



The
**Prisoner
Ombudsman**
for Northern Ireland

OFFICIAL - SENSITIVE

**INDEPENDENT INVESTIGATION REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE SERIOUS ADVERSE
INCIDENT INVOLVING**

MR STEPHEN SMITH

**AGED 26
AT MAGHABERRY PRISON
ON 10 APRIL 2023**

Section	Contents	Page Number
	Foreword from the Prisoner Ombudsman	3
	The Role of the Prisoner Ombudsman	5
1	Investigation Objectives	7
2	Methodology	8
3	Summary of Mr Smith's Case	10
4	Circumstances and Events Surrounding Mr Smith's SAI	12
5	Findings	27
6	Conclusions	40
7	Good Practice and Failings	41
8	Learning and Recommendations	42
Appendix 1	Reports <ul style="list-style-type: none">• CJINI• RQIA• IMB	46
Appendix 2	Maghaberry Prison	48
Appendix 3	Glossary	49

Foreword from the Prisoner Ombudsman

Mr Stephen Smith was a 26 year-old remand prisoner who had been in prison custody from 3 April 2023. On 10 April he tried to hang himself while in the Care and Supervision Unit of Maghaberry Prison. The Northern Ireland Prison Service advised the Prisoner Ombudsman of this serious adverse incident and asked for an independent investigation to be undertaken.

This report details the outcome of the investigation into the treatment and care Mr Smith received prior to the incident of attempted hanging on 10 April 2023 and the circumstances leading up to it.

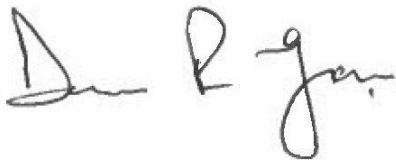
The responsibility for the care and wellbeing of prisoners lies with the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust and both organisations have cooperated fully in this investigation.

It is crucial any opportunities for learning are addressed and good practice is acknowledged and shared across the custodial environment. It is only through this process prisoners and their families can be assured of confidence in the prison system, the standard of medical care, the investigation itself and the operational independence of the Office of the Prisoner Ombudsman.

I am conscious of the length of time Mr Smith's family have had to wait for the completion of this investigative process and appreciate their patience. Mr Smith's recent passing in January 2026 makes publication of this report a poignant reflection on key events in his life and I offer my condolences to his family.

This report provides as much detail as possible about Mr Smith's time in custody and the circumstances surrounding his attempted hanging. I hope this information will be helpful to his family.

I would like to thank all those who contributed to the preparation of this report including the Northern Ireland Prison Service and South Eastern Health and Social Care Trust.

A handwritten signature in black ink, appearing to read "Darrin Jones". The signature is written in a cursive style with a large initial 'D' and a long, sweeping tail on the 'j'.

Darrin Jones
Prisoner Ombudsman for Northern Ireland

The Role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation into incidents of serious self-harm in prison custody in Northern Ireland. On 15 May 2023, the Director of Prisons invited the Office of the Prisoner Ombudsman to conduct an investigation into the circumstances surrounding a Serious Adverse Incident (SAI) which occurred on 10 April 2023. This was in accordance with the Northern Ireland Prison Service (NIPS) Suicide and Self-Harm Prevention Policy 2011¹.

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

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 NIPS and the South Eastern Health and Social Care Trust² (the Trust) for improvement where appropriate. By highlighting learning to NIPS, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

In the interests of transparency, investigation reports are published on the Ombudsman's website. Reports are also disseminated to those who independently monitor services in prisons and the care and treatment of prisoners and patients.

These include:

- Criminal Justice Inspection Northern Ireland (CJINI);
- the Regulation and Quality Improvement Authority (RQIA); and

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

- without *immediate* intervention the prisoner would have died;
- as a result of the incident the prisoner has suffered permanent 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'.

² The Trust was established on 1st April 2007 and is one of 5 Trusts in total within Northern Ireland. The South Eastern Health & Social Care Trust has responsibility for providing healthcare to all prisoners in Northern Ireland. This is delivered on a day to day basis by the Healthcare in Prison (HiP) team. While they are based in the establishments, they are not part of NIPS.

- Independent Monitoring Board (IMB).

More information about these organisations can be found at Appendix 1.

SECTION 1: Investigation Objectives

The specific objectives for this investigation are to:

1. Examine the care provided by NIPS, including:
 - a. The monitoring of Closed-Circuit Television (CCTV) during custody in the Care and Supervision Unit (CSU);
 - b. The quality of the Supporting People at Risk (SPAR) Evo³ care plan put in place for Mr Smith on 3 April 2023 and how it was managed, including the response to increasing indicators of risk of self-harm;
 - c. The use of the x-ray body scanners (XRBS) by NIPS and the reliability of scan interpretations;
 - d. XRBS Deployment Project Planning.

2. Examine the healthcare provided to Mr Smith by the Trust, including:
 - a. Healthcare in Prison (HiP) readiness for the healthcare needs of prisoners post-introduction of the XRBS by NIPS;
 - b. The policy applying to management of prisoners suspected of (or confirmed to be) concealing drugs internally and the associated withdrawal of medications;
 - c. Commission an independent Clinical Review of the healthcare provided to Mr Smith.

3. Whether or not the incident involving Mr Smith could have been predicted and if there were opportunities to prevent it.

4. Identify areas of good practice and any broader learning arising from this case.

5. Examine holistically the joint working of NIPS and HiP to provide effective care for prisoners.

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.

SECTION 2: Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of this case. This comprises interviews and meetings with prison staff, HiP staff, prisoners, family and friends. All prison records in relation to the prisoner's life while in custody are examined. This includes examination of evidence such as CCTV footage, telephone calls and mail. The report is structured to detail the events leading up to Mr Smith's serious incident of self-harm on 10 April 2023 and the emergency response once he was found.

Notices of the investigation into this incident were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and the IMB. This encourages anyone with information to come forward and speak to the Ombudsman's Investigators.

All of the information gathered was carefully examined with relevant matters that underpin this report's findings detailed.

2.1 Independent advice

After further consideration of the issues, independent professional advice from a Clinical Reviewer was obtained. The Clinical Reviewer is a registered Mental Health Nurse with over 20 years' experience, a fully accredited Advanced Nurse Practitioner and a registered Specialist Non-Medical Prescriber.

The Clinical Reviewer was previously employed as National Head of Nursing for the largest provider of prison healthcare services in England, overseeing Primary Care, Mental Health and Substance Misuse services in 48 English prisons encompassing prisoners in all categories.

The information and advice which informed the findings and conclusions are included at Section 5 of this report. The Ombudsman has discretion, based on the overall context of the case, whether the advice is included within the recommendations for this report.

2.2 Family Liaison

Liaison with a prisoner's family is a very important aspect of the Ombudsman's role when conducting an investigation.

A number of meetings with Mr Smith's family have been held since the incident to consider their questions and concerns. The first was held on 17 August 2023 and updates on progress and answers to specific questions have been shared on a regular basis. The Ombudsman and his investigating team met Mr Smith's mother, sister and the family solicitor on 3 September 2025 to validate an understanding of their principal concerns.

The family confirmed they were primarily concerned about:

- I. The use of the x-ray body scanners;
- II. Withdrawal of Mr Smith's medications; and
- III. The care of Mr Smith given his vulnerability.

The Ombudsman assured the family these matters were among those being addressed under this investigation and that the report would be shared with them prior to publication.

SECTION 3: Summary of Mr Smith's Case

Mr Smith had multiple spells in prison since 2015, having most recently been released on 20 March 2023. Mr Smith was committed to Maghaberry Prison on remand on 3 April 2023 and on 10 April 2023 he tried to hang himself while in the CSU. NIPS referred this SAI to the Prisoner Ombudsman for independent investigation.

During the committal process, it was recorded Mr Smith had a history of anxiety, depression, mental health issues, self-harm and illicit substance use. It was noted he was prescribed methadone and pregabalin prior to entering custody. Mr Smith said he was addicted to methadone and suffering withdrawals.

