The Prisoner Ombudsman for Northern Ireland

REPORT INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF "MR F" IN MAGHABERRY PRISON

[21st March 2014]

Names and dates have been removed from this report, and redactions applied, solely to preserve the privacy of the deceased, their family and others who contributed to the investigation. All facts and analysis which are in the public interest have been retained.

[Published on 7th May 2014]

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Glossary

ASIST	Applied Suicide Intervention Skills Training
CCTV	Close Circuit Television
CJI	Criminal Justice Inspectorate
CPR	Cardiopulmonary Resuscitation
DSH	Deliberate Self Harm
EMDR	Eye Movement Desensitisation and Reprogramming
EMIS	Egton Medical Information Systems
HMIP	Her Majesty's Inspectorate of Prisons
IP	In-Possession
IMR	Injury Medical Report
IPC	Inmate Personal Cash
NCO	Night Custody Officer
NICE	National Institute for Clinical Excellence
NIPS	Northern Ireland Prison Service
OD	Overdose
PER	Prisoner Escort Record
PTSD	Post Traumatic Stress Disorder
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure
SPAR	Supporting Prisoners at Risk
TNWL	Thoughts of Life Not Worth Living
TSH	Thoughts of Self harm

PREFACE

As Prisoner Ombudsman for Northern Ireland I have responsibility for investigating deaths in prison custody in Northern Ireland. My investigators and I are completely independent of the Northern Ireland Prison Service (NIPS). Our Terms of Reference are available at www.niprisonerombudsman.com/index.php/publications .

I make recommendations for improvement where appropriate; and my investigation reports are normally published after consultation with the next of kin in order that investigation findings and recommendations are disseminated in the interest of transparency, and to promote best practice in the care of prisoners.

As required by law the Police Service of Northern Ireland is notified of all deaths in custody.

Objectives

The objectives for Prisoner Ombudsman investigations of deaths in custody are to:

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

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of all prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. Where necessary independent clinical reviews of the medical care that was provided to the prisoner are commissioned. In this case two clinical reviews were undertaken:

- Dr Keith Rix, Consultant Forensic Psychiatrist examined Mr F's healthcare needs and the medial treatment he received whilst in Maghaberry Prison. Dr Rix's review was forwarded to the SEHSCT and comments from their response are included at the appropriate places in this report;

- Ms Victoria Jenkins, Registered Forensic Practitioner also assisted with some specific queries relating to Mr F's medication.

The report is structured to provide the reader with contextual information that highlights key events (pre committal and during the current custodial period) in a chronological format.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Prisoner Ombudsman's role when investigating a death in custody. My predecessor first met with Mr F's next of kin and contact has been maintained with them throughout the investigation. I also met his family recently in order to explain and discuss the findings and recommendations of this report.

Although this report will inform several interested parties, it is written primarily with Mr F's family in mind. The concerns they raised were about the levels of care provided to Mr F, and they asked why he was accommodated in a single cell. They also queried the effectiveness of information sharing about his mental health between community services and prison healthcare staff.

I am grateful to Mr F's family and partner, the NIPS, the SEHSCT and the clinical reviewers for their contribution to this investigation.

I offer my sincere condolences to his family and his partner for their sad loss.

Tom McGonigle.

TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
21st March 2014 (Published 7th May 2014)

SUMMARY

Mr F was born on (date redacted). He was (age redacted) when he died in his cell in Erne House, Maghaberry Prison, on (date redacted). The post mortem found that he died by hanging.

When he came into prison in Northern Ireland for the third time in (date redacted) Mr F was already a troubled man. His first suicide attempt was in (date redacted), and he had most recently attempted suicide in (date redacted), shortly before being remanded in custody on assault charges.

There were several contributory factors to Mr F's troubles: he had a longstanding diagnosis of Depressive Disorder and Post Traumatic Stress Disorder. He feared he was under threat and had a tendency to cope by self-medicating with mood-altering substances. He had a sense of guilt in relation to his current charges which alleged serious violence against his partner.

There were evident contradictions in Mr F's character. He was an intelligent man who had been studying law. He related well to staff and other prisoners in Maghaberry, and gave no cause for serious or prolonged concern about his mental stability. Prison staff described him as *"a gentleman who kept himself to himself, a model prisoner who gave staff no cause for concern,"* and he was given a single cell as a reward for good conduct. At interview staff and prisoners did not recall him ever being visibly upset or emotional.

On the other hand his phone calls indicate immense difficulty in accepting the reasons he had been remanded in custody, and in coping with prison life. He distorted reality and made persistent efforts to have his charges withdrawn. While his partner was the victim on this occasion, he professed deep love for her and hoped to maintain their relationship. When he arrived in Maghaberry Mr F suggested he had no network of support from family or friends, yet during his seven weeks in prison he had regular visits from his partner and mother, and numerous phone calls with them.

Because he gave such mixed messages the Northern Ireland Prison Service (NIPS) and South Eastern Health and Social Care Trust (SEHSCT) staff who were responsible for his care were not fully aware of Mr F's changing and deteriorating social circumstances. He was not known to the Prisoner Safety and Support Team, and was not recognised as a vulnerable prisoner. Dr Rix summarises the issues well in relation to identifying his level of vulnerability:

"I do not know what could or should have been done to understand better the difficulties in the Deceased's relationship with his partner…. Any intervention with his partner… would have been problematic as presumably his partner was a prosecution witness, or had to be treated as such, and the reference to the non-molestation order suggests that he may have been forbidden from communicating with her. There might have been opportunities for

discipline staff, when he returned from visits, to find out how the visit had gone or for staff to make similar enquiries after telephone calls. Sometimes this happens but to mandate for this would probably be to impose extra and unsustainable responsibilities on discipline (prison) *staff making it more difficult for them to carry out those duties which contribute to prison discipline and the security of prisoners and the prison establishment…There is even the risk that staff would spend so much time making almost token enquiries, that they would not have the time to act on their initiative and spend more time, as I know that they sometimes do, listening to and counselling, troubled prisoners."*

Dr Rix also observed that Mr F's decision to hang himself was a sudden and impulsive decision that could not have been predicted.

Several features of good practice by NIPS and SEHSCT personnel are commended in this report. Despite limited recognition of his vulnerability, there were significant levels of intervention with Mr F during his seven weeks in Maghaberry. He saw a range of mental health specialists, including a psychiatrist and EMDR therapist; and there were several staff from a variety of disciplines who demonstrated genuine care for his wellbeing. Dr Rix said:

"The NIPS is to be commended for providing the deceased with therapy which in other parts of the United Kingdom, and perhaps also in Northern Ireland, would have taken many months, if not a year or more, to have been initiated outside prison."

Mr F also received additional phone credit to assist with maintaining family contact, and was able to make an average of five calls per day, though not all were answered. While we criticize some aspects of how the SPAR process was implemented, Dr Rix also said:

"The SPAR procedures were initiated promptly, reviews were timely and thorough and the procedure was appropriately terminated."

This investigation has identified several matters requiring improvement. It is disappointing that four of these matters have previously been raised in Prisoner Ombudsman reports into deaths in custody; and that related recommendations were accepted, but in this case not fully implemented (recommendations 4, 6, 10 and 12 of this report). It is also concerning that, while Maghaberry received a phone call from Lifeline two weeks before Mr F died, there is no evidence that the information he had *"threatened to kill himself"* reached his landing, or that anything was done with this information.

It is impossible to assess the individual or joint contribution of any of these matters to Mr F's demise. However they are important in relation to the care of other prisoners in NIPS custody in the future. The issues of concern about NIPS practice include internal communications, aspects of the SPAR process, practical matters such as the need for prison officers to have equipment that is fit for purpose, and staff training. In relation to the SEHSCT they include antidepressant prescribing and monitoring methods, risk assessment

for in-possession medication, EMIS[1] recording, and awareness of factors that can increase suicidal ideation. As a result I make 19 recommendations for improvement by the NIPS and SEHSCT.

The NIPS have responded to this report by saying that they accept the recommendations that apply to them and work in relation to them is underway.

The SEHSCT has accepted that NICE (National Institute for Clinical Excellence) guidelines on the management of depression were not appropriately adhered to by all practitioners involved in the deceased's care. They confirm that due care and attention will be given forthwith to individual and team training, development, supervision and appraisal in all aspects of nursing practice. They also point out that from April 2013, the Trust has employed its own permanent GPs, which has improved prescribing practices in line with NICE guidelines.

[1] EMIS – Egton Medical Information System. The database used for storing patients medical records.

RECOMMENDATIONS

As a result of my investigation into the death of Mr F, I make 19 recommendations for improvement by the NIPS and SEHSCT. The Governor of Maghaberry Prison and the Director of Prison Health of the SEHSCT have confirmed that these recommendations will be addressed.

NIPS -

1. **Reception Process** – Audit arrangements should be put in place to ensure all staff involved in a prisoners committal process thoroughly review the PER and PACE 15 forms to identify a risk of self harm or suicidal ideation. (Page 15)

2. **Threat Assessments -** When a threat assessment has been completed and forwarded to the relevant areas for processing, effective procedures should be in place to ensure it is acted upon. (Page 16)

3. **SPAR Observation Level Changes** – The NIPS Suicide and Self Harm Prevention Policy should be clarified to indicate explicitly who has authority to amend frequency of observations in open SPAR cases. (Page 18)

4. **Attendees at SPAR Case Reviews** - Effective procedures should be put in place to ensure attendance at SPAR Case Reviews is policy compliant. (Page 19)

5. **SPAR Conversational checks** - These ought to be 'meaningful conversational checks' and they should be documented so that the next person to engage with the prisoner can build on the previous engagement and not be lulled into a false sense of security by a prisoner who engages superficially and with the intention of misleading staff as to his state of mind. (Page 21)

6. **SPAR Log Book Entries** – Audit arrangements should be put in place to ensure all significant issues that are documented in SPAR log book are considered at SPAR Case Reviews in order to reach a balanced assessment of the prisoner's wellbeing. (Page 21)

7. **Identification of Vulnerable Prisoners** - When a prisoner notifies staff, through any means, that they are not coping, there should be a mechanism in place for staff to easily identify whether the prisoner has been on a SPAR recently so that their self report can be fully considered. (Page 26 & 35)

8. **Journal/ECR Log Entries** - When information has been received that identifies a prisoner as being vulnerable (e.g. bad phone call / visit/ threats of self harm & suicidal ideation etc) a contemporaneous note of this should be recorded in all relevant journals / ECR occurrence log, as well as a note of the action taken. (Page 39)

9. **ECR Safer Custody Call Training** – Training should be provided to ECR staff about handling safer custody calls, including how to action and record them. (Page 39)

10. **Family Liaison & Visits Booking Lines** - Arrangements should be made for the answer phone message on the Family Liaison and Visit's booking lines to inform callers to call the switchboard number should they have concerns about the wellbeing of a prisoner. (Page 46)

11. **Blunt Hoffman Knife** - Procedures should be in place to ensure that all emergency equipment, including Hoffman Knives, is fit for purpose. (Page 49)

12. **First Aid Training** - A training needs analysis should be conducted in relation to whether senior officers on night guard duty should hold an up-to-date certificate in First Aid training. (Page 49)

SEHSCT -

13. **Community GP Records** – Audit arrangements should be put in place to ensure that GP records are requested in line with the SEHSCT's own policy. (Page 16)

14. **EMIS Records** - In line with the Northern Ireland Practice and Education Council for Nursing and Midwifery 'Standards for Record Keeping', entries to medical records must demonstrate details of all assessments and reviews undertaken, and provide clear arrangements made for the person. (Page 20/21)

15. **Antidepressant Prescribing & Monitoring Methods** - The SEHSCT should ensure the prescribing and monitoring of antidepressant medication is conducted in accordance with best practice. (Page 28 & 38)

16. **SPAR Consideration** – When prisoners do not have an active suicide plan or current thoughts of self harm at the point of their healthcare assessment but indicate they have recently been contemplating suicide or having thoughts of self harm, SPAR procedures should be considered and residential managers informed of the prisoner's vulnerability. (Page 29)

17. **Risk Assessment for 'In-Possession' medication** - When risk assessments for in-possession medication are undertaken, healthcare staff should review the prisoners medical records for previous indicators of self harm and other relevant factors. They should not rely upon a prisoners' self report. (Page 33/34)

18. **Sleep Management** – Healthcare staff should be made aware that long term lack of sleep may increase a person's risk for suicide ideation. (Page 40 & 44)

19. **Missing Medical Reports** - When confidential medical reports, such as injury report forms, are completed, effective procedures should be in place to ensure their safe keeping. (Page 48)

Maghaberry Prison

Maghaberry is a high security prison which holds male adult sentenced and remand prisoners. It was opened in 1987.

