appendix 1. These Terms of Reference are then used in each investigation to set out objectives which define the scope of the investigation into that particular death. These objectives will include queries and concerns raised by the family of the deceased. Section 3.3 sets out the objectives for this investigation.

I circulate reports to those who provide services in prisons and publish them on the Prisoner Ombudsman's website, following consultation with the Coroner, in the interests of transparency, and in order that learnings from each investigation can be spread as widely as possible.

Date finalised: 21 June 2024 Date published: 08 July 2024

Table of contents

Section		Contents	Page number
		Glossary	7
		Foreword from the Prisoner Ombudsman	9
1.		**Recommendations**	
	1.1	Recommendations list and factual accuracy responses	11
	1.2	Areas raised in previous reports: kept under review	11
2.		**Background information**	
	2.1	Maghaberry Prison	12
	2.2	Criminal Justice Inspection Northern Ireland	12
	2.3	The Regulation and Quality Improvement Authority	13
	2.4	Independent Monitoring Board	14
	2.5	Previous incidents at Maghaberry Prison	14
PART A		**INVESTIGATION AND FINDINGS**	
3.		**Framework and scope for investigation**	
	3.1	Investigation methodology	15
	3.2	Independent advice	15
	3.3	Objectives of this investigation	16
4.		**Circumstances and events surrounding the death of Mr Ramage – his first committal during the pandemic**	
	4.1	Background	18
	4.2	Mr Ramage's first committal during the pandemic on 01 June 2020	19
	4.3	Serious Adverse Incident	19

	4.4	Hospital	20
	4.5	Return to Maghaberry Prison	20
	4.6	Family contact	21
	4.7	Opioid Substitution Therapy	21
	4.8	Mental Health Assessment	22
	4.9	Release	22
5.		**Circumstances and events surrounding the death of Mr Ramage – his second committal during the pandemic**	
	5.1	Committal on 14 September 2020	23
	5.2	Committal call	24
	5.3	The evening of 17 September 2020	24
	5.4	The events of 18 September 2020	25
	5.5	The incident response	25
6.		**The impact of Covid-19 – isolation in Foyle House**	
	6.1	Custody during the pandemic	27
	6.2	Foyle House during the Covid-19 pandemic	28
	6.3	Mr Ramage's contact with family while in Foyle House	29
	6.4	Conditions in Foyle House as experienced by those in isolation	30
	6.5	The impact of isolation on Mr Ramage	31
7.		**Healthcare provision for Mr Ramage**	
	7.1	Healthcare in Prisons	32
	7.2	At risk and wellbeing assessments	32
	7.3	Insulin dependence and medication	34
	7.4	The standard of healthcare provided	38

PART B		LEARNING FOR IMPROVEMENT	
8.		**Learning and good practice**	
	8.1	Information sharing	39
	8.2	The importance of family contact	39
	8.3	Engagement with Mr Ramage	39
	8.4	Approach to risk and healthcare assessments	40
9.		**Conclusions**	
		Conclusions	41
Appendix 1		Terms of Reference for Prisoner Ombudsman investigations into Deaths in Custody	43
Appendix 2		Terms of Reference for Clinical Review	45
Appendix 3		Questions asked by Mr Ramage's family	47
Appendix 4		Timeline of Events 28-31 December 2018 – drawn only from events listed in the report	48

Glossary

BPD	Borderline Personality Disorder
BWVC	Body Worn Video Camera
CCTV	Closed-Circuit Television
CJI	Criminal Justice Inspection Northern Ireland
CSU	Care and Supervision Unit
ECR	Emergency Control Room
ETI	Education and Training Inspectorate
HMI Prisons	His Majesty's Inspectorate of Prisons
IPC	Individual Prisoner Cash Account
IMB	Independent Monitoring Board
NIPS	Northern Ireland Prison Service
OST	Opioid Substitution Therapy
Prison Service	Northern Ireland Prison Service
PSST	Prisoner Safety and Support Team
PTSD	Post Traumatic Stress Disorder
RQIA	Regulation and Quality Improvement Authority

SPAR	Supporting People At Risk (procedure)
SPAR Evo	Supporting People At Risk Evolution (procedure)
SEHSCT/Trust	South Eastern Health and Social Care Trust

Foreword from the Former Ombudsman

Introduction

The death of a loved one is always difficult. When a death occurs in prison, it is particularly challenging as families have already experienced loss when a loved one is taken into custody. They place their trust in the Northern Ireland Prison Service (the Prison Service), the South Eastern Health and Social Care Trust (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. Above all, families need to have confidence that their loved one is safe while in custody.

Findings made in this report, together with learnings identified, will address and inform those who provide care for people in custody. Where appropriate, I will make recommendations directly to the Prison Service and the Trust. Both organisations provide my Office with a response indicating whether they accept my recommendations and what steps they are going to take, or have taken, to address them.

While improvement to how people in custody are cared for is important for ensuring confidence in the prison system, I am writing this report with Mr Ramage's family in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am conscious of the length of time families wait for investigative processes to complete. Mr Ramage's family have been keen to hear the results of my investigation and I acknowledge the delays that have arisen, not least due to the impact of Covid-19. I appreciate their patience and continued engagement and am grateful to them for their contribution to this investigation.

My investigation

In my investigations I aim to develop a picture of the individual who has died, the events leading up to their death and a broader picture of the challenges they may have faced in their lives, including any health matters that may have affected how they experience the world. I provide here as much detail as possible about Mr Ramage, his time in custody and the circumstances surrounding his death. I hope the information will be helpful to his family as they piece together the last events in his life. I commissioned a Clinical Review to consider the healthcare Mr Ramage received and the outcome of that review is contained within my report. I make a recommendation focused on learning to improve the care of all those in custody in light of Mr Ramage's death.

In 2020, Mr Ramage had four short periods in custody. His third period in custody began on 01 June 2020 and following an overdose, he was taken from Foyle House quarantine unit to Craigavon Area Hospital. He was released from hospital back into the community. Mr Ramage returned to custody in September 2020.

Regrettably, Mr Ramage spent two periods in custody during the Covid-19 pandemic. Arrangements to keep those in custody safe from the coronavirus particularly affected those arriving into custody, as they were isolated for 14 days. I will discuss this arrangement in my report. It is important to acknowledge that Mr Ramage faced isolation twice due to these measures and that may have influenced his wellbeing.

Some important questions arise from the experience Mr Ramage had and I will examine these in my report. I will consider how isolation may have affected him, particularly as he was insulin dependent and there were decisions about his medication that have prompted questions from his family. I want to ensure that those who provided services to Mr Ramage maintained best practice in the care he received. To assist my consideration of the healthcare aspects of Mr Ramage's time in custody and the potential impacts on his wellbeing, I commissioned Consultant Nurse Annie Dale RNMH ANP to provide an Independent Clinical Review of the healthcare provided to Mr Ramage. I reference her report throughout my report and the Terms of Reference for the Clinical Review at Appendix 2.

How Prison Officers spoke to my Investigating Officer about Mr Ramage is of note. They agreed that he was friendly, quiet and polite.

I offer my sincere condolences to Mr Ramage's family. I hope this report provides information to address some of the questions they raised and explains events leading up to his death. The learning, expressed in my recommendations, will, I hope, bring some comfort and confidence to those who have family members in custody.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland

Section 1: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

Recommendation 1: Committal Calls

That the Prison Service establish a robust system for ensuring that individuals in custody receive a committal call at the earliest possible opportunity, including adequate arrangements for dealing with problems accessing telephone numbers. The Prison Service should share actions with the Prisoner Ombudsman's Office when completed.

Recommendation 2: Healthcare in Prison Committal Procedures

That the Trust consider how they can improve reflective conversation with individuals coming into custody about any impact the crime they are charged with may have on their mental health and also how recording of such conversations can be improved.

1.2 Areas raised in previous reports kept under review

I draw the attention of the Prison Service to a recommendation in a [1]report published on 22 February 2023, which is relevant to this investigation:

The Prison Service and Trust should review how information related to the risk of suicide or self-harm is shared to ensure Prison Officers have the information they need to respond appropriately to individuals in custody and their behaviours.

[1] Investigation into the death in custody of Mr Gavin Mawhinney, published 22 February 2023, page 10, https://niprisonerombudsman.gov.uk/publications/download/161

Section 2: Background information

2.1 Maghaberry Prison

Maghaberry Prison is a high security prison for male adults both sentenced and on remand. At the time of the incident involving Mr Ramage, the population in the prison was 972, within standard operating levels.

At the time of Mr Ramage's death, the prison operated a quarantine unit known as Foyle House in response to the Covid-19 pandemic under guidance from the Government. New committals resided in Foyle House, in single cells and on a reduced regime, for their first 14 days in custody. This was part of a suite of measures to limit, and if possible prevent, Covid-19 from being transmitted within the prison and aimed to contain any infection from those arriving into custody following contact outside the prison. Ultimately, the Prison Service focused on keeping everyone safe, both Prison Officers and those in custody.

