The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

COLIN MARTIN BELL

AGED 34

IN MAGHABERRY PRISON

IN THE LATE HOURS OF 31 JULY

AND EARLY HOURS OF

1 AUGUST 2008

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CONTENTS **PAGE**

PREFACE

Colin Martin Bell was born on 10 October 1974. He was 34 years old when he died in Safer/Observation Cell 16 on Landing 5, Lagan House, Maghaberry Prison, between the late hours of 31 July and early hours of 1 August 2008.

Within his family, Colin Martin Bell was known as 'Colin' and with the agreement of his family that is the name which I have used throughout my report.

I offer my sincere condolences to Colin's mother and father, and family and friends for their sad loss. I have kept in close contact with Colin's mother, father and sister and have updated them on developments as they have arisen.

My report contains this preface and a summary, followed by an introduction and background information, leading to my overall conclusions and associated recommendations; it is followed by a number of Annexes which include a detailed factual account of Colin's time in custody.

I will in due course add anything else which comes to light in the way of an addendum to this report and I will notify all concerned of my additions or changes. But to all interested parties, I feel my findings, conclusions and recommendations within this report, reflect the full picture.

As a result of my investigation, I make **44 recommendations** to the Northern Ireland Prison Service.

PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
15 December 2008

SUMMARY

Colin was committed to Maghaberry Prison on 5 March 2003. Apart from one incident of self harm in January 2005 and a short period in November 2006, when a PAR 1 was opened after Colin was feeling *"a bit down*", Colin's time in prison was relatively uneventful.

Then on 28 March 2008, Colin was found guilty of stealing a photograph frame and was moved from Wilson House, a lower risk house within Maghaberry Prison, back to the general prison population.

Between April and July 2008, Colin repeatedly told prison and Healthcare staff, external bodies and his own family that he believed he was under threat from paramilitaries/other prisoners. During this period, Colin self-harmed on 15 occasions and was moved between locations 30 times for his own protection, and in response to his fears. Colin was housed in a Safer/Observation Cell, designed for prisoners deemed to be at risk of serious self-harm, for a total of 40 days, varying from 1 to 14 day periods.

The psychiatric (specialist) opinion expressed suggests that Colin was not suffering from a psychotic or a depressive illness but that he was paranoid and pre-occupied by threats of self-harm and that it was part of his personality make-up and personal vulnerability that, in situations of perceived threat or unmet need, he may resort to these emergent behaviours. Professor Roy McClelland who produced a clinical review report as part of my investigation suggests that, within the context of his life situation within prison, the loss of privileges and change in circumstances resulting from Colin's misdemeanour in March were probably a devastating experience for him.

Between April and July, multi-disciplinary Case Conferences and Safer Custody meetings were held, in line with Prison Service policy to discuss Colin. Many members of prison, healthcare staff, chaplains, listeners,

Independent Monitoring Board and others were concerned for Colin and played a role in trying to help him. Care plans were agreed, an important element of which was arranging for Colin to spend time in the Healthcare Centre each day for occupational activity and human contact. These were implemented at some times but not at others.

Different Healthcare staff and governors at various times had a role in deciding on and implementing particular actions in relation to Colin but he was not allocated a Care Co-ordinator with responsibility for ensuring continuity and overseeing the implementation of agreed plans.

Colin's behaviour and, in particular, his determination to self-harm, was extremely challenging for those trying to help him. From a medical management perspective, Professor McClelland concludes that there was not much more that medical staff could have contributed to managing this situation. However, expert psychological, psychotherapeutic and psychodynamic inputs to the deliberation of the multi-disciplinary team, as the situation became more and more difficult, would likely have been of assistance. In the absence of some alternative management strategy for Colin's concerns, perceptions, anxieties, distress and self-harming behaviour, there was little alternative for staff but to make use of Safer/Observation Cells.

By late July, the situation in respect of the management of Colin was evidently deteriorating. Professor McClelland notes that *"something of a power struggle was developing."* At a Safer Custody meeting on 24 July it was noted *"each time he reaches a certain point in the plan and then he misbehaves, he goes back to the beginning. He does not like the Safer Cell so each time he misbehaves, he will remain a further day until he realises he is not the winner."*

Colin went into a Safer/Observation Cell at 01.08 on 26 July and remained there until he died in the late hours of 31 July and early hours of 1 August. It was evident by the level of his attempts to self-harm during this period that any belief that remaining in the Safer/Observation Cell would encourage him to stop self-harming was flawed. However, the absence of a designated Care Co-ordinator and on-going failures in the application of the Prison Service's own policy in respect of the extension of the use of the Safer/Observation Cell and anti-ligature clothing, meant this was not picked up and addressed.

During Colin's last 6 days, there is no evidence that, contrary to his Care Plan, Colin was accessing any activity or occupational therapy in the Healthcare Centre. Records suggest that over his last 6 days Colin left his cell for less than 4 hours in total. This included a drugs test, attendance at a video link and one consultation with a doctor. A doctor is also recorded on Landing logs to have entered Colin's cell on 26 July, 29 July, and 30 July, but there are no associated entries on medical or PAR 1 records in connection with these visits. Professor McClelland comments that *"CCTV footage of Colin's cell during his last day highlights the degree of isolation, boredom and barrenness of Mr Bell's living environment."* He goes on to say that *"these conditions almost amount to solitary confinement."*

For the period of 26 July to 31 July there is no evidence that the extension of Colin's stay in the Safer/Observation Cell and the extended use of anti-ligature clothing was correctly authorised or subject to proper multi-disciplinary consultation, as required by Prison Service policy.

Because Colin was dressed in anti-ligature clothing and his blanket had been removed for his own protection as a result of his attempts at making ligatures, he appeared at times cold. There is evidence of this on 3 consecutive nights, and on 2 of those nights Colin wrapped toilet paper around his feet in what appears to be an attempt to keep warm. On both

nights Colin can be seen on CCTV footage waking up during the night to re-wrap the toilet paper that has unravelled. There is no evidence of any discussion with Colin about whether he is cold or any attempt at intervention. Colin did have a blanket in his cell on 30 and 31 July.

On 31 July, CCTV footage shows Colin making ligatures in the morning. There is no evidence that this is noted by Prison staff or of any attempted intervention.

That evening, CCTV footage shows that over a period of 14 minutes commencing at 22.57, Colin was holding a ligature and made three attempts to hang himself. Colin's fourth, successful, attempt was at 23.41. Even before his first attempt and between his third and fourth attempts, Colin could be seen walking around his cell with a ligature in his hands.

During the course of the evening of 31 July, Landing Officers were not carrying out checks at the 15 minute intervals required by Prison Service policy; the Secure POD Officer responsible for viewing CCTV footage of Colin's Safer/Observation Cell from the Secure POD was not carrying out or recording checks at the 15 minute intervals required by Prison Service policy; Landing Officers who should not have been in the Secure POD, and the Secure POD Officer, can be seen on CCTV footage chatting, smoking, watching television and using the computer; the Secure POD Officer can be seen making and using a makeshift bed; a Senior Officer made a supervisory visit to the Secure POD and Landing but did not `check the CCTV, enquire about the two prisoners in the Safer/Observation Cells or check that the observation records, which the Secure POD Officer and the Landing staff should have been completing, were completed.

Between 16.12 on 30 July and 22.21 on 31 July, Colin pressed the Samaritans' call button in his Safer/Observation Cell 73 times. Evidence suggests that around 63 of these presses resulted in an engaged tone. There is no evidence of any intervention in response to this level of attempted contact with the Samaritans.

Colin's fourth and final attempt to take his life was at 23.41 when he hanged himself from the ligature at his cell door. It was a further 38 minutes before Colin was discovered by prison officers.

INTRODUCTION TO MY INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[1] for Northern Ireland, I have responsibility for investigating the death of Colin Martin Bell in Maghaberry Prison between the late hours of 31 July and the early hours of 1 August 2008. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Annex 1.

2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. I am independent of the Prison Service, as are my investigators. As required by law the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives

4. The objectives for my investigation into Colin's death are:

   - to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;
   - to examine any relevant healthcare issues and assess clinical care afforded by the Prison Service;
   - to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;
   - to ensure that Colin's family have the opportunity to raise any concerns that they may have and that these are taken into account in my investigation; and
   - to assist the Coroner's inquest.

[1] The Prisoner Ombudsman took over the investigations of deaths in prison custody in Northern Ireland from 1 September 2005.

Family Liaison

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the family.

6. My predecessor, Brian Coulter, first met with Colin's mother, father and sister on 13 August. I am also grateful for the opportunity to keep in close contact with Colin's family and personally met with them on numerous occasions to update them on progress. I also met with them again recently in order to explain and discuss my findings, conclusions and recommendations within this report.

7. It was extremely important for my investigation to learn more about Colin and his life from his family. I thank Colin's mother and father for giving me the opportunity to talk with them about Colin's tragic death. I am also grateful for the insight they gave me into events throughout Colin's life.

8. Although my report will inform many interested parties, I write it primarily with Colin's family in mind. I also write it in the trust that it will inform policy or practice which may make a contribution to the prevention of a similar death in future at Maghaberry Prison or elsewhere in any Northern Ireland Prison Service establishment.

9. Along with many other issues, I took forward the family's four main areas of concern about Colin's care which they believe may have contributed to his death in custody, namely:

   - Why was Colin able to hang himself - what supervision did he have?
   - How was Colin able to make a ligature without anyone seeing him?
   - Following a case conference on 24 July held to discuss Colin, why was better care not taken to protect him?
   - Was Colin being bullied by prison officers or under threat from other prisoners?

10. As part of my investigation into Colin's death, I also commissioned a clinical review of his healthcare needs and medical treatment whilst he was in custody, including risk management and medication.

INVESTIGATION METHODOLOGY

Notification

11. In the early hours of 1 August, my predecessor, Brian Coulter, was notified by the Prison Service about Colin's death in Maghaberry Prison. I replaced Brian as Prisoner Ombudsman on 1 September and subsequently took over the investigation into Colin's death in custody.

12. A member of the Ombudsman's investigation team attended Maghaberry Prison at 09.00 on 1 August to be briefed about the series of events leading up to and following Colin's death.

13. The investigation into Colin's death began later that morning when Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison announcing the investigation, and inviting anyone with information relevant to Colin's death to contact the investigation team.

Notice to Prisoners

14. In response to the Notice to Prisoners sent out on 1 August following Colin's death, 15 prisoners responded. These prisoners were interviewed by my investigation team and the following points were raised:

- Attitude of some staff on the REACH Landing
- REACH Landing not being a therapeutic environment
- Staff not properly trained to deal with mental health issues
- Moving Colin so many times from house to house
- Colin's thoughts that other prisoners were coming to attack him
- Colin being refused a Listener.

15. All of these comments were considered as part of my investigation.

Prison Records and Interviews

16. My investigation team and I visited Maghaberry Prison on numerous occasions and met with prison management, staff and prisoners. We retrieved all the prison records relating to Colin's period of custody, including his medical records.

17. My investigation team and I carried out an extensive range of interviews with prison management, staff and prisoners, in order to obtain information about the circumstances surrounding Colin's death. The Independent Monitoring Board at Maghaberry Prison also provided information to my investigation team.

Telephone Calls

18. My Investigation Team listened to the last 11 telephone calls made by Colin in July 2008. Five of these conversations were transcribed. Apart from telephoning his mother, the remainder of Colin's telephone calls were to the Human Rights Commission and to friends. In each call, Colin said that he was worried about his safety.

Clinical Review

19. There was a substantial amount of documentary information about Colin's health contained in his custody records. This included records of his medical care and treatment throughout his time in the Northern Ireland Prison system.

20. As part of my investigation into Colin's death, I commissioned Professor Roy McClelland, Emeritus Professor of Mental Health at Queens University Belfast, to carry out a clinical review of his healthcare needs and medical treatment whilst in prison and, in particular, his mental health management. I am grateful to Professor McClelland for his assistance.

21. Professor McClelland's clinical review formed an important part of my investigative report and I drew from it in framing some of my conclusions and recommendations. His review report is attached as Annex 5.

Working together with interested parties

22. An integral part of any of my investigations is to work together with all the interested parties involved. To that end my investigation team worked closely with Lisburn Police and liaised with the Coroner's Service for Northern Ireland.

Early Recommendations

23. As a result of my initial enquiries into Colin's death, I felt it necessary to share a number of early observations and recommendations with the Prison Service in connection with the circumstances surrounding his death.

24. It was my view that immediate action in respect of these would directly impact upon the risk of a similar death occurring and as such it would have been inappropriate to wait for the production of my report. My early letter, with associated recommendations, is attached as Annex 2.

Factual Accuracy Check

25. I submitted my draft report to the Director of the Northern Ireland Prison Service on 12 November for a factual accuracy check.

26. The Prison Service responded on 12 December with a list of comments for my consideration.

27. I have fully considered these comments and made amendments where appropriate. This is, therefore, my final report.

BACKGROUND INFORMATION

Maghaberry Prison

28. Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[2] and integrated[3] conditions.

29. Maghaberry Prison was built to accommodate 682 prisoners, however, there were 844 prisoners in Maghaberry on the day Colin died.

30. Maghaberry Prison is one of three Prison establishments managed by the Northern Ireland Prison Service, the others being Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre.

31. Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. Four Square Houses - Bann, Erne, Foyle and Lagan, along with purpose built separated accommodation houses of Roe and Bush, make up the present residential house accommodation.

32. There are two lower risk houses within the Mourne Complex of Maghaberry Prison, called Wilson and Martin Houses. These are used specifically to house lifer prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU) located at Crumlin Road, Belfast.

33. There is also a Landing within Maghaberry Prison called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Lagan House, called the REACH[4] Landing, used for housing poor coping prisoners.

34. The REACH Landing is a facility which the Prison Service states *"identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working and person centred planning."*

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[2] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.

[3] Integrated – general residential accommodation houses accommodating all prisoners

[4] REACH Landing definition – **R**eaching out to prisoners through **E**ngagement, **A**ssessment, **C**ollaborative working **H**olistic approach.

35. There is also a Special Supervision Unit[5] (SSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.

36. The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and resettlement of which addressing offending behaviour is an element.

37. Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[6] (PREPS).

38. Maghaberry Prison was last inspected by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[7] in Northern Ireland in October 2005.

39. As well as taking into account the clinical review carried out by Professor McClelland mentioned earlier, I also draw references in my report to a publication called: *"A review of Non–natural Deaths in Northern Ireland Prison Service Establishments (June 2002–March 2004)"* which was chaired by Professor McClelland.

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[5] Special Supervision Unit (SSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

[6] Progressive Regimes and Earned Privileges (PREPS) - There are three levels of regime. Basic - for those prisoners who, through their behaviour and attitude, demonstrate their refusal to comply with prison rules generally and/or co-operate with staff. Standard - for those prisoners whose behaviour is generally acceptable but who may have difficulty in adapting their attitude or who may not be actively participating in a sentence management plan. Enhanced - for those prisoners whose behaviour is continuously of a very high standard and who co-operate fully with staff and other professionals in managing their time in custody. Eligibility to this level also depends on full participation in Sentence Management Planning.

[7] Website link - http://inspectorates.homeoffice.gov.uk/hmiprisons/inspect_reports/547939/551446/maghaberry.pdf?view=Binary

The REACH Landing

40. The REACH Landing in Lagan House was established in April 2007. This is a facility which the Prison Service states *"identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working and person centred planning."*

41. The original ethos and expectation for the REACH Landing was to manage the needs of prisoners and staff within a supported environment to help improve prisoners' mental well-being and social functioning, reduce staff distress, improve relationships and reduce the use of Rule 32[8]. The average length of time a prisoner is located on the landing is 10 weeks.

42. The REACH Landing provides accommodation for between 16-20 prisoners who are referred and assessed by staff for suitability. Prisoners are reviewed after 4 weeks on the Landing to ascertain if they are suitable to be located back into the general prison population.

43. The staff working on the REACH Landing undertake mental health awareness training. The programme includes learning how to deal with psychiatric illnesses, learning therapeutic communication skills, motivational interviewing and dealing with personality disorders.

Safer/Observation Cell Accommodation

44. The other unique function of the REACH Landing in Lagan House within Maghaberry Prison is the Safer Custody suite.

45. The Safer Custody suite consists of two Safer/Observation Cells, Cell 15 and 16, and a double Listener cell at Cell 17/18 which is two cells joined together.

[8] Prison Rule 32 – where it is necessary for the maintenance of good order or discipline, or in his own interests that the association permitted to a prisoner should be restricted, either generally or for particular purposes, the governor may arrange for the restriction of his association by placement in the Special Supervision Unit (SSU).

46. All Safer/Observation Cells have CCTV camera, built in television in a panel which also incorporates panel buttons for access to an intercom/telephone to the Samaritans, as well as an emergency call bell and intercom to the Secure POD.

47. The Secure POD is located at the entrance to each residential house and is the key control point within each house where all prisoner and staff movement is managed and logged.

48. During the day, the Secure POD is staffed by two Main Grade Officers and in the evening by one Night Custody Officer.

49. The Secure POD is locked and access is restricted. If a member of staff requires entry to the Secure POD, the keys should be passed out through a key window and the door is opened from the outside.

50. In Lagan House, the Secure POD is also responsible for monitoring the Safer/Observation Cells located on the REACH Landing.

51. There are CCTV cameras in all the Safer/Observation Cells and the Secure POD Officers on duty are responsible for monitoring the occupants of those Safer/Observation Cells at 15 minute intervals using observation logs.

52. All Safer/Observation Cells are fitted with anti-ligature furniture and fittings which include:

- *"A high security window with polycarbonate glazing*
- *24 hour CCTV observation facility*
- *Cast synthetic resin wash hand basin and WC Pan with push button water controls*
- *Audible cell call system and intercom facility directly linked to staff*
- *Direct help line to Samaritans*
- *Fixed resin cell furniture and bed*
- *Cornice light fitting and TV recessed into protective metal casing."*

POLICIES AND PRISON RULES

Prison Rules

53. Rule 47 of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 gives the authority under which a person can be confined in a special cell or protected room. This Rule is replicated below:

"Temporary confinement

***47.** –(1) For the purpose of preventing disturbance, damage or injury, a refractory or violent prisoner may be temporarily confined in a special cell or protected room approved for the purpose by the Secretary of State; but a prisoner shall not be confined in such a cell as a punishment or after he has ceased to be refractory or violent.*

(2) The governor shall inform the medical officer of the intended removal of any prisoner to a special cell or protected room, but where this is not possible the medical officer shall be informed as soon as possible thereafter.

(3) Notwithstanding the provisions of paragraph (1) and (2) the medical officer may, for the purpose of preventing a prisoner from causing injury to himself or to others, order that he may be temporarily confined in a protected room and to be confined there for as long as the medical officer considers necessary.

(4) The governor, the Secretary of State and a member of the board of visitors (now called independent monitoring board) shall be informed of any prisoner who is so confined.

(5) Every prisoner who is temporarily confined in a special cell or protected room shall be visited at least once a day by the governor and by the medical officer.

(6) Every prisoner so confined shall be observed at least once every 15 minutes by an officer and a record shall be kept of such observations."

54. Rule 55 of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 relates to a prisoner's right to exercise and association. This Rule is replicated below:

"Exercise and association
***55.** –(1) Every prisoner shall be given the opportunity of association for not less than one hour each day which may be taken as exercise in the open air, weather permitting.*

(2) Where on any day a prisoner participates in exercise consisting of sport or physical training indoors, or is engaged in outside work the requirement that association be taken as exercise in paragraph (1) shall not apply.

(3) The medical officer shall decide upon the fitness of every prisoner for exercise, sport and physical training and may excuse a prisoner from, or modify, any such activity on medical grounds.

(4) Where necessary, special arrangements shall be made, in consultation with the medical officer, for remedial physical education or therapy.

55. Rule 13 of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 relates to heating, lighting and ventilation. It states:

"the Governor shall ensure that the arrangements for heating, lighting and ventilation in the prison are satisfactory…"

56. Rule 14 of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 relates to beds and bedding. It states:

"every prisoner shall be provided with a separate bed and with separate bedding adequate for warmth and health."

Standard Operating Procedures

57. The policy for the use of the Safer/Observation Cell in Maghaberry Prison is reflected in its Standard Operating Procedures Document SOP/01, issued on 27 May 2008. This document is attached as Annex 3.

58. The Standard Operating Procedures Document SOP/01 for the Use of the Safer/Observation Cell in Maghaberry Prison is further reflected, service-wide, in the CRC 1 Use of Safer/Observation Cell (Special Accommodation) Authorisation Booklet, which I mention at paragraph 63.

Self-Harm and Suicide Prevention Policy

59. In a desire to improve its arrangements for dealing with vulnerable prisoners, the Prison Service revised its Self-Harm and Suicide Prevention policy in September 2006.

60. The revised policy states that it:

"aims to identify prisoners at risk of suicide or self harm and provide the necessary support and care to minimise the harm an individual may cause to him or herself. The Service recognises that this is an important priority and one that demands a holistic approach."

61. An extract of this document is attached as Annex 4.

Par 1 'Prisoner At Risk' Booklet

62. A Prisoner at Risk (PAR 1) Booklet is an authorisation and observation booklet which is opened when a prisoner is put under closer observation, usually in his own cell, for his own protection and safety.

63. The Prison Service's Self-Harm and Suicide policy states that *"a multi-disciplinary case conference must be held at least every 14 days*" for a prisoner with an open PAR 1.

CRC 1 'Use of Safer Cell' Authorisation Booklet

64. The policy reflecting the Use of the Safer/Observation Cell in Maghaberry Prison is laid out in the Standard Operating Procedures Document SOP/01 mentioned earlier in paragraph 57 and 58 and replicated in Annex 3.

65. In line with the policy, if a prisoner has shown, or has demonstrated, a greater risk of self-harm, an authorisation for the prisoner to be placed in a Safer/Observation Cell can be initiated using a CRC 1 Use of Safer/Observation Cell (Special Accommodation) Authorisation booklet. The CRC 1 booklet also states:

"Extension -
Authority to extend the use of Special Accommodation (Safer/Observation Cell), anti-ligature clothing or mechanical restraints should only be granted following full consideration of all the relevant information. Authorisation for the use of special accommodation, anti-ligature clothing or mechanical restraints for any period in excess of 24 hours may only be granted by the Secretary of State through the Deputy Director, Head of

Operations at Prison Service Headquarters. The reasons for an extension must be fully documented."

[Note: Although the CRC 1 sets the authorisation level for the extended use of the Safer/Observation Cell for any period in excess of 24 hours at Deputy Director level, this is not fully reflected in the Standard Operating Procedures Document SOP 0/1]

66. However, in line with those Standard Operating Procedures, the CRC 1 instructions, as quoted above, contain the necessary instructions for the authorisation for the use of anti-ligature clothing or mechanical constraints, including the requirements to be adhered to, at Deputy Director level, if these measures are to be used for any period of extension in excess of 24 hours.

Samaritans Listener Scheme

67. The Samaritans' Listener Scheme was launched at Maghaberry Prison on 11 December 2006. The scheme is controlled by the Samaritans. A Principal Officer acts as a Co-ordinator on behalf of the Prison Service.

68. The agreement for provision of the scheme is laid out in a Service Level Agreement between the Governor of Maghaberry Prison and the Samaritans Belfast Branch. Guidance on the scheme is set out in Governor's Order 7-22, Notices to Staff 124, 125, 126/06, and Notice to Prisoners 69/06.

COLIN'S CUSTODY IN MAGHABERRY PRISON

Background

69. Colin was committed to Maghaberry Prison on 5 March 2003. He was sentenced to life imprisonment on 23 November 2004 and was given an eight year tariff[9].

70. From his committal on 5 March 2003 until 14 January 2005 Colin's time in prison was largely uneventful.

71. There was one isolated incident, on 15 January 2005, where Colin self-harmed when he attempted to hang himself using a ligature in his cell in Erne House, which is generally used to house life sentence prisoners.

72. Colin was immediately moved to the Prison Healthcare Centre and a PAR 1 booklet was opened, placing Colin under observation. A Nurse said at the time that some of Colin's statements were contradictory. Colin had told her that "*he did not want to die*" and then he re-iterated that he *"would try to kill himself".*

73. Colin's PAR 1 booklet was closed on the 2 February 2005, when his mood was reported to be stable and it was reported that he had no further thoughts of self-harm. He was retained in the Healthcare Centre until a cell in one of the Residential Houses became available. Colin returned to Erne House on 23 February 2005.

74. Colin appeared to settle into prison life. An Officer commented in October 2006 that Colin was: *"a quiet prisoner in the Landing."*

75. One further isolated incident was recorded in late November 2006 when a PAR 1 booklet was opened in respect of Colin. It was recorded that Colin was feeling "*a bit down.*" This PAR 1 only remained open for a few days until a Healthcare review which took place on 4 December recorded *"does not feel down any more. No thoughts of deliberate self-harm."*

[9] Tariff – the earliest a prisoner can be assessed by the Parole Commissioners for his/her release into the community on Life Licence.

76. Colin progressed again in prison causing few problems, spending the latter of his time from 4 May 2007 in Wilson House within the Mourne Complex[10], the lower risk area of Maghaberry Prison housing primarily life sentence prisoners.

77. An Officer commented on Colin's demeanour in October 2007 saying*: "I have known Colin for approximately 18 months. Colin's behaviour in prison has been good. No adverse reports…Colin has a good relationship with staff and other inmates."*

78. Colin remained in Wilson House until 28 March 2008, when an incident occurred in which he was found guilty of stealing a photograph frame from a Senior Officer. Colin was moved immediately to Cell 18 on Landing 2 in Roe House that day at 16.04, until a place in the general prison population in Erne House became available.

79. Colin was charged under Prison Rule 38 (13) - *"takes improperly any article belonging to another person or to a prison."* His adjudication for this charge was heard and adjourned on 31 March on the grounds that he was seeking legal assistance.

80. On 3 April, Colin was moved to Cell 5 on Landing 2 in Erne House.

81. Around this time, Colin started to report to prison and healthcare staff a continual fear that he and his family were under threat from other prisoners.

82. Colin also expressed these fears to a number of outside bodies, including the Prisoner Ombudsman's Office. His concerns were reported back to Prison Service officials with an expectation that they would re-assess his safety. Colin was subsequently moved on many occasions to other Residential Houses and Landings in an attempt to placate his fears.

83. From April 2008, Colin made a number of attempts to self-harm and also to take his life and, on numerous occasions, he was being monitored under the Prison Service's self-harm and suicide prevention and monitoring procedures, including the PAR 1 and CRC 1 booklet requirements.

10 Mourne Complex – a complex in the grounds of Maghaberry Prison with two houses, Wilson House and Martin House, generally used as lower risk area to house Life Sentence Prisoners nearing the end of their tariff and as a stepping stone to the Pre-Release Assessment Unit (PAU) based at Crumlin Road Belfast.

84. Colin's mother and father told me:

"Colin was happy in Wilson House but was moved because of a minor incident involving a photograph frame (on 28th March 2008). Following his move from Wilson House Colin became very nervous and anxious. He would ring us saying that he was going to be murdered and that the paramilitaries were coming to get him."

85. Colin's father also said to me that he was constantly telling them that *'they were out to get him'* and his family thought that Colin was *"being bullied by prison officers and other prisoners."*

86. From the incident on 28 March 2008, when he was removed from Wilson House following the theft of a picture frame, Colin was moved location within Maghaberry Prison **30 times.**

87. This included Colin being housed for periods of time between two Safer/Observation Cells, Cell 15 and Cell 16 on the REACH Landing (Landing 5) in Lagan House.

88. Colin was placed in Safer/Observation Cell 16 on 26 July, and remained there for 6 days until he took his life in the late hours of 31 July and early hours of 1 August.

89. An autopsy was carried out on Colin's body later on 1 August. The report stated:

"Death was due to hanging. There was a ligature mark around the neck and its position was such that when the material was tightened, under the partial weight of his body, it would have interfered with breathing and the flow of blood to and from the head. Unconsciousness would probably have occurred quite rapidly with death supervening within a few minutes."

Analysis of Evidence

90. I have included a summary of Colin's custody in prison following his move from Wilson House on 28 March at Annex 6.

91. I have also included a more detailed analysis of Colin's last six days in the Safer/Observation Cell, from 26 July up to when he took his own life in the late hours of 31 July and early hours of 1 August, at Annex 7. Any gaps in the chronology mean that I have not seen any recorded evidence to support any commentary.

92. My findings, conclusions and recommendations from my investigation into Colin's death are detailed in the sections that follow.

FINDINGS AND CONCLUSIONS

1. USE OF SAFER CELL/OBSERVATION TO HOUSE COLIN

The Standard Operating Procedures SOP/01 for the use of a Safer/Observation Cell in Maghaberry Prison, issued on 27 May 2008, state:

"the use of the observation cell facility should be regarded as a short term intervention and should not be used for prolonged occupancy."

