The Prisoner Ombudsman for Northern Ireland

INVESTIGATION REPORT

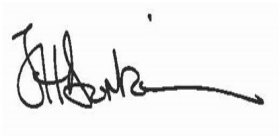
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR O

AGED 33
WHILE IN THE CUSTODY OF
MAGHABERRY PRISON
ON 28 SEPTEMBER 2020

Note from the Interim Prisoner Ombudsman

This report, including the foreword, was at an advanced stage before the former Prisoner Ombudsman, Dr Lesley Carroll, left office on 29 February 2024. Dr Carroll was fully engaged with the investigation and report concerning Mr O's death in custody and I believe it is appropriate that her foreword is included in this published report. I also appreciate how difficult and lengthy the investigation and reporting process has been and wish to express my condolences to the family on the loss of Mr O.



JACQUI DURKIN
INTERIM PRISONER OMBUDSMAN
03 June 2024

The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland (the Ombudsman) 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 custody and incidents of serious self-harm.

The purpose of the Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to 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 people in custody.

The Ombudsman's investigation has an important role in the Coroner's Inquest at which cause of death is established. Together with other independent investigations, the Ombudsman's investigation provides information to assist the Coroner to reach a conclusion regarding the cause of death. It is not for the Ombudsman to draw a conclusion as to cause of death but rather to consider what happened and identify any administrative shortcomings, errors and good practice. Independence is critical and while the Ombudsman will co-operate, and when appropriate collaborate, with other parties such as the Police Service of Northern Ireland (PSNI), the investigation's process is safeguarded to ensure independence.

The remit for Ombudsman investigations is set out in the Terms of Reference included at Appendix 01. Each death in custody draws on this remit to decide objectives that define the scope of the investigation into that particular death. These objectives identify specific matters for investigation, the circumstances of the individual case, and include queries and concerns raised by the family of the deceased. In this case, the objectives for the investigation can be found in Section 03.

To spread learning from investigations as widely as possible, and in the interests of transparency, investigation reports are published on the Ombudsman's website following consultation with the Coroner.

Date finalised: 13 June 2024 Date published: 16 July 2024

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Glossary

CCTV	Closed-Circuit Television
CJI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
ECR	Emergency Control Room
GP	General Practitioner
IMB	Independent Monitoring Board
IPC	Inmate Personal Cash Account
IRP	Independent Review of Progress
NIAS	Northern Ireland Ambulance Service
NICE	National Institute for the Health and Care Excellence
PHA	Public Health Authority
Prison Service	Northern Ireland Prison Service
PSNI	Police Service of Northern Ireland
PSST	Prisoner Safety and Support Team
RQIA	Regulation and Quality Improvement Authority
SPAR	Supporting People At Risk (procedure)
SPAR Evo	Supporting People At Risk Evolution (procedure)
Trust	South Eastern Health and Social Care Trust

Foreword from the Former Ombudsman

Introduction

The death of a loved one is always difficult. The fact a death occurs in prison is particularly challenging given the loss families experience when a loved one is taken into custody and the trust they must place in the Northern Ireland Prison Service (the Prison Service), the South Eastern Health and Social Care Trust (the Trust), and others, to ensure the safety and wellbeing of their loved one.

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 their loved one is safe while in custody.

Findings made in this report, together with learning identified, will address and inform those who provide care for people in custody. Where appropriate, I will make recommendations directly to the Prison Service and the Trust. Both organisations 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.

While improvements in the provision of care for people in custody is important to ensure confidence, this report is written with Mr O's family primarily in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am conscious of the length of time families wait for investigative processes to complete. Mr O's family have been keen to hear the results of my investigation and I acknowledge the delays that have arisen, not least due to the impact of Covid-19. I appreciate their patience and continued engagement and am grateful to them for their contribution to this investigation.

My investigation

I aim to establish the circumstances surrounding Mr O's death. I have provided as much detail as possible and hope the information will be helpful to the family as they piece together the last events in Mr O's life. I make two recommendations focused on learning to improve the care of all those in custody in light of what happened to Mr O.

Mr O died on 28 September 2020 whilst in the custody of Maghaberry Prison, having been found unresponsive in his cell. He was 33 years old. The initial cause of death recorded in the post-mortem report is "Hanging".

Mr O had been ordered to attend Court on 04 December 2013 but he failed to attend and a warrant issued for his arrest.

A European Arrest Warrant issued for Mr O. He was arrested in France on 29 July 2020 and committed into the custody of Aix-Luynes Prison. Mr O transferred to Northern Ireland on Friday 11 September 2020 where Police Service of Northern Ireland (PSNI) Officers arrested him on his arrival into Belfast City Airport. While in the custody of the PSNI at Musgrave Street Custody Suite, Mr O was assessed as being fit to attend Court.

On Saturday 12 September 2020, Mr O appeared at Belfast Magistrates' Court and was committed into custody at Maghaberry Prison. He had no history of being in prison custody in Northern Ireland. Mr O was assigned Cell 16 on Landing 01 of Foyle House[1] and when interviewed by Senior Officer A he was advised of quarantine arrangements in Foyle House, designed to mitigate against the transmission of Covid-19 to the general prison population. Mr O was assessed, using the Supporting People At Risk Evolution (SPAR Evo) procedure, as having 'no apparent risk.' Those admitting Mr O into custody and those assessing him found him to be quiet. Overall, no concerns were raised following his committal assessments. Mr O confirmed he was a soldier in the French Foreign Legion and indicated he did not want his family informed that he was in custody.

In the course of my investigation I requested the Prison Service contact their counterparts in France who provided information regarding Mr O's detention in French custody. The information I received notes Mr O had graduated in Biology, had been in France for 07 years and there was no record of him having suicidal thoughts during his time in French custody. While in Aix-Luynes Prison Mr O had appointments at the Health Unit on Tuesday 11 August 2020 and Friday 21 August 2020. On Monday 10 August 2020 and Saturday 05 September 2020 he met with his lawyer. Records show Mr O went out for regular walks, did not register for any other activity, was not subject to any significant report and was described as a calm person with a good demeanour.

On Tuesday 14 September 2020 Mr O's Comprehensive Health Assessment was carried out by Nurse B. Nurse B records how Mr O's behaviour and engagement did not raise any concerns and when his assessment was complete Nurse A referred him to the Trust General Practitioner (GP) for podiatry treatment.

Mr O's 14 days quarantine period in Foyle House ended on 26 September 2020. He was interviewed by Maghaberry Prison Reception staff prior to his transfer into the main prison population and notes of the interview record Mr O presented in good form, was co-operative and seemed relaxed and he did not want any telephone contact numbers registered or his next of kin contacted. As this was Mr O's first time in prison custody in Northern Ireland, the *person in custody journey* was explained

[1] Foyle House was a quarantine unit opened as a safety measure in response to the Covid-19 pandemic. Individuals coming into custody were required to complete 14 days in Foyle House, in isolation. At Maghaberry Prison, individuals did not receive yard or association time but they were entitled to phone calls and showers. Individuals were also given activity packs to help them pass time whilst quarantined in their cells.

to him and he was advised of what to expect. Mr O stated he had no history of self-harm nor any current thoughts of that nature and there were no identifiable reasons for concern.