Maghaberry Prison has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting individuals in custody who are at risk of suicide or self-harm.

Since 2008, the Trust has provided prison healthcare services. There is a 24-hour primary care service and in addition to their core training all primary care staff have some mental health training. The Mental Health Team was on site Monday to Friday between 08:00 and 17:00 at the time of Mr Ramage's death. Since 30 October 2020, the Mental Health Team has piloted provision of a seven days a week service in Maghaberry Prison. Staffing this can be challenging as it requires stretching the original five day staffing resource over seven days. The Commissioners of Healthcare in Prisons are aware of the need for more funding to guarantee a seven-day service across all sites. From October 2020, all Mental Health Committal Screening triages are face to face.

2.2 Criminal Justice Inspection Northern Ireland (CJI)

CJI's most recent inspection of Maghaberry Prison took place in October 2022 and was published in June 2023. From May 2022, HM Inspectorate of Prisons in England and Wales (HMI Prisons) changed how it reported on inspection findings, rather than making a large number of recommendations priority and key concerns are reported on. In June 2023, Inspectors from CJI, HMI Prisons, the Regulation and Quality Improvement Authority (RQIA) and Education and Training Inspectorate (ETI) reported five priority and seven key concerns. The change aimed to encourage leaders to act on inspection reports in a way which generates real improvements in outcomes for those detained in custody.

Since the last inspection in 2018, the new Davis House had opened, providing improved accommodation with in-cell toilets, showers and telephones. Relationships between staff and prisoners were mostly good. Inspectors found that most staff were friendly and approachable, demonstrating good knowledge of the individuals in their care and an understanding of their needs.

A number of notable areas of positive practice were recorded by Inspectors including the introduction and use of computer tablets and a biometric system that enabled more free movement without the requirement for an officer escort. The Donard Centre supported some of the most vulnerable individuals in custody through therapeutic activities. The reward and sanction scheme was adapted for individuals who required additional support due to learning and behavioural difficulties. This also included individuals for whom English is not their first language, who were encouraged to submit complaints and receive responses in their primary language.

Of the four healthy prison tests which CJI and HMI Prisons measure against when conducting their inspections, two had stayed the same while two had declined: safety and respect remained the same while decline was noted in terms of purposeful activity and rehabilitation and release planning. In her foreword the Chief Inspector commented:

"This was a disappointing inspection compared to our visit in 2018 and staff shortages across the prison and a rising prisoner population will continue to hamper progress".

A specific recommendation was made in relation to the Care and Supervision Unit (CSU) which stated – *'The SEHSCT should put in place workforce planning arrangements for accessing out-of-hours mental health crisis response services within three months of the publication of this report'*.

An Independent Review of Progress against the priority and key concerns reported in October 2022 was carried out and published in February 2024. Inspectors reported that reasonable progress had been made against nine concerns, insufficient progress against two concerns and no meaningful progress against one concern.

2.3 The Regulation and Quality Improvement Authority (RQIA)

The RQIA addressed the issue of vulnerable individuals in custody in their Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons, October 2021. The definition of a vulnerable person quoted in the Review was taken from the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007. Under that legislation, a vulnerable person is anyone detained in custody, whether in prison, remand centre or young offenders centre. The RQIA's report and recommendations

specifically focused on those individuals who are more vulnerable because of mental health concerns or because they are at greater risk of self-harm or suicide. The report presents a vision for healthcare within prisons in Northern Ireland which is challenging and important.

2.4 Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB whose role is to satisfy itself regarding the treatment of those in custody. Their 2020-21 Annual Report described the challenges posed by the Covid-19 pandemic. On a positive note, they observed Covid-19 restrictions resulted in a major reduction in illegal substances entering the prison, which resulted in a much safer prison environment. There was also a significant reduction in assaults, both between individuals in custody and against staff.

The IMB noted concerns regarding the cleanliness of Foyle House and the isolation associated with the 14-day period where individuals in custody were unable to leave their cells. Individuals reported to the IMB that they were locked up for 23 hours each day with one hour assigned for a shower and limited exercise. The IMB also raised concerns around the number of showers each individual in custody could avail of within the 14-day isolation period.

They also expressed concern that Closed Circuit Television (CCTV) was not available in Foyle House and that Prison Officer’s body-worn video cameras (BWVC) had to be relied on for evidence. The IMB was concerned that depending on BWVC placed too great a reliance on Prison Officers adhering to policy and procedure.

Finally, the IMB Annual Report 2020/21 noted the urgent need to recruit staff to Maghaberry Prison.

2.5 Previous incidents at Maghaberry Prison

Mr Ramage’s death was one of three incidents that resulted in death at Maghaberry Prison in 2020. His death was one of three fatal incidents that occurred in Foyle House during the Covid-19 pandemic, 2020-2022.

PART A: INVESTIGATION AND FINDINGS

Section 3: Framework and scope for investigation

Prison Officers found Mr Ramage unresponsive in his cell at Maghaberry Prison on Friday 18 September 2020.

The incident causing Mr Ramage's death took place while he was in custody, requiring me to investigate and report the circumstances surrounding his death.

My Investigators conducted this investigation in line with the objectives set out in Section 3.3 below. These objectives include providing explanations, where possible, to Mr Ramage's family. I met with Mr Ramage's family via telephone conference call on 05 November 2020 to hear directly from them. Appendix 3 lists the questions raised by Mr Ramage's family.

3.1 Investigation methodology

The methodology applied in my investigations enables Investigators to thoroughly explore and analyse all aspects of each case. My Office issued Notices of Investigation into the Death of Mr Ramage on 21 September 2020, including to those in custody, the Prison Service and the IMB. My Investigating Officer carefully examined all relevant prison and healthcare records, and I have detailed the relevant matters underpinning my findings in this report.

3.2 Independent advice

When appropriate, I commission an Independent Clinical Review of specific aspects of healthcare. An agreed commissioning list provides a number of professionals who can deliver a peer review of healthcare provision. The Clinical Reviewer supplies me with a report and recommendations. My Office provides the Clinical Reviewer with relevant documentation and Terms of Reference specific to each case to enable them to provide an independent, expert opinion about an individual's care in custody. A Clinical Reviewer may, for example, assess the delivery of care in relation to current clinically approved guidelines, both local and national and/or consider policy and practice within the relevant prison. 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. By 'equivalency' I do not mean that care should be the same as that provided in a community setting but rather that the care should be at least equivalent and take the constraints of the custodial environment into account.

I commissioned Consultant Nurse Annie Dale RNMH ANP to provide an Independent Clinical Review of the healthcare provided to Mr Ramage. She has been a first level registered Mental Health Nurse for over 18 years, a registered

Specialist Substance Misuse Non-Medical Prescriber for the last 15 years and a fully accredited Advanced Nurse Practitioner since 2012. Until December 2020 she was National Head of Nursing with the largest provider of prison healthcare services in England, with oversight for Primary Care, Mental Health and Substance Misuse services in 48 English prisons, including male, female and young people. She now works as a freelance Consultant Nurse and Educator in Safeguarding, Mental Health Awareness and Suicide Prevention and is a Locum SMS Specialist Prescriber.

Appendix 2 sets out the Terms of Reference for the Clinical Review. The Clinical Reviewer considered the following specific areas of care provided to Mr Ramage:

- medical and medication management;
- mental health management;
- the application of Risk Assessments; and
- the impact of the Covid-19 pandemic and Foyle House quarantine unit.

The Clinical Reviewer also highlighted any other issues she thought could be important. She provided me with a report setting out her opinion and I have included her opinion on relevant healthcare matters in my report where appropriate.

3.3 Objectives of this investigation

The scope and remit of my investigation must meet the standards set out in the Terms of Reference for Prisoner Ombudsman Northern Ireland investigations of deaths in custody. These inform the objectives for each individual investigation, which also take account of questions families raise with me about the care their loved one received. The objectives of this investigation are to:

1.	Establish the circumstances and events surrounding Mr Ramage's death, including the care provided by the Prison Service.
2.	Examine any relevant healthcare issues and assess the clinical care provided by the Trust, specifically the handling of decisions regarding Mr Ramage's management of his own medication.

	This objective will address questions Mr Ramage's family asked about whether his mental and physical health were properly assessed when he was committed into custody and whether he was seen by a mental health specialist, and about whether Mr Ramage held his own medication or was supervised and the appropriateness of the decision.
3.	Examine whether any changes in Prison Service or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future.
	This objective will address questions Mr Ramage's family asked about staff awareness of his history of poor mental health and a previous overdose in June 2020 and how that informed his care, whether Mr Ramage should have been on 'suicide watch' and consideration about how families are informed when a loved one dies in custody.
4.	Ensure that Mr Ramage's family has an opportunity to raise any concerns they may have, and take these into account in the investigation.
5.	Consider the impact of the Covid-19 pandemic and Foyle House quarantine unit on Mr Ramage's wellbeing and care.
	This objective will address a question Mr Ramage's family raised about how much time he spent on his own.
6.	Assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible 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.