At the risk assessment on committal, Mr Smith was determined by NIPS and HiP staff to be "*At Risk*" of suicide or self-harm. Accordingly, throughout this short period of custody he was supported by a SPAR Evo care plan.

Mr Smith was scanned by the recently introduced x-ray body scanner upon committal in reception, with NIPS interpreting his scan as giving a positive indication of an internally concealed prohibited item⁴. Due to his scan result Mr Smith was placed in the CSU under NIPS Rule 32⁵. Unlike during Mr Smith's previous spells in prison, HiP had determined prisoners with positive scans were not to be administered Opiate Substitution Treatment (OST) or sedative medication due to risk of overdose if a package containing drugs was being concealed. Mr Smith repeatedly protested this.

The HiP SAI report and Clinical Reviewer capture confusion around the withdrawal of medication from Mr Smith whereby, on the morning of 4 April 2023, his prescription for liquid pregabalin was continued by the HiP pharmacist. This prescription was never administered even though the HiP Addictions Consultant, seeing it had been prescribed, believed it would be.

⁴ Prohibited items include drugs

⁵ Prison Rule 32 Restriction of Association (for good order, discipline and/or safety)

During the following week Mr Smith repeatedly called for the restoration of his medications.

The recent introduction of the XRBS had given rise to a rapid expansion of the CSU population with attendant workload pressures on staff in the unit. This also impacted workload pressures within HiP, who were then reliant on a significant number of agency nurses.

At the time of his attempted hanging on Easter Monday, 10 April 2023, Mr Smith's SPAR Evo care plan required observations every 30 minutes. Mr Smith was in an observation cell in the CSU when, at approximately 17:11 (around 45 minutes after his previous physical observation check at his cell), he was observed to be suspended from a ligature in his cell by Prison Officer A. Prison Officer A called for help and with Prison Officer B entered Mr Smith's cell, cut his ligature and lowered him to the floor. Mr Smith was found to be unresponsive and was given emergency first aid by NIPS and then HiP staff who arrived in response to a code blue alert called by CSU Senior Officer C at 17:12. HiP nurses began arriving at 17:13 with NIPS staff administering CPR under their direction from 17:14. An emergency ambulance was called at 17:16, with the first Northern Ireland Ambulance Service (NIAS) paramedics getting to Mr Smith's cell at 17:37 to take over his treatment.

Mr Smith was treated in his cell until 17:55 when NIAS secured him to a stretcher, removed him from his cell and transferred him to an ambulance. He was taken to the Royal Victoria Hospital (RVH) at 18:30 and was there placed in an induced coma and intubated.

Mr Smith was released from prison custody on bail on 3 May 2023 at which point he continued to be treated at hospital.

SECTION 4: Circumstances and Events Surrounding Mr Smith's SAI

4.1 Background

Mr Smith was known to the Community Addictions Team, Western Health and Social Care Trust and was prescribed OST. He was known to the HiP Addictions Team from previous committals and Mr Smith had a recorded history of self-harm.

In January 2023 during his previous period in custody (24/06/22 – 20/03/23), many of the same components central to this investigation played out in Mr Smith's life in prison: issues with medications, complaints about same, self-harm, concerns raised about his risk of further self-harm or suicide and the invocation of a SPAR Evo care plan to check on him regularly. Across all his periods in custody, Mr Smith had been supported by such care plans on 11 previous occasions.

On the afternoon of 26 January 2023 Mr Smith failed a medication spot check and became "*irate*" and "*abusive*" towards HiP staff. Prison staff intervened, restrained him and returned him to his cell where he was "*locked for good order*". Shortly thereafter Mr Smith activated his cell bell and reported to NIPS staff "*he cut his own leg due to the medication issues*". It was also noted he stated: "*his head was melted and he would 'slice his own throat if he did not get to see another medic and an S/O*". In response to these developments, a risk assessment was completed and a SPAR Evo care plan⁶ was put in place with an observation interval of 60 minutes.

In the notes of his care plan review the following day, NIPS staff recorded that Mr Smith "*has come a long way over the last two years...progressed to a trusted and open landing and has a good trusted job*". They added "*if his medication issue doesn't allow him to continue taking his current prescribed medication, Stephen will remain in*

⁶ SPAR Evo care plans are considered when a concern is raised, beginning with a risk assessment. If the risk assessment outcome determines the prisoner is "At Risk" of suicide or self-harm, a care plan is put in place requiring regular observations by NIPS staff at a determined interval frequency (can be physical and/or camera checks). NIPS officers enter the notes of these observations in the prison service SPAR Evo notes along with the record of the daily SPAR Evo review meetings and agreed actions/ changes to the plan. HiP staff can raise a concern and will often input to the risk assessment and attend the daily plan reviews which they record separately in electronic healthcare records.

a vulnerable position". Staff captured further: "*Stephen cut due to believing he will have these meds taken off him*". These are the themes that return in April 2023.

On 27 January 2023, citing "*recent concerns about tampering with Pregabalin*" the Addictions Consultant changed Mr Smith's pregabalin prescription to liquid. On 30 January 2023, during a review with the Clinical Addiction Team his pregabalin dependence was discussed with Mr Smith and a "*very slow reduction*" was agreed. The Addiction Consultant noted Mr Smith was "*anxious about this but also accepts he can't stay on it forever*". With his pregabalin dosage reduced rather than withdrawn, as he had feared, Mr Smith's care plan review a short time later noted he was "*upbeat and energetic*". As it was seen he accepted the outcome regarding his medication, it was agreed by the combined team – including NIPS Senior Officers, a HiP Mental Health Team Practitioner and a HiP Nurse – to close Mr Smith's SPAR Evo care plan at that point.

On 1 March 2023, NIPS began use of the XRBS at Maghaberry Prison.

With an unexpectedly high number of prisoners scanning positive in the first days and weeks of XRBS use at Maghaberry prison, the number of prisoners in the CSU rose rapidly and exceeded the capacity of 30 cells. This growth meant the use of other prison facilities as part of an extended CSU to cope with demand.

By 9 March 2023 the increased impact on healthcare staff prompted them to call for clear guidance on how to manage these prisoners from a healthcare perspective. The HiP Clinical Director intervened to establish a policy for treatment of prisoners (suspected of) concealing drugs internally. He consulted with counterparts in Great Britain and contacted NIPS for a copy of their XRBS policy for alignment purposes. The NIPS policy⁷ was then shared with HiP's Clinical Director with a request not to circulate it further. This exchange led to a joint NIPS/ HiP meeting on the topic, held on 15 March 2023. The HiP senior team concluded it was safer not to administer any OST to prisoners suspected of concealing drugs internally as this could potentially mean an overdose or risk serious harm or death if a package burst.

⁷ Deployment and Operation of X-Ray Body Scanners (released to NIPS staff 28 February 2023)

The Trust has reported that by 22 March 2023 their policy was operational. However, the formal written procedure was not published or formally communicated to HiP staff or the significant number of agency nurses engaged at the time, until 13 April 2023⁸. That was three days after the SAI involving Mr Smith. In the interim, a list of medications not to be administered to prisoners believed to be concealing drugs was displayed on a whiteboard in the healthcare area of Maghaberry Prison. The Clinical Director advised this investigation that the whiteboard list included Mr Smith's key prescribed medicines, methadone and pregabalin.

Having been rearrested on 2 April 2023, Mr Smith's Prisoner Escort Record states he disclosed to custody officers he had had a seizure and had fallen and hit his head. It is recorded Mr Smith had been advised by a Police Service of Northern Ireland (PSNI) Forensic Medical Officer to attend hospital following admitting taking six pregabalin tablets and having sustained a minor head injury, but Mr Smith refused.

It was recorded that, whilst in police custody, Mr Smith was in a highly intoxicated state on 2 April 2023 but sober and seeking medications on 3 April 2023.

4.2 Maghaberry Prison Monday 3 April 2023

Mr Smith arrived at Maghaberry Prison on the afternoon of 3 April 2023 and was taken to reception to begin the committal process including NIPS and HiP interviews.

