The Prisoner Ombudsman for Northern Ireland

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

[24th March 2014]

[Published on 30th April 2014]

Dates and names 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.

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Glossary

CCTV	Close Circuit Television
CJI	Criminal Justice Inspectorate
CPR	Cardiopulmonary Resuscitation
ECR	Emergency Control Room
HMIP	Her Majesty's Inspectorate of Prisons
NCO	Night Custody Officer
NIPS	Northern Ireland Prison Service
PCO	Prison Custody Officer
PRISM	Prisoner Record Information System Management
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust
SO	Senior Officer
SPAR	Supporting Prisoners at Risk
SIR	Security Information Report

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 published subject to consent of 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. Where the next of kin are unwilling to agree to publication, I still make the full report available to the NIPS, the South Eastern health and Social Care Trust (SEHSCT) and the Coroners Service for Northern Ireland.

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 Northern Ireland Prison Service;
- examine any relevant healthcare issues and assess the clinical care provided by the South Eastern Health and Social Care Trust;
- examine whether any changes in Prison Service 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, Dr Patrick Quinn, Consultant Forensic Psychiatrist at the Yorkshire Centre for Forensic Psychiatry undertook a clinical review of the care provided to Mr E.

The report is structured to outline key events in 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 E's next of kin in (date redacted), and contact has been maintained with them throughout the investigation.

Although this report will inform several interested parties, it is written primarily with Mr E's family in mind.

I am grateful to Mr E's family, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and the clinical reviewer for their contribution to this investigation.

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

Tom McGonigle.

TOM McGONIGLE
Prisoner Ombudsman for Northern Ireland
24th March 2014

SUMMARY

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

Mr E had been remanded in custody on (date redacted) to await trial, and he subsequently received a 2½ year custodial sentence on (date redacted). This was his first time in prison. He regularly phoned his family, but did not receive any visits. He was initially charged on (date redacted) and his family reported he was under considerable stress during the four years that it took for the matter to reach its legal conclusion.

Mr E initially spent a fortnight on Maghaberry's committal landing, and the next seven weeks in Bush House, Landing 3. This location is predominantly for prisoners who are at risk from other prisoners, which in Mr E's case was due to the sexual nature of his charges and his timid presentation. He was never physically assaulted, but he believed he was subject to ongoing verbal abuse while on Bush 3.

During his time awaiting trial Mr E was not required to engage in purposeful activity. Staff encouraged him to attend the 'early yard' each morning because he was nervous about associating with other prisoners. Self-imposed isolation, feeling under threat and vulnerable are common complaints amongst prisoners charged with sexual offences. They require particular levels of understanding and support.

Staff described Mr E as pleasant and polite, *"a bit nervous"* due to the nature of his offences. They said he *"always had a notion that people were talking about him."* However the house nurse said that he never appeared to be in a low mood and was always cheerful.

Regular officers on Bush 3 were aware of Mr E's concerns that other prisoners were talking about him, though they never noted these concerns as significant. They distinguished between general verbal abuse of prisoners on his landing, of which they were well-aware, and personal abuse of Mr E, to which they were oblivious. They said that Bush 3 prisoners were regularly subjected to verbal abuse, but considered their relationship with Mr E was sufficiently strong that he would have addressed specific anxieties with them.

Other prisoners provided conflicting accounts of the levels of abuse to which Mr E was subjected: while his cellmate said he heard nothing, three other prisoners and an anonymous letter to the Prisoner Ombudsman reported hearing repeated, hurtful comments directed towards Mr E from a prisoner in the adjacent cell. Mr E himself was most concerned about verbal abuse from prisoners in Roe House, which was located opposite Bush House. Staff reassured him those prisoners could not touch him, and that he was at little risk of physical attack in Bush. However there was no

consideration of possible physical or verbal abuse from bullies within Bush, or when he was elsewhere in the prison.

Staff indicated a sense of inevitability about verbal abuse of sex offenders, and there was under-recognition of its impact. They viewed Mr E as a model prisoner, albeit somewhat eccentric and deluded. Having housed him on a vulnerable prisoners' landing, and taken a daily interest in his wellbeing, they believed there was nothing more that needed to be done. He had no known history of self-harm or suicide attempts, and cell-sharing and his self-imposed isolation may have been viewed as additional protective factors. Consequently the staff who knew Mr E were surprised when he took his own life.

Despite officers' awareness of Mr E's concerns, the NIPS Anti-bullying policy was not implemented, nor was he referred by staff to the Prisoner Safety and Support Team (PSST). Although officers suggested they would have arranged for perpetrators to be moved if the abuse was personalised, during Mr E's time in Bush House no prisoners were adjudicated for shouting abuse.

Mr E tried to draw attention to his vulnerability in several ways, both formally and informally:

- He verbally informed officers, senior officers and nurses about his fears;
- He passed notes to staff which outlined his concerns;
- He referred himself to the PSST;
- There were indications that his mental health was deteriorating, particularly when he reported verbal abuse of which nobody else present was aware; and two days before he died Mr E was seen behaving in a bizarre fashion, shouting and flailing his arms, which was quite out of character;
- His written request for a transfer to Magilligan included concerns about how he was not coping, and felt under threat, very vulnerable and anxious.

Regrettably these cues were all missed. With hindsight a senior officer said that, had Mr E been recognised as self-isolating and vulnerable, then it should have been addressed via referral to the PSST. As it was, Mr E's self-referral was not actioned before he died.

Mr E's fears were therefore never properly addressed:

- The notes he wrote were not acted upon, and in some instances they were lost;
- Regular officers on his landing did not recognise or respond to his deterioration following sentencing. On one occasion an officer mocked his uncharacteristic behaviour;
- Senior officers did not exercise managerial authority or take control of the situation – the SPAR process was not initiated, the Anti-bullying policy was not implemented and he was not referred to the PSST;
- When he self-referred to the PSST it's procedures were too slow to meet Mr E's needs; and

- Nurses felt his concerns about bullying were not a matter for them; and on the basis of information provided by landing staff, they did not consider that Mr E had mental health problems.

In essence Mr E fell through the safety nets that might have made a difference.

In addition to emotional instability, Mr E had a range of physical health conditions for which he was prescribed medication. These meant he was seen daily by Healthcare staff, and while he discussed his fear of other prisoners, he was assessed as not being at risk of self harm.

Before arriving in Maghaberry, Mr E had been on medication for depression and anxiety. However a communication breakdown meant these were overlooked and he never received this medication during his nine weeks in Maghaberry. Mr E himself did not draw attention to the need for these medicines, nor did he report withdrawal symptoms, which was in keeping with his presentation as someone who did not complain. The clinical reviewer indicated that, the longer someone is without the prescribed medication then the risk of remission into depression and/or anxiety would increase. The clinical reviewer also reinforced the well known fact that sexual offence charges, combined with depression, chronic psychical health conditions and a first time in prison should have prompted Healthcare staff to consider referring Mr E for psychiatric assessment – which was endorsed by the Clinical Director of Prison Health who advised that they now have a mental health triage nurse and if Mr E was committed now, on the basis of what he reported in his committal interview, he would be triaged and assessed as to whether he needed psychological mental health support.

There was an inappropriate amendment to medications that Mr E was prescribed for physical ailments: after three weeks a nurse changed his warfarin and flecainide acetate to monthly in-possession, contrary to the prescription and the SEHSCT's Medication In-Possession policy.

Once the alarm was raised on the night of Mr E's death, the emergency response was prompt.

This investigation has identified several matters requiring improvement, one of which (Recommendation 6 below about Handovers) was previously made and accepted by the NIPS.

I make 13 recommendations for improvement by the Northern Ireland Prison Service (NIPS) and South Eastern Health and Social Care Trust [SEHSCT].