Section 4: Circumstances and events surrounding the death of Mr Ramage

4.1 Background

Prison Officers described Mr Ramage as "quiet," "friendly" and "polite". Mr Ramage had a number of health challenges, including insulin-dependent diabetes, a long history of poor mental health, addiction and overdose. His medical records set out his mental health challenges: Post Traumatic Stress Disorder (PTSD), Borderline Personality Disorder (BPD), anxiety and depression. Mr Ramage attended the Northern Trust Addiction Services until May 2020 where he was prescribed Suboxone, an Opioid Substitution Therapy (OST) for Tramadol addiction, which he collected daily from the pharmacy.

In 2020 Mr Ramage had four short periods in custody; two of these periods were in January 2020, prior to the Covid-19 pandemic. When Mr Ramage returned to custody on 01 June 2020, the pandemic had reached Northern Ireland and the Foyle House quarantine unit had opened in Maghaberry Prison.

At this time, new committals to Maghaberry Prison transferred from the escort van directly into Foyle House and into a single cell. Individuals coming into custody did not come in through Reception, which is normal practice, but instead were searched in their cell and a Committal Risk Assessment was carried out there. This change to normal practice was part of Maghaberry Prison's responsive measures to prevent the spread of coronavirus into the prison and through the general population. Individuals in custody remained in quarantine in Foyle House for 14 days.

In line with measures to contain any spread of Covid-19, Foyle House operated a restricted regime. Access to Foyle House was limited, which meant external agencies that frequented prison landings pre-pandemic were not able to attend in person, although many could be contacted by telephone. There was no association on the Landings in Foyle House and no time outside, access to telephones and showers was also limited. At the time of Mr Ramage's committal on 01 June 2020, individuals could avail of a telephone call and a shower within approximately 24 hours of committal. Normal procedure allowed individuals to avail of a telephone call and shower every other day for the 14-day quarantine period. All individuals in Foyle House were entitled to one video call during their 14 days in quarantine. These restrictions took Public Health guidance into consideration. The Prison Service emphasised that this was the minimum those in custody should be offered. Should there be enough staff and enough time, then additional opportunities for showers or telephone calls were to be offered.

4.2 Mr Ramage's first committal during the pandemic, 01 June 2020

Mr Ramage arrived in Foyle House on 01 June 2020. Prison Officer A carried out the Committal Risk Assessment and Mr Ramage was deemed 'Not at Risk' of self-harm or suicide. At Mr Ramage's Initial Committal Assessment, Nurse A explored his mental health history with him. Nurse A also took note of his OST. Mr Ramage confirmed to Nurse A that he had his medication for that day and his community pharmacy quickly confirmed this. Nurse A gave him a diabetic pack and his prescribed medication was given to him later that evening in his cell.

Senior Nurse A carried out a Comprehensive Committal Assessment with Mr Ramage on 02 June 2020. Senior Nurse A explored his diabetes and mental health history with him and completed a Risk Assessment, which found him suitable to have his medication in his cell with him. As per his Electronic Care Record ten different medications in tablet form and three different insulin pens, were prescribed to Mr Ramage. The doctor properly prescribed his OST, 16mg daily of Suboxone, from 02 June 2020. Given that Mr Ramage had his OST on 01 June 2020 and was prescribed it on 02 June 2020, it is likely he had not missed any OST doses and would not be experiencing withdrawal.

On 02 June 2020, Nurse B, a Mental Health Nurse, completed Mr Ramage's Mental Health Screen. This was a review of his records, including his initial and comprehensive healthcare in prison nursing assessment records. Nurse B concluded that Mr Ramage did not require a referral to the Mental Health Team.

I am satisfied that Mr Ramage received his healthcare assessments and Mental Health Screen[2] within the required timeframes and to an acceptable standard.

4.3 Serious Adverse Incident

At 17:50 on 02 June 2020 Prison Officers found Mr Ramage unresponsive in his cell and raised the alarm. Senior Nurse A and Nurse C arrived at his cell and noted a large volume of empty medication sleeves at the bedside. Prison Service staff called an ambulance and Mr Ramage was transferred to the Intensive Care Unit at Craigavon Area Hospital for treatment.

My Office investigates Serious Adverse Incidents when invited to do so by the Prison Service. It is reasonable, in retrospect, to ask whether this incident should have been referred to my Office. I will discuss this matter with the Prison Service and ensure

[2] At this time, Mental Health Screens were desktop exercises completed by a member of the Mental Health Team.

incidents such as this are referred to me for investigation.[3]

4.4 Hospital

Having reviewed Prison Service and Trust records my Investigating Officer has established the following:

03 June 2020	Mr Ramage was awake in hospital and confirmed that he had attempted to end his life. Staff put a Care Plan in place for Mr Ramage according to the Supporting People at Risk Evolution (SPAR Evo) operating procedures.
04 June 2020	Mr Ramage requested his OST and contact with his family.
05 June 2020	Mr Ramage told a nurse in the hospital that he wished he were dead. He said he had suffered from depression for 15 years. He also said he did not receive a committal telephone call in custody.
06 June 2020	Mr Ramage's prison records show that he shared information about previous self-harm events and that he could keep himself safe. Healthcare records for September 2020 show that he said he had taken the overdose in June because of conditions in Foyle House.
07 June 2020	Mr Ramage explained to Prison Officer B, who was with him at the hospital, that he took the overdose because he had not been able to speak to his solicitor and was put into a cell with urine on the floor. He also said he had felt disorientated because he had not had his OST.

4.5 Return to Maghaberry Prison

On 07 June 2020, Mr Ramage returned to Foyle House and attended a Care Plan Review with Senior Officer A and Nurse D. They recorded that Mr Ramage was still

[3] It should be noted the Trust undertook a Serious Adverse Incident Review of this event during first committal.

feeling down but had no thoughts to end his life. They referred him to the Addictions Team and he was placed on Supervised Administration for his medication, which included his insulin.

4.6 Family contact

While he was in hospital Mr Ramage was able to make a telephone call to his family, and Prison Service records note an improvement in his mood. When he returned to Maghaberry Prison he submitted a request for Prison Officers to access his mobile telephone in order to get his sister's telephone number so he could add it to his telephone contacts list. On 08 June 2020 the number was located and he was able to make his committal call to her. He also telephoned his partner and his solicitor. Mr Ramage's Care Plan record for 10:11 states, "Said he is happy now. Laughing and joking with staff[4]." It is clear from the records that family contact was of great importance to Mr Ramage.

Mr Ramage's Care Plan was closed later that day when Senior Officer A and Mental Health Occupational Therapist A carried out a Care Plan Review and assessed him as being 'Not at Risk' of self-harm or suicide and referred him for mental health assessment. Mr Ramage reported that his actions were impulsive and reactive to his circumstances and that he was glad he had not died.

4.7 Opioid Substitution Therapy (OST)

It does not appear that Mr Ramage was prescribed his OST whilst he was in hospital or on return to custody on 07 June 2020.

On 11 June 2020, Nurse E conducted a Clinical Addictions Team Review and recorded that Mr Ramage missed his OST for more than three days and no longer wished to have it prescribed. He was over withdrawals and "will be glad not to be bullied for his medication in prison".

The Clinical Reviewer found that this review appeared to be thorough and covered all aspects expected from this type of intervention. Mr Ramage's rationale for refusing any further OST was well explored and challenged appropriately. His thoughts and feelings about the incident were appropriately explored along with ongoing treatment options he was offered, including low dose re-toxification and relapse prevention medications. These were appropriately offered and declined.

I am satisfied Mr Ramage received good support from Healthcare in Prison staff in relation to his withdrawal from OST.

[4] NIPS SPAR Evolution Care Plan record for Mr Ramage

4.8 Mental Health Assessment

On 18 June 2020, Mr Ramage attended a Mental Health Assessment with Community Psychiatric Nurse A. The purpose of such an assessment was to uncover and respond to factors that contributed to Mr Ramage's overdose on 02 June 2020. Mr Ramage referred to the lack of telephone contact and the poor state of his cell. He reported that he was glad to be alive and happy to be off OST. Of particular note was Mr Ramage's concern about his insulin. At the time, the administration of his insulin was supervised and as noted above, this was a reasonable decision to have made given the nature of the medication and Mr Ramage's previous behaviour. However, it is clear from the records that Mr Ramage was extremely anxious, potentially triggered emotionally, when he was not able to have autonomy over his routine insulin administration. This was the balance of decision-making that would have to be struck should Mr Ramage return to custody as he did in September 2020 - his anxiety when he was not in possession of his own insulin, and the potential risk of his having possession of his own insulin.

The Clinical Reviewer determined this assessment was thorough, covered all areas expected to a good standard, and was consistent with guidance and equivalent to community provision. The assessment did not identify any immediate risk based on how Mr Ramage presented to Prison Officers and Healthcare in Prison staff. She felt staff took a balanced approach in relation to his history and current circumstances.