Healthcare records capture that Mr Smith was observed to be "*noticeably under the influence*" and "*struggling to walk in straight line*". In addition, he tied a lace round his neck in reception; Mr Smith said this was not an attempt at suicide but "*an effort to speed up the process*". Nurse A noted that, as a precaution, Mr Smith's shoelaces were removed.

Mr Smith's all-round presentation caused both the NIPS officer and HiP nurse to conclude he was "*At Risk*" of suicide or self-harm and, on this reception risk

⁸ HiP P90 v1.0 and v1.1 published officially on 13 April 2023 (latest update v1.3 August 2025)

assessment, a SPAR Evo care plan was put in place with 30-minute maximum observations specified.

The pharmacy was closed⁹ by the time Mr Smith came through reception and it was noted the pharmacist would confirm his medications the following morning.

In the meantime, Mr Smith was scanned by the NIPS XRBS and his scan was assessed as showing a positive indication of concealing unauthorised items internally. As a result, as per NIPS process, Mr Smith was to be placed in the CSU under prison Rule 32. (NIPS staff informed this investigation that Mr Smith would likely have been placed on Rule 32 based on his presentation alone.) The restriction was to run for an initial period of 48 hours before Mr Smith was re-scanned and extension of Rule 32 reviewed (on 5 April 2023). For the first night of custody, however, he was housed in the Committal House at Maghaberry prison, Bann House.

NIPS records confirm that officers conducted his 30-minute observations through the evening and night with Mr Smith repeatedly asking when he would get his medications.

4.3 Maghaberry Prison 4 April 2023

At 02:52 it was noted he was *“starting to give off about not receiving his meds”*.

At 08:40 the pharmacist completed Mr Smith’s medication reconciliation from his electronic healthcare records and continued his liquid pregabalin prescription as per previous custody. Soon thereafter, at 09:34 Mr Smith had a face-to-face consultation with the Addictions Consultant B who noted he had *“failed the body scanner”* and had been observed *“under the influence”* and directed HiP staff to *“hold OST until he is deemed fit and has passed the body scanner”*.

In the course of the Trust’s in-house investigation at a later point, the Addictions Consultant clarified that *“she had presumed Mr Smith would be in receipt of Pregabalin as it had been prescribed”*. She further stated: *“had she known that a blanket approach*

⁹ HiP pharmacy operates 9am-5pm Mon-Fri

was being taken to withholding medication she would have raised concern". On 4 April 2023 she completed Mr Smith's consultation by prescribing symptom relief medication, mebeverine, to be administered if required for cramps due to opiate withdrawal.

In the event, although she had planned see Mr Smith again on 11 April 2023, Easter Tuesday (and, it is reported, had cancelled appointments to do so), Mr Smith was not seen again by the Addictions Consultant or the GP during his week in custody.

At 10:03, NIPS notes record Mr Smith was threatening to cut himself *"as he wants to see the medic for his medication"* and that he went on to cut his left forearm using a screw in the cell. At 10:09 he was visited by NIPS Senior Officer to discuss the incident when the item used was also recovered. The injury was recorded as *"superficial"* by HiP Nurse C.

HiP Nurse A confirmed with Mr Smith's community pharmacy he had last received methadone on 1 April 2023 and collection of a dose by PSNI had not been possible as he *"was too intoxicated in custody"*. HiP Nurse A also made a fresh referral to the Addiction Team for Mr Smith.

At 11:35 a SPAR Evo care plan review was conducted with Mr Smith. A NIPS officer – who recorded he had *"known Stephen for a long time"* – noted in prison records Mr Smith had *"addiction issues and is going through some withdrawals now"*. HiP Mental Health Nurse C similarly noted that Mr Smith reported *"struggling with withdrawals"* and *"voiced medication issues and that he would not feel as bad if same was sorted"*. NIPS notes of the meeting continued that Mr Smith said: *"he wasn't getting his correct medication since he came back in and this was his immediate concern"*. Mr Smith reported his self-harm earlier in the morning was because he was worked up about this. In terms of thoughts or intentions of further self-harm, Mr Smith denied them but said *"this could change if his problem wasn't sorted out soon"*. It is recorded that all were in agreement to change the SPAR Evo care plan maximum observation interval to 60 minutes.

After lunch in Bann House at 12:05 Mr Smith was transferred to the CSU¹⁰ Landing 2, Cell C07, in line with the ruling following his scan on arrival. Mr Smith's observations continued to be recorded through the rest of the day and into the night with no further issues or concerns noted.

4.4 Maghaberry Prison & Hospital 5 April 2023

With nothing further of note from his early morning observations, at 09:00 Mr Smith was unlocked for slop out. Shortly thereafter at 09:24 Mr Smith was found having a seizure in his cell and HiP assistance was called for with NIPS officers placing Mr Smith in the recovery position before Nurse A arrived at 09:27. On cell entry Nurse A found the seizure activity continued and administered the first dose of medication (medaziom) in an attempt to stop the seizure at 09:30. As the seizure activity continued, Nurse A called for further HiP support – with Senior Nurse D joining and calling for an ambulance while treatment of Mr Smith continued in the hallway where he had been moved by NIPS staff. Nurse D recorded that Mr Smith “*was actively witnessed having a grand mal seizure*”. After a dose of Naloxone at 09:40, it is recorded Mr Smith “*began to become alert*” though he remained disorientated for an additional five minutes and then sat up against the wall. On arrival of the NIAS, Mr Smith was handed over to the care of the ambulance crew and noted to be “*responding appropriately*” before he was transferred to Craigavon Area Hospital (CAH) at 10:06.

While Mr Smith remained in the custody of NIPS officers at the hospital, the healthcare provided by the Southern Health and Social Care Trust at CAH is outside the remit of investigation by the Prisoner Ombudsman and commentary on Mr Smith's brief visit is included here only to complete this account of the circumstances of this incident.

Mr Smith was triaged by nursing staff at the hospital but refused treatment and discharged himself against medical advice. The Southern Trust has confirmed to this investigation their records show Mr Smith was not scanned at the hospital.

¹⁰ According to HiP's “*Process for the Care of Persons held within the Care & Supervision Unit (CSU)*” P01, all prisoners in the CSU are to be assessed by HiP staff on a daily basis.

By 16:35, Mr Smith was back at Maghaberry Prison and seen by HiP Nurse E who took his clinical observations (recorded as normal) and noted he was “*moving all limbs, alert and orientated*”. At this consultation, Mr Smith strongly denied concealing any drugs and stated “*he opened his bowels whilst in hospital in front of the officers escorting him*” which Nurse E recorded was confirmed by the escorting officers. Nonetheless, when coming through reception on return to prison, in line with the new policy, Mr Smith had again been scanned by the XRBS and the scan was deemed to be positive as before; his restriction in CSU under Rule 32 was duly extended by seven days (to 12 April 2023) and signed off by NIPS Governor D.

HiP Nurse E also recorded that they “*escalated my concerns regarding his mental state to SO C from CSU*” and recommended that his observation interval should be reviewed (at that point it was 60 minutes). In Mr Smith’s absence at hospital, his daily care plan review had made no changes. When asked about this at interview, CSU Senior Officer C had no recollection of this escalation by the HiP nurse.

In parallel, Prison Officer A recorded at the time: “*Stephen whilst coming through reception stated to the nurse that he didn't know how he was going to cope returning to the CSU and that he stated what do i have to do to get my methodone and pregabalin back say im gonna kill myself*”.

Mr Smith was taken back to his cell in CSU where he was observed regularly through the evening and night without further incident.