During his time in Maghaberry, Mr F was located in the committal landing in Bann House for a short time before being relocated to Erne House. These are normal residential accommodation units for prisoners in the general population.

On the day that Mr F died there were two prisoners in Erne House (where he was located) being managed under the Supporting Prisoners at Risk (SPAR) process, but no other significant incidents occurred.

There have been six deaths in Maghaberry since Mr F died. Three of these deaths appear to have been self-inflicted, and three appear to be due to natural causes.

Maghaberry established a Prisoner Support and Safety Team (PSST) in 2011. The team comprises a governor and five members of staff, and its role is to support prisoners who are identified as vulnerable. Mr F was not known to the PSST.

The last Criminal Justice Inspectorate / Her Majesty's Inspectorate of Prisons Inspection of Maghaberry was conducted in March 2012 and published on 17th December 2012. Several of the 93 recommendations in that report are relevant to the care of vulnerable prisoners.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to independently observe all aspects of the prison regime, and its members have free access throughout the prison. The last IMB annual report did not make any recommendations that are relevant to Mr F's death.

FINDINGS

SECTION 1: BACKGROUND HISTORY

Mr F was born on (date redacted). He was (age redacted) when he died from hanging on (date redacted). This was his third time in prison. On this occasion he had been remanded on (date redacted).

In (date redacted) Mr F was convicted of a number of charges related to the Troubles and spent several days in custody. After release it is recorded that he was kidnapped and tortured for four days and labelled an informer.

In (date redacted) it is recorded that Mr F attempted to take his own life by carbon monoxide poisoning, and in (date redacted) his GP had intended to commit him to compulsory psychiatric care. However this did not happen as Mr F absconded through an open window when police came to his home.

Mr F was ordered to leave Northern Ireland by paramilitaries and he moved to (location redacted). His mother reported that he did not cope well and returned to Northern Ireland. In (date redacted), Mr F was first diagnosed as suffering from depression.

Between (dates redacted) Mr F lived in (location redacted) before returning to (location redacted) to be married. After several years of marriage Mr F separated from his wife. Shortly after the separation he met a new partner, with whom he had two children. In (date redacted) Mr F's partner died and he moved closer to his family for support.

In (date redacted) having assaulted one of his children, Mr F was seen by a community psychiatric nurse as he had expressed suicidal ideation. He was prescribed mirtazapine tablets[2] and advised to engage with Alcoholics Anonymous.

In (date redacted) it is recorded that Mr F was suffering from recurrent depression; that he felt suicidal; that he had vague thoughts of hanging but had no clear plans to take his life; and that he admitted to drinking heavily. It is also recorded that Mr F no longer wanted to take his mirtazapine tablets as he felt that they had not helped him previously; as such he was prescribed molipaxin[3].

During (date redacted) Mr F's brother was awarded custody of Mr F's two children. Shortly thereafter his brother and family brought the children to (location redacted), where they continue to live.

[2] Mirtazapine - an antidepressant used primarily to treat depression.
[3] Molipaxin - An antidepressant used to treat anxiety and depression.

During (date redacted) it is recorded that Mr F had good support from Alcoholics Anonymous and that he suffered more from anxiety than depression and found it difficult to sleep.

Between (dates redacted) Mr F studied law at (name redacted).

In (date redacted) he met a new partner and returned to live in (location redacted). Mr F's mother reported that he was *"besotted"* with his partner. Mr F was remanded to Maghaberry on (date redacted) for three days charged with the assault on his child that occurred in (date redacted). It is recorded that Mr F had consumed five bottles of wine on the day of his arrest and was going to be referred to a doctor in connection with his substance abuse.

In (date redacted) medical notes indicate that Mr F required a letter for a therapist regarding depression and Post Traumatic Stress Disorder[4] (PTSD); and in (date redacted) the GP recorded that, *"Mr F gave me verbal permission to discuss details with his probation officer of past history of bipolar disorder and PTSD. I have no knowledge of bipolar disorder ...."* It is not known whether Mr F had been diagnosed with bipolar disorder by another clinician or whether this was self diagnosis.

Attempted suicide on (date redacted)

On (date redacted) Mr F was admitted to (name redacted) Hospital following a suspected overdose of prescribed medication and alcohol, having indicated in a text to his mother that he intended to commit suicide. A report from the hospital to Mr F's GP identified *"a semi serious intention to end life".* His partner described his behaviour at that time as *"a normal pattern,"* when she was away from him. She said *"*(Mr F) *had suffered from panic/anxiety attacks if he didn't hear from my voice, he would panic both in prison and outside of prison".*

Mr F was reviewed the following day by community psychiatric services who recorded, *"Mr F feels foolish regarding his actions denies having other medications at home".* Prior to discharge from (name redacted) Hospital he denied any suicidal intent or ideas, and he maintained this position when interviewed by community psychiatric services.

A fortnight later he was remanded to Maghaberry Prison.

[4] PTSD is an anxiety disorder caused by very stressful, frightening or distressing events.

SECTION 2: MR F'S COMMITTAL TO PRISON

On (date redacted), following a drunken assault on his partner, Mr F was arrested and charged with grievous bodily harm, threats to kill, possession of an offensive weapon, criminal damage and motoring offences. He was medically examined by a police doctor who recorded that Mr F *"suffered from bipolar for several years, PTSD 16 years,"* and *"keep under observations as wish of self harm."*

Mr F remained in police custody until the following day, (date redacted), when he was brought to Maghaberry Prison at 17.40. As part of the committal process a reception officer[5] spoke with Mr F and completed the first part of the 'Committal/First Night' in prison paperwork. The officer recorded that he had received the PSNI paperwork that accompanied Mr F, including the police doctor's record that is referred to above.

One of the questions on the 'Committal/First Night' documentation asks whether there is any self harm indication on the police forms that accompanied Mr F to prison. The reception officer recorded 'No'. At interview the reception officer said, *"He obviously must have told me 'no' at that stage".* The reception officer also said that he would only look at the Prisoner Escort Record (PER)[6] which, he said, *"does not ask* (and has) *no mention of any self harm".* He also said that he doesn't go through the medical/police doctor's form, which noted Mr F's *"wish of self harm".* It is significant that, whilst on this occasion the PER only noted *"Bipolar – no medication at present"* and did not note any self harm indicators, there are areas on the front page of the PER which should be ticked by the police when self harm concerns are indicated.

It is also significant that the NIPS policy on Suicide and Self Harm Prevention clearly states that reception staff should *"Obtain relevant information about a prisoner's mental and physical state from staff responsible for escorting the prisoner from court, and from the PSNI where the prisoner is transferred from their custody. This information must be taken into consideration by reception and healthcare staff on committal."* Therefore, in order to comply with this policy the reception officer should have reviewed all of the paperwork provided by the police, including the medical form which is not a confidential document.

At approximately 18.40 Mr F was next seen by a committal officer[7], who undertook the first night committal interview. The committal officer recorded that Mr F was a vulnerable prisoner who felt at risk in custody. He also recorded that Mr F had no thoughts of self harm.

[5] Reception Officer. The Reception Officer is responsible for taking initial details from a prisoner upon a prisoner's committal to prison.

[6] Prisoner Escort Record. These are the forms which are completed by the Police and accompany a prisoner who is being transferred from police custody to prison custody. The forms include a record of the detained person's medical form, body chart and PACE forms.

[7] Committal Officer. The committal officer is responsible for completing the committal/first night committal booklet.

A threat assessment[8] was completed by the committal officer who recorded, *"states on committal interview that he is under threat by dissident republicans and was forced to leave the country in* (date redacted). *He returned last year and has been picked up and threatened by dissidents that he will be shot if he remains in the country."* The officer also recorded "*Threat assessment completed and sent to committal unit FAO* (for the attention of) *House S.O.* (senior officer) *and SIC* (Security Department)*".*

At interview the committal officer advised that he would have sent the threat assessment to the Bann House (committal house/unit) senior officer and to the Security Department. When asked what action was taken upon receipt of this information, the Security Department advised, *"We can find no threat assessment recorded either on PRISM[9] or in our logs; neither can we find any record of a SIR[10] referring to the threat."* At interview, the officer did not know why the threat assessment had not been received and could not recall any concerns raised by Mr F in respect of prisoners he felt under threat from within Maghaberry Prison. The investigation obtained a copy of the threat assessment and there is no record of any action being taken by the Security Department or by the senior officer in Bann House.

Mr F was then seen by medical staff within healthcare at around 19.00 who undertook an interim health assessment. The nurse who carried out the assessment recorded that Mr F had never received mental health treatment from a psychiatrist outside of prison or ever stayed in a psychiatric hospital, but that he had taken an *"overdose two weeks ago as an attempt to kill himself".* This finding, based entirely upon Mr F's self-report, is obviously inaccurate. When the nurse asked Mr F if he had past or present thoughts of self harm or life not worth living, it is recorded that he had *"thoughts of killing himself prior to coming to jail".*

The nurse also recorded on the interim health assessment that Mr F was diagnosed with bipolar/PTSD in (location redacted) three years ago*, "Not on treatment by own choice, states can't take meds…has feelings of hopelessness… Vulnerable, SPAR[11] opened 15 mins, no family network, no friends, no MHST* (Mental Health Support Team) *outside of prison."* Mr F's community GP records confirm that he had not recently been receiving medication for bipolar/PTSD.

One of the questions raised by Mr F's family was why, given his medical history and recent history of self harm, his GP record was not requested. At the time of Mr F's committal the SEHSCT policy was that a résumé of the prisoner's community GP records would be requested by administrative staff as part of the committal process. There is no record of such a request being made.

[8] Threat Assessment - Provides details of the perceived threat and is submitted to Security department for action.
[9] PRISM - Prison Records Information System Management.
[10] SIR - Security Information Report.
[11] SPAR Supporting Prisoners at Risk (SPAR) booklets are used at times when staff deem an inmate as vulnerable to self harm and suicide to provide increased observations and support for the inmate.

SECTION 3: MR F'S TIME ON THE SPAR PROCESS

Mr F was managed within the SPAR (Supporting Prisoners at Risk) process between (dates redacted). The SPAR process is designed to support prisoners who are identified as vulnerable, by putting in place and regularly reviewing an individualised care plan.