4.9 Release

On 22 June 2020, Mr Ramage completed his 14 days in isolation in Foyle House and moved to Bann House, the committal house in Maghaberry Prison. He then moved to Erne House on 29 June 2020 and, following a Risk Assessment, he was permitted to carry his own insulin. Healthcare in Prisons reviewed this arrangement on a daily basis. He remained on supervised administration for his tablets which appears reasonable given his recent history of overdose.

On 17 July 2020 Mr Ramage was released from custody on bail.

Section 5: Circumstances and events surrounding the death of Mr Ramage - his second committal during the pandemic, 14 September 2020

5.1 Committal on 14 September 2020

On 14 September 2020 Mr Ramage was one of 23 new committals to Foyle House. This was a significant number of new committals given the conditions imposed across society due to the Covid-19 pandemic. A large number of people coming into custody on any day is significant but during the pandemic this required exceptionally careful management by Prison Officers who were living with the same constraints and concerns as others across society. It is important to acknowledge the pressures Prison Officers coped with during lockdowns and the additional operational challenges they faced every day during the Covid-19 pandemic.

A Committal Risk Assessment found Mr Ramage to be 'No Apparent Risk' of self-harm or suicide. Senior Officer C, who conducted the risk assessment, was aware that Mr Ramage had previously self-harmed by overdosing. Mr Ramage declared that he did not currently have any thoughts of self-harm or suicide, could keep himself safe and was aware of all "help at hand[5]," and how to avail of that help.

On 14 September 2020 at 18:53, Mr Ramage attended his Initial Healthcare Assessment with Nurse A at which they discussed his diabetes and records show he had three insulin pens, in his own possession. While this is a high-risk medication it is only by exception that insulin would be not be in the possession of the individual concerned. I will discuss this further in Section 7.

On 15 September 2020, Mental Health Occupational Therapist A completed a Mental Health Screen of Mr Ramage's records. They noted that Mr Ramage had not been admitted to hospital again since 02 June 2020, had not engaged with Community Mental Health services and that he did not require a mental health assessment. I will discuss improvements to the screening process further in Section 7.

On 16 September 2020 Mr Ramage attended a Comprehensive Committal Assessment with Nurse F where they discussed his diabetes and mental health history. Mr Ramage again denied any thoughts of self-harm and expressed regret over his previous overdose on 02 June 2020. He was issued with two new insulin pens.

[5] NIPS SPAR Evolution Committal Risk Assessment

5.2 Committal Call

Prison Service records for 15 September 2020 show that St Vincent de Paul credited £5 to Mr Ramage's Individual Prisoner Cash Account (IPC) and that he had no telephone numbers for his committal call. At 14:58 on 16 September 2020 Mr Ramage was moved to a new cell, Cell 01, on Landing 06. The fact that he had not received a committal call does not appear to have been recorded so those on his new Landing dealing with his request for telephone numbers were not aware, as far as my Investigating Officer could establish, that he had not yet had his committal call. On the same day he was moved to Foyle House, Landing 06, he requested to have his permitted telephone numbers added to his list of approved numbers.

On 17 September 2020, Mr Ramage's request for his telephone list to be set up and numbers added was approved and actioned. He did not use the telephone on this day as it was the turn of Landing 05 to have access to the telephone[6] and, as staff were unaware that he had yet to make a committal call, he does not appear to have been offered use of the telephone as an exception which would be normal practice. It would be reasonable to suggest that this may have had an impact on Mr Ramage.
The Clinical Reviewer takes the view that it is reasonable to assume that any periods of enforced isolation are likely to have a negative impact on individuals with a complex mental health history such a Mr Ramage. Isolation and the lack of a committal call could have affected Mr Ramage's wellbeing.

The fact that Mr Ramage did not have a committal call may have been an indirect result of being moved off the committal landing 24 hours after he was committed. Staff on the committal landings are experienced in working with new committals and help ease their settlement into custody. This is especially important in Foyle House where individuals were kept isolated for their quarantine period. It was even more imperative for someone like Mr Ramage given he alluded to lack of access to a committal call as a trigger for his overdose on 02 June 2020. It is unfortunate that this information did not appear to be available to staff when he was re-committed on 14 September 2020. It is not within the normal course of action to record triggers from previous self-harm events. I have previously raised this matter with both the Trust and the Prison Service and they have not been able to identify a way in which this could be achieved.

5.3 The evening of 17 September 2020

The last known interaction anyone had with Mr Ramage was at approximately 19:00 on 17 September 2020 when Prison Officer C, who was working on Landing 06, had a brief interaction with Mr Ramage at his cell door while he was receiving his evening medication from the nurse. Prison Officer C recalled at interview that Mr Ramage was very pleasant to both himself and the nurse, thanked the nurse for the medication and said he would see them in the morning. Mr Ramage did not give Prison Officer C any cause for concern when he relocked his cell door that evening.

[6] The regime at this time allowed for alternate landings to access the telephone on alternate days.

At 19:30 on 17 September 2020 the Night Custody Officers started their shift in Foyle House. Prison Service records show that on Landing 06, where Mr Ramage was, the Night Custody Officers conducted regular checks throughout the night. Night Custody Officers checked on Mr Ramage 11 times between the hours of 19:30 on Thursday 17 September 2020 and 07:00 on Friday 18 September 2020. This included two supervised checks carried out when a Senior Officer is present, as is procedure. At interview, Night Custody Officer A recalled that Mr Ramage had not given him any cause for concern.

Prison Service journals indicate that cells were checked in line with Prison Service documentation and Foyle House was staffed in line with night management levels. Operationally, there were sufficient staff available to complete the required work on the night in question.

5.4 The events of 18 September 2020

Prison Service records for Friday 18 September 2020 indicate that the first member of day staff began their shift at 07:00. The handover from the Night Custody Officer to the Prison Officer on day shift was 'nothing of note.'

At 07:30 Prison Officer D completed a headcount of Landing 06. Prison Officer D recounted his experience at interview and explained that when they checked Cell 01 they could see Mr Ramage lying in the bottom bunk. Prison Officer D believed Mr Ramage was asleep.

At approximately 08:47 Prison Officers D, C and E, who were all working on Landing 06, began the morning regime. They collected rubbish and offered hot water to anyone who wished to have it. Prison Officer D opened Cell 01 and called to Mr Ramage twice to ask him if he would like some hot water. When they received no response, Prison Officer D notified Prison Officer C who recalled that they immediately stopped what they were doing and entered the cell with Prison Officer D.

5.5 The incident response

Prison Service records indicate that Prison Officer C called Mr Ramage's name while checking for a pulse on his wrist and on his neck. At interview, Prison Officer C said that Mr Ramage was cold to the touch. They immediately contacted the Emergency Control Room (ECR) with a request to alert the Senior Officer in Foyle House and Healthcare in Prison staff. Prison Officer C also noticed two medical pens and a hand written note on the top bunk. The medical pens were later confirmed to be insulin pens belonging to Mr Ramage and both were empty.

At 08:51 Senior Officer B and Nurses A and G arrived on Landing 06 and entered Cell 01. Prison Officer C and Nurse G turned Mr Ramage onto his back and then placed him gently on the cell floor on top of a duvet. BWVC footage provides evidence of events. Those in attendance agreed that attempts to resuscitate Mr Ramage would be futile as it was clear from his appearance that he had been deceased for some time.

At 08:55, Senior Officer B notified the ECR that Mr Ramage had been found unresponsive and Prison Service staff called an ambulance.

At 09:24, paramedics arrived at the cell and recognised life extinct.

I have no concerns with the incident response and the Clinical Reviewer has raised none. Mr Ramage's family did ask me if consideration could be given to the manner in which families are informed about the death of a loved one. In this instance, policy and procedure were followed. I will continue to consider and monitor this matter as other families have also expressed concerns.

As is customary, a Post Mortem took place and the pathologist concluded that Mr Ramage's death was highly suggestive of an insulin overdose. This will be a matter for the Coroner to review at inquest.

Section 6: The impact of Covid-19 - isolation in Foyle House

In this section, I will consider the impact residing in Foyle House in isolation for 14 days may have had on Mr Ramage. I have taken a broad view of Mr Ramage's time in custody given he was in isolation in Foyle House in both June and September 2020. Mr Ramage's family asked a specific question about his time in Foyle House:

- How much time did he spend on his own in Foyle House?

6.1 Custody during the Pandemic

The *Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020* came into effect on 28 March 2020. I will refer to these as the "Regulations". The effect of the Regulations was to implement the first "lockdown" in Northern Ireland.

The purpose of the Regulations was to restrict contact between people. Within the prison, the aim was to contain the spread of the coronavirus in the interests of protecting public health. Prisons are enclosed environments where people, including staff, are in close proximity. In these circumstances, preventing the introduction of the virus into prisons was an essential element of avoiding or minimising the occurrence of infection and serious outbreaks.