Mr O was relocated to Bann House[2] Cell 13 Landing 02 which is where he was discovered in the early hours of Monday 28 September 2020.

I offer my sincere condolences to Mr O's family on their sad and painful loss. I hope this report provides information to address some of the questions they raised and explains events leading up to Mr O's death. The learning, expressed in recommendations, will, I hope, bring some comfort and confidence to those who have family members in custody.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland

[2] Bann House is the committal house where individuals in custody are located after a period of quarantine to start being integrated in general prison population.

Section 01: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

1. **Hot and Cold Debriefs**

That the Prison Service and Trust review how Hot and Cold Debriefs are carried out to identify any improvements that can be made and inform my Office when that review has completed, together with any recommendations arising from it.

The Prison Service and Trust accepted this recommendation.

2. **Procedures for informing next of kin about a death in custody**

That the Prison Service review the procedures for informing next of kin about a death in custody, paying particular attention to the impact the news will have on them and the length of time it can take after the death to inform them.

The Prison Service accepted this recommendation.

1.2 Areas raised in previous reports: 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.

Night Custody Belt:

I have previously recommended Prison Officers completing cell checks overnight should ensure they are wearing the Night Custody Belt. While there was no delay accessing the Belt and entering the cell on this occasion, in other situations delay may be caused by the need to retrieve the Belt in order to be able to access the cell.

1.3 Resourcing Healthcare in Prison with a paramedic on site overnight at Maghaberry Prison

I have written to the Commissioners of Healthcare in Prison to emphasise the importance of this resource and to encourage them to work with the Department of Health to properly resource paramedic cover as an additional resource.

Section 02: Background information

2.1. Maghaberry Prison

Maghaberry Prison is a high security prison for male adults who have been sentenced or are on remand. The population in the prison at the time of Mr O's death was 964.

Maghaberry Prison has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners.

Since 2008, the Trust has provided Prison Healthcare Services. There is a 24 hour Primary Healthcare Service and the Mental Health Team is on site Monday to Friday, 08:00-17:00. In October 2020 the Mental Health Team commenced a pilot to extend the service provided to seven days a week in Maghaberry Prison. Staffing this can be challenging as it requires stretching the original five day staffing resource over seven days. Healthcare in Prison Commissioners are aware of the need for more funding to guarantee a seven day service across all sites. Since October 2020 all mental health committal screens are triaged face to face.

At the time of Mr O's death, Maghaberry Prison operated quarantine facilities in Foyle House as a response to the risk presented by the Covid-19 pandemic. Foyle House was re-opened to provide the quarantine facility for those coming into custody either at committal or on return from outside appointments. The intention was to, as far as possible, limit the possibility of Covid-19 infection spreading into the main prison population. All new committals were quarantined in single cells and on a reduced regime for their first 14 days in custody. Mr O completed his quarantine period in Foyle House and had been relocated to Bann House where he sadly passed away.

2.2 Criminal Justice Inspection Northern Ireland (CJI)

The most recent full published inspection report of Maghaberry Prison took place in October 2022 and a report was published in June 2023. An Independent Review of Progress (IRP) was published in February 2024. Inspectors reported the prison had settled considerably since the last full inspection in May 2015 and was now a much safer place.

A priority concern in the 2023 report was when a prisoner died at Maghaberry Prison leaders waited for the Ombudsman's and Coroners report to be delivered before they took action rather than conducting their own immediate investigation and putting mitigating measures in place. The IRP report noted reasonable progress against this priority concern.

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

In November 2019, the CJI published a report[3] in which they noted improvements were required in joint-working between the Prison Service and the Trust to increase the safety of the prison. Inspectors viewed the new SPAR arrangements, SPAR Evo, as positive and highlighted one of the most difficult issues facing the Prison Service was identifying those really vulnerable people in their care and took the view that a therapeutic environment to help stabilise at-risk individuals was required. In his introduction to the Report the Chief Inspector at the time noted that relationships between Prison and Healthcare staff were good and had improved but it was also the case that closer working was required to deliver strategies crucial to dealing with suicide, self-harm and substance abuse, and lead to greater safety for individuals in custody.

2.3 Independent Monitoring Board (IMB)

An IMB is appointed for each prison under the Prison Act (NI) 1953. Their purpose is:

> *to enhance the quality of prison life, by working to ensure fairness and accountability in prison.*

Their statutory duties include satisfying themselves about how those in custody are treated and reporting matters of concern to Governors or the Minister of Justice, should that be required.

In their 2020-21 Annual Report Maghaberry Prison's IMB described the challenges presented by Covid-19 as 'complex and demanding'. They noted the positive actions and attitudes of staff and those in custody. The IMB raised concerns about the mental health impacts of isolation. They noted, for example, some concerns about the cleanliness of cells, the impact of being locked for 23 hours each day, the provision of showers and access to telephone calls. Like others, Maghaberry Prisons' IMB were restricted from accessing the prison and they returned in June 2020.

I will discuss some of these matters in this report.

2.4 Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services, including within prisons. RQIA inspect prisons in partnership with CJI, His Majesty's Inspectorate of Prisons and the Education and Training Inspectorate. RQIA identify best practice, highlight gaps or

[3] http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/The-Safety-of-Prisoners.aspx P8

shortfalls in services and identify where improvement is required. All their inspections and reviews are aimed at protecting the public interest.

Following a report of an incident of serious self-harm from my Office in 2016 and the number of recorded suicides in prisons, a review was commissioned jointly by the Departments of Health and Justice to consider provision for particularly vulnerable persons in custody. The RQIA Review, published in October 2021[4], goes some way to addressing my concerns. Recommendations made by the RQIA specifically address mental healthcare. I continue to work with the RQIA, and with others, to raise matters of concern and improve delivery of support to those in custody.

2.5 Measures to contain the spread of Covid-19

The impact of the Covid-19 pandemic was felt across the world and during that time consciousness was raised about particularly vulnerable groups of people who had to be protected during the pandemic, for example, those who shielded due to health conditions, those in hospitals and care homes and those in prisons. As noted by the World Health Organisation[5]:

People deprived of their liberty, such as people in prisons and other places of detention, are more vulnerable to the coronavirus disease (COVID-19) outbreak. People in prison live is settings in close proximity and thus may act as a source of infection, amplification and spread of infectious diseases within and beyond prisons.

For prisons, standards remained critical at a time when they also had to fulfil the positive duty to protect life. These standards are set out in the *UN Standard Minimum Rules for the Treatment of Prisoners*, also known as the *Nelson Mandela Rules*, and are foundational to preventing the ill-treatment of those in custody. My Office received a number of complaints relating to measures in place during the pandemic and continues to consider the longer-term impacts, for example on rehabilitation and wellbeing among the prison population and also among staff. From the information available to me, I have considered how those in prisons were treated by those caring for them, that the facilities provided to them were to standard, and that measures were applied humanely[6]. Healthcare is a theme across society and the prison population is no different. The ongoing impacts of what happened during the pandemic are, therefore, also important and particularly in the area of mental health.