4.5 Maghaberry Prison 6 April 2023

At 10:42 Mr Smith pressed his cell bell to alert staff he was fitting; NIPS staff entered, moved Mr Smith to the landing floor for treatment and called for HiP support. On arrival, HiP Nurse F found his clinical observations all to be within normal limits and although they recorded Mr Smith “*presented to seize again*” they noted this “*did not appear to be of an epileptic presentation*” and there was no need for intervention. They further noted Mr Smith was “*assisted by officers to walk to cell with cameras to ensure his safety*”. NIPS records indicate that Mr Smith was relocated at 11:00 to Level 1, Cell

SPC 1¹¹, due to “Operational Requirements”. In deviation from NIPS policy, no other justification or authorisation by a NIPS Governor for the use of an observation cell was recorded.

For the next hour Nurse F recorded that they checked Mr Smith every 15 minutes and that he “*will be closely monitored under camera*”. During one of their post-seizure observations, Mr Smith again told the HiP Nurse “*he wants his pregabalin and methadone as not receiving them is causing seizures*”.

During his daily care plan review HiP Nurse G noted Mr Smith: “*expressed he is not concealing anything and he feels no one is listening. Determined not to take any medication until further notice as feels he is not being listened to*”. NIPS record of the care plan review meeting noted: “*Stephen made comments of not wanting to carry on if he didn't get these and stated he was really ill and depressed at this time*”. The officer added: “*it was evident to me that he wasn't himself and was struggling at this time. I asked Stephen if he was thinking of suicide and he answered that he wasn't, but he would rather die than not get his medication sorted.*” The maximum observation interval remained unchanged at 60 minutes.

Via the camera in his new observation cell, at 15:20 Mr Smith was observed on the CCTV monitor to be “*lowering himself to the ground*”. NIPS staff promptly attended his cell. As earlier, they placed Mr Smith in the recovery position. Nurse F observed nothing abnormal, noted Mr Smith “*continues to be monitored closely in camera cell*” and restarted frequent checks. He was verbally abusive to the nurse and apologised in a later visit at 16:26 explaining “*he was angry and frustrated and really needs his methadone and does not want to fall off script*”. Nurse F informed Mr Smith they would discuss this “*with healthcare when I go back*” but there is no record of a discussion taking place. Nurse F's next visit to his cell at 17:30 found Mr Smith to be “*in pleasant form with no issues of concerns*”; this was recorded retrospectively almost two hours later “*due to workload*”.

¹¹ This is an observation cell designed to minimise risks of self-harm with an internal CCTV camera. Such cells contain limited specialised furniture and bedding, including a portable chemical toilet.

Notes of the review in his cell by Nurse F at 18:30 were also entered retrospectively “*due to workload*”. Mr Smith advised that “*his bowels moved twice and he is looking forward to his body scan so that he can prove he has no packages concealed internally and recommence his medications*”. At the final cell review by Nurse F that evening at 19:30, Mr Smith was noted to be in good form with no issues. He is noted as accepting his medication and “*happy*” remaining in a close monitoring cell.

No further incidents are recorded for the evening and night.

4.6 Maghaberry Prison 7 April 2023

The Duty Governor recorded that during their rounds in CSU on 7 April 2023 they spoke with Mr Smith who “*queried how he was legally being kept in CSU and why he is not receiving his meds*”.

At 14:24 Mr Smith can be seen on camera kicking his cell door and banging his head in an agitated state. HiP Nurse H recorded Mr Smith was “*extremely aggressive and volatile*”, before setting off the sprinkler in his cell at 14:52. It was also noted by both NIPS and HiP that Mr Smith had used sprinkler parts to self-harm. Electronic healthcare records refer to “*self-inflicted scratches to abdomen and forehead*” while NIPS SPAR Evo notes specify Mr Smith had “*engraved help onto his chest*” with a part of the sprinkler and had done this “*in protest*”. Mr Smith was taken from his cell by NIPS staff using Control and Restraint (C&R) at 15:01 and temporarily taken to a holding cell while his cell was cleaned. In response to this incident, his care plan observation interval was changed to 30 minutes.

NIPS records indicate Mr Smith was observed every 30 minutes by NIPS staff through the evening and night. The period appears to have been without further incident.

4.7 Maghaberry Prison 8 April 2023

The Duty Governor recorded that during their rounds in CSU they spoke with Mr Smith who *“said he wanted medication and that he has no product on his person. He said he would like to be scanned again.”*

Senior Officer E recorded in his journal entry Mr Smith *“pretended to fit”* at 08:50. Prison Officer A noted that HiP Nurse I attending this incident explained to Mr Smith *“he was showing no signs of having a seizure”*. Records indicate Mr Smith told the nurse *“I tried to knock myself out”* and acknowledged *“I didn’t have a seizure, I just want my meds”*. Prison Officer A also noted the nurse explained to Mr Smith again *“the reasons he could not have his medication”*.

At 12:15, NIPS staff recorded Mr Smith pouring contents of his chemical toilet on the floor of his cell. At 14:30 his cell was unlocked to clear out the toilet (which was noted as “broken” with debris and contents across the cell floor and spilled out into the corridor). NIPS officers again used C&R techniques to remove Mr Smith to allow cell cleaning. Mr Smith was noted as stating: *“he will stop damaging the cell etc if he gets his medication”*. In response, Prison Officer F: *“Explained to Stephen again that this was not a prison service issue”*.

These behaviours were highlighted to the night staff in the evening handover (19:30) but noted to have passed. No further incidents or issues were noted that night.

4.8 Maghaberry Prison 9 April 2023

The Duty Governor recorded that during rounds in the CSU on 9 April 2023 they spoke with Mr Smith in respect of the damage he had caused to his cell, Mr Smith *“laughed and said he wants to be scanned again. He denied having items secreted.”*

At 11:25 Mr Smith had his comprehensive Committal Nursing Assessment in his cell with observations recorded as normal. Mr Smith declined referrals to support services for smoking, alcohol and drugs dependency.

Mr Smith was taken back to the XRBS in reception. After an initial inconclusive scan, Mr Smith was re-scanned and a positive indication was determined a third time.

At 17:14 Mr Smith was observed to be *"fitting in cell"* and was placed in the recovery position in case he was having another fit. NIPS placed an emergency call for HiP nursing support. HiP Nurse J attended promptly and undertook Mr Smith's clinical assessment with the outcome that he was deemed not to require further treatment at that time. They noted *"when "seizing" Stephen was banging his head off the wall"*. After assessment, Mr Smith was *"left in the recovery position"*.

HiP Nurse K recorded at 18:48 Mr Smith *"advised he was "hazy"*. They took his clinical observations, which were normal, and advised him *"he is probably slightly hazy following seizure"* which *"he could not remember"*. He showed the nurse speckles of blood on toilet tissue in the cell toilet which they noted *"could be a new issue or slight trauma from tensing so hard during seizure"*.

No further incidents or issues were noted that night.

4.9 Events on the day of Mr Smith's SAI 10 April 2023

Shortly before 09:00, CCTV footage shows Mr Smith holding and rubbing his stomach, crouched and kneeling at his bed for around 10 minutes before using the cell toilet and returning to his bed at 09:10.

During the Duty Governor rounds at 09:32, Mr Smith was noted to say: *"he was in pain and felt he needed to go to hospital as he may have something up his bum"*. When questioned, Mr Smith *"said he didn't remember putting anything up his bum but feels there is maybe something there"*. The Governor was assured Mr Smith would be seen by a nurse.

At 09:50 Mr Smith was assessed by HiP Nurse L and noted to be *"anxious"* and seeking relief for pain in his lower abdomen but with normal clinical observations.

Referencing his continued scan results, the nurse advised Mr Smith *“to drink plenty of water to promote good bowel movement”*.

Between 10:05 and 10:45 Mr Smith engaged in several bouts of exercise in his cell before again using the cell toilet.

HiP Nurse L visited Mr Smith again at 14:29 and noted he appeared in *“better mood... and made no reference to his previous stomach pain”*.

Mr Smith was out of his cell between 15:03 and 15:37 with CCTV footage indicating he was escorted by NIPS staff to the yard in the CSU. NIPS staff brought Mr Smith his afternoon meal at 16:07 and did another physical observation check via his cell flap at 16:26.