RECOMMENDATIONS

NIPS -

1. **Sex Offender Allocation** – The NIPS should ensure that all prisoners who are held on the Bush 3 and 4 landings for additional protection fully understand Maghaberry's zero tolerance policy in respect of bullying, and the consequences of any misconduct in that location. (Page 20)

2. **Written Communications from Prisoners** – An auditable, NIPS-wide process should be designed and implemented to ensure communications from prisoners are acted upon, shared with colleagues and support agencies, and retained on file. (Pages 22, 29-31, 38-39)

3. **Anti-bullying Policy Training** – A NIPS-wide training needs analysis should be undertaken to address the inadequate application of the Anti-bullying policy, and the complacency shown by some staff to levels of abuse experienced by certain prisoners. (Pages 23-24, 26-28, 32-35)

4. **Residential Manager Accountability** – A NIPS-wide training needs analysis should be undertaken to address the shortfalls identified in this investigation by residential managers (senior officers) who did not act upon communications from Mr E about his vulnerability. (Page 24-28, 30-31)

5. **PSST Referrals** – Residential managers and staff should be informed by the PSST when a prisoner on their landing is referred; and a record should be retained of the information that is shared. (Page 28-29)

6. **Handovers** – Handovers between day staff, night staff and others such as PECCS staff should include meaningful information about prisoners' welfare, and a record of the handover should be retained. (Page 29 & 31)

7. **Inappropriate Use of Cell Call Alarms** – The management team in Maghaberry Prison should develop a meaningful and robust solution to the systemic issue of prisoners misusing their emergency in-cell alarms. (Page 37)

8. **Night Guard Responsibilities** – Night Custody Officers should be reminded of their duty to intervene when it appears a prisoner is not coping, particularly when the prisoner attempts to engage with them. (Page 39)

9. **Hot & Cold Debrief Action Points** – Action points arising from death in custody hot and cold debriefs should have an action plan that includes clear timescales for completion. (Pages 42-43)

SEHSCT –

1. **Medication Administration for New Committals** – Procedures should be put in place to ensure newly committed prisoners receive their medication without interruption, as prescribed. (Page 14-17)

2. **Community Medical Information** – A résumé of newly-committed prisoners' community medical history should be promptly obtained to identify current medications, health conditions, outstanding appointments and any history of mental ill health /self harm and suicidal ideation. (Page 15)

3. **In-Possession Medication Policy** – A review of the In-Possession Medication policy should be undertaken, to address the following:
    a. Clarification on why Maghaberry Prison can administer warfarin as weekly in-possession while Hydebank Wood and Magilligan administer it as supervised swallow (Appendix 4a & 4b of the policy). (Page 18-19)
    b. The inclusion of felcainide acetate in Appendix 4a & 4b of the policy considering the risks associated with it, if abused. (Page 19)
    c. Clarification on the process to be undertaken when a patient's prescription has been risk assessed by a nurse as requiring an amendment to its administration. (Page 19)
    d. Monitoring arrangements to ensure Healthcare staff are complying with the policy. (Page 18-19).

Both NIPS & SEHSCT –

1. **NIPS Anti-bullying Policy** – The specific roles and responsibilities of Healthcare staff should be clearly outlined by both the SEHSCT and the NIPS in relation to application of the NIPS Anti-bullying Policy. (Page 33)

NIPS & SEHSCT RESPONSE

The NIPS responded to this report by saying that they accept the recommendations and are determined to use the report to strengthen systems already in operation throughout Northern Ireland's prisons.

In addition to routine hot and cold debriefs, the NIPS also undertook an internal investigation following Mr E's death because of concerns about the issues that are highlighted in this report. That investigation made nine recommendations. At the time of this report, Maghaberry prison advised that those recommendations had been actioned.

The SEHSCT undertook an internal investigation that led to four recommendations for improvement. They provided a comprehensive response to this report, accepting all of the recommendations that pertain to them, and advised they will be discussed at the Prison Healthcare Lessons Learned Forum. In addition the SEHSCT outlined the following improvements that have been made since the death of Mr E:

"Providing a newly committed prisoner is registered with a GP in Northern Ireland, staff from SEHSCT within the prison setting now have access to the community Electronic Care Record (ECR). This allows them to view all current medication and when it was last prescribed. This together with the fact that there is now an on-site pharmacy in Maghaberry makes the continuation of currently prescribed medication much easier. Whilst there is an "out-of-hours" cupboard in the committals house and despite SET now providing a Saturday morning committals clinic, sometimes prison healthcare staff must rely purely on clinical presentation to prescribe medication until such times as a community practitioner can be contacted.

Where appropriate, a mental health assessment will take place within 72 hours of committal. This is usually followed by the mental health team contacting the community GP for more information in relation to the mental health history. It must however be accepted that often symptomatic care is the only option available to the PHC (primary health care) team for the first few days after committal."

The SEHSCT also advised that a review of the "In-possession Medication" policy has been undertaken and came into effect on 21st January 2014, which addresses all of the issues identified in the SEHSCT's Recommendation 3.

The Trust acknowledged that it should have been identified that Mr E was on medication for depression and anxiety, and if there was a decision taken to discontinue these, the doctor should have documented his reasons.

In addition to the feedback above, the SEHSCT shared the findings of this report with their Prison Mental Health Clinical Lead, who provided the following noteworthy comments:

"Mr E in many ways presented as the 'classical' potentially suicidal prisoner having regard to the cumulative and interactional effects of the presenting risk factors identified by Dr Quinn…In my opinion this case illustrates how important it is that all clinical staff dealing with patients with an established diagnosis of depression coupled with the other at risk factors identified by Dr Quinn should be fully familiar with the NICE guidelines of Depression."

The Mental Health Clinical Lead stated that if all clinical staff had been aware of these guidelines, *"There would automatically have been a more cogent approach to the management of his case….In my view, the Trust would be advised to draw up a protocol regarding the assessment and treatment of individuals known to be suffering from depression or at high risk of developing depression in keeping with current accepted good practice but at the same time having regard to the vicissitudes* (variation) *of prison life and the passage of the case through the legal system."*

He also highlighted the need for close interagency working, and said it would be unfair to expect clinical staff to treat depressive symptoms in isolation from other factors that impinged upon the patients / prisoners wellbeing in custody.

MAGHBERRY PRISON

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

During his nine weeks in Maghaberry, Mr E was located on the committal landing in Bann House for 15 days before being transferred to Bush House, Landing 3. This landing is predominantly used for prisoners at risk from others, mainly due to the nature of their offence or their age.

On the day that Mr E died there were three prisoners in Bush House being managed under the Supporting Prisoners at Risk (SPAR)[1] process, two on the same landing as Mr E and one on a different landing, though no significant incidents occurred.

Maghaberry established a Prisoner Support and Safety Team (PSST) in 2011. The team comprises a governor and five members of staff. They have several responsibilities including their role to support prisoners who are identified as vulnerable. Mr E had referred himself to the PSST, but the referral had not been activated by the time he died.

The last CJI / HMI 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 observe all aspects of the prison regime. The 2012-13 IMB annual report did not make any recommendations that are relevant to Mr E's death.

[1] The SPAR process is applied when a prisoner has been identified as being vulnerable to self harm or have suicidal ideation. Its purpose is to provide support through implementing a multi-disciplinary care plan approach.

FINDINGS

SECTION 1: MR E'S COMMITTAL TO MAGHABERRY PRISON

Mr E was (age redacted) years old when he was committed into the custody of Maghaberry Prison on (date redacted) to await sentencing. This was his first time in prison. He was initially charged in (date redacted) and his family reported he was under considerable stress during the four years that it took for the matter to reach its legal conclusion.

On his arrival at Maghaberry Mr E underwent interviews with a nurse and committal officer to determine his healthcare needs, identify any vulnerabilities and the support services available, and explain what would take place over the next few days.

During a phone call on his first day, Mr E told a family member that another prisoner had asked what he was in for. When he did not tell him the prisoner commented that he *"didn't seem to be the type to be in prison"* and then shouted abuse about him to the rest of the prisoners. The family member said *"From that point forward Mr E was very frightened."*

Healthcare Committal Interview & Prescription of Medications

During the healthcare committal interview, the nurse recorded that Mr E had the following medical conditions:

- Type 2 diabetes
- Ischaemic Heart Disease – atrial fibrillation (irregular heart rhythm) - for which he had four direct current cardioversions[2].
- High Blood Pressure
- Depression
- Anxiety

Mr E's medication on committal included; flecainide acetate (to treat heart rhythm disorders); bisoprolol (to treat heart conditions including heart beat rate); warfarin (to thin his blood); crestor (for high cholesterol); metformin (to treat diabetes); omeprazole (to treat excess stomach acid); oxazepam and citalopram (to treat depression and anxiety).

[2] Technique using an electrical shock to convert the rhythm of the heart from atrial fibrillation (or flutter) to normal sinus rhythm.

The nurse also recorded that Mr E had been seen by a doctor within the last few months in relation to his depression and anxiety, but that he had no thoughts of self harm at that time.

The nurse recorded all of these conditions as 'medical markers' to be entered on PRISM[3] so that landing staff would be aware of Mr E's conditions.

At the time of Mr E's committal, the SEHSCT policy was to request a résumé of the prisoner's community GP records as part of the committal process. There is no record of such a request being made.

Had this been done Maghaberry Healthcare staff would have learned that Mr E had been referred to community psychiatric services on (date redacted), and prescribed oxazepam due to anxiety about his case, which included suicidal ideation. He had a community mental health social worker in the months leading up to his committal, and received an additional prescription of citalopram in (date redacted).

The morning after his committal a request for a list of Mr E's current medication was requested from his GP. When this was received all his medications were prescribed to him, with the exception of oxazepam and citalopram. It took two days for Mr E to receive the other medicines. However he never received the medication for his anxiety and depression throughout his time in Maghaberry.

