The Prisoner Ombudsman for Northern Ireland

SUMMARY INVESTIGATION REPORT

INTO A SERIOUS ADVERSE INCIDENT AT MAGHABERRY PRISON – SEPTEMBER 2022

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The Role of the Prisoner Ombudsman

On 02 October 2022 the Director of Prisons invited the Office of the Prisoner Ombudsman to conduct an investigation into the circumstances surrounding a serious adverse incident which occurred on 23 September 2022. This was in accordance with The Northern Ireland Prison Service (NIPS) Suicide and Self-Harm Prevention Policy 2011[1].

The Prisoner Ombudsman for Northern Ireland has discretion to respond to requests from NIPS to investigate serious adverse incidents as per the Justice Act NI (2016) Part 2, para 39. This is the basis on which this investigation was conducted.

Serious Adverse Incident Investigation

During transfer from Antrim Court to Maghaberry Prison on 23 September 2022, the prisoner put his seatbelt round his neck in his cell within the escort van. Prison Service escort staff observed the prisoner with the ligature, stopped the vehicle and tried to get the prisoner's attention at the cell door. As he was initially unresponsive the officers opened the cell, roused the prisoner, removed the seatbelt and relocated the prisoner to the observation cell in the van for the remainder of the journey. On arrival at Maghaberry Prison, Healthcare in Prison (HiP) nurses attended the prisoner and called for an ambulance. The prisoner was transferred to outside hospital by the Northern Ireland Ambulance Service (NIAS).

At the time the investigation was initiated, the prisoner had returned to Maghaberry Prison having received overnight care at hospital. The purpose of the Prisoner Ombudsman's investigation was to find out, as far as possible, what happened and

[1] Northern Ireland Prison Service policy states: 'Generally, all cases involving serious self-harm and death in custody will be reviewed internally by NIPS or externally by the Prisoner Ombudsman, as appropriate. However, an investigation by an independent agency or agency may be required where a prisoner self-harms to the point where:
• without *immediate* intervention the prisoner would have died;
• as a result of the incident the prisoner has suffered permanent or long-term serious injury; and
• as a consequence of the long-term injuries sustained the individual's ability to know, investigate, assess and/or take action in relation to the circumstances of the incident has been significantly affected'.

why, establish whether there are any lessons to be learned and make recommendations to the Northern Ireland Prison Service (NIPS) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

Investigation Objectives

The objectives of this investigation were to:

- establish the circumstances which led to the prisoner being found unresponsive in the van on 23 September 2022, including the care provided by NIPS, the Trust and any other relevant contributory factors;
- examine any relevant health and clinical issues;
- highlight good practice;
- identify learning points; and
- examine whether any operational methods, policy, practice or management arrangements require improvement.

Prisoner history

Previous committal in Maghaberry Prison 30 July 2022 – 16 September 2022

The prisoner had spent time in prison on eight occasions over the previous eight years. During his most recent custody prior to this incident, he received a mental health triage on 09 August 2022 and was allocated for a routine mental health assessment. His case was discussed by the Multi-Disciplinary Team (MDT) and he was allocated a key worker. The prisoner had a mental health assessment on 23 August 2022, the outcome directed that he would be reviewed and supported by the mental health team while he was in Maghaberry Prison. That custody came to an end on 16 September 2022 when the prisoner was released on bail on and discharged back to Community Mental Health Team (CMHT) on 22 September 2022.

Events on the day of the incident 23 September 2022

On the morning of 23 September 2022 the Prisoner was brought by PSNI officers to Antrim Court for a virtual hearing of Laganside Court where the prisoner was remanded into custody.

The Prisoner Escort and Court Custody Services (PECCS) Prisoner Custody Officers (PCOs) of NIPS took responsibility for the prisoner's transfer to Maghaberry Prison. PECCS PCOs carried out a risk assessment on the prisoner who, despite a history of mental health issues, presented with no concerns during his time at Antrim Court. This investigation confirmed this assessment was matched by the earlier assessment of the PSNI officers who had escorted the prisoner to court.

PCO A driving and PCO B in the rear of the vehicle observing CCTV live footage of vehicle passengers left Antrim Courthouse in the PECCS van at around 16:05. The van held two prisoners who were under observation in their respective individual cells.

Overview of the incident and response

During the journey back to Maghaberry Prison at 16:28 PCO B observed on the in-cell CCTV monitor the prisoner had put the seatbelt around his neck. The staff immediately stopped the van and, after trying to get a response from the prisoner, opened his cell to engage with him and check his pulse, finding only a faint response. The officers talked to the prisoner and provided him with water.

At 16:35 the officers escorted the prisoner to the observation cell in the van to facilitate a direct watch by PCO B at close distance. They notified base staff at Maghaberry Prison of the situation and their actions. Both PCO A and PCO B confirmed that, at this time, the prisoner was responsive, was able to walk to the observation cell with a little assistance and was able to drink from the bottle of water they had provided him. This is observed on the CCTV footage from the van.

