The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR DANIEL MCCONVILLE
AGED 22
AT MAGHABERRY PRISON
ON 30 AUGUST 2018

Date finalised: **15 February 2023**

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The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation of deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

The purpose of the Prisoner Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

By highlighting learning to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of those in custody.

Investigation objectives are set out in the Ombudsman's terms of reference and are to:

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

Within the above objectives, the Ombudsman will identify specific matters to be investigated in line with the circumstances of an individual case.

In order that learning from investigations is spread as widely as possible, and in the interests of transparency, investigation reports are published on the Prisoner Ombudsman's website following consultation with the next of kin. Reports are also disseminated to those who provide services in prisons.

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Glossary

ACCT	Assessment, Care in Custody and Teamwork
AD: EPT	Alcohol and Drugs**:** Empowering People Through Therapy
ADHD	Attention Deficit Hyperactivity Disorder
AED	Automated External Defibrillator
CCTV	Close Circuit Television
CPR	Cardiopulmonary Resuscitation
C&R	Control and Restraint
CSU	Care and Supervision Unit
ECR	Emergency Control Room
EMIS	Egton Medical Information System
GP	General Practitioner
HSCB	Health and Social Care Board
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence (Order) NI
PECCS	Prisoner Escorting and Court Custody Service
PSNI	Police Service of Northern Ireland
PREPS	Progressive Regimes & Earned Privileges Scheme
PRISM	Prisoner Record and Inmate System Management
RQIA	Regulation and Quality Improvement Authority
SMART	Self-Management and Recovery Training
SPAR	Supporting Prisoners At Risk (procedure)
SPAR Evo	Supporting People At Risk Evolution
The Prison Service	The Northern Ireland Prison Service
The Trust	The South Eastern Health and Social Care Trust

Foreword from the Ombudsman

Introduction

The death of a loved one is always difficult. The fact that a death occurs in custody, or shortly after someone is released from prison, has particular difficulties given the loss families have already experienced when a loved one is taken into custody.

While in custody, individuals are cared for by the Prison Service, South Eastern Health and Social Care Trust staff (Healthcare in Prisons) and by other agencies who work inside prisons. All those in custody should expect to be treated decently and with respect, receiving the best care possible for their wellbeing and rehabilitation. Above all, families need to have confidence that their loved one is safe while in custody.

This report is written with Mr McConville's family primarily in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am grateful to them for their contribution to this investigation and I appreciate their patience. I offer my sincere condolences to them on their sad loss and hope this report provides information to address some of the questions they raised and explains events leading up to Mr McConville's death. The learning, expressed in recommendations, will, I hope, bring some comfort and confidence to those who have family members in custody.

My investigation

The primary focus of my investigation is to establish the circumstances surrounding Mr McConville's death and to consider if there are any matters of concern to provide learning for the future. It is important that the process of establishing circumstances is based on facts and records. It is also important to get to know Mr McConville, to learn about his life and experience and to listen carefully to those who loved him and had him in their care. This fuller picture of the young man Mr McConville was provides significant insight into how he experienced life. The Terms of Reference for this investigation, set out in Section 3, are designed to take account both of the circumstances surrounding Mr McConville's death and also to address any concerns arising from the complexity of needs he had.

Previous custodial periods

Mr McConville was familiar with the criminal justice system. He had 80 previous convictions and had spent a number of periods in custody at Hydebank Wood College. He had most recently been discharged from Maghaberry Prison 2 months before being re-committed in June 2018. In a 3 year period Mr McConville had 11 short periods of custody during which 5 mental health assessments were conducted and he was managed under Supporting Prisoners At Risk (SPAR) operating

procedures on 12 occasions. I have discussed the impact repetitive short sentences can have on a person, particularly where they have a complex set of needs as in this case, with both the Prison Service and the Trust. In particular, I am concerned that complex needs are identified and that care plans are put in place both while an individual is in custody and on their release into the community. Care planning should stretch across custody and community to ensure continuity and provide the best possible outcome. This is particularly pertinent for individuals such as Mr McConville who have frequent periods in custody and complex needs. In Mr McConville's case that included a history of self-harm, substance misuse, depression, Attention Deficit Hyperactivity Disorder (ADHD) and learning difficulty. I have previously highlighted this concern.

Most recent period in custody, 20 June 2018 to 30 August 2018

During this period in custody Mr McConville had been involved in a number of altercations with other individuals in custody and with Prison Service staff. He was being managed under the prison's SPAR operating procedures at the time of his death. The SPAR was opened after Mr McConville reported he would self-harm if not relocated from Erne House and he had been observed crying and was visibly shaken. I will consider the management Mr McConville received while on the SPAR in Section 5.5.

Mr McConville was committed into custody on 20 June 2018 on burglary and theft charges. He spent 70 days in custody before he was found hanging in his cell, in Erne House, on 29 August 2018 at 23:04. Although attempts were made to resuscitate him the ambulance crew recorded recognition of life extinct at the scene in the early hours 00:10 of 30 August 2018. He was 22 years old.

Over the 70-day period a significant amount of activity occurred which, when considered together, gives an insight into Mr McConville's experience of being in custody, his behaviour and his complex needs. These include:

- **Cell moves.** Mr McConville moved cells 7 times. He was committed into Bann House and then moved to Roe House for 20 days. The remainder of his time was spent in Erne House where he died. During his time in Erne House he was moved to the Care and Supervision Unit (CSU) on 2 occasions. I am satisfied that these cells moves were appropriate. On the final day of Mr McConville's life he moved cells and was seeking a move to another landing within Erne House. I will address the final move later in this report at Section 5.2 where I will consider the conditions of the cell Mr McConville was moved to on 30 August 2018. In Section 5.5 I set out findings regarding the SPAR operating procedures and how they were applied to Mr McConville. He was placed on a

SPAR as he had threatened to self-harm should he not be allowed to move cells.

- **Adjudications**. Mr McConville faced 2 adjudications in relation to his behaviour towards Prison Service staff. One adjudication resulted in a 2-day confinement in the CSU with 14 days loss of privileges and the other resulted in 28 days loss of privileges. At the time of his death, Mr McConville had lost some of his privileges including loss of association and use of the telephone. However, when he was placed on the SPAR he was given access to the telephone when he wished it. I will expand on these matters in Sections 5.2 and 5.5.
- **Adverse reports.** Mr McConville received 3 adverse reports. They were for speaking abusively to officers, taking illicit substances and smoking in the recreation room.
- **Relationships with others in custody.** Mr McConville had 2 altercations with other individuals in custody, one of which resulted in 28 days loss of privileges. I will address Mr McConville's relationships with officers and others in custody in Section 5.2.
- **Drug and substance misuse.** Mr McConville failed a drugs test on 23 July 2018. He was also observed swallowing an unknown substance on 24 July 2018. This was significant given Mr McConville's history of substance abuse.
- **Healthcare support.** The support of Trust staff is critical to the wellbeing of those in custody. Mr McConville saw Trust staff a significant number of times, including at committal and while he was in the CSU. The role Trust staff played in assessing and responding to Mr McConville's needs will be addressed at a number of points throughout this report and specifically in Section 5.3.
- **Prescription medication.** Mr McConville was prescribed Fluoxetine for his depression but he was without his prescription on 3 occasions. On committal his prescription had just lapsed. He received it the next day. On 2 other occasions, including the last 2 days of his life, his prescription was late. As previously mentioned, his medication was handed back to Trust staff twice, once by an officer while he was in Roe House and once by himself while he was in Erne House. The post mortem report recorded that death was caused by hanging. The toxicology analysis excludes the presence of alcohol and did not detect drugs of abuse or pharmaceutical drugs including Fluoxetine, Mr McConville's prescribed medication. One of the independent clinical reviewer's I commissioned, a Forensic Scientist, Mrs Victoria Jenkins stated, "*Discontinuation of Fluoxetine commonly leads to withdrawal symptoms.*

Dizziness, sensory disturbances, sleep disturbances (including insomnia and intense dreams), asthenia (abnormal physical weakness or lack of energy), agitation, nausea or vomiting, tremor and headache are the most commonly reported reactions. Generally these events are mild to moderate, however, in some patients, they may be severe and/or prolonged. It is therefore advised that when Fluoxetine therapy is discontinued, that the dose should be gradually reduced." Given that Mr McConville had missed doses of his medication, that on occasion his prescription was late, that medication was found in his cell and that his prescribed medication was not present at the time of his death I will consider the matter of his medication further in Section 5.3.

- **Alleged assaults.** Mr McConville alleged assault by Prison Service staff on 2 occasions. Additionally, he had an outstanding investigation with the Police Service of Northern Ireland (PSNI) regarding an alleged assault during his previous time in prison custody. He alleged these were incidents of bullying and his family have asked that I explore whether or not it was the case that he experienced bullying from either Prison Officers or others in custody. I will do so at Section 5.2.
- **Good order and discipline.** Mr McConville was locked for good order and discipline twice and experienced control and restraint (C&R) twice. Control and restraint, C&R, is a term used when Prison Officers believe they have no other option but to use reasonable and proportionate force to secure their own or any other person's safety. Prison staff are taught C&R techniques which is designed to restrain as safely as possible, for both staff and those in custody. It is not a comfortable experience for either Prison Officers or those in custody and Trust staff always attend the individual who has been subject to C&R. I am satisfied that Mr McConville was treated decently and with respect following the C&R incidents he experienced.
- **Risk management.** During Mr McConville's last period of custody from 20 June 2018 to 30 August 2018 he had 1 SPAR. This was opened on 28 August 2018 and was still open at the time of his death.
- **Bail arrangements.** Mr McConville attended a bail hearing on 29 August 2018. He was not granted bail as no bail address could be secured for him. I will consider the status and impact of his bail application in Section 5.1. I note that in several other cases recently investigated by my Office people were in a similar situation to Mr McConville in that bail applications were unsuccessful because no suitable address was available. This is a wider issue, which may be

of a systemic nature, beyond the control of the Prison Service, and ought to be addressed. It is not within my remit to make a recommendation.

- **Personal belongings.** Mr McConville had very little money or personal belongings at the time of his death. There was enough money in his account for him to have made a phone call.
- **Family and children.** On 28 August 2018 Mr McConville spoke with a Prison Officer about missing his family, particularly his children. The Officer encouraged him to focus on his children and that seemed to calm him.

Mr McConville made friends while in custody. He was observed laughing and talking with others on his landings and it was reported that he interacted positively with others in custody and got along with Prison Service staff. He engaged in therapeutic activities in the Donard Centre and on the day before his death he agreed to engage with drug and alcohol rehabilitation services.

Impact of a Death in Custody

There is no doubt that an event such as a death in custody has an impact on others, beyond family and friends. Those Prison Service staff who attended the scene of Mr McConville's death and who tried to resuscitate him could not fail to have been impacted by their experience. The Prison Service makes provision for all staff involved in events such as this to address any issues experienced by them or of concern to them either during or following the event. They are referred to as 'Hot' and 'Cold' debriefs which form a critical part of care for those who care for others, to enable them to fulfil their responsibilities well. Debriefs are also an opportunity to gather learning for improved practice. I will consider these post-incident debriefs in Section 5.6 to establish if they were adequately conducted and if Prison Service and Trust staff were signposted to the appropriate services.

Other individuals in custody are also impacted by events such as this. They hear, and sometimes see, what is happening. The level of disruption on the landing immediately following Mr McConville's death is, in the experience of my Office, unusual. In light of this, I will consider if individuals in custody were adequately signposted to support services in Section 5.6.

At the time when Mr McConville passed away and my investigators visited the landing they noted a significant emotional response from others in custody and this was reflected in the statements and accounts they provided to this investigation. From their accounts it is striking that their experiences of prison life were overwhelmingly negative, citing difficulties in their relationships with staff, the regime and conforming to prison rules. All of this was exacerbated by the sudden death of a peer. Many of them, like Mr McConville, had previously been in Hydebank Wood College and some had met in the care system. How they experience and perceive

prison is important and should be heard, particularly in the aftermath of a death in custody. It is clear to me that there is a wider systemic issue relating to the care of young people who are at risk or who, because of their life experience, are likely to become at risk. This is a matter for others and a challenge for those involved in supporting young people within the community.

Learning

This report will address and inform learning for several interested parties. Where appropriate, I make recommendations directly to the Prison Service and the Trust. Both organisations will then provide my Office with a response indicating if they accept my recommendations and what steps they are going to take, or have taken, to address them.

The key learning from my investigation concerns how we might better address the needs of those who face multiple challenges in their lives, including multiple low-level health diagnoses, while they are in custody. Mr McConville's needs, as the needs of others in similar circumstances, present a learning challenge for all involved in his care. The challenge is not only to better assess need but also and importantly to develop long-term care plans and to ensure those care plans are consistent and persistent throughout the treatment of any individual and that, if required, they are shared with Community services on an individual's release from custody. The transition of care from community to custody and from custody to community is critical to achieving the kind of rehabilitation in an individual's life which can ultimately lead to a safer society.

At the initial meeting with Mr McConville's family, his mother expressed concern that throughout his early years and while in custody no one appeared to put together the elements influencing his behaviour. She felt that Mr McConville's needs could have been managed more constructively if this had happened. It is important to consider whether the series of events, cell moves etc., set out on page 7 onwards, are appropriate for the rehabilitation of an individual with ADHD, learning difficulties and wider mental health issues. It would seem sensible to me that Mr McConville's childhood diagnosis of ADHD be treated as indicative and inform his adult care. This well-founded assumption could then inform care plans between not only prison and community but also within the prison itself, including whether it was appropriate for a young man with anxiety and depression to manage his own medication. Not taking anti-depressant medication is likely to influence mood and potentially behaviour and it is my view that the current risk assessment for in-possession medication is not adequate for the protection of individuals like Mr McConville during their time in custody. I am concerned that the prison regime does not currently have adequate resources to provide the responsiveness required to support an individual like Mr McConville. I am concerned that there are many people in custody with underlying mental health issues that do not inform how they are cared for because of legislation

in Northern Ireland and because the Prison Service and Trust have not agreed how to best share information. However, I am conscious that a robust overview of the needs of individuals in custody is essential and without this broad information base, it is impossible to plan. I am encouraged by the approach taken by RQIA, which is to establish this needs profile. I fear lack of resources will delay the required development work. This should not happen and a further piece of work is urgently required so that the prison regime can become flexible to respond to individual needs. Healthcare in Prisons should identify individual needs and share them appropriately with the Prison Service so there can be a collaborative and effective response from both agencies, to meet the needs of individuals such as Mr McConville.

In light of this and another 2 cases[1] where similar issues were identified, I wrote to the Director, Reducing Reoffending, Department of Justice in August 2020 setting out the issues of concern, asking that these be considered by the Departmental Health and Justice Improving Health within Criminal Justice Implementation Group. Not all of these issues are the sole responsibility of the Prison Service or the Trust to action. It would require collaboration with a wide range of agencies and organisations involved in providing care and support to people engaging with the criminal justice system and community services.

