



The
**Prisoner
Ombudsman**
for Northern Ireland

**INVESTIGATION REPORT
INTO
SERIOUS SELF-HARM INCIDENTS BY
SEAN LYNCH
AGED 23
AT MAGHABERRY PRISON
BETWEEN 2nd AND 5th JUNE 2014**

[6TH September 2016]

[Published: 14th September 2016]

Names have been removed from this report, and redactions applied. All facts and analysis remain the same.

PRISONER OMBUDSMAN INVESTIGATION REPORT
Sean Lynch – Serious Self-Harm Investigation

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GLOSSARY

CAH	Craigavon Area Hospital
CJI	Criminal Justice Inspectorate
EMIS	Egton Medical Information System
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
MO	Medical Officer
NCO	Night Custody Officer
NICE	National Institute for Health & Care Excellence
NIPS	Northern Ireland Prison Service
POA	Prison Officers Association
PRISM	Prison Record and Inmate System Management
PSST	Prisoner Safety and Support Team
RVH	Royal Victoria Hospital
SEHSCT	South Eastern Health and Social Care Trust
SSHP	Suicide and Self-Harm Prevention policy
SPAR	Supporting Prisoners at Risk process/document

PREFACE

The Director General of the Northern Ireland Prison Service (NIPS) requested my office on 23rd June 2014 to conduct an investigation into the circumstances surrounding serious self-harm incidents by Sean Lynch in Maghaberry Prison earlier that month.

Terms of reference for this investigation were set by the NIPS; and it was agreed we would work collaboratively with the South Eastern Health and Social Care Trust's (SEHSCT) Serious Adverse Incident investigation. It was provided to my office in March 2016.

Objectives

The objectives for this investigation are as follows:

- Establish the circumstances and events that led to the incidents between 2nd and 5th June 2014, including the care provided by the NIPS;
- Examine any relevant healthcare issues and assess the clinical care provided by the SEHSCT;
- Examine whether any changes in NIPS or SEHSCT operational methods, policy, practice or management arrangements could help prevent a similar incident in future; and
- Ensure that the prisoner and his family have an opportunity to raise their concerns, and take these into account in the investigation.

Methodology

Our investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of prison records; and examination of evidence such as CCTV footage and phone calls. Where necessary, independent clinical reviews of the medical care provided to the prisoner are commissioned. In this case Consultant Forensic Psychiatrist, Professor Seena Fazel, undertook a clinical review of the care provided to Mr Lynch.

This report is structured to provide a chronological analysis of events that led to the most serious self-harm incident on 5th June 2014.

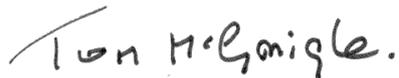
Family Liaison

Family liaison is a very important aspect of the Prisoner Ombudsman's role. I first met Mr Lynch's family on 23rd June 2014 and contact has been maintained with them throughout the investigation.

PRISONER OMBUDSMAN INVESTIGATION REPORT
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Although this report will inform several interested parties, it is written primarily with Mr Lynch and his family in mind.

I am grateful to Mr Lynch and his family, the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust, Dr Chada who chaired the Trust's internal investigation and the clinical reviewer for their contributions.



TOM MCGONIGLE
Prisoner Ombudsman for Northern Ireland
6th September 2016

SUMMARY

The self-harm that Sean Lynch inflicted in Maghaberry Prison between 2nd and 5th June 2014 was extreme and shocking. It followed deterioration of his mental health in the community and increasingly bizarre behaviour in prison, to an extent which had not been apparent during his previous periods in custody.

A detailed Forensic Medical Officer's assessment was prepared for the court which remanded Mr Lynch in custody on 22nd April 2014. It suggested that formal psychiatric assessment was an "*absolute necessity*." Although this assessment was sent to Maghaberry, Mr Lynch was treated as a routine referral. He was meant to have six mental health reviews pending the psychiatric assessment, but only one took place.

It took two weeks for Mr Lynch to see a psychiatrist. He was diagnosed with a drug-induced psychosis, which was reasonable. His care plan consisted exclusively of pharmacological treatment and our clinical reviewer suggests that a more determined effort to obtain collateral history, plus observation in a drug-free environment such as a prison hospital, would have been of considerable benefit in accurately diagnosing and treating Mr Lynch.

He was reviewed by the psychiatrist three weeks later and his medication was increased. The clinical reviewer said that, given Mr Lynch's lack of response, he would have expected the dose to have been increased more quickly; and problems may have been compounded by the fact that there was then an eight day delay in administering the increased dosage.

Mr Lynch was known to Maghaberry's Prisoner Safety & Support Team, and the SPAR process for managing vulnerable prisoners was initiated at the end of May. Numerous people from the NIPS and the SEHSCT were involved, but nobody took overall responsibility for managing him, either as a patient or as a vulnerable prisoner. Events moved faster than the official reaction, and his increasingly bizarre and violent crises were met by short-term responses which included several moves of location and placements in observation cells with anti-ligature clothing.

His final location, Quoile House, was unsuitable for managing someone who was so disturbed. A contemporary, independent assessment by a priest is informative: he said on 1st June "*His condition is beyond anything the officers can cope with.*" A Transfer Direction Order to a secure healthcare setting was considered but the necessary assessment did not take place in time.

It is clear that Mr Lynch faked symptoms on some occasions and this led certain NIPS officers to believe he was being manipulative in order to be moved to a different location. This belief, which was also partly caused by insufficient awareness of his mental illness, impacted negatively upon his management and care.

The escalation in Mr Lynch's self-destructive behaviour required treatment at outside hospitals on two occasions. His conduct was so challenging that he had to be restrained in one instance and tranquilised in the other, and he seriously assaulted a prison officer in

Maghaberry on 3rd June. He inflicted an 8cm cut to his groin, allegedly with a piece of broken flask which he found after moving into a new cell. However this cannot be confirmed as the implement was never sought nor found. Both he and the cell should have been properly searched in advance of moving in.

Mr Lynch's main self-harm episode on 5th June lasted for 67 minutes. During that period he was directly observed by prison officers for 27% of the time. He self-harmed on 20 separate occasions, each lasting an average of 26 seconds. During this time he damaged both eyes to the extent he rendered himself blind and extended his groin injury. It seems remarkable that several experienced NIPS officers, including a Senior Officer, all felt it was neither necessary nor appropriate to enter his cell to prevent Mr Lynch from self-harming further.

The main reason they suggested for the delay in intervening was that they did not realise the seriousness of his injuries. They also believed four staff would be unable to manage him, and that there could be a risk to prison security if he were to obtain the keys they carried. Their duty of care was trumped by security concerns that appear to have had little basis in reality.

It appears nonetheless that the officers complied with a strict interpretation of Maghaberry Governor's Order 8-13. That order requires intervention if a situation is life-threatening, which is defined as *"A prisoner with a ligature, with serious cuts, or unconscious, or any unexplained reason where there is no response from them."* Mr Lynch was not profusely bleeding and therefore did not meet these criteria. On the other hand the NIPS Suicide & Self-Harm policy requires that *"A prisoner who inflicts a serious self-injury.... should not be left alone, even to summon help, as they may attempt further injury if left unattended...."* There is a clear discrepancy here that must be remedied.

This case illustrates the difficulty of managing someone who is severely mentally-ill in prison. The default approach for vulnerable prisoners - the interagency Supporting Prisoner at Risk (SPAR) process - was never designed to care for someone as challenging as Mr Lynch.

Nonetheless there is learning from this experience for improving the SPAR process: assessments, reviews, handovers, attendance and contributions at meetings, observation logs and audits were all below standard. Efforts were made to comply with the letter of the SPAR process, but the spirit was completely missed. Various aspects of the NIPS policy for using observation cells were also deficient.

Some SEHSCT personnel expressed serious concern about the unavailability of a healthcare observation wing in Maghaberry Prison to help manage vulnerable prisoners. There are also indications that Mr Lynch was treated less favourably at outside hospitals because he was a prisoner. These matters need to be addressed by the SEHSCT.

We make 63 recommendations for improvement and the most significant areas are highlighted in this summary. Eleven (recommendations 4, 5, 7, 8, 9, 10, 12, 20, 23, 35 and 63) have previously been made to, and accepted by the NIPS; and four (recommendations 42, 49, 53 and 63) have been made to and accepted by the SEHSCT.

RECOMMENDATIONS

NIPS

1. **Instigation of Serious Self-Harm Investigations** – The NIPS should ensure that requests for the Prisoner Ombudsman to investigate an incident which lies outside the Ombudsman’s current Terms of Reference, are made consistently and at the earliest opportunity in order to avoid loss of potential evidence.
2. **Duty of Care failures** – The NIPS should initiate formal performance management procedures, and if necessary, disciplinary investigation, with all staff highlighted in this investigation who have under-performed in their job role.
3. **Training Needs Analysis** – The NIPS should conduct a training needs analysis in relation to all the concerns raised in this report.
4. **Committal Officer Interviews/Documentation** – The NIPS should take urgent action in relation to the shortcomings highlighted around the committal interview and assessment processes, including management of documentation to ensure this repeat issue is finally resolved.
5. **Handovers** – The NIPS should ensure Maghaberry’s Governor’s Orders 7-25 and 8-1 are updated and reissued to all staff. The orders should fully reflect the learning identified in this investigation.
6. **Policy discrepancy** - The NIPS should clarify the discrepancy between Maghaberry Governor’s Order 8-13 and the NIPS Suicide & Self-Harm policy to ensure the duty of care is always properly fulfilled.
7. **SPAR Records** – The NIPS should ensure all staff are reminded of their responsibility to maintain accurate and meaningful SPAR records, including:
 - All interactions with the prisoner;
 - Observations whilst accompanying them;
 - Reasons for any decisions made;
 - Clarification from the prisoner if they tell staff they are anxious or worried;
 - Evidence that any inconsistent comments or presentation by the prisoner has been discussed with them.
8. **SPAR Care Plans** – The NIPS should ensure that senior officers are reminded of the policy surrounding SPAR Care Plans, including the need for them to mitigate all identified risks and identify actions to help to settle them. Where action points are generated, evidence of their completion must be accurately recorded.
9. **SPAR Assessments/Reviews** – In carrying out SPAR assessments and reviews, the NIPS should ensure all senior officers are fully aware:
 - Of the policy-compliant objectives;
 - That a meaningful and accurate record should be created;

- That all issues identified are reflected in the Care Plan;
 - That conversation with the prisoner is appropriate;
 - Appropriate weight is given to the value of input by a prisoner whose mental capacity may be distorted;
 - That all reasons for decisions made are recorded and evidence-based;
 - That a full review of SPAR log entries since the previous review is carried out, considered and evidenced;
 - That any inconsistencies are discussed and the outcome recorded.
- 10. SPAR Audit Process** – The NIPS should update their SPAR auditing procedures to ensure they address the quality of Assessments, Reviews, Care Plans and their implementation.
- 11. False Allegations** – When a prisoner makes and then retracts, a serious allegation against their cellmate, the NIPS should ensure the process for managers to satisfy themselves that it was false is dynamic and includes action to safeguard the cellmate from further allegations. All enquiries and decisions made must be recorded in the journal / PRISM and provide the rationale for actions taken.
- 12. PSST Referrals** – The NIPS should ensure the process for notifying staff when a prisoner has been referred to PSST is robust. In doing so, consideration should be given to updating PRISM to include a notification alert for anyone accessing the prisoner’s record.
- 13. PSST Reviews** – The NIPS should ensure PSST reviews are structured with clear objectives, outcomes and action plans to address all concerns that have been raised.
- 14. Non-Attendance at an Appointment** – The NIPS should ensure a justifiable reason for a prisoner’s non-attendance at an appointment is fully recorded in the class officer’s journal and in the prisoner’s notes on PRISM.
- 15. Prisoner Debts** – When a prisoner reports, or is suspected of, having debts (i.e. as a result of drugs or gambling) generated within the prison, an SIR should be generated and further enquiries should be made to establish the facts and action should be taken to cease further prohibited activity. If bullying is suspected, the NIPS Anti-bullying policy should be instigated.
- 16. Tuckshop Purchasing Trends** – In order to help identify and evidence potential bullying, drug trading and gambling activity, the NIPS should develop a process which will enable discipline staff and/or the Tuckshop to monitor individual prisoner purchasing trends.
- 17. Drug Screening** – The NIPS should ensure that accurate records are maintained and followed-up when drug screening blood tests are requested. Urinary Drug Screening should be routinely conducted when it is suspected a prisoner is under the influence of drugs.

18. **Observation Cells** – Where observation cells do not have a working television the NIPS should give careful consideration, following an individualised risk assessment, to provide a television or radio.
19. **Flexible Observation Intervals in Observation Cells** – The NIPS should allow flexible observation frequencies, outside of the stipulated 15 minutes, for prisoners located in an observation cell.
20. **Observation Cell Footwear** – The NIPS should ensure checks are carried out daily to ensure the provision of footwear for prisoners held in an observation cell.
21. **Observation Cell Cutlery** – The NIPS should ensure specialist safety cutlery is available for prisoners in observation cells to eat their meals.
22. **Observation Cell Access to Cigarettes** – The NIPS should remind staff that account should be taken of whether prisoners in observation cells smoke tobacco. If it is safe to do so, then a supply of cigarettes should be provided.
23. **Anti-ligature clothing / bedding** – The NIPS should ensure there are adequate supplies of anti-ligature bedding and clothing and that all staff are fully aware of what should be provided.
24. **Use of Force Records** – The NIPS should remind their staff of the legal requirement to complete Use of Force forms; and that failure to do so will result in performance-management.
25. **Location Moves** – The NIPS should ensure that staff who authorise a location move record all their considerations and the reason for the move on PRISM. “Operational Requirements” is not a sufficiently detailed reason. When relocating vulnerable prisoners with mobility and/or mental health issues, the NIPS should ensure their officers liaise with the Prison Healthcare Department before the move takes place.
26. **Individual Prisoner Security Measures** – The NIPS should ensure accurate records are retained on PRISM when specific instructions have been issued about the management of individual prisoners for security reasons.
27. **Requests for Evidence** – The NIPS should ensure all requests for technological evidence by the Prisoner Ombudsman are given priority to ensure evidential opportunities are not lost.
28. **Flasks** – The NIPS should ensure all flasks currently in circulation are replaced with non-glass flasks.
29. **Cell/Prisoner Search Following Self-Harm** – Following a reported or witnessed self-harm incident, where an implement has been used, the NIPS should ensure a search of the cell and / or prisoner is conducted until the item has been secured; and a SIR should be generated.