A doctor who attended Maghaberry on the evening of (date redacted), purely to write up prescriptions, prescribed Mr E's medication on the basis of the faxed information – this was not a face to face consultation. He said his oversight in not prescribing the oxazepam and citalopram may have been because they were listed as "Acute" and not "Repeat" medication on the GP's fax. (The heading under which these medications were listed was in fact "Acute and Repeat Therapy.") The doctor added that with hindsight if he had seen that Mr E was on citalopram *"it is more than likely that I would not have continued him on it as he was also on flecainide. It is recommended by NICE[4] Guidance that citalopram is not given if the patient is on flecainide."*

In relation to cessation of the oxazepam the doctor said *"The information I had in front of me indicated that Mr E had only been prescribed oxazepam two days prior to his committal date."* Had the community GP's résumé been available, it would have shown that Mr E had in fact been on oxazepam for 15 weeks prior to his committal.

On the basis of the GP's fax, the Maghaberry doctor therefore concluded it would *"not have been necessary to put him on an equivalent diazepam* (instead of

[3] PRISM – Prison Records and Information Systems Management (the computer database used to record all prisoner information.
[4] NICE – National Institute for Clinical Excellence produce best practice guidelines for the National Health Service.

oxazepam) *dose and to commence a benzodiazepam reduction protocol*[5]*."* He continued *"The length of time Mr E had been taking oxazepam could have been clarified at a face to face consultation with a doctor in the days subsequent to his committal."* However Mr E did not have a face to face consultation with a doctor as part of his committal.

While his antidepressant or anti-anxiety medications were therefore never prescribed, neither did Mr E request them during the 36 occasions he saw healthcare staff over the nine weeks that he was in prison. Nor were any withdrawal symptoms reported or detected.

Clinical Reviewer's Comments

In his clinical review report, Dr Quinn commented that *"The presence of 'depression' in an adult male against a backdrop of chronic psychical health conditions and a first time in prison should on* (date redacted) *have prompted staff in prison to consider the aforementioned as risk factors in terms of self harm/suicide."* Dr Quinn added that the addition of Mr E's sexual offences *"might have alerted those involved in the committal interview to consider Mr E as warranting an initial assessment by a visiting psychiatrist."*

Commenting on the cessation of Mr E's prescription of oxazepam and citalopram, Dr Quinn said *"An individual suffering from anxiety/depression and in receipt of antidepressant medication would not likely suffer any significant adverse effects in the absence of antidepressant/ anxiolytic medication where it suddenly discontinued.... However, the longer the individual is without the prescribed medication then the risk of remission, i.e. complaints of depression and / or anxiety would increase.... The sudden discontinuation of antidepressant medication should have warranted an assessment of his mental state some time after the medication was discontinued and a decision taken as to whether he required alternative antidepressant medication."*

The Clinical Director of Primary Care and Prison Healthcare for the South Eastern Health and Social Care Trust (SEHSCT) - who at the time of Mr E's death was not responsible for Prison Healthcare - was asked to comment on Mr E's committal process in relation to cessation of his prescribed antidepressant medication. He said *"It should have been identified that Mr E was on citalopram and oxazepam and if there was a decision taken by the doctor to discontinue these two medications the*

[5] Due to the addictive properties of the group of drugs known as benzodiazepam's (such as oxazepam) and their high market value within prison, and therefore the highly likelihood of them being abused, the SEHSCT's policy is that any new committal who had been previously receiving this type of medication will have them reduced so that that they can be either weaned off them or placed on a suitable alternative.

doctor should document his reasons in EMIS[6] for taking that decision. Ideally Mr E would have benefitted from psychological support from the Mental Health Team and a mental health nurse in prison. We now have a mental health triage nurse and if Mr E was committed now, on the basis of what he reported in his committal interview, he would be triaged and assessed as to whether he needed psychological mental health support." This opinion was endorsed by the clinical reviewer, Dr Quinn.

Committal Officer Interview

A cell sharing risk assessment was completed as part of the committal process. It concluded Mr E was suitable to share a cell as he did not pose a risk to others, nor would he be at risk from a cellmate.

A 'First Night in Prison' assessment indicated that Mr E did not think that he was a vulnerable prisoner; did not feel at risk from being in prison; and did not have any thoughts of self harm.

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

SECTION 2: KEY EVENTS DURING MR E'S FIRST FIVE WEEKS IN PRISON

As a remand prisoner awaiting trial, Mr E's only activity was standard induction assessments for drug and alcohol support, education, library and gymnasium during his first five weeks in Maghaberry.

He was encouraged by staff to attend the 'early yard' between 09.30 and 10.30 each morning as he was nervous of associating with other prisoners or even walking down the landing for fear of being attacked. The 'early yard' is reserved for prisoners who felt vulnerable, usually due to their charges, and despite the name it entails indoor use of a common room, rather than outdoor exercise.

Landing staff described Mr E as pleasant, quiet and polite. They said he always felt people were talking about him and was fearful and nervous due to the nature of his offences. Nonetheless the house nurse said that he *"was always cheerful and pleasant*," and never seemed to be down in the dumps or in a low mood.

Warfarin Administration and Monitoring

Mr E regularly visited the house nurse to have his international normalisation ratio (INR) monitored. INR measures how well warfarin is working and frequency of measurement varied from five days, weekly and fortnightly intervals according to analysis of his INR results.

Warfarin is an anticoagulant medicine that works by interrupting part of the process that is involved in the formation of blood clots. This means that blood clots are less likely to form where they are not needed, but can still form when they are required. The risks associated with incorrect dosages include major or fatal bleeding.

After the first two days in prison when Mr E received no medication, he saw a nurse daily over the following 22 days to receive his warfarin, because a nurse had interpreted the SEHSCT's 'In-Possession Medication' policy for warfarin as being administered by supervised swallow[7].

The SEHSCT's 'In-Possession Medication' policy defines how medications should be provided to prisoners. The purpose of the policy is to ensure all prisoners are individually assessed to determine their ability to store and manage their own medications. Medications that might be abused, traded or that carry a risk of overdosing are also categorised according to how they should be administered.

The policy is not consistently applied across the NIPS estate in that warfarin is categorised as requiring to be administered by 'supervised swallow' in Hydebank

[7] Supervised swallow is when medication is taken in front of a nurse and not managed by the prisoner.

Wood and Magilligan Prison, but 'weekly in-possession' (i.e. the prisoner could have a weeks supply at a time) in Maghaberry. The policy does not explain why Maghaberry, which is Northern Ireland's maximum security prison, would be deemed to be less risky. Nonetheless the prevailing policy meant that Mr E should have been given his warfarin medication as weekly in-possession from the outset. Mr E's medication administration record shows that from (date redacted) the nurse incorrectly issued this medication as monthly in-possession.

Flecainide Administration

The doctor who prescribed Mr E's flecainide directed that this should be administered as supervised swallow because of its toxicity and associated risks, should it be stolen from Mr E. He said his decision was based on the type and class of drug rather than *"any risk factor present in the patient."*

Despite being prescribed by the doctor as 'supervised swallow', 24 days into Mr E's custodial period, a nurse decided to administer flecainide as weekly in-possession for one week and thereafter as monthly in-possession.

The nurse said this was because she had assessed Mr E as suitable for having his warfarin medication as in-possession, she considered for the same reasons that he could be responsible for managing his flecainide medication. There was no evidence of a new risk assessment form being completed at this stage, though Mr E signed the 'Prisoner Medication Policy'[8] on the day that these medications changed to 'in-possession'.

The medication sticker on Mr E's flecainide medication record was not updated to reflect the change in administration of this medication. The nurse acknowledged she should have requested the doctor to change this, based on her risk assessment.

Whilst the SEHSCT's 'in-possession' policy does not specify whether flecainide should be administered as supervised swallow, weekly in-possession (those with a high risk if overdosed) or monthly in-possession (those with a low risk if overdosed), given the risks identified by the prescribing doctor it clearly should not have been issued as monthly in-possession.

Location Moves

Mr E's family queried why he was located in the general population rather than on a landing with other prisoners that had similar charges. The PSST governor said that the prison does not have a distinct policy on the management of prisoners charged with sexual offences, and explained that the majority of such prisoners reside

[8] When issued with their medication as in-possession, a prisoner must sign this form to show that they agree with the terms set out.

without issue in the general population. Where concerns were identified due to someone's charges they could be moved to locations such as Bush House – where Mr E spent most of his time - or the vulnerable prisoner unit (VPU) where staff observation was better.

Mr E spent 15 days on the committal landing in Bann House. Thereafter he moved to Bush House, Landing 3, so in fact he did not remain in the general population. He was housed on the side of Bush 3 that faced Roe House, which made him vulnerable to verbal abuse from Roe prisoners. There were a total of 38 prisoners on Bush 3. This placed considerable pressure on the accommodation, and 29 of these prisoners had to share a cell. The numbers required a considerable degree of staff supervision, especially given their vulnerability levels.