Prior to his death on 31 July, Colin had been housed for 6 continuous days in a Safer/Observation Cell on the REACH Landing of Lagan House, commencing 26 July. On 7 previous occasions, Colin had been housed in a Safer/Observation Cell on the REACH Landing:

- from 01.57 on 9 April until 10.53 on 10 April, 2 days;
- from 04.31 on 16 May until 15.56 on 17 May, 2 days;
- from 19.53 on 23 May until 11.40 on 25 May, 2 days;
- from 07.24 on 11 June until 18.00 on 16 June, 5 days;
- from 16.58 on 19 June until 18.14 on 3 July, 14 days;
- from 20.00 on 8 July until 11.24 on 9 July, 1 day;
- from 19.12 on 16 July until 15.07 on 24 July, 8 days.

Colin was, therefore, in a Safer/Observation Cell on 40 days since 9 April 2008.

SOP/01, mentioned earlier, details how a Safer/Observation Cell should be used. It states prisoners:

"*should be located within 48 hours to suitable accommodation, i.e. normal cell or Healthcare.*"

During interviews, Senior Managers pointed out that it is difficult after 48 hours to relocate a prisoner, who is not deemed fit to return to a normal cell, into Healthcare because of the absence of Safer/Observation Cells within the Healthcare Centre. I address this issue in my recommendations.

1a) Colin was held in a Safer/Observation Cell in excess of the Prison Service's own policies and guidelines.

2. ARRANGEMENTS FOR EXTENDING TIME SPENT IN A SAFER/OBSERVATION CELL

The CRC 1 Booklet, used for authorising the use of Special Accommodation such as the Safer/Observation Cell, states:

"Extension -
"Authority to extend the use of Special Accommodation (Safer/Observation Cell), anti-ligature clothing or mechanical restraints should only be granted following full consideration of all the relevant information. Authorisation for the use of special accommodation, anti-ligature clothing or mechanical restraints for any period in excess of 24 hours may only be granted by the Secretary of State through the Deputy Director, Head of Operations at Headquarters. The reasons for an extension must be fully documented."

When the Deputy Director of Operations at Headquarters was asked about this authorisation requirement, he said:

"…it would not be normal practice for Prison Service Headquarters to be involved - that's largely a local matter. I am aware of the requirement under SOP/01 as outlined in the CRC 1 Form. This is presently being changed as the procedure has never been operated, and certainly no request was made in relation to the Colin Bell incident.

Rather the focus should be on local management, who are on the ground and better informed to ensure proper safeguards are in place and where, for example, case conferences or multi-disciplinary meetings can be used to discuss concerns. On this occasion no referral was made to myself."

Evidence confirms that no referrals for extensions to the usage of Safer/Observation Cells were referred to the Deputy Director of Operations at Prison Service Headquarters. However, as the requirement under SOP/01 and CRC 1 had not been revised, authority for authorisation had not been formally delegated to an appropriate Senior Manager at Maghaberry Prison, for example, the Governing Governor.

Interviews with the Governing Governor and Deputy Governor of Maghaberry Prison did confirm that, in practice, they would consider themselves to be fully responsible for the appropriate use of and extension of the use of Safer/Observation Cells.

Further to the requirement for senior level authorisation for extension of the use of a Safer/Observation Cell, SOP/01 states:

"*extensions for keeping a prisoner in a Safer Cell longer than 24 hours should be agreed through consultation with multi-disciplinary teams however prisoners should be located within 48 hours to suitable accommodation, i.e. normal cell or Healthcare.*"

Also Prison Rule 47 (5) states:

"*(5) Every prisoner who is temporarily confined in a special cell or protected room shall be visited at least once a day by the governor and by the medical officer.*"

At interview, the Governing Governor of Maghaberry Prison confirmed his expectation that the Standard Operating Procedures should be fully adhered to, and both he and the Deputy Governor stated that they would always expect to see

the rationale for any decision to keep a prisoner in a Safer/Observation Cell for a further 24 hours recorded on the PAR 1/CRC 1 booklets.

Prior to his death on 1 August 2008, Colin had been held in a Safer/Observation Cell in Lagan House since 26 July, a total of 6 days.

Subsequent to Colin's placement in the Safer/Observation Cell on 26 July, there is no evidence of any Senior Manager at Prison Service Headquarters authorising an extension of Colin's time in the Safer/Observation Cell either on the PAR 1 or the CRC 1 Booklets.

There are also no signatures on Colin's CRC 1 Booklet from any Governor in Maghaberry Prison authorising the extended use of the Safer/Observation Cell or any note on Landing observation logs that Colin had been visited by a Governor in his last 6 days.

There is also no information available on Colin's CRC 1 or PAR 1 Booklets about the rationale for any decision to extend for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

If the correct level of authority had been sought and procedures followed, it may well have been that Colin would have remained in the Safer/Observation Cell, but it would have demonstrated that the decision to keep him in the Safer/Observation Cell for each further 24 hour period was a carefully considered one. It should also have impacted on the plan of care for Colin, as his period in the Safer/Observation Cell went on.

At interview, a Mental Healthcare Nurse who was asked about the involvement of a doctor when Colin was in a Safer/Observation Cell said:

"There seemed to be an area of confusion around who in Healthcare saw Colin when he was in the Safer Cell on the REACH Landing in Lagan House – he was supposed to be seen each day by a doctor but this seemed to be diluted as time went on – sometimes I would be going to see other prisoners on Reach and an officer would say, no-one's seen Colin today – so I saw him – but there seemed to be no tight written in stone instruction about who and when he would be seen from a medical perspective."

Landing records show that during Colin's last 6 days: a doctor was in his cell three times but there are no associated entries on the medical records or on the CRC 1 or PAR 1 as a result of this. Colin did see a doctor on 31 July who noted in his medical records: "*appears settled, denies thoughts of self-harm, continue observation."*

2a) The Prison Service kept Colin in a Safer/Observation Cell in the 6 days up to his death but failed to apply Prison Rules, and its' own policies and guidelines in respect of the requirements for reviewing and agreeing extensions every twenty four hours.

3. REASONS FOR KEEPING COLIN IN A SAFER/OBSERVATION CELL

Colin had a history of self-harm and suicidal attempts and it is very evident that decisions were taken to place Colin in a Safer/Observation Cell, at various times, for his own protection.

However, at a case conference on 24 July, the last recorded Safer Custody multi-disciplinary case conference at which Colin was discussed, it is recorded:

"Each time he reaches a certain point in the plan and then misbehaves, he goes back to the beginning etc. He does not like the Safer Cell, so each time he misbehaves, he will remain for a further day until he realises he is not the winner."

It is also recorded:

"There is a personality disorder with Colin where he thinks people are trying to kill him, but there is no psychiatric diagnosis. The Safer Cell is the only thing keeping him safe. HQ do not agree with this but we have a duty of care to keep Colin alive."

The Governor who chaired the Case Conference on 24 July stated, at interview, that the comment he made was taken out of context and that he had meant that Colin was not "*winning*" because he was not getting back to Wilson House, which was Colin's objective.

The Standard Operating Procedures for the use of a Safer/Observation Cell state:

"an observation cell may not be considered for use under the following circumstances: As a means of punishment or 'time out' facility; or as a location to manage prisoners who are deemed refractory or violent."

It would seem to be the case that, by late July, staff were becoming very frustrated by Colin's behaviour. The extract above from the Case Conference suggests that, over and above considerations relating to his personal safety, Colin was placed in a Safer/Observation Cell to correct "*misbehaving*". In this context, misbehaving appears to mean self-harming.

Professor McClelland comments in his clinical review that *"something of a power struggle was developing by the time of Colin's last period in a Safer Cell."* He also stated that: *"one must recognise the extreme difficulties for staff in this situation, where a prisoner seems so intent at self-harming."*

3a) The Prison Service may have breached its' own policies and guidelines and used a Safer/Observation Cell as a punishment/means to correct misbehaviour.

4. USE OF ANTI-LIGATURE CLOTHING

During Colin's final period in the Safer/Observation Cell, commencing 26 July, he was placed in anti-ligature clothing for his own safety and then remained in this clothing for his last 6 days.

Anti-ligature clothing consists of a short gown and no footwear.

Colin was also placed in anti-ligature clothing for many of the earlier protracted periods he spent in a Safer/Observation Cell, even at times when he had not self-harmed for a number of days. Colin was seen on CCTV footage leaving his cell in his gown and without footwear for two very brief periods on the day he died.

The Standard Operating Procedures SOP/01 for the use of the Safer/Observation Cell states that the use of anti-ligature clothing may only be used in: *"exceptional circumstances"* and if it is to be used: *"in excess of 24 hours may only be granted by the Deputy Director of Operations in Prison Service Headquarters."* This is also stated in the CRC 1 Authorisation for the Use of Safer/Observation Cell Booklet.

The Deputy Director, when asked, stated that this provision is currently being changed and that the emphasis should be on local management, who are on the ground, and better able to ensure that proper safeguards are in place. He said:

"*I am aware of the requirement under SOP/01 as outlined in the CRC 1 Form. This is presently being changed as the procedure has never been operated, and certainly no request was made in relation to the Colin Bell incident. Rather the focus should be on local management, who are on the ground and better informed to*

ensure proper safeguards are in place and where, for example, case conferences or multi-disciplinary meetings can be used to discuss concerns. On this occasion no referral was made to myself."

I have found no documentary evidence that the appropriate level of authority from the Deputy Director of Operations at Headquarters was ever sought for any period Colin was kept in anti-ligature clothing in excess of 24 hours. Because the Standard Operating Procedures SOP /01 had not been formally amended, authority was not sought from or given by a designated Senior Manager at Maghaberry Prison, for example, the Governing Governor.

References were made at some Case Conferences to keeping Colin in anti-ligature clothing. During the 40 days that Colin was in a Safer/Observation Cell between April and July (requiring 28 authorisation extensions), I have found evidence of 10 occasions when a decision to extend the use of anti-ligature clothing was recorded by a Governor Grade.

The Prison Service's Self-Harm and Suicide Prevention policy states:

"*Anti suicide suits should only be deployed as a last resort where it is deemed that a serious attempt to self harm will be carried out by the prisoner."*

In the absence of authorisation by the Deputy Director, Head of Operations at Prison Service Headquarters, if authorisation at Governing Governor level had been required, sought, and recorded for each period of extension, it may have been that

Colin would have remained in anti-ligature clothing, but it would have demonstrated that this was a considered response to an assessment of a current risk of a serious attempt at self-harm.

4a) Prison Service policy for placing Colin in anti-ligature clothing for all the occasions he was in a Safer/Observation Cell for protracted periods in excess of 24 hours was not adhered to.

5. COLIN'S CARE ON 27, 28, 29 JULY WHEN HE IS IN ANTI-LIGATURE CLOTHING AND APPEARS TO BE COLD

An entry in the PAR 1 Landing observation log on 27 July at 23.30 states that Colin is *"wrapping toilet paper around."*

CCTV footage shows Colin wrapping toilet paper around his feet from 21.59 when he has no blanket and appears cold. Colin also puts his hands inside his gown. Colin goes to sleep at around 23.50, but wakes up at 4.53 on 28 July and rewraps the toilet paper around his feet. There is no record of any discussion with Colin, or any intervention.

CCTV footage of Colin in the Safer/Observation Cell on the evening of 28 July shows Colin, at 22.35, putting his arms inside his protective gown, in what appears to be an attempt to keep warm.

CCTV footage of Colin in the Safer/Observation Cell on 29 July shows that Colin has no blanket (this had been removed due to a previous incident of attempted self-harm). At 01.30 Colin can be seen wrapping toilet paper round his feet and ankles in what appears to be an attempt to try to keep his feet warm. Colin can then be seen lying on his bed with the toilet paper wrapped round his feet until 05.10 when he wakes up and again wraps the toilet paper around him, because it has unravelled.

Colin appears to sleep, but is clearly restless and wakes again at 06.52 when the toilet paper has unravelled again. He then removes the paper, throws it into the toilet and sits on the shelf in his Safer/Observation Cell.

During the whole of this period on 29 July there is no entry in the Landing or Secure POD observation records to show that it has been observed and noted that Colin appears to be cold and wrapping his feet in toilet paper. There is also no evidence of any discussion with Colin, or any intervention.

I have established that the temperature in a Safer/Observation Cell is affected by the need for heating pipes to be boxed in.

At interview, a Governor who had been dealing with Colin said:

"*I do not think it would be appropriate for night staff to have given him bedding in case he used this wrongly and an individual was left susceptible but the matter should have been pointed out the following morning and a discussion/decision made regarding the matter."*

When these incidents were drawn to the attention of the Governing Governor and Deputy Governor at interview they suggested, that with the benefit of hindsight, possible intervention in the form of one to one supervision or arranging for the heat to be turned up would have been appropriate. However, it was also stated that it is very difficult to manage such a situation where a blanket has been removed in the interests of a prisoner's safety.

Over and above the principle of care raised by my comments above, Prison Rule 13 states: *"the Governor shall ensure that the arrangements for heating, lighting and ventilation in the prison are satisfactory…"* and Prison Rule 14 states: *"every prisoner shall be provided with a separate bed and with separate bedding adequate for warmth and health."*

5a) There is evidence that Colin, who was in anti-ligature clothing, may have been cold on three consecutive nights shortly before his death and, on two occasions, wrapped toilet paper around his feet in what appears to be an attempt to try to keep warm. There is no evidence of any intervention to discuss with Colin the fact that he may have been cold or any action to address the fact that Colin may have been cold.

6. COLIN'S TIME OUT OF SAFER/OBSERVATION CELL

In his review into Non-natural Deaths in Custody in Northern Ireland Prisons[11], Professor McClelland stated that:

"The regime content and activity levels were also examined as literature points to a correlation between poor regimes and adverse effects on the mental well being of offenders. This can contribute to self-harm and an increase in suicidal ideation."

Professor McClelland also made reference to the Howard League for Penal reform[12] where it criticised the long periods of time spent in 'enforced' idleness.

HM Prison Service Order 2700 which applies to prisons in England and Wales states:

"Independent research has indicated that at prison level, lower rates of self-inflicted death are associated with higher rates of purposeful activity, even when the type of prison is taken into account."

I was able to observe Order 2700 being implemented in a Safer/Observation Cell environment in a prison in London during the period of my investigation.

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[11] Professor Roy McClelland, Professor of Mental Health at Queens University Belfast chaired the group who published, "A review of Non–natural Deaths in Northern Ireland Prison Service Establishments (June 2002–March 2004)".

[12] The Howard League for Penal Reform is the oldest penal reform charity in the UK. It was established in 1866 and is named after John Howard, one of the first prison reformers.

Professor McClelland made the following recommendation which was accepted by the Northern Ireland Prison Service who agreed to create options for achieving its implementation by 31 March 2006:

"Improving activity levels, work placement, education for vulnerable prisoners and therapeutic day care regimes should be established as components of care for this group. More attention to detail should go into the way that vulnerable prisoners spend their days."

Additionally, Prison Rule 55 relates to a prisoner's right to exercise and association and states: "*Every prisoner shall be given the opportunity of association for not less than one hour each day which may be taken as exercise in the open air, weather permitting."*

Of the 34 days Colin spent in a Safer/Observation Cell during the months of June and July, the evidence available suggests that he was involved in a programme of Occupational Therapy/Exercise which involved him attending the Healthcare Centre for a period of at least one hour during the afternoon on 18 of the 34 days that he was in a Safer/Observation Cell and for a further period in the morning on 10 of the 18 days.

Further recorded information for the period 26 to 29 July, after Colin had been housed in a Safer/Observation Cell for the last time, suggests that he was not involved in any purposeful activity regime for this period.

From analysis of Prison Service records for this period, Colin received less than 2 hours out of his cell: 35 minutes on 27 July to use the telephone; 55 minutes on 28 July to attend a drugs test; and a further short period on 29 July to collect his lunch meal. He was seen by a Doctor in his cell on 26 July, 29 July and 30 July.

My investigators have also examined CCTV footage of Colin's cell for his last 48 hours. Over the 48 hour period, Colin was out of his cell for a total of 2 hours and one minute.

On 30 July, Colin was out of his cell for 53 minutes to attend a video link and for 29 minutes to take a shower. On 31 July, Colin was out of his cell for 5 minutes for an unknown reason, 28 minutes to attend a consultation with a Doctor in the Healthcare Centre and 6 minutes to get something to eat from the landing.

In his clinical review report into Colin's death, Professor McClelland comments:

"Review of the CCTV footage of Colin's last days highlights the degree of isolation, boredom and barrenness of Mr Bell's living environment. Contrast with the healthcare entry for 26 June ***"Colin attended the ward today for both sessions. During this time he attended Occupational Therapy and participated well. He made two small craft items for his daughter. In the afternoon session he had the opportunity to engage one to one with nursing staff."*** *This June session reflected his care plan from the multi-disciplinary team conferences. It was not being implemented over the 28 – 31 July period. This late July arrangement was having little impact on the*

rate of self-harming, was not in accord with the multi-disciplinary plan and would not have been conducive to Mr Bell's well being."

6a) The time that Colin spent engaged in purposeful activity when confined to his Safer/Observation Cell in his last 6 days fell well short of that required by Prison Rules, recommended good practice and of the recommendation made by Professor McClelland and accepted by the Prison Service for implementation by 31 March 2006.

In addition, Colin also had very limited in-cell human contact and conversation.

HM Prison Service in England and Wales has a policy of:

"carrying out 'conversational' checks on prisoners in Safer Cells. This is where a member of staff sits down with the person at risk and engages them in a conversation about how they are getting on (three times in every 24 hours, morning, afternoon and evening)."

Over Colin's last 48 hours, he had contact with prison officers inside his Safer Cell on 5 occasions lasting a total of 20 minutes.

CCTV footage shows that on 30 July an Officer enters Colin's cell with sheets of paper and remains there for 10 minutes. The other occasions were: twice to deliver clothing lasting less than 2 minutes each time; and once to deliver tuck shop items.

All other contact with prison officers took place at the door (locked between 20.30 in the evening and 08.30 in the morning) when, for example he requested a light for his cigarettes.

CCTV footage for 31 July shows an unidentified man entering Colin's cell for 25 seconds, and a further occasion an Officer enters his cell with a notebook and remains there for 4 minutes.

In his clinical review report, Professor McClelland, referring to 31 July, states:

"He had very little contact with any person. These conditions almost amount to solitary confinement."

6b) Colin had very limited opportunity for human contact and face to face conversation during his last 48 hours.

7. SAFER/OBSERVATION CELL SUPERVISION AND MONITORING

Prison Rule 47 (6) states:

"Every prisoner so confined shall be observed at least once every 15 minutes by an officer and a record shall be kept of such observations."

The Standard Operating Procedures SOP /01 for the use of a Safer/Observation Cell in Maghaberry Prison state that:

"observations should be carried out and recorded every 15 minutes by both the Class Officer on the Landing and the Secure POD Officer viewing the CCTV monitor, who should keep a running log. Any variations to these monitoring requirements should be noted in the PAR 1 and CRC 1 booklets."

The Governing Governor confirmed that he would normally expect that a variation would result in more, rather than less frequent checks.

On the morning of 31 July, CCTV footage covering Colin's cell shows that he was making ligatures. There are approximately 23 minutes where this is clearly visible. There is no evidence that this was noticed by prison staff or any appropriate interventions made.

On the night that Colin died, he can be observed on CCTV footage pacing the Safer/Observation Cell looking agitated over a period of hours. He is seen at times working with and holding a ligature. From 22.57, there is a 14 minute continuous period where Colin is constantly handling a ligature and tries to commit suicide.

On three occasions, Colin attaches the ligature to the cell door and attempts to take his life. Before his fourth, successful, attempt at 23.41 Colin stood in front of the CCTV camera and very deliberately lifts and places the ligature over his head.

Before his first attempt and between his third and fourth attempt there are other times when Colin has a ligature in his hands or around his neck.

From the evidence contained in the CRC 1 monitoring logs, PAR 1 Landing logs, Secure POD Officer logs, CCTV footage and from staff interviews it is clear that 15 minute observations were not carried out.

Landing Checks

The staff on the REACH Landing carried out and recorded observations at hourly intervals.

Information received at interviews, and an examination of the records made on other nights, suggested that staff on the REACH Landing were unaware of the requirement to carry out observations every 15 minutes, even though this is specified on the CRC 1 document they use to record their observations.

Interviews with day and night staff on the REACH landing suggested that there is confusion about the monitoring requirements for PAR 1 prisoners and prisoners housed in Safer/Observation Cells.

7a) Staff on the REACH Landing in Lagan House were not carrying out and recording the 15 minute monitoring checks required by Prison Service policy.

I have also established from observation logs that hourly observations by Landing staff were carried out at regular and, therefore, predictable times. It was evident from some of Colin's actions observed on CCTV footage, that he was able to predict these checks.

HM Prison Service Suicide Prevention and Self-Harm Management Policy in England and Wales provides that a member of staff will check on a prisoner at least 5 times an hour at irregular intervals in order to make it more difficult for the prisoner to predict the system.

7b) Staff on the Landing in Lagan House were not varying the times of the checks that they carried out, in line with best practice. The checks were, therefore, predictable.

<u>Secure POD Checks</u>

At interview, the Secure POD Officer who was on duty on the night of 31 July stated that he was told to carry out 15 minute observations of the CCTV of the Safer/Observation Cells and to only record *"anything unusual."*

From analysis of observation record logs from previous nights, it would appear that this was the normal practice in the Secure POD in Lagan House. Any recorded observations were routinely made on a sheet of unlined paper. For most of the days that Colin was housed in a Safer/Observation Cell between April and July, no Secure POD observation records are available.

It is also evident from a review of CCTV footage of the Secure POD in Lagan House that observations were not carried out and recorded at 15 minute intervals.

The Secure POD Officer can be observed preparing and using a make shift bed. He and other Officers (four at one point) can be observed sitting, chatting, smoking cigarettes, using the computer and watching television.

The Secure POD Officer noted on the unlined A4 sheet of paper he used as an observation entry log that at 20.00 Colin had activated his cell alarm. At 21.05 and 21.30, he noted that Colin had called the Samaritans.

The only other entries were at 00.05, when he recorded that Colin was *"seen lying beside door in a half upright position"*, and at 00.20, when he recorded that Colin *was "still at door, landing staff informed. Bell had tied a ligature around his neck. Emergency key handed out from break glass."*

At 23.41 Colin had already made his fourth, successful, attempt to take his life.

CCTV footage suggests that the note written in the Secure POD Officer's makeshift log at 00.05 appears to have been completed retrospectively.

An examination of Lagan House Secure POD logs for other dates where records are available shows that, whilst still falling well short of Prison Service Policy, some Secure POD Officers did make more frequent recordings.

HM Prison Service Suicide Prevention and Self-Harm Management Policy in England and Wales states:

"where CCTV is used, there must be protocols in place to ensure someone is actually watching the monitor. Prisoners have in the past played up to the camera and if there is no one at the other end the results could be fatal."

The Governing Governor and Deputy Governor of Maghaberry Prison and other Governors within the prison have confirmed that they would have expected the full implementation of the policy for monitoring prisoners in Safer/Observation Cells and for recording observations.

7c) Staff in the Secure POD in Lagan House were not carrying out and recording the 15 minute observation monitoring checks required by Prison Service policy.

7d) Staff in the Secure POD in Lagan House were watching television and using the computer.

7e) Staff in the Secure POD in Lagan House were smoking in breach of the Prison Service's Smoking policy.

An extract from a Night Custody Officer's interview, when asked about sleeping materials in the Residential Houses within Maghaberry Prison, said:

"I have seen pillows and sheets about the Secure PODs and I have seen a mattress in a Secure POD behind a locker. I have never seen them being used and I have never used them myself. This is nothing new, sleeping materials pillows etc have been around for as long as I have been in the job [over 2 years]. They

may be around when you come on post and may still be around when the Senior Officer arrives. I have not seen anything like this in the Emergency Control Room."

Several Night Custody Officers interviewed gave a similar account and stated that the custom and practice of sleeping materials being available on the Landings and in the Secure POD areas across Maghaberry Prison was well established before the Night Custody Officer grade came into existence.

7f) A makeshift bed was assembled and used by the Night Custody Officer in the Secure POD in Lagan House on the night of 31 July.

Recording of Calls from the Safer/Observation Cell

The facility is in place to record all calls from the Safer/Observation Cell prisoner/staff intercom to the Secure POD.

The Standard Operating Procedures SOP 0/1 for the use of a Safer/Observation Cell state the Secure POD Officer monitoring should:

"Check and ensure all recording equipment is operational noting time of check in the CCTV observation sheets provided;
Maintain running log of 15 minute observation noting use of any interaction via the intercom;
Cassette tapes used for recording staff/prisoner intercom conversations will be retained for 90 days and then wiped clean for reuse. Tapes should be clearly marked with prisoner's name, number, commencement and finishing times and dates;

Completed observation sheets and tapes should be signed off by the POD officer when prisoner has ceased to use the safe cell and passed to house management for filing in a secure cabinet. Hard copies should not be destroyed."

There was no record in any observation log provided by the Prison Service confirming a recording equipment check.

There is some recorded evidence in some Secure POD observation logs in Lagan House in the days before Colin died that he used the staff/prisoner intercom in the Safer/Observation Cell to contact the Secure POD Officer.

I am unable to say whether Colin used the Secure POD staff/prisoner intercom on the night he died on 31 July, because the Prison Service has been unable to provide me with any recording.

7g) There are no records of the required checks of recording equipment in the Secure POD in Lagan House being carried out.

7h) The Prison Service could not provide me with any staff/prisoner intercom recordings that Colin may have made from the Safer/Observation Cell to the Secure POD on the evening that he died. The staff/prisoner intercom recording system in the Safer/Observation Cell to contact the Secure POD Officer appears to be defective.

8. HANDOVER ARRANGEMENTS

I have established that the Night Custody Officers taking up post in Lagan House on 31 July were advised by the day shift staff about which prisoners were on a PAR 1 and that Colin was in a Safer/Observation Cell.

However, no other information relating to Colin, how his day had been, how he was or his particular vulnerabilities appears to have been provided.

The Governing Governor and Deputy Governor of Maghaberry Prison advised at interview that there is a 15 minute period built into the shift to allow for handover between night and day staff and that they would expect a comprehensive briefing to take place.

The evidence suggests that, routinely, a comprehensive briefing was not provided between day and night shift and between Landing and Secure POD staff.

I have also established that any information recorded on the PAR 1, which is intended to be the main vehicle for communicating information about concerns and Care Plans, is not available to or communicated to Secure POD staff and that observations made by Secure POD staff are not captured on the PAR 1 booklet.

8a) The handover briefing to Night Custody staff taking up post within Lagan House on 31 July 2008 did not provide the information necessary to deliver an appropriate standard of care. It fell short of that expected by the Governing Governor and Deputy Governor.

9. LIGATURE POINTS IN SAFER/OBSERVATION CELLS

A Safer/Observation Cell is a cell which has been modified and contains special furniture and window fittings that make anchorage of a ligature extremely difficult.

From reviewing Colin's death, it is clear that this was not the case.

Colin attached a ligature to his cell door at Cell 16 on the REACH Landing in Lagan House on 4 occasions on the night of 31 July 2008.

After Colin's death, the Prison Service immediately carried out some remedial work to the door of Cell 16 to prevent this from happening again.

However my investigators, along with a Senior Officer from the Prison Service carried out an inspection after the remedial work had been completed and at this stage were still able to attach and secure a ligature to the door.

9a) The cell in which Colin was located fell short of the requirements of being a Safer/Observation Cell. Colin was able to anchor a ligature 4 times on the night he died.

10. ACCESS TO CELL KEYS AND HOFFMAN KNIFE

Colin made his fourth, successful, attempt to hang himself at 23.41 on 31 July.

Colin was hanging at his door for 38 minutes before a Prison Officer shone his torch through his cell flap at 00.19 on 1 August.

It took a further 4 minutes, 00.23 until Officers opened Colin's cell door, cut him down, and were able to initiate emergency procedures.

Valuable time was lost due to the fact a Landing Officer had to run downstairs to the Secure POD to retrieve the keys to Colin's cell from a 'break glass' cupboard. The Landing Officer had to return to the Secure POD again to retrieve the Hoffman Anti-Ligature Knife.

This is an issue which has emerged in previous death in custody investigations where the following recommendation was made by the Prisoner Ombudsman:

"*to provide the necessary equipment to enable immediate entry to cells by Night Custody Officers in order for them to respond immediately to emergencies if considered necessary for the preservation of life.*"

10a) There was a 4 minute delay in gaining access to Colin's cell after it was identified that there was an emergency situation.

11. SECURING OF THE SECURE POD DURING NIGHT SHIFT

I have confirmed with the Prison Service that all Secure PODs must remain locked at all times, so that security is never compromised.

The Secure POD in Lagan House on the night of 31 July was intended to be staffed by one Night Custody Officer.

The door of the Secure POD that night was unlocked for periods of time, and there were up to four Night Custody Officers in the Secure POD for prolonged periods, on one occasion for more than 30 minutes.

Officers were observed sitting chatting, smoking cigarettes, using the computer and watching television.

It is clear, from reviewing CCTV footage, that the Secure POD was not secure when the Night Guard Senior Officer arrived in Lagan House to carry out his supervisory check. He was, therefore, aware of this security breach.

An analysis of CCTV footage in the Lagan House Secure POD for other nights and other Secure PODs at Maghaberry Prison has confirmed that this was not an isolated occurrence.

During interviews, the staff concerned stated that they visit and meet in the Secure POD in Lagan House to collect Night Guard belts and torches, to chat with other staff and on occasions to make cups of tea.