- 30. Hospital Escort Staff** – The NIPS should introduce a process whereby hospital escort staff record the name of the nurse or doctor who discharged the prisoner and details of whether a discharge letter was provided. Prison Healthcare should be briefed and a record made to evidence that the letter has been handed over. This full record should be retained in the prisoners file and noted in their PRISM notes.
- 31. Safety of Healthcare Staff** – The NIPS should remind staff of their duty of care towards Healthcare staff within the prison environment.
- 32. ECR In-Cell SPAR Observations** – The NIPS should ensure there are meaningful handovers and clear instructions about the responsibilities of ECR staff who conduct In-Cell SPAR observations.
- 33. Continuous Observation Guidance** – The NIPS should ensure there is clear guidance for staff to determine when a prisoner should be placed on continuous observations, and the steps to implement such decisions.
- 34. Staff Communication Sheets** – The NIPS should conduct a training needs analysis to address the delays in completing staff communication sheets and the regular lack of detail and evidence-based information provided.
- 35. Outside Hospital Protocols** – The NIPS should ensure staff conducting hospital escort / bedwatch duties consistently adhere to outside hospital protocols. Guidance on dealing with families in emotionally-charged situations should also be provided.
- 36. Actions Following an Allegation of Assault** – The NIPS should ensure Security Departments fully implement Governor’s Orders when a prisoner makes an allegation of assault. All actions and decisions made should be fully recorded on PRISM and associated paperwork.

SEHSCT

- 37. Committal/First Night Form** – The SEHSCT should ensure nurses completing the healthcare summary on committal forms provide sufficient information for NIPS colleagues to help them manage the prisoner safely.
- 38. FMO Contact** – The SEHSCT should liaise with the PSNI to establish a process which ensures FMO concerns about risks, recommendations for a psychiatric assessment and/or risk of self-harm or suicide are promptly and fully received by Trust staff at point of committal.
- 39. EMIS** – The SEHSCT should remind all clinical staff to use EMIS as a contemporaneous clinical record of all actions/consultations taken, including multidisciplinary mental health meetings, mental health presentations during GP appointments and challenges made to any inaccuracies.
- 40. Urgent Appointments** – The SEHSCT should ensure that when an acute condition such as a drug-induced psychosis, is diagnosed, an urgent doctors or psychiatrists appointment is provided to help stabilise the patient.
- 41. Diagnosing Drug-induced Psychosis** – The SEHSCT should ensure urinary drug screening is conducted and collateral history obtained at the earliest opportunity when a drug-induced psychosis is suspected.
- 42. Review Scheduling** – The SEHSCT should ensure that, when a care plan requirement for a patient to be reviewed at specified intervals is not fulfilled, then the reason should be fully recorded on EMIS and the Care Plan updated accordingly.
- 43. Collateral History from the NIPS** – The SEHSCT should ensure the mental health team routinely obtain relevant information from the NIPS to assist in diagnosis and treatment options for their patients. Where applicable, this should include documented evidence that SPAR observations logs have been reviewed.
- 44. Collateral History from families** – When Healthcare staff require collateral history from a patient’s family, all efforts to do so must be made at the earliest opportunity and the results recorded on EMIS.
- 45. Mental Health Care Plans** – The SEHSCT should ensure that prison Mental Health Care Plans are holistic and that each patient has a clearly identified key worker whose role is to ensure all aspects of their healthcare are comprehensively addressed.
- 46. Antipsychotic Prescriptions** – The SEHSCT should ensure their prison psychiatrist’s and GP’s prescribing practices for antipsychotics follow NICE Guidance. Any non-compliance with NICE Guidance should be fully justified and recorded to a standard that clearly identifies the clinical rationale.

- 47. Community GP Records** – When a copy of a patient’s community GP record is obtained, the SEHSCT should ensure there is a process in place for this record to be reviewed and for all relevant findings to be summarised on EMIS.
- 48. New Prescription Administration** – The SEHSCT should ensure the eight day delay in Mr Lynch receiving his increased dose of antipsychotic medication, and the inaccurate timing of the administration of his new prescription, are fully investigated; and ensure the learning from this review is used to strengthen current processes.
- 49. Allegations of Bullying** – The SEHSCT should ensure all staff are aware of their responsibility to inform NIPS staff when an allegation of bullying has been made. A record of the information shared and the receiving officer should be recorded on EMIS.
- 50. Healthcare Representation at Safer Custody Fora** –The SEHSCT should ensure a primary care nurse, mental health nurse or doctor is available to attend all multi-disciplinary SPAR reviews and/or PSST Reviews. Their attendance must add value in assisting in the decision-making processes and take account of whether *“this person can keep himself safe?”* There should be a preliminary discussion with the prisoner prior to the review. An accurate record of the review and the Healthcare input should be recorded on EMIS and, where applicable on the SPAR observation log.
- 51. Self-Harm and Suicide Training** – The SEHSCT should ensure the skills and knowledge required by their representatives who attend SPAR Case Reviews are maintained through regular training. Particular attention should be paid to the needs of agency staff.
- 52. Agency staff** - The SEHSCT should ensure that agency staff are properly inducted to work in prisons and understand their responsibilities in matters such as contributing to the SPAR process.
- 53. Assessments of Patients on a SPAR** – The SEHSCT should remind all staff of the importance of using the SPAR Booklet to inform their assessment of the patient, and the importance of recording key aspects in relation to risk and assessment of vulnerability in the SPAR Observation Log.
- 54. Working Practices** – The SEHSCT should take steps to encourage a culture that promotes collaborative working practices between individual Healthcare staff, and in particular between the primary care and mental health teams.
- 55. Appointment Booking** – In line with the Triage SOP, the SEHSCT should remind staff that, when recording the need for a GP assessment or any other appointment/referral during triage, they must schedule it through EMIS, and the onus should not be placed on a patient to submit the request separately.

- 56. Information Sharing** – The SEHSCT should remind staff that information which they share about a patient must be accurate and within the boundaries of patient confidentiality.
- 57. Unattended Appointments** – The SEHSCT should ensure that any patient on the Mental Health Team’s ‘Watch List’ who does not attend a scheduled appointment is actively pursued to attend.
- 58. EMIS Capacity** – The SEHSCT should assess the adequacy of the current EMIS IT system in relation to including a prescribing and dispensing module, which also captures IP risk assessments and automatic review scheduling. If EMIS cannot deliver the service required, the Trust should also investigate alternative IT support.
- 59. Healthcare Centre Beds** – In light of the evidence provided by Maghaberry’s mental health team during the SAI process and the findings of Professor Fazel’s review, the SEHSCT should liaise with the HSC Board to address the placement options for prisoner-patients in Northern Ireland whose healthcare needs cannot be adequately met within the general prison population.
- 60. Transfer Direction Order (TDO)** – The SEHSCT should ensure TDOs are initiated at the earliest opportunity and EMIS records are fully maintained in respect of all considerations and decisions made.
- 61. Outside Hospital Discharge Procedures** – The SEHSCT should bring to the attention of the Health & Social Care Board the concerns about the inequitable standard of treatment that Mr Lynch received in Craigavon Area Hospital and attempts to discharge him prematurely from the Royal Victoria Hospital. The standard of discharge information provided by these hospitals should also be highlighted as part of this concern.

NIPS & SEHSCT

- 62. Suicide and Self-Harm Prevention Policy** – The NIPS and SEHSCT should ensure all staff are aware of when a SPAR needs to be opened and can identify behaviours that are likely to increase the risk of self-harm or suicide in prison. In particular they should identify that prisoners/patients who demonstrate psychotic or bizarre behaviour may still require the support of the SPAR process even if they do not acknowledge self-harm or suicidal ideation.
- 63. Definition of Self-Harm** – The NIPS and SEHSCT should ensure all staff understand that the definition of self-harm – *“When someone intentionally damages or injures their body”* – can be wide-ranging e.g. falling down or throwing oneself against a wall or furnishings should be considered as self-harm.

MAGHABERRY PRISON

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

Procedures to support prisoners at risk of suicide or self-harm include a Suicide and Self-Harm Prevention policy, Supporting Prisoners at Risk (SPAR) process and an associated safer custody meeting structure.

Maghaberry established its Prisoner Safety and Support Team (PSST) in 2011. The team comprises a governor and three members of staff. Their responsibilities include a role to support vulnerable prisoners, some of whom are managed under the SPAR process. Mr Lynch was referred to the PSST on 23rd May, 12 days before his most serious self-harm episode on 5th June.

Responsibility for delivery of healthcare at Maghaberry prison transferred from the NIPS to the SEHSCT in 2008; and following a period of transition all Healthcare staff were employed by the Trust by April 2012. The Trust has subsequently increased the numbers of healthcare staff and the range of services provided. Healthcare is planned and delivered in line with primary care services in the community.

The Trust introduced a Primary Care Pathway with a dedicated committals team providing a first health screening within four hours of committal and a comprehensive health screening, which includes a screen by the Mental Health Team, within 72 hours of admission to the prison. The Trust also introduced a Mental Health Pathway, and an Addictions Team was created in 2009.

An inspection report on the safety of prisoners in Northern Ireland was jointly published by the Criminal Justice Inspectorate and Regulation & Quality Improvement Authority (who inspect healthcare) in October 2014. While inspectors saw evidence of good work being undertaken by Prison Service and Healthcare staff in dealing with damaged and vulnerable prisoners, they also said joint strategies between the NIPS and the SEHSCT were urgently needed to address the risks of suicide and self-harm and access to illegal and prescribed drugs.

The subsequent report of an inspection of Maghaberry Prison, published in November 2015, found that rates of self-harm had increased and inspectors were very concerned that aspects of healthcare provision had deteriorated.

Maghaberry has an Independent Monitoring Board (IMB) whose role is to satisfy themselves regarding the treatment of prisoners. Their 2014-15 annual report highlighted concerns about the quantity and accessibility of drugs (both prescription and illicit) and poor participation in, and outcomes of at Drug Strategy Meetings.

FINDINGS

SECTION 1: BACKGROUND

In November 2013 Sean Lynch, aged 22, was charged with assault and criminal damage. He was granted bail but breached the conditions. As a result he was remanded to Maghaberry Prison on 22nd April 2014. This was his sixth custodial period since October 2010 – his previous stays ranged from two days to two months.

Mr Lynch's family described how his passion for football began to decline when he was a teenager. Around the same time he began to get into trouble with the police and his mental health also began to deteriorate: community medical records suggest he was diagnosed with alcohol dependency, Obsessive Compulsive Disorder and suicidal ideation. The family said most of Mr Lynch's previous convictions were as a result of police being called to their home because he placed them in fear for their safety.

Mr Lynch reported having a daily cannabis addiction, having begun drinking when he was 15 and experimented with drugs for a short time, but stopped due to panic attacks. However he resumed regular misuse of drugs at the age of 18, in particular cannabis and mephedrone¹.

Various child and family services interventions were provided but Mr Lynch was not ready to accept help. The family described how his behaviour had become noticeably more disturbed and bizarre during 2013, to the extent that they had to restrain him for lengthy periods of time when he became aggressive in the home. They were unaware of whether Mr Lynch had previously self-harmed or spoken to his GP about his deteriorating mental health.

¹ Mephedrone is a powerful stimulant, part a group of drugs that is closely related to amphetamines.

SECTION 2: COMMITTAL PROCEDURES

22nd April 2014 – Force Medical Officer (FMO) Assessment

After Mr Lynch was arrested a FMO (police doctor) examined him at Strand Road PSNI station. She was concerned about his presentation and contacted his father to help determine whether Mr Lynch's bizarre behaviour was genuine mental illness or faked.

Mr Lynch (Snr) told the FMO that his son had displayed strange behaviour since the age of 14-15, before he began abusing drugs. He described Obsessive Compulsive Disorder traits and day long disappearances.

Following a lengthy conversation the FMO concluded that a formal psychiatric assessment was an absolute necessity. As a result she wrote a letter to that effect which was to accompany Mr Lynch, should he be remanded in custody. The FMO said it was rare for her to be so concerned that she felt compelled to write a letter for the attention of prison staff.

22nd April - Court

During his court hearing on 22nd April Mr Lynch interrupted the proceedings by shouting (he suggested he was praying) to the extent that the court had to be halted. He did not settle down and was removed from court, where he continued to shout from the police van. His behaviour led escort staff to suggest he would probably be taken to a psychiatric hospital, but in fact he was remanded in custody to Maghaberry Prison.

22nd April – Committal to Maghaberry

The documentation that accompanied Mr Lynch from the court to Maghaberry comprised:

- PACE 15 Form – Detained Person's Medical Form, which stated Mr Lynch was smiling vacantly with an elated mood. He was deemed unfit for interview and kept under constant CCTV observation;
- PACE 16 Form – Prisoner Escort Record (PER), which noted that he was of an extremely violent nature and that a letter had been attached by the FMO;
- FMO Letter.

Upon committal Mr Lynch was interviewed by an officer who asked him a number of predetermined questions from the standard 'Committal/First Night Interview' checklist. The officer recorded "No" in answer to questions about vulnerability, whether Mr Lynch felt at risk in custody or whether he had any thoughts of self-harm. The only comment the officer recorded was *"Tends to whisper, but will speak up if required, no thoughts of self-harm."*

The committal officer also ticked a box to indicate the PACE forms had not been received. This was quite inaccurate, and similar concern about committal forms not being completed properly, in particular full analysis of PACE forms, has led to accepted recommendations in previous Prisoner Ombudsman reports.

The same form also provides an opportunity for the committal nurse to record non-confidential information that would be relevant to share with prison staff. The only comment recorded in Mr Lynch's case was *"Appears under the influence of drugs. Observe."*

Details of the committal nurses interview are contained in Mr Lynch's medical record. Prison officers do not have access to this record. The key points of interest include him being in contact with Woodlea House²/DART (Drug and Alcohol Recovery Team); not being in contact with a community mental health team; denying being under the influence of drugs; being animated and over-dramatised; whispering; and that his eyes darted throughout the interview. The nurse also confirmed receipt of his PACE forms and the FMO's letter.

In her letter the FMO described Mr Lynch as intermittently behaving very oddly, chewing, grimacing, hallucinating, whispering and staring. There is reference to Mr Lynch (Senior's) concerns about his son's behaviour, which he advised had been ongoing for years. The letter did not indicate this behaviour started prior to drug misuse, though this would have been outlined if the FMO had been contacted. The FMO queried whether Mr Lynch was suffering from drug-induced psychosis and requested that he be formally psychiatrically assessed as an *"absolute necessity."*

The initial healthcare committal interview was only partially completed due to Mr Lynch's behaviour. The nurse recorded that he was to be reviewed in the morning and that landing staff had been advised of his behaviour and requested to check on him to ensure his safety overnight.