The Prison Service began contingency planning for the Covid-19 pandemic in February 2020, referencing World Health Organisation guidance to assist and build resilience within the Prison Service and across prison establishments. In planning for safety, the priority concern was for measures to be put in place to contain the spread of the coronavirus and to maintain the best possible regime for the majority of the prison population.

During this time, the Prison Service Covid-19 Fusion Cell, established 11 March 2020, met daily to ensure they were able to anticipate and respond to emerging circumstances with speed. This continued until July 2020 when restrictions in society began to ease. Weekly meetings also took place with the Public Health Agency, the Trust and the Health and Social Care Board, co-chaired by the Director of Prisons and Director of Healthcare in Prison. Additionally, the Prison Service participated in the *Five Nations Covid Response Group* with the rest of the United Kingdom and Ireland.

Prison Service assessment and management of the risks posed by the virus focused on:

- promoting the health and safety of those in custody, prison staff and the wider public;
- preventing the introduction of Covid-19 into prison;
- preventing the transmission of Covid-19 within prison; and
- preventing the spread of Covid-19 from prison to the community.

Consideration of special precautions to prevent introduction of virus in community transmission scenarios.

Prison outbreaks are most likely to occur as a result of introduction of the virus from external sources, especially if there is widespread community transmission. It is therefore advised that a 14-day period of quarantine is used for all people coming into prison (new arrivals and transfers from other institutions) before they are allowed to join the general prison population (59). The same quarantining principles that are used for case contacts should be followed.

World Health Organisation guidelines.
Preparedness, prevention and control of COVID-19 in prisons and other places of detention
Interim guidance 8 February 2021

Taking account of guidance from the World Health Organisation and Public Health Agency, Maghaberry Prison activated plans already in place by introducing Foyle House Covid-19 quarantine unit, where all new committals to Maghaberry Prison were isolated for 14 days.

6.2 Foyle House during the Covid-19 Pandemic

In order to prevent widespread infection and outbreaks in prisons, the Prison Service in Northern Ireland took an early decision to isolate new committals. The purpose of isolation was to act in keeping with the duty under Article 2 of the European Convention on Human Rights to protect life by reducing the risk of exposure. As a result, at times longer periods of time in-cell were experienced across the general prison estate. In Foyle House, it meant that everyone was in their cells unless they were using the telephone or the shower. This period of isolation for all entering prison custody was for 14 days. Mr Ramage experienced this restricted regime in both June and September 2020.

Setting restrictions alongside the positive duty placed on the Prison Service to protect life, my interest is in seeing attempts to mitigate the impacts of what was required for the safety of individuals during the pandemic. For example, family contact for support is always critical for those in custody. In a time when individuals entering custody, some for the first time, were being isolated for 14 days and could be locked for around 23 hours each day without time on the landing with others in custody, I would want to see family contact as a priority. As the hours in isolation were long due to the restrictions, I would further be interested to see the measures taken to allow those who found things difficult to reach out for assistance, whether to Prison Officers, healthcare, family, friends or the Samaritans.

The 'Samaritans Phone' was available to those in Foyle House as on other landings, and both the Prison Service and Healthcare in Prison staff were available for support.

Distraction packs assisted with the longer days and nights alone in-cell, and the

opportunity to shower and use the telephone helped to break up the day. Unfortunately, time outside could not be facilitated in Foyle House largely due to the geography of Maghaberry Prison and the need to keep new committals isolated from one another. In the interests of providing a balanced regime across the prison, moving anyone a distance within the prison was not permitted. These factors resulted in the decision that there would be no provision of outside exercise. Cells in Foyle House had a radio or television and these were used for the first few days when an individual arrived into custody.

6.3 Mr Ramage's contact with family while in Foyle House

As discussed in Sections 4 and 5, Mr Ramage did not have a committal call on both occasions when he was committed into custody in Foyle House. On the second occasion he was keen to speak to his sister and arrangements were eventually made for this call.

Additionally, information that he had not received a committal call in September 2020 was not provided when Mr Ramage moved landings, although staff on Landing 06 in Foyle House answered his request to locate his sister's number, added it to his list and he was able to make the call.

I cannot overstate the importance of this contact, in particular for Mr Ramage's mental wellbeing in custody. It is very unfortunate that he experienced a lack of contact with his family at both committals. Given that Mr Ramage himself cited lack of access to a telephone as a reason that he attempted to take his own life on 02 June 2020, it is reasonable to conclude that this increased his risk from 14–18 September 2020.

Mr Ramage alluded to the conditions in his cell and lack of access to the telephone as contributing factors in relation to his suicide attempt on 02 June 2022. I therefore make the following recommendation:

Recommendation1: Committal Calls

That the Prison Service establish a robust system for ensuring that individuals in custody receive a committal call at the earliest possible time, including adequate arrangements for dealing with problems accessing telephone numbers. The Prison Service should share actions from the review with the Prisoner Ombudsman's Office when completed.

Although some improvements were evident in record keeping in Foyle House as the regime settled during the course of the pandemic, I encouraged the Prison Service to review arrangements for ensuring committal calls take place and to keep robust records. This robust recording should continue post-pandemic. I would be grateful to the Prison Service if they could inform my Office of any actions taken to improve the

system, particularly where there is difficulty accessing telephone numbers to provide those in custody with family contact and support. I am conscious of other occasions when my Office has received complaints about accessing the telephone, access to phone cards and telephone numbers.

6.4 Conditions in Foyle House as experienced by those in isolation

Mr Ramage raised concerns in relation to the conditions in Foyle House. He was not alone in raising these concerns. The IMB passed on concerns they were hearing to my Office in September 2020 and my Office received a number of complaints from individuals in custody in relation to the standard of cleanliness in Foyle House.

Some of my Investigators visited Foyle House and interviewed Foyle House staff as part of the investigation into the circumstances surrounding the death of Mr Ramage. They were interested to understand more about measures to ensure infection control and cleanliness. It was evident that there was a basic understanding of the general cleaning regime although specific details differed between interviews. It was also clear that staff were remarkably busy due to measures in place for infection control and the level of supervision required when delivering a restricted regime.

Prison Officers managed the cleaning and infection control within Foyle House and it was up to Landing staff to manage the deep cleaning of the cells between occupants with support from one Orderly. This responsibility was in addition to running the House, including offering telephone calls and showers, responding to requests from those in custody, providing their meals to them in their cells, answering emergencies and all that goes with running prison Landings. Prison Officers offered individuals in custody the opportunity to clean their own cells regularly but there were reports of some coming into cells that were not clean.

Following a number of complaints about cleanliness to my Office, I visited Foyle House to see for myself how things were being run. This allowed me to compare notes with Investigators who had visited Foyle House earlier in the Covid-19 pandemic, and it was evident that significant improvements had been made in response to the concerns I, and others, had been raising. I was particularly concerned that some of my complaints Investigators were finding that cleaning was not being recorded and therefore could not be proven. There was a similar lack of robust recording of showers and telephone calls. I am very conscious that in the early months of the Covid-19 pandemic there was a steep learning curve both inside and outside prisons and there was uncertainty as to how long restrictions would remain in place. I am satisfied that learning took place quickly and that Governor A immediately responded to ensure records were put in place to show the work Prison Officers were doing to keep Foyle House clean and safe. I am also conscious that staff were not immune to the pressures of the pandemic. Some had to isolate, some had Covid-19, and others, as across society, experienced an emotional weight from the circumstances of that time.

6.5 The impact of isolation on Mr Ramage

In the course of this investigation and of a number of investigations from complainants residing in Foyle House, I have found that the Prison Service and the Trust continually sought improvement to conditions there. Examples of this include improvements to the frequency and quality of cleaning and infection control, recording measures to ensure safety, the provision of activity packs and reading materials for those in isolation, as well as the introduction of virtual visits.

It is important to consider that when Mr Ramage returned to Maghaberry Prison on 14 September 2020, he was familiar with the regime in Foyle House and would have known that he would be isolated for 14 days prior to moving to the committal house.

Nevertheless, it is likely that Mr Ramage experienced some impact from being in isolation not once but twice. Any impacts he experienced are likely to have been compounded by the fact that he had been waiting for a mental health appointment in the community from his release in July 2020 and he had not received support by the time he returned to custody in September 2020.

Mr Ramage's family asked a question about his care in Foyle House, as they were particularly concerned about how much time he may have spent on his own. As described here, Foyle House quarantine unit was set up in response to the Covid-19 pandemic 2020-2022. It ran a restricted regime to reduce the risk of infection in the main population of the prison. Individuals were required to spend their first 14 days in custody[7] in their cells in Foyle House. All cells had single occupancy and at the time of Mr Ramage's death individuals in custody in Foyle House could expect to leave their cell for a shower and to use the telephone on alternate days. Mr Ramage would have spent a considerable amount of time alone during his final period of custody although it is not possible to provide a definitive answer.