At interview the Night Guard Senior Officer said: *"there was a degree of latitude for the Secure POD area to be unlocked at night."*

At interview the Night Guard Principal Officer said: "*With regard to the Secure POD security, I was an instigator in trying to ensure the POD doors were kept secure after it was drawn to my attention by Senior Officers that Secure PODs were not remaining secure through the night. I actively contacted Secure POD officers to ensure they kept doors shut. I was happy for staff to rotate, however the Secure POD should be locked after these movements. There is emergency access to the Secure POD by way of a key held in another house. I also highlighted my concern to the Security Governor who put out a notice, now a Governors Order. I am more content that the Secure PODs are being kept secure now, with only one person in the Secure POD."*

11a) There was a failure to keep the Secure POD in Lagan House secure on the night of 31 July 2008.

11b) Staff from the Landings were in the Secure POD when they should have been carrying out 15 minute Landing observations.

11c) The Night Guard Senior Officer on duty knew of this security breach.

12. NIGHT CUSTODY SUPERVISION

The current security systems in place at Maghaberry Prison prevent management from entering residential houses without access being granted by the staff they are supervising.

The Night Guard Senior Officer on duty on 31 July 2008 carried out just one supervisory check in each of the Residential Houses at Maghaberry Prison.

This included one check in Lagan House which was carried out at approximately 23.00.

The evidence available indicates that the one check carried out each night was at set patterns and times. The Officer in the Secure POD on 31 July is seen to prepare a make shift bed immediately following the visit of the Night Guard Senior Officer.

12a) There is one supervisory check of Lagan House carried out each night by the Night Guard Senior Officer at approximately the same time each night.

The Night Guard Senior Officer completed his supervisory check of Landing staff in Lagan House on 31 July 2008 by observing Night Custody officers carrying out checks from the Landing circle area[13].

In essence, this means the checks were carried out by observing from a distance.

[13] Landing Circle Area – area within a Residential House where staff are based. Landing Circle Areas lead onto corridors with prisoner cells up each side.

The Governing Governor confirmed that he would expect the Night Guard Senior Officer to carry out a physical check of prisoners in Safer/Observation Cells and on open PAR 1s.

12b) The Night Guard Senior Officer did not carry out a physical check of prisoners on open PAR 1's or in Safer/Observation Cells on the REACH Landing when he made his supervisory visit to Lagan House on 31 July 2008.

On the night of 31 July 2008, the Night Guard Senior Officer did not check the observation record log that should have been maintained by the Secure POD Officer. He also did not check the CCTV monitors or enquire about the two prisoners held in the Safer/Observation Cells.

At interview, the Senior Officer, who was responsible for supervising the night shift, stated that he was not aware he was meant to carry out these duties and that he does not have a Job Description.

If the Night Guard Senior Officer had carried out the above checks, it would have been evident that the observations and recordings required by Prison Service policy were not being carried out by the Secure POD Officer.

12c) When carrying out his supervisory check on 31 July, the Night Guard Senior Officer did not check any records in the Secure POD, did not check the CCTV monitor and did not enquire about the two prisoners held in the Safer/Observation Cells that night.

In addition, whilst there is some evidence to show Senior Officers' signing records that they have read on day shift, there is no documented evidence of the Night Guard Senior Officer carrying out a check on the PAR 1 or CRC 1 observation logs maintained by Lagan House Landing staff on night shift.

12d) There is no Job Description specific to the role of the Night Guard Senior Officer.

13. NIGHT CUSTODY OFFICERS

Break Arrangements

Night Custody Officers work 11¾ / 12¾ hour shifts without an official built-in break or rotation of duties.

In relation to the Secure POD, one member of staff is detailed to work in the Secure POD, with responsibility for monitoring the Safer/Observation Cells' CCTV monitor, for an entire shift.

13a) The Night Custody Officer in the Secure POD in Lagan House on 31 July, the night that Colin died, was allocated to the Secure POD for a full shift with no arrangements in place for duties to be rotated and no arrangements in place to take breaks.

Second jobs

I have established that some Night Custody Officers have second and even third jobs.

This may have implications for their capacity and fitness to perform the duties required by the Prison Service and, in particular, their ability to have appropriate rest.

The Governing Governor and Deputy Governor were aware that Night Custody Officers have other jobs but stated that the sole responsibility for employing and implementing the terms and conditions for Night Custody Officers is controlled by the Prison Service's Personnel Department at Headquarters.

13b) Some Night Custody Officers have second jobs which may have implications for their capacity and fitness to carry out their nightshift duties.

13c) The Governing Governor and Deputy Governor at Maghaberry Prison do not have a role in the decision making process in connection with the Night Custody Officers' recruitment and selection, shift arrangements or terms and conditions of employment.

Training and Awareness

The REACH Landing was primarily intended to provide a structured and therapeutic environment for vulnerable prisoners suffering with personality disorders and mental health problems.

When the REACH Landing was opened in April 2007, arrangements were made for appropriate training on matters relating to the recognition, assessment and management of mental health to be provided for day Landing staff. In his clinical review report, Professor McClelland commends this training. Reach Landing staff also visited vulnerable prisoner facilities within Whitemoor Prison in England.

13d) Appropriate training was arranged for day shift Officers when the REACH Landing opened.

Whilst some of the induction training for Night Custody Officers is relevant to the care of vulnerable prisoners, I have established that no specific training relevant to the needs of prisoners on the REACH Landing has ever been provided for Night Custody

Officers who may be assigned to work on the REACH Landing or in the Secure POD in Lagan House.

Interviews also suggested significant gaps in the knowledge and understanding of Night Custody Officers about the function and purpose of the REACH Landing.

13e) Night Custody Officers assigned to work on the REACH Landing at night or in the Secure POD in Lagan House have not received appropriate briefing and training.

14. CASE CONFERENCES AND CARE PLANS

The Prison Service's Self-Harm and Suicide policy states that *"a multi-disciplinary case conference must be held at least every 14 days*" for a prisoner with an open PAR 1.

This requirement was fully implemented.

Between 25 April and 24 July, 13 multi-disciplinary case conferences reviewed Colin. He was also discussed at 6 Safer Custody meetings.

It is evident from the notes from case conference meetings that there was much discussion about how Colin had been since the last meeting and how he could be progressed.

Many staff members wanted to help Colin. All case conferences were attended by a nurse from the Healthcare Centre but there is no evidence that a doctor ever attended.

At each meeting, a number of action points were recorded in the case conference minutes and, correctly, on the PAR 1. Action points were often concerned with arranging for Colin to attend the Healthcare Centre for occupational therapy association, activity and exercise.

14a) Multi-disciplinary Case Conferences to review Colin's progress were held in line with Prison Service Policy and actions agreed were correctly recorded on the Care Plan section of the PAR 1.

The implementation of actions arising from the multi-disciplinary case conferences appears, at times, to have been a problem.

Colin attended the Healthcare Centre as planned for a period of at least one hour during the afternoon for 18 of the 34 days he was in a Safer/Observation Cell in June and July. He also attended the Healthcare Centre in the morning on 10 of the 18 days.

On three occasions, Landing observation logs record that Colin had asked to go for exercise and, for varied reasons, this was refused.

Colin does not appear to have attended the Healthcare Centre for any purposeful activity during his last 6 days in the Safer/Observation Cell.

Interviews with staff suggest that the information recorded on the PAR 1 may not be looked at by some staff and Senior Officers, and that communication of the Care Plan may not always be effective.

Even though the Care Plan is part of the PAR 1, one Night Guard Senior Officer in Lagan House stated at interview that he wished he had received feedback from case conferences because he felt *"out of the loop."*

In connection with the Care Plan, The Prison Service's Self-Harm and Suicide Prevention policy states that:

"information regarding healthcare assessments must be passed to the manager in charge of the prisoners usual location and that of the originator of the PAR 1."

This did not appear to happen.

Colin did not have a Care Co-ordinator responsible for ensuring the ongoing updating and implementation of a comprehensive Care Plan, including, outputs from health assessments and multi-disciplinary case conferences. Such an appointment may have impacted positively on the shortfalls in the delivery of an appropriate plan of care for Colin, particularly, during his last 6 days.

At interview, a Senior Officer who attended many Safer Custody Group meetings to discuss various vulnerable prisoners, including those held to discuss Colin, said:

"I have worked in prisons in Northern Ireland and England for 20 years and I have never seen a prisoner indicating cries for help as clearly as Colin did in the last weeks of his life."

14b) Colin did not have a Care Co-ordinator to monitor and address gaps in the day to day delivery of different elements of his Care Plan.

15. THE SAMARITANS LISTENER SCHEME

The Samaritans run a Listener scheme at Maghaberry Prison for all prisoners including those on PAR 1s or in a Safer/Observation Cell. Governor's Order 7-22 and Notices to Staff 124/06, 125 /06 and 126 / 06 relate to the operation of the Listener Scheme.

Prisoners may ask, at any time, for another prisoner, trained by the Samaritans as a Listener, to come and sit in their cell with them.

The Governing Governor and Deputy Governor at Maghaberry confirmed that Colin should have been afforded access to a Listener at any time, in line with Prison Service policy and instructions.

15a) A Samaritans' Listener Scheme is in operation in Maghaberry Prison in support of prisoners.

Some prisoners from the REACH Landing where Colin died alleged that Colin asked for and was refused a Listener on the night he died. Colin also told his family that he had been refused access to Listeners.

All staff interviewed stated that they had never refused a request from Colin for a Listener. There is documented evidence on CRC 1 and PAR 1 observation logs of occasions that Colin did request and was granted access to a Listener.

There is, however, documented evidence that Colin was refused access to a Listener.

The following are extracts from Colin's CRC 1 and PAR 1 observation logs made by Landing staff in Lagan House:

CRC 1 /PAR 1 logs for 23 July 2008 at 21.50: *"…also informed ECR he had asked for a Listener. They said he would not be getting a Listener as he had a direct line to the Samaritans. Prisoner informed."*

CRC 1/PAR 1 logs for 27 July 2008 at 18.35: *"wanted a Listener. Told to use phone to Samaritans."*

These recorded comments were shared with a Samaritans Listener Scheme Co-ordinator at Maghaberry Prison, who said:

"It is totally wrong to refuse access to a Listener, the Samaritans phone is not there to replace the Listener scheme, it is there to supplement them."

The Governing Governor and Deputy Governor also confirmed at interview that Listeners should not have been refused.

15b) It has been alleged that Colin was refused a Listener on 31 July, the night that he died. It has not been possible to prove or disprove this. There is, however, documented evidence that Colin was, on occasions, refused access to a Listener. This was contrary to Prison Service instructions and Senior Governors' expectations.

16. THE SAMARITANS

Colin had direct access to the Samaritans' service through a phone link any time he was in a Safer/Observation Cell.

Prison records indicate that Colin had tried to make contact directly with the Samaritans using the phone link on 73 occasions between 16.12 on 30 July until 22.21 on 31 July, a few minutes before he made his first attempt to take his life.

Evidence provided by the Samaritans suggests that most of the calls resulted in an engaged tone, 9 were received in Belfast and 2 in Bangor. Some may have been diverted to England.

There is no evidence that prison staff, alerted by the high level of attempted contact with the Samaritans, spoke with Colin or considered asking him if he would like to speak with a Listener.

Since Colin's death, my office received two anonymous telephone calls from Samaritan volunteers. One of these detailed concerns about the response from the Samaritans to Colin's substantial number of attempts to contact them during the times he was in a Safer/Observation Cell.

This, along with other information provided by prison staff about issues raised by representatives of the Samaritans in relation to Colin's calls, has been referred to a Director of Samaritans Ireland, who has chosen to carry out a comprehensive review.

17. RISK ASSESSMENT OF THREATS

Other Prisoners

From 9 April 2008, until the time of Colin's death, there were at least 21 documented occasions when he alleged that he was under threat from other prisoners/paramilitaries.

This does not include comments from other prisoners or staff about any alleged threats raised by Colin.

Colin also expressed his fears to his local MP, the Samaritans, his family and friends, the Human Rights Commission and on four occasions to my office by telephone. These were passed on to the Prison Service.

Throughout my investigation, various people continually referred to the fact that Colin perceived he was under threat from people outside prison, prisoners within prison, and prison staff.

[Note: My conclusion at Section 22 under Healthcare Management – Clinical Review Report, describes the medical assessment of the fears expressed by Colin]

The Governing Governor and Deputy Governor at Maghaberry stated that there was a requirement to check whether there was any evidence of a threat against Colin and that this was taken seriously.

The Governing Governor and Deputy Governor stated that they would have expected the Maghaberry Prison Security Department to have requested a police assessment as part of their own internal threat risk assessment.

A Governor from the Prison Security Department stated that threat risk assessments carried out in relation to Colin were taken internally within the context of Maghaberry Prison.

The Maghaberry Security Department advised that it carried out 3 internal threat risk assessments on Colin, one in August 2006, and two in April 2008.

Records show that whilst the Security Department interviewed Colin, no request for any risk assessment was made to the Police.

17a) The Prison Service did carry out internal prison assessments to see if there was any evidence that Colin was under threat but did not ask the Police Service of Northern Ireland to assess any threat against Colin.

As part of my investigation, I asked the Police Service of Northern Ireland to retrospectively investigate whether there was any evidence of paramilitary or other threats against Colin. The Police have now reported that they found no information to suggest that Colin was at risk.

17b) The Police Service of Northern Ireland has confirmed that they could find no evidence to suggest that there was any threat against Colin.

Prison Officers

Some prisoners alleged at interview that Colin was bullied and threatened by some prison officers. Colin made similar claims to his family.

A member of the Independent Monitoring Board told my investigators that 2 listeners had made similar claims to her alleging that Colin had told them that when he felt suicidal an Officer told him *"to hang himself."*

On 17 October, my office received an anonymous call from a caller claiming to be a Samaritan who stated that her colleague had told her that whilst she was on the phone to Colin she had heard prison officers in the background: *"taunting him and telling him to kill himself*."

I note that, in the event that such comments were overheard, it cannot be concluded that the comments were made by prison officers.

17c) I did not find any evidence to substantiate that Colin was bullied by prison officers.

18. EMERGENCY MEDICAL RESPONSE

Once Colin's cell door was opened at 00.23 on 1 August, staff on the Landing, and Medical staff, promptly attended to initiate resuscitation.

Despite the strenuous efforts of everyone at the scene and the continued actions of the medics, Colin could not be revived. Shortly after, a Doctor arrived at the scene and pronounced Colin dead.

18a) The emergency medical response, once Colin's cell door was opened, was appropriate and prompt.

19. INCIDENT MANAGEMENT AFTER COLIN'S DEATH

In line with the Prison Service's policy for managing Deaths in Custody, outlined in its' Self-Harm and Suicide Prevention Policy (revised September 2006) Section 6.11 - Impact on Staff, the Duty Governor of Maghaberry Prison carried out a 'Hot' De-brief session with staff in the early morning following Colin's death.

The staff present were those who had been directly involved in managing Lagan House during the emergency, with the exception of any member from the Emergency Control Room team.

The Prison Service's Self-Harm and Suicide Prevention Policy Section 6.11 - Impact on Staff, also states that a more comprehensive 'Cold' De-brief session should be carried out *"within 14 days"* from the death, to maximise any opportunity to learn from what occurred.

19a) A Hot De-brief was carried out in line with Prison Service policy.

19b) No member of the Emergency Control Room team, who were also involved in managing the incident from their station when Colin died, were invited to be involved in the Hot De-brief meeting.

19c) A Cold De-brief did not take place within the timeframe specified in Prison Service policy.

20. CULTURE OF CARE

In his review of Non-natural Deaths in Northern Ireland Prisons, Professor McClelland commented that:

"The management of suicide risk, as with management of mental health problems generally requires a culture of care sensitive to the needs of individual prisoners."

Professor McClelland talked about the perceived benefits of getting to know prisoners in terms of reducing the likelihood of self-harm. He went on to say that:

"The attitude of staff working on each residential unit and the support and relationship developed with Healthcare staff are vital in managing PAR I prisoners and ensuring that appropriate care is administered."

The Prison Service's Self-Harm and Suicide Prevention Policy states that:

"The prison officer is the person in most regular contact with prisoners and has the best opportunity to identify a prisoner at risk and assist him or her through a period of crisis."

As with Professor McClelland's research, the evidence examined by my investigation team suggested significant variance in the attitudes of different prison officers.

There were, for example, recorded examples of prison officers sitting down and taking time to talk with Colin.

However, whilst it is accepted that Colin's behaviour was at times very challenging for staff and sometimes difficult to manage, the evidence detailed within this report, clearly demonstrates, shortfalls in the attitude and sensitivity shown by some staff to Colin's needs and their responsiveness to addressing those needs. This is further evidenced by the language of individual comments recorded on observation logs by some staff.

In reviewing the circumstances of Colin's death, Professor McClelland, in his Clinical Review, says that:

"*Such a situation reflects the needs of staff in terms of support, supervision and training. Such situations would, I believe, benefit greatly from expert support and supervision from professionals with appropriate psychological, psychotherapeutic and psychodynamic understanding and expertise.*"

20a) The management and care of Colin would have benefited greatly from expert support and supervision from professionals with appropriate psychological, psychotherapeutic and psychodynamic understanding and expertise.

20b) The attitude of prison officers to Colin and their responsiveness to his needs was variable. There was evidence of good practice. However, there did not appear to be a culture of care that was consistently sensitive and responsive to his needs.

20c) Colin's behaviour was, at times, very challenging and placed significant demands on the prison officers responsible for his care.

21. CORPORATE RESPONSIBILITY

The Prison Service's Self-Harm and Suicide Prevention policy states:

"All staff carry an equal and continuing responsibility for the management of prisoners considered to be at risk of committing suicide or other acts of self harm."

However, in terms of corporate responsibility, it states:

"*Governing Governors must take personal responsibility for the implementation of the Policy on Self-Harm and Suicide Prevention within their establishments.*

Whilst retaining overall responsibility they may delegate individual tasks to other members of their senior management team or to the local Self-Harm and Suicide Prevention Team as appropriate.

The Governor's responsibilities are to:

- *Give all staff in the establishment a clear lead, through their own involvement as appropriate;*
- *Ensure, through training, that **all staff** are aware of their responsibilities in regard to the policy;*
- *Issue instructions to staff on local procedures, including emergency measures in responding to incidents of suicide or self harm;*
- *Keep procedures under review and instigate a self harm and suicide prevention review on at least an annual basis;*

- *Ensure the effective and regular operation of local self harm and suicide prevention teams;*
- *Ensure that an effective system of multi-disciplinary case conferencing is in place."*

At Maghaberry Prison, much of the day to day operational responsibility is delegated to the Deputy Governor, with other Governors reporting into the Deputy Governor post.

The summary and conclusions detailed above suggest failures by the Governing Governor and Deputy Governor of Maghaberry Prison with respect to their responsibility for Colin's care and, in particular, the implementation of Prison Rules, the Prison Service's Self-Harm and Suicide Prevention Policy and Maghaberry Prison's Standard Operating Procedures for the use of a Safer/Observation Cell.

21a) There were failures by the Governing Governor and Deputy Governor of Maghaberry Prison in respect of Colin's care and the implementation of Prison Rules and policies.

22. HEALTH CARE MANAGEMENT – CLINICAL REVIEW REPORT

Professor Roy McClelland carried out, at my request, a review of Colin's medical care whilst in prison. A copy of Professor McClelland's report, which contains detailed information about medical history, conclusions / diagnoses from medical consultations, is attached as Annex 5.

Key points from Professor McClelland's report relating to Colin's healthcare are noted below (*with notes in italics added where other information is available*). Other findings from Professor McClelland's report are referred to as appropriate elsewhere in this report.

- The overall impression is that Colin was not suffering from any serious psychotic illness nor was he seriously clinically depressed. On the other hand there is definite evidence that Colin was quite paranoid and preoccupied by threats of self-harm. The analysis of one doctor that these may have been part of Colin's enduring personality such that under situations of perceived threat or unmet need, he may resort to these emergent behaviours, is reasonable. Colin's pre–occupation with being under threat and self-harming in response to various situational stresses in prison is consistent with an underlying vulnerability to this kind of response. In this context, the loss of privileges and change in circumstances following Colin's move from Wilson House might be expected to have been devastating for him. Other evidence in Colin's medical history and the results of psychological tests would support this view.

- There is also evidence that Colin was manipulative.

- Colin was seen by Healthcare staff on 18 days out of 30 days in April (the first incident of self-harm being 8 April); 21 days out of 28 days in May (he was in hospital for 3 days); 22 days out of 30 days in June; and 19 days out of 31 in July. He was seen by a Doctor on 31 July.

- There was a good multi-disciplinary approach to Colin's healthcare issues. Multi-disciplinary case conferences were held on 13 occasions and Safer Custody meetings were held on 6 occasions. Colin and his parents attended a multi-disciplinary case conference on 3 July, in line with good practice.

- Every case conference was attended by a nurse from Healthcare. Healthcares' main contributions were one of observation, the provision of occupational therapy and general support to Colin, which was entirely appropriate.

- Discussion at case conferences included consideration of options for progressing Colin out of a Safer/Observation Cell and the use of Healthcare provision to complement the use of the Safer/Observation Cell in order to relieve Colin's boredom and provide an opportunity to build trust. These arrangements and the process by which they were agreed were appropriate and inclusive in nature. The involvement of Colin was particularly constructive.

- Care plans produced at case conferences were appropriate for Colin's needs.

- Colin was disciplined on several occasions for his behaviour. From a health perspective managing such behaviours in this way is generally seen as counter-productive.

- Decisions made about what drugs to prescribe for Colin were appropriate but there were some problems with Colin's non-compliance when taking prescribed medication which may have impacted upon its therapeutic effect. Information about the extent to which dosages were reviewed and consideration given to an increased dosage of medication is not clear from the notes.

- There is no evidence of any Doctor attending the multi-disciplinary case conference meetings.

- The first Consultant Psychiatrist assessment of Colin within the prison system since Colin's move from Wilson House appears to have taken place on 1 July with the Prison Consultant Psychiatrist. This is evidenced as a note in the Healthcare records which state that a letter was to be sent to a Governor. There is no evidence in the notes of the Prison Consultant Psychiatrist's assessment that a letter was sent to the Governor.

- Colin was seen on at least 5 occasions by specialist psychiatric doctors, the last being the 11 July. Decisions made were reasonable in medical terms but still left discipline staff with a difficult situation to manage.

- An urgent assessment of Colin by an external Forensic Consultant Psychiatrist was requested by a Prison Governor (in line with discussion at a case conference] on 23 June.

The external Consultant Psychiatrist was due to be absent until 21 July but made contact with the prison and stated that an assurance had been given by the Prison Consultant Psychiatrist that Colin would be kept in the Healthcare Centre until the external Psychiatrist could assess him upon return. There is no evidence that the external Psychiatrist followed up and carried out such an assessment. This was regrettable.

[Note: Prison records show that during this period, Colin, in fact, spent 11 days in a Safer/Observation Cell in Lagan House (23 June – 3 July), 5 days in the Healthcare Centre (3 July – 8 July), 2 days in the Safer/Observation Cell in Lagan House (8 July – 9 July), 5 days in the Healthcare Centre (9 July – 14 July), 2 days in Glen House (14 July – 16 July), 8 days in the Safer/Observation Cell in Lagan House (16 July – 24 July), 2 days in Glen House (24 July – 26 July), and the last 6 days of his life in the Safer/Observation Cell in Lagan House (from 26 July)]

- At a multi-disciplinary case conference on 17 July problems were again noted regarding Colin's feelings of *"paranoia and personal safety which have been unfounded"* and a plan was made for a further referral to the Prison Consultant Psychiatrist.

[Note: Prison medical records do not indicate that there was any referral raised for Colin to be re-assessed by the Prison Consultant Psychiatrist following the case conference on 17 July up to the time Colin died]

- The level of Colin's self-harming presented a major challenge in managing the risks Colin presented to his own safety. In the absence of some alternative management strategy for

Colin's concerns, perceptions, anxieties, distress and self-harming behaviour, the use of Safer/Observation Cells on an increasingly frequent basis was a reasonable response to what seems to have been an escalating problem.

- From a mental illness perspective, there was not much more that medical management could have contributed to this situation. However specialist psychodynamic, psychological, input to the deliberations of the multi-disciplinary team, particularly as the situation became so difficult, would likely have been of assistance. A psychodynamic understanding of Colin's anxiety, anger, concerns and behaviour might have provided alternative strategies for managing this situation.

- There is an impression that something of a power struggle was developing by the time of Colin's last period in a Safer/Observation Cell. Colin became increasingly determined to self-harm whilst it was recorded at a Safer Custody meeting on 24 July *"each time he reaches a certain point in the plan and then misbehaves, he goes back to the beginning etc. He does not like the Safer Cell so each time he misbehaves, he will remain a further day until he realises he is not the winner."*

- This was an extremely difficult situation for staff to manage. Senior prison staff were keen to get advice on Colin's management. Whilst it is impossible to predict what impact such advice would have had on this difficult situation, such input is an important ingredient in situations where prisoners present difficult emotional, behavioural and management problems.

- During the period 26 July to 31 July Colin was in a Safer/Observation Cell but appeared not to be accessing Healthcare for activity, occupational health or for Healthcare staff assessment. Colin was taken out of his cell for short periods on some days over this 6 day period but, the amount of isolation from other people that Colin would have experienced during this period is striking.

- From CCTV footage, Colin had little contact with any person. His condition almost amounted to solitary confinement. His state of boredom is clearly evident.

Clinical Review Report – Prisoner Ombudsman Follow up

On 1 April 2008, responsibility for health provision services for the Northern Ireland Prison Service passed to the South Eastern Health and Social Care Trust. I am aware that, since that transfer, the Prison Service and the Trust have been working together, on a high priority basis, to identify resources to meet the mental health needs of prisoners.

Specific proposals are being developed for additional psychiatry input at consultant and staff grade level, Cognitive Behavioural Therapy services and more targeted use of mental health nurses.

I have provided a copy of my report and that of Professor McClelland's to representatives of the Trust in advance of its publication and have discussed with them both the areas of good practice highlighted by my findings and those of Professor McClelland and those areas of concern.

Particular issues raised, were: (1) gaps relating to the specialist psychodynamic, psychological, input to the deliberations of the multi-disciplinary team, particularly as Colin's situation became more difficult, that might have provided alternative strategies for managing Colin's situation; (2) lack of medical input into multi-disciplinary case conferences and medical input into the decisions to extend the use of a Safer/Observation Cell and anti-ligature clothing; and (3) the fundamental problem of the absence of a secure hospital facility for prisoners with mental health problems in Northern Ireland and the acute difficulties this presents for the Prison Service.

The Trust will now feed the findings in connection with this enquiry, into the Service Delivery Plan that it is currently developing in co-operation with the Prison Service.

The Trust has agreed that in 6 months when a review of the implementation of the recommendations made in my report is carried out, and reported, it will make a statement in respect of progress and plans on the Health Management issues identified.

RECOMMENDATIONS TO THE PRISON SERVICE

There are 44 recommendations to follow. It is intended that the implementation of these recommendations will be reviewed in 6 months time.

SAFER/OBSERVATION CELLS

Recommendation 1 – I recommend that the Prison Service takes immediate steps to ensure that all staff in all Northern Ireland Prison establishments are aware of the policies and guidelines relating to Safer/Observation Cells and Self-Harm and Suicide Prevention and their responsibilities for implementing them.

[Note: I have been informed by the Prison Service that a full review under the auspices of the Corporate Safer Custody Project is to be carried out by a working group, commencing immediately, headed by a Senior Governor. I have also been informed that a Safer Custody section on the Prison Service's Intranet has been set up. A Notice has also gone to all staff informing them of their individual responsibilities and a copy of the current policy and Safer Custody Project Initiation Document is on the Prison Service Intranet]

Recommendation 2 – I recommend that the Prison Service either does not depart from its' original policy that authorisation to keep a prisoner in a Safer/Observation Cell for periods in excess of 24 hours is referred to the Deputy Director of Operations at Northern Ireland Prison Service Headquarters or immediately formalises any policy change, making this the responsibility of the Governing Governor of each prison. Any change should be reflected in existing policies, instructions and authorisation forms i.e. CRC 1 Booklet, and

communicated to all staff with a reminder that any period of extension must be fully documented and signed by the person with the appropriate authority every time an extension is agreed.

Recommendation 3 – I recommend that the Prison Service takes immediate action to ensure that staff in all Northern Ireland Prison establishments are aware of the requirement to carry out and record 15 minute Landing observations on prisoners housed in Safer/Observation Cells.

Recommendation 4 – I recommend that the Prison Service introduces a policy of recorded face to face 'conversational' checks where a member of staff takes time to engage with prisoners on a PAR 1 a number of times in each 24 hour period. I also recommend that all staff are informed that 'conversational' checks must be recorded in the PAR 1 and CRC 1 observation booklets. This should apply to all Northern Ireland Prison establishments.

Recommendation 5 – I recommend that the Prison Service reviews how Landing checks are carried out on PAR 1 prisoners, including those in Safer/Observation Cells, with a view to ensuring that checks are carried out at unpredictable intervals. Decisions made as a result of that review should be communicated to all staff in Northern Ireland Prison establishments.