However it is not clear from the nurses EMIS record or her entry on the 'Committal/First Night Form' what level of additional observation was required for Mr Lynch. Nor is there an entry in the landing journal to indicate his risks were discussed at handover from NIPS daytime staff to night custody officers.

The nurse said she did not open a SPAR at this point because she understood the SPAR process is only for those at higher risk of suicide and self-harm. She explained she would have opened a SPAR if she believed it could address psychotic or bizarre behaviour.

Given the FMO highlighting Mr Lynch's vulnerability and the committal nurse's inability to complete her assessment due to his behaviour, plus her request for extra checks to ensure his safety overnight, a SPAR should have been considered.

² Woodlea House provides a range of specialist interventions / treatments, for people with alcohol or drug related problems.

The nurse also telephoned the mental health team about Mr Lynch and they identified him for urgent assessment.

23rd April

The following morning a full mental health assessment was completed. The nurse recorded similar observations to her colleague and the FMO, noting that Mr Lynch had been referred to the prison mental health team in 2013 due to visual and auditory hallucinations. Although he had poor insight into the effects of cannabis misuse on his mental health, he was agreeable to an Ad:Ept³ referral and for monitoring and psychiatric assessment by the Home Treatment Team (HTT)⁴. The nurse requested Mr Lynch's community medical records and these were received on 13th May 2014.

While the mental health nurse referred to the content of the FMO's letter on EMIS, no consideration was given to contacting the FMO or Mr Lynch (Snr) to help understand his behaviour. Had that been done, the reported commencement of Mr Lynch's strange behaviour before he began abusing drugs would have been shared and would have been useful in any future diagnosis.

The HTT referral was processed on the same day with an action plan to review Mr Lynch three times per week until he underwent his psychiatric assessment. Routine psychiatric referrals have a target timeframe of nine weeks and urgent referrals should be carried out within ten working days.

Despite the FMO's concerns and the significance of her sending a letter to Maghaberry, Mr Lynch was initially deemed to be a routine psychiatric referral. This was not recorded on EMIS. Nonetheless Mr Lynch was seen by a psychiatrist within 13 days, which is within the timeframe for urgent referrals.

Professor Fazel said on the basis of this assessment and that of the FMO, a drug-induced psychosis was the working diagnosis. Nevertheless two courses of action would have been in accordance with good practice. Firstly, as this was an acute illness, Mr Lynch should have been seen urgently by a medical doctor (either the psychiatrist or GP) with a view to starting antipsychotics immediately. Secondly, further efforts should have been made to clarify the diagnosis. The most obvious action would have been a urinary drug screen, and an additional step would have been to request a collateral history from Mr Lynch's family.

Professor Fazel noted that a urinary drug screen was ordered some weeks later but not done. He also noted that attempts to take collateral history were complicated by Mr Lynch consistently refusing consent.

³ Ad:Ept – Alcohol and Drug Therapy services provided at Maghaberry Prison.

⁴ The Home Treatment Team Service provides a range of intensive mental health treatments and therapeutic services to patients, including those in prison, who are experiencing an acute disruption to their ability to function adequately as a result of severe mental illness.

Following the mental health assessment, the nurse who had seen him the day before attempted to complete her committal assessment. Mr Lynch's observations were taken but due to him being "*wide eyed and non-communicative*" she again deferred re-interviewing him until the following morning.

That evening Mr Lynch phoned his father and told him he felt fine. They discussed his breach of bail and his mental state in the court. Mr Lynch told his father that he had seen a psychiatrist, mental health nurse and two doctors who had indicated there was nothing wrong with his mental health. This was of course quite inaccurate.

24th April

Although not detailed on EMIS, Mr Lynch was discussed at the weekly multi-disciplinary mental health team meeting. This was the meeting that decided he would be treated as a routine patient and seen by a psychiatrist within the nine week timeframe.

25th April

Due to Mr Lynch attending an induction programme on the morning of 24th April 2014, his full medical committal assessment took place on 25th April. The nurse who carried out the assessment recorded that, while Mr Lynch answered every question, he behaved bizarrely throughout. She therefore queried the validity of his answers.

Soon afterwards Mr Lynch had his initial HTT review. His behaviour was contradictory, and while he consented to the review, he refused to speak with the nurses, instead sticking his tongue out and repetitively swallowing. Mr Lynch was offered a drink of water. As he left to get the drink he was again heard speaking to the officers. Upon his return the nurses were explicit in telling him that he would need to communicate with them in order to conduct the review. He eventually engaged with the nurses, but to a very limited extent. He denied hearing voices, preoccupations or delusions, maintained a fixed stare throughout and indicated there was nothing the nurses could do to help him.

Despite a plan for HTT reviews three times per week until Mr Lynch was psychiatrically assessed, no further reviews took place prior to his psychiatric assessment on 6th May 2014.

30th April

The only further medical appointment which Mr Lynch had prior to his 'committal' psychiatric assessment was a doctor's appointment on 30th April 2014 to discuss treatment for acne. Mr Lynch mentioned that his father and solicitor wanted him to be psychiatrically assessed, despite his personal belief that he had no mental health problems.

The doctor recorded this comment about Mr Lynch’s mental health but made no additional observations about his presentation which could have assisted future mental health assessments.

SECTION 3: PSYCHIATRIC ASSESSMENT – 6th MAY

Mr Lynch underwent his initial psychiatric assessment on 6th May 2014. As a result of the FMO letter, the assessment was conducted earlier than planned because the psychiatrist prioritised him. She recorded a comprehensive account which included bizarre behaviour, animated gaze for over 30 minutes which caused his eyes to water, and a suggestion from him that his doctor had recommended he continue to use cannabis. The psychiatrist noted that “for now” she would be treating him for drug-induced psychosis and wrote a prescription for Abilify⁵ 10mg. Mr Lynch was to remain on her list and her plan was to speak to his family to obtain further history.

If the psychiatrist had spoken to landing staff she should have received further evidence on his presentation and would have been advised that he had received two adverse reports since arriving in Maghaberry – one for repeatedly using his cell alarm and one for failing to follow an order and threatening violence against prison staff.

Other than pharmacological treatment, there were no other elements to the care plan.

Mr Lynch started taking the Abilify on 8th May and was given it daily thereafter by the house nurse.

Commenting on the prescription of Abilify, Professor Fazel said this prescription was not appropriate nor managed in line with best practice. Firstly, he said it took two weeks after committal for Mr Lynch to be prescribed medication for psychosis which is an urgent psychiatric condition. Secondly, he considered the choice and dose of antipsychotic were unusual. Professor Fazel said Abilify is not recommended as a first line medication by the National Institute for Clinical Excellence or other clinical guidelines.

Professor Fazel said 10mg was reasonable as a starting dose, but without a clinically noticeable response, then it should have been increased.

The prison psychiatrist provided a statement in relation to this consultation which also stated that objectively, Mr Lynch’s mood was “*euthymic*” (normal, non-depressed, reasonably positive). However subjectively, he reported that his mood was low, while maintaining a smile. He denied thoughts of self-harm, paranoid ideation or delusion and refused to elaborate on a preoccupation with what he called “*gay guys*.”

The psychiatrist stated that she reviewed EMIS and obtained history from the HTT (though they only had one limited engagement with Mr Lynch) and mental health team prior to assessing Mr Lynch.

⁵ Abilify is an antipsychotic medication used to treat the symptoms of conditions such as schizophrenia and bipolar disorder (manic depression).

There is no evidence that the psychiatrist contacted Mr Lynch's family as planned, or that she knew he consistently refused consent for such contact. She was therefore not aware of the number of years he had been displaying such bizarre behaviour and his impact on the family.

Telephone Call - 7th May

The following day Mr Lynch telephoned his father and told him that he was OK and that there was no need for him to visit. He explained he had seen a psychiatrist and was given medication for his mental health. His conversation again referred to "gay" prisoners.

SECTION 4: EVENTS AND TELEPHONE CALLS PRIOR TO 26th MAY

Telephone Calls & Visits

Following Mr Lynch's initial telephone call with his father on 23rd April, which was difficult, ten days passed before he called him again. This and 13 subsequent calls to his father up until 26th May were normal. They planned visits, discussed his case and football bets, and that he was now "*clean*" and felt his mental health was improving. He received family visits on 14th and 20th May.

Healthcare Appointments

Mr Lynch's community medical records were received on 13th May, though there is no evidence in EMIS about them being reviewed.

Professor Fazel was not sure whether Mr Lynch's community medical records would have assisted in his management, as there was no formal history of community mental health involvement. However he does indicate they may have assisted if considered in conjunction with a collateral history: GP records from 2012 and 2013 both indicated psychotic symptoms, and in 2014 he displayed obsessional symptoms. This suggested some chronicity to his mental health problems, which may in turn have highlighted the need for a comprehensive psychiatric assessment, possibly as an inpatient.

Mr Lynch's had a mental health review on 15th May and spoke with a mental health nurse on 23rd May 2014.

At the review on 15th May he was described as being pleasant and relaxed with a clean and tidy appearance. His speech was clear and coherent though he continued to be reluctant to fully engage with the nurse and his eye contact was poor. Prison officers told the nurse that fellow prisoners identified Mr Lynch as mentally unwell, though he did not present any behavioural concerns on the landing. The nurse also said that Mr Lynch had reported auditory hallucinations but she did not observe any perceptual disturbance during the review.

Location Move

Mr Lynch was moved to Erne House on 15th May. On 23rd May he approached a mental health nurse on the landing in relation to his medication causing nausea. She encouraged him to continue with his medication and reported that he maintained good eye contact, answering all questions put to him and only occasionally broke into whispering dialogue. No thought disorder was observed and he was responsive to humour. Mr Lynch appeared to find life in Erne difficult, and prison officers confirmed there had been an unsettled atmosphere on his landing. The nurse observed good relationships between prison officers

and Mr Lynch. She planned to discuss his presentation with his key worker and pass on his concerns about being in Erne.

The nurse said Mr Lynch would not tell her why he was unhappy about being in Erne House. She emailed his mental health key worker about their discussion and allocated him an appointment at the 'Wellman Clinic'⁶ to establish if side effects from his medication were still prevalent. However he did not attend this appointment on 29th May because no staff were available to escort him.

One prisoner described Mr Lynch as "*strange.*" Another knew him from Magilligan Prison in 2013 and described him as much quieter on this occasion, with something "*not quite right*" with his mind.

An Erne officer described Mr Lynch as a "*very, very likeable prisoner*" though with peculiar mannerisms and making unusual comments. He said Mr Lynch was normally very polite and friendly. This is diametrically different from behaviour which Mr Lynch went on to display over the next few weeks.

The officer also explained that on one occasion they chose a particular cellmate for Mr Lynch in order to provide a stabilising effect on him.

PSST Referral Friday 23rd May

On 23rd May Mr Lynch was referred to the PSST by a senior officer who was concerned about his ongoing bizarre behaviour, such as hitting his chest whilst talking and falling down or shaking when others were watching.

⁶ Wellman Clinics offer a range of health checks for men, including tests to identify side effects of mental health medications.

SECTION 5: SPAR COMMENCEMENT 26th MAY

On 26th May the Erne House nurse saw Mr Lynch because he felt sick. He told the nurse he could not express himself and had a lot of things going on. He denied thoughts of self-harm or suicidal ideation, but was requesting a house move and said all the cellmates he had shared with were gay. The nurse informed Mr Lynch that he needed to report these concerns to prison staff.

Within 15 minutes of seeing the nurse Mr Lynch reported to an officer that he needed to get out of the house to get fresh air as he was thinking of suicide if he was not moved from Erne House. He did not give specific details of why he wanted to move. The officer immediately opened a SPAR booklet and recorded that Mr Lynch seemed incredibly paranoid and stated he *“may have no option but to commit suicide.”*

Whilst not detailed in the initial SPAR comments, Mr Lynch also apparently told the officer that he had been sexually assaulted by his cellmate. The officer notified his senior officer, who in turn contacted the Duty Manager to seek advice.

The Duty Manager immediately met Mr Lynch who then denied being sexually assaulted and said he made up the allegation as he wanted to move from Erne House because he felt nobody liked him and other prisoners laughed at his bizarre behaviour. He denied being bullied and was not forthcoming with names of perpetrators.

The Duty Manager discussed the SPAR process with Mr Lynch and queried drug use, which Mr Lynch denied.

As required by policy, a ‘Keep Safe’ Immediate Action Plan was created by the senior officer and the officer who opened the SPAR. It recorded that *“Sean is convinced he is not safe in cell. No removal is necessary and he should remain in situ overnight.”* No supporting rationale for the apparent contradiction was noted, or explained during interview. The senior officer recalled checking who Mr Lynch’s cellmate was, but was content to return him to the same cell. Mr Lynch was placed on hourly observations, was to be referred to Healthcare for evaluation and staff were briefed.

Mr Lynch told this investigation that he did not feel safe with his cellmate because of sexual gestures made towards him. While staff said Mr Lynch retracted the allegation, consideration should have been given to safeguarding his cellmate from further allegations and also the possibility that Mr Lynch retracted the allegation for fear of reprisal.

A SPAR Assessment Interview was carried out by the senior officer, with input from the Duty Manager.

The senior officer noted Mr Lynch’s concerns that he feared for his life in Erne and wanted moved; feared advances from his cellmate who he thought was going to kill him and believed everyone was conspiring against him. The senior officer recorded that Mr Lynch indicated he was not contemplating suicide. He did not question the inconsistency of this

answer with Mr Lynch's earlier comments about suicide. The senior officer said it is often the case that such concerns fade once a SPAR has been opened and the initial crisis has passed.

Despite a previous Prisoner Ombudsman recommendation about the need to share information, which was accepted by the NIPS in March 2014, the senior officer was unaware that Mr Lynch had been referred to the PSST three days earlier.

Mr Lynch told this investigation that the senior officer stabbed him in the eye with a pen. However there is no evidence from interviews with staff, prisoners, documentation or CCTV to support this allegation.

Part 5 of the SPAR assessment interview is aimed at exploring the prisoner's view of coping mechanisms, triggers for his behaviour and ways he considers the prison can minimise the severity of his actions. However none of the information recorded in this section was provided by Mr Lynch. Instead the senior officer recorded his own opinion of the reasons for Mr Lynch's behaviour as having inconsistently taken his medication (for which there was no supporting evidence, nor suggestion that Healthcare were informed of the allegation); and that his behaviour appeared to be manipulative.

Distressing Phone Call

Shortly after this interview Mr Lynch phoned home. He was hysterical, saying he expected to die that night and that he was getting bullied but the governor would not listen to him. He eventually calmed down when an officer suggested the call may have to be ended due to the stress it would be causing his father.