On (date redacted) a nurse opened a SPAR booklet for Mr F, and at 20.04 recorded the following on EMIS[12]: *"Seen when brought into custody, keep safe in situ, during interview prisoner became weepy, disclosing that he had lost his wife not so long ago. Has feeling of 'hopelessness' his words, has no family support or networks in place, no friends also as per prisoner, has attempted suicide as a method to die, two weeks ago, offered bed in* (Hospital name redacted),(location redacted)*, refused admission. Also ventilated he has had thoughts on the way to Maghaberry of attempting suicide. SPAR opened on committal for review by GP. Would like support on the outside but unsure how to access, spoke with landing staff via phone recommended 30 minutes obs* (observations)*, prisoner throughout interview interactive, open, no agitation, alert, orientated, on landing obs changed to hourly, post prisoner being spoken to by house SO, await review by GP."*

The NIPS policy on Suicide and Self Harm Prevention states, *"SPAR care plans must state the level of observation required. If it is not recorded, the observation level will default to not more than 15 minutes until a decision is agreed and recorded in the care plan."*

At interview the nurse said that this was why Mr F was originally placed on 15 minute observations. She said that, *"although Mr F had thoughts of killing himself on the way to Maghaberry, he had told me of some of the issues in his life at that time, he had no suicidal thoughts or active plan to take his own life at the time of assessment. I therefore, felt that 30 minute observations were more appropriate."*

One of the issues of concern raised by Mr F's family was *"Were the staff in Maghaberry Prison aware of Mr F's vulnerability, mental health issues and his state of mind in the community, at the point of committal?"*

Commenting on this matter and the actions taken that evening by the nurse, the Clinical Reviewer, Dr Rix said, *"if she was not trained in mental health, and applied the mental health training and experience of a non psychiatric health professional, it appears that she demonstrated good practice. She identified a risk of suicide. She recognised the factors that influenced this. She explored his suicidal ideas and she was able to detect a reason for living. The immediate action plan that she drew up was appropriate in the circumstances…In my professional opinion this was good practice especially given the likely pressures of evening reception duties and what seems to have been a difficult assessment on account of the Deceased's closed behaviour."*

[12] EMIS – Egton Medical Information System. The database used to store patients medical records.

On (date redacted) Mr F was taken from Reception to Bann House where all new committals are located as part of their induction programme. Upon his arrival, the house senior officer spoke with Mr F and concluded that his SPAR observations could be reduced to hourly. At interview the senior officer said the reason for this was because *"He talked very calmly, very politely. He was very, actually very easy to like. I'd have been fairly certain, well I would have been 100% sure that there was no active plan to self harm/commit suicide. I knew that he'd had a history and I knew that he'd had post traumatic stress. The only thing he had left, the only people he had left was his mother and his girlfriend. Disarming - Now, that's, that's the way I always remember him as, as being quite disarming and he sat down and talked things through. So he was, he was actually a very intelligent fella. And he sat down and talked things through himself. You could see that the light was coming on with him, that there were other ways* (to deal with this situation)*, and that's when I would have went to, to hourly* (observations) *with him."*

Following his meeting with Mr F the senior officer recorded in the SPAR booklet, *"Spoke to Mr F. States that he got bail at court, but had trouble getting an address. States he will get out on Thursday. Stated that he was stupid to say that he had thoughts of suicide. ASIST*[13] *model applied. No active plan evident, observations hourly."*

Another question raised by Mr F's family was why the recommendation of a medical professional, to place Mr F on half hourly observations, could be overturned by a senior officer.

The NIPS Suicide and Self Harm policy on this is unclear. It states that *"Managers* (senior officers) *will consult with the person who opened the booklet, other wing staff and Healthcare staff and will put in place an immediate Keep-Safe plan*[14] *until the first case review can be held and care plan agreed."* This suggests that the initial levels of observation are signed off by a senior officer. Yet the policy also states *"Observation levels can only be reduced (e.g. 15 minutes to hourly) by a decision taken during a Case Review."* – Which suggests that the senior officer should have convened a case review prior to changing the nurse's recommendation of half hourly observations. The policy should be amended to clarify this matter.

Nurse Assessment – (date redacted)

The following day Mr F was seen by a nurse who carried out a more in-depth healthcare assessment as part of the committal process. The nurse recorded the following information onto EMIS: *"….alcohol withdrawal – no signs evident at present. Refer to Doctor regarding physical health, referral to mental health team…. Advised re referral re alcohol counselling through Adept*[15] *refused at present. Psychiatrist involved…. Mental state reluctant to*

[13] ASIST - Applied Suicide Intervention Skills Training.
[14] The immediate Keep-Safe plan records the proposed care plan for the next 48hours, including observation levels.
[15] Adept Alcohol and Drug Educational Programme Training.

engage and talk about reasons for thoughts of suicide – closed arms folded. Behaviour assessment – difficult to assess refer to MHS (Mental Health Support)*."*

PBNI Committal Interview

A probation officer also met Mr F and recorded *"Was recently in (name redacted) Hospital after attempted suicide/attempted overdose….States not thinking of harming himself but very emotional."*

Initial SPAR Review (date redacted)

On (date redacted) Mr F attended the Initial SPAR Review. Other participants were the senior officer and a nurse. Prison policy states: *"The initial case review should be attended by; the member of staff who raised the initial concern; the assessor whom completed the interview; Healthcare; landing staff and others relevant to that prisoner."* As highlighted in previous Prisoner Ombudsman Death in Custody Investigations, a member of landing staff should have attended this initial review.

The record of the review states: *"Mr F was in better form today and appeared a bit more animated. He has no active plan for self harm or suicide. He is up for bail tomorrow* (date redacted). *Because of history and low mood, all, including Mr F, are in agreement that SPAR should remain open at least until after his bail application is heard."*

Mr F's SPAR Care Plan was also updated to: *"remain doubled* (cell sharing). *No sharps* (razor's) *unsupervised. Obs* (observations*) hourly x 4 conversational checks per day."* The next review was scheduled to take place on (date redacted).

Chaplaincy

On (date redacted) Mr F was seen by a nun from the Chaplaincy. She recorded in the SPAR booklet, *"Mr F … is at rock bottom …. and needs support. He knows he has mental health problems….. The decision of the Magistrate not to grant bail and the court papers* (non molestation order) *he was given yesterday, have devastated him. He is experiencing panic. He has requested help from mental health."*

SPAR Review – (date redacted)

Mr F's next SPAR review was attended by himself, a senior officer and a nurse. In contravention of prison policy, a member of Mr F's landing staff did not attend the Case Review.

The record concluded: *"While there is no evidence of an active plan to self harm all in agreement that SPAR should remain open and be reviewed on Tuesday* (date redacted)*."*

Mr F's Care Plan was updated to reflect the Case Review. All the actions that were recorded at his initial review on (date redacted) remained in place and were recorded as ongoing. In addition to the record of the SPAR Case Review, the nurse who attended recorded on EMIS that Mr F *"Denies active plan for suicide or dsh* (deliberate self harm) *stating religious beliefs as main reason not to go ahead. Has been speaking to sister/nun and finds her and priest… very helpful. Advised to speak to staff if any concerns develop and I have advised him he has been allocated to mental health support team."*

Commenting on the actions taken that day by the multi-disciplinary review team the Clinical Reviewer, Dr Rix said, *"those present including healthcare as well as discipline* (prison) *staff, took into account the further developments and regard was had to the importance of the religious beliefs and how Mr F had found it helpful talking to a priest and a nun. Again there was appropriate caution and his action plan was continued. It appears to me that this case conference was an example of good practice and especially it was demonstrably holistic with its inclusion of the spiritual dimension of the deceased's care."*

At 09.25 on (date redacted) an officer recorded in the SPAR booklet: *"Spoke with Mr F, asking him how he was today, he replied he was fine in himself. Maintained good eye contact and was smiling. He mentioned that the PSNI had informed him he had death threats against him from outside and he was a bit worried about it."* The Maghaberry PSNI Liaison Officer confirmed that a threat notification was issued to Mr F in prison on the (date redacted) which read *"criminal elements are planning to take physical action against Mr F."* Mr F's solicitor confirmed that the threat against Mr F came from a criminal element rather than a dissident threat.

SPAR Review – (date redacted)

Later that morning Mr F attended a SPAR Review, which was attended by the senior officer, the same nurse who had attended the previous review on (date redacted), and a landing officer.

A record of the Case Review states that *"Mr F was in good form. Allegations have been withdrawn* (Mr F's partner told him that she was going to withdraw her statement). *No thoughts of self harm or suicide. ASIST model applied. No evidence of active plan. All in agreement that SPAR can close at this time."* In contravention of policy requirements the nurse who attended did not record details of the Case Review in Mr F's medical record.

At interview the senior officer said that all in attendance agreed to the closure of the SPAR because *"The allegations had been withdrawn. So as far as he* (Mr F), *was concerned his life had changed. His reasons for an active plan to take his own life had gone and* (he was) *a different fella, totally."*

A review of the SPAR booklet notes that following the opening of the SPAR, Mr F shared no further indication or thoughts of self harm. At interview the senior officer said, "*Mr F totally understood why it was there* (the SPAR) *and it was there as a means of support and as I say I believed him. We had an agreement that throughout this process, his words in fact, I'll not let this man* (the senior officer) *down."*

Whilst it is recorded that Mr F was *"in good form"* and *"fine in himself,"* earlier that morning he also expressed anxiety to a landing officer about the death threat of which the PSNI had advised him. There is no record of this being considered at the SPAR Case Review.

The NIPS Suicide and Self Harm Prevention policy states that as part of the Residential

Commenting on the actions taken that day by the multi-disciplinary review team the Clinical Reviewer, Dr Rix said *"The notes of the final review on* (date redacted) *are limited however, what was documented justifies the decision to discontinue the SPAR procedures. He* (Mr F) *reported no thoughts of self harm or suicide and there was no evidence of an active suicidal plan. It appears to me that the case conference conformed to standards of good practice."*

Commenting on the management of the SPAR process, Dr Rix said, *"the SPAR procedures were initiated promptly, reviews were timely and thorough and the procedure was appropriately terminated."*

Commenting on the effectiveness of the SPAR process the Clinical Reviewer, Dr Rix said *"My only concern is that the deceased's four times daily 'conversational checks' are not obvious from the records and in this sense the entries are not as meaningful as they could be and as they ought to be. These ought to be 'meaningful conversational checks' and they should be documented so that the next person to engage with the prisoner can build on the previous engagement and not be lulled into a false sense of security by a prisoner who engages superficially and with the intention of misleading the discipline* (prison) *or healthcare officer as to his state of mind."*

Managers[16] role, they must: *"ensure a minimum of two conversational checks are carried out daily by staff and sign all logs accordingly…….Entries should reflect the content of any conversation held or observations noted regarding the prisoner's mood, demeanour etc at the time."*

The SPAR booklet also contains the following advice and guidance to staff in relation to: *"Providing on-going support to the person at risk – conversations and observations. The primary purpose of requiring staff talk more frequently to distressed prisoners is to demonstrate concern for them, provide companionship and to amass a comprehensive record of things said that might indicate a change in mood, thought or intention…..Conversations may take place at any time of the day or night, depending on the situation. Staff are encouraged to engage with those at risk as often as possible."*

A review of the SPAR observation logs for the full period indicates that whilst there were two officers who recorded conversational checks in the true sense of the meaning, there was evidence of officer's recording that a conversational check had occurred, when in fact no real conversation took place. Examples of this practice include: *"Asked how he was, he responded ok….conversation check completed;"* and *"Sitting on bed, I asked which one was SPAR, top bunk raised hand. I asked how he was, he said 'good'. Conversation complete."*

In a previous death in custody investigation the Prisoner Ombudsman made the following recommendation which was accepted by the NI Prison Service: *"I recommend that the Prison Service introduces a policy of recorded face to face conversational checks when a member of staff takes time to engage with a prisoner on a PAR 1* (now referred to as SPAR) *a number of times in each 24 hour period. I also recommend that all staff are informed that conversational checks must be recorded in PAR 1 observational booklet. This should apply to all NI prison establishments."*

[16] Residential Manager – The senior officer in charge of the house.

SECTION 4: KEY EVENTS BETWEEN (dates redacted)

Telephone Calls

A number of important themes have emerged from Mr F's phone calls during this period. They reflect his anxiety about the pending court case despite his partner allegedly retracting her statement; his difficulty in coping with prison life; feelings of estrangement from his family and being under threat; and distortion of reality.