Recommendation 6 – I recommend that the Prison Service should remind all staff that Landing and Secure POD observations of prisoners on a PAR 1, including those housed in a Safer/Observation Cell on a CRC 1 must, as well as taking place at the intervals required, be fully recorded in the PAR 1 and CRC 1 observation log booklets. This should apply to all Northern Ireland Prison establishments.

Recommendation 7 – I recommend that the Prison Service takes action to ensure that decisions about the frequency of checks on vulnerable prisoners on a PAR 1 are subject to individual risk assessments and are recorded on the PAR 1 booklet. This should apply to all Northern Ireland Prison establishments.

Recommendation 8 – I recommend that the Prison Service takes the necessary steps to locate some Safer/Observation Cells in the Healthcare Centre in Maghaberry Prison. This would allow vulnerable prisoners housed in Safer/Observation Cells for 48 hours to transfer to the Healthcare Centre in line with the Prison Service's Standing Operating Procedures SOP /01 for the extended use of a Safer Cell. I further recommend that such a facility is made available in all other Northern Ireland Prison establishments.

LIGATURE POINTS IN SAFER/OBSERVATION CELLS

Recommendation 9 – I recommend that the Prison Service takes further action to ensure that all Safer/Observation Cells in Maghaberry Prison are, as far as possible, free from ligature points. I extend this recommendation to cover Safer/Observation Cell facilities in all Northern Ireland Prison establishments.

SECURE PODS

Recommendation 10 – I recommend that the Prison Service reminds all staff about the requirement for Secure PODs in Maghaberry Prison to be kept secure at all times. I extend this recommendation to cover all Northern Ireland Prison establishments where relevant.

[Note: I have been advised that a Governor's Order covering Maghaberry Prison in connection with this was issued on 10 September 2008]

Recommendation 11 – I recommend that the Prison Service takes action to inform all staff in Northern Ireland Prison establishments, including Night Custody Officers, that the use of makeshift beds to relax or sleep during their shift is strictly forbidden, and to ensure that all staff are aware that breaches of this rule will be treated as a disciplinary offence.

[Note: I have been advised that Governor's Order 8-9 was issued on 3 October 2008 in connection with this issue. Staff under investigation are currently suspended]

Recommendation 12 – I recommend that arrangements are put in place for regular observation of CCTV coverage of all Secure PODs in the interests of increased staff supervision, security, and the health and safety of the Secure POD Officer. This should apply to all Northern Ireland Prison establishments.

Recommendation 13 – I recommend that the Prison Service removes televisions from all Secure POD areas in Maghaberry Prison. I extend this recommendation to cover the Secure POD areas in all Northern Ireland Prison establishments.

[Note: I have been advised that Governor's Order 7-26 issued on 13 October 2008 in Maghaberry Prison gives an instruction to remove televisions]

Recommendation 14 - I recommend that the Prison Service takes action to ensure that all Officers detailed to work in all Secure POD areas are aware of the requirement, in line with SOP /01, to record on observation logs that the CCTV monitoring and Secure POD staff/prisoner intercom recording equipment is operational. This should apply to all Northern Ireland Prison establishments.

Recommendation 15 - I recommend that all staff are reminded of the requirement for 15 minute observation checks of the Secure POD CCTV monitoring any occupied Safer/Observation Cell, or more frequent observation checks if determined on a needs assessed basis and recorded in the PAR 1. I also recommend that all staff are reminded of the requirement to record all Safer/Observation Cell CCTV observations at least every 15 minutes in the CRC 1 Booklet. This should apply to all Safer/Observation Cell facilities within the Northern Ireland Prison establishments.

ANTI-LIGATURE CLOTHING

Recommendation 16 – I recommend that the Prison Service either does not depart from its' existing policy that authorisation for a prisoner to be kept in anti-ligature clothing for a further 24 hour period is referred to the Deputy Director of Operations at Northern Ireland Prison Service Headquarters or immediately formalises any policy change making this the responsibility of the Governing Governor of each prison. Any change should be reflected in existing policies, instructions and authorisation forms i.e. CRC 1 Booklet, and communicated to all staff with a reminder that any period of extension must be fully documented and signed by the person with the appropriate authority, every time an extension is agreed. This should apply to the use of anti-ligature clothing across all Northern Ireland Prison establishments.

Recommendation 17 – I recommend that the Prison Service takes immediate steps to ensure that where prisoners are correctly authorised to be dressed in anti-ligature clothing, action is taken to ensure that they are not cold. I further recommend that prisoners in anti-ligature clothing are offered suitable footwear every time they leave their cells.

NIGHT CUSTODY OFFICERS

Recommendation 18 – I recommend that the Prison Service introduces appropriate break arrangements for Night Custody Officers across all Northern Ireland Prison establishments.

Recommendation 19 – I recommend that the Prison Service carries out a review of recruitment and selection processes to ensure that every reasonable effort is made to ensure that its' Personnel Department has knowledge of other jobs held by Night Custody Officers, or any other Officers, and assesses in each case any implications these may have before making offers of employment.

Recommendation 20 – I further recommend that the Prison Service carries out an exercise with existing staff to ensure that up to date records are held for all Officers who may hold other jobs, and that any implications for their role within the Prison Service are adequately assessed.

Recommendation 21 – I recommend that Governing Governors or their delegated representatives should be fully involved, with the Prison Service's Personnel Department, in decisions relating to recruitment and selection and staff shift arrangements.

Recommendation 22 - I recommend that the Prison Service takes action to ensure that all Night Custody Officers who work on the REACH Landing in Maghaberry Prison receive appropriate briefing and training to enable them to carry out their role in caring for vulnerable prisoners effectively. This should include reviewing the training and support available for dealing with difficult and challenging behaviour. I extend this recommendation to cover any Night Custody staff in other Northern Ireland Prison establishments working with vulnerable prisoners.

Recommendation 23 – I recommend that arrangements be made for senior prison staff to receive further training in mental health awareness, for example, the Advanced Awareness programme suggested by Professor McClelland in his Clinical Review Report.

Recommendation 24 – I recommend that the Prison Service also reviews the adequacy of briefing and training for day staff who work on the REACH Landing, including those who are required to cover staff absences.

HANDOVER ARRANGEMENTS

Recommendation 25 – I recommend that the Prison Service takes action to ensure that an appropriate and recorded handover takes place between day and night shift staff, including night shift staff allocated to Secure POD areas. The handover should draw the attention of all staff to information recorded on the PAR 1 and CRC 1 Booklets.

[Note: I have been advised that Governor's Order 8-1 and Governor's Order 7-25 issued on 3 October 2008 addresses some concerns about Handover arrangements]

NIGHT SHIFT SUPERVISION

Recommendation 26 – I recommend that the Prison Service reviews the adequacy of the arrangements for managers to enter Residential Houses in all Northern Ireland Prison establishments.

Recommendation 27 – I recommend that the Prison Service ensures Night Custody Senior Officers and Principal Officers are provided with a detailed Job Description that includes full duties and standards required.

Recommendation 28 – I recommend that the Prison Service increases the number of supervisory visits that are carried out to all Residential Houses in Maghaberry Prison and varies the time of these visits. I extend this recommendation to cover any night supervisory staff in other Northern Ireland Prison establishments.

Recommendation 29 – I recommend that Night Custody Senior Officers are advised that they should carry out physical checks on PAR 1 prisoners, including those on a CRC 1 in Safer/Observation Cells, during supervisory visits and that these must be appropriately recorded. This should apply to all Northern Ireland Prison establishments.

Recommendation 30 - I recommend that Night Custody Senior Officers are advised that they should routinely check Landing and Secure POD records and discuss CCTV Safer/Observation Cell monitoring and observations with the Night Custody Officers on the Landing and in the Secure POD. This should apply to all Northern Ireland Prison establishments.

Recommendation 31 – I recommend that the Prison Service reviews the training of Night Shift Senior Officers in order to ensure that officers fully understand and are competent to deliver all of their responsibilities in respect of staff management, administration and the care of vulnerable prisoners.

CARE OF VULNERABLE PRISONERS

Recommendation 32 – I recommend that the Prison Service takes action, in line with its' own policy, to achieve improving activity levels, work placement and education for PAR 1 prisoners, including those in Safer/Observation Cells on a CRC 1, and to ensure that therapeutic day care regimes are consistently a component of care for this group.

I re-iterate Professor McClelland's recommendation made in his Review of Non-natural deaths in Northern Ireland prisons that more attention to detail should go into the way that vulnerable prisoners spend their days.

[Note: I have been advised that, under the auspices of the Corporate Safer Custody Project, a Senior Governor at Prison Service Headquarters, a Healthcare Manager and a Principal Officer have now been nominated to carry out an exercise to examine the extension of the regime for vulnerable prisoners]

Recommendation 33 – I recommend that the Prison Service takes action to ensure full implementation of the recommendation Professor McClelland made and accepted by the Prison Service that:

"each prisoner with a multi-disciplinary Care Plan should have an assigned Care Co-ordinator."

Recommendation 34 – I recommend that the Prison Service audits the arrangements that operate with respect to the REACH Landing in connection with: staff recruitment and selection; briefing; training; shift handover; communication; performance review; supervision and supervisory training; to identify opportunities for adjustments or developments that might impact positively on the care culture.

SAMARITANS' LISTENER SCHEME

Recommendation 35 – I recommend that the Prison Service takes action to ensure that all staff are aware of, and apply, Governor's Order 7-22 and Notices to Staff 124/06, 125/06 and 126/06 relating to the Samaritans' Listener Scheme.

Recommendation 36 – I recommend that the Prison Service informs all staff that any requests from prisoners for Listeners, and action taken in response to that request, should be fully recorded in the PAR 1 and CRC 1 booklets. This should apply to all Northern Ireland Prison establishments.

RISK ASSESSMENT OF THREATS

Recommendation 37 – I recommend that the Prison Service reviews its' policy for involving the Police Service of Northern Ireland in the threat risk assessment of any prisoner who may be under threat and makes any adjustments it deems necessary.

SMOKING POLICY

Recommendation 38 – I recommend that the Prison Service takes immediate action to remind all staff of the Northern Ireland Prison Smoking Policy 2007 and any local smoking policies or instructions within their prison establishment, such as Governor's Order Number 19-10 covering Maghaberry Prison issued on 27 April 2008, and to remind staff of the requirement for full adherence to the Policy and local instructions. Staff should also be made aware that: *"breaches of the Policy may be treated as a disciplinary matter."*

HOT/COLD DE-BRIEF

Recommendation 39 – I recommend that the Prison Service includes a representative from the Emergency Control Room team at all Hot and Cold De-briefs following the death of a prisoner in custody in a Northern Ireland Prison establishment.

Recommendation 40 – I recommend that the Prison Service ensures that a Cold De-brief takes place following any death in custody, in line with the timeframe outlined in its Self-harm and Suicide Prevention Policy (revised September 2006) Section 6.11 - Impact on Staff – which states that a more comprehensive Cold De-brief should take place *"within 14 days."*

PREVIOUS RECOMMENDATION MADE AS A RESULT OF A DEATH IN CUSTODY IN RELATION TO ACCESSING CELLS

Recommendation 41 - I re-iterate a previous recommendation made by the Prisoner Ombudsman that action should be taken:

"to provide the necessary equipment to enable immediate entry to cells by Night Custody Officers in order for them to be able to respond to emergencies in circumstances where a prisoner's life is at risk."

CORPORATE RESPONSIBILITY

Recommendation 42 – I recommend that the Prison Service takes action to implement the recommendation made by Professor McClelland in his report into Non-natural deaths in Northern Ireland Prisons and accepted by the Prison Service that:

"*robust self audit is introduced as a high priority to measure standards on all prisoner care issues."*

Recommendation 43 – I recommend that action is taken to ensure that the Governing Governor Grade of Maghaberry Prison delivers all responsibilities as defined in the Prison Service's Self-Harm and Suicide Prevention policy. These are to:

"*Take personal responsibility for the implementation of the Policy on Self-Harm and Suicide Prevention within their establishments,*

Responsibilities are to:

- *Give all staff in the establishments a clear lead, through their own involvement as appropriate;*
- *Ensure, through training that* ***all staff*** *are aware of their responsibilities in regard to the policy;*
- *Issue instructions to staff on local procedures, including emergency measures in responding to incidents of suicide or self harm;*
- *Keep procedures under review and instigate a self-harm and suicide prevention review on at least an annual basis;*
- *Ensure the effective and regular operation of local self-harm and suicide prevention teams;*
- *Ensure that an effective system of multi-disciplinary case conferencing is in place."*

Recommendation 44 – I recommend that the Governing Governor and Deputy Governor of Maghaberry Prison, who was acting for the Governing Governor during the two weeks leading up to Colin's death and to whom operational and functional Governors' report, are each subject to a disciplinary investigation in respect of the issues highlighted in this report in connection with Colin's care and, in particular, the failures to adequately implement Prison Rules, the Prison Service's Self-Harm and Suicide Prevention Policy, and the Standard Operating Procedures on the Use of Safer/Observation Cell.

[Note: I am aware that disciplinary investigations are being carried out by the Prison Service into the actions of 17 Prison Officers/Senior Officers at Maghaberry Prison as a result of a wider probe involving the examination of Secure POD CCTV footage across the establishment]

ANNEX 1

PRISONER OMBUDSMAN FOR NORTHERN IRELAND

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

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

   - **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**

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

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

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the

DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that

purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in

particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Secretary of State for Northern Ireland (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

16. Annex 'A' contains a more detailed description of the usual reporting procedure.

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

3. The Service responds within 28 days. The response:
   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication,

the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

ANNEX 2

The Prisoner Ombudsman for Northern Ireland

22nd Floor, Windsor House, Bedford Street, Belfast BT2 7FT
Tel: 028 90443998 Fax: 028 90443993

Mr Robin Masefield
Director
NI Prison Service
Room 314
Dundonald House
BELFAST
BT4 3SU

22 September 2008

Dear Robin

PRISONER OMBUDSMAN INVESTIGATION INTO THE DEATH IN CUSTODY OF COLIN BELL

I explained to you last week that I had decided to report my finding and recommendations in respect of the death of Colin Bell in two phases. In view of the circumstances surrounding Colin's death, it was my view that it would be inappropriate to delay the communication of certain recommendations until the production of my final report, which may take some time.

I am aiming to have my "interim report" ready to discuss with Colin's family and yourself in around four to six weeks time. I will however, review this timescale if I consider it necessary when I have been fully briefed on the content of the interviews currently being undertaken by my investigators.

Further to implementing this approach, I have now determined that there are a number of early observations and recommendations in connection with the events of 31July / 1 August 2008 that can and should be shared now. It is my view that immediate action in respect of these would directly impact upon the risk of a similar death occurring and as such it would be inappropriate to wait, even for the production of my interim report, before notifying you of them.

All the observations and recommendations listed which are attached as Appendix A, will be included and further developed, where appropriate, in my subsequent reports. Related recommendations in connection with the conduct and action of individuals, where appropriate, will also be included in that report.

I would appreciate receiving as soon as possible, your plans and timescales for responding to my observations and recommendations so that I can reflect these in my subsequent reports.

Yours sincerely

PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland

APPENDIX A

Investigation into the circumstances surrounding the death of Colin Bell in Maghaberry Prison on 1 August 2008.

From my preliminary investigations into the circumstances surrounding the death of Colin Bell, I have identified the following areas of concern and included recommendations or actions points where appropriate.

ISSUES EMERGING	RECOMMENDATIONS / ACTION POINTS
LAGAN HOUSE SECURE POD	
Presence of Television in Secure POD - There was a television in the Secure POD[14] where a Night Custody Officer is expected to manage all movement, maintain logs and in particular observe CCTV of prisoners in Safer Cells at 15 min intervals. From reviewing the CCTV provided relating to this incident it is clear at this stage of my investigation that the presence of a television was distracting.	**Recommendation** – I recommend that NIPS remove the television from Lagan House Secure POD. I extend this recommendation to all Secure POD areas within Northern Ireland Prison Establishments.
Securing of the Secure POD during Night Guard Shift - I have confirmed with the prison service that the POD should remain secure at all times. On the night of 31 July / 1 August the door of the Secure POD was unlocked for periods.	**Recommendation -** I recommend that NIPS issue instructions to staff about securing the Secure POD during the Night Guard shift. **Note:** I have now been advised that Governor's Order relating to this was issued with effect from 10 September 2008.
Arrangements for management to enter Residential Houses - It would appear that the current security systems in place for both staff and prisoners prevent management from entering these areas without access being granted by the staff they are supervising.	**Recommendation** – I recommend that NIPS review the arrangements for the adequacy of the capacity for management to carry out their required duties.
Inappropriate actions by Secure POD Officer - On the evening of 31 July 2008 the Night Custody Secure POD Officer prepared a comfort area for use during his shift. This was confirmed from reviewing CCTV footage of the Secure POD for that night. The officer was observed setting out a make shift bed. I have further been advised that NIPS has established that similar practices are	**Recommendation –** I recommend that NIPS take immediate action to eliminate this practice and ensure that all staff are aware that this will be treated as a disciplinary offence. I extend this recommendation to all Northern Ireland Prison establishments.

[14] Secure POD – The key control points within each Residential House where all prisoner and staff movement is managed and logged.

operating elsewhere. This further highlights the problem of appropriate staff supervision. I have also taken account of this matter when reviewing the Management of Vulnerable prisoners.	**Recommendation –** I further recommend that immediate arrangements be put in place for observing CCTV coverage of the Secure POD areas in the interests of increasing staff supervision, security and the health and safety needs of the Secure POD officer. I extend this recommendation to all Northern Ireland Prison establishments.
LAGAN HOUSE REACH LANDING / SAFER CELLS	
Night Custody Officer Information and Training – Early investigations suggest that Night Custody Officers are not fully aware of the purpose of the REACH[15] landing and are not aware of the specialised work of the unit. Night Custody Officers have not received appropriate training to work on the REACH landing or to deal with vulnerable prisoners.	**Recommendation –** I recommend that NIPS take immediate steps to ensure that all Night Custody Officers who are expected to work on the REACH landings receive the necessary training and information to carry out this role effectively.
Ligature Points in Safer Cells - Safer Cells[16] are supposed to be free of ligature points. From reviewing Colin Bell's death it is clear that this was not the case. Colin Bell attached a ligature to the cell door on 4 occasions on the night of 31 July 2008. After his death NIPS immediately carried out some remedial work to the cell door to prevent this from happening again. However my investigators, along with a Senior Officer from the Prison Service carried out an inspection after the remedial work had been completed and at this stage were still able to attach and secure a ligature to the door.	**Recommendation –** I recommend that NIPS take immediate action to ensure all 'Safer Cells' are, as far as possible, free from ligature points. My Final Report will include comparative practice with other Safer Cell cells and Suicide Prevention methods.
Recording of Calls - I have been advised by NIPS that the recording of calls made by Colin Bell from the Safer Cell intercom to the Secure POD is not available due to a possible fault with the equipment.	**Recommendation –** I recommend that NIPS take immediate action to have the equipment operational and that regular documented checks are maintained and supervised in the future.

[15] REACH Landing – **R**eaching out to prisoners through **E**ngagement, **A**ssessment, **C**ollaborative working **H**olistic approach.

[16] Safer Cell – A cell which has been modified and contains special furniture and window fittings that make anchorage of a ligature extremely difficult. They also contain a specially adapted electric package with a CCTV Camera with low light capacity, two intercoms to the Secure POD and the Samaritans as well as a built in television. The cell door has been modified to include an inspection hatch top and bottom allowing better vision into the cell.

NIGHT GUARD STAFF	
Break / rotation arrangements - Staff work 11¾ / 12¾ hour shifts without an official built in break / relief or rotation of duties. One member of staff is allocated to the Secure POD for a complete shift. It would appear that this has contributed to breaches of various NIPS policies and guidance, for example NIPS Smoking Policy, Security of Secure POD and Observation of CCTV. Existing arrangements may be in breach of Working Time Regulations.	**Recommendation –** I recommend that NIPS introduce appropriate, formalised arrangements for taking breaks for Night Guard staff. **Recommendation** – I further recommend that NIPS review the arrangements for staffing the Secure POD with a view to rotating staff during the course of a shift.
Second Jobs – I have been informed that some Night Custody Officers have second and even third jobs. Clearly this may have implications for their capacity and fitness to perform the duties required by NIPS and may mean that new members of staff do not have adequate breaks before commencing night shifts.	**Recommendation –** I recommend a review of recruitment and selection processes to ensure that every reasonable effort is made to ensure that NIPS has knowledge of other jobs and any implications these may have before making offers of employment. **Recommendation** – I further recommend that NIPS carry out an exercise with existing staff to ensure that up to date records are held for all Night Custody Officers who may hold other jobs and that any risk of implications to their role within NIPS is adequately risk assessed. **Recommendation** – I recommend that where management have knowledge of other jobs held by Night Custody Officers that this is communicated to the Personnel Department.
MANAGEMENT OF NIGHT CUSTODY OFFICERS	
Night Guard Senior Officer Job Description - There is no Job Description specific to the role of the Night Guard Senior Officer.	**Recommendation** – I recommend that NIPS take immediate steps to ensure Night Guard Senior Officers are provided with a detailed Job Description that includes full duties and standards required.
Night Guard Senior Officer check on Lagan House - I have established that the Night Guard Senior Officer on duty on 31 July 2008 carried out one supervisory check in each Residential House, to include Lagan House. The check in Lagan House was carried out at 11.00pm. Early evidence suggests that these checks are carried out each night to set patterns and times. One visit to Lagan House is not sufficient or appropriate.	**Recommendation –** I recommend that NIPS increase the number of supervisory checks that are carried out in Lagan House.

Night Guard Senior Officer check on Lagan House landing staff -The Night Guard Senior Officer completed his supervisory check of landing staff in Lagan House on 31 July 2008 by observing them from the 'landing circle area'[17]. In essence this means the checks were carried out by observing from a distance. While this may be acceptable for normal residential houses, I am concerned that it may not be suitable for areas where prisoners are more vulnerable, such as the REACH / VPU landings and where prisoners have been placed on PAR1s or within Safer Cells.	**Recommendation –** I recommend that NIPS take steps to review how management checks are carried out to ensure more robust supervision for staff with responsibility for vulnerable prisoners.
Management and Supervision of records – On the night of 31 July 2008 the Night Guard Senior Officer did not check the record log that should have been maintained by the Secure POD officer. If this check had been done it would have highlighted that the necessary checks had not been recorded by the Secure POD officer. In addition NIPS guidance states that the Safer Cell recording form and authorisation should be checked and signed of by a Governor.	**Recommendation –** I recommend that NIPS take immediate steps to incorporate the appropriate and necessary management checks on CCTV records / logs on a regular basis and that these are reviewed on a regular basis by Senior Management. **Recommendation** – I further recommend that these records are included as part of the handover briefing between night and day staff to ensure continuity of record keeping and duty of care for the prisoner.
Management and Supervision of prisoners in Safer Cells – I have identified that on the night of 31 July 2008 there was no physical management check carried out on prisoners in Safer Cells within Lagan House. The Senior Officer carried out his supervisory check by positioning himself and observing from the landing circle area.	**Recommendation –** I recommend that NIPS, as part of the formalised Night Guard Senior Officer Job Description, incorporate physical checks to be carried out on prisoners in Safer Cells and that these are appropriately recorded, and checked regularly by Senior Management. **Recommendation** – I further recommend that details of these checks by management be incorporated into the handover briefing between night and day staff to ensure continuity.
MANAGEMENT OF VULNERABLE PRISONERS	
Placing a prisoner in a Safer Cell - Prior to his death on 31 July 2008 Colin had been housed in a Safer Cell in Lagan House, REACH Unit since 26 July 2008. I have reviewed Safer Cell Guidance which states that a prisoner should only be held in	**Recommendation –** I further recommend that NIPS take immediate steps to ensure that policies and guidelines relating to Safer Cells are adhered to. (Governors Order 2-29 issued 18/4/07)

[17] Landing Circle Area – Area within a Residential House Landing where staff are based. Landing Circle Areas lead onto corridors with prisoner cells up each side.

a Safer Cell for up to 48 hours in one period. From the evidence available it is clear that Colin was held in the Safer Cell in excess of NIPS own policy and guidelines.	
Frequency of checks for PAR 1 / Safer Cells by landing staff - I have established that landing staff in Lagan House carried out checks on prisoners under PAR1 and in Safer Cells on an hourly basis. I am concerned that some prisoners, particularly those in Safer Cells with a documented history of self harm, would warrant more frequent and continued observation and cell checks by landing staff. All such observations should be appropriately logged / recorded and regularly checked by management to highlight potential risk and ensure continuity between changing staff members. I am examining comparative practice and will address this as part of my subsequent reports.	**Recommendation –** I recommend that NIPS review the frequency of checks on vulnerable prisoners with a view to ensuring appropriate observations by landing staff are based on properly assessed risk management. **Recommendation –** I further recommend that NIPS direct all managers to regularly carry out robust checks to ensure that all staff are carrying their duties with regard to the management of vulnerable prisoners and that these actions are properly logged / recorded.
Frequency of CCTV observations - I have established that there was a requirement for CCTV observations to be carried out and recorded / logged every 15 minutes. I have established that 15 minute checks were not carried out or recorded / logged.	**Recommendation –** I recommend that NIPS take immediate action to ensure all officers are fully aware of the duties to be carried out within Residential House Secure PODs the requirement for 15 minute checks of CCTV and that these are properly recorded / logged. I extend this recommendation to all Northern Ireland Prison Establishments. **Recommendation –** I further recommend that where Secure POD Officers are expected to observe vulnerable prisoners, Safer Cells and operate CCTV equipment that they are made aware of their full responsibilities and are appropriately trained for this purpose. I extend this recommendation to all Northern Ireland Prison Establishments. **Recommendation –** I recommend that NIPS take immediate action to ensure staff are aware that failure to carry out these duties will be considered a disciplinary offence. I extend this recommendation to all Northern Ireland Prison Establishments.

RESPONSE TO EMERGENCY INCIDENTS	
Initial indications on reviewing CCTV would suggest that valuable time was lost due to the fact landing staff had to go downstairs to the Secure POD to retrieve the keys to Colin's cell from a 'break glass' cupboard and collect the Hoffman / Anti Ligature Knife. This is an issue which has emerged in previous death in custody investigations where the following recommendation was made: "*to provide the necessary equipment to enable immediate entry to cells by Night Custody Officers and for them to respond to emergencies if considered necessary for the preservation of life."* I will be commenting in due course on the total response time and actions.	**Recommendation** – I reiterate a previous recommendation to provide the necessary equipment to enable immediate entry to cells by Night Custody Officers and for them to respond to emergencies if considered necessary for the preservation of life.
SMOKING POLICY	
From reviewing the Secure POD CCTV it is clear that some staff were in breach of the NIPS Smoking Policy[18]. Officers can be clearly seen lighting and smoking cigarettes within the working environment in the presence of other colleagues.	**Recommendation –** I recommend that NIPS take immediate action to reaffirm its own Smoking Policy to all staff and that this is monitored on a regular basis. **Note:** As already identified, the introduction of built in official breaks / relief for staff may assist NIPS with the enforcement of this policy.
INCIDENT MANAGEMENT	
I am aware that a Hot Debrief was carried out immediately after Colin's death, however, I have been advised that to date the 'Cold Debrief' that is normally carried out between 14 / 28 days after the incident has not yet taken place.	**Recommendation –** I recommend that in accordance with NIPS own guidelines that a Cold Debrief take place as soon as practicable to ensure learning points are not lost.

[18] NIPS Smoking Policy – April 2007

ANNEX 3

"Standard Operating Procedures Residential

SOP/01 Observation Cell

Directions for Use

"An observation cell may be considered for use under the following circumstance:

- *Where a prisoner is deemed to be at risk of immediate self-harm*
- *Where a prisoner has engaged in an act of self-harm which does not warrant relocation to Healthcare;*
- *The cell may only be used for up to 24 hours;*
- *Extensions longer than 24 hours may be agreed through consultation with multi-disciplinary teams however prisoners should be located within 48 hours to suitable accommodation, i.e. normal cell or Healthcare.*

An observation cell may not be considered for use under the following circumstances:

- ***As a means of punishment or 'time out' facility***
- ***As a location to manage prisoners who are deemed refractory or violent."***

Authorisation

"When a decision has been taken to accommodate a prisoner in an observation Safe Cell the following procedure will apply:

1. A record will be maintained in the Governor's journal and relevant accommodation area.
2. Open a **PAR 1**(Prisoner at Risk Form)at location prior to transfer, interview prisoner, noting use of observation cell as an agreed outcome to keep prisoner safe. Inform the prisoner why he is being located in the cell and when the first review of his circumstances will take place.
3. Duty Governor will open **CRC1** (Use of Safer Cell Booklet: Trim Doc 426730) authorising the use of the observation cell. Class Officers responsible for the area where the observation cell is located will complete the monitoring section of the CRC1 every 15 minutes.