Nursing Input

The Erne House nurse was informed of the SPAR being opened. She noted that the senior officer had expressed concern about Mr Lynch's mental health and planned to request a mental health review the following day.

SPAR Observation Logs

The SPAR observation log indicates that Mr Lynch settled following the distressing phone conversation with his parents. There is also evidence of a good handover from day staff to night staff.

SECTION 6: PSYCHIATRIC ASSESSMENT 27th MAY

SPAR Observation Logs - AM

While morning SPAR entries suggest Mr Lynch was in good form, making good eye contact and mannerly towards staff, there is no evidence that these observations were considered by the psychiatrist who saw him later that morning.

Psychiatric Review

The psychiatrist recorded that Mr Lynch reported his current and previous cellmates were gay. The psychiatrist's EMIS entry states that Mr Lynch explained this meant his cellmate said very little and read all the time. However the psychiatrist subsequently told the SEHSCT's SAI investigation that Mr Lynch believed his cellmate was trying to convert him to homosexuality. He told her he requested a SPAR in order to protect himself, which was inaccurate. There is no evidence the psychiatrist explored this inaccuracy with Mr Lynch.

Mr Lynch also wrongly informed her that the charges against him were discontinued.

The psychiatrist recorded a range of bizarre mannerisms during the meeting. Mr Lynch again denied any thoughts of self-harm or suicidal ideation but stated he wanted to move landing because he felt persecuted by everyone there including the senior officer.

The EMIS notes indicate that the psychiatrist gave Mr Lynch the option of changing to another antipsychotic medicine. He declined the offer providing he could take his medication at night and accepted the plan to increase his dose from 10mg to 15mg. The medication administration record indicates that he did not receive the increased dose until 4th June and there is nothing recorded on EMIS to evidence the reason for this eight day delay.

The psychiatrist also recorded that she had not been able to phone Mr Lynch's mother for a history, though his permission to do so remained. This contradicts her earlier entries that his permission was not forthcoming, and the reason for not being able to phone on this occasion was not recorded.

A further appointment was scheduled for three to four weeks' time.

The clinical reviewer said that, given the lack of clinical response, he would have expected the Abilify dose to have increased more quickly than eight days and by more than 5mg. He also queried why a urinary drug screen had not been checked at this point and queried the gap of three weeks between psychiatric assessments – emphasising that this was longer than he would expect for a patient who was actively psychotic and had recently been prescribed antipsychotic medication.

Allegation of Bullying

In addition to feeling persecuted, Mr Lynch reported to the psychiatrist that he had been called names and spat on. While he did not appear distressed by these allegations, this information should have been reported to prison staff for investigation under the bullying policy.

A regular landing officer said he was unaware of Mr Lynch making any allegations of bullying, and said he appeared to be happy-go-lucky. The officer believed other prisoners liked Mr Lynch because he was a very good footballer.

SPAR Observation Logs/ Telephone Call

The SPAR log shows that Mr Lynch was OK that afternoon and had a reasonable phone call with his father, though was not fully truthful about his engagements with NIPS and SEHSCT staff.

SECTION 7: INITIAL SPAR REVIEW & MENTAL HEALTH REVIEW – 28th MAY

Administration of medication

Although the psychiatrist had agreed Mr Lynch could take his medication in the evening, he was unlocked at 10.15hrs on 28th May to receive it under a nurse's supervision, and continued to receive his medication in the morning for the remainder of his stay in prison.

Cell Move

Mr Lynch's request to move to another house was not accepted, but at 11.00hrs he was moved from his shared cell to a single cell on the same landing in Erne House. A senior officer could not recall the specific reason, but thought it was either because Mr Lynch or his cellmate did not want to share with each other.

While being moved to his new cell, an officer recorded in the SPAR booklet that Mr Lynch stated again that he was afraid and worried. The officer reassured him and reminded him to share his concerns with staff. It would also have been good practice to ascertain why Mr Lynch was afraid and record this.

Initial SPAR Review

At 14.00 hrs as required by NIPS policy, a SPAR Case Review was held. It was chaired by the house senior officer and attended by Mr Lynch and a landing officer. The Probation Department was unable to attend but forwarded an email which outlined key points from Mr Lynch's most recent pre-sentence report in June 2013. Contrary to Prison Service policy a Healthcare representative did not attend, and no reason was recorded for their non-attendance.

The review noted Mr Lynch's coping difficulties, his poor mental health, history of drug abuse, self-isolation, apparent paranoia and interest in getting moved from Erne House to Quoile House, which he believed, was imminent.

The electronic (PRISM) record of the review detailed additional information about Mr Lynch's failure to elaborate on why he felt unsafe in Erne House and the senior officer contacting the Mental Health team.

In contrast to Mr Lynch's reported self-isolation, the SPAR observation logs show he actively sought to be placed on the football list and felt the benefit of using the yard. It is noted on a number of occasions that he interacted well with other prisoners. It would therefore be helpful if SPAR review records were more evidence-based.

Contrary to policy, no Care Plan was written following this review. The senior officer could not recall why this had not been done but surmised it was because the review had not

altered the frequency of Mr Lynch's observations. However SPAR Care Plans are about more than observation frequencies - they should also mitigate identified risks.

Mental Health Review

At 14.45hrs Mr Lynch had a mental health review with a nurse. He discussed his difficulties including bullying allegations. The nurse noted *"the prison authorities are dealing with the issue"* and that he was content with being moved to a single cell. Mr Lynch was also agreeable to being referred to the Donard Programme⁷. This referral was completed and sent to the PSST.

It is unclear whether the nurse corroborated anything Mr Lynch told her with prison officers, or whether she confirmed they were addressing his bullying allegations. The nurse's SPAR log entry only reflected the positive aspects of the review, such as *"settled, cooperative...pleasant...no thoughts of self-harm or suicidal ideation."* This would have been misleading for other personnel who required accurate entries to understand how he was coping. This entry also contradicts the earlier SPAR review which noted Mr Lynch had coping difficulties.

⁷ The Donard Centre at Maghaberry provides day care for up to 20 prisoners with emotional and mental health problems.

SECTION 8: 29th - 30th MAY

Thursday 29th May

The 29th and 30th May 2014 were relatively uneventful. Medical notes indicate Mr Lynch did not turn up for his Wellman Clinic appointment and suggest this was due to escort problems. As there were four prison officers on duty it is difficult to understand why an escort should have been problematic.

The flow of the conversation was erratic in phone calls with his father. Mr Lynch asked about a bail address, stating that if he knew he had only a few more days to do, he could cope with being in prison. They discussed where he would stay if applying for bail and Mr Lynch suggested that if his father would not provide a bail address, the only alternative was to stay in Maghaberry and be bullied. His father told him that any bullying that was being directed towards him was probably as a result of his bizarre behaviour and characteristics.

Tuck Shop Orders

A review of Mr Lynch's tuck shop ordering shows he placed four orders during May. His average tobacco purchase for the first three orders was 32 grams, yet on the fourth he ordered 212.5 grams (17 x 12.5 gram pouches), which was the maximum amount permitted for remand prisoners. While prisoners were allowed to place a double order that week due to a forthcoming bank holiday, this order was over three times his normal purchase. Mr Lynch would have received this tobacco on 22nd May, and it was on 23rd May that he started to report being unhappy in Erne House. Given the currency value of tobacco, it is possible Mr Lynch was trading or being bullied.

Mr Lynch reported that he had poker debts and a serious marijuana problem. He said nine pouches were to pay for his poker debts and the other eight were to last him for the two weeks. There is no evidence that staff conducted any further enquiries to establish what debts Mr Lynch owed or to eradicate the root cause.

Purchase trends are not automatically detected by tuck shop staff as they do not know individual prisoners. The tuckshop manager expected landing officers to notice whether prisoners' ordering patterns indicated anything suspicious.

Telephone Call to Mr Lynch (Snr)

Mr Lynch (Snr) said that he received a phone call from a mental health nurse on 29th May informing him that Sean had self-harmed and that she was very concerned about his mental health. He said the nurse told him Sean was on medication and was being looked after by three nurses. He said the nurse would not give her name but provided him with a number that he could call if he had any concerns.

The only call recorded on EMIS from a mental health nurse to Mr Lynch (Snr) is on 3rd June. He did not self-harm on 29th May and did not have three nurses caring for him.

Friday 30th May

Shortly after morning unlock, Mr Lynch was told that he was going to be moving back into a shared cell. The relevant entry in his SPAR observation log states he was happy enough with this information. None of the records explain why Mr Lynch was returned to a shared cell so quickly though a senior officer thought he may have requested it as he did not like being in a cell on his own.

Log entries for the rest of the day show Mr Lynch was settled and asked to be put on the gym list, which was full. He went to the yard for 85 minutes but did not engage in much conversation with the officers. It is not clear whether the lack of engagement was as a result of his mood lowering or staff not initiating as many conversations.

His new cellmate said Mr Lynch was very well-mannered but had some bizarre behaviour traits.

That evening Mr Lynch called his father. He sounded slightly slurred. They talked about his case and he told his father about all the positive things he was going to do with his life after release. Mr Lynch (Snr) sounded sceptical of his son's desire to change.

SECTION 9: SATURDAY 31st MAY

SPAR Observation Logs – AM

The SPAR observation log suggests Mr Lynch was in good form during the morning. He wanted to engage in purposeful activity and staff were helpful. He spent time walking around the yard on his own and did not speak to, or interact with the other prisoners while queuing for lunch.

Lunchtime Lock-Up

Mr Lynch's SPAR log shows that, while everyone was locked over lunchtime, he activated the cell alarm twice – once to request toilet roll and on the second occasion in a panic, asking to be let out of his cell. He was allowed out.

No further information was recorded in relation to whether staff tried to ascertain why Mr Lynch was panicking. Mr Lynch told this investigation that he felt "*crazed*" because his lunch had been spiked with poison.

Control & Restraint in Erne House

There are no CCTV cameras in Erne House.

His cellmate said that during lunchtime lockup Mr Lynch repeatedly pretended to fit and fall to the ground. He helped him up a number of times, but after 15 minutes raised the alarm and staff responded.

The NIPS personnel involved in this indent, an officer and senior officer took time to try and calm Mr Lynch and offered him a cigarette. He immediately stopped shaking and accepted the cigarette, which suggested to the senior officer that the behaviour was faked. Nonetheless he was taken to the nurse.

Mr Lynch's behaviour then became more aggressive and erratic. The officers said he crawled along the floor, went underneath the table in the interview room and started to take his clothes off.

At 14.25hrs the senior officer restrained him for his own safety and the safety of staff. When Mr Lynch became more aggressive and resisted, the dedicated search team (DST) were summoned and took control of him.

The senior officer requested advice from the PSST governor. He was advised to manage Mr Lynch in-house and ask a nurse to take a blood test to detect whether he was under the influence of any substance. While blood tests always require patient consent, and can only be initiated by Healthcare personnel, none were subsequently conducted and there was no

record made by either the PSST or SEHSCT to detail why not. It would not have been clinically appropriate to obtain a blood test at that time, but the SO's request should have been followed up at an appropriate time. The senior officer told the governor that Mr Lynch could not be managed in-house, and he was handcuffed and taken to the Care and Supervision Unit (CSU). DST staff described continuing bizarre behaviour.

After arriving at the CSU, Mr Lynch was taken to a cell and his handcuffs were removed. A nurse came to examine him but at that point he slithered onto the floor and out onto the landing.

This investigation requested CCTV footage of Mr Lynch's time in the CSU, well within the timescale before it would be overwritten. However the footage was not provided.

The nurse corroborated the bizarre behaviour that officers had noted. His impression was that there was no evidence of any psychotic features and that Mr Lynch appeared able to control his behaviour. The nurse was aware Mr Lynch was under the care of the Mental Health Team. He provided a verbal and written handover at the end of his shift, and expected the mental health team would be updated when they returned on Monday.

As a result of threats of self-harm and bizarre behaviour, the Duty Manager authorised Mr Lynch be taken to an observation cell in Lagan House.

Transfer to Lagan House Observation Cell

An officer checked the intercom (which allows a prisoner to speak directly to the officer in the pod) before Mr Lynch was placed in the observation cell. A record of the check also noted there was no television in the cell, so he had nothing to provide mental stimulus or distraction.

At 14.43hrs Mr Lynch entered the cell. He initially refused to change into the anti-ligature clothing provided, but quickly changed his mind. However contrary to Prison Service policy, a previously accepted recommendation by the Prisoner Ombudsman, and a SPAR entry, Mr Lynch was not provided with footwear.

At 14.50hrs a nurse arrived. Mr Lynch's behaviour continued to be bizarre (slithering off the bed, lying on the ground or on his hands and knees) and non-compliant, so DST officers lifted him back onto the bed and a decision was made to Fast Strap him in order to facilitate the nurse's assessment.

Mr Lynch was Fast Strapped for nine minutes and DST officers did not leave the cell until 15.18hrs. Despite their observations and conversations with Mr Lynch over a period of 35 minutes, none of the DST staff recorded their dealings with him in the SPAR Observation Log.

Over the next 50 minutes, Mr Lynch paced the cell and exposed himself. He was told by a senior officer to clothe himself, which he did temporarily and he was provided with a meal of sausages and mash, without any cutlery.

The Senior Officer reported that Mr Lynch was quite disoriented, asked if he was in a morgue and if he was going to die in his cell. He said he repeatedly told Mr Lynch that he was not going to die, and if he did die, it would be his own fault and by his own hands. The detail of this conversation was not adequately recorded in the SPAR document, and was an inappropriate comment to make to a vulnerable prisoner. The Senior Officer explained that his comments were made in a manner to assure Mr Lynch that he was at no risk from anyone and was not being poisoned by gas.

Control & Restraint Incident

At 16.07hrs Mr Lynch pressed his cell alarm and two officers opened his cell door. Mr Lynch slowly walked towards the door and told the officers he needed air and a drink of water. He then crouched down and darted between them, hitting them with force before fleeing into the cell opposite. Twelve seconds later Mr Lynch and the two officers can be seen tussling on CCTV as he was removed from the opposite cell onto the landing. They then disappeared from camera view and there is no CCTV to verify what happened thereafter.

Nine minutes later Mr Lynch was returned to the observation cell with a severely swollen and bruised right eye. The DST officers remained with him until he was again assessed by a nurse at 16.29hrs.

Accounts of the two landing officers both state that Mr Lynch attacked them as they tried to restrain him. Both officers said they were assaulted during the struggle and one had visible injuries to his face. The senior officer also responded to the incident and assisted in restraining Mr Lynch until the DST arrived.

The DST officers incident reports all state that Mr Lynch was already restrained on the ground and had sustained the injury to his eye before their arrival.