Prison records show that Mr F made 225 telephone calls between (dates redacted). 123 of these were unanswered. Recordings of the 102 calls were obtained and analysed. The Prison Service operates an intelligence based approach in monitoring prisoner's phone calls. Mr F's calls were not being monitored, therefore Maghaberry staff were unaware of the content of his conversations.

During his time in Maghaberry Mr F received a total of eight visits, of which seven were from his partner and/or his mother. At interview staff and prisoners did not recall Mr F ever being visibly upset or emotional.

Significant phone calls are as follows:

(Date redacted)

Mr F made two phone calls. On both occasions he spoke with a family member and his partner, and discussed the non molestation order and the fact a PSNI Officer from the Domestic Violence Unit told her (partner) that she could not retract her statement. Mr F replied *"The only thing that is keeping me going is the fact that you are ok; if I thought you were not, I would just break, lose the plot."*

(Date redacted)

Mr F phoned a family member. During the call he told the family member that he did not receive bail. The family member mentioned a name and Mr F asked for this person to visit him to *"help with the dissident issue"*. The family member told Mr F *"You need to be truthful with this person and tell him that you are suffering from depression and that your head is up you're a***, don't be putting on the big hard man act"*. Mr F replied *"I'm about to burst out crying, the hard man's gone."*

(Date redacted)

During the day Mr F made several telephone calls to the same family member. During one call that morning, Mr F told the family member that the PSNI would not allow his partner to withdraw her statement. Mr F said *"I can't take it my head is about to explode,"* he then started to cry. In a further call to the same family member later that afternoon, Mr F started to cry after the family member started to shout at him.

(Date redacted)

Mr F called a family member who passed the telephone to his partner. Mr F informed his partner that following the visit from a family member the previous day, he was *"ten times worse off."* He went on to tell his partner that he was in an awful state, *"then my cell mate slashed his throat with a coke can."* This was one of the concerns raised by Mr F's family who asked about what level of counselling and support Mr F received from the Prison Service following this traumatic experience. Extensive enquiries have established that this incident did not take place. Mr F's partner advised *"Mr F tended to blow things up, and it was hard to know when he was telling the truth or not. He would have used this type of behaviour to manipulate a situation."*

During the call, Mr F also told his partner that after the visit from a family member, he returned to his landing and the senior officer remarked that he was as *"white as a sheet."* At interview the senior officer was asked if he could recall this event. The senior officer stated that *"When I saw Mr F walking through the grill that day I thought, Mr F what happened. I did talk to him, I'm not sure if his family member wasn't going to give him the address* (bail address). *But again, he talked and managed his way through it. It was never, I'm going to go off and put up the sheets* (hang himself) *I'm going to go down and cut myself or….it was nothing like that."*

During the same call, his partner told him that she had been confronted a few times by republicans, *"who are looking for you".* Mr F replied, *"What kneecapping or shot dead, are they super republicans or genuine ones"?* His partner replied that she was concerned about them. In a call later that afternoon, to a family member, they talked about the possibility of getting an intermediary involved. The phone was passed to his partner and Mr F told her, "*I have spoken to the PSNI liaison officer about my security upon my release; once I get out I will move, get a job and have a quiet life."*

(Date redacted)

Mr F telephoned the same family member. The family member told Mr F that they were in bad form and that they didn't hold out much hope for him getting out.

In a call later that evening Mr F spoke with his partner and told her that a prisoner from (location redacted) had killed or attempted to kill himself that day, he then became emotional. Extensive enquiries have established that this incident did not take place. Mr F told his partner about what the family member had said earlier that afternoon and she replied, *"I am stressed out with the PSNI Domestic Violence Officer talking to me about retracting my statement".* Mr F replied *"I had a panic attack as I got a new cell mate who is in prison for 99 years, I don't know if it is for murder or killing kids".* Prison records indicate that Mr F did get a new cellmate on this date.

(Date redacted)

During a phone call with the same family member, the family member raised their voice to Mr F. Mr F told the family member, *"I can't cope, my head is up my a***."* In a call later that evening to his partner, she told Mr F that she had heard his defence in relation to his charges, in which Mr F is alleged to have said that his partner was going out with half of the local bar, and that she was saying things about Mr F's dead partner. Mr F denied this and told his partner that the family member was *"playing mind games with her head."*

(Date redacted)

During a telephone call to the same family member, Mr F advised that he had got the *"dissident thing sorted out."*

(Date redacted)- Emergency Phone Credit Request

On the (date redacted), Mr F handed a written request form to a landing officer seeking £13 emergency phone credit for the following reasons:

- He was refused bail and needed to inform his family
- He wanted to ask his solicitor to lodge a High Court appeal
- He had been informed by the PSNI that a threat had been made on his life and needed to speak with his solicitor
- His partner was not coping well whilst he is in custody
- He was not coping well either and would like to speak with his family

An officer then inputted the request form onto PRISM and electronically forwarded it onto the senior officer for their consideration.

At interview the senior officer was asked what action she took following Mr F's request for emergency phone credit and the fact that he had written that he was not coping well in prison. The senior officer explained *"The request was granted as it was not considered excessive or the system was being abused by Mr F. Mr F advised in his request that he was not coping well, I checked with staff who advised that after the phone credit was approved Mr F was content."*

The senior officer said that she was not aware that Mr F had recently been on a SPAR and that *"there were no signs that Mr F was in distress".* She continued *"There's nothing on the system* (that) *will flag up* (if he's previously been on a SPAR). *The only time you will get that information is if you go in to open a SPAR on a prisoner and it will show you previous SPARs that have been flagged up. They flag up previous SPARs and who they've been opened by and the details of them, but there's nothing, when he comes to this house. Unless there's some big mark on his file says prisoner previously on a SPAR, but that doesn't happen."*

The senior officer was therefore unaware that Mr F' had been on a SPAR between (dates redacted) when he wrote that he was *"not coping well".*

SECTION 5: MENTAL HEALTH ASSESSMENT

On (date redacted), the day after Mr F was committed to Maghaberry Prison, a nurse referred him to the mental health team. On (date redacted) the mental health team assessed Mr F's referral and agreed to offer him support. On (date redacted), Mr F undertook a mental health assessment. During the assessment the mental health nurse recorded that Mr F described his mood as low and had frequent thoughts of suicide, recording that, *"since the age of 16 he had deliberately self harmed on a number of occasions, the attempts included, over dosing on prescribed medication, cutting, gassing via an exhaust and hose pipe….Mr F reported bullying at primary school…that he joined a paramilitary organisation at the age of (age redacted). He was kidnapped and tortured for four days as he was suspected of being an informer. He frequently suffered from low mood and at times in the past (number redacted) years he had been overwhelmed by despair and has thoughts of dsh* (deliberate self harm). *Reports that he has no intent or plans to dsh, describes recent thoughts of suicide are related to circumstances but he is now stable. Recent developments have made him realise he needs assistance."*

The nurse continued, *"Mr F describes that he currently has feelings of despair but he has no intentions or plans to dsh. He has been on a SPAR as he was overwhelmed by despair; he advises this phase has now lifted. While his mood is low and he has fleeting thoughts of suicide, he has no intent or plans to act on these thoughts."*

The nurse assessed Mr F's active risk and recorded, *"limited risk at present as Mr F describes as having a 'wobble' in respect to current situation."*

The nurse recorded the following as an EMIS entry in Mr F's records: *"Mr F at times displayed emotionally liability; the PHQ9[17] depression scale produced a score of 15 out of 27 which places him in the moderately severe classification, which indicates immediate initiation of pharmacotherapy[18]. He also has symptom pathology that indicates a trauma disorder, and I have made a referral to EMDR[19] trauma therapy. He indicates that his current situation has increased TLNWL* (Thoughts of Life Not Worth Living) *and he has had frequent thoughts of suicide, he describes this as despair at his current situation. I have also initiated a remand psychiatric referral based on the apparent severity of his current depression."*

Commenting on the assessment undertaken by the nurse, the Clinical Reviewer, Dr Rix said *"Nurse* (name redacted) *got the deceased to complete the PHQ9. The deceased scored 15/27. I do not know what training psychiatric nurses have concerning this instrument, which is widely used in general practice but used little, if at all, by mental*

[17] PHQ9 is a nine item depression scale of the Patient Health Questionnaire that is used in diagnosing depression as well as selecting and monitoring treatment.
[18] Pharmacotherapy is the treatment of disease through the administration of drugs.
[19] EMDR Eye Movement Desensitization and Reprocessing therapy for relief from emotional issues, trauma, abuse, anger, guilt, anxiety, depression etc.

health professionals, but I would disagree completely with his conclusion that a score of 15/27 'indicates immediate initiation of pharmacotherapy'. I am unaware of the source of such an interpretation and it flies in the face of rational antidepressant prescribing to base a decision to initiate antidepressants on a score on a self administered depression rating scale."

Dr Rix continued: *"It appears that a reliance on the deceased's answers to the 9 questions in this questionnaire became a substitute for taking a history of the deceased's depressive symptomatology.*

However, the nurse did appropriately identify or endorse the referral of the deceased for EMDR, he ascertained that the deceased had been having thoughts about life not being worth living and he ascertained that the crisis had passed in this regard. He was aware of the risk of deterioration in this regard and he made sure that the deceased was aware of how to get access to help if he felt overwhelmed by a sense of despair and hopelessness.

Furthermore, he initiated what I presume was a referral to a psychiatrist to address the apparent severity of his depression. I am not qualified in psychiatric nursing but if the nurse was in my team, I would not identify this intervention as best practice and although there were some aspects of good practice, such as the exploration of suicidal ideas, ascertaining that the deceased knew how to get access to help, identifying him as someone who should be considered for EMDR and referring him to a psychiatrist, it was bad practice to recommend antidepressant drug therapy on the basis of a score on a questionnaire."

Dr Rix continued, *"If the mental health nurse is a community practitioner who has completed the necessary training, I have to question his qualification to advise as to antidepressant prescribing. Likewise, I accept that Nurse Independent Prescribers are able to prescribe any medicine for any condition, but it takes at least five to six years to train a doctor to prescribe antidepressants, and I have to call into question the qualification of the mental health nurse, even if he is an Independent Nurse Prescriber, to advise a doctor to prescribe antidepressants."*

The nurse held a BSc in Nursing Sciences - Mental Health, and commenced work in Maghaberry Prison in (date redacted).

At interview the nurse said that he was not advising the doctor to prescribe antidepressants but that he had spoken to the doctor and based on the information that he presented to him, the doctor prescribed the medication the following day.

When discussing the PHQ9 instrument at interview, the nurse said: *"The PHQ depression scale, it's typically, it's used by… many people who have worked in Mental Health. It obviously requires the participant or patient to describe….in part their emotions, feelings at*

the time and some biological issues and level of energy…. Now while these tools are useful because they ask very specific questions…….all of these tools have their limitations; you can't necessarily interpret them in the literal sense. So you have to weigh, you have to weigh up and objectively subjectively what you have presented in front of you…It's a very useful tool, it's widely used, but again it's a tool that has to be used not, in isolation."

The NIPS policy on Suicide and Self Harm Prevention states that *"All staff carry an equal and continuing responsibility for the management of prisoners under their care considered to be at risk of suicide or other acts of self harm."* Given that Mr F described *"his current situation has increased TLNWL* (Thoughts of Life Not Worth Living) *and he has had frequent thoughts of suicide"* it is concerning that the nurse did not consider opening a SPAR booklet on this occasion.

SECTION 6: ANTIDEPRESSANT MEDICATION AND EMDR ASSESSMENT

Antidepressant Prescription

On (date redacted) a prison doctor recorded on EMIS *"repeat prescription – patient not seen, Fluoxetine Hydrochloride Capsules*[20] *20mg, 28 capsule one capsule to be taken in the morning."* Mr F had not previously been prescribed fluoxetine and, therefore, should not have been issued with a repeat prescription.