After eating the last of his afternoon meal, Mr Smith tidied his bed before lying on it for around 20 minutes. Mr Smith got up at 16:55 and is seen on CCTV footage picking up a T-shirt from the floor at the foot of his bed. With his back to camera, Mr Smith tore the T-shirt and went towards the cell door where he moved the toilet closer to the door and continued to tear the T-shirt. At 16:57 Mr Smith stepped onto the toilet making only his legs below the knee visible on camera. At 16:58 Mr Smith stepped off the toilet and went to sit on his bed for around 20 seconds before he returned to stand on the toilet. At 17:00 Mr Smith’s lower legs and feet are visible onscreen off the toilet and just above the cell floor.

Mr Smith remained suspended until seen at 17:11 by Prison Officer A when scanning his Zebra¹² handheld scanner at Mr Smith’s cell and looking through the cell flap to notice Mr Smith hanging on the other side of the door. Prison Officer A called for assistance and, with the help of Prison Officer B, entered the cell to cut the ligature with his Hoffman Knife and lower Mr Smith to the floor for treatment. They got no response from Mr Smith and Senior Officer C called an emergency “code blue” over the radio system at 17:12. NIPS officers put a defibrillator in place and, with the arrival of HiP nurses at 17:14, commenced Cardiopulmonary Resuscitation (CPR). Nurse A

¹² The CSU Zebra Android device is used to record prisoner activity/ movement or a SPAR Evo log.

noted Mr Smith “*did not appear to be breathing and carotid pulse could not be felt...pupils fixed, dilated and large*”. An emergency ambulance was called for at 17:16 at which point chest compressions were being administered by NIPS staff in rotation.

Mr Smith was administered oxygen to assist his breathing and a nurse felt a pulse after four cycles of CPR which was then stopped. It was noted Mr Smith’s pupils remained fixed. Naloxone was administered at 17:22 followed by three further doses at 5-minute intervals. It is recorded Mr Smith responded to the second and third doses by taking intermittent deep breaths, then vomited and began to breathe spontaneously. At this point, NIPS staff had stepped out of the cell to give the healthcare team of six present the space to treat Mr Smith.

The first of two ambulances arrived at the prison main gate at 17:31. NIAS staff arrived at the cell at 17:37 and took over Mr Smith’s treatment. They administered a further dose of naloxone before Mr Smith was transferred onto the ambulance stretcher by the four paramedics in attendance and was ready for transit by 17:55. Mr Smith was wheeled out of the cell at 17:57 and it is recorded Mr Smith was taken to the RVH from the prison at 18:30. Mr Smith was taken to the RVH Intensive Care Unit (ICU) where he was placed in an induced coma and intubated.

Hand-written notes to family found in Mr Smith’s cell indicated he had reached the point of determining life was no longer worth living.

The hot de-brief took place at 19:25 and, in the meantime, Governor D called Mr Smith’s next of kin leaving a voicemail message when unable to speak to them directly.

4.10 Events after 10 April 2023

As per standard practice, NIPS officers attended the RVH for round-the-clock bed watch, recording updates in daily journals and reporting to Governors at Maghaberry Prison.

HiP nurses also made daily contact with their counterparts at the RVH ICU for updates on Mr Smith's clinical condition. On 11 April 2023 Mr Smith was noted to be critically ill but stable and ventilated, requiring a high dose of oxygen. On 22 April 2023 HiP staff were informed that review of a hospital scan taken two days previously had findings "*consistent with profound hypoxic ischaemic brain injury*".

While still at hospital, Mr Smith was released from prison custody on bail on 3 May 2023.

4.11 Hot and Cold De-brief Meetings

Standard 25 of NIPS Suicide and Self-Harm Prevention Policy 2011 (updated 2013) states hot and cold de-briefs must take place following a serious incident of self-harm or death in custody. The hot de-brief will involve all staff (where possible) who were closely involved with the incident.

They offer all parties directly involved in the incident the opportunity to discuss the action taken, identify good practices and highlight any difficulties, identifying opportunities to make changes, if applicable.

The hot de-brief will be held by the Duty Governor or the most senior manager at the time (depending on the circumstances of the case) and will take place as soon after the incident has been brought under control as possible. During the hot de-brief staff should have the opportunity to express their views in relation to how the situation was discovered, managed and any additional support or learning that could have assisted. In addition, the hot de-brief is an opportunity to identify if staff themselves require specific support.

The hot de-brief took place on 10 April 2023 at 19:25 hours under the chairmanship of Governor D with no issues raised. The timeline of events was captured and recorded. Staff were thanked for their efforts to revive Mr Smith and advised of support services available to them.

The cold de-brief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning. This investigation has been advised no cold de-brief took place for this incident.

SECTION 5: Findings

This section outlines the findings of this report in relation to its objectives and concerns raised by the family.

5.1 To establish the circumstances and events surrounding the incident involving Mr Smith, including a detailed timeline of his care during custody.

The circumstances and chronology of Mr Smith's SAI have been established by this investigation and recorded in Section 3 by way of summary with more detail given in Section 4.

5.2 To examine the care provided by NIPS.

5.2.1. The Monitoring of CCTV during Custody in the CSU

On 6 April 2023 Mr Smith was relocated from cell CSU 2 C07 into an observation cell – CSU 1 Sp01.

NIPS procedures stipulate only people at high risk with "*immediate intent to complete serious self-harm or suicide*" are relocated to observation cells. NIPS procedures also call for Governors to authorise use of an observation cell and record the justification; they also recognise that being in an observation cell can have an adverse impact on a prisoner's mental health or general wellbeing. It is expected that prisoners should be held in observation cells for as short a time as possible.

No specific reasoning for Mr Smith's relocation is available in NIPS records. The Governor of Maghaberry Prison has advised this investigation cell Sp01 is used by NIPS as a "*drug recovery cell*" to facilitate monitoring of prisoners whose condition can deteriorate quite quickly.

Cell CSU 1 Sp01 has a CCTV camera inside the cell which is viewable in the NIPS office within the CSU alongside other monitors simultaneously showing views from

additional cameras elsewhere in the unit. The screens are not continuously monitored. No specific CCTV monitoring regime was defined or implemented for Mr Smith.

On the afternoon of 6 April 2023, it was recorded that CCTV camera footage alerted staff to another possible seizure as Mr Smith was “*lowering himself to the ground*” and staff promptly went to the cell to place him in the recovery position and call for HiP assistance.

When noting his observation check of Mr Smith on 10 April 2023 at 12:30 Prison Officer G recorded: “*error made between the hrs of 0900-1100 under constant camera obs and seen duty gov at 09:30hrs as well as staff interaction throughout morning period*”.

At interview, the NIPS officer who found Mr Smith post-incident on 10 April 2023 indicated he had looked at the screen in the office and thought Mr Smith was standing behind the cell door at the time (around 17:10) before going down the corridor to make his physical cell observation check.

When studied closely and in isolation, the CCTV footage shows Mr Smith’s activities from 16:55 on 10 April 2023 amounted to preparation for, and initiation of, hanging. As per the footage, Mr Smith first takes a T-shirt to make a ligature and, by 17:00, has positioned himself on top of his toilet close to the cell door. While not fully in view due to the fixed angle of the camera, Mr Smith is then seen to step off the toilet with his feet suspended just above the floor.

As per the NIPS hot de-brief after the CCTV footage had been reviewed: “*17:01 CCTV shows Stephen Smith standing on the cassette toilet with a ligature around his neck and appears connected to the sprinkler head*”.

The errors in Mr Smith’s SPAR Evo notes recorded at 12:30 were noted again by CSU Senior Officer C post-incident. He added “*Also pr did not attend Rule 32 at 1530 hrs*” as had been recorded earlier. On review of footage in-cell and beyond, Mr Smith’s interactions with NIPS and HiP staff throughout the day are generally in line with his

care plan expectations. However, the SPAR Evo notes reflect not those physical interactions his care plan called for but what can be seen on CCTV at the time (with two erroneous entries for another cell camera).