Mr Lynch was seen by a nurse who noted that his eye was only slightly opened and difficult to assess because of his extreme agitation and aggression. He was to be reassessed during evening association. However there is no record in Mr Lynch's SPAR booklet in relation to the nurse's observation.

The nurse was a bank nurse and believed it was the responsibility of NIPS staff to record details in the SPAR, and that she would only contribute if they brought concerns to her attention.

Mr Lynch paced the cell, occasionally falling onto his bed and hitting his head on fixtures and fittings. CCTV footage suggests these falls appeared to be fabricated. However they would have been painful e.g. on one occasion he appeared to hit his head off the door frame, very close to his already injured eye.

He also had a lengthy, emotional conversation with the Samaritans and asked officers if he could have access to a Listener. This was refused on the basis of his previous behaviour and continued agitation.

At 18.59hrs another nurse recorded that she had visited Mr Lynch's cell to complete the follow-up check. However she decided not to enter the cell due to the earlier assault on staff and his continued agitation. There is no record in Mr Lynch's SPAR booklet in relation to the nurse's observations.

SPAR Observation Logs

Mr Lynch had a restless afternoon and evening, pacing the cell, at times shouting, and occasionally attempted to make himself vomit by putting his fingers down his throat. Despite the earlier assaults, the same officers attempted to engage in conversation and develop a rapport with him, but to no avail. However SPAR entries by night staff should have been more informative – they described him as shouting and screaming for help, though did not explain what he was shouting about or how he felt he could be helped.

SECTION 10: SUNDAY 1st JUNE

Overnight Events

Mr Lynch remained unsettled through the night, ringing his cell bell, shouting that he could not breathe, felt too hot and that he was going to die. He requested a sleeping tablet, but this was refused after consultation with a doctor due to uncertainty about whether he had taken any illicit substances. He was however to be monitored and reviewed by a doctor on Monday morning (2nd June). However the appointment audit trail on EMIS shows that no appointment was booked.

Mr Lynch continued to be irate the next morning. Despite reassurance, he believed that gas was coming into his cell and he was going to be leaving the prison in a body bag. He told staff his food had been spiked, that his intestines were coming out of his ears, his blood was too thin and he was going to have a heart attack.

SPAR Review

At 10.30hrs a SPAR Case Review took place in Mr Lynch's cell. A senior officer chaired and a nurse and two landing staff also attended. The senior officer was unaware that Mr Lynch had been referred to the PSST/Donard Programme on 23rd and 28th May and there was therefore no input from them, nor were any related actions points decided for Mr Lynch's Care Plan.

The review lasted for eight minutes. The written record notes that Mr Lynch presented as agitated, but with no thoughts of self-harm or suicide. There appeared to have been little conversation between the nurse and Mr Lynch.

There is no evidence that staff considered letting Mr Lynch go outdoors for fresh air – which previous SPAR records showed he enjoyed - to help settle him.

The record of the review refers to a phone call which had not happened prior to the review taking place. It states *"After the phone call he stated that the s/cell (safer cell which is a former term for an observation cell) scared him. All agreed he could move out of s/cell. And to 30 mins."*

While Mr Lynch felt scared in the observation cell, it is not clear from this record how anyone was satisfied that the risks which led to him being placed in the cell in the first place, had been mitigated.

The updated care plan further suggests that the reason for agreeing to move Mr Lynch back to a normal location was because he said he was *"dying"* in the safer cell. The self-harming behaviour that he had already demonstrated was not identified as a risk.

However there was subsequent disagreement about the proposal to move Mr Lynch out of the safer cell: the Duty Manager became aware of his most recent phone call when he was distressed, and immediately contacted the Lagan House senior officer to direct that Mr Lynch should remain in the observation cell. The senior officer did not agree because he considered Mr Lynch was being manipulative, to get out of Erne House, rather than suicidal.

The nurse subsequently contacted the Duty Manager. She told him that Mr Lynch did not have any mental health problems, but a personality disorder, and should be returned to a normal cell. This contradicted the psychiatrist's opinion that Mr Lynch was suffering from a drug-induced psychosis. A trained mental health nurse should not have disclosed a diagnosis that was inaccurate.

While the nurse stated her belief that Mr Lynch should return to a normal cell, when the Duty Manager queried his capacity to keep himself safe in normal population, the nurse replied *"No, if you put it like that."*

The nurse both told the Duty Manager that it was not fair to expect prison officers to deal with Mr Lynch. These were further indicators that he was not suitable to return to a normal cell.

The nurses EMIS entry only refers to Mr Lynch having no self-harm or suicidal ideation and that he wanted to get out of Erne. It does not accurately reflect what was initially agreed at the meeting or subsequent discussion with the Duty Manager and his subsequent overriding decision.

Telephone Call

During a phone call with his father at 10.42hrs Mr Lynch was hysterical and displayed very distorted thinking. He asked an officer to speak to his father and outline his behaviour over the past 24 hours. The officer did so and explained why his son was in an observation cell and in anti-ligature clothing. Mr Lynch's father responded that this behaviour was not drug-related and that this was how he behaved in the community, which came as a shock to the officer who had previously considered Mr Lynch to be a model prisoner. However there is no evidence in the SPAR log that the officer shared this information with Healthcare or with the senior officer who had just conducted the SPAR review.

Mr Lynch was permitted to make this phone call as part of his SPAR Care Plan. Whilst it was not effective in helping to keep him safe, it was recorded on the SPAR documentation as being completed. There is no evidence that the officer updated the senior officer on the content of the call, or of the senior officer seeking feedback.

Visit by a Priest

Mr Lynch asked to see a priest and this request was added to his Care Plan. At 11.45hrs

a priest and senior officer entered his cell. The priest subsequently wrote in the SPAR observation log:

“I found Sean Lynch deranged. It’s impossible to communicate with him. He needs to be in a psychiatric hospital. He is deranged by fear. I could make no rational contact with him. His condition is beyond anything the officers can cope with....”

Cigarettes

Despite being in the observation cell since 14.43hrs the previous day, Mr Lynch – who smoked around 10 cigarettes per day - was not provided with a cigarette for almost 24 hours, which would have added to his agitation. However CCTV footage shows that cigarettes were given to him regularly after this.

There was a marked improvement in Mr Lynch’s demeanour following his initial cigarette at 14.00hrs, a shower at 15.00hrs and the ongoing supply of cigarettes. It is also clear that he was more relaxed and that staff were less guarded in his company.

SECTION 11: EVENTS PRIOR TO SELF-HARM EPISODE ON MONDAY 2nd JUNE

SPAR/CCTV Observations

Following a settled night on 1st/2nd June, Mr Lynch became agitated again the next morning. An officer recorded that he was very nervous and paranoid.

Healthcare

The PSST manager phoned the mental health team to expedite Mr Lynch's assessment for the vulnerable prisoners landing, Quoile 1.

Shortly afterwards the Samaritans phoned to advise the Healthcare Department of their serious concern for Mr Lynch. The Samaritan's Listener said this was the first time in five years that he had felt compelled to contact any prison to relay his concerns.

SPAR Review

At 10.39hrs a SPAR review took place with Mr Lynch in his cell. It was chaired by a senior officer and the other attendees were a nurse, the PSST Manager and two landing officers. A record of the review concluded: *"All agreed he should come out of the safer cell and return to Erne House as this may do some good. All agreed to change his obs to 30 minutes."*

There is no evidence from this record or any other sources that consideration was given to the potential risks of returning Mr Lynch to Erne house, or of his continuing bizarre behaviour. Nor is there any reference to the plan to have him assessed for Quoile House.

The NIPS Suicide & Self Harm policy states that the minimum frequency for observations in a safer cell should be 15 minutes. There is no flexibility for SPAR case managers who may want to place a prisoner on a less frequent trial period (e.g. 30 minute observations) before returning them back to normal location.

CCTV footage shows there was minimal conversation between the nurse and Mr Lynch. Previous Prisoner Ombudsman investigations have commended nurses who conversed meaningfully with prisoners prior to SPAR reviews, as it evidenced efforts to encourage the prisoner's involvement in their multi-disciplinary Care Plan. Had the nurse done so in this instance, she may have gained additional insight to assist in the development of Mr Lynch's Care Plan.

The nurse's EMIS entry reflected good observations of Mr Lynch and his cell environment. She noted he was very emotional, kept falling over and stated he had difficulty with breathing. He was advised to focus on breathing techniques and not to fall over as this

behaviour would reduce the likelihood of him getting out of the observation cell. The nurse also left a message for him to be assessed by the mental health team as soon as possible.

On reflection the nurse felt she should have included the agreement to return Mr Lynch to a normal cell in her EMIS entry, and the name of the person she spoke to in the mental health team. The nurse added that she felt out of her depth when assessing mentally ill patients as she had little training in this area.

The senior officer could not recall the specifics of this review. He said he would approach every review with an open mind, taking account of all available information including SPAR reviews and logs, aiming to achieve the best outcome for the prisoner. He would record his perception of the general outcome of what was agreed, though not exact details of everyone's contribution.

Return to Erne House

Mr Lynch left the safer cell at 11.05hrs and was taken back to his former cell (and cellmate) in Erne House. His cellmate said he was a lot quieter than normal and would not eat any food without his cellmate tasting it first.

Nurses Assessment

At 11.53hrs the house nurse saw Mr Lynch in response to a query about his physical health and fainting episodes. His clinical observations were all normal. She also noted that he had control of all four limbs but was deliberately shaking his arms and legs. He wanted sleeping tablets and the nurse informed Mr Lynch that he would have to request a doctor's appointment to have them prescribed, but did not offer to place him on the next available clinic.

Emergency Call-Out

At 13.05hrs a Code Blue⁸ emergency call-out was raised after Mr Lynch collapsed on the cell floor. There is limited detail in the SPAR observation log about what took place but the nurse who attended noted in EMIS that Mr Lynch was lying on the bed. He was shaking, though was able to stop when asked.

Mr Lynch told the nurse he wanted his head "*sorted out*" and she informed him that as it was an emergency call-out she would only be attending to the acute nature of his complaint.

The nurse was aware of Mr Lynch's earlier mental health review and that a referral to PSST

⁸ Code Blue – This term is used when a prisoner/patient appears to be unconscious and / or not breathing.

had been completed. He immediately calmed down after the senior officer gave him a cigarette and his observations were normal.

Mental Health Review

Two mental health nurses met Mr Lynch to carry out a review.

He provided conflicting accounts of his willingness to return to Erne House; and again mentioned being bullied, but would not name alleged perpetrators.

It is recorded that NIPS staff were aware of the bullying allegation, though there is no reference to say how the nurses knew this. The bullying allegation was not explored with the nurses during the SEHSCTs internal investigation; and despite this being the third reference to Mr Lynch being bullied, there is no evidence that the NIPS Bullying policy was initiated.

The EMIS entry also notes that Mr Lynch said he was responding well to the increased Abilify prescription, yet this would have been impossible since his increased dose did not commence until three days later on 4th June. The nurses assumed that he was already receiving the increased dose and Mr Lynch was obviously unaware of what medication he had been given.

Mr Lynch again denied any thoughts of self-harm or suicidal ideation.

There is no evidence of the nurses reviewing Mr Lynch's SPAR booklet in order to ascertain his behaviour pattern. While he had repeatedly advised Healthcare and prison staff that he had no thoughts of self-harm, his episodes of falling down, which had caused injuries, were not being considered as self-harm.

Adjudication

At 15.10hrs Mr Lynch was taken to the Care and Supervision Unit (CSU) to have a 'Notice of report against Prison Discipline' read to him in relation to the allegations of assault on the two officers when he ran out of the observation cell on 31st May.

SPAR Observations

That afternoon, Mr Lynch frequently used his cell alarm inappropriately to request hot water. When unlocked, he sought tobacco from other prisoners rather than water. An officer spoke with him about this at 16.30hrs.

At 18.10hrs the senior officer recorded that Mr Lynch asked to use the phone. He was advised that the senior officer was busy and while it was noted that his behaviour appeared "*somewhat erratic*," specifics were not recorded.

At 19.25hrs Mr Lynch asked for permission to phone his parents *“to hear his Dad’s voice one last time.”* As a result of this comment the senior officer spoke with Mr Lynch. He told her he had no thoughts of self-harm or suicide but felt he was *“dying inside.”* The senior officer reassured him and his erratic behaviour was discussed at the handover to night guard staff.

SECTION 12: SELF-HARM INCIDENT 2nd JUNE

The SPAR booklet notes that at 20.10hrs Mr Lynch pressed the cell alarm and when an officer arrived at the cell, he was lying on his bed breathing heavily, but his cellmate told the officer Mr Lynch was OK.

A further entry by the same officer at 20.18hrs states Mr Lynch's cellmate raised an alarm. No details of what happened, or any conversation the landing officer had with Mr Lynch, or his cellmate, are recorded in the SPAR observation log. An entry in the night guard journal suggests that Mr Lynch's self-harming was ongoing at the time the alarm was raised.

However Mr Lynch's cellmate's recollection of the events differs significantly. He described a frantic scene for approximately 25 minutes, during which Mr Lynch tried to choke and drown himself, and used a knife and fork to poke his eyes and face and bit his fingers. He also asked for his cellmates razor blades (which were not provided), lifted the TV and hit his head with it. However he found a blade and started slashing his neck with it, before being stopped by his cellmate. The cellmate described frequent attempts to stop Mr Lynch and at some point he triggered the emergency alarm.

Staff responded within a minute of the alarm being raised. The cellmate alleged he was shouting for them to open the cell door but they remained outside as they were trying to sort something out. When Mr Lynch's cell door was eventually opened, his cellmate was removed and he did not see Mr Lynch again. This incident is significant because, if true it indicates delayed intervention by the same Senior Officer (though different main grade officers) with Mr Lynch, three days before his most serious self-harm episode.

Another prisoner in the cell opposite said that when he heard Mr Lynch's cellmate shouting, he heard officers respond immediately and said they spent approximately 45 minutes trying to calm Mr Lynch.

The senior officer stated it took approximately 15 minutes to open the cell door because they had to wait for Mr Lynch to calm down before allowing the nurse to assess him.

CCTV cameras are not present on the landing to verify any of these accounts.

This incident could have had serious implications for Mr Lynch's cellmate, though the senior officer said if he had attacked his cellmate, then officers would have entered the cell immediately. The senior officer praised Mr Lynch's cellmate's efforts to prevent further self-harm.

The nurse recorded his attendance as an emergency Code Red⁹ noting that Mr Lynch had cut his throat, albeit not deeply, and wounded his forehead against the cell door. The nurse considered the injuries would require sutures and queried whether Mr Lynch's fainting was related to the injury.

⁹ Code Red – This term is used when a prisoner/patient is bleeding.