[4] https://www.rqia.org.uk/RQIA/files/95/955cfa4a-5199-4be7-9f1a-801e1369ce84.pdf
Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons, RQIA, October 2021

[5] https://www.who.int/europe/activities/ensuring-prevention-and-control-of-covid-19-in-prisons-and-other-places-of-detention

[6] Measures taken amid a health crisis should not undermine the fundamental rights of detained people, including their rights to adequate food and water. Safeguards against ill-treatment of people in custody, including access to a lawyer and doctor, should also be fully respected.
https://www.ohchr.org/en/statements/2020/03/urgent-action-needed-prevent-covid-19-rampaging-through-places-detention

From the beginning of the pandemic, the Prison Service was aware of the enormity of the task facing them. They had a responsibility, a positive Article 2 of the European Convention on Human Rights duty, to keep those residing and working in prisons safe. At the same time, they had to balance prevention and containment with maintaining standards for the care and rehabilitation of those in custody.

The Minister of Justice and Prison Service followed a similar incremental pathway as Great Britain with regard to prisons: suspending visits on 20 March 2020, gradually closing the prison estate to all but essential workers, limiting movement within prisons and ensuring safety measures were in place within each prison.

In March 2020, Governors received instructions to focus on infection control and minimise the risk of transmission. Between 20 and 25 March 2020, they took significant action to minimise risk, including the:

- suspension of all domestic and legal in-person visits to prisons;
- suspension of accompanied and unaccompanied temporary release, including all release under the home leave scheme;
- suspension of Burren and Murray Houses, units for working outside the usual prison setting while in custody;
- access to prisons was restricted for all but essential prison staff and healthcare workers; and
- quarantine for 14 days for those coming into custody.

Testing, contact tracing and infection control measures kept pace with wider society. From March 2020, all new committals were placed in isolation for 14 days on arrival, in line with Public Health Authority (PHA) advice. From April 2020, the Prison Service met weekly with the Trust, the PHA and the Health and Social Care Board to oversee what was happening within prisons and share knowledge and learning. In the early stages of the pandemic, everyone was learning and developing an understanding of how the coronavirus behaved and affected health.

The PHA published *Guidance for Prisons and Places of Detention in NI* on 20 April 2020, and the Prison Service formalised its *Pandemic Plan and Procedures* in June 2020, which set out infection control measures for staff testing and remained in place until 01 July 2022. These measures aimed to prevent the introduction of the coronavirus into the prisons. There is no doubt that those held in isolation for 14 days experienced challenges. The 14 days was reduced to 10 from 14 December 2020, in line with guidance at that time. At the same time, Foyle House, along with other measures to protect people in custody during the pandemic, provided a significant safety buffer.

Ultimately, the test was how many individuals in custody died due to Covid-19 and the answer is none. This is in stark contrast to the situation for example in England and Wales where 185 individuals died in custody due to coronavirus infection.

2.6 Previous incidents at Maghaberry Prison

Mr O died at Maghaberry Prison on 28 September 2020. His death was one of two deaths in custody that occurred there in that year. There does not appear to be any connection or similarity between these deaths.

PART A: INVESTIGATION AND FINDINGS

Section 03: Framework and scope for investigation

Mr O was found unresponsive in Cell 13, Bann House, Landing 02 (Bann 02), Maghaberry Prison on 28 September 2020. As he was in prison custody at the time of his death, I am required to investigate the circumstances surrounding his death, report my findings as a matter of public accountability and inform the Coroner's inquest. I met with Mr O's family to listen to their questions and concerns which have informed the objectives for this investigation. These objectives can be found in Section 3.2 of this report.

3.1 Questions raised by Mr O's family

When I first met with Mr O's family on 12 November 2020 they raised a number of important matters for this investigation and requested further information. The family has been profoundly impacted by Mr O's death given he had not been at home in Belfast for some years and they were not aware he had arrived into the custody of Maghaberry Prison. Among their questions and concerns Mr O's family raised key issues regarding:

- the manner in which information about their son's death was communicated to them (by the Prison Service) was particularly upsetting for them and they are concerned about how families are informed;
- the support Mr O received while he was in custody, including contact with services such as probation, chaplaincy and counselling services;
- whether Mr O had timely and appropriate access to legal representation;
- the adequacy of the mental healthcare support delivered to Mr O; and
- whether Mr O had access to what he needed to contact family and friends.

At a subsequent meeting with Mr O's family they raised additional questions which I have addressed in the course of my investigation.

3.2 Objectives for this investigation

The objectives for this investigation take account of the questions Mr O's family raised and are to:

1.	**establish the circumstances and events surrounding Mr O's death on 28 September 2020, including an overview and examination of immediate responses when he was found;**
2.	**examine how Mr O was cared for by the Prison Service and Trust while at Maghaberry Prison, particularly the standard of his mental health care given the circumstances of his detention;**
3.	**examine Covid-19 risk control measures and their application by the Prison Service and Trust and any possible implications for Mr O;**
4.	**consider the adequacy of policy and procedures for informing families of the death of a loved one in custody;**
5.	**provide information to Mr O's family in response to the issues they have raised;**
6.	**assist the Coroner's investigative obligations 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 death are learned; and**
7.	**identify any learning for the future.**

3.3 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. Notices of Investigation into Mr O's death were issued to relevant parties on 28 September 2020, including to those in custody, the Prison Service and IMB, to allow anyone with information to come forward and speak to my investigators. Individuals were also identified for interview by my Investigating Officer. All relevant prison and healthcare records were carefully examined and I have detailed the relevant matters underpinning my findings, in this report.

3.4 Independent advice

When appropriate, I commission an independent clinical review of specific aspects of healthcare. In this instance I have not commissioned a clinical review. My reasons are twofold:

1. the length of time Mr O was in custody and the lack of records for a clinical reviewer to examine; and

2. a number of clinical reviews have been commissioned in other cases where the death in custody occurred during Covid-19. Any matters of concern regarding the care of people in custody during that period will be raised appropriately via those investigations.

It was difficult to conclude a clinical review was not required. Families deserve to have every avenue explored. However, the fact Mr O presented in good health, engaged well at all interviews, was explicit about what he wished to discuss and that there were no indicators to those caring for him of any intent to self-harm nor any history of self-harm, has persuaded me this is the right decision.

Mr O's family raised an important question about the impact of crime on the individual in custody. The National Institute for Health and Care Excellence (NICE) guidelines encourage discussion about this at interview and during assessments. From the records available to me, it is clear there were attempts by Healthcare in Prison staff to engage in deeper conversation with Mr O, who maintained he had no thoughts of self-harm and was not taking any medication.