As noted, no regular camera checks of Mr Smith were specified as part of his care plan and, in line with policy, no recording of camera observations was required. Accordingly, this investigation cannot find any failing in CCTV monitoring and the Ombudsman would have no concern with the use of combined physical and camera observations, as was happening on the day of his SAI. Nonetheless, combined with a 45-minute interval between his last physical checks, not observing what was going on onscreen real time does represent a missed opportunity to respond to Mr Smith sooner on this occasion.

5.2.2 The quality of the SPAR Evo care plan put in place for Mr Smith on 3 April and how it was managed, including the response to increasing indicators of risk of self-harm

Mr Smith's presentation and behaviour demanded a high level of resource involved in his care and assessment. Frequent observation checks, care plan reviews and nursing rounds were interspersed with incidents of self-harm, vandalism and other issues on a daily basis.

Initially, Mr Smith's SPAR Evo care plan specified a maximum observation interval of 30 minutes and this was followed throughout his first night in Bann House. While still in Bann House on the morning of 4 April 2023, Mr Smith used a screw to cut his arm shortly after "*threatening to cut himself as he wants to see the medic for his medication*".

In the care plan review that followed, Mr Smith was recorded as "*worked up due to not getting his medication*". Mr Smith also answered that he had no thoughts of self-harm but added "*that this could change if his problem wasn't sorted out soon*". From this review, Mr Smith's observations were relaxed to a 60-minute interval.

The next day, on 5 April 2023 HiP Nurse E recorded that she escalated to CSU Senior Officer C her concern about Mr Smith's mental state and that his observations should be reviewed. The observations were unchanged until a further incident on 7 April 2023 when Mr Smith damaged his cell and self-harmed. At that point, observations returned to the 30-minute maximum interval. Even though Mr Smith was relocated on 6 April 2023 to an observation cell, CSU 1, SpC01, no camera observations were specified at any time as part of his care plan, meaning all observations were to be physical checks on Mr Smith, day and night.

In respect of the nurse's escalation, the Clinical Reviewer noted: "*there was no documented evidence that this concern was escalated to other members of the healthcare team. A multidisciplinary team (MDT) approach could have provided a*

more comprehensive discussion of Mr Smith's care, considering his concurrent issues with medication, SPAR EVO, self-harm, and seizures".

This investigation finds the cumulative indicators of increased risk amount to a missed opportunity to support Mr Smith more effectively through an escalation within HiP. At some point, his indicators of heightened risk of suicide should have given rise to an intervention to involve suitably qualified medical staff who could have reconsidered the withdrawal of pregabalin medication and considered further symptom control medications for Mr Smith.

This investigation finds that NIPS staff at the time of this incident had no reason to question the approach being taken by the HiP nurses they were working with. At interview, NIPS staff have indicated awareness now that a more flexible, individual approach is sometimes taken and is an option.

5.2.3. The use of the XRBS by NIPS and the reliability of scan interpretations.

NIPS received delivery of the XRBS at Maghaberry Prison in early December 2022. The equipment was tested and certified by a qualified third party, as required under the regulations. Justifying Authority had been received via the Home Secretary in 2022 stipulating the requirements for NIPS scanning individual prisoners which, in practice, the service met through identifying cohorts of prisoners who would be scanned as they represented a reasonably justified risk of concealing contraband. One of these cohorts was all new committal prisoners who, from 1 March 2023, would be asked to submit to scanning¹³.

Prison officers had been trained in the months ahead of "Go Live" in the use of the scanner, interpretation of images and radiation protection. They assessed each scanned image to determine if there was a positive indication of internal concealment of an illicit item in the body. If a scan was deemed inconclusive, the prisoner would typically be held for 20 minutes before re-scanning by which time any concealed item

¹³ Refusing a scan may be considered an offence against prison discipline and/or lead to a full body search.

would have moved within the body. A positive scan for contraband would trigger a prisoner being asked to surrender whatever they were concealing and be relocated to CSU under prison Rule 32.

This investigation concludes NIPS has a robust framework in place to oversee the operation and maintenance of the XRBS. This investigation has learned that an independent review indicates NIPS assessments are predominantly accurate.

NIPS used external resources to check quality and interpretation of scans in the early months of operating the scanners. Progressively, controls have been expanded in-house and continue to be reviewed for quality assurance, improvement and regulatory compliance.

This investigation finds NIPS has taken significant care to introduce and improve their ability to operate the scanners safely and as reliably as possible with extensive due diligence up front and professional oversight since first use in March 2023.

To establish whether Mr Smith's scans had been correctly interpreted by NIPS (which he disputed), this Office sought a second opinion from a qualified technician in the Body Scanner Governance Support Team of HM Prison & Probation Service (HMPPS) in England. In early 2025, the technician duly reviewed electronic copies of Mr Smith's positive images from the XRBS (taken in April 2023). It must be noted, this process can never be definitive as a copied electronic image does not give a like-for-like representation of the image viewed real time by the officer(s) operating the scanner originally. The feedback was ultimately inconclusive – partially agreeing with the NIPS interpretations – in one *“there appears to be a package in the large bowel”* – and partially not (*“images are negative”*). Accordingly, and particularly given the difficulties in retrospective comparison, this investigation can draw no finding in this regard.

5.2.4. NIPS XRBS Deployment Project Planning

In planning the XRBS deployment (considered an operational necessity for the good running of prisons¹⁴), NIPS carried out risk assessments in respect of radiation risks, health & safety at work risks, data protection risks and screened their policy for equality impacts. These were all effectively legal requirements upon NIPS and they were put in place, tested and certified as required by the various regulations.

There is no evidence of a similar assessment of the potential healthcare impact from a prisoner perspective, nor of the impact on demand for HiP support of prisoners.

The planning of the XRBS deployment by NIPS and, specifically, the omission of a healthcare impact assessment in collaboration with HiP, with associated risk mitigations being in place prior to scanner “Go Live” on 1 March 2023, exposes a siloed approach to the management of this project. Given the importance placed on the scanner deployment at the highest levels of NIPS leadership as “*transformational*,” this investigation finds such a major change should have been managed in a more holistic manner from a prisoner perspective.

This investigation confirmed NIPS did deliver a briefing on the planned XRBS deployment to members of the HiP management team in December 2022. However, NIPS should have done more in advance of “Go Live” on 1 March 2023 to ensure readiness on the part of the Trust.

The planning of the XRBS deployment by NIPS failed to consider the effect positive scan results could have on the potential increase in demand for CSU accommodation and, most critically, staff resource. Discussions with NIPS during this investigation revealed they were initially surprised by the high proportion of prisoners with “positive” scans. No staffing increase was in place at the start of March 2023 nor added when the prisoner population in CSU increased by 211% by the time of Mr Smith’s SAI on

¹⁴ The use of XRBS technology by NIPS was recommended by a CJINI and RQIA report “*The Safety of Prisoners Held by the Northern Ireland Prison Service*” (November 2019)

10 April 2023. As a result, the CSU and HiP staff had to absorb the impact of this increase within pre-existing resources.

There is no evidence of contingency planning for additional staff to be added to the CSU and no evidence of allowance for a learning curve on new or additional activities such as taking prisoners back to the scanner for repeat scans.

NIPS planning for the introduction of XRBS at Maghaberry Prison and the rest of its estate was exhaustive in many respects as detailed in this report. However, in respect of the impact on staffing, records indicate the only expectation was for the prison population as a whole and anticipated a reduction in workload for NIPS officers due to a lower level of drugs circulating inside prisons.

While over time such an expectation may have been well-founded at an overall level, workload impact at a local level – in particular for NIPS and HiP staff in the CSU – was not considered.

This investigation concludes the CSU resources (both NIPS and HiP) were stretched to an unadvisable level at the time of Mr Smith's custody.

5.3 Examine the healthcare provided to Mr Smith by the Trust.

5.3.1 HiP Readiness for the Healthcare needs of prisoners post-introduction of the XRBS by NIPS

The Trust was not prepared for the impact of the XRBS deployment on 1 March 2023. HiP management has acknowledged this was the case during this investigation.