An ambulance was called. The nurse described how Mr Lynch calmed down once he was in the cell with him and was grateful when advised that he was going to hospital. The nurse described his behaviour as “worrying” and observed periods of blankness when Mr Lynch was staring vacantly.

Events at Craigavon Area Hospital (CAH)

Mr Lynch was disoriented en route to the hospital, and while there he had to be restrained due to biting his lip. His behaviour deteriorated further – he was shouting, verbally abusive and threatened to kill one of the escorting officers. They restrained Mr Lynch while awaiting police assistance and a doctor injected him with a tranquiliser.

Despite prison staff applying their Use of Force policy to restrain Mr Lynch, no forms were completed as required.

The Maghaberry nurse was disappointed that Mr Lynch was not kept in hospital for at least 24hr observation as his EMIS entry indicated he ought to be kept in for observation and possibly a CT scan. CAH records suggest a diagnosis of psychosis and awareness that Mr Lynch was being seen by psychiatrists in the prison, which may explain why he was not assessed by their mental health team as required by their own policy following a self-harm admission.

No discharge letter was provided by CAH and the nurse established that he was only treated for the wound to his forehead. The nurse also recorded that no other treatment was provided, despite him being injected with 5mg of Haloperidol (which acts as a rapid tranquilizer), and noted that the hospital doctor believed his fainting episodes were faked – an assessment with which the nurse disagreed.

Professor Fazel said Haloperidol is commonly used at a dose of 5mg for rapid tranquilization. The most common side effect is muscle stiffness. He said no care plan is required following a one-off administration, though prison Healthcare should have been informed of its use.

Mr Lynch told this investigation that the doctor in CAH wanted to keep him in hospital to be seen by a psychiatrist the following morning but the escorting prison officers refused and insisted he be taken back to prison. However it appears he was referring to a different visit to CAH.

Mr Lynch was returned to Maghaberry at 00.05hrs and placed in an observation cell in Lagan House.

SECTION 13: TUESDAY 3rd JUNE

SPAR/CCTV Observation Logs

Following Mr Lynch's return from Craigavon Area Hospital he, remained in bed in anti-ligature clothing until 08.15hrs, apart from twice using his cell alarm to request medication and a nurse.

During a conversation with an officer that morning CCTV footage shows Mr Lynch's cell door was wide open for 13 seconds before a second officer could be seen standing in the doorway. This suggests there were no concerns over him trying to run out of the cell as he had done previously.

Assault on a Prison Officer

At 09.47hrs Mr Lynch stood up when his cell door was opened. The officer who opened it recorded that Mr Lynch had activated his alarm and when he responded, he saw Mr Lynch lying on the bed. Having received a mumbled response, the officer opened the cell door.

CCTV footage shows Mr Lynch getting up, putting on his flip flops and slowly shuffling towards the door. He then lunged forward as the officer started to close the door, attacked the officer with his fists and unbalanced him. Mr Lynch then ran off down the landing, followed by three officers. The incident lasted for 90 seconds.

The DST arrived fifteen minutes later and took Mr Lynch out onto the landing for approximately 50 seconds. No entry was placed in the SPAR booklet nor were C&R/Use of Force forms completed by any of the DST officers to explain their contact with Mr Lynch.

The officer who was assaulted had to attend outside hospital where he required four stitches for facial injuries.

SPAR Review

At 11.45hrs a SPAR Review was carried out in Mr Lynch's cell with a senior officer, an officer, a nurse and Mr Lynch. A record of the review concluded:

"Wanted to get to hospital so he cut himself. Cell covered in urine and started talking lucidly to MO. Offered move to Quoile House and agreed to move 'to save my life'. Stated he didn't want to die but go to hospital?? Stated he had no thoughts of self-harm or suicide. Demeanour improved when told he could go to Quoile. Presented as confused and lucid. Wanted out of Safer Cell and repeated no thoughts of self-harm or suicide. All agreed to move him from Safer Cell to Quoile. Obs to 30 mins."

There was no reference to the earlier serious assault on the officer, his mental health or whether Quoile 1 was a suitable location given its lower complement of staff. The decision to move him to Quoile House therefore appears to have been uninformed.

The senior officer was subsequently unable to recall this review or explain why these matters were not considered.

Mental Health Review

A retrospective EMIS entry regarding a mental health review was recorded by the same nurse who attended the SPAR review. It is unknown whether this review took place before or after the SPAR review because no entry was made in the SPAR booklet and there was no supporting CCTV evidence available.

The record of this mental health review noted that Mr Lynch continued to present as thought-disordered, though demonstrating control over his behaviour. Although his behaviour remained bizarre, he still denied thoughts of self-harm or suicidal ideation. The nurse also outlined that the Quoile landing did not have staffing levels to maintain Mr Lynch if his difficult behaviour continued.

Decision making process - transfer to Quoile 1

The Quoile 1/Donard manager was asked by the Security Department whether any prisoners were ready to be moved onto Quoile 1 as there were capacity shortages elsewhere in the prison. He identified three prisoners who could be moved, including Mr Lynch, and said his presence there would facilitate the Donard assessment.

It was only shortly afterwards that the Donard Manager learned Mr Lynch had assaulted staff. He immediately attempted to prevent his move to Quoile House and suggested he should be placed in the Care and Supervision Unit under observation, where staffing arrangements were more likely to protect both Mr Lynch and officers, and reduce the possibility of him taking drugs.

However the move to Quoile House went ahead. Although all location moves within Maghaberry are authorised by the Security Department, this investigation has been unable to obtain any records or information about who authorised Mr Lynch's move to Quoile House.

The Security Department advised staff that any movement of Mr Lynch within the prison would require a three officer escort. However this would be impossible in Quoile given its low number of staff. Evidence for the basis of this decision has been requested, but not provided to this investigation.

Move to Quoile House

Mr Lynch arrived in Quoile 1 at 14.48hrs and was taken straight to his cell. This was an ordinary cell, without CCTV coverage, and he had single occupancy.

Despite the instruction from Security that Mr Lynch was to be supervised by three staff at all times, there were only two officers on the landing and he was unescorted when he fetched his meal at 15.40hrs.

He was given a plate and cutlery and sat at a table on the landing. He did not make any attempt to interact with others or take an interest in what was happening on the landing.

At 15.51hrs an alarm meant all the prisoners had to return to their cells. Sixteen minutes later the landing was unlocked with the exception of Mr Lynch. He was the only prisoner to remain locked for the remainder of the association period, apart from eight minutes when he was permitted to use the Senior Officer's phone to contact his father.

Another Quoile prisoner said that Mr Lynch presented as mentally ill and withdrawn. He said Mr Lynch's recent history was well-known within Maghaberry and that he heard officers talking about him in derogatory terms. There is no record of any such remarks. All comments made when a door flap was lifted should have been captured by audio recording equipment. However this investigation has been informed the equipment was not working at that time. A request for the audio file was made in order to facilitate an independent assessment of the nature of the corruption, but it had not been retained.

Mental Health Team

Four EMIS records were made on the afternoon of 3rd June by the mental health nurse who had seen Mr Lynch earlier that day.

The first outlined a phone call to inform her that Mr Lynch had assaulted a prison officer in Lagan House and could not now be managed in Quoile 1.

The nurse however believed Quoile House would provide a more settled and therapeutic environment for Mr Lynch and would facilitate his mental health assessment.

The lead consultant psychiatrist at Maghaberry and mental health nurses made clear that, since closure of the Healthcare beds in the prison, they no longer have the same opportunities for patient observation. One mental health nurse suggested their current practice only provides a snapshot of patients' presentations. This gap in provision is strongly endorsed by the NIPS who were simply unable to manage Mr Lynch in the general population. They and others point out that life in prison is so different from the community that an in-patient facility is required to accurately diagnose and treat seriously disturbed prisoners.

The second EMIS entry was in relation to a further Home Treatment Team (HTT) referral. The nurse also recorded on the referral form that the psychiatrist was considering applying for a Transfer Direction Order¹⁰ (TDO). However this was not included in the EMIS entry and her Healthcare colleagues would therefore not have been aware of this consideration.

In addition to considering a TDO the psychiatrist ordered a blood test and urinary screening for drugs and scheduled to see Mr Lynch urgently on 5th June. The nurse also said the reason the psychiatrist requested the referral to the HTT was to provide more intensive nursing interventions and assessment.

The third entry involved a telephone call to Mr Lynch's father to obtain collateral history. In contrast to information Mr Lynch's father provided to this investigation and to the Forensic Medical Officer in April, the record of this call is scant. It details longstanding concerns about his son's mental health, conduct problems since the age of 15, and the fact that he had not received treatment for psychiatric symptoms which had become more prevalent over the last eight months.

The fourth EMIS entry noted that Mr Lynch had been deemed unfit to attend court on 5th June 2014.

Commenting on whether a TDO should have been considered, Professor Fazel felt this was appropriate on the basis that he had psychotic symptoms which were not responding to medication, had assaulted staff and was self-harming.

Professor Fazel considered the timing of a TDO application was more difficult to judge. He said consideration would have been appropriate at the second self-harming incident on 4th June because it targeted his scrotum, which he said is highly unusual and more typical of psychotically-driven self-harm.

¹⁰ A Transfer Direction Order is a warrant that allows transfer from a custodial setting to a healthcare setting for treatment.

SECTION 14: EVENTS PRIOR TO SELF-HARM EPISODE ON WEDNESDAY 4th JUNE

Request to see a Nurse

When Mr Lynch asked to see a nurse at 05.04hrs one of those on duty explained he would not be attending because Mr Lynch was being supported by the mental health team, who would be seeing him later that day, and also because he had recently assaulted staff.

The nurse's EMIS entry made no mention of this explanation. It only noted that Mr Lynch would have to see the nurse in the morning as he did not require emergency treatment.

Family Visit

Mr Lynch had a visit with his father and grandfather that morning. His father described him as looking like someone from a *"Nazi Concentration Camp."* he had staples in his forehead, a black eye, slashed throat and wrists and could not walk properly, shuffling on his toes.

The visit only lasted ten minutes because Mr Lynch wanted to use the toilet, which meant it was curtailed for security reasons.

PSST Case Review

The PSST database has two referrals for Mr Lynch, received on 23rd and 30th May 2014. While not all PSST referrals result in a case review, the increasing concerns about Mr Lynch led to a review at the weekly PSST meeting on 4th June. It was attended by a member of the PSST, a chaplain, the Donard Manager, a Healthcare representative and the Quoile House Senior Officer. The Probation and Education Departments contributed by e-mail.

Points of interest included:

- Healthcare had informed the PSST they found no evidence of Mr Lynch's food being spiked as he claimed, though this could not be substantiated without a drug test;
- Security advised that Mr Lynch was dangerous and required three staff to unlock him, which would only be possible in the CSU. Security had been informed of the concern about his location in Quoile;
- Concerns were raised that Mr Lynch was on a landing with only one member of staff;
- Mr Lynch would be locked from 08.30am to 5pm due to the escorting restrictions implemented by the Security Department;
- There had been no issues with Mr Lynch during his short time in Quoile House;
- The psychiatrist had advised that Mr Lynch *"can be treated like other prisoners."* It is not clear what is meant by this.

There was no recorded contribution from the Healthcare representative other than to inform the review that Mr Lynch was known to the Mental Health Team; and no record was made in EMIS regarding their attendance at this meeting.

The only “action” recorded was to review Mr Lynch again in one week, which makes the purpose of the review questionable given the multiplicity of needs that were evident.

Nurse Visits

Later that morning the house nurse saw Mr Lynch in his cell. He was given his medication and she booked him onto the doctors list for Friday, 6th June.

Despite entering this detail on his SPAR log and an audit trail of appointments to see the doctor on Friday, no record was made on EMIS in relation to her actions.

Another nurse subsequently entered Mr Lynch’s cell to conduct a mental health review. However he was reluctant to discuss his mental health, only telling her that he was dying inside and wanted to see a doctor. He was agreeable to be seen by the psychiatric team and reviewed the following day.

Lunchtime

At 11.39hrs Mr Lynch and the other prisoners on his landing were unlocked for lunch. He sat at a table on the landing and talked with two prisoners. Apart from the vacant and emotionless expression as he walked around the landing, there was nothing obvious in his body language to cause concern.

At 12.19hrs Mr Lynch asked to be locked back in his cell while the rest of the landing remained unlocked. The reason for this request is not detailed in the SPAR booklet.

SECTION 15: SELF-HARM INCIDENT 4th JUNE

At 13.43hrs six officers ran to Mr Lynch's cell in response to an alarm and raised a Code Red alert. The cell door was unlocked, staff entered, and a first aid box was handed in.

Within ten minutes a mental health nurse and two additional nurses arrived with response bags. An ambulance was requested.

Mr Lynch's injury was described in EMIS as being an *"8cm full thickness laceration to his scrotum in the perineal area."*

Mr Lynch said he used a 15cm piece of broken glass from the inside of a flask which he found in a bin in his cell. However it has never been confirmed what he actually used to cut himself as the implement was never retrieved. This indicates inadequate searching of a vulnerable prisoner and his cell, both before and after the event.

A chaplain also attended the scene. He saw Mr Lynch sitting on his bed, an officer on each side, with their arms linked with his. No force was being applied and the officers were using this technique to prevent further injury. The chaplain found it remarkable that Mr Lynch appeared to be free from pain given the extent of his injury.

The mental health nurse remained in the cell with Mr Lynch until paramedics arrived and he left for A&E at 14.32hrs. She recorded that he claimed to have cut in order to go to a psychiatric hospital, hoping that he would stay there and not return to prison.

Events at Craigavon Area Hospital

Mr Lynch had to be restrained en route to the hospital as he attempted to exacerbate his wound. On arrival he stated he had taken rat poison and again had to be prevented from biting his fingers.

Mr Lynch's injury was cleaned and stitched and he was transferred to the short stay ward, pending assessment by the hospital's mental health team, as required by their policy for all self-harming admissions. However in contravention of this policy, a handwritten note on the Emergency Departments documentation states:

"D/W (discussed with) Night Sister Bluestone. HMP prisoners are not assessed. If medically fit to go back to prison and can be assessed by their team."

One of the concerns raised by Mr Lynch's father was that prison staff prevented him from staying in hospital against the advice of the A&E doctor. A nurse from Maghaberry who had attended Mr Lynch also expected he would have been assessed by the Psychiatric Liaison Team given the extent of his self-harm. However the evidence proves that prison staff followed the orders of hospital staff in this instance.

Mr Lynch was therefore transported back to Maghaberry and was placed in an observation cell in Quoile House at 23.40hrs, where he changed into anti-ligature clothing. He was given a cigarette and hot drink, after which he slept for the rest of the night.