Section 04: Circumstances and events surrounding Mr O's death

4.1 Committal to Maghaberry Prison

Mr O was arrested in France when a European Arrest Warrant was issued. He was detained in a French prison, flown into Belfast City Airport and arrested on Friday 11 September 2020. He was committed to Maghaberry Prison the following day, Saturday 12 September 2020. This was his first time in prison custody in Northern Ireland.

At the time of Mr O's committal, measures to address the risk presented by Covid-19 were in place across society and within the prison. Mr O was, therefore, held in Foyle House for 14 days quarantine, initially in Cell 16, Landing 01. He was relocated to Cell 13, Landing 05 on Thursday 17 September 2020 until he completed his quarantine period on 26 September 2020. The movement of individuals between cells in Foyle House was not unusual. He was housed in single cells as was practice for everyone in custody at that time due to Covid-19. I will discuss the impact of Covid-19 later in this report.

4.2 Committal Procedures and Healthcare Assessments

Senior Officer A carried out Mr O's committal interview. The committal summary record shows that he informed Senior Officer A he had no history nor active thoughts of self-harm or suicide and that he had no contact with mental health services. He confirmed he did not need support, for example from a Samaritans Listener. The notes show Mr O confirmed there were no recent events that could negatively impact on his thoughts of self-harm or suicide. Foyle House arrangements were explained to Mr O and the records note that he appeared to understand the arrangements.

In order for Prison Officers to be well prepared to meet their duty of care for those in their custody, all Prison Officers receive training in the Supporting People At Risk Evolution (SPAR Evo) procedure, which provides sufficient training for them to identify matters of concern in relation to mental health and wellbeing and to respond accordingly. All Prison Officers also receive 20-Minutes to Zero Suicide, Mental Health First Aid and Safe Talk training. For those at management levels, for example individuals completing committal interviews, there is additional Applied Suicide Intervention Skills training. At Mr O's committal interview, therefore, those interacting with him were trained sufficiently well as to be alert to any concerns regarding mental wellbeing and to pass those concerns on appropriately. The committal interview itself provides the opportunity for engagement on matters relating to safety and risk.

During the committal process Nurse A carried out an Initial Health Assessment and Mr O engaged well during the assessment. He informed Nurse A that he had been in the French Foreign Legion and had been detained on a European Arrest Warrant, that he did not want to contact his family and did not want his family informed that he was in custody. Nurse A noted Mr O reported he had no history of drug use and had not consumed alcohol. He maintained good eye contact throughout the assessment. Nurse A provided Mr O with a patient information pack and the healthcare screening leaflet. He was not prescribed any medication at the time of his committal.

Mr O declined a Comprehensive Health Assessment on Monday 13 September 2020 but he availed of this on Tuesday 14 September 2020. There is no reason recorded for him not consenting on 13 September 2020. The Assessment was carried out by Nurse B. Records show Mr O's medical observations were normal, he had no allergies, he reported no history of self-harm and he informed Nurse B that he felt fine. Nurse B noted his presentation was calm and co-operative during the assessment. Mr O was provided information about support for anyone who felt themselves to be struggling, including how to access the Samaritans telephone. Mr O highlighted podiatry issues and requested treatment from a GP. He declined a blood borne virus test as he had recently been tested in France.

As primary care nurses, Nurses A and B would have received mental health training including suicide awareness training. It is mandatory for all Healthcare in Prison staff with patient contact to undertake suicide awareness training.

As was standard practice at that time Mr O was tested for Covid-19 and his test was negative. The PSNI Police and Criminal Evidence (Northern Ireland) Order 1989 form had reported possible Covid-19.

Standard procedure at the time when Mr O was committed into custody was for a Mental Health Screening of initial committal healthcare assessment and associated documents to take place the next working day, by a Mental Health Practitioner or nurse. A Comprehensive Health Assessment usually took place within three days after committal into custody, completed by a nurse. There is no record of a Mental Health Screening taking place for Mr O. I will consider this matter later in my report.

The committal process was streamlined during Covid-19 to ensure as little contact as possible amongst those in custody and with those carrying out professional services. An initial committal process was completed and then when individuals moved from custody in Foyle House to custody in Bann House the remainder of the committal process was completed including relevant information, updates on information already provided and a further assessment of wellbeing. The following Section sets out what arrangements were in place at that time.

Across all records it is evident from the information provided by Mr O that he gave no indication he was at risk.

4.3 Foyle House – isolation arrangements for those entering custody

In March 2020 Foyle House was reopened as a *Quarantine Isolation Unit* in response to the Covid-19 pandemic. Prison Service Headquarters led on responses across the prison estate, in line with government policy and guidance at that time, with an expectation that each prison would put local arrangements in place. Foyle House provided those entering or returning to custody with isolation measures to reduce the risk of Covid-19 spreading into the main prison population. The Prison Service worked closely with the Trust to ensure standards were adhered to and to assist them they developed a joint checklist including, for example:

- all those arriving into custody must be screened by healthcare practitioners;
- 30 minutes per day exercise, which could be in-cell;
- access to a telephone to maintain contact with family and friends or legal representation;
- access to washing facilities or showers at least weekly and facilities for in-cell ablutions;
- sufficient provision of welfare support such as access to the Samaritans telephone;
- meals delivered to each cell; and
- how to respond should a concern about an individual in custody's mental health become evident, particularly where they had been in isolation for some time.

Prison Service Headquarters encouraged each prison to aim to deliver more than the minimum set out on the checklist.

The regime in Foyle House remained broadly the same throughout the pandemic although in the early weeks considerable learning was gathered from the experiences of those living and working there and as understanding of how the coronavirus behaved increased. For most of the time isolation was in place, individuals were isolated for 14 days, in line with Public Health and Prison Service guidance. There is no doubt the positive duty to protect life led to a restricted regime which, in line with guidance from Headquarters, Maghaberry Prison responded to with measures including:

- two hourly committal checks for new committals in the first 24 hours;

- no association or yard exercise (this was not possible to provide given the geography of the facility);
- showers and telephone calls offered every other day;
- all meals provided daily - breakfast, lunch and dinner and served in-cell;
- packs provided in cells to provide some activities;
- information about the prison regime, including how to request telephone calls, access accounts to purchase from the tuck shop and telephone cards;
- essential toiletries provided in each cell to ensure hand hygiene;
- access to Chaplains and other support such as the Samaritans Phone; and
- access to Zoom calls to assist with supporting family contact and for legal consultations.

Prison Service records for the time Mr O was in Foyle House, 12-26 September 2020, show that those on the Landings where he was held received their meals every day and that they were offered the use of showers and telephones on the 14, 17, 20 and 22 September 2020 respectively. Those on other Landings would have been offered the opportunity on alternate days. Interviews with Prison Officers in Foyle House revealed that not all telephone and shower requests were recorded. This was not unusual due to the management priorities at that time.