I would like to see some innovative thinking and proposals developed and tested on how we might engage with people such as Mr McConville differently to improve their lives, keep them safe and reduce the risk of them reoffending. This is a matter of doing better for the sake of those in custody with particular sets of needs. One particular aspect of this is connecting custody and community services for those with multiple problems who spend relatively short periods in prison and the community; another is information sharing between healthcare providers in community and prison settings and with the Prison Service where such information would assist in how those in custody are cared for.

Mr McConville's family had questions about how responsive services were when working with people who have ADHD and about the level of training provided to Prison Service staff in relation to ADHD. I address this in Section 5.4 of my report. I have made 2 recommendations in relation to ADHD with regards to identification, training and a needs reviews. I have also referenced this above in relation to the regime provided to Mr McConville and the role the Trust plays in providing information.

[1] Mr U report published on 09 February 2022
https://niprisonerombudsman.gov.uk/publications/download/143
Mr Emmett Cassidy published on 16 March 2022
https://niprisonerombudsman.gov.uk/publications/download/145

I have made recommendations in relation to protocols around information flow between the Prison Service and PSNI in respect of ongoing criminal investigations and the documentation of requests and actions taken in respect of relocating individuals within the prison.

The full scope and remit of my investigation is set out in Section 3.

Concluding comments

I am grateful to the Prison Service, the Trust and the independent Clinical Reviewers for their contributions to this investigation. Others have helped in the information gathering process and to them I also extend my gratitude. My 5 recommendations are aimed at what is necessary to achieve learning and bring assurance to those whose loved one is in the care of the Prison Service and the Trust. I conclude this forward by acknowledging that the McConville family do not believe their son would have been able to plan and carry out the actions that led to his death. They make this judgement based on what they knew of Mr McConville and the impact his ADHD and learning difficulties had on how he approached and experienced life. While I have found that Mr McConville's care was within standards, I am also convinced that there is considerable work to be done to ensure that the notion of rehabilitation is a reality for young men such as Mr McConville.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
15 February 2023

Section 1: Recommendations

1.1 Recommendations List and Responses from the Prison Service and Trust:

Recommendation 1: Allegations of assault protocol The Prison Service should consider a formal protocol with the PSNI to ensure they are kept informed about the progress of investigations into allegations of staff assault, including when they have completed.
The Prison Service accepted this recommendation and I note that each Prison has a PSNI Liaison Officer on site who deals with allegations made to the PSNI.
Recommendation 2: In cell fire protection activation If the in cell fire protection water sprinkler system is activated, any person in the cell should be moved as soon as it is safe to do so and be given the opportunity to change into dry clothing. The incident should be escalated to a Senior Officer and properly documented including a timeline of events.
The Prison Service accepted this recommendation.
Recommendation 3: Identification of ADHD and other neurodevelopmental disabilities Trust staff in Prison should proactively contribute to the development and review of regional service models to ensure that the needs of those in custody with ADHD and other neurodevelopmental disabilities can be met.
The Trust accepted this recommendation.
Recommendation 4: ADHD and other neurodevelopmental disability training Trust and Prison Service staff should access available training on neurodevelopmental disabilities including ADHD, as appropriate to job-role to inform practice in response to behaviour and presentation of individuals in custody.
The Prison Service and Trust accepted this recommendation.

Recommendation 5: Relocation of those in custody The Prison Service should ensure that requests for the relocation of individuals in custody who are being supported under a SPAR Evolution (SPAR Evo)[2] care plan are documented, including the rationale for the decision made.
The Prison Service accepted this recommendation.

Areas of care raised in previous reports which will be kept under review

I do not repeat the recommendations made in previous reports but note the progress made and plan to keep these matters under review.

- That the Prison Service ensure that residential staff arrange for the return of all in-possession medication with the residential nurse and advise that the prisoner has been relocated to the CSU. The Trust should then manage the issue of medication.
- If it is identified that a patient is not taking their prescribed medication, the Trust should ensure disposal of unused medication and offer the patient an appointment with a GP to discuss. The outcome should be documented in the patient's records.
- The Prison Service should remind staff that a cell compact form is to be completed for each cell move and a copy placed on the prisoner's residential file.
- I reiterate to the Prison Service previous recommendations regarding attendance at debrief meetings and the need for a formal mechanism to follow-up with any staff who did not attend the meeting. I would also highlight to the Prison Service a previous recommendation that learning points identified at debrief meetings should be assigned to a named individual or department to implement and include clear timescales for completion. I acknowledge the Prison Service are working to implement recommendations from a Review of Support Services for Operational Prison Staff published on 30 November 2021. When this ongoing work is completed I will review this in relation to recommendations regarding support for those who do not attend debrief meetings. It is my hope that these measures will

[2] Mr McConville was being managed under SPAR at the time of his death. This has since been superseded with SPAR Evo.

provide needed support to Prison Service officers and others involved in traumatic events.

Section 2: Background information

2.1 Maghaberry Prison

Maghaberry Prison is a high security prison, which holds male adult sentenced and remand prisoners. The population in the prison at the time of the incident involving Mr McConville was 817.

It has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable individuals in custody.

Since 2008, the Trust have provided prison healthcare services. There is a 24-hour primary care service. The primary care staff all have some Mental Health training in addition to their core training. The Mental Health Team was on site Monday to Friday between 08:00 and 17:00 at the time of Mr McConville's death. Since 30 October 2020 the Mental Health Team commenced a pilot to provide a service 7 days a week in Maghaberry Prison. Staffing this can be challenging as it requires stretching the original 5 day staffing resource over 7 days. Healthcare Commissioners are aware of the need for more funding to guarantee a 7 day service across all sites. Also from October 2020 all mental health committal screens triage take place face to face.

2.2 Criminal Justice Inspection NI (CJINI)

The most recent inspection of Maghaberry Prison was in April 2018 and the report published in November 2018. Inspectors reported that the prison had settled considerably since the last full inspection in May 2015 and was now a much safer prison.

Inspectors reported that the overall picture of safety had progressed hugely and that levels of violence and disorder had reduced. However, they remained concerned that work to support the most vulnerable individuals in custody at Maghaberry Prison had not developed to the same level as other aspects of safety.

The CJINI Safety of Prisoners Report, published jointly with the Regulation and Quality Improvement Authority (RQIA) in November 2019, highlighted that one of the most difficult issues facing the Prison Service was the identification of those really vulnerable people in the population. The report describes "a concentration of need within prison establishments"[3] and emphasises remaining concerns that prisons do

[3] "The health profile of prisoners, the high level of mental ill-health, personality disorder, learning difficulty, drug and alcohol addiction, the proportion of prisoners on medication, and in numerous cases a combination of these factors, together with other vulnerability factors, all created a concentration of need within the prison establishments." The Safety of Prisoners held by the NIPS: A Joint Inspection by CJINI and the RQIA, November 2019, p40

not provide, "the therapeutic environment required for prisoners with complex needs…"[4] Recommendations in this report chime with my concerns about collaboration to ensure information is shared between agencies to ensure effective assessment of and response to the needs of those in custody. I reiterate the recommendation that the Trust and the Prison Service review and address the effectiveness of joint working so as to create a therapeutic environment to help stabilise individuals at risk and manage their imprisonment more safely.

An Inspection Report is anticipated in the early part of 2023.

2.3 Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB whose role is to satisfy themselves regarding the treatment of those in custody.

The 2018-19 IMB annual report for Maghaberry Prison reiterated the continued improvement with the Core Day – a more structured approach to education and greater focus on reducing the amount of drugs coming into prison.

The Board reported that Maghaberry Prison was now a safer and more stable environment than previously and recognised developments in safer custody.

As in previous years, the IMB drew attention to the high percentage of those in custody with mental health issues and substance/alcohol misuse problems, which often interlink. There were also individuals in custody diagnosed with a personality disorder which do not come under the scope of the Mental Health Order in Northern Ireland. The Board acknowledged the challenges the Prison Service and the Trust had in terms of managing this client group. As a Board they acknowledged the care, compassion and understanding shown to these individuals in custody.

2.4 Regional and Quality Improvement Authority (RQIA)

RQIA is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. Following events in 2016 when my Office carried out an investigation into a serious adverse incident and a number of suicides in prison, a review was commissioned by the Departments of Health and Justice to consider provision for particularly vulnerable persons in prison. The purpose of RQIA reviews is to identify best practice, highlight gaps or shortfalls in services where improvement is required and to protect the public interest. A long awaited report of the Review of Services for Vulnerable

[4] Ibid. p8
http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/The-Safety-of-Prisoners.aspx

Persons Detained in Northern Ireland Prisons was published on 05 October 2021[5]. All recommendations are to be delivered within 18 months of publication of the report.

I had made a further request for work such as this to be completed following a meeting with the Director, Reducing Offending and representatives of the Trust who provide healthcare in prisons services. In that request, 19 August 2020, I had raised concerns about adequate information being shared between community and prison care and between services working within prisons to ensure that those in custody received the best possible healthcare. My request was specifically that alternative models of care arising from current death in custody investigations be examined, Mr McConville's being one of these.

The RQIA review goes some way to addressing my request.

2.5 Previous incidents at Maghaberry Prison

Mr McConville's death was the second self-inflicted death in the prison during 2018. Although the 2 individuals were located in different residential units and the circumstances of their deaths are unrelated, a number of shared learning points have emerged from my investigation of these deaths. I will comment on these in Section 5.

[5] https://www.rqia.org.uk/RQIA/files/95/955cfa4a-5199-4be7-9f1a-801e1369ce84.pdf

Section 3: Framework for this investigation

Mr McConville died in his cell whilst in the custody of Maghaberry Prison. I am, therefore, required to investigate and report on the circumstances surrounding his death.

My Office conducted this investigation in line with the objectives set out on page 2, which include providing explanations, where possible, to Mr McConville's family.

3.1 Questions raised by Mr McConville's family

Mr McConville's family raised a number of concerns relevant to my investigation when they met with my predecessor. These are summarised below:

- Whether or not Mr McConville's needs could be met in prison. Mr McConville's family expressed concern about the way he was cared for given his vulnerability.
- If any one person put the 3 elements influencing his behaviour together in order to manage him in a more holistic fashion. Mr McConville's mother described her son as someone who needed familiar faces, voices and routines to assist him manage his behaviour.
- If the prison environment was responsive to addressing the unique challenges presented by people with ADHD and learning difficulties and whether prison staff received training for working with people with ADHD. Mr McConville's family advised he had been formally diagnosed with ADHD and learning difficulties at the age of 6 or 7.
- If Mr McConville was regarded as at a high or low risk of suicide.
- If there was any foundation to allegations that Mr McConville was assaulted and bullied by Prison Service staff and if this contributed to his death.
- If Mr McConville had any interaction with Nurse K who was allegedly arrested in relation to drugs offences and if this contributed to his death.

3.2 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. The following information was gathered and analysed by the Investigating Officer:

- Prison Service records including Close Circuit Television (CCTV)[6] footage, radio transmissions and telephone calls made by Mr McConville prior to his death;
- Interviews with Prison and Trust staff;
- Interviews with individuals in custody; and
- Medical records.

All of this information has been carefully examined and I have detailed the relevant matters, which underpin my findings, in this report.

3.3 Independent advice

I commissioned an independent clinical review of the healthcare provided to Mr McConville. The Clinical Review was conducted by Professor Jenny Shaw who is a Consultant Forensic Psychiatrist at Greater Manchester Mental Health Foundation Trust and a Professor of Forensic Psychiatry, University of Manchester. As a forensic psychiatrist she has particular experience of assessing and treating patients involved in the judicial process, and in the preparation of psychiatric reports.

I commissioned a second independent review to examine some queries relating to Mr McConville's medication regime. Mrs Victoria Jenkins, Forensic Scientist specialising in cases involving alcohol and drugs, conducted this.

The independent clinical reviewers each provided me with a report setting out their opinion on the matters they were asked to consider. I have included their opinions on relevant matters in my investigation report.

3.4 Scope and remit of the investigation

The specific objectives of this investigation were to:

Establish the circumstances surrounding Mr McConville's death

- What was the impact of Mr McConville's bail application at the time of his death?

Was the care provided by the Prison Service adequate?

- Were complaints raised by Mr McConville prior to his death adequately examined?
- Is there any foundation to allegations that Mr McConville was bullied prior to his death?

[6] CCTV footage is not available on the landing Mr McConville was on as there are no cameras in that area. It was available for other areas within the residential house, such as circle/reception area and communal areas, as well as, the entrance and exit to Erne House.

- Comment on the condition of the cell in which Mr McConville died and the adequacy of the light fitting.

Was the clinical care provided to Mr McConville equivalent to that which he could have expected in the community?

- Was Mr McConville taking his medication at the time of his death and if not what was the impact of this?
- Was the response to Mr McConville handing back his medication appropriate?
- Were the interactions between Nurse K and Mr McConville appropriate and professional at all times?

Were Mr McConville's particular needs and vulnerability identified, assessed and appropriately managed by Prison Service and Trust staff?

Was Mr McConville appropriately managed under the SPAR[7] at Risk procedures?

- Assessment of Mr McConville's risk of self-harm and suicide
- The handling of Mr McConville's request to be moved out of Erne House.

Was the response to the incident effective and was resuscitation conducted in accordance with national guidelines?

Were the post incident debriefs adequately conducted and were Prison Service staff, Trust staff and those in custody signposted to support services?

Could Mr McConville's death have been predicted and were there opportunities to prevent it?

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

A description of the key events leading up to Mr McConville's death is set out in Section 4 and my findings are set out Section 5.

[7] At the time of Mr McConville's death the Prison Service Suicide and Self-Harm Prevention Policy 2011 (updated October 2013) and associated operating procedures were in place. New SPAR operating procedures – SPAR Evolution (SPAR Evo) - were introduced at Maghaberry Prison on 11th February 2019.

Section 4: Description of key events

4.1 Committal

Mr McConville was remanded to Maghaberry Prison on 20 June 2018 for a number of alleged offences including burglary with intent to commit grievous bodily harm and drugs possession.

When he arrived at Maghaberry Prison, a reception officer reviewed the information provided by the PSNI and Prisoner Escorting and Court Custody Service (PECCS) who transferred him from court to the prison. These details and a record of his committal interview were recorded on the Prisoner Record and Inmate System Management (PRISM).

The PECCS documentation noted that:

- Mr McConville did not feel at risk;
- his last history of self-harm was 1 year ago
- he had mental health problems and was last involved with mental health services 4 years ago
- he had ADHD identified; and
- he last used drugs 6 months ago.

The Police and Criminal Evidence (Order) NI (PACE) 16 document completed by the PSNI when transferring custody to the Prison Service identified that Mr McConville had last cut himself a year ago, that he had no current thoughts of self-harm and that he had been identified as having depression and ADHD.