Given the delay with community mental health appointments and the length of time Mr Ramage spent on his own during his first 14 days in custody, the standard of risk and healthcare assessments was critical. I will examine these assessments in the following section and consider if Mr Ramage's time in custody in June 2020 and events during that time were taken into account in those assessments.

[7] As pandemic isolation measures across society began to be more permanently relaxed, in 2022 the length of time in isolation was reduced to 10 days.

Section 7: Healthcare provision for Mr Ramage

7.1 Healthcare in Prison

The Trust is responsible for delivering prison healthcare services, known as Healthcare in Prison staff. During the pandemic, Healthcare in Prison staff, like Prison Officers, faced significant challenges as they came and went from prisons, concerned that they would not transmit the virus or be infected by it.

For someone like Mr Ramage, who had a number of health issues including insulin-dependent diabetes, healthcare support was essential. As referenced in Sections 4 and 5, Mr Ramage's medication was prescribed appropriately and he was supported by risk and healthcare assessments. Given the revised and reduced regime during the pandemic, I will consider if there were any repercussions for healthcare provision.
Specifically I am interested in how Mr Ramage's withdrawal from opioids was managed (OST) and in how his insulin was provided to him. Mr Ramage's family asked some questions, outlined below, about his healthcare that I will address in this section:

- Was his mental and physical health properly assessed on committal and was he seen by a mental health specialist?
- Was Mr Ramage in possession of his own insulin and was this appropriate for someone with his history?
- Was Mr Ramage supervised in relation to his medication?
- Was Mr Ramage's overdose of 02 June 2020 considered in relation to his care?
- Were staff aware of his history of poor mental health?
- Should Mr Ramage have been on 'suicide watch' given his history of overdose?

7.2 At-risk and wellbeing assessments

When Mr Ramage returned to custody on 14 September 2020, he was assessed as being at 'No Apparent Risk.' I have confirmed that the Senior Officer who conducted the assessment was aware of Mr Ramage's previous period in custody and of events leading to him being taken to hospital.

Records of the Risk Assessment show discussions took place about Mr Ramage's overdose three months previously. The record shows "when asked directly, no current thoughts of suicide or self-harm. States he can guarantee safety and is regretful of previous actions". Documentation notes several times that Mr Ramage emphatically denied thoughts of suicide or self-harm and this was revisited and confirmed.

The Clinical Reviewer commented whilst past suicidality is key to assessing current risk, the immediate presentation of the individual is also very important. Mr Ramage did not report previous instances of self-harm and he was adamant he was not

experiencing thoughts of self-harm. I am satisfied that the Risk Assessment concluded appropriately. I also highlight there is nothing in the records to suggest Mr Ramage lacked the capacity to understand the importance of accurately disclosing his medical history.

Mr Ramage was then assessed by Healthcare in Prison staff, firstly at his Initial Healthcare Assessment on 14 September 2020. Records of that assessment discussion note his diabetes, and he was recorded as having three insulin pens as prescribed, not full, that he kept in his cell with him overnight. Records show that Mr Ramage empathetically denied any thoughts of suicide or self-harm and that he was regretful of his previous actions. Nurse A completed a Contingency In-Possession Risk Assessment[8] that indicated Mr Ramage required supervised administration of his tablet medication. The Clinical Reviewer viewed the content and detail of this Initial Healthcare Assessment as consistent with policy, guidance and standard expectations. It also appropriately took account of Mr Ramage's frequently expressed desire to manage his diabetes.

The In-possession Risk Assessment correctly identified Mr Ramage should not be given general or high-risk medications in possession due to his overdose history. It is standard practice for insulin to be omitted from this restriction due to the very high risk associated with not being able to access insulin when required. Should insulin not be available when required there is the potential for hyperglycemia leading to diabetic coma, a life-threatening complication if not treated immediately.

A Mental Health Screen followed the Initial Healthcare Assessment on 15 September 2020. Mental Health Occupational Therapist A concluded no referral was required. This has been significantly improved and all individuals now have a face-to-face Mental Health Triage on committal into custody. This undoubtedly provides a better approach to assessing an individual's mental health than any desktop exercise could. I commend this development.

On 16 September 2020, Mr Ramage attended a Comprehensive Committal Assessment, carried out by Nurse F. The Assessment Interview included discussion about all previous areas covered including his diabetes, mental health, and any thoughts of self-harm and the previous attempt at self-harm while he was in custody. He was given his insulin pens.

It is unclear whether anyone from the mental or primary healthcare team discussed how the specific events leading to his committal to prison were affecting his mental health. Guidance does provide that such discussions should take place in relation to some crimes, specifically murder, manslaughter, offences against the person and sexual crimes. While it is not the role of Healthcare in Prison staff to discuss why someone has arrived into custody it is important that opportunities are given for discussion of anything that could weigh on an individual's mind. It is my view, therefore, that the Trust should consider how they could improve reflective conversations with those in

[8] Contingency In-Possession Risk Assessments were introduced for the administration of medication in Maghaberry Prison when there are decreased primary care nursing staff levels.

their care, along with improving how they record any impacts that being charged with a crime may have on that individual's mental health.
Such records provide a tool for others to build on and to develop greater insights into the needs of those in prison custody. I therefore recommend:

Recommendation 2: Healthcare in Prison Committal Procedures

That the Trust consider how they can improve reflective conversation with individuals coming into custody about what, if any impact the crime they are charged with may have on their mental health; and also, how recording of such conversations can be improved.

Mr Ramage's family wanted to know if Mr Ramage should have been on a SPAR Evo care plan, which would mean he was evidently at risk of self-harm or suicide. They were particularly concerned given his previous history. I have explained the Clinical Reviewer's position regarding previous suicidality being key to any assessment and that this is set alongside how the individual is presenting. Mr Ramage consistently presented as regretful of his previous actions and aware of what the impact had been on his family. In the days and hours before his death, Prison Officers report that there were no reasons for concern that would have invoked protective action on their part and they were aware of his previous history. In light of these concerns raised by the family and in light of their concern that he was properly assessed on committal by a mental health specialist, I asked the Clinical Reviewer to provide an overall opinion. She examined the relevant healthcare records and concluded that suitably qualified healthcare professionals, within the required timescales, completed Mr Ramage's committal assessments. She also concluded that medical information was appropriately gathered during assessments and that there was nothing to suggest that Mr Ramage lacked the capacity to understand the importance of accurately reporting his medical history.

Prescribed community medicines were confirmed and checked on the Electronic Care Record, as per best practice and policy guidance, and there were no delays. When medication was required to be re-prescribed this took place effectively and in a timely manner. Mr Ramage was referred to the mental health team for triage appropriately.

During assessments, Mr Ramage was asked directly about his mood and suicidality and he stated clearly that he was not experiencing thoughts of suicide or self-harm. The Clinical Reviewer considered the content and detail of the initial screening assessment to establish if it was consistent with policy, guidance and standards. She also examined whether these assessments took account of Mr Ramage's frequently expressed desire to manage his own diabetes medication.

7.3 Insulin dependence and medication

When Mr Ramage was in custody in June 2020, he was assessed as being sufficiently at risk to require his insulin to be administered by medical staff rather than in his possession. This caused him distress and the Clinical Reviewer commented in her report that 'withholding insulin would only ever be considered in the most extreme circumstances.' She also noted that it is standard practice to exempt insulin from in-

possession risk assessments due to the risk presented by not having insulin immediately to hand. There is a significant risk to life when insulin is not quickly accessible when required. She agreed that withholding Mr Ramage's insulin was proportionate in June 2020 given his recent history.

On return to custody and isolation in Foyle House in September 2020 Mr Ramage was assessed as being able to self-administer his insulin. His family want clarification about whether his previous mental health history was taken into account, particularly his previous attempt at self-harm while in custody in June 2020.

When an individual returns to custody previous records are available. In Mr Ramage's case, given the information I have provided above about staffing and their interview accounts of their knowledge of events during his previous time in custody, it would be surprising if his overdose had not informed his care. Records of the conversations that took place at each of his assessments clearly record discussions about his previous overdose in June 2020. These conversations formed a key part of his risk assessment on 14 September 2020 in relation to his in-possession medication.

The Clinical Reviewer found the in-possession risk assessment policy and process are appropriate in an effort to balance the security risk of misuse of medicines with overall safety and patient autonomy. However, it is challenging to balance patient safety and personal autonomy to support individuals to manage their health as if they would in the community when they are in fact in custody. The Trust's policy adequately groups medicines to varying levels of risk and differing amounts of medication are given in possession according to those guidelines. A supplementary policy was in place during the Covid-19 pandemic to further manage the additional risk of patients being unable to access essential medicines due to unavoidable imposed restrictions. However, the policy and assessment appear to have been properly applied in Mr Ramage's case.