Given this information it is likely that Mr O was offered the use of telephones and showers every other day as he should have been. I am unable to confirm whether Mr O availed of the opportunity to have a shower whilst in Foyle House. While in Foyle House he made a telephone call to his legal representative on 17 September 2020. He left a voicemail saying he would call again. I will discuss Mr O's access to the telephone and his personal account in the following section.

4.4 Transfer from Foyle House to Bann House

Mr O completed his 14 days in isolation on Saturday 26 September 2020 and was transferred to Bann House that afternoon, as was agreed practice.

Mr O was interviewed by the Prison Service to complete committal processes after his 14 days in Foyle House and the Committal Summary notes were updated accordingly. The notes confirm he communicated he had no mental health concerns. The interviewer recorded that he was 'in good form and co-operative and seemed relaxed.' Mr O again confirmed he did not want anyone informed of his whereabouts or any numbers registered to his telephone list. Given the nature of the interview and the information provided by Mr O he was assessed as having, "No

Apparent Risk" as had been the case at his initial assessment made in Foyle House on 12 September 2020.

4.5 Mr O's time in Bann House

Mr O arrived at Bann 02 around lunchtime on 26 September 2020. He entered the showering area at 14:13 and when he returned to his cell he was given milk and a bag at 15:57. Shortly afterwards, at 16:01, he had some conversation with a Prison Officer and then he made his way to collect his evening meal and returned to his cell at 16:16. While he had been collecting his meal Orderlies had left breakfast cereal into his cell. There was a cell check at 16:35 and another, this time by a Night Custody Officer, at 19:33. A Supervised Check took place at 23:07 and a number of checks took place overnight as per standard procedure: at 01:48, 04:27 and 07:11 when the night shift was ending. Hourly checks also took place.

On the morning of 27 September 2020 Mr O was checked by the day shift at 07:28. Closed Circuit Television shows him cleaning out his cell during the morning and interacting with Prison Officers. He was unlocked at 09:50 and CCTV shows him waiting, probably for a shower, going to the class office and back towards the shower area and entering at 09:55. The Landing records show that telephone calls were offered while those on the Landing were unlocked for showering and some individuals in custody can be observed using the telephone. At 12:10 Mr O left his cell and went to the servery to collect his lunchtime meal and he was locked when he returned to his cell at 12:12. Checks took place at 12:19 and 13:17. Mr O's cell was unlocked at 14:12 and CCTV shows him speaking with a Prison Officer who then locked his cell again. Records suggest Mr O was offered yard time and as he was locked again it is likely he did not avail of the offer. At 15:22 Mr O was given milk into his cell and he was unlocked at 16:11. He collected hot water, spoke with some Orderlies and then returned to his cell followed by an Orderly who left him a cup. At 16:13 he again left his cell and went to the servery to collect his evening meal, returning to his cell at 16:14 when he was locked.

Having reviewed CCTV and Landing records I am satisfied Mr O was offered a shower on both 26 and 27 September. He can be observed interacting with Prison Officers and with others in custody and he was content to leave his cell to collect his meals as is normal practice on the Landing. I am also satisfied Mr O was offered yard time but that he chose not to avail of the opportunity.

The family has expressed some concern about Mr O's engagement with what was a routine that was alien to him. From CCTV observations he seems to have been coping with the routine. He was also aware of how to make use of his personal cash account (IPC) from which he could purchase items from the tuck shop, purchase a telephone card and pay for telephone calls. There were adequate funds in his account should he have wished to make calls or purchase from the tuck shop. A telephone card was found in his cell following his death. Others on the Landing were

using the telephone on 27 September so it is highly likely had he wanted to he could have used the telephone and records show he was given information about how to add numbers to his telephone list using the request system. On a number of occasions he was offered the opportunity for contact with family and to begin the request process.

Mr O's family were anxious to know whether he had access to the numbers he required. Some issues had arisen, following his death, about whether he had access to those numbers and there was some confusion about where those numbers were. There was mention of a post-it in his belongings on which he had recorded numbers. Prison Officers could not locate this and records show Mr O was asked to provide Prison Officers with the personal identification number for his mobile telephone so the numbers could be retrieved from there. Mr O also asked the Prison Officer to bring him a contact card with his solicitor's details on it. The original post-it was later discovered in Mr O's belongings by his family, indicating a more thorough search may have been required to locate the information. There is no further evidence regarding this matter and no requests were made by Mr O to have telephone numbers added to his list. This would have been necessary if he wanted to make calls. Following his death, the card with his solicitor's details was found in his cell and we also know he had told staff several times he did not wish to have his family contacted nor to contact them himself. From the family's point of view, there is remaining uncertainty about whether Mr O would have chosen to call them himself should he have had the telephone numbers added to his call list.

Given all of this evidence I am content Mr O was managed in line with prison policy and procedures. From interviews conducted with Prison Officers I am aware they had no concerns about Mr O. Neither his behaviour nor his interactions with them suggested he was at risk. Healthcare in Prison records bear out the same understanding of Mr O. Nevertheless, I acknowledge there will be a remaining uncertainty for Mr O's family about the choice he could have made to make contact with them himself.

4.6 Events overnight on 27/28 September 2020

It is the responsibility of the Prison Service to provide checks that maintain the safety of those in custody. Two types of mandatory checks are carried out:

a. overnight hourly checks are required across all Landings in the prison, during which a Prison Officer walks through each Landing allowing those in custody to raise concerns or the Prison Officer to actively check on an individual's wellbeing should they have reason to; and

b. supervised checks which take place at times specified by the Governor and require a Senior Officer to attend. These Supervised Checks involve the cell flap being lifted so that the room can be scanned and a Prison Officer can assess if all is well with the individual in custody.

All those in custody are aware these checks take place and should they require assistance between checks they can ring their cell bell and a Prison Officer will attend. As with the hourly checks, supervised checks are recorded.

On the night of 27 September and the early morning of 28 September the following checks took place on Mr O's Landing, Bann 02:

27 September 2020	
16:43:43	Day shift headcount check.
19:24:24	Night shift headcount check.
20:44:10	Supervised check.
28 September 2020	
02:59:02	Supervised check at which Mr O was found unresponsive.

In addition to these checks, I am content the hourly checks took place and were recorded properly.

While I am content the checks took place appropriately and Mr O had opportunity to raise concerns should he have wanted to, I was concerned the length of time between the supervised checks was 06 hours and 15 minutes, although there was an unsupervised check in between. I spoke with the Governor at the time. Governor A had already noted this and taken action to add another check. This is now standard practice across Maghaberry Prison. It is a difficult balance to strike, on the one hand checking to ensure the safety of those in custody and on the other hand allowing those in custody to rest undisturbed as night checks can sometimes be experienced as intrusive and disruptive. On balance, safety must take precedence.