Bush Landings 3 and 4 mainly housed vulnerable sex offenders and also some prisoners who were under threat for other reasons. Investigators were told a minority, while vulnerable in some respects, were also bullies who could target sex offenders, especially timid people such as Mr E. The NIPS routinely experienced difficulty in placing certain prisoners, especially as Maghaberry was overcrowded.

Figures produced by the Home Office Safer Custody Group in 2002 indicated that self-inflicted deaths among sex offenders equalled the proportion of self-inflicted deaths in the overall prison population; and this concurred with the experience of the Prisons and Probation Ombudsman.

However other research[9] indicated that men charged with sexual offences *"are subjected to considerable violence from other prisoners, which may make them more vulnerable to suicidal behaviour."* The same report also outlines *"Several authors (Livingston & Beck, 1997; Power & Spencer, 1987; Toch, 1975) have suggested a relationship between bullying and suicidal behaviour."*

There is however no indication that such violence was used against sex offenders in Bush House.

Abuse and Intimidation from Other Prisoners / Houses

A regular Bush officer said that while he could not recall the specific conversations he had with Mr E, he remembered that he had mentioned to him *"a couple of times"* that other prisoners were talking about him – usually while locked in the evening or during the night. The officer said that Mr E never really elaborated, but referred to prisoners within Bush House and from the building opposite who would have shouted from their yard or cell windows.

[9] Safer Cells Evaluation Report, by the Jill Dando Institute of Crime and Science, 2004.

The officer explained that the prisoners from Roe House (the building opposite) *"would have shouted across a lot of times to Bush because they obviously knew who was housed in Bush 3* (i.e. the types of offences they had been charged with)*....and I think they'd give them a lot of grief in the evenings, you know, shouting across."*

The officer said he told Mr E several times that Roe prisoners would not be able to touch him, and that the abuse was not specifically aimed at him. He said that these comments never appeared to be of great concern to Mr E, and felt they had a good enough relationship that Mr E would have spoken to him about his concerns.

This officer also believed the risk of Mr E being attacked was reduced because he spent most of the time locked in his cell. When not in his cell, he was either in the yard with other sex offenders or on the landing to get meals or cleaning materials. The officer said that he and his colleagues knew which prisoners would have posed a threat to Mr E and would ensure they were never on the landing at the same time.

The officer said that verbal abuse would have been regular during the day and when he heard it, he would take a position which allowed him to listen to what was being shouted. He said if there were specific prisoners being named he and his colleagues would have tried to identify the culprit and *"get them moved."*

However during the 47 days that Mr E was in Bush House no prisoners there or in Roe House were adjudicated for shouting abuse at another prisoner; and while 20 bullying reports were opened in Maghaberry Prison during this same period, 13 of which resulted in prisoners being monitored, none of them were opened in either Bush or Roe House.

Prison Rule 38 (16) states that a prisoner shall be guilty of an offence against prison discipline, if he *"is disrespectful to any person or uses threatening, abusive, or insulting words or behaviour*.

Another prisoner who attended the early yard with Mr E was able to identify a prisoner on their landing who used to verbally abuse Mr E. Despite a number of prisoners intervening, he said the abuse, which started two weeks after Mr E's arrival in Bush House, continued up until he died. He said that Mr E refused to name this prisoner because he thought the abuse would only get worse, and then he would be called *"a tout."*

SECTION 3: KEY EVENTS DURING THE WEEK PRIOR TO SENTENCING

Information of Bullying relayed at Court (date redacted)

On (date redacted) Mr E spent the day at Court. While in his holding cell he asked to speak to the (acting) supervising prison custody officer (PCO). The supervising PCO spoke with him for approximately 10 minutes. His impression was similar to the impressions of several other staff – that Mr E found it difficult to talk about his concerns. Nonetheless Mr E reported how other prisoners were shouting abuse into his cell in Maghaberry during the previous night saying intimidating things such as *"We know what you did"* and *"We know what you are…"*

The supervising PCO wrote a staff communication sheet about the matter, which was to be given to the Reception senior officer at Maghaberry. He wrote how Mr E had *"concerns and fears that other prisoners in Bush House were threatening him…"* He said that he could not remember what the specific threats were and that Mr E did not know the names of the people who were shouting.

He also said that Mr E *"was very complimentary of landing staff….*(that) *they couldn't do enough for him and that they couldn't be there 24 hours a day."*

The Reception senior officer's recollection differed in that he thought a letter, rather than a staff communication sheet, from Mr E was handed to him. He also believed this took place on (date redacted). However on the balance of probabilities it appears his recollection of events refers to the (date redacted).

The senior officer said that because the content of the document referred to Mr E as having been bullied, he personally escorted him back to Bush House in order to inform the house senior officer. He could not recall which senior officer was on duty in Bush House but remembered that he *"must have been a regular"* because he said he talked as though he knew Mr E and that the information did not come as a shock to him.

The senior officer who was identified as having been on duty that evening said he had no memory of ever receiving any document about Mr E. He explained that *"The sheet completed* (by the PCO) *is entitled "Prisoner Under Threat" and had I received such a communications sheet I would have generated a prisoner Threat Assessment Form and passed it onto Security…..I have no memory of ever initiating a Prisoner Under Threat Assessment*[10] *for Mr E or having generated any threat assessment form."*

[10] Prisoner under Threat Assessments/Forms are carried out when it has been identified that an individual may be subject to attack from other prisoners. This assessment is a risk assessment which is then forwarded to the security department who will assess whether the individual needs to be moved from that location.

In essence therefore Maghaberry's communication procedures broke down on this occasion, and it is clear that someone in the chain of communication got it wrong.

New Cellmate

Mr E shared a cell continuously throughout his time in Bush House, due to accommodation pressures. While not intended as a protective factor in his case, the very fact of sharing a small cell should make it inherently more difficult for a prisoner to successfully complete a suicide.

On (date redacted) a new cellmate was lodged with Mr E. His cellmate said, *"I thought that Mr E had mental health issues from the start because he thought that the whole prison was talking about him."* He said that other prisoners in Roe House (which was opposite Bush House) could have been talking about drugs or shouting to each other from their windows, but *"Mr E thought they were talking about him."* He said that he used to tell Mr E to relax and reminded him that they were in Bush House *"for protection."* However he felt Mr E's *"head was tortured and he wouldn't listen"* to him. He added that Mr E could never focus on having a normal conversation.

During the three weeks that they shared a cell, his cellmate said that Mr E passed about ten notes to staff, during the day and night. Mr E told him these were about being threatened by other prisoners.

Prisoner Accounts of Mr E Being Bullied

Another prisoner described how Mr E's previous cellmate said Mr E was *"paranoid"* that any shouting between the houses was about him, when actually it was not. He described how no-one on the landing knew Mr E or anything about him because he kept himself to himself and stayed in the cell; and he named three staff who were worried about him and would go to his cell daily to check on his wellbeing.

One of these officers took the opportunity when Mr E was out of his cell to speak to his cellmate to find out about the verbal abuse. However Mr E's cellmate said he had never heard anyone shouting at him (Mr E).

This officer said that because Mr E was still getting his breakfast and his tea, and was dressed every morning when staff opened his cell door, "*It's not like he totally withdrew within himself."* Consequently he did not feel that Mr E needed to be on a SPAR. The officer had not received training in the Anti-bullying policy, and did not consider completing an AB1 form.[11]

[11] AB1 Form – The Initial Bullying Report which gleans information about the alleged bullying and any interviews conducted of the victim, witness and alleged bullies. Once completed this form is forwarded to their residential manager who will determine what action, if any, is required.

PREPS Reports

The Progressive **R**egimes & **E**arned **P**rivileges **S**cheme (PREPS) is tailored to encourage and reward prisoners for their commitment to pro-social behaviour within the prison and to contribute to a better controlled, safer and healthier environment for prisoners and staff based on mutual respect. For the period of (dates redacted), an officer completed Mr E's monthly proforma report as follows:

Statement	Never	Sometimes	Always
1. Interacts positively with prisoners	**X**		
2. Interacts positively with staff			X
3. Approachable			X
Supporting comments for 1-3: **[Nothing entered]**			
4. Co-operative			X
5. Accepts Guidance/ Instructions Well			X
6. Motivated to Change		X	
7. Good Work Ethic		X	
Supporting comments for 4-7: **[Nothing entered]**			
8. Appears tense or unable to relax			**X**
9. Changes social circle often	X		
10. Aggressive or threatening	X		
Supporting comments for 8-10: *"Very nervous of other prs* (prisoners) *– uses early yard. Spends rest of time in cell."*			
11. Appears self centred	X		
12. Argumentative	X		
13. Impulsive	X		
14. Manipulative or exploits other	X		
15. Easily distracted	X		
16. Mood swings	X		
Any other observations/behaviours: *"Now happy to go to Magilligan as he got sentenced."*			

It is clear from this report that the officer was aware of Mr E's anxieties about other prisoners.