At committal, Nurse A conducted initial and comprehensive healthcare assessments[8] with Mr McConville. The initial assessment recorded details of Mr McConville's alcohol intake assessment and previous polysubstance misuse and Nurse A recorded that he declined a referral to Alcohol and Drugs**:** Empowering People Through Therapy (AD: EPT) – the prison's drug and alcohol support service. Nurse A explored and documented Mr McConville's history of self-harm and that he reported diagnosis of ADHD and depression. Nurse A noted that Mr McConville had been attending his own Doctor but was not currently engaged with a Community Mental Health Team and that he had also been admitted to a Community Mental Health

[8] These assessments are conducted in line with NICE Guideline 57 Physical health of people in prison. The initial healthcare assessment is conducted in the prison reception within 4 hours of committal. The purpose of this screen is to gather information to keep a prisoner safe during the early stages of their time in custody. The assessment focusses particularly on medication, alcohol and drugs misuse, immediate mental health issues (including risk of suicide and self-harm) and any conditions that fall under the critical medications list. This is followed by a comprehensive health assessment within 1 week of committal but currently is usually completed within 72 hours of committal.

Unit 2 years previously following an incident of self-harm. Mr McConville reported that he had been taking Fluoxetine[9], but did not have any with him. Nurse A accessed Mr McConville's Electronic Care Records, to check his medication history and noted that a recent prescription for Fluoxetine had just lapsed. A new prescription was issued on 21 June 2018. Nurse A noted a cut to Mr McConville's left thumb that did not require dressing. Mr McConville had learning difficulties and he had attended a school for special needs.

The committal process took place late in the day on 20 June 2018. The committal healthcare assessment was recorded at 18:06 and the medication check at 18:15.

On 21 June 2018 a Mental Health Nurse, Nurse B, conducted an initial mental health screen[10]. This screen was not a face to face assessment but entailed a review of the committal records. Nurse B recorded that a pre-assessment had been conducted by the prison mental health team in April 2018 and a decision was made not to refer Mr McConville to the mental health team at that time and that Mr McConville's "*maladaptive behaviour appears to be driven by learning difficulties and alcohol*".

On 21 June 2018 the Trust assessed Mr McConville as being suitable to administer his own medication in accordance with the Trust's in possession risk assessment. The Trust also requested medical details from Mr McConville's community Doctor but this information was not received prior to Mr McConville's death. There is no record to explain why Mr McConville's Fluoxetine prescription was not processed and issued to him on the evening of his committal. PRISM records show that Mr McConville was allocated his cell in the committal house, Bann House, at 18:40. There is a note on the Trust's computer system the following morning at 08:54 to document Mr McConville's prescription. I am content this was completed in a reasonable timescale.

On 22 June 2018 Mr McConville tried to ring his father but the call went straight to a messaging service.

4.2 Roe House

After completing his prison induction in Bann House, Mr McConville transferred to Roe House on 26 June 2018 where he remained for 20 days. During this time a number of events of note took place.

Trust notes record that Mr McConville was examined following an altercation with another individual in custody on 03 July 2018. He was not injured and he did not

[9] Fluoxetine is a medication used for the treatment of depression.
[10] This screen entails a review of the Electronic Care Record and information obtained during the initial and comprehensive healthcare assessment. It is not a face to face consultation. The purpose is to identify risk and decide if a referral for a more detailed mental health assessment is required or not.

want to make a written statement. Mr McConville did not appear to know who had hit him and said he was a bit shocked by the incident.

On 06 July 2018 Mr McConville was involved in another altercation with a different individual in custody. On this occasion Mr McConville was restrained using C&R techniques. As is required following an incident when C&R is used, Mr McConville was examined by Nurse C and an injury report was completed which recorded "*minimal redness to left cheek bone*".

On 07 July 2018 Prison Officers found loose medication in a drawer in Mr McConville's cell in Roe House and brought it to the treatment room. Trust staff confirmed that this was Mr McConville's medication, put it in a new packet and labelled it, returned it to him and reminded him to keep his medication in the packet. From a security and safety perspective it is important that all prescription medication is properly stored and labelled so it can be easily identified.

On 08 July 2018 Mr McConville was given an adverse report after he had spoken abusively to a Prison Officer.

On 09 July 2018 Mr McConville had a Progressive Regimes & Earned Privileges Scheme[11] (PREPS) review and records note that he "*Interacts positively with prisoners and mostly ok with staff*", "*Follows Landing routine*" and "*Does not work or attend education/gym*". The outcome was that Mr McConville remained on standard regime.

Mr McConville attended a mental health team cooking activity on 10 July 2018 in the Donard Centre[12]. It is not evident from the records how the referral for this activity came about but it appeared he attended the Centre to engage in therapeutic activity. How Mr McConville interacted with other individuals in custody while in the Donard Centre would later have a bearing on his request to move landings.

On 12 July 2018 Mr McConville tried to ring his father again but the call went straight to a messaging service.

[11] The aim of Progressive Regimes and Earned Privileges Scheme (PREPS) is to provide a mechanism whereby those in custody are motivated to engage fully with developmental activities outlined in their resettlement plan. The objectives are:

- To provide a mechanism whereby prisoners are motivated to engage fully with developmental activities outlined in their resettlement plan;
- Encourage pro-social behaviour within the prison; and
- Build up self-esteem and self-worth.

(Northern Ireland Prison Service, Progressive Regimes & Earned Privileges Scheme, (PREPS), Corporate Framework, July 2007)

[12] The Donard Centre is a wellbeing hub at Maghaberry Prison where the mental health team are based. A range of low level group psychological interventions are delivered in the Centre including art and drama therapy, relaxation session and mindfulness.

Mr McConville attended another mental health cooking activity in the Donard Centre on 17 July 2018.

On 23 July 2018 Mr McConville failed a drugs test for a novel psychoactive substance and Pregabalin[13], which was not prescribed to him.

On 24 July 2018 Mr McConville was observed receiving a substance and swallowing it before Prison Officer A was able to intervene. Consequently, it was not possible to establish what he might have taken. Mr McConville was given an adverse report for this incident.

On 29 July 2018 Mr McConville received his third adverse report during his 20 days in Roe House. It was for smoking in the recreation room.

On 31 July 2018 Mr McConville attended the Donard Centre and on return to Roe House he was given a full body and cell search in response to an intelligence report. No contraband was found during this search. He attended the Donard centre again on 03 August 2018.

On 05 August 2018 during morning unlock Mr McConville refused to clean out his cell when asked to do so by Prison Officer B. When interviewed the Officer said he asked Mr McConville 3 times if he was slopping out[14]. He said he could not see Mr McConville as his entire body was covered by a blanket. The Prison Officer said he became concerned for Mr McConville and he removed the blanket to check that he was alive. Prison Officer B went to leave the cell and, as he was standing at the door, Mr McConville turned in his bed. At this point the Officer saw blood on the mattress and he approached Mr McConville to ask about the blood and check if he was okay. Prison Officer B reported that Mr McConville then kicked out at him and that he subsequently controlled and restrained Mr McConville using approved techniques along with a second Prison Officer, Prison Officer A. CCTV footage shows the officers entering and leaving the cell and also additional staff attending the scene in response to the incident. Mr McConville was examined by Trust staff and blood was noted on the side of his face and on the floor. Nurse D recorded that Mr McConville had a bleeding nose, no cuts and no swelling. The medical notes stated that he reported a sore lip. Mr McConville was moved to the CSU for a cooling off period and was returned to Roe House later that day. There does not appear to be any record of a conversation with Prison Service staff to ascertain why Mr McConville had been under the blanket or about the blood on the mattress. However, this was clarified at interview with Prison Officer B.

[13] Pregabalin is a medication used to treat epilepsy and anxiety. It is also referred to as Lyrica.
[14] Before in cell sanitation was introduced this term was used for emptying chamber pots and collecting water for washing. It is now a term referred to for cleaning and mopping a cell.

On 06 August 2018 Mr McConville made a complaint using the Prison Service internal complaints process, alleging that Prison Officer B who had entered his cell the previous day, had assaulted him.

The complaint was recorded on PRISM on 07 August 2018 and as it concerned an allegation about a staff member, it was brought to the attention of a Duty Governor, Governor A, on 08 August 2018 to respond to. On 08 August 2018 Governor A asked Governor B to take over the role of Duty Governor and to deal with the complaint from Mr McConville. On that day, Governor B initially spoke to Mr McConville and then afterwards spoke with a Roe House Senior Officer, Senior Officer A, about the complaint.

On 09 August 2018 Mr McConville tried to ring his father for the third time but again the call went straight to a messaging service. Later on the same day he spoke with a woman recorded as his Aunt, Relative A on his telephone record and during this call said he was hopeful of getting bail in a couple of weeks. He talked about needing to have contact with the kids. This was the last telephone call he made, although he did have a small amount of phone credit left.

On 14 August 2018 Mr McConville attended a failed drug test review[15] with AD: EPT. He agreed to apply for the kitchen, cookery, workshops and refer himself to AD: EPT and SMART[16] (Self-Management and Recovery Training) recovery.

4.3 Care and Supervision Unit

On 16 August 2018 Mr McConville was involved in an altercation with another individual in custody, Individual A, and as a consequence Mr McConville was moved to the CSU. Nurse E saw him and observed bruising under his eye.

The following day there was an incident involving Mr McConville in the CSU. CCTV showed Mr McConville was handed food at his cell door at 15:51 and that he then threw it at 2 Prison Officers, Prison Officer C and Prison Officer D. CCTV shows the 2 Officers entering the cell where they remained for no longer than 18 seconds during which time they report they issued Mr McConville with a warning about his behaviour. After this incident Mr McConville complained that he had been kicked

[15] Healthcare and AD: EPT are informed of all failed drugs tests. A Prison Service member of staff will talk to the prisoner and see if they are willing to engage with AD: EPT. An incentive is used whereby prisoners can avoid adjudication if they engage in the process.
[16] SMART (Self-Management and Recovery Training) provides training and tools for people who want to change their problematic behaviour, including addiction to drugs, alcohol, cigarettes, gambling, food, shopping, Internet and others. Guided by trained facilitators, participants come to help themselves and help each other using a variety of cognitive behaviour therapy and motivational tools and techniques.

and punched, stripped to his boxers and left without a mattress and blanket. Nurse L examined Mr McConville and the only visible injury was swelling and bruising under the left eye as had been observed and recorded in the medical notes the previous day. Nurse L recorded, "I note swelling under eye was documented following the incident yesterday". The CCTV footage confirmed that neither a mattress nor blanket were removed from the cell as claimed by Mr McConville.

Later on the same afternoon (16:27 on 17 August 2018) Mr McConville was reported to have activated the cell's fire protection water sprinkler[17]. A number of Prison Officers responded to this incident. They quickly established that there was no fire and the sprinkler was de-activated. Mr McConville was charged under Prison Rules[18] and moved to another cell at 19:05. The same Officers who had been present during the earlier incident, Prison Officer C and Prison Officer D, were among those who responded to the incident with the sprinkler. This was evident from the CCTV footage that was reviewed. However, when interviewed neither could recall any details of this specific incident. Prison Service records provided limited information about the incident.

4.4 Erne House

The following day (18 August 2018) Mr McConville was moved to Erne House, Landing 2, Cell 18 after completion of his cooling off period in the CSU.

On 20 August 2018 Mr McConville made a complaint alleging he had been assaulted while in the CSU on 17 August 2018. The complaint was recorded on PRISM the same day and the record shows that Senior Officer B spoke to Mr McConville on 21 August 2018 to establish the nature of the complaint. As a result the complaint was passed to Governor C for investigation on 22 August 2018. Governor C interviewed Mr McConville on 23 August 2018, responded on the same day and the complaint was closed. I am content that procedure was followed.

On 20 August 2018 Mr McConville received a third week's supply of his 28 day Fluoxetine prescription.[19]

He also met with the Prisoner Development Unit. His previous needs profile was reviewed but Mr McConville stated he would not complete his remand plan as he did not want to be tied down to a particular agreement while in custody. Mr McConville also spent time in the Donard Centre.

[17] In cell fire protection system.
[18] Prison officers are responsible for enforcing prison rules to maintain good order and discipline.
[19] Mr McConville was assessed as being suitable for in possession medication. A 28 day prescription would be split into weekly supply for prisoners to manage.

4.5 Care and Supervision Unit

On 22 August 2018, Mr McConville received 3 days cellular confinement as a result of an adjudication for the incident which took place on 05 August 2018 and he spent this time in the CSU. He also received 14 days loss of evening association (including telephone), 14 days loss of earnings and 14 days loss of tuckshop.

Trust staff reviewed Mr McConville on 22 August 2018 and 23 August 2018 and no medical issues were noted. Trust staff were unable to see Mr McConville on 24 August 2018 as he attended court that day.

4.6 Erne House

On 24 August 2018 Mr McConville returned to Erne House and was located in Cell 14 on Landing 2. Mr McConville shared the cell with Individual B from 16:01 until 18:00. At 18:00 Mr McConville was moved to Cell 16 on Landing 2 and shared this cell with Individual C.

Mr McConville received a further adjudication relating to charges brought following the incident on 03 July 2018 when he had been observed fighting with another individual in custody. He was given a further 28 days loss of evening association (including telephone), 28 days loss of earnings, 28 days loss of tuckshop and 28 days loss of television/video/DVD.

On 25 August 2018 Mr McConville initially refused to go back to his cell and sat on the ground outside the Class Office. Prison Officer E activated the discipline alarm and Mr McConville then complied with the order, returning to his cell which was then locked.

On 27 August 2018 Mr McConville attended the Donard Centre. There is no record that he received his fourth week's supply of Fluoxetine.

28 August 2018

On 28 August 2018 at 11:40 while staff were unlocking Mr McConville's cell door, they said he swore at them and threatened to take their keys so his cell door remained locked. At that time Mr McConville occupied Cell 16 on Landing 2. At some point over lunch, according to Prison Officer accounts at interview, Mr McConville damaged the contents of his cell. The Landing Journal confirms that everyone on the landing was locked between 12:00-13:45 but neither the Landing Journal nor inmate notes record that Mr McConville damaged the contents of his cell or broke a radio.

At 15:11 Mr McConville was moved to Cell 18 on Landing 2 and he occupied it by himself. Approximately 30 minutes later an Erne House Senior Officer, Senior Officer C, opened a SPAR for Mr McConville. Prison Officer F said at interview that prior to

the SPAR being opened Mr McConville had threatened to cut himself. Prison Officer F said he managed to get Mr McConville to give him any sharp instruments out of the cell, which turned out to be a broken plastic pen. One concern recorded in the SPAR booklet is that Mr McConville would self-harm if he was not moved from Erne House. The second recorded concern is that Mr McConville was crying, visibly shaken and had poor eye contact. The immediate action plan developed to keep Mr McConville safe was:

- staff to carry out 3 conversation checks daily with Mr McConville;
- staff to observe Mr McConville every 30 minutes;
- Mr McConville should remain in his own cell; and
- Mr McConville should have access to the telephone as and when required.

The initial Trust assessment record in the SPAR booklet documented that Mr McConville was, "*placed on SPAR due to low mood*." Senior Officer C recorded in the opening entry in the SPAR logbook that Mr McConville believed he was being bullied by staff on the landing and wanted to be moved from Erne House.