Hospital Discharge Letter

No discharge letter was provided by CAH. Usual practice would have dictated that a nurse should review Mr Lynch upon his return. However he had been on duty the previous night and knew what Mr Lynch had been through. When advised that Mr Lynch was sleeping he considered it was in his best interests to allow him to sleep.

CAH records note that the discharge letter was provided on the night, but was not picked up by NIPS escort staff.

The discharge summary was received by Maghaberry's Healthcare Department on 10th June. It detailed the closure of Mr Lynch's wound with dissolvable stitches and indicated that psychiatric input was required. In the absence of a discharge summary, a member of staff should have contacted the hospital, as had been done on 1st June, to obtain relevant details to inform the patient's care plan.

Professor Fazel said Mr Lynch should have received the same level of care after self-harming as anyone living in the community. Therefore he said it was not appropriate to send him back to prison without a psychiatric assessment, for two reasons: the nature of self-harm suggested a highly disturbed mental state; and it was the second time in three days that he had self-harmed. Professor Fazel also noted that CAH records indicated some CAH staff were not aware of their responsibility towards prisoners who attended A&E.

Professor Fazel also stated that due to the unusual location of the self-harm injury, he would have expected an emergency assessment by a psychiatrist within a few days of Mr Lynch's return to prison.

SECTION 16: EVENTS PRIOR TO SELF-HARM EPISODE ON THURSDAY 5th JUNE

SPAR/CCTV Observation Logs

Mr Lynch was monitored at intervals as stipulated in his SPAR care plan and observations were noted.

At 08.40hrs a senior officer and officer went into the cell and spoke with him. He appeared relaxed and they thought he was happy about the options of returning to Foyle House or the CSU.

An hour later an officer asked Mr Lynch whether he was OK. He said he was not OK, though there is no evidence that the officer attempted to ascertain why Mr Lynch said he was not OK.

At 10.45hrs Mr Lynch submitted an emergency tuck shop order and soon afterwards was demanding the order with a slightly aggressive demeanour.

Between 11.24hrs and 11.44hrs Mr Lynch was at the cell door speaking with someone on four occasions and was given three cups of water. Over lunchtime he appeared to be settled and at 14.30hrs was permitted to make a phone call. When he was unlocked the escorting security measures were relaxed, as CCTV shows he went alone to the phone in the interview room, while the officer who opened his door spoke with another prisoner. As this call was not made from the prisoner phone, details of the conversation are not available and were not recorded in the SPAR booklet.

At 15.15hrs and 15.30hrs Mr Lynch rang his cell bell to ask when he would be taken to see his psychiatrist, and around the same time he fell to the cell floor twice. Both falls appeared to be faked.

Escorting procedures were again relaxed at 15.46hrs when Mr Lynch walked to the office alone to attend his SPAR review.

CCTV and SPAR observation logs for the rest of the afternoon/early evening are unremarkable and at 19.13hrs Mr Lynch went to bed.

Psychiatric review cancelled

Mr Lynch had been scheduled to attend his psychiatric appointment at 14.15hrs but it did not proceed. He told the investigation that an officer phoned and was told by the Healthcare Department that it had been cancelled. Mr Lynch's reaction was that "*All hope was gone.*" The Psychiatrist told the SAI investigation the appointment was cancelled because he could not be brought to the consultation room due to his ongoing risk of self-harm and further threats of violence that morning. Yet as detailed above this was clearly not the case, given the relaxed approach to managing him on the landing.

The psychiatrist also noted that Mr Lynch had been reviewed by mental health nurses and that he had disclosed to one of them he had taken tablets four days earlier in Erne House. The psychiatrist thought that this may explain his sudden aggressive behaviour over the past week. The psychiatrist also thought that his Abilify prescription was not providing any benefit, and there was an increased risk of respiratory depression given the illicit drugs use. As a result she changed his medication to Chlorpromazine Hydrochloride 50mg (an antipsychotic) to help settle him. The psychiatrist was unaware that the increased Abilify dose had not been issued to him until that morning, nor that it had been provided in the morning rather than at night as stipulated on the prescription label.

The fresh prescription was not administered before Mr Lynch's next self-harm episode, and he did not return to prison afterwards.

The senior officer told this investigation that, if he had known about the psychiatrists appointment he would have made sure Mr Lynch attended it, because he was so concerned about his mental health.

The psychiatrist told the SEHSCT's internal investigation that, with hindsight, she would have made a greater effort to obtain collateral history, though explained this was difficult due to Mr Lynch repeatedly changing his mind about who he would give her permission to contact i.e. his mother or father. This difficulty is not highlighted on EMIS. She also indicated that, given the conflicting information provided by staff and Mr Lynch and his varying presentations, she would have liked to see him in a different environment (i.e. in a ward) but this was no longer possible in Maghaberry.

Professor Fazel queried why the psychiatrist did not visit Mr Lynch in his cell. Given the ongoing concerns about his mental state, behaviour and response to medication, he felt a cell visit was a clinical requirement.

Professor Fazel considered the starting dose of Chlorpromazine Hydrochloride was low, as it usually started at 75mg, and can be increased to around 1g in acute psychoses.

SPAR Review

A SPAR Review took place at 15.50hrs, attended by the senior officer, a landing officer, the house nurse, a shadow Duty Manager and Mr Lynch. The record noted that Mr Lynch was still very paranoid, agitated and unpredictable. However contrary to the SPAR review record, the nurse recorded in EMIS that Mr Lynch made good eye contact and was calmer.

Mr Lynch was allowed to phone his father, and as he made several comments about his impending demise during the call, it was agreed he should remain in the observation cell.

Despite the increasing severity of Mr Lynch's self-harm since the last SPAR review and change in the frequency of his observations, his Care Plan was not updated and no

concerns were raised about his missed psychiatric appointment. There was also no evidence of Mr Lynch's involvement in the review.

The senior officer told this investigation that he did ask Mr Lynch why he had self-harmed but did not receive a response. He said the nurse also tried to engage in conversation with Mr Lynch, but to no avail. In relation to the Care Plan, the senior officer believed that as Mr Lynch was already in the observation cell on 15 minute observations, no changes were required. Conversational checks, phone calls with his father, mental health support and additional cigarettes were all being provided as support mechanisms, to varying degrees, and should therefore have been identified as elements of the Care Plan.

Mental Health Review

At 16.43hrs an EMIS entry noted that a mental health review could not go ahead due to "*operational requirements.*" This was the second missed mental health appointment on the day after a serious self-harm episode, and it is concerning that no clearer explanation was provided as to why this appointment did not take place.

The senior officer said that during the SPAR review he and the nurse had both voiced their concerns over Mr Lynch's mental health. He had requested that someone from the mental health team should attend the review, but said that "*As usual, no one did.*"

SECTION 17: SELF-HARM INCIDENT AND STAFF RESPONSE ON 5th JUNE

While a handover took place on the evening of 5th June, no information was provided to night staff about Mr Lynch’s previous and recent self-harm incidents. There was one officer (Officer A) on duty on Quoile 1 Landing and one officer on duty on Quoile 2 (Officer B) that evening.

The following timeline of events is taken from CCTV footage:

Time	CCTV Observation
19.51hrs	Out of bed to make a roll up cigarette.
19.52hrs	While making the cigarette Mr Lynch fell onto the bed and slithered to the floor, stood up and fell onto the bench and down onto his knees, before getting up again.
19.54hrs	Mr Lynch walked around his cell.
19.55hrs	Officer A at Mr Lynch’s door responding to his cell alarm. At the door for one minute then returned to the class officer’s desk to make a phone call. Officer was on the phone for approximately one minute. During the minute that the officer was at the door, Mr Lynch’s body momentarily shook, he collapsed onto the bed, got back up, collapsed twice more and landed heavily on the floor.
19.56hrs	While Officer A was on the phone, Mr Lynch walked around his cell, periodically staring at himself in the mirror.
19.58hrs	Officer A at the cell door for 50 seconds – No entry in the SPAR booklet to reflect this interaction.
19.59hrs	Mr Lynch staggered around his cell. Officers A & B came to light his cigarette and stood at the door for 20 seconds.
20.00hrs	Mr Lynch sat on his bed smoking then walked around his cell.
20.02hrs	Mr Lynch finished his cigarette and got into bed.
20.04hrs	Mr Lynch got out of bed and pressed the alarm. The same officer went to his door immediately as Mr Lynch walked around the cell, stumbling over the end of his bed and against the walls. While leaning against the door he fell backwards onto the floor without trying to stop himself. He lay there for a few seconds before slowly sitting up and curling into the foetal position. He lay like this for 10 seconds before crawling onto the bed and

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Sean Lynch – Serious Self-Harm Investigation

Time	CCTV Observation
	<p>lying on his stomach. This behaviour lasted for approximately two minutes.</p> <p>Officer A watched this behaviour for one minute before returning to the desk to make a phone call which lasted approximately three minutes.</p> <p>Officer A said that he contacted the ECR to ascertain further details about Mr Lynch’s behaviour and why he had slurred speech. No further information was provided other than to confirm that the ECR was carrying out their observations of him.</p>
20.11hrs	Mr Lynch moved from on top of the bed to under the duvet.
<p>20.12hrs</p> <p>(Self-harming for 28 seconds)</p>	<p>30 seconds after getting under the duvet, in a calm and controlled manner, Mr Lynch got up and walked to the mirror with the index finger of his left hand in his left eye, before putting his middle finger also into his eye. He turned away from the camera but the position of his arm would suggest he continued to injure his eye. After stopping he fell onto his knees and lay on the floor near the end of his bed.</p> <p>Mr Lynch told this investigation he blinded himself in order to go to hospital and have the poison taken out of his body.</p> <p>Officer A and B were at the class office desk whilst this was occurring.</p>
<p>20.13hrs</p> <p>(Self-harming for 37 seconds)</p>	<p>Officer A returned to his cell door for 15 seconds. Mr Lynch was continuing to injure his eye and continued to do so for 12 (out of the 15) seconds that Officer A was observing him. Mr Lynch was on his knees facing the cell door so his actions would have been visible. As he stood up, the officer was already walking away.</p> <p>The officer continued down the landing to check another cell before returning to the desk to write something.</p>
<p>20.14hrs</p> <p>(Self-harming for 32 seconds)</p>	<p>Mr Lynch got onto his feet with both eyes closed and a facial expression of severe pain. He stumbled around the cell, falling into furnishings and continued to use his fingers and thumbs to damage his right eye, again in a controlled manner.</p> <p>Officers A and B remained at the desk during this episode.</p>
<p>20.15hrs</p> <p>(Self-harming for 19 seconds)</p>	<p>Mr Lynch’s expression changed to someone experiencing severe pain as he stumbled and fell around the cell with his arms out trying to feel his way around. He started to gouge his right eye.</p> <p>Officer A was at the desk at this time.</p>

PRISONER OMBUDSMAN INVESTIGATION REPORT
Sean Lynch – Serious Self-Harm Investigation

Time	CCTV Observation
20.16hrs	Officer A returned to the cell, looked through the door flap for 45 seconds and returned to the desk to use the phone for 38 seconds . ECR records show that a nurse was requested to attend due to the damage to Mr Lynch's eyes and self-reported blindness.
20.17hrs (Self-harming for 12 seconds)	Five seconds before the cell door flap closed and Officer A stopped observing him, he should have witnessed Mr Lynch gouging his right eye. After this Mr Lynch bashed the cell door and could be seen shouting and crying.
20.18hrs (Self-harming for six seconds) (Self-harming for 15 seconds)	Officers A and B were at the desk. Officer A was still on the phone to the ECR. Officer B glanced through the door flap intermittently for approximately 12 seconds , during which time Mr Lynch was writhing on the floor before getting back to his feet. During the last 5 seconds of the flap being open, Mr Lynch continued to injure his right eye.
20.19hrs (Self-harming for 48 seconds)	Mr Lynch fell to the ground and began to pull at the wound he caused to his scrotum the day before. Both officers were at the desk.
20.20hrs (Self-harming for 58 seconds)	Mr Lynch continued to injure his groin area. During 48 seconds of this self-harm episode he was being watched by Officer B who was then joined by Officer A, who observed him self-harming for 31 seconds .
20.21hrs - 20.25hrs (5 self-harm occasions totalling 2 minutes 42 seconds/ averaging 32 seconds each)	Mr Lynch continued to stumble around his cell and fall on the floor. He pulled at the wound to his scrotum. At 20.23hrs Officer A observed Mr Lynch's self-harming behaviour through the cell door flap for one minute 15 seconds .
20.25hrs – 20.38hrs (4 self-harm occasions totalling one minute 7	Mr Lynch repeatedly got up, stumbled, felt his way around the cell and fell to the ground. He continued to injure his scrotum and had a bloodied face and groin. There were blood smeared handprints across the cell wall, the floor was strewn with toilet paper, bedding was on the floor and his chair was tipped up.

PRISONER OMBUDSMAN INVESTIGATION REPORT
Sean Lynch – Serious Self-Harm Investigation

Time	CCTV Observation
seconds/ averaging 17 seconds each)	None of these self-harm episodes were directly observed by officers from the landing. During this time: 20.28hrs – Officer A observed Mr Lynch through the cell door flap for approximately 49 seconds . He was not self-harming but was in a distressed state, falling around the cell. 20.30hrs – The senior officer arrived with a dog handler and looked through the cell door flap for five seconds . 20.31hrs – Officer A looked through the door flap for 15 seconds . 20.36hrs – A nurse, four officers, the senior officer and a dog handler were all outside Mr Lynch’s cell. The nurse and senior officer intermittently looked through the door flap for two minutes nine seconds until the cell door was opened at 20.38hrs.
20.38hrs	Mr Lynch was instructed to sit on his bed as the cell door was opened. The nurse entered the cell while the NIPS officers remained at the doorway. The nurse hesitantly approached Mr Lynch and only went in far enough to quickly observe his injuries. No conversation took place and she left the cell within 30 seconds. The nurse then left the landing.
20.40hrs	An officer observed Mr Lynch through the cell door flap for 20 seconds , followed by the senior officer for 30 seconds .
20.41hrs	The senior officer and Officer A returned and gave Mr Lynch a cigarette.
20.42hrs	Mr Lynch tried to extinguish the cigarette on the bench but missed and it landed on the floor which was strewn with tissue paper.
20.48hrs	Officer A checked Mr Lynch for five seconds . During this time he was pacing in a small area he knew would not result in him banging into anything.
20.49hrs – 21.02hrs	Various staff observed Mr Lynch while he continued to pace. He was given another cigarette at 21.02 which he accidentally dropped onto the floor.
21.05hrs (Self-harming for five seconds)	Mr Lynch poked at his groin wound while staff were at the desk or out of camera shot. This was the last incident of self-harm.
21.07hrs	Mr Lynch continued to pace his cell, then felt his way to the sink where he washed his face and hands. This could have caused further injury or irritation to his eyes. He then lay down on the bed.
21.14hrs	Officer A requested him to put on his shorts. This proved difficult and he had to use his feet to feel for the shorts on the floor.