Following deployment of the XRBS HiP introduced policies to guide staff (HiP P90 and HiP P91); however, they were not sufficiently developed or communicated to healthcare staff at the time of Mr Smith's committal.

As the Clinical Reviewer captured it: *"the policy to manage patients confirmed or suspected of concealing drugs, was either not effectively followed and/or implemented"*.

A possible symptom of withdrawal from pregabalin is seizures and Mr Smith was observed by HiP to have seizures on multiple occasions while in custody. (He also pretended to have seizures.) However, Mr Smith was not being assessed for withdrawal symptoms and this has been acknowledged by HiP as a failure. A procedure on Withdrawal Assessment¹⁵ has since been introduced.

These gaps in readiness by the Trust are reflected in the failure to meet the standards of care expected which HiP has acknowledged in their own SAI report having investigated this incident internally. That report identified a number of recommendations to improve the provision of healthcare moving forward and this investigation has verified implementation of those recommendations.

This investigation found the briefing given by NIPS to HiP on the planned deployment of the scanners was not effectively shared within the HiP organisation and did not trigger a healthcare impact assessment internally as might have been expected. That omission has not been explained satisfactorily. As a result, the Clinical Director, HiP

¹⁵ HiP P91 Procedure for Caring for a Patient in Drug or Alcohol Withdrawal (latest update January 2025)

was left to react as he did from 9 March 2023 to begin to define and implement appropriate policies.

5.3.2 The policy applying to management of prisoners suspected of (or confirmed to be) concealing drugs internally and the associated withdrawal of medications

NIPS policy¹⁶ on the use of XRBS was distributed to its staff on 28 February 2023 and could have been communicated earlier and more widely (including towards HiP staff). This investigation finds NIPS policy with the potential for such profound impact on how a prisoner is treated from a healthcare perspective could have been developed in close collaboration with the Trust and in tandem with the policies HiP necessarily had to create.

The NIPS policy dictates that once an officer determines an image shows contraband being internally concealed, *“this information must be relayed to healthcare as soon as possible in case the internally concealed item may cause a risk to the prisoner”*. The primacy of this policy imperative to notify healthcare speaks to the inherently integrated nature of operational care for prisoners submitting to scanning between NIPS and HiP on the ground.

As above, in respect of the Trust, the Clinical Reviewer reported: *“the policy to manage patients confirmed or suspected of concealing drugs, was either not effectively followed and/or implemented”*.

This investigation finds the relevant policies of both parties are well-intended and appropriately define prisoner care in an environment that uses scanners to help tackle contraband flow into prisons. When followed responsibly to deliver a multi-disciplinary, individually-tailored approach that listens to the prisoner as per policy on suicide prevention, these policies are not of concern.

¹⁶ Deployment and Operation of X-Ray Body Scanners, NIPS v 1.0 – February 2023

5.4 This investigation commissioned an independent Clinical Review which examined the care provided by the Trust in respect of Mr Smith’s medical and mental health concerns in support of the following objectives.

The Clinical Reviewer considered multiple elements of Mr Smith’s healthcare including:

5.4.1. *Withdrawal Monitoring*

In respect of withdrawal symptom monitoring, the Clinical Reviewer commented:

“Staff must be competent in recognising when to use NEWS2¹⁷ and skilled in its application, ensuring timely and accurate recording within patient records. The Trust should use audit frameworks to monitor implementation and embed best practices.” Adding:

“Healthcare staff should consistently apply NEWS2 in clinical practice to enhance patient assessments and identify deterioration risks.” And:

“A structured plan for healthcare monitoring should be established for patients presenting as under the influence or withdrawing from substances to ensure early identification of deterioration and appropriate intervention. A structured approach to withdrawal monitoring should be implemented to ensure staff can identify symptoms, provide symptomatic relief, and escalate concerns to the Addictions Consultant when necessary.”

This investigation finds this aspect been addressed by the Trust with the implementation of written procedure HiP P91 and additional awareness training provided to HiP staff.

¹⁷ The **National Early Warning Score (NEWS2)** is the standardised, evidence-based tool used across the NHS to improve the detection of, and response to, clinical deterioration in adult patients.

5.4.2. Clinical Review Conclusion

Overall, the Clinical Reviewer found:

“gaps in structured withdrawal monitoring, escalation pathways, and holistic assessment of Mr Smith’s reported symptoms were evident. Moving forward, consistent application of withdrawal assessment tools, improved communication between medical professionals, and heightened responsiveness to patient-reported symptoms are necessary to ensure individuals withdrawing from opioids receive comprehensive and patient-centred care within custodial settings.”

This investigation concurs with this assessment of gaps in Mr Smith’s care from a healthcare perspective. The HiP SAI report had matching findings.

5.5 Whether or not the incident with Mr Smith could have been predicted and if there were opportunities to prevent it?

Mr Smith was at times challenging, disruptive and required significant additional resources to respond to his acts of self-harm and vandalism. His behaviour was also consistent with a pattern evident in previous custody – for example in January 2023 when his preoccupation with his medications also led to self-harming.

The Clinical Reviewer reported:

“there appeared to be a lack of structured assessment linking his symptoms to withdrawal. The omission of his medications could have been a contributory factor. Furthermore, the absence of a proactive approach to listening to Mr Smith’s self-reported symptoms and incorporating them into his treatment plan suggests a missed opportunity for timely intervention to support his health and wellbeing.”

5.6 Identify areas of good practice and any broader learning arising from this case

The Clinical Reviewer identified three areas of good practice which are included in Section 7 with learnings identified by this investigation laid out in Section 8.

5.7 Examine holistically the joint working of NIPS and HiP to provide effective care for prisoners

In practice, NIPS and the Trust – through HiP – collaborate to deliver effective, integrated, holistic care to prisoners that meets the expected standards. The Clinical Reviewer called out that joint working was evident in the response to the numerous incidents during Mr Smith's custody – with NIPS calling out HiP and the latter responding promptly.

Equally, this investigation found comments and ways of working by staff in both organisations at multiple levels that, at times, demonstrated attitudes towards the other entity that can, and should, be further improved. An example of this was evident in the level of involvement HiP had in the preparations prior to use of the XRBS at Maghaberry Prison.

SECTION 6: Conclusions

This investigation concludes that while there were surprises and challenges for NIPS following their introduction of XRBS in 2023, the prison population as a whole is better served by a service responsibly taking on the significant threats posed by contraband by all means at their disposal.

Looking forward, the Ombudsman is further assured about the future care of vulnerable prisoners like Mr Smith by changes that have been introduced since April 2023 when staffing levels were stretched and the approach to medication withdrawal was being applied under a blanket approach and symptoms of medication withdrawal were not being monitored adequately.

This investigation finds the Trust is now prepared for the care of prisoners suspected of concealing drugs. HiP's written procedures on concealment and monitoring for withdrawal are now solidly in place, up-to-date, effectively communicated and fit for purpose.

The HiP Clinical Director has indicated on the healthcare side it would be considerably different now given the learning, training and actions to promote awareness among HiP staff: *"we have a lot more time under our belt managing people who have failed the scanner in CSU"* adding *"We would manage signs of acute drug withdrawal symptomatically"*.

This will be of some comfort to Mr Smith's family who desired the prevention of similar injury to other prisoners who might find themselves in circumstances in any way resembling Mr Smith's.

SECTION 7: Areas of good practice or failings identified.

As a result of the conclusions made by the Investigator and Clinical Reviewer I recognise the following areas of good practice and/or failings identified:

7.1 Good Practice

The Clinical Reviewer identified the following areas of good practice:

- *“Preventative healthcare measures, including vaccinations and health screenings, were offered in line with public health best practices”*
- *“Healthcare staff actively participated in SPAR EVO reviews¹⁸, ensuring continuous assessment and documentation”*
- *“Healthcare staff and NIPS colleagues responded promptly to incidents and delivered CPR following recognised resuscitation frameworks”*

7.2 Failings

This investigation identifies several areas of concern.