4. Ensure all monitoring equipment in the observation cell has been checked and found to be in working order. Activate the CCTV and POD intercom cassette recordings systems. Staff assigned observation PODS will commence a running log (Trim Doc 302946) to record monitoring of observations every 15 minutes. Inform prisoner whilst located in an observation cell he will be monitored by staff through the use of both recording systems.
5. **It is the responsibility of the prisoner's residential Principal Officer or Senior Officer from where he has temporarily transferred to arrange a review of the case within 24 hours.** Outcomes should include an exit strategy and a way forward i.e. relocation to another area of prison, remaining in present location and or an agreed care plan. All directions should be noted in prisoner's PAR 1.
6. Healthcare must be notified of all prisoners relocated to an observation cell and they must arrange for the prisoner to be medically examined as soon as operationally possible.
7. The Doctor must examine the prisoner within 24 hours and if the period of confinement is to continue at least every 24 hours thereafter. This should be noted in the CRC1.
8. Prisoners will not be permitted lighters whilst located in observation cells.
9. A record will be automatically maintained of all CCTV observations and intercom exchanges. All monitoring equipment is subject to RIPA in relation to maintaining records of surveillance and therefore is subject to examination by both NIPS and PSNI if a death in custody occurs. All CCTV recordings should be retained for 31 days whilst voice recordings (intercom exchanges) should be retained for 90 days before being wiped clean.
10. Prisoners will be routinely placed in the observation cell with their own clothing, staff should ensure shoe laces and belts are removed.
11. **Under exceptional circumstances the Duty Governor or Doctor have the authority to place an individual in protective clothing if the risk of self-harm has increased, i.e. whilst located in the observation cell a prisoner has engaged in an act of self-harm or attempted hanging. At no time will the decision to use protective clothing be taken by any other member of staff. On all occasions where protective clothing (anti-ligature clothing) is used a record should be made in the CRC1 by the Governor.**

12. The use of anti-ligature clothing for a period in excess of 24 hours may only be granted by the Deputy Director of Operation HQ."

"Directions for POD Officer

1. Check and ensure all recording equipment is operational. Noting time of check in the CCTV observation sheets provided.
2. Maintain running log of 15 minute observation noting use of any interaction via the intercom.
3. Cassette tapes used for recording staff/prisoner intercom conversations will be retained for 90 days and then wiped clean for reuse. Tapes should be clearly marked with prisoner's name, number, commencement and finishing times and dates.
4. Completed observation sheets and tapes should be signed off by the POD officer when prisoner has ceased to use the safe cell and passed to house management for filing in a secure cabinet. Hard copies should not be destroyed.
5. Staff are reminded that observation cells in themselves do not prevent prisoners from self-harming or attempting suicide and therefore regular observations and contact are vital in reducing risk and acting as an early warning system assisting staff response times for effective intervention."

"Procedures for Reviewing Use of Observation Cells and Closure of CRC1

- It is the responsibility of the Duty Governor and PO/SO of the area where a prisoner has been temporarily transferred from, to arrange a Case Conference to decide how the prisoner should be managed.
- Prisoner should be seen by a Doctor prior to being released from observation cell.
- Healthcare must be informed and a note placed in the PO/SO journal lagan House noting briefly the decision of the case conference.
- On closure, CRC1 Forms should be lodged in the prisoner's file (General Office) for reference **IG 21/07."**

"First Night Custody and Short Term Intervention

The use of the observation cell facility should be regarded as a short term intervention and should not be used for prolonged occupancy. Staff should be aware of managing actively suicidal and self-harming prisoners during first night in custody.
Therefore placement of those prisoners or any prisoner in a double cell with the appropriate prisoner (listener) may be more an effective strategy due to its minimisation of social isolation and increased observation levels."

"Long Term Intervention

The most effective way to deal with self-harm or suicidal person in the long term is to develop trusting prisoner-staff relationships, good assessment and support structures, staff training, identification of the root causes of the behaviour and the effective use of resources such as the Listeners Scheme and the Samaritans.

Signed: Principal Officer 27 May 2008."

ANNEX 4

NI PRISON SERVICE

SELF-HARM AND SUICIDE PREVENTION POLICY
REVISED SEPTEMBER 2006

The policy states that:

"All staff carry an equal and continuing responsibility for the management of prisoners considered to be at risk of committing suicide or other acts of self harm.

***All staff** in direct or indirect contact with prisoners must:*

- *be aware of the NIPS Policy on Self Harm and Suicide Prevention and their role in contributing to the implementation of that policy;*
- *be familiar with the preventative measures that might help to prevent a prisoner harming him or herself;*
- *be prepared to intervene and support any prisoner through a period of crisis, either individually or as a member of a multi-disciplinary team;*
- *report the details of any prisoner whose behaviour is giving cause for concern, with due regard to issues of confidentiality and information sensitivity;*
- *appreciate the importance of personal contact in helping prisoners to cope with imprisonment.*

There are particular roles and specific responsibilities assigned to individual groups of staff in implementation of this policy.

In terms of corporate responsibility, the policy states:

"Governing Governors must take personal responsibility for the implementation of the Policy on Self Harm and Suicide Prevention within their establishments.

Whilst retaining overall responsibility, they may delegate individual tasks to other members of their senior management team or to the local Self Harm and Suicide Prevention Team as appropriate.

The Governor's responsibilities are to:

- *give all staff in the establishment a clear lead, through their own involvement as appropriate;*

- *ensure, through training, that **all staff** are aware of their responsibilities in regard to the policy;*
- *issue instructions to staff on local procedures, including emergency measures in responding to incidents of suicide or self harm;*
- *keep procedures under review and instigate a self harm and suicide prevention review on at least an annual basis;*
- *ensure the effective and regular operation of local self harm and suicide prevention teams;*
- *ensure that an effective system of multi-disciplinary case conferencing is in place."*

"The Prison Officer is the person in most regular contact with prisoners and has the best opportunity to identify a prisoner at risk and assist him or her through a period of crisis.

The Prison Officer's responsibilities are to:

- *report through the Prisoner At Risk booklet (PAR1) to the relevant Principal Officer or Senior Officer, any circumstances or incident that leads him or her to believe that a prisoner may be at risk of suicide or self harm, particularly those returning from court, home leave or a visit etc;*
- *offer contact and support to any prisoner thought to be at risk;*
- *carry out supervision procedures as agreed in a care plan or other relevant document, and record such actions;*
- *attend multi-disciplinary case conferences on at-risk prisoners as necessary."*

"The role of the Healthcare staff is to work in partnership with medical staff and others in the provision of clinical services that meet prisoners' health care needs.

The responsibilities of the Healthcare staff are to:

- *make a preliminary assessment of suicide risk at the screening interview on the day of reception;*
- *where a prisoner is undergoing detoxification, ensure that appropriate treatment interventions are actioned;*
- *stipulate interim preventative measures as necessary;*
- *respond to the scene of incidents of suicide or self harm and administer appropriate clinical care;*
- *contribute to any plan for the care of prisoners at risk located in the Healthcare Centre or on normal location;*
- *attend multi-disciplinary case conferences on prisoners at risk as necessary;*

- *respond appropriately to any concerns from prisoners family members raised through the Family Care Line."*

"The role of the Residential Manager is to support staff in the identification of potentially suicidal prisoners and those at risk of self harm and to co-ordinate their management in normal location. He or she also has a role in creating a supportive environment for prisoners at risk.

The Residential Manager's responsibilities are to:

- *ensure that staff who identify a prisoner at risk initiate a PAR1;*
- *co-ordinate referrals of prisoners deemed to be potentially at-risk to the Self Harm and Suicide Prevention Co-ordinator (SPC) using the PAR1;*
- *ensure that any Healthcare stipulations on preventative measures for prisoners in their area of responsibility are recorded and carried out;*
- *chair or attend the multi-disciplinary team meetings held to develop plans for the management of at-risk prisoners in his area."*

Multi-Disciplinary Case Conference

"Once a prisoner has been identified as being potentially at risk, the identifying member of staff will raise a PAR1 booklet, report the matter to the residential manager and a multi-disciplinary case conference will be convened by the residential manager within 72 hours, and preferably sooner. The prisoner must be informed that he/she is deemed to be at risk and the process of how he/she is to be managed must be explained. Informing the prisoner of this process must be recorded in the daily log, contained in the PAR1 booklet. Further case reviews must be convened at least every 14 days following the initial case conference.

Prisoners should be encouraged to participate in case conferences and be offered the opportunity to be accompanied by someone they trust such as a landing officer, listener or chaplain. They should also be given the opportunity to provide a written contribution, as well or instead.

Convening a case conference will be the responsibility of the residential manager. The initial case conference must be held as soon as possible but no later than 72 hours from the initiation of the PAR1. Those attending should include the originator of the form, his/her manager, the Residential Governor, a member of Healthcare staff, representatives from Probation and Psychology,

and, where appropriate, the prisoner involved and others as required such as a chaplain and a psychiatrist. The outcome of a case conference will either be a consensus that no further intervention is necessary, or the drawing up of a care plan for the prisoner. Part of the role of the SPC will be to check that a case conference has taken place and to establish the outcome. In exceptional cases, it may also be appropriate to include a member of the prisoner's family and/or their legal representative.

The chair of a case conference will normally be a residential manager who has the authority to take forward agreed recommendations. The group will record any action agreed on the PAR1 and review progress on a frequent basis as indicated. The PAR1 will only be closed on the unanimous agreement of those attending a multi-disciplinary case conference. Subsequent case conferences must be convened on a regular basis, but no more than 14 days apart. The purpose is to review the progress of a prisoner on a PAR1 and make amendments to the care plan where appropriate."

Care Plans

"A comprehensive and meaningful Care Plan must be drawn up and documented by the residential manager at or immediately following the case conference. It is also the responsibility of the residential manager, as chair person of the case conference, to allocate responsibilities, monitor progress and ensure that the Care Plan is implemented.

The nature of each Care Plan will be determined by the needs of the individual. The Care Plan must cover the following areas:

- *the level of risk to the prisoner;*
- *the underlying causes of the prisoner's situation;*
- *consideration of what type of accommodation the prisoner should reside in;*
- *the allocation of work to staff responsible for delivering specific elements of the care plan.*

The documentation will take the form of a residential care plan, where the action points required will be managed in normal location, and a healthcare plan, where activities must be carried out by healthcare staff in the Healthcare Centre. The format of residential and healthcare plans will be devised in line with best practice and be the subject of regular review until it is considered that the risk has significantly diminished. PAR1 booklets will be closed by unanimous agreement of those attending a review. A closing review must be carried out by at least three staff

including one representative from healthcare and one from residential. Representations in writing may be made where members of the case conference cannot attend."

Care Plans - Healthcare Centre

"Where the prisoner is located in the Healthcare Centre, the formulation of a healthcare plan will be the responsibility of the appropriate healthcare staff. A document to record these plans will be drawn up following a multi-disciplinary case conference and will record relevant activities and observations which will be the subject of review at a multi-disciplinary case conference at agreed intervals. A copy of this document should be retained with the PAR1 on the prisoner's healthcare record. Information regarding the healthcare assessment must be passed to the Manager in charge of the prisoner's usual location for his information and that of the form's originator."

60. *Annex A of the Prison Service's Self Harm and Suicide Prevention policy gives a number of preventative measures. These are replicated below:*

"Where a prisoner is assessed as being at risk of suicide or self harm, it is important that appropriate measures are taken to prevent the prisoner harming him or herself. It may be that the prisoner feels suicidal as a result of temporary factors which do not require clinical intervention and will respond to the general support or expertise which may be provided by any member of staff. In other cases consideration may have to be given to their location or arrangements made for special observation."

Shared Accommodation

"Any prisoner who is assessed as presenting signs of being at risk may be placed in appropriate shared accommodation in a residential area. Shared accommodation should provide the opportunity for meaningful human contact which may assist a prisoner through a period of crisis."

Wing-Based Observation

"At the lowest level, where risk is assessed as minimal but worthy of further assessment, it may be sufficient to decide to observe the prisoner intermittently at pre-determined intervals throughout the night or to pay particular attention during pegging rounds where applicable. Instructions for monitoring the prisoner and resulting observations will be detailed on the PAR1.

*Observation by an officer can be usefully supplemented by use of the Remotely Activated Surveillance Camera & Light (RASCAL). However, while RASCAL is a useful tool in supplementing normal supervision, it **must not** be used to replace regular human contact with the prisoner, which can have a positive therapeutic value in itself."*

Healthcare Centre-Based Observation

"Healthcare staff assessment of a prisoner will be a critical factor in deciding where they should be located. Location within the Healthcare Centre will be a matter for healthcare staff. Dependent on the risk presented by the prisoner, the Healthcare Centre has a number of options for supervision:

- *Intermittent observation in shared ward accommodation (which may be supplemented by CCTV observation).*
- *Location in a safer custody observation room (where available).*
- *Intermittent observation in a single room."*

Special Supervision Unit

"Housing an 'at risk' prisoner in the SSU is not conducive to a caring environment and should only be considered as a last resort, when the at-risk prisoner presents a serious control problem."

Isolation

"Only in very extreme and justifiable circumstances should a prisoner at risk be placed in an environment where they may feel isolated and are without human contact on a regular basis. Every effort must be made to provide an opportunity to engage in purposeful activity."

Anti-Suicide Suits

"Anti suicide suits should only be deployed as a last resort where it is deemed that a serious attempt to self harm will be carried out by the prisoner."

Removal of Personal Items

"Consideration may be given in some cases to remove items such as a belt or laces from an at-risk prisoner, depending on the level of risk posed."

Family Hotline

"Each prison establishment must implement a family hotline. This is to enable the families and friends of prisoners to ring a confidential telephone within the prison and leave messages detailing their concerns."

ANNEX 5

CLINICAL REVIEW

Death in custody of Mr Colin Martin Bell on 31 July 2008

Expert Medical Report

prepared by

Professor Roy McClelland

on

Mr Colin Martin Bell

Date of Birth:	10 October 1974
Date of Incident:	31 July 2008
Requested by:	Mrs Pauline McCabe Prisoner Ombudsman for Northern Ireland
Date of Report:	31 October 2008

CONTENTS Page

INTRODUCTION

1 I have been requested by Mrs Pauline McCabe, Prisoner Ombudsman for Northern Ireland, to review the medical and healthcare records and CCTV footage of the prisoner Mr Colin Bell and prepare a report based on my expert clinical opinion. See Appendix 1 for Terms of Reference and short CV at Appendix 2

2 This report is based on a review of the following documentation:

All Northern Ireland Prison Service documentation including Staff Reports, PAR 1 records, Observation/Safer Cell Records;
Medical Records – Colin Bell;
CCTV footage of Colin Bell in the Observation/Safer Cell prior to and after his death by hanging

REVIEW OF DOCUMENTS

3 This review focuses on Mr Bell's mental health history, care and related matters.

Time line summary of key events

4 From review of the various records Mr Bell was last committed to prison in March 2003. [text redacted].

5 From review of the records there is a marked contrast between Mr Bell's general wellbeing and social functioning within the prison situation between the period of committal in 2003 until April 2008 and the period subsequent to this until his death on 31 July 2008.

6 2003 – April 2008. Following initial committal in 2003 Mr Bell required mental health support.

7 In his psychiatric assessment, a Consultant Forensic Psychiatrist (September 2004) concluded that Mr Bell at that time was not suffering from any disturbance of mood and there was nothing to suggest that he was suffering from any specific mental illness.

8 In his preliminary report, the Governing Governor, HMP Maghaberry, states that Mr Bell posed few disciplinary problems and as a consequence of his behaviour was assessed as being suitable for the lower risk area where he was moved in 2007.

9 From a mental health perspective there appear to have been two episodes of disturbance during this period. An episode of attempted hanging occurred in January 2005. At clinical review in February 2005 it was noted that Mr Bell was alleging that he had been the target of

paramilitaries and had had death threats in the past. The disturbance in behaviour at that time was considered "situational" in nature and appeared to settle quickly.

10 On 26 November 2006 a PAR 1 form was opened and at clinical review Mr Bell described himself being "a bit down". Again any disturbance in mental health functioning settled quickly and by the time of Healthcare review on 4 December "does not feel down any more. No thoughts of deliberate self-harm".

11 Prison Officer comments substantiate the view concerning Mr Bell's overall social and psychological functioning:
19 October 2006. "A quiet prisoner in the landing". "Nothing of note in the past year".
19 November 2006. "Very open in his attitude".
15 October 2007. "I have known for approximately 18 months. Colin's behaviour in prison has been good. No adverse reports". "Colin has a good relationship with staff and other inmates".

12 Nevertheless the possibility of an underlying vulnerability to impulsivity is reflected in a Pychologists risk assessment report (24 September 2007) – "landing staff in both Erne and Wilson House would describe Mr Bell as being impulsive and tending to become confrontational quickly and for little reason".

13 Mr Bell remained in the lower risk area of Wilson House from May 2007 until April 2008.

14 8 April and 28 July. Because of an offence against prison discipline Mr Bell was moved from Wilson House back to Erne House. Shortly after and until the time of his death Mr Bell's behaviour deteriorated dramatically.

15 On 8 April Mr Bell self-harmed using razor blades both by causing superficial scratches and by swallowing razor blades. He was placed on a PAR 1 on which he remained until his death in July 2008.

16 There were 15 detected attempts at self-harm or threats of self-harm during this 4 month period. Several of these included attempted hanging. The first instance of attempted hanging was on 12 April following which Mr Bell was transferred to the Special Observation Ward in the Healthcare Unit. A major concern expressed by Mr Bell at this time and remaining as a pervasive concern until his death was that his safety within the prison was under threat. Also at this time he was described as being agitated and frightened. He described previous threats from paramilitaries prior to going into prison, that rumours had been spread about him that he was [text redacted] and that these problems had all started up again. It was noted that he had

similar complaints in 2005 but at that time no evidence of mental illness was found. Mr Bell remained in the Healthcare Unit until 12 May 2008.

17 Over subsequent weeks he had many moves which appeared to be informed both by Mr Bell's own wishes and by concerns regarding his safety arising from attempts at self-harm:

18 Following an initial move to an observation cell in Bush House on 12 May he was transferred to a Safer Cell in Lagan House on 14 May.

19 Following his request he was moved back to an Observation Cell in Bush House on 17 May.

20 Because of ongoing risks and actual attempts of deliberate self-harm he was moved from Bush House to a Safer Cell in Lagan House on 23 May where he remained until 25 May.

21 On 25 May he was moved to an Observation Cell in Bush House. Because of a serious episode of deliberate self-harm he was briefly transferred to the Belfast City Hospital A&E Department.

22 Mr Bell was returned to Maghaberry Prison on 28 May and was placed in the Special Observation Cell of the Healthcare Unit.

23 Mr Bell was moved to Glen House on 5 June but because of a ligature being found in his cell was moved back to Healthcare the same day.

24 Mr Bell was moved to a Safer Cell in Lagan House on 11 June.

25 Because of further instances of self-harm he was transferred to the Special Observation Ward in the Healthcare Unit on 15 June.

26 Because of continuing problems with making ligatures he was transferred to a Safer Cell in Lagan 5 on 19 June.

27 Following a case conference attended by Mr Bell's parents on 3 July he was moved to the Healthcare Unit for a period of assessment. In the medical records it is stated that if during this period he does not make ligatures or attempts deliberate self-harm he will move to Glen House.

28 On 8 July Mr Bell was moved to Glen House Safer Cell.

29 Mr Bell was moved back to Healthcare on 9 July where he remained for a further 5 days.

30 On 14 July Mr Bell was moved to Cell 2 in Glen House under the arrangements of the previous discharge plan.

31 On 16 July Mr Bell made several superficial lacerations to his neck. He subsequently surrendered two pieces of broken glass. He was considered to be in an agitated state and because of his safety needs was transferred to a Safer Cell.

32 Mr Bell remained in a Safer Cell in Lagan House from 16 July until 24 July.

33 Mr Bell was moved back to Cell 2 in Glen House on 24 July. He was observed and prevented from using a ligature on 25 July. He had also been banging his head on the cell wall.

34 On 25 July Mr Bell was again moved to a safer cell in Lagan House where he remained until his death on 31 July.

35 Recent history of self-harm:

8 April 2008 – superficial cuts
12 April 2008 – found with a ligature
21 April 2008 – cuts requiring stitches
16 May 2008 – superficial cuts
18 May 2008 – superficial cuts
23 May 2008 – superficial cuts and found with a ligature
25 May 2008 – serious attempt at hanging
28 May 2008 – superficial cuts
31 May 2008 – superficial cuts
14 June 2008 – superficial cuts
16 June 2008 – attempted hanging
19 June 2008 – found with a ligature
16 July 2008 – superficial cuts
21 July 2008 – banging head on cell wall and found with a ligature
28 July 2008 – found with a ligature

36 Review of Recent Mental Health Issues and Mental Health Care

37 (A) Mental Health Issues

38 The first evidence that Mr Bell may have had mental health difficulties would appear to be an episode of self-harm on 8 April 2008. In response to this an IMR 12 was raised followed by a PAR 1 being opened on the same day. The PAR 1 remained opened until Mr Bell's death on 31 July 2008. Over the intervening interval there are approximately 130 entries into the medical records, the great majority of which related to Mr Bell's behaviour and mental health issues. From the outset Mr Bell's concern and preoccupation was his personal safety. For example on 8 April 2008 he requested to be moved out of house and to the prison hospital. On 11 April the records note that Mr Bell appeared "agitated and believed that other prisoners think he [text redacted]. Wants to move to the hospital".

39 **The first medical entry** is by the prison doctor on 15 April in which he reports "he claims he heard of plans by others in Bann to get him. He alleges it is because he has been accused of being [text redacted] both inside and outside prison ....wrongly he says. He refers to paramilitaries in this context. He also describes a number of assaults in the past [text redacted] quite vividly even though they occurred a number of years ago when outside prison". The prison doctor describes Mr Bell as "very ill at ease. Restless. Very keen to say he is not imagining how he is under threat. Talks in very agitated terms". The prison doctor suggested that Mr Bell may have PTSD.

40 **The first specialist psychiatric assessment** was carried out by a career grade psychiatrist on 15 April 2008. The entry indicates a consistency in Mr Bell's concerns about his personal safety. The psychiatrist notes that Mr Bell's explanation for the two episodes of self-harm were expressly to achieve a move out of present cell situation. The psychiatrist notes that when previously assessed by 2 other doctors no diagnosis of mental illness was made at that time. He is described at the time of assessment as "mildly anxious", but "no evidence of mood disorder". While the psychiatrist notes Mr Bell's concern "in relation to personal safety" from her assessment concludes that "there is no evidence that this is delusional in origin". She expressly notes no evidence of symptoms and phenomena typically of a psychotic illness such as schizophrenia (for example no passivity, no hallucinations). She concluded that "there is no evidence of the presence of a significant mental illness". She advises on a brief admission to stabilise Mr Bell, that there were no indications for psychotropic medication but that Mr Bell should continue on a PAR 1.

41 **The first multi-disciplinary Safer Custody meeting** was held in Bush House on 15 May 2008. I note that this meeting was attended by a Nurse and member of Healthcare. Mr Bell was described as having "anxiety issues" but that "his fears of assault are unfounded". It was proposed that the Mental Health Team would see him and provide support following a proposed move to Bush. Plans were also in place to ensure that Mr Bell could get to occupational therapy (OT).

42 The psychiatrist carried out four further assessments of Mr Bell – 2 May, 17 June, 8 July and 11 July 2008. Mr Bell was also assessed by a Specialist Registrar in Psychiatry on 29 May 2008. The records also state (1 July 2008 – Nurse) that prison psychiatrist saw and assessed Mr Bell on 1 July 2008.

43 During Mr Bell's brief transfer to Belfast City Hospital he was seen by a consultant psychiatrist on 25 June 2008. The psychiatrist expressed the view that Mr Bell was suffering considerable distress. The psychiatrist however was unclear if this was either a situational reaction, some form of manipulation or some form of psychotic

disorder. He advised a further assessment within the Healthcare Centre.

44 **Pattern of self-harming.** Over the 4 month period in question there is documented evidence of 15 separate instances of self-harm or threats of self-harm before the series of incidents on 31 July culminating in Mr Bell's death. Time line analysis reveals a clear clustering with a total of 4 clusters. At least one instance in each cluster consisted of attempted hanging or the preparation of a ligature that would likely have led to attempted self-hanging. Cluster one, consisting of 3 episodes of self-harm occurred over a 2 week period in mid-April. The second cluster consisting of 6 instances of self-harm occurred over a 2 week period in the second half of May. The third cluster consisting of 3 episodes occurred over a 5 day period in mid-June. The fourth cluster, of 3 episodes prior to 31 July, 4 attempts on 31 July and the fifth and final episode resulting in Mr Bell's death. This fourth cluster occurred over a 2 week period in the second half of July.

45 There were substantial periods between each cluster when there was no clear evidence of self-harming consisting of just over 3 weeks between cluster one and two, approximately 2 weeks between cluster two and three and approximately 4 weeks between cluster three and four.

46 From the frequency distribution of attempts at self-harm there is no obvious escalation or overall change in the pattern from month to month. However the episodes in late July occurred against a background of increased use of Safer Cells, in which head banging occurred for the first time and the use of ligatures occurred on 2 separate occasions, 16 and 31 July. The series on 31 July revealed several episodes of self-harm before Mr Bell succumbed during the fifth attempt.

47 The impression of the problems presented to prison staff by Mr Bell by late June is reflected in an email communication from the Lifer Governor (23 June 2008). He states that since Mr Bell's return to the main prison he has presented "as a difficult case, attempting self-harm/threatening self-harm. The most serious incident was an attempt to hang himself during the early hours of 16 May. Only the very prompt actions by staff saved his life. Since this period he has been managed under the watchful eye of Safer Custody. As yet, it has not been possible to relocate him to a normal cell environment because of his repeated references to his perception that he is going to be killed and raped".

48 While the dominant characteristics exhibited by Mr Bell have been his pre-occupation with threats to his safety and frequent attempts at self-harm, it is noted that on several occasions his behaviour could be quite normal. For example in the Safer Custody meeting report (19 June

2008) it is stated that Mr Bell's behaviour had been "quite normal yesterday". Also that he told a Reverend that if he could get back to Wilson House this would solve a lot of things.

49 **The prevailing specialist psychiatric opinion** appears to be that Mr Bell was not suffering from a psychotic illness or a depressive illness, that he was stressed and distressed, the prison psychiatrist described him as paranoid. Another psychiatrist in her more dynamic formulation on 17 June 2006 suggests that while there is no evidence of a significant mental illness namely mood disorder or psychosis there is evidence of threatened and actual deliberate self-harm being used as a means to obtain secondary gain. She expresses a view that this may be an enduring and integral part of Mr Bell's personality. That under situations of perceived threat or unmet need he may resort to these emergent behaviours.

50 In his letter to the Lifer Management Unit (26 June 2008) the prison doctor summarises the ongoing behavioural problems presented by Mr Bell including a number of acts of self-harm noting that one of these could have been fatal without timely interventions. He notes however that Mr Bell does not express a definite wish to die and that after one episode of self-inflicted wounding said it was to effect a move. While considering him to be pre-occupied by perceptions of threats to his safety including that his food had been tampered with, the prison doctor reports "no definite findings have been made as to the underlying condition". He understands that the prison doctor is to be approached to carry out an examination and that another psychiatrist may be approached to prepare a report.

51 While I have not seen any report prepared by the prison psychiatrist the entry by a Nurse on 1 July states that "the prison psychiatrist is under the impression Colin is low IQ, had been well supported in Wilson, and after the incident with the picture frame Colin has become highly stressed, this manifesting in him being paranoid but not mentally unwell. Is at risk of DSH and a case conference needs to be called to see how best to move forward to maintain Colin safely". It is stated that the prison psychiatrist was to send a letter to the Lifer Governor on this issue.

52 (B) Interventions

53 **PAR 1.** One of the most fundamental categories of interventions in relation to Mr Bell has been management of his safety in relation to self-harm. This began with the early introduction of a PAR 1 form and was maintained over the interval until his death. The provisions for his safety introduced over the period included substantial use of the Safer Cell arrangement together with the observational arrangements in Healthcare.

54 I note there were a number of multi-disciplinary case conferences. The first was on 22 May 2008 in relation to the present round of difficulties. These were all attended by a nurse from Healthcare. There is no evidence that any medical staff attended these meetings.

55 Multi-disciplinary case conferences were held to consider Mr Bell on the following occasions:
25 April 2008
9, 15, 22, 23 May 2008
12, 16, 19, 25 June 2008
3, 10, 17, 24 July 2008

56 Safer Custody meetings were held on the following dates:
15, 22 May 2008
12, 19 June 2008
10, 24 July 2008

57 At the 25 June meeting the general social and activity needs of Mr Bell were recognised in relation to his management while at the same time keeping him safe.

58 A further multi-disciplinary case conference was held one week later on 3 July at which it had been noted that Mr Bell was allowed to dress in his normal clothes during the day, attend the hospital and take part in activities. A progression away from the more high intense observations and security arrangements were planned for dependent on Mr Bell's progress. Significantly Mr Bell was invited to the meeting together with his parents. The boundary conditions in relation to further instances of self-harm the consequences of return to a Safer Cell appear to have been explained to Mr Bell at the meeting.

59 Use of Healthcare. From review of the health records Mr Bell was either in Healthcare or seen by Healthcare staff on a majority of days in April through to 31 July. This included a total of 18 out of 23 possible days in April (the first incident of self-harm being 8 April), 21 out of 28 days in May (he spent 3 days at BCH), 22 out of 30 days in June and 19 days out of 31 days in July. He was seen on 31 July by a Doctor.