At 02:59:02, the early hours of the morning, on 28 September 2020 a supervised check was carried out. Senior Officer B attended Bann 02 as was required and Prison Officer B carried out the check and saw Mr O unresponsive. Prison Officer B immediately raised the alarm and requested assistance. At approximately 03:00 Paramedic A and Nurse C received the call and made their way to Bann 02. Prison Officer D was on duty on a nearby Landing where the alarm was heard and following a call from the Emergency Control Room (ECR) Prison Officer D also made their way to Bann 02 to assist.

Prison Officer B went to collect the Night Custody Officer Belt from the end of the Landing and Prison Officer C made his way down the Landing to assist. Senior Officer B joined them at 03:00:49 and they entered the cell at 03:00:56: Senior Officer B was followed by Prison Officers B and C. Senior Officer B and Prison Officer C placed Mr O in a position where they could begin cardiopulmonary resuscitation (CPR). Prison Officer B went to collect the defibrillator which was deployed but did not advise a shock. At 03:05:52 Paramedic A and Nurse C arrived at Cell 13 and took over CPR from the Prison Officers B and C who had been maintaining CPR. At 03:09 Paramedic A called life extinct and efforts to resuscitate ceased.

At 03:13:08 Senior Officer B locked Cell 13.

Some matters of concern have emerged during evidence review:

1. the Prison Officer checking Mr O was not wearing a Night Custody Belt;
2. the length of time between supervised checks;
3. Prison Officer staffing levels on the night in question; and
4. the standard of resuscitation efforts.

I will discuss these matters further in Part B of this report.

Section 05: Events following Mr O's death

5.1 Securing the scene

Northern Ireland Ambulance Service (NIAS) staff arrived on the scene after the Landing was quiet and the cell locked. At 03:26:37 Senior Officer B opened Cell 13 and NIAS paramedics entered. Senior Officer B relocked the cell at 03:32:46 when the NIAS paramedics exited it.

Following a death in custody it is important the cell is sealed appropriately and those who do enter the cell are recorded by the individual responsible. Procedures appear to have been followed in this regard.

5.2. Informing Mr O's family

Mr O's family were informed of his death on the afternoon of 28 September 2022. Governor A telephoned the family as is set out in procedures. I will address this matter in the next Section.

5.3 Support for Prison Officers, Health in Prisons staff and individuals in custody

Following a serious incident such as this, support for staff involved is critical for their wellbeing, to enable them to continue to carry out their duties to a high standard. Support is initially offered during the Hot Debrief which takes place within hours of any event and again at a Cold Debrief some weeks later. In addition to offering support, these debriefs ensure important information is shared quickly and follow-up actions taken where they are required. In this case, Prison Officer B was impacted by events and was unable to complete full duties that evening. It was their first experience of an incident such as this.

The Hot Debrief took place at 08:00 on 28 September 2020 in the Chapel at Maghaberry Prison. Some procedural norms were not observed:

- not everyone involved in the incident attended, although this can often be the case due to other calls on their time; and
- there is no record of learning or remedial action.

The Cold Debrief took place on 09 October 2020 at 08:00 within the stipulated timeframe. It took place in the Prisoner Safety and Support conference room and as with the Hot Debrief I note procedural shortcomings:

- not everyone who attended Mr O's cell on the morning of 28 September 2020 was present;

- no healthcare staff were present;
- no one from Prison Service Headquarters attended; and
- those who did not attend were not offered additional support services although they should have known they were available.

Those who attended the Cold Debrief noted the value of having a paramedic present on the morning of 28 September 2020.

I am satisfied the Hot and Cold Debriefs took place within procedural timeframes. The shortcomings I have noted are likely to have been in large part due to pressures arising from Covid-19 risk management measures. It is important these Debriefs take place and it is also important, both for individual wellbeing and for learning and improvement, that Prison Service and Healthcare in Prison staff attend together. I therefore reiterate recommendations I have made previously about how Hot and Cold Debriefs are carried out and I remind both the Prison Service and the Trust they should be implemented.

Given the significant society-wide concerns about mental health and wellbeing I am recommending Debrief procedures for both Prison Service and Healthcare in Prison staff are reviewed for effectiveness and improvement. While individuals will express a variety of needs and impacts following serious incidents, there is a duty of care to each of them and an assurance that they process events to lessen any impact on their daily work and general wellbeing. The Prison Service has put new measures in place for Prison Officers, including a peer support programme which is likely to be invaluable given the insights from shared experience. The Trust has also put new measures in place to support Healthcare in Prison staff when they have been involved in serious incidents such as deaths in custody, including a written process for managers about how to support staff following a critical incident and the offer of psychological support on an individual or group basis. Healthcare in Prison staff have also been trained in the Community Resiliency Model and some Prison Officers have participated in the same training. Nevertheless, a review of procedures will give confidence to all. I therefore recommend:

The Prison Service and Trust review how Hot and Cold Debriefs are carried out to identify any improvements that can be made and inform my Office when that review has completed, together with any recommendations arising from it.

It is important those involved in serious events such as this are supported. It is equally important others in custody are offered support as they share in events from behind their cell door, sometimes losing friends. The Samaritans telephone was available to anyone on the Landing who needed it, they could request support from a Listener[7], and the mental health team was also available to any who needed additional support and Chaplains visited the Landing.

5.4 Healthcare in Prison's Local Serious Incident Review

The Trust completed a Significant Incident Review in May 2021. In that Review the Trust acknowledge there is no record of a Mental Health Screen being completed and also that should one have been completed the outcome would most likely have been no referral for additional support given the evidence available. However, this is a view in retrospect and Mr O's family should have had the assurance of a fully completed process. The Trust further acknowledge the Mental Health Screening process has been improved since the time of Mr O's death. At the time of his death the screening process was a review of written records with no face-to-face engagement.

I have reviewed Healthcare in Prison records and can confirm Mr O received the standard Initial and Comprehensive Health Assessments that were procedure at that time. These were normally followed by a Mental Health Screen which was a review of written records. In Mr O's case this did not happen. I queried this with the Trust who informed me there were some difficulties, not related to Covid-19, with screening at that time, in that a robust process for ensuring and recording what took place was lacking. This was improved following Mr O's death although this was not the sole reason for the improvement. Improvement had already been under consideration due to knowledge the processes were not robust and in light of NICE guidance that had been issued in 2017. This a welcome improvement and is a mental health triage completed within the first seven days of committal by a mental health professional.

Since January 2021 a new process has been in place in Maghaberry Prison. One significant aspect of that improvement is that the Mental Health Screen takes place face-to-face with the individual in custody. This provides them an important further opportunity to supply further information about their history and current thoughts and feelings.

[7] *Listeners* are trained by Samaritans to provide peer support to those requiring it within the prison.

Section 06: Matters of Concern

6.1 How Mr O's family were informed of Mr O's death

The last message Mr O's family received from Mr O was on 29 July 2020 at 15:53. He was diligent in keeping them up to date with what he was doing and in a WhatsApp message he said he was 'going on terrain for a few days' and that he 'would be in contact again soon'. His parents found this somewhat odd in that he had planned dental surgery for 04 August 2020 which would have required 02 nights in hospital.