There is no finding of failings on the part of any individual member of NIPS or HiP staff that caused Mr Smith to attempt hanging. Rather, the failings that contributed to the environment in which Mr Smith attempted hanging were a mixture of immature policy and practice in the aftermath of a major change. The introduction of the scanners in prisons had not then been fully adjusted to.

¹⁸ SPAR Evo reviews are coordinated by NIPS staff, including the facilitation of HiP involvement

SECTION 8: Learnings and Recommendations

I have identified two learnings for NIPS and have made two recommendations to NIPS and the Trust jointly and one recommendation NIPS:

8.1 Lessons learned

NIPS

8.1.1. NIPS was surprised by the high proportion of prisoners failing the XRBS in the early months of operation and this amplified the impact on staff working in the CSU.

NIPS did not make any provision for an initial trial period in their XRBS deployment planning, nor calculate what learning curves might need to be taken account of. Had such arrangements been made or had benchmarking similar deployments elsewhere given a clearer indication of issues that may arise, there might have been the opportunity to anticipate some of the difficulties experienced by Mr Smith.

The Ombudsman considers these learning opportunities for NIPS in terms of their approach to major projects and encourages NIPS management to implement a review of its major project management methodology and scoping to reflect on what could have been done differently in this case to minimize negative prisoner impact.

8.1.2. NIPS duty of care to vulnerable prisoners such as Mr Smith should mean maximum observation intervals defined in a care plan are not missed or delayed. In contrast, Mr Smith's cell observation checks were not recorded in a reliable manner on the critical day for this prisoner and his final check was outside the defined observation interval. In parallel, the CCTV footage shows Mr Smith's activities from 16:55 on 10 April 2023 were observable but not seen by staff on the day. Combined, these issues indicate the need for NIPS to reinforce towards its staff the importance of every check being on time and put in place controls at Senior Officer and Governor levels to satisfy this expectation consistently. The time Mr Smith remained suspended that day is a tragic learning indicator in this regard.

The decision not to include camera observations as any part of Mr Smith's SPAR Evo care plan when he was relocated to an observation cell is confusing when there was an expectation, as repeatedly recorded in electronic healthcare records, he would be "*closely monitored under camera*" and the Governor of Maghaberry Prison has explained the intended use of this "*drug recovery cell*". The Ombudsman calls on NIPS to reflect on this case and whether there are lessons to be learned for the future.

8.2 Recommendations

NIPS and The Trust

8.2.1. The Ombudsman recommends that NIPS and the Trust should each be obligated to screen policies – to include major change initiatives and/or new ways of working – to determine whether they are likely to have an impact on each other. For NIPS to screen for prisoner healthcare and for the Trust in respect of potential impact of healthcare policies on NIPS operations.

The operation of these parallel reciprocal screening processes should be agreed between NIPS and the Trust at the earliest opportunity.

NIPS has accepted this recommendation.

The Trust has accepted this recommendation and commented: *“The Trust has been compliant with recommendation 8.2.1 for many years and is happy to formalise a process to consult with NIPS on relevant policy development.”*

8.2.2. There is an imperative to continue to build a professional partnership between NIPS and The Trust with mutual trust, respect and joint commitment to shared outcomes in terms of prisoner care and wellbeing. The Ombudsman recognizes achieving this – in a complex and challenging environment – is neither simple nor easy. The refresh of the formal joint partnership between NIPS and the DOH this year is a timely opportunity for all concerned to recommit to this imperative in the interests of prisoners and all working to deliver their care.

In support of this recommendation, the leadership of both organisations will provide an update to the Ombudsman detailing their plan to progress partnership and joint working.

NIPS has accepted this recommendation.

The Trust has accepted this recommendation and commented: *“The Trust accepts recommendation 8.2.2 as continually working our relationship with NIPS is fundamental to providing safe services.”*

NIPS

8.2.3. The Ombudsman recommends where observation cells are to be used for prisoners, the camera observation interval should be defined at the outset. Observations from the camera should also be duly noted in prison service records. If cameras in observation cells are not to be so used, a Governor should explicitly justify in writing why this is the case.

NIPS has accepted this recommendation.

Criminal Justice Inspection Northern Ireland (CJINI)**Appendix 1**

CJI is a United Kingdom National Preventive Mechanism (NPM) member body that independently monitors places of detention to prevent the ill treatment of prisoners. CJI inspects Northern Ireland prisons in partnership with His Majesty's Inspectorate of Prisons (HMIP), the RQIA and the Education and Training Inspectorate. HMIP and the RQIA are also NPM members.

In November 2019 CJI and RQIA reported on the Safety of Prisoners held by NIPS and made two strategic and ten operational recommendations for improvement including better joint-working between NIPS and the Trust to increase the safety of prisoners.

The report "*The Safety of Prisoners Held by the Northern Ireland Prison Service*" (November 2019) promoted the adoption of XRBS as follows:

'The NIPS should examine the introduction and implementation of body-scanning technology in prisons in England and Wales, with a view to introduction in Northern Ireland to reduce the supply of illicit and prescription drugs, New Psychoactive Substances (NPS) and other contraband into prisons, as an element of the strategy to address substance misuse, bullying and violence.'

The most recent inspection report on Maghaberry Prison was published in June 2023 followed by an Independent Review of Progress (IRP) published in February 2024. Inspectors reported the prison had settled considerably since the last full inspection in May 2015 and was now a much safer place. The overall picture of safety has progressed hugely and levels of violence and disorder had reduced; however, Inspectors remained concerned that work to support the most vulnerable men at Maghaberry Prison had not developed to the same level as other aspects of safety.

CJI reports are available at [Maghaberry Prison inspection report June 2023](#), [CJINI Independent Review Progress Report 2024](#) and [CJINI Report on an unannounced inspection of Maghaberry Prison \(9-19 April 2018\)](#)

Regulation and Quality Improvement Authority (RQIA) Review of Services for Vulnerable Persons detained in Northern Ireland Prisons

Following a report of an incident of serious self-harm from the Prisoner Ombudsman's Office in 2016 and the number of recorded suicides in prisons, the Departments of Health and Justice jointly commissioned a review to consider provision for particularly vulnerable prisoners. The RQIA Review, published in October 2021, goes some way to addressing concerns. Recommendations made by the RQIA specifically address mental healthcare. The Ombudsman works with the RQIA and others to raise matters of concern and improve the delivery of support to prisoners.

Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB of volunteers whose role is to independently monitor the care and treatment of prisoners. From the 2021-2022 Maghaberry Prison IMB annual report the IMB state there has been clear evidence of prison staff intervention in relation to prisoners who may attempt suicide or inflict self-harm which has improved the safety and wellbeing of prisoners.

From the 2022-2023 Maghaberry Prison IMB annual report the IMB provide extensive commentary on the introduction of the XRBS at the prison.

IMB Annual Reports can be viewed at [Independent Monitoring Board \(imb-ni.org.uk\)](https://www.imb-ni.org.uk)

Appendix 2**Maghaberry Prison**

Maghaberry Prison was established in 1986 to provide a secure environment for the detention and rehabilitation of individuals involved in serious criminal activities.

Maghaberry Prison is classified as a high-security prison. It houses individuals on remand alongside those who have been convicted of serious offenses and pose a significant risk to public safety. The prison employs stringent security measures to ensure the safety of staff, visitors, and the wider community.

GLOSSARY**Appendix 3**

CAH	Craigavon Area Hospital
CCTV	Closed-Circuit Television
CJI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
CSU	Care and Supervision Unit
HiP	Healthcare in Prison
ICU	Intensive Care Unit
IMB	Independent Monitoring Board
NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
OST	Opiate Substitution Treatment
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
RVH	Royal Victoria Hospital
SAI	Serious Adverse Incident
SEHSCT/Trust	South Eastern Health and Social Care Trust
SPAR Evo	Supporting People At Risk Evolution
XRBS	X-ray Body Scanner