The van returned to the road towards prison at 16:38 with the prisoner remaining under constant observation for the remainder of the journey. On approach to the prison PCO B noticed the prisoner had become unresponsive and was slumped in his seat. The van arrived at Maghaberry Prison's external gate at 16:48 and entered the airlock at 16:50.

PCO's A and B along with SO A, Custody Prison Officer (CPO) A and CPO B continued to attend to the prisoner until relieved by healthcare staff.

At 16:55 HiP Sister A was the first nursing responder on the scene after the radio call for assistance, arriving with two other nursing staff. She reported being immediately concerned by the colour of the prisoner and his presentation. She asked NIPS staff

to remove him from the van to the ground outside in the airlock to allow sufficient space to administer treatment. Sister A asked for an urgent ambulance to be called[2] as she and the other nursing staff present continued to work on the prisoner. The prisoner became responsive again and, in the view of Sister A, the prisoner had been very close to cardiac arrest.

As part of their emergency response, HiP staff considered the prisoner may have been unresponsive due to ingesting a substance rather than being caused solely by the seat belt ligature. On that assumption, Naloxone was administered. While not harmful, when reviewing the case retrospectively, HiP found this may not have been appropriate.

NIAS paramedics arrived at the scene at 17:20 and took over treatment of the prisoner before transferring him by trolley to the ambulance and onward towards hospital.

After recovery in hospital, the prisoner was returned to Maghaberry Prison the following morning and placed on a SPAR Evo[3] care plan with 15-minute observations, given anti-ligature clothing and placed in an observation cell. Two officers met with him in his cell on the afternoon of 24 September 2022 and recorded a positive conversation in which the prisoner "*made us aware that he regrets making that attempt and is grateful that staff and healthcare assisted him*". His observations were reduced to 30-minute and arrangements were made to move him to a standard cell and he was recorded to be "*happy with this*".

On 25 September 2022, the prisoner completed the prison committal process and it is recorded that "*he engaged well answering all questions fully and maintaining eye contact. States he never wanted to die when he put seatbelt around the neck and it was frustration at coming back into custody, appears more settled and is forward planning in trying to obtain a new bail address so he can be released*". In a care plan review on 26 September 2022 the prisoner was referred to a Mental Health Practitioner (MHP). His care plan was closed in line with the SPAR Evo process with full agreement from the prisoner, prison staff and the HiP MHP.

[2] In line with a previous recommendation of this Office and as of latest guidelines (*NIPS Suicide and Seld Harm Prevention – Standard Operating Procedures, August 2025*) "*staff should not wait for HiP attendance before requesting an ambulance*".

[3] Supporting People at Risk Evolution (SPAR Evo) was jointly developed by NIPS/SEHSCT in 2018 and was signed off by both organisations in April 2019. The approach is person-centred and aims to support people through a period of crisis or distress in a way that meets their needs.

On 03 October 2022 the prisoner was seen by his MHP for mental health triage. The prisoner admitted to a drug addiction to pregabalin and a referral to Alcohol and Drugs: Empowering People Through Therapy (AD:EPT) was completed.

He was sentenced on 18 October 2022 and released due to Time Served on 02 November 2022 without further incident. In contrast to his previous release, on this occasion there was no referral for the prisoner to the Community Mental Health Team.

A summary timeline of events is at Annex 1.

Healthcare in Prison Incident Report

As per the Trust's process, in the aftermath of this serious adverse incident, HiP undertook their internal review in the form of a Local Significant Incident Review (LSIR) under the Lead Nurse HMP Maghaberry Prison as the Lead Reviewer supported by HiP's Mental Health Team Leader.

The HiP review identified eight aspects of the prisoner's care during this custody that did not go so well and made recommendations for nine follow up actions to address the learnings identified. All learnings have been actioned.

This investigation noted in particular it was found:

- The use of Naloxone administered by HiP staff during the emergency response – on the assumption that the prisoner had ingested drugs to explain his lack of consciousness – may not have been appropriate.
    - HiP nursing staff have since been provided with awareness training on their new Naloxone Algorithm.
- "*Contrary to HiP MH process, [the prisoner] was not referred to community mental health services on discharge despite having had a recent serious self-harm incident occurring and being previously known to the service*".

Conclusion

This case is notable as the critical events all took place within approximately one-hour before the prisoner was committed into prison. As such, it serves to highlight the importance of professional care from prisoners' first engagement with NIPS staff.

Having thoroughly examined the circumstances of this incident, this investigation did not find any action, or lack of action, by NIPS or the Trust which directly contributed to this prisoner self-harming.

As there were no indications that the prisoner was at imminent risk of self-harm, I am content that Prison Service PECCS officers involved acted in line with good practice in assessing, caring for, and responding to, the prisoner when in van custody between Antrim Court and Maghaberry Prison.

Moreover, I would like to thank all NIPS and HiP staff involved for the response taken in relation to this incident which resulted in a prisoner's life being saved without long-term harm.