Commenting on the fact, the Clinical Reviewer, Dr Rix said, *"I am concerned that, presumably on the recommendation of the mental health nurse on* (date redacted)*, the doctor prescribed fluoxetine 20 mg for the deceased on* (date redacted) *without having consulted with or examined the deceased. I am surprised that he did so, but he may have been under the impression that he was being asked to authorise a repeat prescription.*

However, what was in the deceased's records should have indicated that the deceased had not previously been prescribed fluoxetine and it was therefore inadvisable, so to initiate the prescription of fluoxetine even if it was on the recommendation of a Nurse Independent Prescriber (formerly Extended Formulary Nurse Prescriber).

There was insufficient (information) *in the records for him to have decided whether or not the deceased should have been prescribed an antidepressant drug. Indeed, I do not understand why he thought that it was a repeat prescription.*

Not only does the initiation of antidepressant drug therapy require a careful consideration of the factors in favour of antidepressant therapy, which have to be carefully balanced against the factors against its prescription, but if an antidepressant is being prescribed, this requires a careful explanation to the patient of the rationale, the likely benefits, including their time course, and the possible side effects. Without such an explanation upon the initiation of prescribing, there may be misunderstanding, poor compliance and ineffective therapy."

Furthermore, Dr Rix said, *"his prescription should be considered in the light of the General Medical Council's Good Practice in Prescribing Medicines (September 2008) which states:*

- *that before prescribing the doctor must: 'be in-possession of, or take an adequate history from the patient;*
- *reach agreement with the patient on the use of any proposed medication, and the management of the condition by exchanging information and clarifying any concerns;*
- *satisfy yourself that your patient has been given appropriate information*

[20] Fluoxetine is used to treat depression or obsessive compulsive disorder in adults.

In my opinion the doctor was not in-possession of an adequate enough history to initiate the prescription of fluoxetine. He did not reach agreement with the deceased on the use of fluoxetine, exchange information with him or clarify any concerns and there is no evidence that he satisfied himself that the deceased had been given appropriate information."

Ms Jenkins, who provided a clinical review on the medication Mr F received, said *"the patient information leaflet with this medication warns that thoughts of suicide or self harm may increase in the first few weeks of treatment for depression, until the antidepressant effect becomes apparent. Patients receiving fluoxetine should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present…He should also have been closely monitored at the start of treatment and following a change in dose, but again this does not appear to be the case."*

The investigation wrote to the prison doctor, who has since left the Prison Service, on three occasions, inviting him to assist with our enquiries. He did not make himself available for interview.

EMDR Assessment

Eye Movement Desensitisation and Reprogramming (EMDR) – is a technique to help people who suffer from trauma, anxiety, panic, disturbing memories, post traumatic stress and many other emotional problems. On (date redacted) Mr F was seen by an EMDR therapist who assessed him for trauma work. The nurse made the following entry into EMIS, *"discussed issues in brief detail only as did not wish to leave Mr F traumatised without Safe Place Exercise*[21] *being installed. Keen and motivated to work on symptoms, no contradictions noted. Safe place exercise discussed and to prepare for next session. Distress levels citied at 9/10, daily intrusive thoughts, for ongoing assessment and work on traumatic symptoms."*

At interview the EMDR therapist said *"He* (Mr F) *was referred to me because of symptoms of trauma. He'd informed me that he had been kidnapped and tortured for a period of days, quite brutalised, and he was having flashbacks to that time and nightmares and difficulty coping. At that stage and on the next visit basically it was just building a rapport and information gathering. There was no actual, no trauma work actually carried out."*

The nurse also said *"There were relationship difficulties that he was concerned about because his partner was of a different religious persuasion and background. There was a lot going on about that and he felt under threat where he was living…."*

[21] Safe Place Exercise. This exercise is designed to stimulate those experiencing trauma without coping devices in place.

The nurse said *"Over a period of time we were going to use techniques called EMDR therapy ….to reduce, I think maybe in the notes I said his SUDs[22] levels and that's your subjective distress levels and his were quite high and the idea behind the EMDR therapy is to reduce those distress levels by use of therapy."*

When asked if the nurse had any concerns about how Mr F presented, she said *"At the time I met Mr F I had no reason to place him on a SPAR, although emotional, he did not express any thoughts of suicidal ideation, or life not worth living or thoughts of self harming. If I had thought for a moment that he should have been placed on a SPAR, I would have done so."* She said "*The triggers for me placing a patient on a SPAR would be lots of negativity, thoughts of suicide, life not worth living and thoughts of self harm."*

Commenting on the assessment undertaken by the EMDR therapist, the Clinical Reviewer, Dr Rix said *"Her assessment was conducted with some care. She did not want to leave the deceased traumatised. The Prison Service is to be commended for providing the deceased with therapy which in other parts of the United Kingdom, and perhaps also in Northern Ireland, would have taken many months, if not a year or more, to have been initiated outside prison."*

During a telephone call to his partner that afternoon Mr F informed her that he had been to see a counsellor and that he was definitely suffering from trauma. He told her that he was going to start a course of therapy and medication. He went on to say that the counsellor told him, that what he had was common among soldiers, and that, *"the counsellor told me to go to the gym three times a week, I found her helpful."*

[22] SUD's - Subjective Levels of Distress. On a scale of 0-10 a patient will describe their levels of stress.

SECTION 7: RISK ASSESSMENT FOR IN-POSSESSION MEDICATION

On (date redacted) Mr F was assessed for in-possession medication by a nurse following the prescription of fluoxetine. This is an assessment to establish if the prisoner is suitable to take control and be responsible for their own medication. As part of the assessment he was provided with a copy of the Prison Service medication policy, which Mr F signed and accepted. The in-possession risk assessment consists of a number of questions and follows a flow chart process. At the end of the process the flow chart indicates whether the prisoner is suitable for in-possession medication or supervised swallow (when the prisoner has to take their medication in front of the nurse).

As part of the assessment the question was asked 'Has the prisoner overdosed on prescribed medication in the last three months? The 'No' box was ticked. A number of further questions were asked which led to Mr F being found suitable to be in-possession of his own medication. However Mr F's prison medical records note that he overdosed on medication two weeks before he was committed to Maghaberry.

As recommended, and accepted in a previous Death in Custody investigation report, previous episodes of self harm should be fully taken into account when conducting an assessment to ascertain a prisoner's suitability for in-possession medication.

At interview, the nurse said that she *"…did not check the EMIS database for background information on Mr F. As Mr F responded to the questions in the IP* (In-Possession) *assessment I ticked the appropriate boxes. I just ask the question, 'have you overdosed on medication in the last three months'. Mr F advised me that he had not, I did not check EMIS and I did not have any paperwork to check the validity of his answer."* The nurse went on to say, *"if Mr F had advised that he had overdosed on medication he would have been found not suitable for in-possession. I had no papers in relation to Mr F other than the IP assessment. In Mr F's case I was content to accept his answers to the questions posed in the IP assessment."* The 'in-possession' risk assessment was not recorded on EMIS by the nurse.

The nurse also said *"I am aware that Healthcare received an instruction from Healthcare Management which advised that when undertaking an IP assessment that EMIS should be checked and that nursing staff should not just accept the word of the prisoner. I am not sure when this instruction was issued."*

Attempts were made to obtain a copy of the instruction issued by Healthcare Management regarding the weight to be attached to prisoners' self–reporting in relation to in-possession assessment. An Operational Nursing Manager advised, *"I do not routinely keep copies of emails regarding good practice, if I issue an instruction I keep those and this was not issued as an instruction."* It was ultimately not possible to establish the existence of an instruction, guidance or other form of communication (e.g. minutes of a meeting) to SEHSCT staff about this important matter.

The SEHSCT 'In-Possession' medication policy states *"Within the Northern Ireland Prison Service a prisoner will be assessed on their suitability for storing and taking their own prescribed medication within 1 week of committal. Healthcare staff will work according to the Standard Operating Procedure 'In-Possession Risk Assessment.' Three areas will be taken into account when making an assessment:*

- *patient factors e.g. whether a patient has a history of overdose or self harm;*
- *environmental factors e.g. whether a patient is sharing a cell; and*
- *medicine factors e.g. how potentially dangerous a medication is in overdose or liable to misuse."*

Point three of the abovementioned Standard Operating Procedure states *"In order to complete this assessment HCS* (healthcare staff) *must endeavour to obtain a complete medical history and an up-to-date list of the patient's current medication."*

Regardless of what instruction or guidance was issued to staff it was however the case that the nurse should have endeavoured to obtain a complete medical history.

It is also significant that an 'In-Possession' Risk Assessment was undertaken when Mr F had previously been in Maghaberry on (date redacted). At that stage it was decided he was deemed **not** suitable for In-Possession medication due to his self harm history.

SECTION 8: KEY EVENTS BETWEEN (dates redacted)

Prisoner Request – Phone Credit

Mr F submitted a written request seeking £21 emergency phone credit on (date redacted) for the following reasons: "*I have a case tomorrow and I need to make several legal calls. My partner is not coping too well with my incarceration and neither is my mum and nor am I. I would like the opportunity to speak with them.*"

As detailed previously, such requests are handled electronically without the senior officer discussing the request with the prisoner.

The senior officer granted the request stating; *"I am prepared to grant this request on this occasion, however I have become aware that you also asked for this facility last week, as you are aware phone credit is requested on a Thursday and you are responsible for ensuring that you have sufficient money in your IPC[23] to ensure this does not happen again."*

At interview, the senior officer who approved the request said *"I had just been promoted to senior officer that week and was covering in Erne House. When I received the request I spoke with the landing officer who told me that Mr F was a good prisoner and caused no problems. I was aware of the emergency guidance and in Mr F's case I showed flexibility and granted him his request."* The senior officer was asked if he took any action as Mr F had indicated in his request that he was not 'coping well'. The senior officer advised *"At present I would receive five such requests each day and deal with each case on its own merits. The content of Mr F's request on* (date redacted) *would be similar language that is used in such requests."*

Mr F had a SPAR Booklet closed three weeks earlier, and this was the second time, within seven days that he had indicated, through correspondence to senior officers, that he was not coping well. This highlights the need for staff and managers to be constantly vigilant to prisoners' demeanour and other risk indicators. Providing staff with a mechanism to identify those prisoners who have recently been on a SPAR would be of assistance when trying to distinguish those prisoners who genuinely need to be identified as being vulnerable.

Phone Calls

Later that afternoon Mr F asked his partner to contact the PSNI Domestic Violence Officer and formally withdraw the charges against him. (It is unclear what is meant by this as

[23] IPC - Inmate Personal Cash (prison account).

previous calls indicate his partner had already withdrawn her statement.) His partner responded by telling Mr F that if she did withdraw the charges, she would get into trouble with the authorities and would make her *"out to be a liar."* Mr F responded *"Just withdraw the allegation, everything else has been taken care of, it is my only shot left, there are other things at work here. I am not supposed to be telling you this, you do it, I'm begging you to do it."*

The conversation moved on with Mr F asking his partner if she had thought of a new surname (as part of his plan to move to Belfast, change his name and start a new life with her upon his release) yet. She did not reply. The telephone call ended with his partner asking Mr F if he was taking his medication - he did not reply. Mr F's partner told him to take the tablets, and he said *"No, you know what I am doing with it."* Mr F's partner told him to take them again and he said, *"I'll start tonight, you know what I was saving them for."* It is unclear what Mr F meant by this statement. When asked, Mr F's partner could not recall the conversation.

Shortly after speaking to his partner Mr F made contact with a family member. The family member asked Mr F if he was taking his medication and he said, *"I am but they are not working and I am hyperventilating every day".* It is therefore unclear - from these calls or from any other source of evidence - whether Mr F was taking his antidepressant medication as prescribed.