Governor B was in Erne House investigating a separate, unrelated incident and heard Mr McConville crying while speaking to an individual in custody. Governor B spoke with Senior Officer C about Mr McConville and asked them to try and arrange a move for him to Quoile House, Donard Landing, a vulnerable persons landing. Senior Officer C confirmed they had contacted the Governor responsible for Donard Landing, Governor D, by telephone to request the move. Governor D agreed to a trial move but informed Senior Officer C that they should contact the Donard Landing, Senior Officer, Senior Officer D. Senior Officer D concluded, on the basis of the information provided by Senior Officer C that Mr McConville was not getting on with staff and wanted a move and that Mr McConville did not, therefore, meet the criteria for a move to the Donard Landing. Senior Officer D also said that Mr McConville had been attending the Donard Centre and there had been some issues with him. Additionally, there were only 2 cells available and Senior Officer D felt they would be needed for other individuals in custody with potentially more acute needs. The fact that the Donard Landing was primarily for vulnerable individuals in custody and Mr McConville had a history of altercations with others in custody also informed the Senior Officer's decision.

Senior Officer C then spoke with the Security Department within Maghaberry Prison by telephone to request a move for Mr McConville. The decision was pending at the time of Mr McConville's death. Staff requesting moves through security is normal practice. Most moves are considered by security in the morning and after a certain time of day moves would only be considered in exceptional circumstances. It is, therefore, not surprising that a decision about moving Mr McConville was pending.

Senior Officer C said they updated landing staff about the efforts to arrange a move for Mr McConville and for them to keep him informed. Senior Officer C reported exploring if there were any issues dealing with Mr McConville with the landing staff. Landing staff who were interviewed in the course of this investigation were unable to corroborate this.

At 16:31, Prison Officer F had a conversation with Mr McConville. He recorded, "*he struggles being in prison and that is made worse by not having family and no access to his kids*." Prison Officer F said he told Mr McConville to make "*them his main focus*" and attempted to reassure him.

Some individuals in custody in Erne House alleged that Mr McConville was deliberately given his dinner last that afternoon and that it was thrown at him. At interview the landing staff said this did not happen. There is no CCTV of the landing outside Mr McConville's cell to verify these reports. At 17:28, Prison Officer F recorded in the SPAR logbook, "*Not happy that he is still locked and said he didn't want dinner. I got his plate anyway and got his food and he seemed to calm again very quickly*." At 17:52 more information was recorded: "*Eating in cell. Requesting lighter fluid*[20] *and butts. Seems in much better form*." Senior Officer C completed a handover with Senior Officer E that evening. At interview Senior Officer E confirmed he was aware that Mr McConville wanted to move out of Erne House from information recorded in the SPAR booklet. The SPAR logbook records that, at 19:12, Mr McConville was given lighter fluid, hot water and tea and that he expressed gratitude.

At 21:55 Mr McConville found medication in his cell and gave it to Night Custody, Senior Officer F. This was documented in the Night Custody Officer's Journal. Mr McConville had previously been in this cell (Erne House, Landing 2, Cell 18) from 18 August until 22 August 2018. He told Senior Officer F that the medication was actually his but he did not want to get in trouble for having excess medication. While this is a possibility the matter was not explored further at that time. Senior Officer F gave the medication to Nurse F.

Nurse F put the medication "*in the medication trolley for safekeeping*." Nurse F reported the details of this incident to Nurse G, the Nurse in Charge that night, but did not record this on Egton Medical Information System (EMIS). Instead she documented it on the handover sheet for the day staff the following morning. She recorded that the medication was Fluoxetine, which Mr McConville was prescribed at that time.

[20] Individuals in custody are not allowed gas lighters for security reasons. They are given Zippo style lighters – Prison officers control access to lighter fluid and will fill the lighters.

29 August 2018

SPAR logbook entries provide an account of Mr McConville's activities on the morning of 29 August 2018. He responded to staff during the morning routine, enquired about his appointments. He was offered hot water and took a shower before leaving Erne House at 09:30 to attend a bail hearing in the video link suite. At 09:59 he was observed talking to other individuals in custody in a holding cell at the video link. A few minutes later, when he was called to attend the bail hearing Prison Officer G recorded that he was laughing and joking with other individuals in custody.

Mr McConville appeared at his bail hearing via video link and was refused bail because a suitable bail address was not available. He had a consultation with his solicitor after the hearing at 10:13. Mr McConville's solicitor, Solicitor A, said that it was his impression that Mr McConville appeared a bit depressed about being refused bail. There is no record of Solicitor A raising concerns of this nature to the Prison Service. Solicitor A explained that he had difficulty securing a suitable bail address among family, friends and hostels for a variety of reasons and at the last minute a hoped for bail address was not confirmed.

At 10:30 Mr McConville was escorted back to Erne House and he went to the yards when he returned. He was observed talking with other individuals in custody in the yard at 10:55 and walking in the yard at 11:20. There is no record of Mr McConville communicating with staff that he was upset about his bail application being refused.

At approximately 11:35 Senior Officer E completed Mr McConville's SPAR assessment interview[21]. This interview took place at Mr McConville's cell door and was attended by Prison Officer H. At interview Senior Officer E explained that Erne House was a busy place, although Mr McConville was in his cell on his own and it was quiet at the time. He felt it was the ideal place to complete the SPAR assessment interview. From the discussion Senior Officer E said it was clear that Mr McConville had issues with his medication. Afterwards Senior Officer E spoke with Nurse H and asked her to check Mr McConville's medication.

A doctor issued a repeat prescription for Mr McConville's medication on 29 August 2018 but this had not been administered at the time of his death.

In the course of the SPAR interview Mr McConville mentioned he had issues with a member of staff. Senior Officer E tried to explore this but Mr McConville was unwilling to provide a name and said that it did not matter. Senior Officer E was aware that Mr McConville wanted a move out of Erne House but said that it was their

[21] The purpose of the SPAR assessment interview is to gather risk pertinent information and provide re-assurance to the individual. It is also an opportunity to complete an information sharing agreement – this enables the Prison Service to involve family as a support mechanism. The assessment interview must be completed before the initial case review.

impression that Mr McConville did not seem too bothered about it. Senior Officer E said he asked Erne residential staff to request a move for Mr McConville but did not know if this had happened. Senior Officer E said they spoke with Prison Officer H who attended the assessment interview and asked if they were aware of any issue between staff and Mr McConville. Prison Officer H confirmed no awareness of any such issues. At interview Senior Officer E remarked that had the assessment interview been a SPAR review they would have closed the SPAR as, following interactions with Mr McConville, there were no indications that Mr McConville intended to complete suicide.

Mr McConville was given his lunch at 11:45 and Prison Officer H observed him in his cell at 12:15 eating lunch. At 14:20 Mr McConville went out to the yards where he remained until 15:20. At 15:45 he was again locked in his cell and was offered hot water. Mr McConville was observed at 16:00 in his cell smoking then doing press-ups 5 minutes later. At 17:20 he went out of his cell to get his evening meal. At 18:55 he was given hot water and lighter fluid, he was asked how he was and replied he was okay. At 19:20 Mr McConville was observed shouting out the window[22] and then 5 minutes later he was doing press-ups for a second time.

Erne House day staff completed a regular handover to the late shift at 19:35 which included information about Mr McConville who, "*seemed in good form today with no issues observed or any reason for concern*." At 20:40 a further handover was completed with Night Custody Officer A and again no issues were reported. Night Custody Officer A recorded in the SPAR logbook at 20:50, "*Spoke to Prs. McConville, asked him if all OK. He replied yes. Prs appears in good form. Passed Cig*." After this checks were recorded in the SPAR logbook at 21:05 (smoking in his cell), 21:35 (awake in his bed) and at 22:05 and 22:35 he was noted to be lying on his back.

At 23:04, 29 minutes later, Night Custody Officer A who had conducted the earlier checks proceeded to do a further check on Mr McConville. When Night Custody Officer A looked through the cell door they saw that Mr McConville was hanging in his cell so they immediately transmitted an urgent message across the radio to the Emergency Control Room (ECR) tasking a nurse to Erne House. A second Night Custody Officer, Night Custody Officer B, who was working on a different landing in Erne House, heard the urgent radio call and immediately went to Landing 2 to assist their colleague. After sending the urgent message Night Custody Officer A opened the cell door and entered the cell, lifted Mr McConville and with Night Custody Officer B's assistance, lowered him to the ground.

Mr McConville had used a strip of bedsheet threaded through 2 holes which appeared to have been burned in the ceiling light fitting as a ligature point. Night

[22] Individuals in custody often communicate with each other from different cells by talking or shouting through their windows.

Custody Officer B remembers the ligature untwisting as they cut it. The 2 Night Custody Officers laid Mr McConville on the ground and commenced Cardiopulmonary Resuscitation (CPR) straight away. Night Custody Officer B took control of Mr McConville's head and opened his airway. Night Custody Officer A began chest compressions and Night Custody Officer B performed mouth to mouth breaths immediately without a face shield. Radio transmissions record an ambulance was requested at 23:08:09 by Night Custody, Senior Officer G.

The table below sets out the timeline of events that happened over the next approximately 35 minutes:

23:11:54	Nurse I radio messaged Nurse J with the request to bring extra oxygen to the landing.
	CCTV shows Nurse I running to the external door of Erne House.
23:13:37	Nurse I entered Erne House, ran to the medical room and then continued to run to Landing 2 carrying a large green medical bag.
23:13:43	Senior Officer G entered Erne House and went straight to Landing 2.
23:14:40	Prison Officer I entered Erne House.
23:15:10	Prison Officer J entered Erne House
	The Prison Officers rotated chest compressions between them, whilst Nurse I maintained Mr McConville's airway and administered oxygen.
23:16:45	Prison Officer I got the Automated External Defibrillator (AED) from the Erne Circle and went to Landing 2 with it.
	The AED was attached and no shock was advised throughout the CPR. Nurse I also administered Naloxone whilst Prison Officer I recorded the timings of medication being administered.
23:18:58	A second nurse, Nurse J arrived in Erne House and brought 2 oxygen tanks to Landing 2. This second nurse provided guidance and support for the Prison Officers involved in CPR and helped maintain the airway, while Night Custody Officer B administered the oxygen using the ambu-bag.
23:18:58	A further Night Custody Officer, Night Custody Officer C entered Erne House and assisted with carrying equipment and ensuring timely access by the ambulance service.
23:38:59	First ambulance crew entered Erne House.

23:43:55	The second ambulance crew arrived in Erne House and took over CPR. They administered Adrenaline.

Senior Officer G tasked 2 Officers at the scene, Night Custody Officer C and Prison Officer J, to prepare to escort Mr McConville to hospital. Unfortunately, no signs of life were detected throughout the resuscitation attempt and Mr McConville's recognition of life extinct was recorded by the ambulance crew at 00:10 on 30 August 2018, over an hour after he had been found and during which time continued attempts were made to resuscitate him.

Throughout the incident those in custody in Erne House, from within their cells, shouted abuse at and threatened to kill staff. Prison staff reported this continued for some time. This is particularly unusual as those in custody are normally respectful during an incident of this nature. Items were set on fire and thrown from cell windows into the yards of Erne House. Nurse I reported this to the ECR by radio at 00:26 and the Northern Ireland Fire & Rescue Service responded at 01:00:29 and left at 01:05:42. My investigators spoke to several individuals in custody and some said that lighting items and throwing them out the windows was a mark of respect to Mr McConville. Prison Officer I recalled a couple of the individuals in custody shout out, "*he deserved it*" during the incident.

4.7 Post incident

Chaplain A received a telephone call from the prison in the early hours of 30 August 2018 to notify them of Mr McConville's death. Chaplain A arrived at the prison at approximately 03:00 and went onto the landing. Chaplain A said that Mr McConville's body was still in the cell and that he stayed by Mr McConville's cell door for 10 to 15 minutes, prayed and then left.

Paragraph 9.4 of the Northern Ireland Prison Service (NIPS) Suicide and Self Harm Prevention Policy 2011 (updated October 2013) provides guidance on contacting next of kin in the event of a serious injury or death. This states that the Governor in charge or Duty Governor must inform, as a matter of urgency, the immediate family or next of kin or arrange for another appropriate person to do so. The policy also provides for the Governor to arrange for a family chaplain or local PSNI officer to inform the next of kin.

Given the Chaplain's personal contact with Mr McConville, Governor E asked him to notify Mr McConville's parents, in person, of his death on behalf of the Prison Service. Chaplain A arrived at the family home at approximately 05:30 and spent some time with Mr McConville's father and members of the family who were present and understandably distressed. Chaplain A reported that Mr McConville's father had

mentioned at that time that his son had been in contact with him to try and arrange a bail address but he had not consented as he was trying a different approach. While this may have played on Mr McConville Senior's mind it is important to note that the family were trying a different approach to supporting their son as they were concerned he would repeat past behaviours and they believed him to be safe in prison custody. Mr McConville's father asked the chaplain if he could visit his son's cell. Chaplain A subsequently relayed this request to Governor E. It was not possible for this to be arranged.

Governor F made a telephone call to the family at 08:30 on 30 August 2018. He offered condolences and support and informed the family that the PSNI and my Office would be in touch with them regarding investigations.

For some considerable time after Mr McConville's death, his father maintained a vigil at the gates of Maghaberry Prison. Relationships between the Prison Service and Mr McConville's family were strained and difficult at that time.

A Hot Debrief[23] meeting was conducted at 03:20 on the morning of 30 August 2018 in Maghaberry Prison Boardroom, chaired by Governor E. The majority of Prison Service staff directly involved in the efforts to resuscitate Mr McConville attended along with the Trust nurses involved in the incident.

The following morning, a Senior Officer briefed Erne House residential staff and gave instructions that there was to be no undue restriction on movement for those living on the landing, that if any individuals in custody were upset they should be offered counselling and staff interactions with them should be done so with a degree of sensitivity.

A Governor also spoke to some of the inmates in Erne House the following morning.

The Cold Debrief meeting took place on 19 September 2018 and was again chaired by Governor E.

[23] Standard 25 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody. The hot debrief should take place as soon after the incident as possible and involve all staff who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted. The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning.

Section 5: Findings

This section sets out my findings under each investigation objective.

5.1 Establish the circumstances surrounding Mr McConville's death.

In Section 4 I have set out the events and circumstances leading up to the point Mr McConville was found. A summary of important dates is included at Appendix A.

I hope this provides some information and insight for Mr McConville's family and others about Mr McConville's most recent period of custody in Maghaberry Prison.

What was the impact of Mr McConville's bail application at the time of his death?

As set out in Section 4, Mr McConville attended a bail hearing via video link the day before he sadly passed away. At that hearing a suitable bail address was not available, therefore his application was refused and the matter was adjourned to a later date. As a result Mr McConville remained in custody.

Following the adjournment of his bail application Mr McConville's behaviour did not raise any concerns for Prison Service staff and as previously acknowledged, he did not comment to them about the situation. There is, therefore, no evidence of the adjournment of his application having had an adverse impact on Mr McConville's wellbeing.

5.2 Was the care provided by the Prison Service adequate?

An examination of a number of specific aspects of the care provided to Mr McConville by the Prison Service is set out below.

Were the complaints raised by Mr McConville prior to his death adequately examined?

Mr McConville made 3 complaints alleging serious assault by Prison Service staff. One related to a previous period of custody and 2 complaints were raised since his committal in June 2018. The complaints were brought to the attention of my Office shortly after Mr McConville's death. On 1 complaint form, Mr McConville said that he felt he had nowhere to turn and if the behaviour of the officer did not stop he could end up dead.