This form was reviewed by a senior officer on (date redacted) who recorded *"No concerns – make more use of yards/association?"* There is no evidence that further enquiries surrounding Mr E's anxieties were investigated.

The officer who completed this assessment said that Mr E spent most of his time in the cell. He would have liked him to get out a bit more, but suggested *"You can't make them, you can only offer them"* time out of cell.

He also said that when he identified that Mr E never interacted positively with other prisoners it was a misrepresentation because he did in fact go to the early yard and also played pool occasionally on the landing.

The officer said this report did not highlight any risks, stating that Mr E was *"Just...nervous of other people. At that stage we hadn't really noticed anything else about him....no cause for concern anyway."* The officer continued *"He must've said that he was happy to go Magilligan because that's what I've recorded: 'Now happy to go to Magilligan' now that he's got sentenced."*

The senior officer said that at that time he was not linked to any particular residential house and was not regularly detailed to work in Bush House, which made it more difficult to know the prisoners. He said that if he had received two consecutive PREPS report stating that Mr E was self-isolating then *"It would need to be addressed."* The senior officer also said that if that was the case he would have talked to Mr E and considered a referral to PSST or the possibility that he was being bullied.

The reviewing senior officer said that he placed a query at the end of his comment to direct an officer and /or Mr E to discuss this, because all PREPS reports should be shared with the prisoner. This report is not signed by Mr E as having been read.

The senior officer said that while there was not enough information in the PREPS assessment to highlight a serious concern, if he had been a regular senior officer on Bush 3 and a worrying picture was beginning to develop over a couple of PREPS reports, then he would have looked into the matter further.

SECTION 4: MR E'S SENTENCING AND SUBSEQUENT EVENTS

Mr E's Sentencing (date redacted)

On (date redacted) Mr E spent the day at Court where he was sentenced to five years, comprising 2 ½ years imprisonment plus 2 ½ years supervision on release. He had first been charged in (date redacted), and had been under considerable stress in the intervening period.

On his return to prison the senior officer who recommitted Mr E and took him back to Bush House said he was extremely talkative and enquired about going to Magilligan Prison. The senior officer explained that he needed to make a request and that there were weekly prisoner moves from Maghaberry to Magilligan.

Request to Transfer to Magilligan (date redacted)

Mr E had often spoken with officers about his desire to be transferred to Magilligan, and knew that he had to wait until he was sentenced before this could be authorised. The morning after being sentenced Mr E submitted the following request:

"I wish to be transferred to HMP Magilligan as soon as possible. Reasons:
1] My wife cannot visit me due to having to care for a son…
2] Caring for our daughter...
3] I feel under threat and very vulnerable and anxious.
4] I confine myself in the cell every day as I have a phobia about going to the yard because of name calling and attack.
5] I only go out of the cell at 9.30 to 10.30 to the recreation area as I feel safer with older inmates to play pool."

Point one of the request identifies the difficulties prisoners face in receiving visits when their family do not live nearby. Mr E did not receive any family visits during his time in custody.

Points three, four and five of the request raise concerns about how Mr E was feeling. His request was entered on PRISM by an officer and then electronically forwarded to a senior officer for onward approval. The senior officer then sent it to the general office who responded to say:

"This request has been noted and inmate will be added to the next list of inmates who are eligible for consideration to Magilligan. The list will be considered on (date redacted)*."*

The following day an officer updated Mr E about when his request would be considered. On (date redacted) Mr E was approved for a transfer to Magilligan and placed on the waiting list. The next scheduled transfer of prisoners to Magilligan took place on (date redacted), though Mr E would not have been moved that week due to Magilligan having its full complement of sex offenders.

The senior officer who actioned the transfer request explained that during Mr E's custodial period he was only responsible for Bush House on this single occasion and had not met Mr E. In relation to points three, four and five he expected the landing staff to have considered whether there was anything further that was required.

He also outlined his expectation would be that the officer who recorded the request would have considered completing a 'Prisoner Under Threat[10]' form, or if more appropriate, implementing the Anti-bullying policy.

The NIPS Anti-bullying policy states that if someone suspects bullying it should be reported to the residential manager (i.e. the senior officer) who will then instigate further actions – i.e. talk to the prisoner, talk to landing staff etc.

The senior officer could not recall whether he spoke to landing staff or Mr E about the matter, and he did not attempt to ascertain whether the Anti-bullying policy was currently or previously implemented in respect of Mr E. There is no record of the policy ever being invoked. The senior officer added that *"From the point of view of an attack from other prisoners, he* (Mr E) *was preventing that himself by his, by the actions that he had taken in section four and section five* (of his request)*"* (i.e. his self-isolation, which is actually another indicator that the Anti-bullying policy should at least be considered).

The senior officer further added *"I'm now aware of what has happened, I think yes it probably would be dealt with slightly differently through talking more to the landing staff and finding out the background."*

In relation to Mr E confining himself to his cell everyday a regular officer said that *"You can't do anything about that…..it's not free association."* This referred to the fact that Bush House operated their own version of the closed door policy.[12] It meant that unless out for association, at work or the library etc, a prisoner would be locked in their cell - the exact opposite of what vulnerable prisoners such as Mr E required.

Another regular officer was surprised to learn of Mr E's fear of attack and verbal abuse. While aware of his general nervousness, he did not know of specific concerns until this investigation. He said that if he had been made aware of this he would

[12] The Closed Door Policy was introduced in September 2005 following advice from DOE Fire Section and the Health and Safety Executive to keep cell doors closed whether occupied or vacant. The policy does not stipulate that doors must remain locked.

have taken appropriate action by taking a statement and referring it to the PSST and/or implementing the Anti-bullying policy.

Both the senior officer and a regular officer on the landing have highlighted that the officer who recorded the transfer request should have been the primary initiator of further enquiries in relation to points three, four and five of the transfer request. The officer said when he entered the request on the system he considered it only as a request to be transferred to Magilligan. When questioned about points three, four and five of the request he inferred that it was normal for prisoners who go to the early yard to feel vulnerable, and he did not anticipate his senior officers would expect him to address these concerns.

Previous Prisoner Ombudsman complaint investigations have evidenced that Maghaberry staff can effectively implement the Anti-bullying policy to good effect. If the policy had been implemented in this case, then direct challenge to those prisoners who issued threats, and meaningful options (such as a cell move to the opposite side of Bush where Roe House prisoners could not be heard, or a location move to the vulnerable prisoners unit) could have been considered in Mr E's case. As it was, there was no recognition of a bullying problem, and therefore a failure to implement the Anti-bullying policy.

Self Referral to Prisoner Safety and Support Team (PSST) referral (date redacted)

The PSST have responsibility for monitoring and trying to improve safety for prisoners by working alongside others such as Healthcare, Residential Staff, Probation, Psychology, the Chaplaincy, Ad:Ept and the Offender Management Unit. Prisoners who require support can be referred by any member of staff or can refer themselves. Prisoners are advised during their induction programme that a response to a self referral can take approximately seven days.

At 19.00 on (date redacted) Mr E completed a self referral form to the PSST. He wrote:

"I feel very vulnerable and anxious about my safety. I confine myself in the cell for 23 out of 24 hours and I have a phobia about going outside to the yard due to the fear of being attacked by other inmates. Since Thursday (date redacted) *I overheard inmates planning to hurt me since I came back from court."*

This form would have been submitted through Maghaberry's internal post but it is not possible to confirm when this referral was posted. The PSST could not confirm when the referral was received, but logged it on their system on (date redacted). They were also unable to confirm what action they took immediately after receiving Mr E's form, or whether they took any action between (date redacted) and (date redacted). A handwritten note at the bottom of the form says *"Passed to* (Donard Manager) *on* (date redacted)*"* – within six days of his self referral having been

received. The PSST governor advised that the details in Mr E's self referral were similar to many prisoners in similar circumstances, and were commonly seen. He saw no indication of an imminent likelihood that Mr E would die by suicide, nor anything different in Mr E's form from numerous other referrals - it contained the *"usual"* language.

The then Donard manager had no recollection of receiving this referral, and surmised that it must have been left in his office for action, rather than having been personally handed to him. No further action was taken due to Mr E's death.

None of the regular Bush 3 officers or senior officers were aware of his self referral to the PSST; and one was not aware that a self referral process existed.

The Prisoner Ombudsman has been advised that following a PSST review after Mr E's death, a new process for recording receipt of referrals and subsequent actions has been implemented.

Mr E's Last Phone Call on (date redacted)

Since committal Mr E contacted his family by phone on one, two or three occasions each week. The conversations ranged from two to seven minutes in length and discussions surrounded his impending court case and family matters.