Mr F made a further call to his partner and said to her that if she told the police that the assault never happened, then he would be released from prison. He said that if she did not, he could receive a six to eight year sentence. At interview, the EMDR therapist stated that when she met him on (date redacted) *"He* (Mr F) *was making positive plans for the future, to move to Belfast,* (and) *to change his name..."*

(Date redacted)- Telephone calls

Mr F phoned his partner on three occasions on (date redacted). During the first call there were raised voices between them because his partner did not want to tell police that the assault was not committed. Mr F became very stressed about the situation saying *"You need to get up tomorrow* (prison visit). *Jesus f***, I'll die myself, I'll tell you what, I'll sort it out myself, cause I'd rather die than do what I am going to have to do."* The conversation deteriorated as both Mr F and his partner became frustrated with each other. Mr F's partner said *"When it goes to court it's going to be very dirty* (the case). *I am about to open my statement* (his partner had previously withdrawn her statement but despite this the PPS were still prosecuting Mr F) *again if it goes any further. I'll have to go against you."* The conversation ended with Mr F telling his partner *"Please don't walk away, if you walk away from me I am dead, I'd be dead by tonight".* His partner told Mr F that she was not walking away from him.

The second conversation was more settled than their previous telephone call. Mr F also mentioned that he had not taken his tablets as *"they are not worth a f***"*. Mr F's partner said to him she was going *"off the rails"* and *"I'm going to kill myself."* Mr F replied *"Don't you dare, I have two letters written to you tonight and if I didn't get speaking to you I was going to do something* (crying) *don't you dare…. If I didn't get you this evening, I have it all sussed….. I wrote out my letter to you this evening. Don't kill yourself, because if you do I will do the same I swear to god I will, I'm hanging on by a thread as it is, the only thing that keeps me going is you."*

At interview, Mr F's partner was asked if she made contact with the Prison Service following her conversation with Mr F in which he was indicating that he would take his own life. She said *"I did not take any action as Mr F would make similar comments whilst outside of prison"* and was not alarmed by them.

During the third call to his partner, Mr F told her that the tablets were not working. He was advised by his partner that it would take time for the tablets to *"kick in"*. Mr F told her that his heart was going mad, *"I am scared today and my heart is racing"*. At interview the prison psychiatrist, suggested the reason why Mr F's heart would have been racing was down to the fact that he was not taking his medication at all or as prescribed.

The final call ended with Mr F sobbing a lot. During the investigation both staff and prisoners were asked if they ever observed Mr F being emotional or upset. Other than the one occasion, which was observed by the senior officer and reported on (date redacted) as part of the investigation, no member of prison staff or prisoners could recall any instances of him being visibly upset.

(Date redacted) – Telephone Call

Mr F called his partner and asked her again if she had thought of a new surname yet. In response, his partner said *"That's if I'm around."* Mr F told her that he had spent the previous night making a noose and practising how to hang himself. He went on to tell her *"that's what I spent last night doing, getting the length right, getting it on the pipe, making the noose, setting everything up. It's surprisingly hard, the cell is designed not to do it* (availability of a ligature point) *but I have got a way round it. I don't want to cause you anymore pain."*

At interview the prisoner with whom Mr F had been sharing a cell with up until (date redacted), said *"Mr F would have asked me at times how a prisoner would hang himself, he was more curious than anything else. He told me that if he was going to get a few years he was not going to do it. He did not express that he was suicidal."*

During the call Mr F continued to discuss that he wanted to die and promised his partner that if he *"hurt"* her again he would hang himself. His partner responded by telling him

"You're just being stupid". Mr F continued to tell her that he had run out of his medication and that although he had taken seven tablets the previous evening *"They were no good".* At interview the prison psychiatrist said that if Mr F had taken seven fluoxetine tablets *"It would increase his restlessness or give him some cardiac difficulties".*

(Date redacted)– Telephone Call

Mr F called his partner and they discussed a statement that he was going to make to his solicitor in relation to his case. His partner was concerned and told Mr F that if she did not like what she heard she would *"open"* her statement again stating, *"I am the victim here, do you not see that?"* Mr F replied *"that's why I want to kill myself every night. I just want to kill myself; I just want to kill myself. I could do the decent thing and just end it here because I can't do this anymore* (started to cry*)."* His partner replied *"you won't do it I know you won't, because you won't leave me. I know you won't do anything because you will know that I will be on my own."* Mr F pleaded again with his partner to withdraw the charges against him.

(Date redacted)– Lifeline Contact

A family member contacted Lifeline[24] because they were concerned about Mr F. They outlined their concerns about him being *"very distressed"* and that he had *"attempted to end his life"* three weeks before he was sent to Maghaberry.

Lifeline confirmed that at 19.22 on (date redacted) they contacted Maghaberry's Emergency Control Room (ECR) on behalf of the family member and relayed their concerns. Lifeline was told the person who took the call was going to *"pass the message on to security staff,"* and would *"keep a closer eye"* on Mr F. The Lifeline record also states that the family member did not want Mr F knowing that it had come from them.

The ECR log has an entry at 20.10 on (date redacted) that notes: *"Upon handover from ECR day staff, we were informed information had been received that Mr F, Erne 4, cell 15 &* (prisoners' name & location redacted) *had both threatened to kill themselves. Staff informed."* It is recorded that the duty principal officer and night guard senior officer were also informed of this message.

The night custody officer (NCO) who recorded the message in the ECR journal could not remember the specifics of his log entry, but was emphatic that due to the time the call was made by Lifeline, and the timing of the entry, that he would have received this information at handover from day staff. He said that the information recorded would have been a

[24] Lifeline is the Northern Ireland crisis response helpline service for people who are experiencing distress or despair.

verbatim account of the handover he received and the actions he took – that landing staff, the duty principal officer and senior officer were informed.

The senior officer who was recorded as having received the message said he could not recall the matter; and said that if he had received such information he would have assessed the vulnerability of Mr F by speaking to landing staff and carrying out a background check on previous SPARs. He said that this type of information would not have automatically meant that a prisoner would have been placed on a SPAR.

The night guard journal for Mr F's landing does not contain any record of the message. The NCO who was on duty at the time said that he could not remember the specific night in question. He insisted that if he had been told Mr F was threatening to kill himself, he would have made a record in the journal and, in consultation with his senior officer, opened a SPAR booklet.

It was also established that this NCO received a handover from a senior officer pertaining to Mr F a few days earlier, to the effect that he was asked to *"keep an extra eye"* on him as he had received a bad phone call. The NCO said that as a result he checked on Mr F every hour when conducting his routine peg checks[25]. There is no record of this in the journal because, he said, Mr F was not on a SPAR and he was only asked to keep an eye on him.

Two out of the three ECR day staff (the third was unavailable for interview), who were on duty at the time the Lifeline call was received said they could not remember receiving it. It was also clear that there was no consistent approach to recording such calls. The Switchboard has a policy to record such calls in a 'Safer Custody Call Log Book', including to whom they were passed. Despite the ECR being responsible for managing the switchboard out of hours, no such training or policy has been shared with ECR staff, and they were unaware that a call log book existed.

In summary, while the ECR log confirms that Lifeline's phone call was received at Maghaberry, it appears that Mr F's threat to kill himself was not acted upon appropriately.

Initial Psychiatric Assessment

On (date redacted), Mr F had his initial psychiatrist assessment. The prison psychiatrist noted the following in Mr F's medical notes: *"He was referred to MHS* (Mental Health Support) *after he advised that he had attempted suicide by OD* (overdose) *two weeks before committal. He was seen and commenced on fluoxetine and referred to nurse* (name redacted) *for some work on trauma. He reports his mood seems to fluctuate, but the panic and anxiety attacks are still present. He reported being remorseful of his offence and*

[25] Peg checks are when officers walk the landing to check that the landing is still secure.

accepted that alcohol may have played a role. He has so far had a first contact for trauma work and hopes to engage well.

He reported anxiety still present and panic attacks which he finds stressful present. He stated his sleep remains poor and was not a good sleeper anyway. His appetite is ok. He denied any TSH (thoughts of self harm) *and he is hopeful of the future. He denied any paranoid ideation or any other psychotic symptoms.*

Comment: my impression is that Mr F has mixed depressive and anxiety difficulties secondary to his social circumstances. Sometimes depending on the stressors in his life, his depressive symptoms may intensify. He is keen to continue work with EMDR nurse on trauma. He did not wish to engage with CRUSE[26] as he feels in his own way he has dealt with the death of his ex partner. I increased fluoxetine to 40mg."

The psychiatrist also said that she reviewed Mr F's medication with him. She said that *"he said he was taking the medication. I asked* (Mr F), *it's required of me, if a patient has commenced on medication, if he feels the medication is effective or that he has any side-effects from it, he said things were improving for him."* The psychiatrist said that because he was not having any side effects and he was feeling an improvement from them she said that *"it was the right thing that I increase it to 40mg".* The psychiatrist would not have been aware of Mr F's phone calls which suggested misuse of his medication.

Commenting on the actions taken that day by the psychiatrist, the Clinical Reviewer, Dr Rix said, *"on the evidence recorded, her impression cannot be faulted. By this time the deceased was taking fluoxetine 20mg daily, or at least she thought he was, and her decision to increase the dosage was within a range of reasonable opinion even though, within that range of opinion, there were psychiatrists who would not, on the evidence available, have found a justification for antidepressant drug therapy. By this time on* (dates redacted)*, the deceased had made implicit threats of suicide to his partner but he had not acted on these. The psychiatrist did not know this. There are two possibilities. First, these were genuine threats and they were concealed from, or not revealed to the psychiatrist on* (date redacted). *Second, they were manipulative and the deceased denial of thoughts of self harm and suicide and his expressed hopefulness on* (date redacted) *were genuine."*

Dr Rix also said, *"It is unfortunate that the health professionals were not aware of his incomplete compliance with, or adherence to, the medication regime. However, he was not in the healthcare centre, where there would have been opportunities for supervision and there was no reason for him to be. He was the equivalent of a psychiatric outpatient*

[26] CRUSE Provides bereavement support and counselling to people suffering from grief.

at home in the community and trusted by his general practitioner and mental health specialists to take his medication as prescribed."

Ms Jenkins was asked to comment on what impact, if any, Mr F's intermittent taking of his fluoxetine would have had on his wellbeing. She said: *"It can take some time after the start of treatment before there is an improvement in symptoms even if the drug is taken regularly, so in the initial stages, missing a dose may have little effect… Mr F told his partner on* (date redacted) *that he was out of medication as he had taken 7 tablets the previous night. If this were true, when* (the psychiatrist) *increased his dose to 40 mg on* (date redacted)*, he would not in fact have been taking fluoxetine for the previous week. Rather than receiving a dose increase on this day, it would have effectively resulted in him receiving a starting dose of 40 mg.*

Moderate overdoses of fluoxetine (up to about 30 times the usual daily dose) are generally associated with minor symptoms at most, so Mr F is unlikely to have exhibited any significant problems if he had taken 7 tablets in one go."

In considering whether the increase in dose of fluoxetine (from 20mg to 40mg) on (date redacted) had any bearing on Mr F's wellbeing, Ms Jenkins said: *"Although an increase in fluoxetine dose could potentially have elevated Mr F's mood, the incidence of suicidal thoughts is often increased in the first few weeks of treatment and this in itself does not necessarily warrant an increase in dose. Prior to the increase in dose, Mr F is experiencing panic attacks, poor sleep and symptoms of a racing heart. These are all side effects of fluoxetine and have the potential to worsen with increased dosage. It is recommended that patients and in particular those at high risk should be closely supervised in early treatment and following dose changes. This does not seem to have been the case with Mr F either at the start of treatment or following the increased dose.*

As Mr F does not appear to have been taking fluoxetine for a week prior to this increase in dose, it would in my opinion have been more appropriate to re-introduce fluoxetine at a 20 mg dose and see if there was an improvement in symptoms…."