Given the serious nature of the allegations made by Mr McConville and potential impact on his state of mind, the handling of these complaints was included within the terms of reference of this investigation and information is provided here.

Mr McConville submitted a complaint on 23 April 2018 alleging he had been sexually assaulted by Prison Officers during a full body search on 19 April 2018. This matter was referred to the PSNI, investigated and a file was passed to the Public Prosecution Service (PPS) to review. The PPS agreed with the recommendation from the PSNI not to prosecute as the evidential threshold had not been met. This decision was not made until after Mr McConville had passed away. It is not clear what information Mr McConville received in respect of the progress of this complaint or if he continued to have contact with Prison Officers he alleged had assaulted him. Nevertheless, proper procedure was followed in the handling of this complaint.

On 06 August 2018 Mr McConville complained that he had been assaulted by a Prison Officer in Roe House on 05 August 2018. CCTV, Trust records and all relevant documentation were reviewed in relation to this incident. Prison Officers were also interviewed in the course of my investigation to establish the timeline of events. I have already referenced this complaint in Section 4.2. My Investigating Officer has examined the processes followed in relation to Governor's Orders relating to allegations of assault. A follow up investigation, carried out at the request of the Head of the Prison Service, is of note.

On 07 September 2018 the Head of the Prison Service requested that an investigation be conducted as information was available indicating that the processes for investigating the complaint made on 06 August 2018 had not been fully adhered to. This investigation was led by a Senior Governor, Governor G and a copy of the terms of reference for the investigation were shared with the then Director of Operations in my Office. Following the investigation a report was completed on 27 November 2018. All findings and recommendations were accepted and as a result a member of staff was charged with and disciplined for misconduct. It is important to note that while Mr McConville had been spoken to about his complaint and it had been referred to the PSNI, disciplinary action was taken because correct procedure had not been followed.

On 20 August 2018 Mr McConville further complained that he had been assaulted in the CSU on 17 August 2018. As with the earlier complaint, CCTV, Trust records and all relevant documentation were reviewed in relation to this alleged incident. Prison Officers were also interviewed and the details of what happened are set out in the relevant sections in Section 4 (4.3 and 4.4).

This complaint was referred to and investigated by a Duty Governor. In this instance, based on the information examined, Governor C deemed the complaint to be vexatious and did not refer the matter to the PSNI to investigate. It is not clear from Prison Service records if this response was issued to and received by Mr McConville.

One of the actions that the Prison Service takes when dealing with allegations of assault against staff is to ensure that the staff involved do not work in the same

residential area as the complainant. This is normally reviewed after the allegation has been investigated. There is no formal protocol in place for the PSNI to keep the Prison Service updated on relevant progress of an investigation which makes it difficult for the Prison Service to manage restricting areas of work for staff. If a staff member is cleared of an allegation it is important that they are informed at the earliest opportunity and returned to normal duties as appropriate. It is also important that complainants are informed in a timely way when matters are concluded.

It is not possible to determine to what extent the circumstances giving rise to each complaint impacted Mr McConville. As PSNI investigations were ongoing in respect of 2 of the complaints we do not know what Mr McConville's perception was of how they were being managed. One complaint had been ongoing for some significant time and was only concluded after his death. The impact of the time taken to conduct and conclude matters referred to the PSNI will inevitably have had a bearing on the actions taken by the Prison Service and for complainants awaiting the outcome of investigations. Mr McConville confided in one individual in custody, Individual D that he was worried whether anything was going to be done about the complaint he had referred to the PSNI and that he planned to follow this up.

From my review of the complaints raised by Mr McConville it appears to me that where there was a suspicion that procedure had not been followed the Prison Service took appropriate action to ensure redress and to establish learning for the future. However, there was an issue with information sharing and ensuring those involved were kept informed and so I make the following recommendation:

Recommendation 1: Allegations of assault protocol

The Prison Service should consider a formal protocol with the PSNI to ensure they are kept informed about the progress of investigations into allegations of staff assault, including when they have completed.

Is there any foundation to allegations that Mr McConville was bullied prior to his death?

The Prison Service received 3 complaints from individuals in custody shortly after Mr McConville's death and these were forwarded to my Office to be considered as part of my investigation. The complaints contained allegations that prison staff mentally and physically tortured Mr McConville prior to his death. A significant number of individuals in custody also came forward to give statements after his death. Many made allegations that Mr McConville had been mistreated by prison staff and, in some instances, by others in custody.

Mr McConville's father also made a number of serious allegations including that his son was abused and mentally tortured by Prison Officers.

Out of 33 individuals in custody interviewed during the course of this investigation, 28 provided statements detailing accounts of incidents they believed were instrumental in Mr McConville's decision to take his own life. The majority of people providing statements did not witness events concerning Mr McConville directly but were told of them either by Mr McConville or others in custody. While there were inconsistencies in their accounts, most appeared to revolve around the 3 incidents about which Mr McConville had formally complained to the Prison Service about and alleged events leading up to his death.

Five individuals in custody stated that they witnessed incidents between Mr McConville and Prison Officers in Erne House. One Prison Officer was mentioned in connection with 2 specific events:

- Individual E said that on the night before Mr McConville was found (28 August 2018) sometime between 17:00 and 17:30 he first heard raised voices at the end of the landing between Mr McConville and Prison Officer K about the meal not being the one Mr McConville ordered and that he saw Prison Officer K slap the plate out of Mr McConville's hand.

  Records for 28 August 2018 and 29 August 2018 indicate that Prison Officer K was on duty from 08:00 on both days but their finish time is not recorded on the 28 August 2018. Prison Officer K made no entries in Mr McConville's SPAR logbook on 28 August 2018. Up until 19:35 Prison Officer F made the entries, including a record at 17:28 that Mr McConville was not happy that he was still locked and that he did not want his dinner. Prison Officer F recorded that he got Mr McConville his food anyway and that he seemed to calm very quickly and at 17:52 Mr McConville was eating in his cell. Prison Officer L recorded in the SPAR logbook on 29 August 2018 that Mr McConville had been unlocked to get his evening meal at 17:20. There is no CCTV footage of Erne 2 landing available for analysis. At interview Prison Officer K refuted that they bullied individuals in custody and the allegation that they threw food at Mr McConville.

  On the basis of an examination of the available records and on the balance of probabilities, I conclude that this incident did not occur.

- Individual F said he saw food being "tipped" into Mr McConville's cell by Prison Officers and that on several occasions he had seen Prison Officer's grab Mr McConville and throw him into his cell.

  Individual F's statement mainly refers to events in Roe House and there are no specific dates and times specified. These allegations cannot, therefore, be substantiated.

- Individual C said that he heard Prison Officer K tell an individual in custody, Individual B that the only way he could get Mr McConville moved from sharing a cell with him was to hit him. Individual C admitted he felt bad that he was in on this joke. Individual B confirmed this was said to him. A common method of dealing with altercations between those in custody is to separate them as on 16 August 2018 when Mr McConville was moved to the CSU.

  Both Individual C and Individual B stated that Mr McConville had been returning to Erne House from the CSU. Having checked the Prison Service records in relation to cell location history Mr McConville did return to Erne House from the CSU on 24 August 2018 and he did share Cell 14 on Landing 2 with Individual B from 16:01 until 18:00. Mr McConville was then moved to Cell 16 on Landing 2 and shared this cell with Individual C.

  Individual C said that Mr McConville and Individual B hated each other and Prison Officer K knew exactly what he was doing putting them in the same cell. However, Individual B stated that he got on alright with Mr McConville.

  This specific allegation was not put to Prison Officer K at interview but allegations of bullying individuals in custody were. Prison Officer K responded that they did not bully those in custody. A follow up request on the matter was made but the Prison Officer had left the Prison Service by that time. At interview they did describe another incident when they had charged Mr McConville after he had damaged the contents of his cell but they did not recall any other notable incidents.

  Whether Prison Officer K intentionally put Mr McConville with Individual B and the degree to which they were actively in dispute with one another, is impossible to say. It is possible to confirm that the cell Mr McConville had left

was occupied by another individual when he returned to the landing. Sharing was, therefore, a reasonable option. It is possible to say that Individual B and Mr McConville did not have an altercation and within 2 hours Mr McConville was relocated.

- Individual G said in his statement that he had observed the incident in Roe House on 05 August 2018 and alleged that Prison Officer B gripped Mr McConville and slammed his head into the floor.

  Given the layout of Roe House, the respective cell locations, line of sight and CCTV footage relating to this incident it is highly unlikely that Individual G could have witnessed what happened inside Mr McConville's cell.

Eight individuals in custody said that they heard incidents involving Mr McConville and Prison Officers when in their cells. Five accounts related to the incident concerning Mr McConville's food being thrown at him the day before he died and 1 individual reported that he heard Prison Officers go into Mr McConville's cell on the day before he died and kick him in the stomach to get him up. In 3 statements individuals in custody described hearing McConville crying while in the CSU and 1 said he heard screams during the alleged incident with the search team earlier in the year.

The matter in relation to food being thrown at Mr McConville the day before he died has been dealt with above. It is entirely possible that Mr McConville was distressed and crying while in the CSU. The incident in the CSU and involving the search team were both subjects in complaints made by Mr McConville and the latter was referred to the PSNI who found that the evidential threshold had not been met. It appears that the complaints raised by Mr McConville prior to his death were largely examined in line with the Prison Service policy and the actions taken, given the information available and examined, were reasonable.

When interviewed Individual H said Prison Officer A told him that a colleague, Prison Officer B had picked on Mr McConville, that what Prison Officer B had been doing was wrong and that it wasn't right what he was seeing. This was put to Prison Officer A at interview and he refuted these allegations.

Twenty-eight Prison Officers were interviewed in relation to the circumstances surrounding the death of Mr McConville. They gave accounts of their interactions with Mr McConville, their involvement in incidents concerning him and they had the opportunity to respond to allegations of mistreatment and bullying.

Among the concerns which resulted in Mr McConville being identified as at risk of self-harm or suicide was that there was an issue with a member(s) of staff in Erne

House. Mr McConville did not provide details of who this was. The Erne House Senior Officer, Senior Officer C, said at interview they had asked staff if there was an issue with Mr McConville but none was reported.

In the interviews conducted with Prison staff, Mr McConville's behaviour was described by a number of them as being challenging and in several instances those who worked with him regularly said they felt he was difficult to manage. A number reported they took a firm approach with him at times. He appeared to respond better to female staff even though they said they took the same firm approach with him as male colleagues.

CCTV and incident reports were examined in relation to the altercations Mr McConville had with others in custody. In one instance, it is clear he was attacked and in another it appears he was the instigator. From the information examined it was not possible to discover what lay behind these incidents.

Mr McConville failed a drugs test on 23 July 2018 and he was observed swallowing a substance on 24 July 2018. During interviews with prison staff, 2 Prison Officers, Prison Officer M and Prison Officer N and an individual in custody, Individual I recalled seeing him under the influence of a substance on at least one occasion. Although neither Prison Officer thought he required to see healthcare staff. No specific dates were cited. Prison Officer E observed Mr McConville passing tablets. There was a further report of him being suspected of contraband possession but nothing was found when he was searched.

Mr McConville received no cash payments from visits between 20 June 2018 and 28 August 2018. The balance in his account was never more than £13.80 at any one time and this mainly comprised earnings associated with his regime status. He spent his money on the telephone and tuckshop. When interviewed some individuals in custody mentioned that Mr McConville did not have much in comparison to others and that he tended to borrow items such as trainers, clothes, food and tobacco from others in custody. We were told this was a source of annoyance amongst some of his peers.

Given the reality of the prison environment and the information above, one reasonable belief is that Mr McConville could have been under pressure from others in custody because of debt but there is no hard evidence to support this.

Mr McConville did not complain about how the incident in the CSU on 17 August 2018, where he had activated his water sprinkler, was dealt with. I acknowledge the operational actions that need to take place in such circumstances where there is a need to ensure that other areas are not flooded. However, I am concerned that it took approximately two and a half hours to relocate Mr McConville from a wet cell. It is likely that Mr McConville would have had access to dry clothing to change into but

there are no records to confirm this. While I am content that it can take some time to complete operational actions it would be helpful to have records confirming what had happened and actions taken. Given the length of time someone in custody may have to be in a wet cell written reasons for this should be made along with mitigations such as the provision of dry clothing and any other efforts to ensure wellbeing.

Recommendation 2: In cell fire protection activation

If the in cell fire protection water sprinkler system is activated, any person in the cell should be moved as soon as it is safe to do so and be given the opportunity to change into dry clothing. The incident should be escalated to a Senior Officer and properly documented, including a timeline of events.

Under my terms of reference if I come across matters where it is my view that a criminal or disciplinary investigation should be undertaken, I am required to alert the PSNI and Prison Service respectively. I did not identify any such matters in this case. Based on materials examined as part of this investigation and the significant number of interviews conducted, I was not able to substantiate the allegations made of mistreatment and bullying. It seems more likely that, at least in part, Mr McConville's behaviour was challenging for Prison staff who had very little understanding or knowledge of his underlying conditions. This is something I will return to in a later section of the report.

Comment on the condition of the cell in which Mr McConville died and the adequacy of the light fitting

The condition of Mr McConville's cell was not surprising given he was subject to adjudication. There was no television, radio or reading materials and limited furniture. There was some paperwork, which he had drawn/written on, and several pens in the cell. The lack of stimulation does not sit comfortably with the knowledge that Mr McConville was deemed to be at risk of self-harm and suicide. While I acknowledge that Mr McConville benefitted from normal routines during the day, when he was locked he appears to have had very little activity or distraction. I appreciate the balance that needs to be struck in terms of minimising risk of harm from allowing items to be available in the cell and maintaining order and discipline but when someone is deemed to be at risk and is being managed as such, consideration should be given to providing some form of in-cell material to occupy them.

As was mentioned by other individuals in custody, he had very few personal belongings. He appeared to spend time smoking and was observed on 2 occasions doing press-ups when locked in his cell. He did benefit from time out of his cell to shower, attend the video-link and he had access to the yards. He spent around an hour in the yards before and after lunch. Individuals in custody reported that he had spoken to them at their cell windows during this period and had asked them to give him tobacco. Furthermore, Prison Officers recorded in the SPAR logbook that he had interacted with others in custody at the video-link. After collecting his tea-meal at 17:20 on 29 August 2018 he was locked for the remainder of the evening.

The light fitting in Cell 18 was a Ministry of Justice National Offender Management Service approved standard cell light fitting. A different specification is used in observation cells. As Mr McConville was not assessed as needing to be monitored in an observation cell (also referred to as a safer cell), he was monitored while remaining in a normal cell.