The next contact was on 11 September 2020 when Mr O telephoned his parents and spoke briefly with them. He told them his mobile was not working properly and that he would call them weekly, as best he could, to keep them up to date.

On 28 September 2020 at 15:00, Mrs O answered the telephone to Governor A who informed her that her son had died. Her words express how she feels about the call:

> *"The manner in which that news was delivered to me was nothing short of appalling. The Governor did not even afford me 30 seconds to call my husband in from the garden. It was a brutal statement with no forewarning, no invitation to take a seat, no preparation in the form of a warning of impending bad news… I wish to record my strongest objection to the manner in which the message was delivered and the conduct of the messenger himself".*

Governor A's recollection of the conversation is somewhat different and they were devastated to hear how the process of informing the O family had been experienced.

A number of families have shared with me how difficult it has been to hear the news of their loved ones death. Some have found that difficult over the telephone while others have expressed the view that they preferred to receive the news by telephone as it meant the information was communicated to them more quickly.

There is no easy way to tell someone bad news. It is important the news is conveyed with clarity and empathy. While it is difficult to discern options that would satisfy everyone, I consider it important for the Prison Service to review their policy and procedures for informing next of kin. I therefore recommend:

> The Prison Service review the procedures for informing next of kin about a death in custody, paying particular attention to the impact the news will have on them and the length of time it can take after the death to inform them.

6.2 The impact of isolation and support provided to those in custody

Mr O's family raised very particular questions about the mental health support available to those in custody while in isolation. They were concerned that there would have been a significant impact on their son as he had travelled from France, this was his first time in custody and he knew he would have to appear in Court in the following weeks. He was also a young man who was disciplined and followed a challenging exercise regime. Any stress he was experiencing would have been assisted by the freedom to continue that exercise regime.

Isolation arrangements for those coming into custody at Maghaberry Prison did not include facilities for outside exercise. This is in large part due to the geography of the prison and the risks that would have presented to both Officers and individuals in custody if they had been moved around the prison to an area for exercise. There was limited movement permitted within the prison to restrict the risk of spreading coronavirus infection. Another complicating factor was the number of committals coming into Maghaberry Prison. Courts across Northern Ireland slowed during the pandemic with an expectation that the number of people coming into custody would be reduced. The reality was quite the opposite: committals were often at pre-pandemic levels. Ensuring safety had to take priority.

One option would have been for the Prison Service to permit those in custody within Foyle House to exercise in small groups. While this may have mitigated the situation for those who were held in isolation, it would have been contrary to the intent of quarantine that was to avoid transmission of the virus by separating individuals from one another so they could not spread the virus. It is noteworthy that at the time when complaints from Foyle House were being investigated 04 individuals tested positive for Covid-19 within the general population and 14 tested positive in committal quarantine. The fact that 14 individuals committed into custody could have entered the general population or otherwise infected either staff or others in custody is important to note when considering the overall arrangements required for safety. Overall, while far from satisfactory, when investigating complaints I found it was reasonable for the Prison Service to limit exercise in Maghaberry Prison during the quarantine period. On balance, those in Foyle House were safer because it existed than they would have been had it not existed, even with its limitations.

While the decision to restrict movement makes sense given the presenting risk, everyone was aware there could be negative impacts on those in custody. Mitigations were provided in terms of single cells which allowed individuals to continue limited exercise within their own cell. It is notable when Mr O moved to Bann House he was offered time in the yard outside where he could have exercised but he refused the opportunity on the afternoon of 26 September at 14:03.

The question Mr O's family have asked about his mental health and wellbeing is an important one and is compounded by the concern that he spent 23 hours alone, locked in his cell. The positive duty on the Prison Service to protect life has to be balanced with the impacts caused, but the impacts caused can never outweigh the positive duty. Safety from Covid-19 was the first concern during the pandemic. The question is whether or not mitigations at the time were sufficient to at least in part offset the negative impacts of being locked for most of the time and not having access to outside exercise facilities. Others will examine this in detail.

I can identify some mitigations that were in place in the form of activity packs, engagement with Prison Officers when meals were delivered, on the way to showers or the telephone and through the door when they had time to talk to those in custody. Despite the apparent lack of activity on all my visits to Maghaberry Prison during the pandemic, I was surprised by the continual business of the Landings, including within Foyle House, as people moved from one to cell to another, meals were delivered, doors were opened to allow ablutions and cleaning. There was constant noise and activity. Nevertheless, the important questions about exercise and human contact raise questions about the extent to which the circumstances an individual finds themselves in are, or should be, taken into account during assessments or whether it would be considered such assessments are robust to uncover concerns no matter what the circumstances. In Mr O's case there was somewhat extraordinary circumstances in terms of his detention with a European Arrest Warrant, his journey back from France, his choice not to have contact with family, the fact he had not been in Northern Ireland for seven years and the sudden loss of a meaningful, challenging and busy life.

6.3 The Night Custody Officer Belt and the standard of immediate responses

In previous reports I have made recommendations about the Night Custody Belt, including that it should be worn when completing supervised checks. When Prison Officer B observed Mr O in need of assistance, he was not wearing the Belt and had to make his way to the end of the Landing to collect it. Review of evidence shows there was no delay to entering the cell. Two Prison Officers must be present before the door can be opened. The time it took Prison Officer B to collect the Belt meant he arrived at the cell door within a few seconds of Prison Officer C and they entered the cell together. If he had not been collecting the Belt he would have had to wait at the door for Prison Officer C. There were approximately two minutes between the time when Prison Officer B saw Mr O and the time when they entered the cell with Prison Officer C, CPR commenced at approximately 03:04 and life extinct was called by Paramedic A at 03:09 approximately given the lack of response and evidence of rigor mortis.

6.4 The adequacy of Prison Service staffing levels and overnight checks on those in custody

On the night Mr O died the prison population was 964. I asked the Prison Service for information about staffing levels and their adequacy on that night. It is important operational standards are maintained. I am particularly mindful of the impacts Covid-19 could have had on staffing levels.

Staffing levels were within normal levels for providing checks and overnight care and I am content they played no part in Mr O's death.

PART B: LEARNING

Section 07: Learning and Good Practice

One of the purposes of my investigations is to ensure learning is identified to improve practice in the future, including identifying existing good practice to ensure it continues. Such learning should enhance process, procedure and the experience of those involved with a death in custody.

7.1 Night Checks

During the investigation it became evident a significant length of time had elapsed from when Mr O had last been checked until he was found in the early hours of 28 September 2020. Although there had been no breach in policy improvement was required to consider the timings of the checks completed. This matter was raised with and accepted by Prison Service who have issued and implemented new policy guidance around the timing of night checks. I welcome the proactive action taken by the Prison Service very quickly after Mr O's death.

7.2 Night Custody Officer Belt

Prison Officer B, the Night Custody Officer on duty in Bann 02 on 27 September 2020 into 28 September 2020, was not wearing a Night Custody Officer Belt which is standard working practice whilst on duty. I have reminded the Prison Service of recommendations I made in previous reports and I will continue to monitor the situation and make recommendations as required. I reiterate I am satisfied this had no impact on the outcome for Mr O.