His last phone call with a family member lasted for two and a half minutes and he talked about getting a *"rough time"* from some of the other prisoners who had seen the news about his sentencing and charges since he returned from court three days earlier. He said that one of the older prisoners told him to ignore what they were saying, which he said he would do. Mr E talked about the fact that he had requested his transfer to Magilligan and that he would *"just have to wait and take each day by day."* He asked about whether the local community was aware of his court appearance, and was advised *"Everyone knows about it."* General talk continued about matters in the family home before he ended the call to continue playing pool with a group of prisoners around his own age, whom he described as being *"all very good"* to him.

Despite having £10.74 phone credit Mr E did not phone his family for the last nine days of his life. The reason for this is not known.

Note Passed – Three Days after Sentencing - (date redacted)

Seven days prior to Mr E's death, a note was entered in the night guard journal at 20.00. It stated:

"While on Bush 3 I noticed a letter under the door of cell 5 from Mr E addressed to 'Senior Officer Bush House.' In the letter he stated that he had heard that other prisoners were planning to kill him and that he wished he was in Magilligan Prison. (Senior Officer's Name Redacted) *informed. Mr E is in a double cell and I was unable to discuss this any further with him."*

The night custody officer (NCO) said that because of the content of the note it would not have been appropriate for him to speak to Mr E due to the risk of other prisoners hearing the conversation. He did however report the matter to the senior officer.

Based on the fact that Mr E said he overheard prisoners threatening to kill him the senior officer determined Mr E was not at risk while locked in his cell, and decided the matter would be best dealt with by the Bush House senior officer coming on duty the following morning.

The NCO recalled that during handover the following morning he passed the note to the first officer who arrived on duty, and asked her to pass it to the senior officer when he came on duty, as the senior officer was not scheduled to be on duty before this NCO finished his night shift. This is recorded in the journal. The officer who received the note said that she was only on the landing to conduct a headcount and knew she was not rostered to work on Bush 3 that day. She explained she was not informed of the content of the letter during her handover, did not read it and handed it to her senior officer.

The following night when the same NCO started his shift he saw the day time senior officer and checked that he had received Mr E's note. The NCO said that the senior officer confirmed he had received the note and that Mr E had *"passed other notes,"* implying this was not the first one. The senior officer denied that he said to the NCO that Mr E had passed other notes.

The senior officer said that on receipt of the note he considered the Anti-bullying policy and asked *"somebody"* to *"keep an eye"* on Mr E. He said that he remembered there being a number of officers in his office at the time of receiving the note and gave the *"general instruction"* to keep an eye on him. His assumption was that an officer would speak with Mr E and try and establish the names of the prisoners who were making the threats, whether he was sentenced, and if he was, to advise him to put in a request to transfer to Magilligan. By this stage Mr E had of course already requested a transfer to Magilligan, and this was logged on PRISM. The senior officer said that he did not give an officer direct instructions to carry out these further enquiries with Mr E because the officers were *"all experienced"* and would *"know the routine."*

The senior officer advised that three or four days after this letter was passed he purposely spoke with a prisoner who he thought was Mr E to see how he was. However when he looked at Mr E's photo after he had died, he realised it actually was not Mr E he had spoken with. The senior officer said that prior to this he had

attempted to speak to Mr E on a couple of occasions whilst he was on the landing to discuss the note, but was unable to do so as Mr E was at court or on visits. However PRISM records show that Mr E had no appointments between (dates redacted), other than with the nurse two days prior to his death; and apart from going to the early yard between 09.30 and 10.30 each day, he would have been in his cell. This senior officer also said staff had asked him to see Mr E as they were *"keeping an eye on him...because he was keeping himself in his cell."* Nonetheless he said the staff had "*no major cause for concern"* about Mr E.

One of the regular staff could not remember this particular note, but commented that Mr E would have quite often communicated by passing a note to staff whereas the majority of prisoners would have made a verbal request. He said that any notes passed to night guard staff would normally have been placed in the senior officer's journal for their attention, and also mentioned in a verbal handover to day staff.

This officer said he had never been informed that someone was threatening to kill Mr E. He said if any such threats had been made then the Security Department would have been notified.

As Maghaberry Prison could not establish the whereabouts of this note and the security department had no knowledge of its existence, this investigation has been unable to confirm its contents.

As a result of a PSST review and debrief meetings following Mr E's death, the 24 hour Duty Manager's Report has been updated to incorporate a reminder that indicators of distress, such as notes or unusual behaviour, should be recorded in journals and reported to the PSST. A Notice to Staff was also issued to advise the process that should be followed when a prisoner communicates with staff by passing notes.

SECTION 5: MR E'S LAST 73 HOURS

Note passed to Night Guard

On (date redacted) at approximately 01.00 Mr E passed a note to a night custody officer (NCO 1). The note read: *"….I am being threatened by other inmates that they will give me a kicking if they can catch me…. Both staff and I are always listening to those who want to beat me up from day and night. I'm afraid to go outside because of this and stay in my cell 23 hours a day. I am very afraid and anxious about my life here. I wish to be transferred to Magilligan Prison both to cause peace to the staff and myself. Yours sincerely, Mr E. "*

NCO 1 said that he remembered receiving the note, reading it and passing it on to an officer coming on day shift. He could not recall any discussions he had with Mr E.

An entry in the journal at 01.10 records: *"Mr E said he couldn't sleep due to the fear of being threatened. Letter passed under the door stating his issues. Told him to get into bed and try and sleep and to speak to staff in the morning. Asked if he had any thoughts of self-harm to which he said no. Letter to be passed to day staff in morning."*

NCO 1 said that he would probably have kept an extra eye on Mr E that night, given the content of the note.

The NIPS Anti-bullying policy states that where bullying is suspected it should be reported to the residential manager/senior officer. While the journal records that this note was handed over to a named officer at handover, NCO 1 did not report it to his senior officer.

NCO 1 could not remember what conversation, if any, he had with the officer to whom he gave the note.

The officer who is reported to have received this note could not recall receiving it or any subsequent actions he took if he did receive it. He said that if he had received such a note he would probably have given it to the senior officer and discussed it with Mr E to get more specific details. There were therefore several opportunities to initiate an anti-bullying investigation, but these were not utilised.

Nursing Concern prior to Mr E's Death

On (date redacted) at 12.11 Mr E's medical records show that he visited a nurse. Landing staff had asked the nurse to speak to Mr E because they felt he had been quieter than usual. An officer said he and his colleague noticed Mr E was hearing things that were not happening and were concerned *"a mental health issue* (was)

starting." The other officer said when he unlocked Mr E he had his bags packed as he thought he was transferring to Magilligan (which was not the case), and *"came across a wee bit agitated but disorientated."*

The nurse said the officers did not provide any examples of their concerns. When Mr E met her he was unsure about the reason for being referred. She had to probe as he denied having any problems. When she explained that landing staff were concerned he told her he had *"things going on"* but did not want to elaborate. However he then said he felt he was being threatened by other inmates. The nurse told him he should speak to landing staff if he was being bullied. Otherwise she found he was *"friendly"* and *"there was nothing alarming… nothing concerning"* about the consultation.

The nurse could not fully recall what type of bullying Mr E reported to her, but thought it might have been about people laughing at him and talking behind his back.

The Maghaberry Anti-bullying Policy clearly states that a "whole prison approach" applies, involving the commitment and contribution of everyone working and residing there.

The nurse was unaware of this policy and had not seen any instructions from the SEHSCT about this. She considered her route for addressing a bullying complaint would be to inform the landing staff because she thought it was their responsibility to escalate it.

Following her consultation with Mr E, the nurse discussed his alleged bullying with a Bush 3 officer. Significantly the officer told her that earlier that morning Mr E had asked him *"Do you hear them shouting at me?"* Yet the officer reported there was no one shouting at the time. Surprisingly the nurse said she was not concerned to learn Mr E appeared to be hearing voices, and was content that he was to be reviewed in three days time (the day that he died) in relation to his warfarin monitoring and to see if his issue of bullying had been resolved.

Neither of the officers could recall this discussion with the nurse, and there is no evidence that they took this episode seriously, as the Anti-bullying policy was not initiated. It is also significant that none of the senior officers interviewed said Mr E's concerns about being bullied had ever been reported to them.

Early Yard – (date redacted)

Although a prisoner said Mr E had not used the early yard for four days prior to his death, on (date redacted) at 09.34 CCTV shows Mr E attended the early yard and played pool with other prisoners before returning to his cell at 10.30.

Outburst 29 Hours Prior to Mr E's Death

At 16.15 on (date redacted) CCTV footage shows Mr E walking from his cell to the servery for his meal. He can be seen shouting and flailing his arms, apparently angry, while there were other prisoners and staff in the vicinity. Prisoner accounts indicate he was saying *"Look, I've had enough. If you want to fight me, come down to the yard."* An officer who was there heard Mr E shout *"I am not going to commit suicide."*

The officer and the senior officer approached Mr E and tried to calm him down. The officer said Mr E's behaviour was out of character. He could not recall what happened after this point but recalled that he had no concerns, which is surprising.