It appears there were previous holes in the light fitting that had been repaired. It is not clear when these happened. In accordance with a Maghaberry Prison Governor's Order, fabric checks must be conducted on a daily basis and that during those checks particular attention is paid to fittings and ceilings. Any damage must be recorded and reported to trades for repair. Mr McConville's residential file could not be located so it is not possible to establish what was recorded on the cell compact form. There was no written record of any damage to the light fitting prior to Mr McConville occupying the cell nor was there a cell compact form indicating the cell had been checked prior to him being relocated. His residential file could not be located after his death. The journals for the 28 August 2018 and 29 August 2018 record the structure of cells checks as being completed. The holes made in the light fitting appear to have been caused by burning. Mr McConville had been given some tobacco and lighter fluid and had a lighter in his cell. It cannot be established with certainty whether Mr McConville made the holes in the fitting himself or if they were already there.

I raised this as a particular issue as a second individual in custody appeared to use the same methodology to inflict self-harm some months later. The risk that this can happen, especially when someone is being managed on a SPAR, should be brought to the attention of all staff and the importance of fabric checks in these circumstances underlined. It is also important that proper records are kept.

In a previous death in custody investigation the following recommendation was accepted by the Prison Service, 29 August 2018:

> *The NIPS should remind staff that a cell compact form is to be completed for each cell move and a copy placed on the prisoner's residential file.*

I would like to reiterate this recommendation to the Prison Service.

I welcome the opening of new accommodation at Maghaberry Prison which will result in the closure of some of the older square houses such as Erne House. This goes some way to addressing the type of cell in which Mr McConville was accommodated.

5.3 Was the clinical care provided to Mr McConville equivalent to that which he could have expected in the community?

The clinical care provided to Mr McConville was considered by an independent clinical reviewer, Professor Shaw.

Professor Shaw found it difficult to get a full picture of Mr McConville as there was no detailed personal and mental health history available in the records. She noted there were several diagnoses and symptoms but no evidence of a detailed understanding or formulation of his difficulties with a plan of management. Not much information was available from the community about his previous care and treatment. Professor Shaw found this particularly relevant in relation to his ADHD.

An initial mental health screen was completed with Mr McConville. This involved a review of the patient's electronic healthcare record. Following a previous committal to custody on 20 June 2018 a mental health assessment had been carried out and Mr McConville was not referred for assessment. Professor Shaw said this is not an uncommon picture across UK prisons. In her opinion Mr McConville should have been referred for a more detailed mental health assessment and consideration given to whether there was evidence of any mental disorder, including ADHD. She pointed to the use of complex case reviews in many prisons and believed that Mr McConville would have been a good candidate for such a discussion. In her experience however such reviews are usually reserved for highly complex cases causing significant problems for the regime and it was therefore likely that Mr McConville would not have reached the threshold for discussion.

In Professor Shaw's view the presentation of people with multiple lower level needs, such as Mr McConville, is very common in prison and his care was not unusual, with a reactive rather than proactive managed approach.

I welcome the fact that the Trust completed a quality improvement project in relation to mental health screening. As a result of this work, face to face triage is done for every committal in both committal prisons.

Improvements with this new service include: building therapeutic relationships; enhanced participation and future communication; breaking down barriers;

promoting empathy and providing a deeper insight, which in turn promotes the quality of care. It is imperative that these improvements are embedded and that reviews are a regular occurrence.

Was Mr McConville taking his medication at the time of his death and if not what was the impact of this? : Was the response to Mr McConville handing back his medication appropriate?

The toxicology analysis carried out after Mr McConville's death did not detect drugs of abuse in his system. Tests for a range of pharmaceutical drugs, including Fluoxetine, the medication he was prescribed at the time of his death, found that this was not present. I commissioned a separate, independent clinical review of Mr McConville's medication which was conducted by Mrs Jenkins, a Forensic Scientist. In her report Mrs Jenkins writes that Fluoxetine would remain at detectable levels for up to a week after daily dosing.

Trust records showed that Mr McConville received the third week's supply of a 4 week prescription for Fluoxetine on 20 August 2018. His cell location at this time was Erne 2 Cell 18. On 22 August 2018 he was placed in the CSU to complete 3 days cellular confinement as part of a previous adjudication. He returned to Erne 2 cell 14 on 24 August 2018 and was moved to Erne 2 Cell 16 later that day. Mr McConville was due his fourth week's supply of a 4 week prescription on 27 August 2018, but he did not receive this. It is not clear from the records why he did not receive this medication. Mr McConville damaged the contents of Cell 16 on 28 August 2018 and was subsequently placed into Erne 2 Cell 18 later on that day.

On the balance of probabilities, from the evidence available, when Mr McConville was moved from Erne 2 Cell 18 to the CSU on 22 August 2018, his medication was not taken with him. It is likely the medication remained in Erne 2 Cell 18 until Mr McConville returned to this cell on 28 August 2018.

While in the CSU on 22 August and 23 August 2018 Mr McConville was seen by nurses and reported no medical issues. He was not seen on the 24 August 2018 as he had a court appearance. He could have raised issues about his medication during these 2 consultations.

Mr McConville handed a quantity of tablets to staff on the evening before his death (28 August 2018). Nurse F left a note for the day staff to discuss the return of the medication the following day at the daily huddle. On 29 August 2018 Senior Officer E completed a SPAR assessment with Mr McConville and afterwards asked Nurse H to check Mr McConville's medication. A new prescription was ordered for Mr McConville on 29 August 2018. He had not received this medication before he died.

It is not clear:

- why he was not issued with week 4 of the monthly prescription on 27 August 2018;
- if and when he stopped taking his medication and whether this was explored with him;
- what arrangements were in place to ensure continuity of medication when he went to the CSU;
- if he was able to access the medication that would have been in Cell 18 when he returned to Erne House from the CSU (as he was then placed in a different cell); and
- how many Fluoxetine tablets he handed back on the evening of 28 August 2018.

All of these matters led to the question as to how long Mr McConville may not have been taking his medication and what the potential impact of this was.

Mrs Jenkins, who specialises in cases involving alcohol and drugs, was invited to review these matters and provide an opinion. She was asked:

i. What is the impact of an individual not taking Fluoxetine as prescribed?
ii. How long would Fluoxetine remain in the system, and does its absence at therapeutic levels provide any indication as to how long Mr. McConville had not been taking Fluoxetine?

She was also invited to share any other observations she might have.

Her conclusions were:

i. It is not possible to predict how long Mr. McConville had not been taking Fluoxetine, but it is likely to have been at least 1 week and may have been significantly longer. Discontinuation of Fluoxetine is likely to have put him at higher risk for suicide and his age, demeanour as observed on 28 August and possibly the prison setting may have put him at higher risk for suicidal events.

ii. Mrs Jenkins would have expected Fluoxetine to remain at detectable levels in the blood stream for at least a week following daily dosing and its metabolites possibly for several weeks. Considering the sequence of events of cell moves and issue of medication, combined with the Fluoxetine and metabolites in Mr McConville's blood sample suggested to Mrs Jenkins that he may not have had any medication from leaving the cell on 22 August 2018.

iii. Mrs Jenkins said that the procedural aspects of the case were outside her

area of expertise but that it would make sense for checks to be made when inmates are moved between cells to ensure they have taken medication with them and that when medication is returned that the number of tablets is recorded and cross referenced with when it was last prescribed to identify any issues with non-compliance. She noted that checks of that nature had been conducted on 07 July 2018 in relation to Mr McConville's medication. She also made comment if checks had been done when Mr McConville handed back his medication on 28 August 2018 it may have become apparent that he did not receive his medication on 27 August 2018.

Professor Shaw also commented on Mr McConville returning medication and recommended that a standard procedure should be developed on what to do when excess medication is handed to staff, including detailed follow up regarding the reason for the accumulated excess with detailed documentation in the records.

A similar issue was identified in a previous death in custody investigation and the Trust accepted the following recommendation:

> *If it is identified that a patient is not taking their prescribed medication, the Trust should ensure disposal of unused medication and offer the patient an appointment with a GP to discuss. The outcome should be documented in the patient's records.*

Medication is currently disposed of in accordance with South Eastern Trust Policy. However, the Trust recently revised the Medicines Management Policy and Medicines Optimisation Policy became operational on 07 February 2022. I will monitor the application of this policy as my hope is that it will provide person-focussed care, with less focus on the medication or available resources.

When individuals in custody who manage their own medication move to the CSU there appears to have been a delay in medication following them at that time. This was identified in this investigation and a previous complaint dated 30 October 2018 investigated by my Office. The Prison Service accepted the following recommendation when the draft report was issued to them for comment on 16 October 2019:

> *That the Prison Service ensure that residential staff arrange for the return of all in-possession medication with the residential nurse and advise that the prisoner has been relocated to the CSU. The Trust should then manage the issue of medication.*

The Prison Service confirmed to my Office that this recommendation was implemented and complete in January 2020.

It is also worth noting that the Trust conduct medication spot checks, which aim to identify patients who are non-adherent with their prescribed medication and appropriately signpost patients to help them with this non-adherence. Medication adherence, or taking medications correctly, is generally defined as the extent to which patients take medication as prescribed by their doctors. Non adherence may limit the benefits of medicines, resulting in lack of improvement, or deterioration, in health.

A spot check involves the patient bringing their in-possession medication to the treatment room where a nurse, or pharmacy technician, will check it off against their prescription list, identifying any discrepancies and the nurse, or pharmacy technician, would explore the reasons behind this.

The Healthcare in Prison team will initiate medication spot checks if they have concerns about a patient's adherence with their medication and the outcome may lead to changes to their medication regime or a switch from in-possession to direct administration of medication to support them.

Were the interactions between Nurse K and Mr McConville appropriate and professional at all times?

The interactions between Mr McConville and Trust staff were examined and all appear to have been professional. No issues of concern were identified. I am satisfied that the interactions between Nurse K and Mr McConville were none other than appropriate and professional.

5.4 Were Mr McConville's particular needs and vulnerability identified, assessed and appropriately managed by Prison and Trust staff?

Mr McConville presented with a number of particular needs and vulnerabilities including substance misuse, depression and anxiety. Among those needs was ADHD which is referenced by his mother in her question about whether or not anyone, either in prison or elsewhere, pieced together elements influencing his behaviour? In relation to ADHD, Mr McConville's needs were not assessed. Mr McConville is not unusual in this respect in that ADHD takes some time to diagnose and so prisons are dependent on either knowledge of a childhood or adult diagnosis[24]. Diagnosis

[24] An additional diagnosis is required for adults who have been diagnosed as children.

requires a lengthy process which could not be completed at committal nor could it be completed in the context of frequent, short-term stays in custody.

Professor Shaw noted that experts at a meeting hosted by the United Kingdom ADHD Partnership suggested identification is the key. By identification they did not mean diagnosis but rather the ability to recognise and put together sets of behaviours and conditions that would indicate ADHD. They highlighted that raising awareness is vital and all staff should be trained to recognise the signs and be knowledgeable on treatment options.

Professor Shaw said there is no specific ADHD intervention provision within the prison and this is not uncommon across the prison estate in the UK. Given the prevalence of the disorder in prisons and also its 'treatability,' it was her view that all staff should be aware of the symptoms of ADHD, there should be assessment for ADHD at reception with a pathway into treatment including the provision of pharmacological approaches.

It is difficult to assess the importance of this proposal when there is no Northern Ireland specific data available in regard to the prevalence of ADHD. Nevertheless, the same body of experts as Professor Shaw refers to, identified key elements to dealing properly with those individuals in custody who have ADHD:

- Effective identification
- Treatment
- Multiagency liaison
- Requirement for different approaches based on age or gender

Given that diagnosis may be a near insurmountable challenge in the context of prison life identifying factors pointing to the presence of ADHD is critical. It is also essential to build on existing medical information to assess potential symptoms and provide a consistent care plan. Building on existing information is in itself a challenge as it requires multi-agency cooperation and the tools to gather information together to inform a consistent and persistent approach to care management.

Changes will be implemented to the current needs assessment which should assist with the provision of a better understanding of the needs of the prison population generally and individuals within it. While diagnosis may be difficult it remains of concern to me that someone, like Mr McConville whose behaviours and childhood diagnosis could indicate an ongoing challenge, may not have these taken into account in care provision. This would require a level of information sharing that may not currently exist, between community and Trust staff in prison and between Trust staff and prisons.

The focus of investigation is on care equivalent to that provided in the community. As Mr McConville's mother was aware of mechanisms that allowed him to remain balanced and to cope with his context equivalency must include the input others around the person concerned would experience while in the community. Improvement is also an issue for the future to ensure that others are treated in a manner that enables coping. I am aware of the significant challenges this presents to those caring for people in custody. Nevertheless, issues such as this must be addressed for the safety and wellbeing of those in custody and the confidence the wider public have in the system. I am hopeful that the new needs assessment approach will assist in this matter. In their report of October 2021 RQIA acknowledged that the needs assessment, commissioning and planning arrangements for healthcare in prisons required substantial improvement due to "demand greatly exceeding capacity". They further recognised the lack of specialist support for people with personality disorder and for those with specific vulnerabilities such as learning disability. As a consequence, RQIA recommended:

> *"Commissioners and providers should ensure that there is a robust screening and data collection system for specific vulnerabilities such as learning disability, autism, ADHD, acquired brain injury and dementia. This data should be used to inform the needs assessment, planning and commissioning of specialist provision to ensure that services meet the needs of these vulnerable groups."*[25]

It is also important to acknowledge that healthcare in prisons is significantly underfunded and without the funding required such improvements discussed here may be too great a challenge to meet. The RQIA review of services for vulnerable persons has noted the insufficient resource for healthcare in prisons, in particular as it compares to other jurisdictions. Resource is required to properly provide service to those in custody, which is a critical aspect in the rehabilitation process and should, therefore, be adequate to provide what is required to deliver services effectively. It is critical that decision-makers ensure that required resource is provided to support both the changes identified as essential by RQIA and longer-term delivery of services. It is my hope that a needs assessment would take into consideration concerns that I have raised in recent reports and that it will be fully resourced to ensure the safety of those in custody. I have raised the matter of gathering information to inform care in previous reports[26] and I would like to see continued innovative thinking about how we might engage with people such as Mr McConville

[25] Review of Services for Vulnerable Persons Detained in NI Prisons, RQIA, October 2021, Recommendation 2, p36f

[26] Mr U report published 09 February 2022
https://niprisonerombudsman.gov.uk/publications/download/143
Mr Emmett Cassidy published on 16 March 2022
https://niprisonerombudsman.gov.uk/publications/download/145

differently to improve their lives, keep them safe and reduce the risk of them reoffending. ADHD should be part of their deliberations.

Effective care and response to individuals with specific vulnerabilities such as ADHD will require awareness training for all staff and specific training on the assessment and treatment of ADHD for Trust staff. It will also require raising Prison Service staff awareness and keeping that awareness to the fore given the potential numbers of individuals in custody who have ADHD and conditions that often occur with it, for example Autism Spectrum Disorder, Personality Disorder and Anxiety.

In effect, the result of ADHD can be that the prison regime may aggravate symptoms and what is a cry for help or evidence of a disorder for an individual in custody could be treated as bad behaviour thereby eliciting an inappropriate response. I am very conscious of the strain there is on resources within prisons. Yet without some significant, informed changes in approach it is likely that the kind of rehabilitative work which society expects prisons to deliver will be impossible for many who are in custody.