60 Medication. In addition to these social and behavioural interventions Healthcare prescribed the antipsychotic major tranquiliser Olanzapine, 5 mg daily. This appears to have been introduced on 7 June. There appear to have been problems with Mr Bell's compliance, for example refusing medication on 27 June and again on 9 July. Whilst agreeing to change to oral rather than liquid medication he was observed to spit his medication down the toilet on 20 July. The use of a major tranquiliser for symptom relief including reduction of anxiety and agitation and for possible impact on paranoid ideas was entirely reasonable. There is no evidence however that this had any therapeutic effect. This may in part be related to non-compliance.

61 **Specialist Opinion.** The Lifer Governor in his email of 23 June considered Mr Bell as "a very urgent case" and sought an early assessment from an external consultant psychiatrist. In an email reply of 23 June the consultant psychiatrist indicates leave commitments until 21 July but had discussed Mr Bell with the prison psychiatrist who gave the assurance that Mr Bell will remain in Healthcare until assessment upon return. I can find no evidence that the consultant psychiatrist did actually see or assess Mr Bell on return from leave.

62 **(C) Review of CCTV footage for 31 July**

63 From my review of the CCTV prisoner observation footage I have made the following observations. In the morning period between approximately 9.30 am and midday there are several occasions when Mr Bell can be seen making a ligature, putting a ligature around his neck and taking it off. My estimate is that there are approximately 23 minutes over this period when such behaviour is clearly visible from the recorded material.

64 Second during the evening period around 11.00 pm Mr Bell is seen to make four definite suicidal attempts at hanging. My estimate is that these are clearly visible over 10 minutes of a continuous 13 minute interval.

65 My third observation relates to Mr Bell's completed act of suicide. At 23.41 Mr Bell hangs himself from a ligature which he has attached to the cell door. All movements appear to cease about 3 minutes later. My estimate that it is 38 minutes later before there is any outside intervention. The first consists of a torch being shone through the lower observation panel at 00.19 1 August. It is a further 4 minutes, at 00.23, that the door is opened and Mr Bell is attended to.

66 CCTV footage of secure pod in Lagan House 31 July 2008. I have been provided with a transcript of review of footage between 21.10 and 02.00. I note at 23.00 that an officer is observed monitoring Safer Cells. At 23.03 an officer appears to be watching TV and at 23.15 officer walks to monitor and uses phone. It was during this period that Mr Bell made four attempts at hanging.

67 I also note that at 23.16 an officer places a mattress or duvet on the floor, turns the light out and appears to be watching TV. Further that at 23.27 the officer lies down on the mattress and pulls cover over him. At 23.31 another officer enters the room and both are chatting. At 23.35 an officer makes tea/coffee for his colleague; between 23.35 and 23.59 the two officers are chatting beside the computer – it was during this period that Mr Bell died by hanging.

68 Relevant personal history

69 I have relied on the reports of a Professor of Psychiatry (17 May 2004) and the prison consultant psychiatrist (12 October 2004) for information regarding Mr Bell's personal history. Although I did not have direct access to GP medical records these were reviewed by the prison psychiatrist for the period prior to committal in 2003. Since then Mr Bell would have been within the prison system and I have relied on the prison medical and other records for this purpose.

70 From Mr Bell's account to the prison psychiatrist he was born in Belfast, [text redacted], being brought up together in the family home by both parents……He described "rowing a lot" during childhood and that his mother had been unable to control his behaviour from an early age. He denied being neglected or abused in any way as a child. He described "very good" relationships with both parents and siblings [text redacted].

71 Mr Bell reported that during primary school years he had been transferred to Harberton Special School when he was 7 years old. During secondary school he had been disciplined repeatedly because of disruptive and defiant behaviour in class and fights with other pupils. He reported that he left school at 17 with no formal qualifications and without basic literacy skills. The Professor in his reports states that there had been a number of estimates of IQ ranging from ESN to lower average and he suspected some form of dyslexia. There was also a history of being hyperactive at school.

72 On leaving school Mr Bell attended a YTP scheme but was excluded for being disruptive. Since then he has been unemployed.

73 Relationships. Mr Bell reported to the prison psychiatrist in 2004 that his longest relationship had been with his ex-partner….. [text redacted]…….

74 Alcohol and drugs. Mr Bell acknowledged that he started drinking when 14 and began taking drugs 2 years later. He stated that he had used speed (amphetamine sulphate), acid (LSD), E's (MDMA) and blow (cannabis). He stated that he would typically smoke something in the order of 2 ozs of cannabis per week at the time of interview.

75 Mr Bell also described drinking excessively when not in custody, drinking up to 24 bottles of lager a day. He described a history of tremulousness, blackouts and night sweats typically of alcohol withdrawal. The prison consultant psychiatrist administered the Short Alcohol Dependence questionnaire with a score indicating significant alcohol dependence.

76 **Forensic history.** The criminal record summary, within the bundle of papers provided (Binder 2) shows that between 1991 and 2004 Mr Bell had a number of convictions including 4 traffic offences [text redacted]. Mr Bell had in fact left prison in late February 2003, 2 days before his last criminal offence in March 2003.

77 **Previous health history.** From the prison psychiatrist review of General Practitioner records Mr Bell does not appear to have had any significant previous physical health problems.

78 However there are a number of mental health related issues. At 11 years of age he was admitted to BCH with soft tissue injuries to the head attributed to "being beaten up".

79 He is described by his GP as being of low IQ and with difficulty reading and writing.

80 In 1995 he suffered multiple stab wounds.

81 In 1996 he is stated to have informed his GP that he had been smoking cannabis for about 7 years and also admitted to using psycho-active substances. He attended the local community addiction services between December 1996 and again in 1998, discharged on both occasions due to failure to keep appointments.

82 Mr Bell's GP noted repeated requests for Benzodiazepine medication in 2000 and for "strong painkillers".

83 In 1999 Mr Bell presented to his General Practitioner with low mood and poor sleep, "paranoid ideas". He was worried about his personal safety. He described having to leave his previous area due to accusations and paramilitary threats. Mr Bell had attended anger management sessions [text redacted].. Antidepressant medication was prescribed by his General Practitioner in 1999 but he failed to attend counselling provided by community psychiatric services.

84 Mr Bell attended his GP in May 2000 with ongoing symptoms of anxiety and depression considered to be related to "paramilitary threats". There was ongoing misuse of psycho-active substances. However there was no evidence noted of disturbance of Mr Bell's mood or mental state to suggest clinically significant depressive disorder or active mental illness.

85 Mr Bell's General Practitioner re-referred him to Community Psychiatric Services in March 2002. It was considered at that time that personality and relative lack of personal resources were significant factors

in his difficulties. He was however discharged from Community Psychiatric Services due to failure to attend.

86 Reviewing the prison medical records for 2003, 2004 Mr Bell sought medical advice regarding insomnia during the months following committal. Propranolol was prescribed to reduce anxiety and the antidepressant Cipramil was prescribed in July 2004. The antidepressant Effexor was introduced in September 2004.

87 The prison consultant psychiatrist in his report of 8 February 2005 stated that Mr Bell had been placed within the psychiatric unit at the prison, following an attempted hanging on 15 January 2005. While not showing symptoms of formal mental illness he was expressing concern regarding his personal safety. He attributed the origins of this back some years when he had been accused by a paramilitary organisation of passing information to MI5. He thought that since coming into hospital old animosities had been rekindled and that he had been referred to as [text redacted]. He had concerns that he would be killed if he returned to the wing. He expressed a wish for transfer to a prison in England.

88 Mr Bell's distress, disturbed behaviour and perception appear to have settled spontaneously. For example on 8 April 2005 a Nurse states that Mr Bell had reported being "OK" and had no problems. He appeared keen to get back to the education room and it was decided that no further follow-up was required.

89 On 30 August 2006 Mr Bell was referred to Healthcare because of becoming increasingly paranoid and with bizarre behaviour. At assessment on 31 August no abnormalities of mental state were found and he was discharged.

90 In November 2006 he was again referred to Healthcare because of concerns of other inmates that he was feeling fed up and suicidal. A prison officer also reported that he admitted to feeling depressed at times. On assessment he was anxious but there was no evidence of thoughts of self-harm. A PAR 1 form had been opened on 26th and closed on 28th.

91 Between February 2007 and April 2008 Mr Bell was seen on approximately 30 occasions by Healthcare. Apart from requesting to see a nurse on 17 February and being allowed to "ventilate" all other entries were for explicitly minor physical health reasons only.

92 Personality. As noted above Mr Bell appears to have had limited intellectual abilities and it was thought that his IQ level fell within the borderline category. It was also thought he may have been dyslexic. He was illiterate.

93 Mr Bell had significant conduct and behavioural problems during schooling and continued to display maladaptive behaviour during adult life. Both in his criminal behaviour and substance misuse there is a strong impression of impulsivity. Mr Bell also acknowledged with the prison consultant psychiatrist [text redacted] and that he had been prone to feeling "nervy" and "paranoid" in situations that involved mixing with unfamiliar people, including the prison environment. He also reported to being prone to periods of low mood.

94 A pyschologist (24 September 2007) carried out a risk assessment on Mr Bell. On the Hare Psycopathy Checklist Mr Bell score fell within the 70th percentile placing him above the average range compared with a normal sample of UK male offenders. On the second factor of this Scale, reflecting features of psychopathy associated with impulsiveness, antisocial and unstable lifestyle he scored at the 88th percentile. The psychologist thought that this reflected Mr Bell's high level of antisocial behaviour prior to entry into prison and linked to impulsivity and the need for stimulation. Nevertheless the psychologist noted that Mr Bell had never been formally assessed for the presence of personality disorder. The psychologist concluded from his assessment that there was a moderate level of Mr Bell acting in a violent way in the future while he remained in prison and a moderate/high risk should he be considered for release at that point in time.

95 Prison staff training and prison provision

96 I note from the policy documents that a listener scheme has been introduced to Maghaberry in December 2006 in conjunction with access to Samaritans. Five prisoners have been trained over a period of 8 weeks and were supported by the Samaritans.

97 I also note that Maghaberry Prison has established a new REACH Unit (Reaching Prisoners through Engagement, Assessment, Collaborative Working, Holistic Approach) to provide a therapeutic environment for prisoners who may be assessed as vulnerable or poor at coping. These facilities were available in the Lagan House and included a dedicated psychologist to work with staff. There were also two Safer Cells and a Listener Cell. I note that managers and officers who volunteered to work in REACH received 2 weeks intensive training at the prison.

98 SUMMARY AND OPINION

99 Nature of Mental Health and Behavioural Problems

100 From the documented records of prison officer staff, Governors and healthcare staff it is quite clear that Mr Colin Bell's behaviour became

markedly disturbed beginning 8 April 2008. Over approximately a 4 month period there are numerous documented instances of self-harm including attempted hanging. Associated with this behavioural disturbance Mr Bell consistently expressed concerns about his personal safety. This change is clearly timed from his relocation back from a low secure situation to more secure accommodation.

101 The overall impression is that on the one hand Mr Bell was not suffering from any serious psychotic illness nor was he seriously clinically depressed. On the other hand there is definite evidence that he was quite paranoid and pre-occupied by threats of self-harm. A psychiatrist questions whether these were actual delusions or not. Her view that this was part of Mr Bell's enduring personality such that under situations of perceived threat or other unmet need he may resort to these emergent behaviours is, in my opinion, a reasonable analysis of the likely processes that may have been underpinning Mr Bell's behavioural disturbance. I expect the loss of privileges and change in circumstances resulting from Mr Bell's misdemeanour in March was a devastating experience for him, within the context of his life situation in prison. That he showed similar behavioural responses including anxiety and pre-occupation of being under threat in response to other situational stresses in 2004 and 2005 are consistent with an underlying personal vulnerability to this kind of response.

102 Mr Bell acknowledged in his interviews that in addition to anxiety about threat he was also experiencing anger feelings. I expect Mr Bell's anger and frustration at the devastating loss of privileges in March 2008, given his personal make-up and personality vulnerability, would be sufficient to trigger a paranoid response and an eruption of misperceptions that he was being persecuted. That he fixes on a paramilitary basis, would be consistent with his socio-cultural background and indeed may have some historical validity, while without any basis in reality with respect to his then current prison situation. The threat had been considered and excluded by prison staff.

103 Issues related to Mr Bell's personality make-up and personal vulnerability are I believe relevant to understanding the nature of the disturbance in his behaviour. As noted above there have been previous instances during the present committal when he has expressed similar concerns regarding his personal safety and which have been associated with self-harming. Problems in relation to impulse control and impulsivity were noted by the prison psychiatrist in his assessment in 2004. The psychologist in his risk assessment in 2007 found psychological test evidence of psycopathy associated with an impulsive, anti-social and unstable lifestyle and reflecting Mr Bell's high level of anti-social behaviour prior to entry into prison, juvenile delinquency, early behavioural problems. It should be noted that his overall score on the Hare Psychopathy Checklist fell at the 70th

percentile compared with a sample of UK male offenders and much higher in scores related to impulsivity.

104 It should be noted that in contrast to Mr Bell's antisocial behaviour and the number of incidents and offences during the period prior to the most recent committal in 2003 sits in significant contrast to the relative stability of Mr Bell's behaviour and social functioning over almost all of the period 2003 until April 2008. This would suggest that the prison mellieu including the supports provided may have had a positive effect in moderating Mr Bell's history of impulsivity and psychopathy. He progressed in that his risk was considered to be sufficiently low to be moved to the low risk area in 2007.

105 I expect there is a link between the serious episode of attempted hanging on 25 May and the adjudication decision on 16 May regarding his offence in March which led to his relocation out of Wilson House. In addition to anxiety expressed by Mr Bell during the period of increased disturbance between April and July 2008 there was also evidence of anger and expression of anger (example healthcare records for 18 June and 24 July).

106 There is also evidence that Mr Bell was manipulative. This is suggested for example in refusing to speak to one listener and subsequently requesting another. Another is the request to move out of his own Safer Cell to the one next door. On at least one occasion he indicated that a move back to Wilson House would make a difference.

107 Mental health care for period 5 March 2003 – 7 April 2008

108 The initial reception health screen appropriately documents a previous history of accessing mental health services. During the pre-trial period Mr Bell complained intermittently of sleep difficulty and was appropriately prescribed night time sedation for a short period only on each occasion. This was an appropriate response to his needs.

109 Following sentencing in late 2004 Mr Bell again became unsettled. There are healthcare reviews beginning the day after sentencing (23 November 2004) and on the 26th was prescribed the minor tranquiliser Diazepam for one week. He was reviewed one week later and the dosage reduced. The level of monitoring and medication prescription was in my opinion appropriate for such a situation.

110 Mr Bell engaged in an episode of attempted hanging on 15 January 2005 and was reviewed by Healthcare staff that same day. He was placed on a PAR 1 and reviewed on 17th and again 18th. He was subsequently seen by a Doctor (undated but prior to 28th January) and by a consultant psychiatrist on 8 February who provided a detailed psychiatric assessment. He communicated his impressions to the Prison Governor, in particular the need to clarify any actual threats of

self-harm given Mr Bell's concerns. On 23 February a Governor attended the ward area and provided the necessary reassurance. Overall this is in my opinion an appropriate series of responses to Mr Bell's mental health needs.

111 On 26 November Mr Bell appears to have been feeling somewhat low and a PAR 1 form was opened for 2 days only. When medically reviewed on 4 December he was considered mentally well. Night sedation was provided for 4 days. The reactions and interventions over this minor incident were in my opinion appropriate.

112 Mental health care for the period 8 April 2008 – 31 July 2008

113 The challenge presented in the face of Mr Bell's determination to self-harm was considerable for prison staff and healthcare staff.

114 One of the earliest responses to Mr Bell's first act of self-harm during this period was the opening of a PAR 1. This was done promptly and appropriately was maintained open throughout this high risk period. Healthcare team involvement was also prompt, also beginning on the day of this incident. There is in my opinion good documentation of the problems presented by Mr Bell over subsequent days. It would appear that a Senior Nursing Officer advised that Mr Bell did not have a mental illness. It is not clear on what basis this was made at this time and in my opinion does seem somewhat premature.

115 An attempted hanging occurred on 12 April and the Healthcare entry on that day notes Mr Bell was both agitated and paranoid. He was placed in the hospital ward and in protective clothing in an Observation Cell which seemed an appropriate response to the risks presented by this behaviour.

116 On 15 April Mr Bell received his first specialist psychiatric assessment by a psychiatrist who provided a comprehensive report in the Healthcare records. The opinion of this staff grade psychiatrist was that Mr Bell did not present any evidence of a significant mental illness although was mildly anxious. Based on the factual information presented in this doctor's report I would agree with her conclusion regarding the absence of significant mental illness.

117 As noted in my factual review, over subsequent weeks Healthcare staff were heavily involved almost on a daily basis with Mr Bell's care. They also participated in both Safer Cell review meetings and multi-disciplinary case conferences. It would seem that Healthcare's main contributions were one of observation, the provision of occupational therapy and general support to Mr Bell, which was entirely appropriate.

118 In addition antipsychotic medication Olanzapine was introduced in June 2008. While the prevailing clinical view was that Mr Bell did not

present with any major mental illness the use of a major tranquiliser was in my opinion entirely appropriate. Such medication can be used to reduce anxiety. Further there was a view, expressed by a consultant psychiatrist that Mr Bell's mental state was also characterised by one of paranoia. I believe this to be consistent with Mr Bell's ongoing concerns which from all available evidence had no basis in reality. A trial of Olanzapine or similar antipsychotic medication would be appropriate as a possible means of dampening down such abnormal thinking. There were problems with compliance although I note that continuing attempts were made to encourage Mr Bell to take medication. From the documentation there is no evidence that Mr Bell's mental state actually improved or that he benefitted from this. It is unclear from the medical notes to what extent the dosage was reviewed and consideration given to an increased dosage of medication.

119 When Mr Bell was transferred to Belfast City Hospital he was seen by a consultant psychiatrist within 24 hours and a report prepared. Written in May 2008 it gives a very reasonable view of a differential diagnosis based on the limited information available at that time.

120 While I note consistent Healthcare staff input to all multi-disciplinary meetings there is no evidence of any medical input. It is clear from the reports of individual staff and from case conference minutes that Mr Bell's behaviour was providing a significant challenge for all staff. A Governor sought the assistance of an external consultant psychiatrist on 23 June 2008. Unfortunately the psychiatrist was on leave until 21 July. While the psychiatrist indicated an intention to assess Mr Bell on return there is no documented evidence that such an assessment was carried out. This is regrettable. Nevertheless the external psychiatrist did liaise with the prison psychiatrist before going on leave who agreed to keep Mr Bell in Healthcare until the external psychiatrist returned. The first consultant psychiatrist assessment of Mr Bell within the prison system appears to have taken place around 1 July. This is evidenced by the entry of a Nurse (1 July 2008). The Nurse states that a letter was to be sent to the Lifer Governor. There is no evidence in the notes of the prison consultant psychiatrist's assessment or letter to the Lifer Governor.

121 From review of the documentation it is clear that Mr Bell's self-harming behaviour and his ability to self-harm in spite of the surveillance efforts of staff presented a major challenge in managing the risks he presented to his own safety. I believe the recourse to use of Observation Cells and Safer Cells on an increasingly frequent basis was a reasonable response to what seems to have been an escalating problem. In the absence of some alternative management strategy for Mr Bell's concerns, perceptions, anxieties, distress and self-harming behaviour, there was little alternative, in my opinion, than the use by staff of these Cells. It was also clear that on many occasions Mr Bell

himself requested and wished to be placed in a Safer Cell for his own perceived security needs.

122 Mr Bell was seen on at least five occasions by specialist psychiatric doctors the last occasion being 11 July. On that occasion the psychiatrist assured herself that Mr Bell understood the process involving his safe return to Wilson House which appeared to be his wish. She reasonably considered discontinuation of antipsychotic medication although it was later recommenced. She encouraged Mr Bell to ventilate his feelings and considered him suitable to transfer to Glen House in accordance with a previous discharge plan. In medical terms this was a reasonable set of proposals for managing Mr Bell. Nevertheless discipline staff were left with a very difficult situation.

123 It is clear that on occasions Mr Bell was manipulative. Mr Bell's behaviour must also be understood in the context of what I expect was a catastrophic situation for him, albeit as the result of his own misbehaviour in March 2008. Given Mr Bell's nature, as evidenced by his previous history and other evidence of impulsivity and psychopathy, regression of behaviour, eruption of emotional disturbance (including both anger and anxiety) and paranoid ideation can be readily explained and understood. Further disruption and deterioration, reflected in the serious incident of self-harm in late May, shortly after the adjudication of his March misdemeanour can also be understood.

124 From a mental illness perspective I do not think there was more that medical management could have contributed to the present situation. However specialist psychodynamic, psychological, input to the deliberations of the multi-disciplinary team, particularly as the situation became so difficult would likely have been of assistance. A psychodynamic understanding of Mr Bell's anxiety, anger, concerns and behavioural disturbance might have provided alternative strategies for managing this situation.

125 Over a period of weeks Mr Bell was disciplined on several occasions for his behaviours. From a health perspective managing such behaviours in this way is generally counter-productive. Although these instances do not appear to have been formally adjudicated on, over the period in question it is highly likely that Mr Bell would have perceived his behaviour as a struggle with prison staff (e.g. refusing medication, destroying a blanket to make a ligature to self-harm). He was also actively continuing attempts at self-harm.

126 Mr Bell's determination in making ligatures and attempting self-harm appear to have intensified over the period beginning 23 July. In spite of being in a Safer Cell situation he succeeded in making ligatures and attempting self-harm including attempted hanging.

127 It is my impression that something of a power struggle was developing within this situation. This is part reflected in Mr Bell's increasing determination and success at self-harming while under such Safe Cell/Observation Cell arrangements. It is also reflected in staff attitude for example on 24 July a minute of the Safer Cell meeting (24 July 2008) "each time he reaches a certain point in the plan and then misbehaves, he goes back to the beginning etc. He does not like Safer Cell so each time he misbehaves, he will remain a further day until he realises he is not the winner".

128 One must recognise the extreme difficulties for staff in this situation, where a prisoner seems so intent at self-harming for whatever reason. On the other hand it is clear that Mr Bell until his final demise persisted in his concern about feeling unsafe and that it would be better to take his own life than that imagined others might take his life. In general terms it is likely that both psychopathic and neurotic aspects of Mr Bell's personality were playing out in this situation.

129 Senior prison staff were clearly keen to get expert advice on Mr Bell's management. While it is impossible to predict what impact such advice would have had on this difficult situation I consider such input as an important ingredient in situations where prisoners present difficult emotional, behavioural and management problems.

130 Use of Safer Cells and Observation Rooms

131 It would appear that recourse to Safer Cells and Observation Rooms were in the majority of instances responses to the risk posed by Mr Bell although on some occasions they were actually requested by Mr Bell.

132 The overall ethos in the use of the Safe Cell provision for Mr Bell is I believe captured in the notes of the various multi-disciplinary case conferences, including those attended by Mr Bell and Mr Bell's parents. For example on 25 June the meeting considered whether it was then possible to place Mr Bell into a normal cell within either the hospital setting or Glen House. "Unfortunately it was agreed that there was no evidence to suggest a change in the circumstances was in his interest". It was agreed that a period of observation was necessary. The use of the hospital provision to complement the use of Safer Cells was also reflected in these meetings. That is that Mr Bell be "escorted to the hospital in the mornings and afternoons to join in with any activity that might be ongoing. This would help him in two ways, it would relieve the boredom of sitting in his cell in isolation and would present an opportunity for Colin to build trust and then progress if appropriate". It was noted at this case conference that Mr Bell himself was "demanding and wanted more than this but accepted the outcome". In my opinion these arrangements and the process by which the arrangements were agreed were appropriate and inclusive in nature. In particular the involvement of Mr Bell and the negotiated agreement with him and his

acceptance were a constructive approach to managing the risks and Mr Bell's other needs.

133 This approach is again reflected in the subsequent case conference on 7 July which was joined by Mr Bell's parents as well as Mr Bell. The arrangement of using the Safe Cell along with hospital provision during the day was again emphasised and it was noted that this would "afford staff an opportunity to assess Colin". The proposal to use these arrangements as a stepping stone depending on Mr Bell's self-harming were emphasised and discussed with Mr Bell at the meeting. Again both the arrangements and the process by which these arrangements were arrived at seemed entirely appropriate at this stage.

134 The last documented multi-disciplinary case conference in the records was on 17 July. The ongoing risks of self-harm were noted. Problems were again noted regarding Mr Bell's feelings of "paranoia and personal safety which have been unfounded". It was considered that his behaviour was manipulative in order to achieve a move back to Wilson House. The plan to utilise Healthcare Monday to Friday morning and afternoon if possible for exercise were included within the care plan together with a referral to the prison consultant psychiatrist.

135 Review of the daily log for the period subsequent to this case conference indicate that in broad terms the daily arrangements were followed. That is Mr Bell attended Healthcare typically once only however each day usually for a 90 minute period. Other activities included visits and meetings with a prison listener. Towards the end of this period it is recorded that Mr Bell expressed boredom and distaste for the Safer Cell arrangement and requested a move which was duly implemented on 24 July when he was transferred to Glen, his requested location.

136 However late on 25 July Mr Bell again became very concerned about his safety, believing himself to be under threat from other prisoners and requested a move. The issue was reviewed and he was again moved to a Safer Cell that evening.

137 Safer Custody meeting 24 July 2008. Entry for Mr Bell states that a case conference and plan was set out at this meeting. This plan appeared to have shifted in its approach to managing Mr Bell – "each time he reaches a certain point in the plan and then misbehaves, he goes back to the beginning, etc. He does not like the Safer Cell so each time he misbehaves, he will remain for a further day until he realises he is not the winner". Such prisoner management is at variance with the purpose and ethos of Safer Cell use (see further comment below).

138 During the period 26 July – 31 July 2008 Mr Bell remained within the same Safer Cell situation. I could find no evidence that Mr Bell was

accessing Healthcare for activity, occupational therapy or for healthcare staff assessment. On the one occasion he was out for Healthcare drug testing he was discovered having ripped his jacket in the toilet and a ligature subsequently found. Mr Bell's mental state appears to have remained unchanged in relation to his concern about safety – "terrorised and other prisoners are going to get me" and "would rather do it myself than have others do it to me". Mr Bell was taken out of his Safer Cell environment for short periods on some days over this 6 day period. Nevertheless one is struck by the amount of isolation from other people that he would have experienced during this period. I can find no documented evidence of Safer Custody meetings or other multi-disciplinary reviews during this period either by Healthcare or by prison staff.

139 Review of the CCTV footage of Colin during his last days highlights the degree of isolation, boredom and barrenness of Mr Bell's living environment. Contrast this with the Healthcare entry for 26 June "Colin attended the ward today for both sessions. During this time he attended OT and participated well. He made two small craft items [text redacted]. In the afternoon session he had the opportunity to engage one to one with nursing staff". This June situation reflected his care plan from the multi-disciplinary case conferences. It was not being implemented over the 28-31 July period. This late July arrangement was having little impact on the rate or level of self-harming, was not in accord with the multidisciplinary plan and would not have been conducive to Mr Bell's mental wellbeing.

140 On 31 July Mr Bell was confined to a cell for almost the entirety of the day. From review of CCTV footage he appears to have been out of the cell for little over half an hour. He had very little contact with any person. These conditions almost amount to solitary confinement. His state of boredom is clearly evident from the CCTV footage. The CCTV footage also provides clear evidence that Mr Bell was making ligatures in the morning. There was no evidence that this issue was detected by prison staff and appropriate interventions made.

141 In the late evening Mr Bell made a number of hanging attempts over a period of 13 minutes. There is no evidence that this activity was identified by staff responsible for monitoring his state and behaviour. Given the POD CCTV footage the opposite would appear to be the case. Further evidence of the failure to adequately monitor Mr Bell is reflected in the long interval (41 minutes) between onset of Mr Bell taking his own life and the first contact being made with him thereafter.

142 Further comment on Mr Bell's care and treatment

143 From my review of documentation, the health and safety management problems presented by Mr Bell during the period April – July 2008 were both complex and challenging. Mr Bell was clearly highly distressed by

his concerns about safety. He was paranoid about his situation. He was both anxious and angry. He was manipulative. He made numerous, often serious, attempts at self-harm. In the face of increased use of Safer Cell provision his attempts at self-harm persisted. In my opinion the multi-disciplinary case conference provided a key forum for optimising Mr Bell's care and treatment over this difficult period. The care plans were in my opinion appropriate for Mr Bell's need. The involvement of Mr Bell's parents and Mr Bell is to be commended. Given the complexities and persistence of the difficulties presented by Mr Bell I expect the multi-disciplinary discussions would have benefitted from consultant psychiatrist or consultant psychologist input. I note that the opinion of a consultant psychiatrist had been sought as a matter of urgency.