After Mr E returned to his cell, CCTV footage shows this officer gestured twice to someone else that Mr E was mentally deluded. The officer said this was an *"off the cuff gesture"* about Mr E's abnormal behaviour; and he emphasised that despite this behaviour he had no concern that Mr E was going to harm himself.

Another officer confirmed this type of behaviour was out of character for Mr E.

The officer who made the gesture had no idea what may have triggered Mr E's outburst, and was unaware whether Mr E had previously been bullied or threatened. He also said *"Because he* (Mr E) *was very rarely out of his cell there wasn't really the time or the… to be bullied… He wasn't in a position where he could be bullied, unless it was happening with other prisoners that were in the early yards period."*

The problem was that from Mr E's perspective he felt bullied by verbal abuse, in settings where staff considered he was safe i.e. in his cell and in the early yard. He was also fearful of bullying on the landing, en route to other parts of the prison or to court.

It is concerning that records indicate this officer, and the majority of regular Bush 3 officers who had contact with Mr E had not received Anti-bullying training, nor had any of the night custody officers who were in contact with him.

Page 1 of the SPAR Booklet[13] indicates that prisoners who display irrational behaviour, withdrawal from social contact and/or anxious in appearance, especially when there is an obvious change in character, should be considered as being at risk.

[13] Supporting Prisoners at Risk (SPAR) booklets are used when an individual has been identified as being at risk of self harm or suicide. A multi-disciplinary care plan is implemented to support the individual.

Night-time Visits to Mr E by Staff

Between 21.30 on (date redacted) and 01.00 the following morning CCTV footage shows staff going to Mr E's cell door on three occasions in addition to their routine checks. The timings and lengths of contact with him are as follows:

Time	Duration	Action	Person Checking
22.52	3 minutes	Talks through the cell door flap	Female NCO
23.40	1 ½ minutes	"	NCO 1
01.04	6 seconds	Puts ear to the door briefly, looks through cell door flap	NCO 1

NCO 1 said that he could not remember anything about these visits to Mr E's cell, and did not make a connection that he had received a note from him the previous night.

Both NCOs could not remember their discussions with Mr E, but said that if it had been anything of concern they would have made an entry in their journal. There are no journal entries about these visits.

Prisoner Accounts of Verbal Abuse

Three prisoners stated that between 20.00 and 01.00 on (date redacted) a prisoner in the adjoining cell was shouting comments at Mr E such as *"Dirty b*****d," "Don't go down the yard," "Go on hang yourself"* and *"You're going to get jumped."* They said that they reported the matter to staff the following day and that they approached the prisoner who was shouting the abuse to ask him to stop. These prisoners could not recall which staff they reported to, and all the staff who were interviewed for this investigation denied receiving any such information.

SECTION 6: THE DAY MR E DIED

Handover to Night Staff

At each shift changeover there is a handover from the duty governor to the two night senior officers. The senior officer for the main prison stated he did not receive any information in relation to Mr E, and that he had never come to his attention before.

Court Attendance

At 08.01 on (date redacted), Mr E left his cell to attend court.

Despite having received his sentence on (date redacted), his solicitor explained he was requested to return to court because *"The Judge was concerned that he had not fully explained the nature of the sentence which he had imposed and he was anxious that Mr E would have it clearly explained to him and would acknowledge that he understood the terms of the sentence."*

The Judge informed the investigation of the following: *"I can confirm that any restatement of the sentence was due to the complexity of the sentence and ancillary orders and not as the result of any concerns suggested by Mr E's demeanour. In so far as I can recall his demeanour and behaviour were normal."*

The solicitor added that Mr E had told him about his request to be transferred to Magilligan but as he had not received a response to that request Mr E had written to the Prison Governor to express his concerns. However the Governor advised he had no record of having received a letter from Mr E.

Return from Court

At 20.28 Mr E was escorted back to the landing after spending the day in court. The escorting senior officer said this was the first time that he had met Mr E. Along with two other prisoners who returned from the same court, Mr E was searched before returning to Bush House. The senior officer recalled there was very little conversation between them but recalled that Mr E had commented that he thought it was going to be a frosty night but the senior officer thought otherwise because of the cloud coverage.

When Mr E was returned to his cell the senior officer said that he greeted his cell mate and accepted a meal which had been kept for him, and asked for his flask to be filled with hot water.

Mr E's cell mate said Mr E explained the reason for his late return from court was because *"prisoners in the holding cells at court and whilst in transit had been threatening him."* However the Prisoner Escort group advised that the prison van left the court at 17.05 with ten prisoners on board – one for Hydebank Wood Young Offenders Centre (YOC) and nine for Maghaberry. The prison van went to the YOC first, which was the reason for Mr E's late return.

His cell mate said that, despite telling Mr E to settle down, watch a bit of TV and get something to eat, he kept pacing up and down the cell. He said that Mr E paced for most of the night and only settled for half an hour before going to bed, sometime before 00.30.

Mr E calls for an Officer

At 22.24 the in-cell buzzer for Mr E's cell was pressed. One minute later a night custody officer (NCO 1) arrived outside the cell. In NCO 1's communication sheet (a statement of fact written soon after Mr E's death) he said that he was on the landing to carry out a supervised body check along with the senior officer and another NCO (NCO 2) when Mr E pressed his buzzer. NCO 1 recorded *"On looking* (Mr E) *reminded me that he had been at court today. At this stage I told him the SO* (senior officer) *would speak to him."*

NCO 1 was at Mr E's cell door, apparently engaged in conversation for 69 seconds. NCO 1 said *"We wouldn't drop everything and run because of the cell alarm."* (This is because prisoners can hear staff arriving to carry out checks and frequently seek attention by pressing the buzzer; which in turn means it is impossible for staff to distinguish between a genuine emergency and a routine request for attention). This is a challenging situation for staff given that every second counts when a prisoner's life is at risk.

NCO 1 said he could not remember his conversation with Mr E. He wanted to continue his checks, so he asked if Mr E wanted to speak to the senior officer (SO).

The SO then went to the cell door and asked Mr E if he was OK and if he wanted to talk. He said Mr E replied *"I'm fine"* and walked away from the cell door. The SO said that this type of behaviour would happen frequently while he was completing his rounds, but unless the prisoner wanted to talk through the cell door there was no other opportunity for a meaningful conversation. The SO said if Mr E had indicated self-harm or suicidal ideation there were processes in place to allow the cell door to be opened and permit a more detailed conversation.

He further advised that when he asked NCO 1 whether he had any concerns about Mr E, he was informed *"No"* and that when NCO 1 spoke to Mr E on his return from court he told him he was *"in good form"* and said he was "*the type of prisoner that just liked to chat."*

His cellmate thought Mr E's conversation with NCO 1 was in relation to his view that he was threatened in court and whilst in transit back to Maghaberry.

Further Officer Presence on the Landing

At 23.03, 23.33 and 00.35 NCO 1 was on the landing to check a prisoner who had an open SPAR booklet. Mr E did not press his in-cell buzzer or seek the attention of the officer on any of these occasions, nor at 01.00 when another check was carried out. Apart from these checks there were no officers on the landing.

Mr E's cellmate said that their television was switched off at 01.00, and up until then Mr E had been *"ranting."* He suggested Mr E was paranoid, continually talking about not feeling safe and thinking he was going to be attacked.

After a further supervised body check at 01.25 NCO 1 recorded that there was *"nothing of relevance noted."*

Prisoner Accounts of Verbal Abuse

The three prisoners who reported verbal abuse the previous night said there was further abuse on the night that Mr E died.

An anonymous letter to the Prisoner Ombudsman from a *"Concerned Prisoner"* in Bush House named the same prisoner (as these three prisoners) as the person who verbally abused Mr E. The letter also said this prisoner continued to tell Mr E he was *"going to be killed or seriously hurt"* when he left his cell.

Contrary to this, at no point did Mr E's cellmate recall any prisoners verbally abusing or threatening Mr E on the night he died, or on any other night.

Passing of another note

At 01.39 NCO 1 arrived on Bush 3 to check the SPAR prisoners. Soon after the officer passed Mr E's cell a note was pushed under his door onto the landing. On his return from checking a prisoner the NCO noticed the note and read it with his torch.

The note read:

"The staff up at the court today recognised what was happening and were discussing it. The two prisoners were taken out of prison bus and the staff decided to move me to Magilligan today because they feared for my safety but return back because the

other prisoners were up in their cells. That's why I was late tonight. Phone the staff at the Court to verify this."

Unlike Mr E's note two nights earlier, this note was not addressed to anyone, nor signed by Mr E. It was undated, not as grammatically accurate as previous correspondence, and his handwriting appeared to be unsteady.