7.3 Paramedic on duty in Maghaberry Prison

The Trust began to pilot the use of paramedics on duty within the prison during 2020. The practice put some financial demand on the system but has proven to bring confidence to others on duty, both Healthcare in Prison and Prison Service staff. From the point of view of the ability a paramedic has to declare life extinct, CPR can cease before NIAS crew arrive at the scene. This is important for the dignity of the deceased and the wellbeing of those administering CPR. It is also important standards are maintained to ensure the confidence of families who lose loved ones during their time in custody. Overall, this is a very welcome development.

In Mr O's case, those interviewed felt having a full time paramedic resource on site would be very helpful. Whilst I fully support this new initiative by the Trust, I would welcome the opportunity to have this service available full time seven days a week and I urge Commissioners to ensure the Department of Health provide the necessary funding. I have written to the Commissioners of Healthcare in Prison in this regard.

Section 08: Conclusions

The specific objectives of this investigation were set out in Section 3.2 of this report:

1.	**To establish the circumstances and events surrounding Mr O's death on 28 September 2020, including an overview and examination of immediate responses when he was found;**
	The circumstances surrounding Mr O's death are recorded in Section 4 and Appendix 2. An overview of the responses when Mr O was found are set out in Section 4 and 5.
2.	**To examine how Mr O was cared for by the Prison Service and Trust while at Maghaberry Prison, particularly the standard of his Mental Health Care given the circumstances of his detention;**
	I am satisfied the care provided by Prison Service and Trust was reasonable and appropriate. It was in line with policy at that time. I am pleased improvements have been made to mental healthcare as the Mental Health Screen which is completed after the Comprehensive Healthcare Assessment, now takes place face to face.
3.	**To examine Covid-19 risk control measures and their application by the Prison Service and Trust and any possible implications for Mr O;**
	Measures in place to protect those living and working within prisons were necessary, in line with public policy, regularly reviewed and important for the safety of those in the care of the Prison Service. It is impossible to assess implications for Mr O with any certainty.
4.	**To consider the adequacy of policy and procedures for informing families of the death of a loved one in custody;**

	I have made a recommendation for review of policy and procedure given how Mr O's family experienced receiving the information and given the issues some other families have raised.
5.	**To provide information to Mr O's family in response to the issues they have raised;**
	My report provides information that takes account of the questions Mr O's family have raised.
6.	**To 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;**
	This report will be provided to the Coroner along with full disclosure of investigative materials and inform the inquest.
7.	**To identify any learning for the future.**

	I have identified learning and follow-up action taken by the Prison Service who have added an additional safety check to reduce the length of time between checks. I have referenced previous recommendations from which learning needs to be reinforced with regard to Night Custody Officers wearing the Belt during checks. I have referenced the introduction of the paramedic during the night which gave confidence to staff and note the difficulties the Trust face in resourcing such a position. I have written to the Commissioners of Healthcare in Prison with regard to resourcing an on-site paramedic overnight at Maghaberry Prison. I have recommended a review of how next of kin are informed about the death of a loved one in custody and of the Debriefs provided following incidents. These reviews should result in learning for the future.

Appendix 01: Terms of Reference for Prisoner Ombudsman investigations into Deaths in Custody

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:
   - prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently.

     However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.
2. The Ombudsman will act on notification of a death from the Prison Service.

   The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.
3. The aims of the Ombudsman's investigation will be to:
   - establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors;
   - examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence;
   - in conjunction with the (DHSS & PS) replaced with South Eastern Health and Social Care Trust as the healthcare provider in prisons, where appropriate, examine relevant health issues and assess clinical care;
   - provide explanations and insight for the bereaved relatives; and
   - assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.
4. Within this framework, the Ombudsman will set Terms of Reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 01 where a common factor is suggested.

Appendix 02: Timeline of Events

July 2020	
30 July	Mr O was arrested in France under the provisions of a European Arrest Warrant and committed to Aix-Luynes Prison.
August 2020	
10 August	Mr O met with his lawyer.
11 August	Mr O attended an appointment at the prison's health unit.
21 August	Mr O attended an appointment at the prison's health unit.
September 2020	
05 September	Mr O met with his lawyer.
11 September	Mr O arrived into Belfast City Airport where he was arrested by the PSNI and taken to Musgrave Street Custody Suite.
12 September	Mr O appeared at Belfast Magistrates' Court and was committed into custody at Maghaberry Prison where he was assigned to Foyle House, Cell 16 on Landing 01.
12 September	Initial Health Assessment completed along with the Mr O's committal interview.
13 September	Mr O refused to participate in the Comprehensive Health Assessment.
14 September	Comprehensive Health Assessment completed.
17 September	Mr O moved to Cell 13 on Landing 05 in Foyle House.

26 September 2020	
	Mr O's 14 days in isolation in Foyle House ended and he moved to Bann House, Cell 13 on Landing 02 around lunchtime.
14:13	Mr O entered the showering area.
15:57	Mr O was given milk and a bag into his cell.
16:01	Mr O had conversation with a Prison Officer and then went to collect his evening meal.
16:16	Mr O returned to his cell.
16:35	Cell check.
19:33	Cell check.
23:07	Supervised check.
01:48	Cell check.
04:27	Cell check.
07:11	Cell check.
27 September 2020	
07:28	Day staff cell check.
09:50	Mr O was unlocked.
09:55	Mr O entered the showering area.
12:10	Mr O went to the servery to collect his lunchtime meal.
12:12	Mr O returned to his cell and was locked.

12:19	Cell check.
13:17	Cell check.
14:12	Mr O's cell was unlocked, he spoke to a Prison Officer and his cell was locked again.
15:22	Mr O was given milk into his cell.
16:11	Mr O was unlocked.
16:13	Mr O went to the servery to collect his evening meal.
16:14	Mr O returned to his cell and was locked.
16:43:43	Day shift headcount check.
19:24:24	Night shift headcount check.
20:44:10	Supervised check.
28 September 2020	
02:59:02	Supervised check at which Mr O was found unresponsive.
03:00 approx.	Paramedic and Nurse receive a call and made their way to Bann 2 to assist.
03:00:49	Senior Officer B joined Prison Officer B C and D on the Landing.
03:00:56	Senior Officer B joined Prison Officer B and C entered Mr O's cell and commenced CPR.
03:05:52	Paramedic A and Nurse C arrived at Mr O's cell.
03:09	Paramedic A called life extinct and CPR was ceased.
03:13:08	Senior Officer B locked Cell 13.
03:26:37	NIAS paramedics entered Cell 13.
03:32:35	NIAS paramedic exited Cell 13.

03:32:46	Senior Officer B relocked Cell 13.
08:00	Hot debrief completed.
October 2020	
09 October	Cold debrief completed.