Records suggest that Mr Ramage's community OST was confirmed without delay by his community pharmacy, who reported that Mr Ramage had collected three x 16mg OST doses on 29 May 2020 prior to committal. When Mr Ramage spoke to the nurse on arrival in prison at 18:40 on 01 June 2020 he confirmed to her that he had had his dose for that day. The Clinical Reviewer comments in her report that it is not unusual for OST medication to be issued 'day in hand' in order to allow for patient autonomy in terms of dosing times and that ongoing OST 16mg daily of Suboxone was prescribed by the doctor from 02 June 2020; the first morning after arrival based on this declaration. It appears that Mr Ramage had not missed any OST doses and she would therefore not expect him to be experiencing any adverse effects caused by opiate withdrawal.

In addition, it is important to recognise medication such as Suboxone is active in the body at its full potential for 24 to 48 hours when dosed regularly over a period of time and it would be highly unlikely for a patient to experience any distressing opiate withdrawal symptoms for several days even if doses were missed. It is normal for patients to begin to experience symptoms no sooner than the second, third or even fourth missed dose.

The Clinical Reviewer found that Mr Ramage was not a resident at Maghaberry Prison long enough to have qualified for specialist input and education with regard to Long-Term Conditions. In Mr Ramage's case this is a reference to his diabetes. However, it is reasonable to assume that given the duration of Mr Ramage's diabetes, and his contact in the community with a specialist diabetes nurse, that he would have received the appropriate education relating to his condition and medicines management as recommended in diabetes guidance prior to committal.

For maximum effect, on 15 September 2020 Mr Ramage was prescribed a combination therapy involving oral biguanide medication (metformin) and three different insulin pens used at different times of the day depending on the outcome of blood glucose monitoring.

I am satisfied, from the evidence supplied to me that Mr Ramage's overdose history was taken account of in terms of risk assessment for in-possession medications, and his autonomy and experience at self-management of his diabetes in the community were also respected. I understand that it remains best practice to allow patients to self-manage insulin administration as the risks associated with failure to administer the required insulin doses are more likely to occur and are as great in terms of consequence as the likelihood of overdose even with an individual who has a history of overdose such as Mr Ramage.

Suicide is impossible to predict accurately and whilst there are validated tools for identifying levels of risk, ultimately the only tools available when assessing current suicidal ideation are client self-disclosure and objective presentation. The process has to account for human self-determination whereby an individual may choose not to disclose key information, thoughts and feelings if they do not wish to be deterred from ending their own life. Self-disclosure, whilst unreliable, is important. Objective assessment of presentation was documented during each encounter.

When Mr Ramage returned to custody in September 2020 he clearly expressed regret on a number of occasions at risk assessment interviews that he had previously attempted to self-harm. The Clinical Reviewer found that it was 'a reasonable decision' to allow Mr Ramage to administer his own insulin given how he was presenting and that he was an experienced manager of his own insulin for over 30 years. It is understandable that Mr Ramage's family have asked about the appropriateness of this decision and it is undoubtedly the case that there is a careful balance to be struck given the anxiety Mr Ramage experienced when he was not managing his own insulin. The Clinical Reviewer considered this balance and concluded:

All documented interactions with primary care nurses clearly feature discussion about diabetes self-care and direct challenge regarding suicidality relating to overdose. Mr Ramage had been observed during the process of self-administration to ensure safety and had been suitably assessed in regard to diabetic self-management and insulin dosing. It was clear from previous mental health interventions that Mr Ramage's anxiety was triggered intensely if he was not able to have autonomy over his routine insulin administration.

Annie Dale RNMH ANP

Mr Ramage's family were also keen to know whether staff were aware of his history of poor mental health. The degree to which Prison Officers are aware of an individual in custody's medical history and contact with healthcare depends largely on whether or not they have had previous contact with the individual. While there may be some exchange of information between Healthcare in Prison staff and Prison Service staff and while the individual in custody themselves passes on information, it is unclear to me whether there are other appropriately robust mechanisms for sharing information that families consistently expect will be shared.

To answer the question positively to provide some confidence for Mr Ramage's family, I can confirm that Prison Officers attached to Foyle House seemed to remain with Foyle House over many months and they would, therefore, have had knowledge of Mr Ramage and his previous time in custody in June 2020. When interviewed a number of Prison Service staff who worked on the landings in Foyle House shared their knowledge of events in June 2020. All recalled Mr Ramage as pleasant and polite and one Prison Officer recalled how he thanked him for raising the alarm after discovering him unresponsive on 02 June 2020.

At the same time, it is important to be clear that Prison Service staff would not have had access to Mr Ramage's medical records. As is appropriate for the privacy of individuals in custody they would not, therefore, have been aware of the specific details of his mental health history. They would have been aware of what he had told them at his committal interviews. For example, the Senior Officer who carried out the committal assessment for Mr Ramage was aware of his previous attempt to self-harm. Nevertheless, sharing healthcare information remains of concern to me given that Prison Officers are responsible for the safety of individuals in custody yet they may not be in possession of information that would assist them.

Regardless of how information is shared, in all his interactions with Healthcare in Prison staff Mr Ramage's mental health history was discussed and recorded. The Clinical Reviewer cited the number of conversations that took place with Mr Ramage about his previous overdose in June 2020 as an example of good practice. Mr Ramage consistently said how much he regretted his actions and he felt he had let his family down. Despite Prison Officers not being aware of Mr Ramage's detailed mental health history, every opportunity was taken to discuss his emotional wellbeing, his intentions and his previous attempt at self-harm. I hope this provides some comfort to his family.

7.4 The standard of healthcare provided

The Clinical Reviewer concluded that the care Mr Ramage received in Maghaberry Prison was to standard and could be considered as equivalent to, or of equal standard to, that provided in the wider community:

In the round, this episode of care was good; compliant with policy and guidelines and equitable to community service provision, with Mr Ramage being encouraged to disclose any thoughts of suicide and self-harm at each healthcare encounter.

Annie Dale RNMH ANP

From records examined, it certainly appears that there was a good rapport between staff and Mr Ramage and that his treatment was friendly, dignified and thorough.
The fact that his overdose of 02 June 2020 was discussed openly and on a number of occasions allowed assessments to be carefully made and gave Mr Ramage opportunity to say how much he regretted his actions. I am satisfied that his mental state and thoughts of self-harm were discussed and challenged at each relevant encounter. I am also satisfied with the standard of healthcare received by Mr Ramage.

PART B: LEARNING FOR IMPROVEMENT

Section 8: Learning and Good Practice

8.1 Information Sharing

In my report, I have explained that staff at Foyle House had consistently been there over months and were aware of Mr Ramage previously being in custody. They were aware that events had taken place that led to him going to hospital. What is not clear to me is the degree to which Prison Officers were aware of the nature of that incident, that it was a significant incident of self-harm which could have had dire consequences or that they were aware Mr Ramage's medication was a 'high-risk' medication. I encourage the Prison Service and Healthcare in Prison to consider how better to share information to protect individuals in their care.

8.2 The importance of family contact

I have made a recommendation regarding committal calls to encourage Prison Officers to ensure numbers, which may be available but not accessible to the individual in custody, are accessed and their committal call made. It is necessary to emphasise the role that family or other support contact plays in keeping individuals in custody safe and assisting with their rehabilitation. I encourage the Prison Service and the Trust to ensure their staff are fully aware of the Mandela Rules, specifically Rule 58, including the intention behind the rule that, in this case, is to ensure that those in custody are not cut off from the outside world.
Those who deal with individuals in the first few days of custody will be conscious of the impact those early days can have on the individual's health and wellbeing. The support provided by a committal call is a critical aspect of ensuring safety in those early days. There were, however, challenges at times given the impact the Covid-19 pandemic was having.

8.3 Engagement with Mr Ramage

The Clinical Reviewer notes that 'all interactions with Mr Ramage were friendly, dignified and thorough.' Conversations with a level of rapport built on empathy provide a 'safe space' for individuals like Mr Ramage and in his case it provided an opportunity for him to share his regret about the incident of self-harm in June 2020. In turn, this enabled staff to make assessments based on good information. I commend this approach and express appreciation to staff for it.

8.4 Approach to risk and healthcare assessments

Mr Ramage was released from custody in June 2020 and he returned in September 2020. While initial assessments meet Mandela Rules and National Institute for Health and Care Excellence [9] Guideline standards where there is an emphasis on exploring the impact of the offences committed by those coming into custody, it is not clear that any mental health impact of his return to custody was fully explored. The Clinical Reviewer examined records and commended staff for the manner in which they considered risk and respected Mr Ramage's autonomy and experience at self-management of his diabetes. However, she also comments:

"I feel there could have been more discussion from a mental health perspective about the events which precipitated Mr Ramage's recall to prison, focusing on how this was affecting his mental state."

As I noted above, this may have been a matter of omission in record keeping or it may not have happened, as it is not specifically mandated, although the Clinical Reviewer, rightly in my view, is of the opinion that conversations such as these about the impact of a crime should take place. It is important to note that the Clinical Reviewer's work generally provides her with an awareness of how different offences can make an impression on mental health in particular. In an ideal world, those carrying out assessments would be well versed in how different types of offences can have an effect on individuals coming into custody. I have made a recommendation for improvement in Section 7.2 above.