NCO 1 told police *"When I moved on there was a knock on Mr E's cell door. I carried on with my SPAR checks…"* Despite Mr E clearly trying to gain NCO 1's attention, the officer did not look into his cell. He said this was because *"There was nothing really in it* (the note) *that gave me concerns that he was going to do something,"* and added he knew Mr E had been in *"good form"* on his return from court. He also explained that staff have to assess each situation, and sometimes it is easier for the prisoner by not engaging with them because they may have calmed right down by that point, and speaking to them would reignite their anxiety.

NCO 1 did not note any significance in the fact that this was the fifth contact he had had with Mr E on three consecutive nights.

The night senior officer said *"To be fair to* (name redacted - the NCO) *it didn't say that he was going to kill himself. If it had, it'd have been a matter of a SPAR straightaway."* The NIPS Suicide and Self Harm policy does not require explicit intent of self harm or suicidal ideation before the SPAR process should be applied; and it defines a vulnerable prisoner as:

"An individual whose inability to cope with personal situations within the prison environment may lead them to self harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication."

The senior officer who escorted Mr E from Reception back to Bush House said he was not given any information from the Reception staff in relation to how Mr E was feeling, either at court or on the journey back to prison. The supervising PECCS officer said Mr E *"appeared fine."* She recalled he asked about a transfer to Magilligan, and she described him as a *"model prisoner."*

<u>Emergency Call Out</u>

At 01.50, eleven minutes after Mr E passed the note, the light outside his cell illuminated. Mr E's cell mate had awoken to use the toilet and found Mr E hanging from the end of the bunk beds. The cell mate said he immediately raised the alarm and the officers arrived *"straight away."*

At 01.51 NCO 2 responded to the alarm and having looked in the cell called his colleague for assistance. NCO 1 arrived less than a minute later. Within 10 seconds

NCO 2 had entered the cell, and NCO 1 used his radio to raise the alarm before entering the cell. Within a minute of entering the cell, NCO 1 brought Mr E out onto the landing and immediately commenced CPR chest compressions. NCO 2 was not trained in CPR and chose not to assist.

CCTV footage shows that, within a minute of Mr E being brought onto the landing, his cellmate stole an item which was on the landing floor while NCO 2's back was turned. It is not clear what the item was. Mr E's cellmate subsequently denied that he stole anything. Shortly afterwards NCO 2 searched for the item in his pockets, in both his and his colleague's night custody belts and the surrounding area.

NCO 2 refused to be interviewed as part of this investigation and shortly afterwards went on a period of sick leave before leaving the NIPS on early retirement.

At 01.56 NCO 2 left the landing and returned promptly with a nurse. She was an agency nurse and immediately commenced use of an AmbuBag to administer rescue breaths.

At 01.57 the nurse requested the defibrillator, which was located downstairs. Mr E's cellmate was taken downstairs by NCO 2 while the defibrillator was being obtained.

At 01.58 the senior officer tasked an ambulance and gave the defibrillator to the nurse. The nurse could not recall why she did not bring the Healthcare defibrillator to the scene, but suggested it was probably because she knew each house held one.

Shortly after providing the nurse with the defibrillator NCO 2 was in discussion with the senior officer and appeared to still be searching for the stolen item.

CPR continued until 02.34. At 02.22 two paramedics arrived and for the next few minutes the nurse worked alongside them until they had their equipment set up. At 02.34 the paramedics and nurse agreed to cease CPR on Mr E.

The on-call prison doctor was tasked to attend the prison, but advised he could not assist. As an alternative a PSNI Force Medical Officer arrived at the prison and confirmed Mr E's time of death as 03.44.

Taking account of all of the events after Mr E was sentenced, Dr Quinn, the clinical reviewer, stated that *"It does not appear there was much by way of joined up thinking i.e. meaningful multidisciplinary discussions about Mr E as might have led to a formulation of the risk of suicide and an approach to managing his complaints that he was being threatened by other prisoners."*

SECTION 7: AUTOPSY & TOXICOLOGICAL FINDINGS

The Autopsy report records Mr E's cause of death as hanging.

The report of Forensic Science Northern Ireland showed that at the time of Mr E's death there was no alcohol and only the cardiac medication Flecainide present in the sample of blood obtained. The sample was not tested for his other medications.

SECTION 8: EVENTS FOLLOWING MR E'S DEATH

Hot Debrief

In accordance with Prison Service policy, at 07.00 on (date redacted) the staff immediately involved in this incident were brought together for the purposes of a hot debrief. Minutes of the debrief show that staff were offered support and given special leave to help them come to terms with the tragedy.

During the discussions both night custody officers identified issues surrounding the electronic locking gates which had in the past *"exposed difficulties in accessing the landings during an emergency response."* This did not impact on Mr E's demise, but may be an important factor in a future emergency.

Two recommendations were made –

1. ***Contingency plans for electric lock failure should be made available for all staff in Bush and Roe Houses.***
2. ***Review night guard orders re internal electric locks in Bush and Roe Houses.***

Maghaberry has advised that the Night Guard orders regarding the electric locks has been reviewed and they are content that no change to the current procedures is required.

Cold Debrief

In accordance with Prison Service policy, a Cold Debrief was held on (date redacted). In attendance were the Deputy Governor, the Head of Safer Custody, the Head of Prisoner Safety and Support, a Healthcare representative, a member of the Chaplaincy team, Residential senior officers, an ECR senior officer and one of the night custody officers who was involved in the incident.

The minutes provided Mr E's background history, and detailed the Hot debrief, and also a separate debrief that was held for prisoners. Maghaberry's Head of Prisoner Safety and Support provided a sequence of events that took place in the weeks leading up to Mr E's death.

Actions arising from this debrief included:

1. Information regarding the process to follow when reporting a death to the next of kin;

   Maghaberry advised that this will be included as part of the review of their Suicide and Self Harm policy

2. To provide appropriate screens when a body remains in situ on the landing;
   Maghaberry advised that this has been completed

3. To review the seven day response time to PSST referrals;
   Maghaberry advised that this has been reviewed and a new process implemented

4. To review the committal process for when a prisoner is returning from court to identify when a prisoner has received bad or unexpected news.
   Maghaberry are content that this is already covered within the current Suicide and Self Harm Prevention policy

PSST Review/ Lessons Learned Meeting and Actions

On (date redacted) a review of the actions arising from the cold debrief were undertaken by the Deputy Governor of Maghaberry, the Head of Safer Custody from Prison Service Headquarters (PSHQ), the Head of Maghaberry's Prisoner Safety and Support Team and the Bush House residential governor.

Minutes of this meeting indicate that *"letters"* Mr E wrote and passed to staff were discussed. It was agreed that the information contained within them *"should have led staff to consider appropriate support measures."*

It was also acknowledged that the letters were not passed to the Security Department and the PSST as they should have been; and there was no evidence that the letters have been discussed or shared within the residential team.

The following actions were agreed by this meeting:

1. Mr E's PSST request form of (date redacted) to be redacted and circulated to all staff and residential managers in Maghaberry as well as the Prison Service College trainers as an example of information that should be acted upon.
   Maghaberry advised that this has been completed

2. The Head of PSST to attend the PSHQ Safer Custody Forum and present an overview of the events leading up to Mr E's death.
   We are advised this was completed on (date redacted)

3. An awareness session to be delivered to all residential managers.
   Maghaberry advised that this has been completed

4. Staff and managers on duty at the time Mr E handed over notes on (date redacted) and (date redacted) to be interviewed.
   Maghaberry advised that this has been completed

5. An overview of the death to be presented at the next Senior Management Team meeting.

Maghaberry advised that this has been completed

6. Update the PSST self-referral form to ensure immediate actions taken are captured.

Maghaberry advised that this has been completed

7. A Notice to Staff to be issued reminding them to complete and forward a threat assessment to Security where appropriate.

A Notice to All Staff was issued by NIPS HQ on (date redacted)

8. A Notice to Staff to be issued reminding them to notify the PSST or during the night, the night guard manager, when there is a concern for the safety of an individual.

A Notice to All Staff was issued by NIPS HQ on (date redacted)

9. To update the 24 Hour Daily Management Report to capture safer custody issues that occur during night shift and include warning signs or indicators as a reminder to staff as follows – letters, any concerning verbal interaction, unusual behaviours, sleeplessness, volume on TV high.

Maghaberry advised that this has been completed

Prisoner Complaint & Security Information Reports (SIRs)

Two SIRs were submitted to Maghaberry's Security Department by NIPS staff on (dates redacted) in relation to the actions of certain prisoners on the landing. These suggested a prisoner had alleged NCO 2, who attended the scene of Mr E's death, was laughing throughout the incident. The prisoner also alleged that he heard other officers blaming NCO 2 for not doing his job properly, and telling him *"that if he'd have tried harder he could have saved his* (Mr E's) *life."* This prisoner also submitted an internal complaint about the matter.

There is however no evidence that NCO 2 was laughing during the incident; and the findings of this investigation indicate that all possible efforts to resuscitate Mr E were made at the time.