With this in mind, and accepting the complex nature of work in this area, I make the following recommendations:

Recommendation 3: Identification of ADHD and other neurodevelopmental disabilities

Trust staff in Prison should proactively contribute to the development and review of regional service models to ensure that the needs of those in custody with ADHD and other neurodevelopmental disabilities can be met.

Recommendation 4: ADHD and other neurodevelopmental disability training

Trust and Prison staff should access available training on neurodevelopmental disabilities, including ADHD, as appropriate to job-role to inform practice in response to behaviour and presentation of individuals.

ADHD is a matter of importance to Mr McConville's family. From the evidence available it is also important to say it is unlikely that if any of the above recommendations were implemented the outcome would have been different for Mr McConville. What now presents is an opportunity to learn and to consider good practice from other jurisdictions who work from indicative figures towards improved

practice. For example, the Scottish government received a report in January 2021[27] in which it was stated:

> *"Hidden disabilities, including … ADHD and other neurodevelopmental disorders, are conditions that are not easily recognisable or visible. These impairments are more difficult to identify in prison settings, due to lack of awareness, resources and specific assessment systems in the criminal justice system."*

If increased awareness is to have an impact, it must take a whole justice system approach and indeed an approach that takes these matters seriously at every stage in an individual's life. Mr McConville did not arrive into prison without prior life-experience. The systems around him had been unable to make the impact necessary for him to build a life outside of the prison or other care systems.

Mr McConville spent 11 short periods in custody during a 3 year period from 2015 until 2018. During this time the Trust carried out 11 non face to face mental health screens and 5 more in depth face to face mental health assessments. Following his last committal he was not referred for assessment but was referred to the prison's drug and alcohol support service, AD: EPT and the Donard Centre for therapeutic classes. Mr McConville was managed under the SPAR process on 12 occasions between 2015 and 2018.

Professor Shaw said that short periods of time in custody make it difficult for Trust staff to engage with a person and provide interventions during the custodial term. The risk she said was that the person with multiple admissions just has multiple assessments with limited time to provide/engage in interventions.

In her view Mr McConville's needs could have been better managed in prison if:

- A more detailed assessment was carried out, informed by reviewing prison health and community records;
- Consideration was given to whether there was evidence for any mental disorder, including ADHD and what treatment was required;
- The development of a management plan that was regularly reviewed by Trust and custodial staff.

In her opinion this approach would have allowed the significance of events such as the alleged assault by staff, desire to move wings and the handing in of tablets to have been recognised, understood and managed in a holistic way. She

[27] 2. Literature Review - Understanding the social care support needs of Scotland's prison population: research - gov.scot (www.gov.scot)

acknowledged that it was not unusual for prisons to not work in this way for this group of people. In previous reports I have written about 'care formulation and management plans'.

I note that the Prison Service has a Safer Custody Structure and all establishments have a caseload approach that supports people with complex needs to be supported in a multi-disciplinary way. However, Mr McConville was not being managed on the Safer Custody caseload.

I would encourage the completion of an information sharing agreement between the Trust and the Prison Service, currently underway. In my opinion it would be beneficial for the Trust to share information beyond an 'at risk' basis. This may help the Prison Service identify individuals that could be better managed on the Safer Custody caseload and it would help them to establish what behaviours to look out for. It could also lead to the Prison Service considering different disciplinary approaches to individuals, based on the information shared.

I will monitor closely the implementation of recommendation 12[28] in the RQIA Review Report. Its implementation should ensure a range of specific vulnerabilities, including ADHD, are picked up at an early stage and services tailored to meet individual needs.

I am conscious of efforts the Prison Service and the Trust make to ensure records 'travel' with those in custody. However, the matter of relevant knowledge and consistent care planning persists within a number of my investigations. The Trust have embarked upon work to implement recommendations within the RQIA Review Report. My hope is that this work will address concerns I have in relation to planning consistency based on good and up to date information about individuals health and wellbeing.

5.5 Was Mr McConville appropriately managed under the SPAR at Risk procedures?

At the time of Mr McConville's death the operating procedures[29] as set out in the Prison Service Suicide and Self-Harm Prevention Policy 2011 (updated October 2013) applied. This policy aimed to identify vulnerable individuals in custody who are at risk of self-harm or suicide, and provide the necessary support and care to minimise the

[28] Commissioners (currently the HSCB) and providers (SEHSCT) should ensure that there is a robust screening and data collection system for specific vulnerabilities such as learning disability, autism, ADHD, acquired brain injury and dementia. This data should be used to inform the needs assessment, planning and commissioning of specialist provision to ensure that services meet the needs of these vulnerable groups.

[29] The operating arrangements were revised and introduced to Maghaberry Prison in February 2019.

harm individuals may cause themselves throughout their time in custody. Within the Prison Service policy a 'vulnerable prisoner' was defined as:

> *"An individual whose inability to cope with personal situations within the prison environment may lead them to self-harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication."*[30]

The policy document provides guidance on risk factors. This guidance then informs Officers/anyone opening a SPAR who apply guidance and exercise their professional judgment about what is necessary for the individual who will be treated using the SPAR approach.

Assessment of Mr McConville's risk of self-harm and suicide

Professor Shaw felt that it was appropriate for a SPAR to be opened on 28 August 2018. She noted that Mr McConville was asked if he had any thoughts of self-harm or suicide and he had said no. She noted that at various times while in prison Mr McConville was placed on SPAR, including at the time of and immediately prior to his death and it therefore had been recognised that he was at increased risk of self-harm at this time.

Professor Shaw said that the daily SPAR entries were superficial with no exploration of his problems and that there was no triangulation, as far as she could see, from the Trust records. She said individual observations need to be much more in depth, to try and understand what the underlying issues are.

It was her opinion that SPAR processes should be reviewed with particular reference to improving the quality of reviews and monitoring by prison staff. She saw no evidence in the records of meaningful conversation checks as was required under the SPAR operating procedures in place at that time.

In Professor Shaw's experience similar problems had been recognised in England with their equivalent process, Assessment, Care in Custody and Teamwork (ACCT) and that a review of these arrangements was underway. She believed that there was potential learning for the Prison Service from this review.

Since 2018 the Prison Service has updated its SPAR operating procedures to SPAR Evo and these arrangements were fully rolled out across Maghaberry Prison by August 2020. The updated procedures aim to take account of shortcomings identified by Criminal Justice Inspection Northern Ireland and my Office. SPAR Evo

[30] Prison Service Suicide and Self-Harm Prevention Policy 2011 (updated October 2013) p4. https://www.justice-ni.gov.uk/sites/default/files/publications/doj/april-2014-suicide-and-self-harm-prevention-policy.pdf

introduced a person centred approach, giving staff much more flexibility to create a more bespoke plan to suit individual needs. Portable IT has been developed and put to use so that staff have a full history of previous concerns. The outcome of these concerns have been colour coded, red (at risk), amber (no apparent risk with referral or other action) and green (no apparent risk). This allows staff to see at a glance the outcomes of previous concerns.

While the new SPAR Evo has yet to be evaluated the shift in emphasis is obvious. This is a significant and important development for supporting those in custody. The encouragement to engage directly with the individual who is potentially at risk is also significant and can contribute to increased trust. However, without evaluation the full extent of the improvement is unknown. I endorse the RQIA recommendation for an external review of the SPAR Evo approach and emphasise the urgency of this evaluation being completed. This should include information which assures me that the issues raised by Professor Shaw in respect of risk factors and triggers are adequately addressed in the operating procedures. I have been informed by the Prison Service that an evaluation of this organisational change is due and the results will be shared with me. I await a copy of that evaluation.

The handling of Mr McConville's request to be moved out of Erne House

As detailed in Section 4 of this report, efforts were made to move Mr McConville to a different residential location after a SPAR was opened on 28 August 2018. Senior Officer C in Erne House had requested that he was moved to the Donard landing[31] (Quoile 2) and then made a request to the Security Department for him to be moved.

These requests were not formally documented and decisions were not recorded at the time. The rationale behind the decision not to relocate Mr McConville to the Donard landing was established at interview during the course of this investigation and is documented in Section 4 of this report. From what has been established, the process to request moves through security could be improved in certain circumstances. In this case, where the decision was not made on the day of request, continuity of the request is lost. The person making the request and the person receiving the request may not be on duty the following day and without formal documentation of the request and a follow up procedure it may lead to delays in requests being processed. I therefore make the following recommendation:

[31] *Quoile 2 is a residential location for individuals with a mental health diagnosis requiring additional support and management from both discipline staff and the Mental Health Team. This is also inclusive of those who are awaiting Transfer Direction Orders for assessment and treatment and those who are returned to custody on completion of psychiatric treatment. With regards to access at this time any referral would be considered by Prisoner Safety and Support in conjunction with the Mental Health Team. Access criteria would include those with a mental health diagnosis.*

Recommendation 5: Relocation of individuals in custody

The Prison Service should ensure that requests for the relocation of individuals in custody who are being supported under a SPAR Evolution care plan are documented, including the rationale for the decision made.

Was the response to the incident effective and was resuscitation conducted in accordance with national guidelines?

Professor Shaw said that the response to the incident was rapid and was carried out in accordance with national guidance. I acknowledge that this was carried out in difficult circumstances – others in custody were making a lot of noise and I have had reports of threatening behaviour towards both Prison Service and Trust staff at the time of the incident.

I commend the staff for their efforts to resuscitate Mr McConville.

5.6 Were the post incident debriefs adequately conducted and were prison staff, Trust staff and individuals in custody signposted to support services?

The Hot Debrief[32] should take place as soon after the incident as it can be arranged and involve all the staff, where possible, who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

A Hot Debrief meeting was conducted and minutes show it commenced at 03:20 on the morning of 30 August 2018 in Maghaberry Prison Boardroom. The prison's Governor, Governor E chaired the debrief meeting. It was attended by the majority of staff who were directly involved in the efforts to resuscitate Mr McConville, including nurses. The initial timeline of events was established and staff were signposted to

[32] Standard 25 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody. The hot debrief should take place as soon after the incident as possible and involve all staff who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted. The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning.

support services. Governor E referred to the pro forma within the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated 2013) to ensure all points were covered.

The Cold Debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning. This also provides a further opportunity to check in with staff involved in an incident.

The Cold Debrief meeting took place on 19 September 2018 and was again chaired by Governor E. It was acknowledged that it had not taken place within 14 days due to difficulty getting staff attendance from both the Prison Service and the Trust. There was representation from some of the staff who were directly involved with responding to the incident on the night of 29 August 2018 and the nursing staff. There was also representation from the PSST, a nursing manager and the IMB.

From the documentation available, Professor Shaw noted debriefs appeared to involve the right people and were timely and appropriate. Professor Shaw said it would be useful to have a learning lessons forum following the investigations, for Prison Service and Trust staff.

I welcome this observation. It is important that where learning is identified it is effectively communicated and shared. A strategic priority for my Office for 2020 - 2024 is to work with the Prison Service and the Trust to enhance the impact and learning from death in custody investigations and ensure learning is widely shared and communicated.

Night Custody Officer B highlighted that she did not have access to a mouth-to-mouth resuscitation aid during CPR. An action point to make barrier protection available on Night Custody Officer Belts was raised at the Cold Debrief meeting. This was considered by PSST and the response was that 2 barrier protection units are contained within the AED units covering all locations so that they are available to first responders.

It was also reported by Night Custody Officer B that up until her interview with my Office she had not seen the completed minutes of the debriefs.

It is difficult to have everyone present at debrief meetings due to the number of people involved, shift patterns and personal circumstances. I strongly believe that all those directly involved in serious incidents in prison must be involved in post incident meetings unless attendance would be detrimental to their well-being. I reiterate to the Prison Service previous recommendations regarding attendance at these meetings and the need for a formal mechanism to follow-up with any staff who did not attend the debrief meeting. I would also highlight to the Prison Service a

previous recommendation that learning points identified at debrief meetings should be assigned to a named individual or department to implement and include clear timescales for completion.

Two night staff felt that there appeared to be a difference with support services depending on whether or not you are off sick. Their perception was that staff on sick leave as a result of an incident get automatic referrals whereas staff that continue to work do not. One of them felt that it may be beneficial for all staff directly involved in the incident to get automatic referrals for support services.

One night staff member felt the pathway to the Police Rehabilitation & Retraining Trust[33] support was difficult and did not get an appointment until November 2018. This staff member also asked for a 'non-prisoner facing' role after the incident and this could not be accommodated.

Two residential day staff that had interacted with Mr McConville prior to his death said they were unaware of support services available to them. It would be useful to remind staff of support services available. Another residential day staff member that had managed Mr McConville while he was on SPAR prior to his death was not directly offered support but did not feel he needed it.

Residential staff were briefed by their Senior Officer the morning after the incident and informed staff to be mindful of sensitivities and to signpost those on the landing to support services where required. One individual in custody that spoke with my Office stated that he had received bereavement support and another said that he had been offered support and was aware how to avail of it.

It is common practice for the Prison Service to inform those in custody of a death in the immediate residential location of the deceased. Support services are offered and regimes are maintained where possible to keep them engaged in purposeful activity to keep their minds occupied.

It is important not only that follow up support is provided and signposted but also that its effectiveness is regularly reviewed by the Prison Service and Trust. A Review of Support Services for Operational Prison Staff report was published on 30 November 2021. I welcome the recommendations made within this report and acknowledge that the Prison Service is working through their implementation. I will monitor the progress of this ongoing piece of work.

[33] This is a support service that Prison Service staff can avail off.

5.7 Could Mr McConville's death have been predicted and were there opportunities to prevent it?

Mr McConville had multiple complex needs with a long history of self-harm. In Professor Shaw's view he was always potentially at risk of further self-harm and eventual suicide.

Professor Shaw's opinion was that Mr McConville's "death could not have been predicted with any certainty." She identified missed opportunities in care provision, for example around ADHD provision and a more detailed exploration of the reasons for his current distress through the SPAR process.

Whilst provision of improved care could have helped in the understanding and potential alleviation of this distress, she concluded that it would not have prevented his death.

While not asked to comment on whether or not Mr McConville's death could have been predicted, Mrs Jenkins does make the following comment in her review of his medication:

> *"Discontinuation of Fluoxetine is likely to have put him at higher risk for suicide and his age, demeanour as observed on 28 August 2018 and possibly the prison setting may have put him at higher risk for suicidal events."*

While there is no evidence that the lack of medication contributed to Mr McConville's death, given it cannot be calculated with any degree of certainty how long he had not been taking his medication, it is nevertheless of concern that he was not taking this medication. It is imperative that the Trust ensure that medication is properly monitored, that medication handed back is counted and that there is proper oversight of depression medication to ensure withdrawal is not having an impact should an individual in custody fail to take medication or that medication is properly taken. While this is no doubt challenging for Trust in terms of resourcing it is nevertheless important to remember that while in custody many of the other supports an individual may have are not present on a daily basis.

5.8 Identify areas of good practice and any learning opportunities arising from this case.

Professor Shaw noted the process whereby all receptions are reviewed by mental health staff was good practice and the triage system sensible. She welcomed plans to do this review face to face. She regarded this process as essential given the high prevalence of mental health problems among those in custody and the need to prioritise people with serious mental illness.