From a healthcare perspective, the Trust's practice in rigorously and transparently identifying areas of learning is a healthy indicator of an organisation that promotes openness and continuous learning. I am satisfied that the Trust targeted appropriate follow up actions to address the learnings identified in this case.

I would like to thank all those who contributed to the preparation of this report.

Darrin Jones
Prisoner Ombudsman for Northern Ireland
12 November 2025

Annex 1

Timeline		
Date	**Time**	**Notes**
30/07/2022		Start of the prisoner's most recent committal prior to this one.
09/08/2022		He received a mental health triage and was allocated for a routine mental health assessment. The MDT allocated a key worker to the prisoner.
23/08/2022		The prisoner had his mental health assessment. The outcome of the assessment was he would be reviewed and supported by the mental health team while he was in Maghaberry Prison.
16/09/2022		The prisoner was released on bail on and discharged back to Community Mental Health Team on 22 September 2022 with a discharge letter.
23/09/2022	10:18	PSNI arrive at Antrim Courthouse with the prisoner.
23/09/2022	16:05	The prisoner leaves Antrim Courthouse in PECCS van.
23/09/2022	16:25	Van can be seen driving along the A26 towards Maghaberry Prison – N.B. CCTV timestamp in PECCS van 1 hour behind - showing 15:25 versus actual time 16:25.
23/09/2022	16:25	Escort staff (PCO B) observed sitting in back of van, can be seen checking cell cameras which scroll across his screen.
23/09/2022	16:27	The prisoner pulls seat belt from wall, is seen holding seat belt before putting it round his neck and applying pressure.
23/09/2022	16:28	Noticed on camera by escorting staff, driver notified and asked to stop van.
23/09/2022	16:29	Van pulls over to side of road.
23/09/2022	16:29	PCO B at cell door attempting to get a response from the prisoner.

Timeline		
Date	**Time**	**Notes**
23/09/2022	16:29	Driver enters back of van and joins PCO B at prisoner cell door.
23/09/2022	16:29	Both staff at door, they open the door and remove the seat belt from the prisoner.
23/09/2022	016:30	Attempt made to engage the prisoner. Pulse checked and chest felt for heartbeat, faint response from prisoner.
23/09/2022	16:30 – 16:34	Staff continue to talk to prisoner and provide water.
23/09/2022	16:35	The prisoner is moved to observation cell with assistance of staff, shoes removed.
23/09/2022	16:37	Driver leaves back of van.
23/09/2022	16:38	Van back on road towards Maghaberry Prison.
23/09/2022	16:40 - 16:41	The prisoner appears to slump in seat, staff knock on door to get a response, movement observed.
23/09/2022	16:46	The prisoner falls against the door in the observation cell, staff at door of cell attempting to gain a response. The prisoner can be seen moving slightly.
23/09/2022	16:47	The prisoner appears to slide off the seat, manages to get back on, staff again at door to check if he is okay.
23/09/2022	16:48	Van at external gate of Maghaberry Prison.
23/09/2022	16:50	Van enters vehicle airlock.
23/09/2022	16:51	Staff open observation cell and attempt to get a response from the prisoner. SO A enters the van and attempts to gain a response. Limited response gained.

Timeline		
Date	**Time**	**Notes**
23/09/2022	16:52	SO A instructs staff to call for a nurse. Code Blue radio message issued.
23/09/2022	16:52	The prisoner opens his eyes, staff continue talking to him to keep him awake.
23/09/2022	16:53	The prisoner can be heard saying he is sorry, staff continue to engage him in conversation and continue to check his pulse when he doesn't respond.
23/09/2022	16:55	Nurses arrive on scene, staff instructed to move the prisoner outside van to allow treatment.
23/09/2022	16:56	NIPS staff place the prisoner on the ground in front of the van in the airlock area. Nurse asks NIPS to call an emergency ambulance.
23/09/2022	16:57	Nurses treat the prisoner on the ground.
23/09/2022	17:20	NIAS paramedics arrive on scene and take over treatment.
23/09/2022	17:40	The prisoner is placed on trolley, taken to ambulance and onwards to Craigavon Area Hospital.
24/09/2022	05:55	The prisoner returns to Maghaberry Prison.
24/09/2022	am	The prisoner is placed in Bann House on a SPAR Evo care plan with continuous observations in an observation cell with anti-ligature clothing.
24/09/2022	pm	SPAR Evo Care plan review conducted.
25/09/2022	10:19	The prisoner complied with committal interview processes.
26/09/2022		SPAR Evo Care plan review. SPAR Evo process was closed with full agreement from the prisoner, prison staff and HiP Mental Health practitioner.

Timeline		
03/10/2022		The prisoner was seen by MHP for a mental health triage and referred to AD:EPT
10/10/2025		Prisoner induction completed.
18/10/2025		Prisoner was sentenced.
02/11/2025		Discharged without further incident.