144 It is my impression that there was a degree of intensification of Mr Bell's behavioural disturbance requiring an increased use of Safer Cells. His anger with the situation as well as anxiety are evident as is his manipulation, for example refusing medication, wanting night medication, refusing a listener, wanting another listener, wanting to change Safer Cells. That such behaviour would have been difficult to manage I am in no doubt. It is my impression that in this context there appears to have been something of a power struggle. I believe this is reflected in the language of the last Safer Custody Report (24 July 2007) where the stated policy for managing Colin at that time was to use the Safer Cell as a negative reinforcer for his misbehaviour and to prove to him he is "not the winner".

145 I am of the view that such a situation reflects the needs of staff in managing such situations in terms of support, supervision and training. Such situations would I believe greatly benefit from expert support and supervision from professionals with appropriate psychological, psychotherapeutic and psychodynamic understanding and expertise.

146 Policies and Procedures

147 I have had the opportunity to review the policies and procedures including Observation Cell, Safer Cell and REACH training. It is my impression that since my formal review of non-natural deaths in our prison services, reported on in 2005, there has been a significant development of these policies. The listener scheme and REACH Unit are in particular to be commended, including the training provided for staff. The multi-disciplinary approach to dealing with healthcare issues is also to be commended.

148 I expect senior prison staff would benefit from further training in mental health awareness for example the Advanced Awareness programme based at the Portman Hospital led by a former Governor Pentonville Prison.

Roy McClelland
Emeritus Professor of Mental Health,
Consultant Psychiatrist

APPENDIX 1

TERMS OF REFERENCE

To review Mr Bell's medical healthcare for the whole time in prison;

To review Mr Bell's mental healthcare, level of provision while on PAR 1's or in Observation Cell and interventions;

To consider Mr Bell's location history while in prison particularly in relation to placing him in Observation Cells;

To consider how appropriate it is to retain a prisoner in an Observation Cell for prolonged periods;

To give a view on CCTV footage for 31 July/1 August with regard to Mr Bell's actions, state of mind and treatment.

APPENDIX 2

BRIEF CURRICULUM VITAE

ROY J Mc CLELLAND, OBE

School of Medicine, Dentistry & Biomedical Sciences

Queen's University Belfast

QUALIFICATIONS:

MB BCh BAO
1967
MD (Research, Queen's University Belfast)
1971
Member Royal College of Psychiatrists (London)
1974
Diploma of Electrical Engineering Applied to Medicine
1976
PhD (University of London)
1982
Fellow Royal College of Psychiatrists (London)
1984
Order of the British Empire for Services to Medicine
2008

PRINICIPAL APPOINTMENTS CURRENT AND RECENT

Consultant Psychiatrist, Belfast City Hospital
1976 –
Chairman Board for Mental Health and Learning Disability (NI)
2007 –
Professor of Mental Health, Queen's University Belfast
1984 – 2004
Emeritus Professor of Mental Health
2004 –
Chairman, Royal College of Psychiatrists' Confidentiality Advisory Group
1996 –
Chairman, Healing Through Remembering Initiative (NI)
2000 – 2007
Chairman, Review of Mental Health and Learning Disability (NI)
2006 – 2007
Chairman, Privacy Advisory Committee (NI)
2006 –
Member, Patient Information Advisory Group, Dept of Health, London
2005 –

Member, Board of Trustees, Northern Ireland Centre for Trauma and
2002 – Transformation

TRAINING

Following internship in 1968 I joined staff at the Department of Physiology Queen's University Belfast for 3 years as lecturer in physiology. I entered residency training in psychiatry in 1970 first at the academic Department of Mental Health, then at the Maudsley Hospital London in 1971. Before returning to Belfast in 1976 as a Consultant Psychiatrist and Associate Professor, I spent one year at the Department of Engineering Applied to Medicine training in quantitative neurophysiology.

RESEARCH

With over 200 peer-reviewed publications the main focus of recent Research and Development work has been as a Principal Investigator in epidemiological and health services research, including studies of head injury:
Epidemiological studies of mental illness – grant income totalling £120,000, main source DHSS(NI), Lead Investigator.
Suicide research – grant income totalling £420,000, chiefly DHSS(NI),Health Research Board (Dublin) and European Commission, NI Lead Investigator.
Development of European Standards and Practice Guidelines in Confidentiality for Healthcare – grant allocation €634,000 EU 5th Framework, Lead Investigator. This initiative was awarded the Geneva Prize on Human Rights in Psychiatry.

TEACHING

University. Over the past 30 years I have been deeply involved in medical and health professional education at undergraduate, postgraduate and CPD levels. In addition to core psychiatry teaching my focus has been on information sharing, interpersonal and communication skills and healthcare ethics. This work has included responsibility for the undergraduate core curriculum in psychiatry, Director of postgraduate psychiatric training and development and delivery of communication skills training in the undergraduate medical curriculum. I have been closely involved with the establishment of several postgraduate degree programmes including an inter-faculty MA in Medical Ethics and Law, Masters degree in Psychotherapy, Masters in Addictions, Diploma in Mental Health for GP trainees and Diploma in Cognitive Therapy.

National. In addition to extensive external examining work over the past 25 years I have been closely involved with the Royal College of Psychiatrists' educational programme as a former Chairman of the Overseas Doctors' Training Committee, sub-Dean, member of the College's Educational Strategy Group and Education Committee.

CLINICAL PRACTICE

Neuropsychiatry Services. Since my appointment as Consultant in the Academic Department at Queen's in 1976 I have been responsible for the development of neuropsychiatric services in Northern Ireland in collaboration with colleagues in the Departments of Neurology and Neurosurgery at the Royal Victoria Hospital Belfast. Current services include an out-patient service and inpatient Brain Injury Rehabilitation Unit serving Northern Ireland and receiving referrals from the Republic of Ireland.

During 1992 and 1993 I was commissioned by Eastern Health & Social Services Board (NI) to carry out a needs assessment of people with Brain Injury. The findings have contributed to the subsequent development of brain injury rehabilitation services in Northern Ireland. During the same period I chaired a Working Group of the Royal College of Psychiatrists responsible for developing College recommendations on services for brain injured adults in the UK.

I have been closely involved with the development of Clinical Neurophysiology services in Northern Ireland over the past 30 years. I am a trained consultant neurophysiologist providing an EEG service for psychiatrist referrals within the Eastern Health Board (population 700,000).

Trauma Services. I have been closely involved with the establishment and development of the Northern Ireland Centre for Trauma and Transformation as a trustee and medical member of its Board. The Centre was established as a charitable trust in 2002 to build upon the therapeutic work undertaken by the public sector mental health services after the bombing in Omagh in August 1998. This event was the largest single event associated with the recent years of conflict in Northern Ireland and besides 31 deaths and over 400 injuries, thousands of people had been exposed to traumatic experiences. A special team was established to address the psychological, mental health and associated practical and social needs of people involved in the tragedy.

The Centre sees on average 200 referrals each year. The team, with the support of Professors David Clark and Anke Ehlers from Oxford University developed a trauma focussed cognitive therapy programme for people suffering post-traumatic stress disorders and other trauma related disorders.

The Centre has also established a humanitarian programme. The Centre developed relationships with the emergency services in New York that had been affected by and involved in the response to the events of 9/11. Following a visit by the Centre staff to New York in 2003, a visit to Omagh by staff care therapists from the NYPD, the Fire Department and the Port Authority, took place in 2004 and was followed up by a workshop in New York in 2005. Following the tsunami of 2004 staff have been involved in the training of mental health practitioners in Columbo Sri Lanka. In 2006 training staff went to Sarajevo to train mental health practitioners who were dealing

with the consequences of the siege of the city in 1992-93. The Centre's current programme is in Nepal working with the Leprosy Mission Ireland in the development of trauma focussed psycho-education programme for villages in two districts to the west of Kathmandu.

Expert Medical Witness. As a specialist in neuropsychiatry I have over the past thirty years had extensive experience as an expert witness and in the provision of medical reports on issues relating to brain injury and post trauma sequelae. I have also had extensive experience on the medical assessment of health care professionals for the UK General Medical and Nursing & Midwifery Councils.

ANNEX 6

SUMMARY OF EVENTS IN COLIN'S PRISON CUSTODY

FROM APRIL 2008

1. On 28 March 2008, Colin was charged with the theft of a picture frame. He was moved at 16.04 to Cell 18 on Landing 2 in Roe House, until a place in Erne House became available.

2. Colin was charged under Prison Rule 38 (13) - *"takes improperly any article belonging to another person or to a prison"*. His adjudication for this charge was heard and adjourned on 31 March on the grounds that he was seeking legal assistance.

3. Whilst in Erne House, Colin started to report to prison and healthcare staff a continual fear that he and his family were under threat from other prisoners.

4. Colin also expressed these fears to a number of outside bodies, including myself. Colin's fears were reported back to Prison Service officials with an expectation that his safety would be re-assessed.

5. Colin was subsequently moved on many occasions to other Residential Houses and Landings. From 28 March 2008, Colin was moved location **30 times**, until his final move on 26 July to Safer/Observation Cell 16 on the REACH Landing in Lagan House.

   This included

Residential House	**Cell**	**Number of days**	**Reason**
Roe 2 28.03.08 – 03.04.08	Regular	6 ½	From Wilson House following theft of picture frame
Erne 2 03.04.08 - 09.04.08	Regular	5 ½	Incident
Lagan 5 09.04.08 – 10.04.08	Safer	1	Observations following incident
Bann 4 10.04.08 – 12.04.08	Regular	2	Operational requirements
Healthcare 12.04.08 – 24.04.08	Observation	12	Observation and assessment

Healthcare 24.04.08 – 12.05.08	Observation	18	Assessment
Bush 3 12.05.08 - 16.05.08	Observation	4	Observation
Lagan 5 16.05.08 – 17.05.08	Safer	1	Observations
Bush 3 18.05.08 - 23.05.08	Observations	5	Observations
Lagan 5 23.05.08 – 25.05.08	Safer	2	Observations
Bush 3 25.05.08 – 28.05.08	Observations	3	Observations
Healthcare 28.05.08 – 05.06.08	Observations	8	Observations
Glen House 05.06.08 – 06.06.08	Vulnerable Prisoners	1	Progression – part of care plan
Healthcare 06.06.08 – 11.06.08	Observation	5	Observations
Lagan 5 11.06.08 – 16.06.08	Safer	5	Observations
Healthcare 16.06.08 – 19.06.08	Observations	3	Close Observations
Lagan 5 19.06.08 – 27.06.08	Safer	8	Observations
Lagan 5 27.06.08 – 03.07.08	Safer	6	Staff request and observations
Healthcare 03.07.08 – 08.07.08	Ward	5	Progression – part of care plan
Glen House 08.07.08 – 08.07.07	Vulnerable prisoners	½ day	Progression – but moved back for observation
Lagan 5 08.07.08 – 09.07.08	REACH	½ day	Temporary
Lagan 5 09.07.08 – 09.07.08	Safer	1	Observations

Healthcare 09.07.08 – 14.07.08	Observations	5	Progression
Glenn House 14.07.08 – 16.07.08	Vulnerable Prisoners	2	Assessment and progression
Lagan 5 16.07.08 – 24.07.08	Safer	8	Observations
Glen House 24.07.08 – 26.07.08	Vulnerable Prisoners	2	Close observation
Lagan 5 26.07.08 -	Safer	6	Observations

6. Colin remained in Safer/Observation Cell 16 in Lagan House for 6 days until he took his life in the late hours of 31 July and early hours of 1 August.

Incidents of Self Harm

7. Over the 4 month period from April to July, there is documented evidence when Colin made 15 separate instances of self-harm or threats of self-harm before the series of incidents on 31 July, culminating in his death. These were:

- 8 April – superficial cuts
- 12 April – found with a ligature
- 21 April – cuts requiring stitches
- 16 May – superficial cuts
- 18 May – superficial cuts
- 23 May – superficial cuts and found with a ligature
- 25 May – serious attempt at hanging
- 28 May – superficial cuts
- 31 May – superficial cuts
- 14 June – superficial cuts
- 16 June – attempted hanging
- 19 June – found with a ligature
- 16 July – superficial cuts
- 21 July – banging head on cell wall and found with a ligature
- 28 July – found with a ligature

Colin's Time Spent in a Safer Cell

8. From 9 April 2008, the first time in this latter period of custody when he self-harmed by making cuts to his wrists, until the time of his death, Colin was located in the Safer/Observation Cells in Lagan House, mainly Cell 16, on 8 occasions totalling 40 days. These varied from 1 day to 14 day periods.

9. Colin also spent 8 occasions during this period in observation cell and ward areas in the Healthcare Centre, ranging from 4 to 18 day periods.

10. Colin was under close observation for a total of 67 days.

Colin's Time Spent in Anti-Ligature Clothing

11. Authorisation for Colin to be placed in anti-ligature clothing in the Safer Cell was recorded on 7 occasions between 16 May and 25 July.

12. During the 40 days that Colin was in a Safer/Observation Cell between April and July (requiring 28 authorisation extensions by a Governor), I have found evidence of 10 occasions when a decision to extend the use of anti-ligature clothing was recorded by a Governor Grade.

Colin's Exercise when in the Safer Cell

13. During the 40 days Colin spent in the Safer/Observation Cell, prison records indicate that Colin went to the Healthcare Centre in the afternoon for occupational therapy and exercise on 18 of those days.

14. However, from 26 July until his death, there is no documented evidence that Colin had any opportunity to avail of exercise, either by going to the Healthcare Centre, or to be offered, or him refusing any other exercise facility. There were, however, two recorded occasions when Colin asked about getting exercise and Officers gave him a negative response.

Safer Custody Review Meetings

15. Colin was first referred to the Safer Custody Group following his expulsion from Wilson House on 28 March 2008. His initial Safer Custody Group meeting was held on 8 May 2008.

16. A review was arranged for one week when more information was available. Colin was discussed at a further nine Safer Custody Meetings. These were:

- 15 May 2008 - review 1 week
- 22 May 2008 - review 2 weeks
- 5 June 2008 - review 1 week
- 12 June 2008 - review 1 week
- 19 June 2008 - review 1 week
- 26 June 2008 - review 2 weeks
- 3 July 2008 - (separate Case Conference held 3 July)
- 10 July 2008 - review in 2 weeks
- 24 July 2008 - review in 2 weeks

PAR 1 Multi-Disciplinary Reviews

17. On 8 April 2008, a PAR 1 Booklet was opened following a multi-disciplinary case conference after Colin swallowed razor blades and alleged his life was under threat.

18. This PAR 1 remained opened until Colin took his life in the late hours of 31 July and early hours of 1 August, a total of 115 days.

19. As well as the first multi-disciplinary case conference held on 8 April, which opened the first PAR 1, eight further multi-disciplinary case conferences were held on:

- 25 April 2008
- 9 May 2008
- 23 May 2008
- 6 June 2008
- 12 June 2008
- 19 June 2008
- 25 June 2008
- 17 July 2008.

CRC 1 Use Of Safer Cell Booklets

20. Seven CRC 1 Use of Safer Cell booklets were opened from 9 April until Colin's death. These were opened on the following dates:

- 9 April (2 days)
- 16 April (2 days)
- 23 May (2 days)
- 11 June (4 days)
- 19 Jun (14 days)

- 16 July (9 days)
- 25 July (7 days).

Healthcare Interventions

21. From 8 April 2008, when his PAR 1 was initially opened, until his death, Colin was seen by Healthcare staff on numerous occasions.

22. These consultations took place in Colin's cell, in the Residential House medical room and the Healthcare Centre. Colin's consultations ranged from treatment for self-harm to mental health assessments, and regularly to give out his daily medication.

Perceived Threats

23. From 8 April 2008 until the time of his death, there were at least 21 documented occasions when Colin alleged that he was under threat.

24. This does not include comments from other prisoners or staff about any alleged threats against Colin. The Prison Service carried out 3 internal threat risk assessments on Colin, one in 2006 and two in April 2008.

25. On 29 August 2006, Colin perceived he was under threat from loyalists for an offence he had committed in the past, although he was vague about actual persons and could not name any names. The Maghaberry Security Department considered a PSNI assessment was not required and that Colin should remain in his current location with local staff monitoring the situation. A Governor noted *"Colin had psychiatric history and may perhaps be attention seeking".* He asked that Colin be referred to safer custody for case conferencing.

26. On 9 April 2008, Colin advised that he [text redacted] and was *"under threat from another prisoner that he gave evidence against".* The Maghaberry Security Department noted that was no corroboratory evidence to back up his claims and that it appeared "*to be in his head".* It was agreed that Colin should remain in his normal location and that mental health should be asked to speak with him. A Governor recommended on 29 May 2008 that a package of support should be put in place for Colin.

27. On 10 April 2008, Colin had contacted his local MP advising that "*people were out to get him*". This information was passed to the Maghaberry Security Department who determined the

threats to Colin could not be substantiated and that he should remain in his normal location and monitored. On 28 May, a Governor recorded *"this individual requires a mental health assessment. His claims are becoming increasingly bizarre. If he is not on a PAR 1 consideration should be given to opening one".*

28. Colin also expressed his fears by telephone to the Samaritans, his family and friends, the Human Rights Commission and on four occasions to my own office. These were passed to the Prison Service.

ANNEX 7

COLIN'S LAST SIX DAYS

1. The following paragraphs give a detailed day by day account of Colin's last six days in prison, from 26 July up until he died in the late hours of 31 July and early hours of 1 August.

Friday 25 July

2. A CRC 1 Form was signed and dated at 23.45 on 25 July by a Principal Officer recording: "*prisoner Bell showed NCO Hanna marks to his neck and said he had attempted to hang himself. Special Instructions from Nursing Officer – protective clothing authorised."*

3. There is, however, no entry on the CRC1 Form against the frequency of observation heading. Therefore, the default Landing check and Secure POD CCTV observation interval of every 15 minutes would apply.

Saturday 26 July

4. As a result of the CRC 1 authorisation being signed at 23.45 the previous evening, Colin was moved to Safer/Observation Cell 16 in Lagan House 5 at 01.08 on 26 July.

5. CRC 1 and PAR 1 Landing observation logs for 26 July are completed recording approximately 1 hour landing observation entries.

6. Prison Service rules, policy and instructions state that Landing observations and log entries should have been carried out at 15 minute intervals on 26 July. This was not adhered to.

7. Those Landing observation log entries made during the day of 26 July were largely uneventful apart from Colin *"pacing his cell."* An entry at 14.35 reported Colin "*requesting a listener.*" At 15.25 a listener went to Colin's cell. At 17.45 an entry reads: "*cell light activated. Prisoner has been banging his head off the cell wall. Medic informed.*"

8. A medical injury report for Colin dated 26 July at 18.05 recorded Colin *"sustaining a superficial grazed area to his scalp caused by friction from hitting his head repeatedly off the cell wall – nil needed."*

9. A Landing log entry at 19.00 reads: *"prisoner has continually activated cell alarm claiming they are coming to stiff me in an agitated state."* Another entry at 21.40 reads: "*just upset /agitated.*" There were no further significant entries that evening.

10. There was an unlined A4 sheet of paper used as a Secure POD observation log on 26 July, however, apart from an entry 01.00 which reads: "*lying in bed appears asleep*", the only other entry up to 07.45 the next morning reads: *"checked at 15 minute intervals throughout the night."* An entry at 08.05 reads: "*awake and moving, camera not clear, bad picture*". An entry at 08.30 reads: "*day staff on post. Will monitor throughout day."* An entry at 11.50 reads: "Bell visited by doctor in cell" and another at 12.30 reads: "*continuing to monitor".* The next entry recorded was at 20.15 reading: "*phoned secure POD."*

11. Two other notable Secure POD entries made recorded at 21.45 and 22.45 were: *"contacted Samaritans and Secure POD on several occasions"* and *"walking around cell and observed biting at blanket."*

12. Prison Service rules, policy and instructions state that Secure POD CCTV observations and log entries should have been carried out at 15 minute intervals on 26 July. This was not adhered to.

13. An entry by a Nurse Officer in Colin's medical records for 26 July reads:

    "Internal – attempted self-harm. Prisoner moved to a Safer Cell in Lagan 5 due to staff observing and preventing him from using a ligature that he made earlier. Issued him with protective clothing for his own safety, reassured him of his safety and explained to him that he would be assessed by nursing staff tomorrow."

14. Prison Service rules, policy and instructions state that a CRC 1 review to authorise the use of the Safer/Observation Cell for a further 24 hour period should have been authorised by the Deputy Director of Operations at Prison Service Headquarters level and signed off by a Governor or Doctor within a multi-disciplinary input context. There was no evidence of input from any senior manager or information about the rationale for any decision to extend for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend. Apart from the Nurse Officer's entry in Colin's medical records, the policy was not adhered to, although Colin had been in the Safer/Observation Cell for more than 24 hours at this stage.

15. In addition to the CRC1 review and correct authorisation not taking place for the extension of use of the Safer/Observation Cell for another 24 hours on 26 July, the policy for the authorisation of the use of anti-ligature clothing for another 24 hours being granted by the Deputy Director of Operations at Prison Service Headquarters was not adhered to. There was no evidence of input from any senior manager or information about the rationale for any decision to extend the use of anti-ligature clothing for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

16. At interview, a Senior Officer of Lagan House gave an account of the Secure POD Officer's duties in the context of the CRC 1 and PAR 1 observation logging requirements. The Senior Officer said:

"In terms of my explanation as to why the NCO POD Officer had only a blank A4 sheet of paper on the night of 31 July with no proper instructions – the CRC1 Form – the actual real form – are very hard to obtain. I think there was only one print done some time ago. What we have is a couple of originals – so we photocopy and put them into it's own booklet. There is an overall problem here in that there are no original CRC1 Forms – they are not fit for purpose anyway as they really only properly cover a 24 hour observation period. If everything was normal an original CRC1 Form would go to the NCO POD Officer or the Landing staff and an exact copy to the other. There is the full guidance in the CRC1 which the staff member would likely adhere to. They are only for 24 hour observations, they are not fit for longer periods such as in Colin Bell's case. If we contrast that with the PAR 1 Booklet – it is a better designed document. The PAR1 allows for all entries, including the reviews and MD team meetings – there is nothing in the CRC1 Booklet to allow for this. Only the Landing staff have the PAR 1 booklet and the information contained within it and as such the Landing staff would have a knowledge of the prisoner's daily activities and a greater understanding of the prisoner's circumstances. Whereas the NCO POD Officer knowledge is purely observational and has no access to prisoner information so he can only go by the observational recordings and the history through that document – I would agree that on that night the NCO POD Officer had a distinct disadvantage as he only had that one blank sheet – really only half a picture and at a serious disadvantage – for example – the PAR 1 booklet follows the prisoner all day, so it is the most accurate history of his chain of custody we have and the reason something else happens somewhere else is recorded on the PAR 1 booklet – but because the Day POD Officer only has what he sees, he has no knowledge of any other event which has happened outside – therefore

something significant could have happened previously but the Day POD Officer would not be aware of it. Then he cannot pass this on to his Night time relief NCO POD Officer because it's not in the records. There is no specific instruction for how long a 15 minute observation would take – Landing staff would open the flap and do a physical check and may even talk to him. The POD man has additional difficulties in that if both Safer Cells and the Listener Cell may be occupied and he has all the other cameras in the House – but the POD man would only glance and that would be called an observation."

Sunday 27 July

17. CRC 1 and PAR 1 Landing observation logs for 27 July are completed recording approximately 1 hour entries.

18. Prison Service rules, policy and instructions state that Landing observations and log entries should have been carried out at 15 minute intervals on 27 July. This was not adhered to.

19. A CRC 1 and PAR 1 Landing log entry at 08.30 on 27 July reads: *"unable to open door. Piece of plastic has been put in door."* An entry at 9.20 reads "*cell door fixed. Unlocked and milk handed in."* Further entries were largely uneventful mentioning *"standing at door"* and *"pacing cell."* At 16.30 an entry by an Officer reads: *"spoke to Colin at door. Says he is terrified someone will come into his cell".* Between 16.50 and 18.35 an Officer records: "*never off cell alarm."* An entry at 18.45 reads: *"wanted listener. told to use phone to Samaritans."* An entry at 23.30 reads: *"wrapping toilet paper around."*

20. There was an unlined A4 sheet of paper used as a Secure POD Officer night observation log on 27 July starting off with four 15 minute entries reading: "*lying on bed and appears asleep*". An entry at 01.15 records *"lying in bed, appears asleep."* This entry is repeated at 04.15 and 07.00. There were a further six entries recorded by the Night Secure POD Officer at 19.35, 21.00, 23.30, 06.30, 07.45 recording things such as "*has been pacing cell, now appears to be sleeping and for past hour has paced cell."*

21. Prison Service rules, policy and instructions state that Secure POD CCTV observations and logging entries should have been carried out at 15 minute intervals on 27 July. This was not adhered to.

22. There are no entries in Colin's medical records for 27 July.

23. Prison Service rules, policy and instructions state that a CRC 1 review to authorise the use of the Safer/Observation Cell for a further 24 hour period should have been authorised by the Deputy Director of Operations at Prison Service Headquarters level and signed off by a Governor or Doctor within a multi-disciplinary input context. There was no evidence of input from any senior manager or information about the rationale for any decision to extend for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

24. In addition to the CRC1 review and correct authorisation not taking place for the extension of use of the Safer/Observation Cell for another 24 hours on 27 July, the policy for the authorisation of the use of anti-ligature clothing for another 24 hours being granted by the Deputy Director of Operations at Prison Service Headquarters was not adhered to. There was no evidence of input from any senior manager or information about the rationale for any decision to extend the use of anti-ligature clothing for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

25. There is evidence from CCTV footage on 27 July that Colin appeared to be cold in the Safer/Observation Cell.

26. At 21.59 CCTV footage shows Colin walking to the toilet area. He picks up a toilet roll and walks to the bed. Colin begins to wrap the toilet roll around his left foot. At 22.01 he removes the toilet roll and starts again. At 22.07 Colin begins to wrap toilet roll around his right foot. He applies water taken from the sink to the toilet roll in an effect to make it stick.

27. Between 22.10 and 22.24 Colin sits on the bed and continues to apply toilet roll to his feet. At 22.34 Colin puts his arms inside the anti-ligature gown and lies down on the bed. At 22.50 Colin gets up and presses the button on the control panel. At 22.51 Colin lies back on the bed.

28. At 04.37 Colin gets up and uses the toilet. The toilet paper has unravelled. Colin sits on the bed and wraps the toilet paper around his feet again. He then puts his arms into the anti-ligature gown and lies down on the bed. At 04.53 Colin gets up and again wraps toilet roll around his feet. At 06.04 Colin gets up again. He removes the toilet roll from his feet and sits on the shelf. From this time until 07.00 Colin paces the cell and regularly presses the button on the control panel. He sits on the shelf and looks out the window.

Monday 28 July

29. CRC 1 and PAR 1 Landing observation logs are completed recording approximately 1 hour landing observation entries.

30. Prison Service rules, policy and instructions state that Landing observations and log entries should have been carried out at 15 minute intervals on 28 July. This was not adhered to.

31. A CRC 1 and PAR 1 Landing log entry at 10.45 by an Officer reads: *"discovered mattress ripped – removed from cell due to health and safety reasons Colin found making ligatures recently."* Another entry by the same Officer at 11.40 reads: *"I retrieved remains from jacket in Reception. It was completely ripped to shreds and he had made a ligature. He has very red marks on his forehead where he had tried to pull the ligature over his head but it was too tight."*

32. Another entry by the same Officer at 11.30 reads: "*everything, including cigarettes removed from cell – instructions of SO for health and safety of Colin.*" An entry at 15.30 by the same Officer reads: "*making demands to see a Governor and get exercise. Told for his own safety he would have to remain in safer cell."* An entry at 16.00 reads: "*constantly onto Samaritan call bell."*

33. Records show Colin was charged on 28 July by an Officer under Rule 38 (24) for the previous day's incident with – 'in any other way offends against good order and discipline' – saying: *"you disabled the locking mechanism on your cell door and you ripped the safety blanket."*

34. The adjudication was adjourned as a Nurse Officer who attended to Colin in his cell deemed him *"not fit for adjudication."* In a statement Colin said he "*had ripped the strip of cloth off with his teeth and flushed it down the toilet*". Colin added he "*had wedged an item between the door and stop, thus disabling the mechanism."*

35. The rest of the entries in the Landing observation logs for 28 July were largely uneventful recording things such as *"sitting at monitor*" or "*lying on the bed."*

36. There was an unlined A4 sheet of paper used as a Secure OD observation log on 28 July starting off with an entry at 08.15 which reads: *"day staff on post – will monitor when possible throughout the day and record any incidents."* The only other Secure POD entry for 28 July was at 19.30 which reads: "*Night Guard on post – prisoner pacing cell."* There were no further

Secure POD observations recorded on the night of 28 July until 07.45 the next morning, when the day staff came on duty.

37. Prison Service rules, policy and instructions state that Secure POD CCTV observations and log entries should have been carried out at 15 minute intervals on 28 July. This was not adhered to.

38. An entry in Colin's medical records for 28 July reads:

"Nurse – Attempted self-harm; made ligature from his jacket while in drug testing this morning. Nil to see when I spoke to him. Says he does not want to die or kill himself but still feels people are out to get him and kill him. Quite a lot of contradictions in his statements and had a smirk on his face while speaking to me. Fair eye contact. Wants to move from Safer Cell, was advised this would not be happening. Had also ripped up mattress and same removed. Wanted another one. Was told not at present. Remains in anti-ligature clothing in Safer Cell at present. Took his medication – supervised swallow."