In her view prisons needed to develop a better system for the shared management of people like Mr McConville who have multiple 'lower level' problems but no serious mental illness. I believe it is part of a wider systemic issue and needs to include Trust and community agencies. Roundtable discussions have started on this and I am hopeful that work on this will progress well.

Professor Shaw recognised the Donard Centre and landing as a model of good practice.

Section 6: Conclusions

With regard to my responsibilities to investigate Mr McConville's death and specifically considering the objectives of my investigation, I draw the following conclusions:

6.1 Establish the circumstances and events surrounding the death, including the care provided by the Prison Service.

The circumstances and events surrounding Mr McConville's death have been established and these are set out in the key events and in my findings sections of this report.

Although a large number of individuals in custody stated that Mr McConville had been mistreated, these allegations were not substantiated. It is clear from a number of incidents that Mr McConville presented with challenging behaviour and this was managed differently by different members of staff.

Staff managing Mr McConville on a day to day basis were unaware of much of his background and there is no specific service for those with ADHD in custody.

The care provided by the Prison Service was appropriate based on the information and knowledge available to Prison Officers.

In relation to the complaints that Mr McConville made before he died, I am satisfied that these were largely examined in line with the Prison Service policy and the actions taken, given the information available and examined, were reasonable. The Prison Service referred allegations of assault to the PSNI, when appropriate to do so, and removed relevant staff from working in Mr McConville's residential location while investigations took place.

With the roll out of Davis House accommodation I would encourage the Prison Service to close the older square house accommodation, such as Erne House, where

possible. This will improve the living accommodation for those currently living in the older houses and particularly for those being managed under SPAR Evo operating procedures. I understand this may, at times, be difficult due to operational challenges.

6.2 Examine any relevant healthcare issues and assess the clinical care provided by the Trust.

Mr McConville's healthcare was managed reactively and whilst this is not unusual I believe improvements could be made if work were to progress on developing consistent care planning. This would require bringing together information from the community and that held from previous committals so that at each new committal an individual coming into custody could have an information base on which healthcare and others could build from.

A *Review of services for vulnerable persons detained in Northern Ireland Prisons*, carried out by RQIA, was published, 05 October 2021 and all recommendations are to be delivered within 18 months of publication. In relation to this investigation I am particularly interested in the outworking of recommendations 2 and 12 in the RQIA report.

Recommendation 2 in the RQIA Review Report points to how the needs of a person coming into custody can be addressed more effectively.

RQIA recommendation 2: Commissioners (currently the Health and Social Care Board [HSCB]) and its provider (SEHSCT) should work together and with NIPS to define and agree the metrics needed to inform an ongoing assessment of need. A robust system for regular data collection and analysis, utilising all relevant sources of information, should be developed and implemented as an interim measure ahead of the introduction of Encompass. In the absence of a reliable electronic system, consideration should be given to harvesting data manually.

A new data management system, *Encompass*, is envisaged but it will take some time to put in place. An enhanced model is, therefore, required in the interim. Both short and long-term improvements involve gathering information from a variety of sources. Gathering information from different sources is a critical aspect, in my view, to the success of improvement. It is not clear to me how, for example, the number of times a person has been in custody will be gathered to inform the needs assessment. Mr McConville had 80 previous convictions and was recommitted within 2 months of his last release. In a 3 year period he had 11 short periods in custody. This could be critical information for assessing need, specifically complex need, and should also assist in gathering the impact of ADHD which is addressed in recommendation 12 of the RQIA report. Nor is it clear to me that reliance on self-report can be overcome and I will keep a watching brief on the outworking of information sharing

arrangements to allow for gathering what is required for an effective assessment of an individual's needs. In the meantime, I endorse RQIA's recommendation 2 and urge the Prison Service and the Trust to consider what other information prisons and the criminal justice system generally hold, to inform a robust needs assessment.

Mr McConville's ADHD has been a concern for his family in relation to how he was cared for in prison. I endorse the work flowing from RQIA's recommendation 12 to identify and develop appropriate response to those in custody with particular needs:

RQIA recommendation 12: Commissioners (currently the HSCB) and providers (SEHSCT) should ensure that there is a robust screening and data collection system for specific vulnerabilities such as learning disability, autism, ADHD, acquired brain injury and dementia. This data should be used to inform the needs assessment, planning and commissioning of specialist provision to ensure that services meet the needs of these vulnerable groups.

I note a comment on page 34 of the RQIA report which references the environment in which individuals in custody find themselves: "consideration should be given to how the prison environment impacts on those with personality disorder diagnosis". The environment is also significant for those with other vulnerabilities: acquired brain injury, ADHD, learning disorder and autism. Addressing the environment will assist not only those in custody but also staff who have the responsibility of their day to day care. I hope that in the case of those in custody who have ADHD that the environment in which they live will not be overlooked as a contributory factor in how they behave.

In cases where an individual in custody hands back medication or the Trust become aware that an individual is not taking their medication, I am satisfied that a previous recommendation from my Office has been accepted and that policy has been updated.

In relation to there being a delay with medication transferring with the individual in custody to the CSU from other residential locations, I am satisfied that a recommendation from my Office was implemented in January 2020 and I am not aware of any complaints in relation to this since then.

Trust records indicate that Mr McConville missed a weekly prescription of his medication. From the records available to me this is an isolated incident and the Trust needs to be satisfied that their current pharmacy process is robust to ensure that this does not happen again.

I concur with Professor Shaw that the response to the fatal incident was fast and the resuscitation effort was in accordance with national guidelines.

6.3 Examine whether any changes in Prison Service or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future.

The independent clinical reviewer, Professor Shaw, concluded that Mr McConville's death 'could not have been predicted with any certainty.' Professor Shaw also took the view that there were missed opportunities in the care provided to Mr McConville including more considered exploration of the distress he was experiencing. The SPAR process was the opportunity to consider this with Mr McConville. Nevertheless, Professor Shaw is clear that such exploration of his distress would not have prevented his death. I agree with Professor Shaw's view.

I also agree with Professor Shaw that conversations with individuals in custody being managed under SPAR should be meaningful and explore potential concerns. I note that these procedures have now evolved and that such conversations are expected during the SPAR Evolution process. I await an evaluation of them to be assured that they address the issues raised by Professor Shaw.

I again highlight the needs of those with multiple lower level needs who are repeatedly committed to custody and look forward to seeing if innovative approaches to working with this group of people can be developed.

6.4 Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation.

We have addressed, where possible, the concerns raised by Mr McConville's family and acknowledge that his family raised valid concerns about how their son's particular needs were addressed in custody.

I listed in Section 3.1 the questions that the family asked me to address during the course of my investigation. These questions were considered throughout the investigation and I have summarised my findings below:

- Mr McConville's needs could have been met better in prison if a care formulation and management plan had been in place.
- Mr McConville's ADHD was reported by him at the initial committal health screen but was not reviewed to provide appropriate treatment.
- There is no specific ADHD training for staff within the prison.
- Mr McConville was being managed on a SPAR at the time of his death and therefore was considered having an increased risk of completing self-harm and suicide. With the evidence suggesting that Mr McConville had not taken

his medication for at least a week prior to his death this also put him at an elevated risk of suicide.

- There is no evidence to suggest Mr McConville was assaulted and bullied by Prison Officers.
- There is no evidence to suggest interactions with Nurse K were other than appropriate and professional.

6.5 Assist the Coroner's investigative obligation under Article 2 of the European Convention of Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing exposed, any commendable practice is identified, and any lessons from the death are learned.

We will make full disclosure of our materials to the Coroner.

APPENDIX A: Summary of dates and times referenced in this report

	20 June 2018
	Mr McConville committed into custody and sent to Bann House, Maghaberry Prison
18:06	Committal healthcare assessment recorded
18:15	Medication check completed
18:40	Mr McConville placed in Bann House
	21 June 2018
	Initial mental health screen completed
08:54	New prescription recorded for Mr McConville
	22 June 2018
15:04	Mr McConville rang his father but was put through to the answering service
	26 June 2018
	Mr McConville transferred to Roe House, Maghaberry Prison
	03 July 2018
	Healthcare examined Mr McConville following an altercation with another individual in custody
	06 July 2018
	Mr McConville restrained using C&R following an altercation with another individual in custody and he was examined by healthcare
	07 July 2018
	Prison officers found loose medication in a drawer in Mr McConville's cell and brought it to the treatment room where it was placed in a new packet, labelled and returned to Mr McConville with instructions
	08 July 2018
	Mr McConville given an adverse report for speaking to a Prison Officer in an abusive manner
	09 July 2018
	PREPS review resulting in Mr McConville remaining on standard regime
	10 July 2018
	Mr McConville attended a mental health team cooking activity
	12 July 2018
10:40	Mr McConville rang his father but was put through to the answering service
	17 July 2018
	Mr McConville attended a mental health team cooking activity

	23 July 2018
	Mr McConville failed a drugs test
	24 July 2018
	Mr McConville observed swallowing an unknown substance
	29 July 2018
	Mr McConville received an adverse report for smoking in the recreation room
	31 July 2018
	On his return from the Donard Centre Mr McConville was full body searched following an intelligence report. Nothing was found
	03 August 2018
	Mr McConville attended the Donard Centre
	05 August 2018
	Mr McConville refused to clean his cell at morning unlock and remained under his blanket. Trust staff checked Mr McConville and noted a bleeding nose. He was sent to the CSU for a cooling off period and returned to Roe House later in the day
	06 August 2018
	Mr McConville made a complaint of assault which he alleged had occurred the previous day
	07 August 2018
	Mr McConville's complaint was logged on PRISM
	08 August 2018
	Mr McConville interviewed about his complaint by Governor B
	09 August 2018
18:25	Mr McConville rang his father for the third time but got through to an answering service
	14 August 2018
	Mr McConville attended a failed drug test review with AD: EPT
	16 August 2018
	Mr McConville involved in an altercation with another individual in custody and was taken to the CSU where he was examined by trust staff
	17 August 2018
	Incident in the CSU
15:51	Mr McConville handed food at his cell door which he threw at 2 Prison Officers and the officers entered the cell. Healthcare examined Mr McConville as he alleged he had been struck
16:27	Mr McConville activated the cells fire protection water sprinkler and he was charged under Prison Rules
19:05	Mr McConville moved to another cell in the CSU
	18 August 2018

	Mr McConville moved to Erne House, Landing 2, Cell 18
	20 August 2018
	Mr McConville received a third week's supply of his 28 day fluoxetine prescription and met with the PDU
	Mr McConville complained he had been assaulted on 17 August 2018 while in the CSU
	21 August 2018
	Senior Officer B spoke to Mr McConville about his complaint
	22 August 2018
	Complaint passed to Governor C for investigation
	Mr McConville received 3 days cellular confinement following adjudication for events on 05 August 2018. Trust staff reviewed him and no issues were noted
	23 August 2018
	Governor C interviewed Mr McConville about his complaint and responded deeming the complaint to be vexatious
	Trust staff reviewed him and no issues were noted
	24 August 2018
	Mr McConville attended court by video-link
16:01 – 18:00	On return from court Mr McConville located to share a cell
18:00	Mr McConville moved to Cell 16, Landing 2, also a shared cell
	Mr McConville received a further adjudication in relation to events on 03 July 2018 and lost privileges as a result
	25 August 2018
	Mr McConville refused to comply with instructions to return to his cell and the discipline alarm was activated
	27 August 2018
	Mr McConville attended the Donard Centre
	28 August 2018
	SPAR opened for Mr McConville
11:40	Mr McConville swore at staff when they unlocked his cell door and he was locked again as a result
12:00-13:45	All were locked. At some time during this lock Mr McConville damaged the contents of his cell
15:11	Mr McConville transferred to Cell 18, Landing 2
15:45 (approx.)	Senior Officer C opened a SPAR for Mr McConville following an interview carried out by Prison Officer F during which Mr McConville threatened to cut himself
	Governor B attended Erne House on unrelated business, heard Mr McConville crying and asked Senior Officer C to try and relocate him to Quoile House
16:31	Mr McConville spoke with Prison Officer F about missing his family

17:28	Prison Officer F had a conversation with Mr McConville and recorded he was unhappy and did not want to eat dinner but he got it for him anyway
17:52	Mr McConville recorded to be eating his dinner
19:12	Mr McConville given lighter fluid, hot water and tea
21:55	Mr McConville gave medication he had found in his cell to Senior Officer F
	29 August 2018
09:30	Mr McConville left Erne House to attend a bail hearing
09:59	Mr McConville observed talking to other individuals in custody in holding cell waiting for bail hearing
10:13	Following bail being refused Mr McConville had a consultation with his solicitor
10:30	Mr McConville escorted back to Erne House
10:55	Mr McConville observed talking with others in the yard
11:20	Mr McConville observed walking in the yard
11:35 (approx.)	Senior Officer E completed Mr McConville's SPAR assessment interview with Prison Officer H
	A repeat prescription was issued for Mr McConville's medication
11:45	Mr McConville given his lunch meal
12:15	Prison Officer H observed Mr McConville eating his lunch meal
14:20-15:20	Mr McConville in the yard
15:45	Mr McConville locked in his cell
17:20	Mr McConville left his cell to collect his evening meal
18:55	Mr McConville given hot water and lighter fluid and asked how he was. He replied he was okay
19:20	Mr McConville shouting out the window
19:25	Mr McConville observed doing press ups
19:35	Staff change over
20:40	Staff change over
20:50	SPAR check: Night Custody Officer A recorded he had spoken to Mr McConville who said he was okay, appeared in good form and was given a cigarette
21:05	SPAR check: smoking in his cell
21:35	SPAR check: awake in his bed
22:05	SPAR check: lying on his back
22:35	SPAR check: lying on his back
23:04	SPAR check: Mr McConville found hanging in his cell in Erne House. Emergency message transmitted; Nurse tasked; Night Custody Officer B immediately went to the landing to assist; Night Custody Officer A opened the cell door; ligature cut; CPR commenced

23:08	Ambulance requested
23:11:54	Nurse I radioed colleague, Nurse J, to bring oxygen
23:13:37	Nurse I entered Erne House
23:13:43	Senior Officer G entered Erne House
23:14:40	Prison Officers I and J entered Erne House
23:16:45	Prison Officer I got AED and took it to the landing
23:18:58	Nurse J arrived at Erne House with 2 oxygen tanks. Night Custody Officer C arrived at Erne House
23:38:59	First ambulance crew arrived at Erne House
23:43:55	Second ambulance crew arrived at Erne House
	30 August 2018
00:10	Recognition of Life Extinct recorded by Ambulance crew
00:26	Nurse I reported unrest on the landing, including throwing lighted items from cells, to the ECR
01:00:29	Northern Ireland Fire and Rescue Service attended
01:05:42	Northern Ireland Fire and Rescue Service left
03:00	Chaplain A arrived on the landing following a phone call from the prison
03:20	Hot debrief took place
05:30 (approx.)	Chaplain A arrived at the family home to inform them Mr McConville had passed away
08:30	Governor F telephoned the family to express condolences and offer support
	19 September 2018
	Cold debrief took place