As previously noted, the investigation established from Mr F's phone calls that the psychiatrist was unaware of Mr F's self report that he was taking his fluoxetine irregularly.

It is also significant that Mr F had been requesting his medication at weekly intervals which would indicate to the issuing nurse that he was taking it as prescribed.

SECTION 9: MR F'S MOVE TO A SINGLE CELL

One of the concerns raised by Mr F's family was about why he was in a single cell at the time of his death. The move took place on (date redacted), three days prior to his death. At interview staff advised this was a reward for his behaviour and conduct whilst in Erne House. Prison staff described Mr F as *"a gentleman who kept himself to himself, a model prisoner who gave staff no cause for concern."* One of the officers said that Mr F, *"was keen to get his own single cell, the staff had made the decision to give him the orderly's job to help him into a single cell."*

At interview, another officer said that two days after moving into the single cell Mr F was making plans and had asked for a shelf to be put up for books and a new notice board in his cell. The officer said that he told Mr F to leave it with him and that he would *"sort it out"*. The officer said Mr F *"was thinking ahead and it was all positive at the time"*.

The prisoner with whom Mr F last shared a cell said *"Mr F talked on a few occasions about hanging himself. I would ask him why he wanted to hang himself, Mr F said that he could not live without his girlfriend."* The prisoner said *"On the day that Mr F moved to a single cell I told two regular female members of staff that he should not be moved into a single cell as he was talking about taking his own life, they replied that they would look after him."*

In the absence of CCTV on the landing and despite extensive enquiries, this investigation has been unable to identify the female officers to ascertain whether this conversation took place and, if it did, what actions were taken as a result.

Commenting on the decision to move Mr F to a single cell, Dr Rix said: *"Health considerations and suicide risk form only part of what I understand to be a number of considerations involved in cell allocation decisions... I understand the potential benefits of cell sharing for a prisoner identified as being at risk of deliberate self-harm or suicide, but cell sharing could increase rather than decrease the risk. Given that the Deceased's cell-mate was loud and aggressive and taking drugs, it would be understandable that the Deceased should look forward to getting into a single cell and his statement that he had been 'promised' one is consistent with this..."*

SECTION 10: EVENTS BEFORE MR F WAS FOUND HANGING IN HIS CELL

Telephone calls

At 09.15 on (date redacted) Mr F called his partner who said that she had been speaking to one of his family members the previous night and that there had been a discussion about Mr F not telling the truth. His partner said *"When I visited you in prison on* (date redacted) *you told me bare faced lies and then after a while you told me the truth."* Mr F's demeanour changed and he could be heard sighing during the call. Mr F asked his partner to keep away from the family member because they were *"poison"* and not to fall out with him. His partner replied *"You have lied to me all along, if you can't tell me the truth don't ring me again".*

Between 09.36 and 09.42 Mr F made a total of nine unanswered calls to his partner. At 09.43, his partner answered and Mr F pleaded with her saying *"I just want to get out of prison to be with you. I want to marry you."* His partner replied *"You love every woman you have been with and made promises to all of them. I know what you have done and you have done the same to every woman."* Mr F continued to plead for forgiveness from his partner but received no response. Mr F ended the call by saying, *"I'll tell you what you do, I'm f*****g going down now. I have a rope and I'm going to f*****g do it."*

Further EMDR Assessment

At around midday Mr F met with the EMDR therapist for the second time, as part of a pre-scheduled continuation of his EMDR assessment. During the course of the assessment the nurse recorded that Mr F presented as being anxious and tearful about his offences and guilt. The nurse recorded that *"he remains concerned about his girlfriend who appears to be struggling at home."* The nurse continued *"He was sweating profusely today, unsure if distress related or the fact that his fluoxetine has been increased. Mr F feels the fluoxetine is making his sleep worse and has only slept 40 minutes in the last 48 hours."*

Commenting on the nurse's observation that Mr F was sweating profusely, Ms Jenkins said, *"Hot flushes are a side effect of fluoxetine treatment and this may explain Mr F's sweating."*

In relation to Mr F's lack of sleep, Ms Jenkins said, *"Studies have shown that long term lack of sleep may increase a person's risk for suicide ideation. If Mr F was sleeping for less than an hour at night as suggested…this could potentially have increased his risk for suicide."*

Bearing in mind Mr F's recent increased dose of fluoxetine, Ms Jenkins said *"An increase in dose of fluoxetine may have made this symptom* (poor sleep) *worse and a sleep aid such as temazepam could have been used in conjunction with an antidepressant to combat this side effect."*

At interview, the nurse said that she was aware that Mr F had spoken to his partner the morning of the assessment or the evening before and *"he was very concerned about her because her family were putting her under pressure to end the relationship. He was upset, he was more concerned about her at that stage, but, again, he had thought that they were going to be together, he was making plans."*

The nurse also said *"He denied being suicidal to me … and … because he was making positive plans for the future I did not at any time think that he was going to end his life. I would suggest that he went on a SPAR if I thought there was any plans for self harm or suicide. You know, you couldn't, put them* (prisoners) *on SPARs because they're anxious."*

Asked how she challenged what Mr F had told her at the review, the nurse said, *"I would say to him, what would your protective factors against suicide be and his protective factor is that he has got two children living … with his brother. He was making positive plans for the future, to move to Belfast, to change his name, he even actually told me the name that he was, he was changing to."*

The nurse said that she brought the assessment to an end by undertaking a relaxation exercise with Mr F and by the end of the session he was *"in fairly good form"*. She added *"I was slightly concerned about him but not to the extent were he should have been placed on a SPAR. He was positive, looking towards the future, moving to Belfast when he was released from prison to start a new life with his partner."*

On EMIS the nurse recorded *"I will continue to see re trauma work, he denies any thoughts of self harm or suicide currently, hoping that he will get better and begin a new life with his partner on release"*.

The nurse also said that following her session with Mr F, she spoke to one of the landing officers and told him that Mr F was *"not in great form,"* although, she said *"I didn't think there were any major concerns to be honest*". Whilst the nurse could not confirm what actions, if any, the staff took she said, *"The officers on that landing I have to say were particularly good."*

At interview, the landing officer with whom the nurse had spoken to said that the nurse told him that she didn't think he (Mr F) was likely to *"do anything to himself,"* but just to keep an *"eye on him"*. The officer said that within half an hour of the nurse speaking to him he went down to Mr F's cell and spoke with him. He said that, *"I told him* (Mr F) *that the nurse had told me she was concerned about him and I asked him was he okay. He said he was fine and*

I told him that he could talk to any one of the staff and if there was anything we could do to help we would do our best and he was smiling and nodding saying yes and thank you throughout that (the) *conversation. Then at 14.00 or around 14.00 hours I observed Mr F taking his, his tea meal from the servery and then some time between that and half four I observed him using the telephone in the circle* (an area on the landing)*."*

The officer also said that, *"After the nurse had left Mr F, I gave him that opportunity that if he wanted to talk to somebody, he could talk to me, we're here now, there's no other prisoner's around. If he wanted a chat we could have a chat. As I would do with any prisoner who's maybe a bit depressed or low I would have offered him the listener phone at any time he wanted it sorry, the Samaritan phone or a listener to come to his cell and I told him to, not to hesitate and knock the door or hit the cell alarm if he wanted to talk to any of us. I said that if there's somebody else you want to talk to, because you don't really know me, I'll certainly try and you know we're here to help you."* The officer also said that Mr F *"didn't express any concern to me at all, on any issues he had. If I had come away alarmed or worried in any way I wouldn't have had any hassle at going and opening a SPAR up on him, but because the conversation went quite well and he assured me that he was okay and that he didn't need any of the resources that I had offered to him, I felt quite content."*

Commenting on the actions taken that evening by the nurse the Clinical Reviewer, Dr Rix said that the nurses consultation with Mr F was *"…critical, given what happened that evening, where the deceased's denial of any current thoughts of self harm or suicide and his hope that he would get better and begin a new life with his partner on release. If by this time he was planning to end his life, he skilfully concealed this from the nurse. If by this time he was still hopeful in the way that she ascertained, his decision later to hang himself was a sudden and impulsive decision that could not have been predicted."*

Dr Rix also said *"The main concern in this case is that prison staff seem to have been unaware of the desperate state of the Deceased's relationship with his partner and with his family members…. By the day he died the Deceased seems to have given the impression that this was why he was not having thoughts of self harm or suicide."*

Telephone calls

Between 14.58 and 15.06 on (date redacted), Mr F made 11 unanswered telephone calls to his partner. At 15.07, Mr F made a further call to his partner, leaving a message on her answer machine asking her to call the prison to let him know that she was alright. Between 15.08 and 15.16, Mr F made a further nine unanswered telephone calls to his partner.

At 16.06 Mr F made contact with a family member. Mr F told this person that when his solicitor was last in with him he had told them that he may get three to four years in prison. He went on to say *"I'm not going to do it"* (the prison sentence). When the family member asked what choice he had, Mr F did not reply and moved onto another subject. The

conversation became heated and Mr F ended the call by agreeing to make contact again soon.

At 16.14 Mr F made one further and final attempt to contact his partner. He left another message on her answer machine saying *"please contact the prison to let me know you are ok as I won't sleep a wink tonight."*

Call to Maghaberry by family member

The family member with whom Mr F had spoken at 16.06 said that following their last conversation they realised that it had ended in bad terms, so they decided to call the prison. They asked to be put through to the visits booking office to relay their concerns and to book a visit for the following morning. However they were kept on hold for 20 minutes, and when they finally got through, an answer phone message indicated the booking office was closed. They did not then know to whom they could relay their concerns. The visits booking office is open Monday to Friday between 08.00 and 17.00, and on Saturday and Sunday for amendments to bookings and emergencies only.

The member of staff who took the call advised that he could remember receiving a call from a person on the evening of (date redacted) at around 16.55 who asked to be put through to the 'Family Information Unit[27].' The staff member advised the caller that it was the family officer they required. However there was no one on duty and he suggested they phone back the following day. The staff member described the caller as being calm, *"very matter of fact"* and said there was no urgency in their call. He also said the caller did not raise any concerns or identify who they were. It was unfortunate that the family member did not identify the extent of their concerns as they could have been put in contact with the Duty Governor or landing staff.

Mr F's family suggested that the answer phone message for the Family Liaison Officer and Visits booking line should provide information on how to relay concerns about a loved one when their offices are closed.

All prisoners in Erne House were locked down in their cells from 16.45. There was no association period for prisoners that evening due to staff shortages.

Prisoner's Accounts

The prisoner who had shared a cell with Mr F in the past, said at interview, that he had seen Mr F on the day of his death and described his mood as being good and that he, *"had a bit of banter with him."*

[27] Family Information Unit offers support and guidance to families and friends of prisoners.

Another prisoner, who was interviewed, said that on the afternoon/evening of Mr F's death he saw Mr F use the telephone. He said that when Mr F finished his call he greeted Mr F but did not receive a response. The prisoner described Mr F as looking frustrated and slightly agitated.

Mr F's last cell mate advised that on the day of his death he had spoken with him at around 16.30. He said, *"I knew by looking at him he wasn't just right. I asked him how he was feeling and he said he was alright. He did not mention that he was going to take his own life, but I just knew that things were not right with him. At 5pm I spoke to officers on the landing and told them that Mr F was talking about taking his own life".*

Another prisoner on the landing, said that Mr F looked a *"bit down"* but that he did not know him well enough to talk to him.

Incident Involving Razor Blade

It is recorded in the senior officer's journal that at 17.15 on (date redacted), Mr F had cut his finger and, as a result, a nurse attended and dressed the cut.