39. Prison Service rules, policy and instructions state that a CRC 1 review to authorise the use of the Safer/Observation Cell for a further 24 hour period should have been authorised by the Deputy Director of Operations at Prison Service Headquarters level and signed off by a Governor or Doctor within a multi-disciplinary input context. There was no evidence of input from any senior manager or information about the rationale for any decision to extend for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend. Apart from the Nurse Officer's entry in Colin's medical records, the policy was not adhered to.

40. In addition to the CRC1 review and correct authorisation not taking place for the extension of use of the Safer/Observation Cell for another 24 hours on 28 July, the policy for the authorisation of the use of anti-ligature clothing for another 24 hours being granted by the Deputy Director of Operations at Prison Service Headquarters was not adhered to. There was no evidence of input from any senior manager or information about the rationale for any decision to extend the use of anti-ligature clothing for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

41. There is evidence from CCTV footage that Colin appeared to be cold in the Safer/Observation Cell on 28 July. From 20.30 Colin was observed continually pacing his cell from the cell door to the window. He is wearing a protection gown and has no

footwear. He also regularly pressed the buttons in the control panel. There is no blanket in his cell.

42. At 22.35 Colin was observed lying on top of the bed. Colin takes his arms out of the sleeves of his protective gown and puts both his arms inside the gown. It appears that Colin was trying to keep his arms warm. Colin sleeps until 01.23.

Tuesday 29 July

43. CRC 1 and PAR 1 Landing observation logs are completed for 29 July recording approximately 1 hour landing observation entries.

44. Prison Service rules, policy and instructions state that Landing observations and log entries should have been carried out at 15 minute intervals on 29 July. This was not adhered to.

45. Those CRC 1 and PAR 1 Landing Log entries made for 29 July were largely uneventful with items recorded such as *"watching television and sleeping."* One entry at 15.10 recorded Colin as having been seen by a Doctor. Colin is recorded as being asleep from 21.30 until 7.00 the next morning.

46. There was an unlined A4 sheet of paper used as a Secure POD observation log on 29 July starting off with an entry at 07.45 which reads: *"day staff on post – will carry out visual 15 minute obs and record any occurrences."* An entry at 15.05 records *"Doctor in cell."* The next entry was at 19.30 recording: *"Night guard on post, cell open, two staff entered."* There were four 15 minute observation entries recording things such as "*sitting by monitor, lying on bed and constantly hitting alarm/contacting Samaritans.*"

47. The next Secure POD entry was at 21.30 which reads: *"lying in bed, appears asleep."* There was a downward arrow to the next entry at 07.00 which had nothing written against it.

48. Prison Service rules, policy and instructions state that Secure POD CCTV observations and log entries should have been carried out at 15 minute intervals on 29 July. This was not adhered to.

49. There are no entries in Colin's medical records for 29 July.

50. Prison Service rules, policy and instructions state that a CRC 1 review to authorise the use of the Safer/Observation Cell for a further 24 hour period should have been authorised by the

Deputy Director of Operations at Prison Service Headquarters level and signed off by a Governor or Doctor within a multi-disciplinary input context. There was no evidence of input from any senior manager or information about the rationale for any decision to extend for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend. Apart from the log entry about the doctor being in Colin's cell, the policy was not adhered to.

51. In addition to the CRC 1 review and correct authorisation not taking place for the extension of use of the Safer/Observation Cell for another 24 hours on 29 July, the policy for the authorisation of the use of anti-ligature clothing for another 24 hours being granted by the Deputy Director of Operations at Prison Service Headquarters was not adhered to. There was no evidence of input from any senior manager or information about the rationale for any decision to extend the use of anti-ligature clothing for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

52. There is evidence from CCTV footage that Colin appeared to be cold in the Safer/Observation Cell in the early hours of 29 July.

53. Colin remained on top of the bed until 01.23 when he was observed going to the control panel and appears to be pressing the buttons. There was no blanket in his cell. At 01.30 Colin sits on top of the bed again and wraps toilet roll around both his feet and ankles several times, like a bandage to try to keep his feet warm. Colin takes his arms out of the sleeves of his protective gown and puts both his arms inside the gown. Again it appears as if Colin is trying to keep his feet and arms warm.

54. Colin is observed at 01.45 lying on top of the bed and is observed staying there until 05.10. Colin then wakes up and wraps the toilet roll around his feet and ankles as it had unravelled. Colin lies back down on top of the bed. At 05.45 he repeats this process because the toilet roll had unravelled again. He lies down on the bed again. He appears to sleep but is restless and moves about a lot. At 06.52 he wakes up again. The toilet roll had unravelled again. He throws this into the toilet and he sits on the shelf beside the control panel until the footage ends at 07.00.

55. Further evidence that Colin was cold on the night of 29 July was deduced from CCTV footage. At 20.30, Colin was observed continually pacing his cell from the cell door to the window. He was wearing a protection gown and had no footwear. He also regularly pressed the buttons in the control panel. There is a

blanket on his bed. At 21.05 Colin got into his bed and pulled the blanket over his head. He sleeps until 01.21.

Colin's Last 48 Hours

Wednesday 30 July

56. CRC 1 and PAR 1 Landing observation logs for 30 July are completed recording approximately 1 hour entries.

57. Prison Service rules, policy and instructions state that Landing observations and log entries should have been carried out at 15 minute intervals on 30 July. This was not adhered to.

58. The early morning hourly Landing observations record Colin as *"appears to be sleeping."* A Landing observation entry at 08.00 on 30 July records: *"Colin pacing his cell and standing at the cell door at 08.30 when it opened. Handed a light, hot water and cereal.*"

59. A PAR 1 Landing entry at 09.30 records Colin getting his medication. An entry at 10.30 reads: "*taken to Video link – returned at 11.10.*" Further entries up to 13.30 mention Colin "*sleeping*" and "*getting his lunch meal.*"

60. There are no further observation entries in the PAR 1 log from 13.30 until 20.20 at which point it reads: *"headcount – appears ok."*

61. The next PAR 1 entries were hourly, recording things such as "*sitting on the bench and the bed"* and at 00.30 it was recorded: *"appears asleep."*

62. A CRC1 Landing entry at 15.05 records: *"Doctor in cell".* The next entry in the PAR 1 was at 19.30 recording: *"Night guard on post, cell open, two staff entered."* There were four 15 minute observation entries recording things such as "*sitting by monitor, lying on bed and constantly hitting alarm/contacting Samaritans.*"

63. There was an unlined A4 sheet of paper used as a Secure POD observation log on 30th July starting off with an entry at 08.15 which reads: *"day staff on post – will monitor and record any unusual activity during day.*" From 19.30 until 00.30 there were 30 minute observations recording things such as *"sitting on shelf, sitting at door and appears to be sleeping."*

64. Prison Service rules, policy and instructions state that Secure POD CCTV observations and log entries should have been carried out at 15 minute intervals on 30 July. This was not adhered to.

65. There are no entries in Colin's medical records for 30 July.

66. Prison Service rules, policy and instructions state that a CRC 1 review to authorise the use of the Safer/Observation Cell for a further 24 hour period should have been authorised by the Deputy Director of Operations at Prison Service Headquarters level and signed off by a Governor or Doctor within a multi-disciplinary input context. There was no evidence of input from any senior manager or information about the rationale for any decision to extend for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend. Apart from the log entry about a doctor being in Colin's cell, the policy was not adhered to.

67. In addition to the CRC 1 review and correct authorisation not taking place for the extension of use of the Safer/Observation Cell for another 24 hours on 30 July, the policy for the authorisation of the use of anti-ligature clothing for another 24 hours being granted by the Deputy Director of Operations at Prison Service Headquarters was not adhered to. There was no evidence of input from any senior manager or information about the rationale for any decision to extend the use of anti-ligature clothing for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

Colin's Cell CCTV for 30 July

68. My Investigation Team reviewed the CCTV footage on 30 July for both Safer/Observation Cell 16 in Lagan House 5 where Colin was held and the Secure POD holding the CCTV with the responsibility for observing Colin for his safety.

69. A synopsis of the CCTV footage of Colin's cell for 30 July follows:

70. At 01.21 on 30 July Colin is observed getting up and moving about. He goes back to bed at 01.24. He is observed sleeping up to 07.00 that morning.

71. At 07.00 Colin is sleeping in bed. He has a blanket and is in anti-ligature clothing. Colin wakes at 08.19 and walks to the toilet area. He picks up a cigarette. He knocks and listens at the cell door. At 08.25 the cell door opens and Colin gets a light

for a cigarette. He talks to two Officers for a minute and is given some milk. The cell door closes.

72. At 08.28 the cell door opens and an Officer enters the cell with cereal and a mug which he puts on the table. A second Officer enters the cell holding several sheets of paper. The Officer speaks with Colin and points out things from the sheets of paper. The Officer and Colin speak for a couple of minutes and then both the Officer and Colin sign the bottom of one of the sheets of paper. The Officer leaves the cell.

73. At 08.34 Colin eats his breakfast and then knocks the cell door. The door opens at 08.53 and Colin gets a light for a cigarette. He then paces the cell smoking. At 09.10 the cell door opens again and Colin gets another light.

74. From 09.18 to 09.57 Colin presses the button on the control panel regularly and at times he appears to be speaking to someone. During this period he also paces the cell. At 10.03 the cell door opens and an Officer hands Colin a brown bag containing his clothes. Colin wipes his feet with his hands and dresses.

75. At 10.08 Colin leaves the cell and returns at 11.01. One Officer stands inside the cell as he removes his clothes and a second Officer stands at the cell door. The Officer removes the brown bag and at 11.04 Colin leaves the cell. At 11.05 an orderly enters the cell. He brushes and then mops out the floor of Colin's cell. Colin returns to the cell at 11.33 after having a shower.

76. At 11.35 Colin is given a cereal bowl and he eats the contents. At 11.39 the cell door is opened and an Officer gives Colin his lunch in two plastic containers. Colin eats his lunch and gets a light for a cigarette at 11.42.

77. At 11.58 Colin gets into bed and pulls the blanket over him. Colin gets up at 12.15 and presses the button on the control panel and listens at the cell door. He gets back into bed at 12.25 and appears to be sleeping until 13.45. Colin gets up and rolls a cigarette. He presses the button on the control panel and knocks the door of the cell. Colin continues to do this until 14.51 when the cell door opens and he gets a light for a cigarette.

78. From 15.00 to 15.15 Colin continues to press the button on the control panel and appears to be speaking to someone.

79. At 15.20 an unknown person comes into the cell. Colin sits on the bed and the person stands. They speak for 25 seconds before the person leaves the cell and the door closes. From 15.21 to 15.49 Colin sits on the shelf, paces the cell and listens at the cell door. At times he appears to be speaking to someone via the intercom.

80. At 15.50 the cell door opens and an Officer enters with two plastic food containers. Colin eats the contents of one of the containers standing and then sits on the shelf and eats the content of the second container. At 15.59 the cell door opens. An Officer enters the cell, has a quick look around and leaves.

81. From 16.00 to 19.31 Colin paces the cell, listens at the door and looks out the window. He also sits on the shelf. At 19.31 and 19.50 the cell door opens and Colin gets a light for a cigarette. From 19.51 until 20.30 Colin paces the cell, listens at the cell door and looks out the window. He also sits on the shelf.

82. From 20.30 Colin was observed continually pacing his cell from the cell door to the window. He was wearing a protection gown and had no footwear. He also regularly pressed the buttons on the control panel. There was a blanket on his bed.

83. At 20.55 Colin is seen knocking the wall of the next cell and walks to the window. At 23.13 he is observed standing at the cell door facing outwards with his arms behind his back. He appears to be pushing or thrusting his body towards the inside of the door. This continues for 18 minutes. He then moves away from this position at 22.34 and is observed pacing his cell from the cell door to the window. He gets into bed at 23.12 and pulls the blanket over his head. He gets up again and then paces the cell. He moves between lying on the bed and pacing the cell floor until 00.27.

Secure POD CCTV for 30 July

84. A synopsis of the CCTV footage of the Secure POD from 20.30 on 30 July follows:

85. At 20.30 the POD Night Custody Officer (NCO) is sitting in the monitor area where the screen observing the safer cells is located. At 20.36 the POD NCO is seen making toast before sitting in the computer area which is at the opposite end of the Secure POD. At 20.38 the POD NCO sits back at the monitor area, observes the screen and can be seen writing something. The POD NCO remains beside the monitor until 20.52. At 21.19 the POD NCO hands the key of the POD out to a second NCO.

At 21.41 a third NCO is given access to the POD. This third NCO leaves the POD at 21.52.

86. At 21.52 the POD NCO makes tea, the television is on in the background. At 21.55 the POD NCO walks to the monitor area and observes the screen. At 22.00 the POD NCO is seen with what appears to be a log book in his hand and he remains at the monitor area until 22.58.

87. At 22.58 the POD NCO turns off the light in the POD and he can be seen moving around. At 23.05 the POD NCO appears to be around the toilet area of the POD out of sight of the POD camera. At 23.07 the POD NCO walks to the monitor area but does not sit down. He walks back to the toilet area and remains out of sight of the camera. The Landing lights are activated but it doesn't appear that the Officer responded. The Landing lights go back out again.

88. At 23.21 another NCO enters the circle area from the stairwell. The POD NCO is still out of sight of the CCTV camera. At 23.23 and 23.33 the Landing cell light was activated. There is still no sign of the POD NCO. At 23.36 the POD NCO appears from the floor area near the toilet and moves towards the monitor. He has a log book in his hands. At 23.41 the POD NCO walks towards the toilet area and out of sight of the CCTV again.

89. At 23.51 the POD NCO walks towards the computer area and then towards the monitor area. Moments later the POD NCO again walks towards the monitor area and then sits at the computer terminal. At 23.58 an Officer enters Lagan House and at 23.59 other staff are seen entering the house.

Colin's Last Day

31 July into 1 August

90. CRC 1 and PAR 1 Landing observation logs for 31 July are completed recording approximately 1 hour landing observation entries. These log entries were largely uneventful recording "*appears asleep.*"

91. Prison Service rules, policy and instructions state that Landing observations and log entries should have been carried out at 15 minute intervals on 31 July. This was not adhered to.

92. Entries in the CRC 1 and PAR 1 Landing logs at 05.30 and 06.30 for 31 July record Colin as "*appears asleep.*" The next entry at 07.10 records: "*response given.*" The next entry was at 17.40 recording: *"opened for a light.*" The next was at 19.00 reads: "*in cell smoking.*" An entry at 20.00 reads: "*headcount – appears ok."* An entry at 21.25 records: *"looking out window"*. An entry at 22.30 reads: *"wanted a light."* The last entry in the CRC1 and PAR 1 observation log was at 23.30 which reads: *"pacing cell.*"

93. There was an unlined A4 sheet of paper used as a Secure POD observation log for 31 July. The first entry at 00.30 was followed by a downward arrow to the next entry at 06.30. Both of these entries read: "*appears to be sleeping.*" A POD entry at 07.45 reads: *"day staff on post – will carry out 15 minute visual obs and report any occurrence."* There were no other POD observation entries until 19.30 when it was recorded: *"moving around cell – 15 minute visual obs carried out – will record any occurrence."*

94. Prison Service rules, policy and instructions state that Secure POD CCTV observations and log entries should have been carried out at 15 minute intervals on 31 July. This was not adhered to.

95. An entry in Colin's medical records for 31 July reads:

"Dr at Maghaberry – appears settled, denies thoughts of self-harm, continue observation."

96. Prison Service rules, policy and instructions state that a CRC 1 review to authorise the use of the Safer/Observation Cell for a further 24 hour period should have been authorised by the Deputy Director of Operations at Prison Service Headquarters level and signed off by a Governor or Doctor within a

multi-disciplinary input context. There was no evidence of input from any senior manager or information about the rationale for any decision to extend for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend. Apart from the entry in Colin's medical records, the policy was not adhered to.

97. In addition to the CRC1 review and correct authorisation not taking place for the extension of use of the Safer/Observation Cell for another 24 hours on 31 July, the policy for the authorisation of the use of anti-ligature clothing for another 24 hours being granted by the Deputy Director of Operations at Prison Service Headquarters was not adhered to. There was no evidence of input from any senior manager or information about the rationale for any decision to extend the use of anti-ligature clothing for a further 24 hours or any evidence of multi-disciplinary consultation about the decisions to extend.

98. Apart from the initial CRC 1 which was authorised and signed by the Night Principal Officer and a Hospital Officer at 23.45 on 25 July, there is no further recorded evidence of CRC 1 reviews carried out for keeping Colin in the Safer/Observation Cell up or the use of anti-ligature clothing authorisation by anyone including the Deputy Director of Operations at Headquarters until Colin took his own life in the late hours of 31 July and early hours of 1 August.

Colin's Cell CCTV for 31 July

99. An account of the CCTV footage for Colin's cell on 31 July follows:

100. Colin appears to be in bed asleep until 08.33 on 31 July when he gets up and presses the buttons on the control panel. At 08.38 the cell door opens and an Officer hands him in a carton of milk and what appears to be a cereal bowl. At 08.41 he goes to the cell door and knocks it. At 08.45 he rolls a cigarette and the cell door opens again. He hands the cereal bowl out to the Officer and he gets a light for a cigarette. At 08.51 the cell door opens and an Officer hands him the cereal bowl back in. He is seen eating his cereal. At 08.53 the cell door opens and a Nurse Officer is at the cell door for a few seconds.

101. From 08.53 until 09.39 Colin is observed pacing the cell, rolling cigarettes, listening at the cell door and sitting at the control panel. At 9.39 Colin is seen sitting on the bed. He appears to be manipulating at the bedclothes using his hands and mouth. At 9.46 he walks to an open cupboard and appears to put

something into it with his hand. He then goes back to the bed and for 4 minutes he appears to be manipulating at the bedclothes. He has his back to the CCTV camera. At 9.52 Colin walks to the toilet area and back to the bed. He is then seen making the bed. At 10.01 he sits on the toilet with his head down. He remains there for 6 minutes. At 10.07 he paces about the cell and then it appears he has something in his hand and goes to the open cupboard area. For 10 minutes he continually paces the cell. At 10.30 he starts looking up at various corners of the ceiling. He keeps doing this until 10.45 when he knocks the cell door. The cell door opens at 10.48 and he gets a light. At 11.01 he picks something up from the open cupboard and looks up at the camera. A ligature can be clearly seen in his hand. He then walks to the cell door, listening. The cell door opens at 11.07 when he speaks briefly to an Officer. The cell door closes again.

102. At 11.19 the cell door opens and an Officer is seen giving Colin tobacco. Colin is seen rolling a cigarette and knocks the cell door. The door opens at 11.33 and he gets a light. At 11.40 Colin picks something up from the toilet and moves to the cell door with what looks like white material in his hand. He walks to the monitor area and looks up to the camera. He moves back to the cell door. At 11.45 he walks back to the monitor area and clearly takes the ligature from around his neck in view of the camera. He walks back towards the toilet area.

103. At 12.00 the cell door opens and an Officer takes tuck shop from a plastic bag and puts it on the table. Colin then eats 4 bars of chocolate, one after another. At 12.15 Colin knocks the cell door again and listens. He paces his cell for the next 20 minutes until 12.46 when he gets into bed, pulls the blanket over his head and appears to go to sleep. He remains in that position until 13.34 when he gets up and eats another confectionary bar. For the next 20 minutes Colin paces his cell, occasionally looking up at the camera and going towards the toilet area. He is wearing a protection gown and has no footwear. He also regularly presses the buttons on the control panel.

104. At 14.31 the cell door opens and he gets a light. For the next 15 minutes he is observed knocking the cell door and pressing the buttons on the control panel. At 14.47 the cell door opens and Colin leaves his cell wearing the protective gown. He has no footwear on. He returns to the cell at 14.52. There is a person, who looks like a prisoner standing at his cell door and he gives Colin a light. The cell door closes.

105. At 14.55 the cell door opens and an Officer brings in a brown paper bag containing clothes which he puts on in view of the Officer. At 14.58 Colin leaves the cell. At 15.25 Colin is seen entering the cell again, removes his clothing and puts the protective gown on. An Officer is seen standing at the cell door and he then takes the brown paper clothing bag away.

106. For the next 30 minutes Colin is seen pacing the cell. At 15.58 Colin is seen bending down to the bottom flap of the cell door getting a light for his cigarette.

107. From 16.09 until 17.05 Colin moves back and forward about the cell. He appears to spend time around the toilet area but his head is downwards so we cannot establish what he is doing.

108. At 17.05 Colin goes to the cell door facing outwards and stands in this position until 17.17. He appears to be trying to push his head into the top corner of his cell door. He then paces the cell again. At 17.21 he rolls a cigarette and knocks the cell door. The cell door opens at 17.28 and an Officer gives Colin a light. At 17.34 Colin goes to the toilet area and sits down with his head tilted downwards. He gets up and appears to place something in the open cupboard. He then goes back to pacing his cell.

109. At 17.57 the cell door opens. An Officer comes into the cell with a notebook. Colin writes in the notebook and then hands it back to the Officer. The cell door closes at 18.01. At interview the Officer confirmed the notebook had been Colin's address/phone number book. From then until 18.39 Colin paces the cell smoking, going to and from the toilet area and sitting on the shelf. He also presses the button on the control panel on occasions. Colin is continually seen biting his nails at this stage.

110. At 18.39 the cell door opens and Colin leaves the cell in his protective gown. At 18.45 he returns to the cell with bread. The cell door closes. Colin is seen sitting on the shelf eating the sandwich. He starts to pace the cell again making body movements. He also goes to the toilet area and the open cupboard and puts his hand in. At 19.01 he knocks the cell door. One minute later the cell door opens and he gets a light. He gets a second light at 19.05. From 19.10 until 20.00 he goes between pacing the cell and sitting on the shelf.

111. At 20.09 Colin gets up and sits on the bed and pulls the blanket over his face and body. He gets up 2 minutes later and goes to the cell door with a cigarette. He gets a light from the bottom

flap at 20.13. From 20.13 until 20.30 Colin is seen standing at the cell door smoking.

112. At 20.45 Colin is pacing the cell and then sits on the shelf. At 20.51 Colin appears to lift something from the open cupboard and walks to the window. He then walks to the toilet area and puts his head down. He then walks to the cell door.

113. At 20.55 Colin walks to the window. He appears to have something in his hand but it is unclear. At 21.00 Colin sits on the shelf and appears to be speaking to someone via the monitor. He does this until 21.47. At 21.49 Colin presses the button on the control panel again and at 21.58 he obtains a light for a cigarette from the bottom flap in the cell door.

114. At 22.00 Colin is observed pacing his cell, listening at the door. At 22.17 he appears to turn on the panel button for the television and sits down on the shelf. At 22.24 he is seen with something in his hand, manipulating it. At 22.26 he walks to the open cupboard, lifts something and goes to the toilet area.

115. At 22.27 Colin gets into bed and pulls the blanket over his head and body. At 22.31 he gets up, pushes the bed towards the window, and appears to have a ligature around his neck. He then gets back into bed. At 22.36 a torch shines through the top flap of his cell door. Colin gets up, gets a cigarette and goes to the cell door. He crouches at the bottom flap of the door and gets a light from an Officer. At 22.41 he appears to retrieve a material ligature from the toilet area. He sits on the shelf and appears to manipulate the material. At 22.48 Colin clearly has something in his hand at the cell door. He remains at the cell door with his arms folded.

116. At 22.53 Colin is seen standing at the toilet area. At 22.56 he presses a button of the control panel and walks towards the cell door with something in his hands. At 22.57 Colin can clearly be seen putting a ligature around his neck. He then tries to attach the ligature to the top inside of the cell door. At 22.58 Colin appears to be hanging at the cell door with his legs moving about supporting him.

117. At 23.00 Colin stands upwards and clearly takes the ligature from around his neck. He listens at the cell door and then moves towards the window. At 23.04 he puts the ligature around his neck again and walks to the cell door. At 23.05 he takes the ligature from around his neck and tries to attach it to the inside of the cell door. At 23.06 Colin tries to hang himself again. He is seen hanging from the inside of the cell door with

his legs supporting him. He then stands up again. He adjusts his gown around the neck area and sits on the bed. At 23.07 a torch is shone through the top flap of the cell door.

118. At 23.08 Colin walks to the cell door and places the ligature on the top inside of the door. He then tries to hang himself facing inwards. He stands up almost immediately and appears to be re-adjusting the ligature on the cell door. He tries to hang from the ligature again with his legs supporting him.

119. At 23.10 he stands up again and walks towards the window with the ligature clearly around his neck. Moments later Colin removes the ligature from his neck and walks to the cell door. He then puts the ligature around his neck again and sits at the door facing inwards looking at the camera. Between 23.11 and 23.22 he gets up again and paces the cell, moving to the window. The ligature can clearly be seen in his hand.

120. At 23.25 Colin walks to the cell door and points his head inwards. He is seen making sharp movements and moves towards the toilet area. He goes back to the cell door at 23.28 and he appears to lift something from the open cupboard area. He continues to pace the cell from the door to the window. At 23.35 he stands at the window with his hands apart as if measuring the width. He then goes to the cell door and stands inwards.

121. At 23.39 Colin moves to the toilet area, picks up a ligature, and walks towards the window. The ligature can clearly be seen as he stretches it between his hands facing the CCTV camera. He clasps the ligature in his hand and walks back to the toilet area. At 23.40 he walks from the toilet area to the cell door and can be observed fixing the ligature to the inside of the door. At 23.41 Colin hangs himself from the ligature and his body shakes and moves for around 3 minutes.

122. At 23.45 Colin's body is slumped and leaning against the cell door. There is no further body movement observed.

123. Colin is hanging at his door for 38 minutes before a Prison Officer can be seen shining his torch through the cell flap at 00.19 on 1 August. It took until 00.23, a further 4 minutes, for Officers to open Colin's cell door and initiate emergency procedures.

Secure POD CCTV for 31 July

124. A synopsis of the CCTV footage of the Secure POD covering Colin in the Safer/Observation Cell from 20.30 on 31 July follows:

125. The POD NCO is observed at 20.30 sitting at the monitor in the control area. At 20.44 an NCO enters Lagan House and the POD NCO passes out the key to open the POD. The Officer enters, takes his coat off and stands beside the monitor. He chats with the POD NCO until 20.45 when he leaves.

126. The POD NCO uses the telephone from 20.48 to 21.05. He makes a second call at 21.06 and receives a call at 21.08. At 21.20 two NCOs walk through the circle area and enter the POD. A third Officer enters the POD at 21.21 and the POD door remains open. One of the Officers lights a cigarette and one sits at the computer. The POD NCO remains sitting at the monitor area under 21.31 when he makes tea for himself and colleagues. The Officers chat until 21.45.

127. At 21.46 a further NCO enters the POD and stands chatting to colleagues until 21.54 when one Officer leaves. One Officer can clearly be seen smoking during this period.

128. At 22.10 three NCOs are observed sitting in the secure POD. One NCO is sitting at the desk where the camera monitoring the safer cells is located. One NCO is sitting at the desk beside the computer and the third is sitting on a chair partly obscured by the angle of the CCTV camera. The Officers sit chatting for 30 minutes. At 22.40 the NCO sitting beside the computer smokes a cigarette. At 22.43 one NCO leaves the POD after being given a set of keys. At 22.44 two other NCOs enter the POD and stand chatting. At 22.46 one NCO leaves the POD and the others sit chatting. At 22.58 an Officer, believed to be the Senior Officer on his night checks, enters Lagan House and the two Officers in the POD leave.

129. At 23.00 the POD NCO is alone in the POD. He sits at the computer and watches TV. At 23.03 he makes a sandwich and continues to watch TV. At 23.15 the POD NCO walks to the monitor area and uses the phone. At 23.16 the POD NCO places what appears to be a mattress onto the floor and, after turning out the light in the POD, he sits down beside the computer.

130. At 23.27 the POD NCO lies down on the mattress and pulls a cover over himself. At 23.31 the POD NCO gets up and walks to

the monitor area. He opens the POD door and a second NCO enters the POD. The Officer makes tea at 23.35. From 23.35 until 23.59 both NCOs are observed sitting beside the computer chatting. At 23.59 the POD NCO walks towards the monitor area, observes the camera and walks back to the area where the computer is located.

131. At 00.17 the second NCO leaves the POD. The POD NCO walks towards the monitor and observes. He then turns the POD lights out and lies down on the mattress. At 00.18 he gets up, goes towards the monitor and lifts up what appears to be the log book and begins to write. At 00.20 the POD NCO observes the camera and continues to write in the log book. At 00.21 an Officer comes into the circles area and enters the Secure POD. The POD NCO appears to either make or receive a phone call. Both Officers are looking at the wall where the break glass cupboard where the keys for cells are kept. One Officer breaks the glass and obtains a key. At 00.22 the second Officer leaves the POD with a key. The POD NCO uses the telephone and then folds up the mattress and puts it away.

132. At 00.24 the main lights in the POD come on and the POD NCO continues to use the telephone. There is movement in the circle area at 00.26 and additional staff enter Lagan House at 00.28.

133. Colin had already taken his own life approximately 40 minutes earlier.