[9] National Institute for Health and Care Excellence standards apply to the standard of healthcare provided and the Nelson Mandela Rules set out United Nations adopted standards for the care of those in prison custody

Section 9: Conclusions

1.	Establish the circumstances and events surrounding Mr Ramage's death, including the care provided by the Prison Service;
	I have explored the circumstances and events surrounding Mr Ramage's death in Sections 4 and 5 and have made one recommendation.
2.	Examine any relevant healthcare issues and assess the clinical care provided by the Trust, specifically the handling of decisions regarding Mr Ramage's management of his own medication;
	I address these matters in Section 7 of this report.
3.	Examine whether any changes in Prison Service or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future;
	I have made one recommendation at Section 7 which may affect Prison Service operational methods and identified some learning in Part B of my report.
4.	Ensure Mr Ramage's family has an opportunity to raise any concerns they may have and take these into account in the investigation;
	I have addressed questions raised with me by Mr Ramage's family throughout my report. Appendix 3 lists these questions.
5.	Consider the impact of the Covid-19 pandemic and Foyle House quarantine unit on Mr Ramage's wellbeing and care;
	I have considered the impact of the Covid-19 pandemic, in particular of measures in place that required those coming into custody to isolate in Foyle House for 14 days, in Section 6 of my report.

6.	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.
	This report provides a detailed analysis of the circumstances surrounding Mr Ramage's death and a copy of this investigation report, along with all supporting documentation, will be shared with the Coroner.

My Office will fulfil this duty by making full disclosure of materials to the Coroner.

Appendix 1: Terms of Reference for Prisoner Ombudsman investigations into Deaths in Custody

1. The Prisoner Ombudsman (the Ombudsman) will investigate the circumstances of the deaths of the following categories of person:

   - Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently.

However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.

2. The Ombudsman will act on notification of a death from the Prison Service.

   - The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

   - establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors;

   - examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence;

   - in conjunction with the Department of Health Social Services and Public Safety, replaced with South Eastern Health and Social Care Trust as the healthcare provider in prisons where appropriate, examine relevant health issues and assess clinical care; provide explanations and insight for the bereaved relatives; and

   - assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising 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 action or practice is identified, and any lessons from the death are learned.

4. Within this framework, the Ombudsman will set Terms of Reference for each

investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph one where a common factor is suggested.

Appendix 2: Terms of Reference for a clinical review of healthcare in the case of Mr Ramage

I asked the Clinical Reviewer to review the medical, healthcare and other records, to consider a number of questions and produce a report with recommendations giving expert clinical opinion. I asked the Clinical Reviewer to address the following questions:

1. Was Mr Ramage's mental and physical health appropriately assessed on committal both in June and September 2020?

2. In the opinion of the Clinical Reviewer, was Mr Ramage adequately monitored by primary healthcare on 01 and 02 June 2020 in relation to withdrawal from his Opioid Substitution Therapy? What impact did this have, if any, in relation to Mr Ramage's mental health and suicidal ideation, in relation to his attempt to complete suicide on 02 June 2020? Please also consider and give an opinion on if there was any further risk of suicidal ideation with Mr Ramage being in isolation and not receiving a committal telephone call, in addition to withdrawing from Opioid Substitution Therapy.

3. In the opinion of the Clinical Reviewer, to what extent did the Covid-19 pandemic impact on Mr Ramage's primary and mental health care during both periods of custody? And what impact, if any, could 14 days of isolation have had on someone with Mr Ramage's mental health history?

4. In the opinion of the Clinical Reviewer, was the In-Possession Medication Risk Assessment completed on 14 September 2020 to an adequate standard, and were previous relevant risk factors considered in this decision-making, bearing in mind Mr Ramage's previous overdose on 02 June 2020 and the In-Possession Medication Risk Assessment completed on his return from hospital 07 June 2020?

5. In the opinion of the Clinical Reviewer, is the In-Possession Medication Risk Assessment process that was in place at the time of Mr Ramage's periods of custody of an adequate standard for someone with Mr Ramage's mental health history, the 14 day isolation period and in relation to the actual medication he was prescribed?

6. Mr Ramage had a long history of overdose and had previously attempted suicide in custody on 02 June 2020, by overdosing on prescription medication. In the opinion of the Clinical Reviewer, would it have been more be beneficial to Mr Ramage, considering his mental health and history of attempted overdose, to have his insulin in possession or not in possession?

7. In the opinion of the Clinical Reviewer, was Mr Ramage in possession of enough

insulin on 18 September 2020 to fatally overdose? Please also provide exact detail on how a fatal overdose with insulin happens within the body, how long it would take to cause death and how long it would take for rigor mortis to set in.

8. In the opinion of the Clinical Reviewer how effective is the Self-Harm and Suicide Prevention Policy 2011 (updated 2013) and Suicide and Self-Harm Risk Management – SPAR Evolution in managing someone with Mr Ramage's mental health history and addressing identified root causes throughout any future periods of custody, bearing in mind the reliance on self-disclosure?

9. In the opinion of the Clinical Reviewer was the primary healthcare Mr Ramage received whilst he was in Maghaberry Prison equivalent to what he would have received in the community? (Diabetes and mental health).

10. Any shortcomings in care or service provision you observe.

11. Any examples of good practice.

12. Any learning opportunities and recommendations identified for future practice.

13. Any other observations relevant to Mr Ramage's case.

Appendix 3: Questions asked by Mr Ramage's family

The Ombudsman's Terms of Reference for investigation of deaths in custody requires that any question's next of kin ask are taken into consideration. The Ombudsman meets families to hear directly from them and having listened to their questions crafts objectives for each individual investigation to respond to those questions. During the course of an investigation, the Ombudsman may meet with families to answer their questions more directly and to avoid delay in providing them information that may bring some comfort to them.

Mr Ramage died during the early months of the Covid-19 pandemic when Government Guidelines restricted face-to-face meetings. I am grateful to Mr Ramage's family for meeting with me by telephone and, while it was not ideal, it gave me the opportunity to listen to them. I agreed to consider the following questions during my investigation:

1. Was Mr Ramage's mental and physical health properly assessed on committal and was he seen by a mental health specialist?
2. Were Prison Service staff aware of Mr Ramage's history of poor mental health?
3. Was Mr Ramage's overdose of 02 June 2020 considered when planning his care in Maghaberry Prison?
4. Why Mr Ramage was in possession of his own insulin and was this appropriate for someone with his history? Was Mr Ramage being supervised in relation to his medication?
5. Should Mr Ramage have been on "suicide watch" given his history of overdose?
6. How much time did Mr Ramage spend on his own in Maghaberry Prison?
7. Can consideration be given to how families are notified of a death?

Appendix 4: Timeline of events

01 June 2020	
16:15	Committal Risk Assessment completed. Mr Ramage found not to be at risk of self-harm or suicide.
18:22	Initial Healthcare Assessment completed.
02 June 2020	
11:56	Mental Health Screen (desktop exercise) complete.
17:50	Mr Ramage found unresponsive by landing staff in his cell.
18:21	Ambulance at scene. Mr Ramage was transferred to hospital.
07 June 2020	
16:00	Mr Ramage returns to Maghaberry Prison.
18 June 2020	
11:46	Mental Health Assessment completed.
17 July 2020	
	Released from custody.
14 September 2020	
14:58	Mr Ramage returns to Maghaberry Prison and is housed in Foyle House.
16:36	Committal Risk Assessment completed. Mr Ramage found not to be at risk of self-harm or suicide.

15 September 2020	
08:53	Initial Healthcare Assessment completed. Contingency Risk Assessment completed and found Mr Ramage to be unsuitable for in possession tablets. He was permitted to keep his insulin in cell.
14:39	Mental Health Screen completed (desk top exercise)
14:58	Cell move from Landing 01 to Landing 06.
16 September 2020	
N/K	Request for telephone numbers.
17:35	Comprehensive Committal Assessment completed.
17 September 2020	
N/K	Request for telephone numbers granted and complete.
11:40	Lunch meal to house.
16:05	Evening meal to house.
18:35	Hot water and breakfast packs to landing.
19:30	Night Guard on post.
21:10	Supervised landing check.
23:30	Landing check.
18 September 2020	
00:30	Landing check.
01:30	Landing check.
02:00	Supervised landing check.
02:30	Landing check.

03:31	Landing check.
04:30	Body check.
05:30	Landing check.
06:30	Landing check.
07:00	Alarms / Final safety check.
07:30	Day staff on post and headcount of Landing 06 completed.
08:47	Mr Ramage found to be unresponsive by Landing staff.
08:51	Medics arrive on scene.
08:55	Ambulance tasked.
09:20	Paramedics arrive at scene.
09:24	Paramedics declare recognition of life extinct.