At interview the senior officer said that she and the nurse both found him *"embarrassed, he said oh this is such a fuss and I asked him because I was genuinely interested how he done it."* The senior officer said that Mr F told her that he had cut into a cigarette butt to extract tobacco that could be used for a *"rollie[28]",* which she said she had seen done in the past. The senior officer also said that because the tuck shop would not have been available for two weeks (because of the July holidays) she thought his actions surrounding the tobacco *"would have implied, you know, there was a long-term goal there. He's saving his tobacco."*

The senior officer continued by saying, *"we were firm in our minds at that time that this was a genuine accident, he was embarrassed, he disliked the fuss that had been caused because he knew the lockdown, prisoners round about were shouting things like has he cut himself and, and we were saying no, no it's been an accident. Don't be panicking, nobody panic. Then, when we closed the door, Mr F was fine. Mr F was absolutely fine. As I said, I mean, there were long-term goals there, he was eking out his tobacco, no indications at that time of anything at all."*

The nurse who attended recorded in Mr F's medical record: *"…denies any thought of self harm or life not worth living. Apologetic about having cut his finger. IMR[29] completed."* Maghaberry's healthcare department have been unable to locate the IMR or any record to show it was processed, which is a matter of concern.

[28] Rollie - A cigarette rolled using barely any tobacco and paper skins.
[29] An IMR is an injury report form.

At interview the nurse said Mr F *"demonstrated how he accidentally cut his finger. He claimed it was an accident and he actually demonstrated exactly how he had actually cut himself. He was opening a cigarette* (butt) *to get tobacco, you can make it last longer from an ordinary cigarette into a rollie, and that's how he did it. He seemed in an upbeat form, you know he was chatty, he had no thoughts, there was no concerns and as he said himself it was accident, he had no thoughts of harming himself that day or not want to live or anything like that so, he was actually surprised, it seemed like a genuine accident."*

The nurse could not remember what review of Mr F's medical file she did before she attended or the specific conversation she had with him saying, "*as a rule, unless there was a total emergency, normally we would look to see has he any medical conditions and if he had a history of harm, has he a history of overdoses, a general history. My background is in mental health, so I would have asked a lot of in depth questions. From the responses that I was receiving to my questions and his mood, he was very upbeat and there wasn't anything to show me or cause me any concern at all."*

Commenting on the actions taken that evening by the nurse, Dr Rix said *"I do not recall ever seeing someone whose pattern of Para suicidal or deliberate self injury included, or was limited to, cutting their forefinger. Even knowing that the deceased had a history of self injury, I would not have expected even a mental health professional to have considered it very likely that this was Para suicidal behaviour let alone attempted suicide. Be that as it may, the nurse asked the deceased about suicidal ideas and she received a reassuring answer. She had no reason to try to go behind the answer. It appears to me that the nurse demonstrated good practice."*

The landing officer who was present for the medical unlock confirmed that Mr F's reaction to this incident was one of embarrassment. The officer also said that whilst standing at the cell door, he *"noticed an envelope with a letter inside it which I assumed was for posting out, as it was the normal place for outgoing mail. I also observed some blood smears on this envelope. I decided that Mr F had placed the envelope there after his accident and with the information* (the EMDR therapist) *had passed to me earlier I decided to lift the letter and read it so that I might get an insight into his frame of mind... The letter was all about him, his girlfriend, their life and the future, his dislike of prison and not wanting to ever make a mistake to put him back in prison. If anything, the letter was positive, pro-life, about their future. I had no reason for concern with regards to him and self harming and the senior officer and my other colleague agreed, you know, that it was all very positive."*

SECTION 11: EVENTS AFTER MR F WAS FOUND HANGING

Discovery of Mr F hanging and actions of staff

At 21.45 on (date redacted), a supervised check commenced in Erne House by the Night Custody Officers (NCO's) and the night guard senior officer. It is recorded in one of the NCO staff communication sheets that *"at approximately 22.56 hours…during my check of landing 4, I discovered that in cell 10, Mr F was positioned in the corner of his cell behind the cell door."* The NCO went on to describe how he and his colleague entered Mr F's cell and saw that Mr F *"had a ligature tied to some pipework behind the door and around his neck."* It is recorded that the ligature was cut and once Mr F was placed on the ground cardiopulmonary resuscitation (CPR) was commenced until further help arrived.

At interview, and in his staff communication sheet, the NCO who found Mr F in his cell said that the Hoffman knife[30] on his belt was blunt and wouldn't cut the ligature. He said *"Within a split second,"* he reached over to his colleagues belt and used his colleagues Hoffman knife, which was sharper, to cut the ligature. He said that he "*could tell right away,"* that Mr F didn't look *"normal"* and *"wasn't a good colour… He had sort of mucus and stuff coming from his mouth."* The NCO said that it was the senior officer who commenced CPR first, supported by two other officers rotating between them.

At interview, when asked whether there was anything that he would have done differently, the senior officer said *"The only thing, from my own point of view that I would have certainly benefited with and obviously hindsight is a wonderful thing, if I had some first aid training."* The senior officer said "*I think they* (night guard officers) *had some first aid training but, I mean, at night time it would be great if everybody could have first aid* (training)." The senior officer had not received any First Aid Training since 1998, which is when training records began.

In discussing what CPR he applied, the senior officer said "*It was probably at most 20 seconds, just we literally lay him on the floor. I literally said does anybody have any training in this. I think it was the other officer who entered the cell said he had. I believe that's the way it came about that,* (the officer) *said yes I have, and he took over."* He went on to say *"The limited training I had was many, many years ago. It's not that I've no training but it was a long, long time ago."* He also said he had not received First Aid training since Mr F's death.

The NCO who applied CPR to Mr F said *"There was* (were) *no signs of breathing. I checked for a pulse around his neck...couldn't find any pulse. I think between the three of us* (senior officer and two NCOs) *we realised that there was, you know, no pulse there, so we carried*

[30] Hoffman knife. A Hoffman knife is used to cut a ligature and is carried on the night guard's belt.

on with our CPR. Between myself and the senior officer we commenced compressions on Mr F's chest."

Four minutes after Mr F was found and emergency assistance was requested, a nurse arrived in Erne House. In her EMIS record the nurse recorded: *"I entered the cell and the prisoner was lying on the floor and unresponsive, eyes fixed and dilated. I checked the prisoner for vital signs. No carotid pulse present*[31]*, no breathing noted, airway clear. CPR continued, heart start applied and CPR continued, 0² applied via ambu-bag, vital signs checked – none noted. At 23.14* (another nurse) *arrived and assisted with CPR. She applied suction to the prisoner who had copious amounts of brown coloured bodily fluid noted. Ambulance crew arrived at 23.25 and took over."*

The second nurse recorded the following in Mr F's EMIS record: *"Called by ECR to bring oxygen and 2nd response emergency bag. I arrived at* (the) *cell at Erne House at 23.14. I assisted with CPR and commenced suction as copious amounts of passive vomit/brown bodily fluid noted, pt* (patient) *turned on his rt* (right) *side to allow for easy access to suction. Vital signs taken and none noted. Heart start advised no shock and to continue with CPR 30/2.* (The other nurse) *tried to cannulate*[32] *but unsuccessful. CPR continued until ambulance crew arrived and took over at 23.25hrs. Ambulance crew pronounced death at 23.30hrs, pt pupils fixed and dilated, no output recorded."*

Prisoner Accounts

A number of prisoners were interviewed and questioned about the night Mr F's body was discovered in his cell. The prisoner who had shared a cell with Mr F in the past said there was confusion between staff and it appeared that staff did not know what they were doing.

Another prisoner said that on the night of Mr F's death he heard a male voice, which he assumed to be that of a night guard officer, shout at a female, who he assumed was a nurse, saying, *"you have the wrong box,"* and then he heard a female start to cry. He went on to say that he heard the female run down to the medical room and return a few minutes later and the officer shouted at her again, *"it's the wrong box".* The prisoner said that he heard another prisoner shout, *"you stupid b*****d"* in response to the wrong box being brought up. He described the female as being hysterical by this time and he heard someone take her off the landing.

A third prisoner who was located close by said that at about 22.30/22.45 he heard an officer shout *"He's hanging."* He then heard a female voice say *"Get the key, get the key,"* and he thought this related to a medical box rather than a cell. He went on to say that he heard a

[31] Carotid pulse - Palpated by gently pressing a finger in the area between the larynx and the sternocleidomastoid muscle in the neck.

[32] Cannulate. Intravenous cannulation is a technique which is used to place a cannula inside a vein for the purpose of providing venous access.

female *"give off"* that someone had brought the wrong key and she raised her voice. He advised that this went on for about 45 minutes.

These prisoners spoke with an IMB member who visited Erne House on the morning after Mr F's death. The IMB member recorded, *"I spoke to landing staff who were quite shocked because they had not seen any of this coming. Indeed other prisoners who I later talked to said the same thing. Mr F was a quiet, inoffensive type of bloke who kept himself to himself, was pleasant, unassuming. I spoke to his past two cell mates. Some of the prisoners thought Mr F had shown indications of depression and had used the listener scheme. Others were shocked because the death re-traumatised them about other cases they themselves had suffered."*

Information received from The Samaritans (the organisation who runs the Listener Scheme) states that Mr F had informal contact with a prisoner, who had been a Listener in England and was going through his renewal training in Maghaberry at the time, on the day that he died. Listener contacts are confidential and, therefore, the contents of which cannot be disclosed to this investigation.

In the absence of CCTV it is not possible to categorically determine the true version of events that took place. There was, however, no record that prisoners raised any issues with the IMB member in relation to hearing a female being hysterical or crying; or that there had been disagreements or shouting between medical and prison staff; or indeed any of the confusion they described to Prisoner Ombudsman Investigators on the night of Mr F's death; or that they had previously informed prison staff on (dates redacted) of their concerns that Mr F was depressed and shouldn't be in a cell on his own.

At interview one of the nurses who attended the incident said that there was no confusion or friction between healthcare and prison staff and that *"everyone was very professional"*. She said that all of the medical equipment used was brought to Erne House on the night by rucksack and that there was no hysterical female who had to be taken off the landing, confirming that she and her colleague were the only two females on the landing, and that they both worked on Mr F until the paramedics arrived and took over.

Staff Support and Debrief Meetings

The Prison Service Self harm and Suicide Prevention policy requires that *"following a death in custody, hot de-briefing will take place and will involve all of the staff who were closely involved with the incident, as soon after the incident has been brought under control as possible."* A hot debrief[33] meeting took place at 01.25hrs on (date redacted). The notes from the hot debrief have been examined and there is no record of any confusion between Healthcare staff and prison staff on the night of the incident.

[33] The purpose of a hot de-brief meeting is to talk about the incident and ensure the welfare of the staff involved.

The policy also requires that *"a cold debrief will take place within 14 days of the incident to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional learning from events."* The cold debrief took place on (date redacted). One of the issues raised at the meeting was by the Duty Governor who said *"A review should be carried out on the issue of the Hoffman knives following the report by night staff that the blade on the Hoffman knife used was 'dull' requiring the use of another knife."* The Security Governor, who also attended the meeting, advised *"Security had no intelligence on Mr F but on review of his phone calls following his death, it was noted that he had domestic issues with his partner and fraught conversations with his family member on the day of his death."*

SECTION 12: AUTOPSY REPORT

An autopsy examination was carried out on (date redacted) and gave the cause of Mr F's death as:

I (a) HANGING

The report states:

"Death was due to suspension of the body by a ligature around the neck (hanging). The report of the Forensic Science Northern Ireland shows the presence of fluoxetine that lay within the therapeutic range. Analysis of samples of blood and urine taken at autopsy excluded the presence of alcohol and other common drugs.

The autopsy also revealed there was evidence of pre existing moderate heart disease in the form of narrowing of one of the arteries due to a degenerative process (cornonary artery atheroma). This is a common cause of heart attacks and a very common cause of sudden death. In this instance it would not have made a direct contribution to his death; however it may have caused distressing symptoms.

There were also a few minor injuries on the surface of the body, all of which could have been sustained as a consequence of minor episodes of accidental trauma."