PRISONER OMBUDSMAN INVESTIGATION REPORT
Sean Lynch – Serious Self-Harm Investigation

Time	CCTV Observation
21.17hrs	The senior officer opened the cell door. Mr Lynch held his arms in front of him at chest height in order to be handcuffed. Officer A then placed his shoes on the floor in front of him so that he could put them on.
21.19hrs	Mr Lynch was walked off the landing to the ambulance.

Response Concerns

1. The responses to this episode give rise to a number of concerns: it lasted for 67 minutes, during which Mr Lynch was directly observed and spoken to by landing officers for 17 minutes and 50 seconds, 27% of the total time. He self-harmed on 20 separate occasions, each lasting an average 26 seconds and nobody intervened despite very serious injuries, some of which were inflicted while Officers A and B observed him directly.
2. Maghaberry Governor's Order 8-13 states that *"Staff have a duty to preserve life and should enter a cell to intervene in life-threatening situations and they should do so without waiting for additional support, unless having assessed the risk they decide on reasonable grounds that it is unsafe to do so."* "Life threatening" is defined as *"A prisoner with a ligature, with serious cuts, or unconscious, or any unexplained reason where there is no response from them."* The officers said Mr Lynch did not present any of these symptoms and it would therefore appear they complied with a strict interpretation of Governor's Order 8-13. However the NIPS Suicide & Self Harm policy Para 7.2 requires *"A prisoner who inflicts a serious self-injury.... should not be left alone, even to summon help, as they may attempt further injury if left unattended..."*

There is a clear discrepancy between the Governors Order and the SSH policy that must be remedied.

3. Although Mr Lynch was repeatedly self-harming and in considerable distress, the only intervention by staff (4 x Night Custody Officers, a Senior Officer and a Dog Handler) was to follow a nurse into his cell 35 minutes after responding to his cell alarm, and 18 minutes after he first inflicted first self-harm. However they withdrew almost immediately, and apart from twice giving him cigarettes through the door flap, did not re-enter the cell until paramedics arrived. During the intervening 40 minutes Mr Lynch remained highly vulnerable and appeared to continue self-harming.
4. The cell audio facility was not working as intended, but live CCTV footage of Mr Lynch's actions was available at the Quoile Reception desk. In addition to the officers directly observing him, he was also under regular observation from the Emergency Control Room. However these observations were meaningless when they were not supported by effective intervention.

5. In addition to failings on the evening of 5th June, the rigour of any internal NIPS review that was undertaken is also questionable as this footage was viewed by managers soon after the incident, but the failings were neither identified nor addressed.
6. This footage and associated concerns about quality of internal NIPS review were drawn to the attention of the NIPS Director-General and Maghaberry governor in August 2015. They intend to initiate performance management process with the personnel involved.
7. The NIPS internal review of the matter reported:

“The landing officer has indicated that he did not perform an emergency unlock because the situation was not life-threatening; he was more aware of the injury to Mr Lynch’s scrotum and did not fully appreciate the extent of the injury to his eyes; and Mr Lynch had been very unpredictable and on two previous occasions had pushed past landing staff who had opened his observation cell door, on both occasions he was very difficult to control and there was a violent altercation with staff being injured...”

However the same landing officer told this investigation that on 5th June he was not aware of Mr Lynch’s history.

8. Following arrival of the senior officer, eight minutes elapsed before Mr Lynch’s cell door was unlocked. The senior officer said he delayed in order to observe Mr Lynch on the monitor at Quoile Reception and decide whether it was safe to open the cell door. He felt the four officers present - himself, two night custody officers and a dog handler - were insufficient to safely open Mr Lynch’s cell door. He based this view on Mr Lynch having threatened him with violence on the previous night, and his awareness of Mr Lynch’s violent outburst at outside hospital.
9. The senior officer also said a contributory factor in his delay was that Mr Lynch had ceased self-harming by the time he arrived on Quoile 1. However Mr Lynch injured his groin area on three occasions while the senior officer was on the landing.
10. Two other officers arrived six minutes after the senior officer, though he was not expecting them. However their arrival gave him the confidence to open Mr Lynch’s cell. Until this point, the senior officer did not have a clear plan for dealing with this serious incident.
11. Officer A and B said they never considered entering the cell to prevent further self-harm. Officer B said they did not realise at the time how seriously Mr Lynch was self-harming. Officer A also explained that he did not consider restraining Mr Lynch as he had only been taught Control and Restraint techniques as part of a four man team. He also suggested the security of the prison could have been compromised because he was carrying keys.
12. A Prison Officers Association (POA) representative said the only option available to these officers would have been to handcuff Mr Lynch to prevent further self-injury and

this would probably have caused him to become confrontational. Handcuffing is exactly what the officers needed to have done if they were to fulfil their duty of care.

13. Despite the senior officer opening a link gate between Erne House and Bann House as a short cut, it still took him and the nurse 20 minutes to arrive at Mr Lynch's cell. The senior officer could have arrived in Quoile House sooner if he had not waited to allow the nurse through the short cut route. The distance from the Healthcare Department to Quoile House is considerable and this was one of the reasons why another senior officer believed Mr Lynch should not have been located in Quoile.
14. Staff in the Emergency Control Room complied with the care plan by continuing to observe Mr Lynch at 15 minute intervals. However they did not communicate in any way with officers on the landing or with the senior officer, so their observations were of no value.
15. The senior officer provided conflicting accounts of his instructions to staff after Mr Lynch was seen by the nurse. On the one hand he said he instructed an officer to stay at his cell door and talk to him while the rest of the landing was checked. However he also said permanent observation was not necessary because Mr Lynch had calmed down and ceased self-harming. The senior officer and a representative of the POA also stated that extra resourcing to maintain permanent observation could only be authorised by a Governor or a member of the Healthcare team. Clarity and guidance is required for staff on this matter. In any event the officer who may have been instructed to stay by the door did not do so.
16. The senior officer did not recall the nurse expressing fears for her safety, though he warned her not to spend too long in Mr Lynch's cell. The nurse confirmed she was scared as she was aware of Mr Lynch's assaultive history.
17. The nurse said she could have treated the injury to Mr Lynch's scrotum, but decided not to as she knew he would be going to outside hospital. She also explained there was no requirement to carry out first aid as the bleeding had dried and any other action would make it worse.
18. Mr Lynch did not explain to the nurse why he had self-harmed, but he was compliant with her instructions. She said he reacted as if he had caused himself a minor injury, showing no signs of pain or distress.
19. After the cell was relocked the nurse asked the officers to continuously observe Mr Lynch until the ambulance arrived, while she prepared a letter for the hospital A&E Department.
20. The eventual entry to Mr Lynch's cell appears to have been delayed due the senior officers inappropriate risk assessment, which was based solely on the risk of potential violence. Consideration should have been given to Mr Lynch's physical state, current behaviour, compliance and responses to previous interventions. If this had been done, prison officers could have entered the cell first and sat on either side of him with

interlocked arms as had been successfully done previously, then brought the nurse in to safely assess Mr Lynch's injuries. However in this instance the nurse had to enter the cell ahead of six officers who remained in the doorway.

21. Better sharing of information at handovers could have significantly assisted these officers in managing and caring for Mr Lynch. However the handovers were not sufficiently meaningful and failed to include such important analysis.
22. The lack of supervision when Mr Lynch had cigarettes could have led to further self-harm or an accidental fire.
23. Officers should have assisted Mr Lynch to get dressed in preparation for the ambulance.
24. Some Staff Communication Sheets were poorly completed and used third party evidence. For example the senior officer advised that he got his timings from the ECR log, including a phone call the ECR received, about which he would not have known.

SECTION 18: ALLEGATIONS/INCIDENTS AT OUTSIDE HOSPITAL

Friday 13th June – Royal Victoria Hospital

Mr Lynch (Snr) stayed with his son throughout his time in hospital. He said most NIPS staff were facilitative. However on 13th June a new senior officer came on duty. He told Mr Lynch that all doors to the hospital room must be closed and his son would no longer be permitted to smoke outside. Mr Lynch (Snr) also said the senior officer refused to provide his name or ID number. As a result of their disagreement Mr Lynch (Snr) was barred from being with his son.

The senior officer said that one officer had to stay in the room with Sean Lynch at all times and this was not happening when he arrived. He also had to deal with the hospital's expectations as the father's continuous presence in the room was against hospital rules and was causing difficulties for hospital staff.

Mr Lynch (Snr) and the senior officer subsequently sorted the matter out following the intervention of another officer. This was a tense situation for all involved: the senior officer was following protocol and representing the Prison Service in a hospital environment, while Mr Lynch (Snr) was angry at what he perceived to be a complete change in the rules at a time when he blamed the prison for his son's condition. Prison officers require considerable interpersonal skills in such circumstances, and need to undertake dynamic risk assessments.

Allegation of Prison Officers Sleeping on Night Duty

Mr Lynch (Snr) alleged that some prison officers slept during their night shift duty, to the extent that their snoring meant he was unable to sleep. CCTV in the Royal Victoria Hospital is only retained for 28 days, so the relevant footage was not available to this investigation.

No evidence has been gained to support this allegation and no hospital staff who were interviewed, including the ward sister, witnessed prison officers sleeping while on duty. Nor had the ward sister any record of any such allegations being raised at the time.

Allegation of Assault by Sean Lynch

On 7th June Sean Lynch recognised the voice of a bedwatch officer at the Royal Victoria Hospital, and told his mother this officer had assaulted him in Craigavon Hospital. Mr Lynch's father told him that no one in the room matched the description he gave, and the senior officer present recorded that Mr Lynch (Snr) had said this to his son.

However Mr Lynch (Snr) told this investigation that the officer did match his son's description but he had told him differently because he did not want him to become agitated.

The officer against whom the allegation was made agreed his description matched that given by Mr Lynch (Jnr) but said the allegations were unfounded.

This officer was involved when Mr Lynch had to be restrained at Craigavon Area Hospital on 4th June. 'Use of Control and Restraint' forms were completed. They described how Mr Lynch's arms were 'blanketed' to prevent him from causing further injury. The officer wrote that Mr Lynch did not attempt to pull away or continue self-harming, which resulted in no force being used.

CCTV footage from Craigavon Hospital was no longer available by the time the allegation was made to this investigation.

Maghaberry Governor's Order 2-10 states that it is the responsibility of the senior rank to co-ordinate the response to an allegation of assault, which should include reporting the allegation to the Security Department. This was delayed by 12 days as the senior officer did not submit his Staff Communication Sheet about the allegation until 19th June 2014. In addition to this delay, the level of detail recorded was inadequate: the senior officer only recorded how Mr Lynch (Snr) said that no one in the room matched the description given, which was untrue. He should also have outlined in his Staff Communication Sheet that an officer did in fact match the description given.

The Security Department should then have arranged a proportionate response to the allegation. However only the officer described by Mr Lynch promptly submitted a Staff Communication Sheet to the Security Department - on 8th June. The third officer present completed his sheet on 22nd June.

Maghaberry Security Department responded by advising *"On reading the Communications Sheet, Sean Lynch made the complaint to his mother, as he recognised the officers voice. I am not aware that either Sean or his mother ever made a complaint directly to NIPS. The Communications sheet refers to an incident on 4/6/14. When he had to be restrained en-route to Craigavon Hospital to prevent a further self-harm this is supported by the C&R (Control and Restraint) paperwork."*

All three staff communication sheets highlighted that an allegation of assault was being reported and this should have triggered implementation of Governor's Order 2-10 by the Security Department. However it took no further action. While no complaint was made directly to the NIPS or the PSNI, the allegation was made indirectly to three NIPS personnel. They understood the implications and formally reported the matter. In these circumstances the Security Department should have formally addressed the matter.

SECTION 19: BAIL

After his admission to the RVH Mr Lynch was deemed to be psychotic, extremely paranoid and delusional. Nonetheless the hospital considered him fit to return to Maghaberry following eye surgery. Despite Maghaberry's Healthcare Department outlining the difficulties in providing Mr Lynch with the necessary post-operative care in a prison setting, arrangements were being made for him to return to prison on 6th June 2014. At this stage, RVH staff had not considered that Mr Lynch also required surgery on his scrotum.

His return to Maghaberry would have been a very difficult situation to manage. The SEHSCT's Clinical Nursing Manager explained they would not have been in a position to meet Mr Lynch's needs and that it would have been clinically inappropriate and unsafe to send him back to the prison.

The RVH acknowledged that if Mr Lynch was not a prisoner, then they would not be attempting to discharge him so quickly. This is the second instance when Mr Lynch was treated less favourably, because he was a prisoner, by two different hospitals in other Trust areas. This matter needs to be addressed by the SEHSCT in order to ensure equity of treatment for prisoner patients.

A discharge plan that entailed Mr Lynch being bailed to a psychiatric hospital, under article 54 of the Mental Health (Northern Ireland) Order 1986, was agreed. The NIPS internal investigation into this matter indicates that he was granted bail on 11th June but refused to sign it. However he subsequently agreed to a variation and bail was perfected on 13th June 2014.

SECTION 20: FINDINGS OF THE CLINICAL REVIEWER

Management of Drug-induced Psychosis

Professor Fazel considers the working diagnosis of a drug-induced psychosis was reasonable upon committal, but there were indications that it needed to be reviewed:

- The information from his father that was summarised in the FMO letter suggested a chronic pattern of mental health problems which would not be explained by a drug-induced psychosis. Such psychoses tend to be a short-term condition which will dissipate after a few substance-free days;
- While Mr Lynch may have taken substances in prison which could trigger a psychosis, he spent significant periods in observation cells where access to drugs would have been unlikely and therefore any drug-induced psychosis would have improved. In the absence of a urinary drug screen and other corroborative information, Professor Fazel's view is that his reported psychotic symptoms were part of a chronic and enduring illness, namely schizophrenia.

Absence of an In-Patient Facility in Maghaberry Prison

Professor Fazel said the absence of an in-patient facility had a substantial negative impact on Mr Lynch's management because it would have allowed him to be observed by nursing staff, to monitor more closely his dosages and response to medications, and also manage any changes in his mental state. Access to illegal drugs would have been more difficult, which would have been helpful in discounting their contribution to Mr Lynch's continuing psychotic symptoms.

Preventability

Professor Fazel said it would be difficult to determine whether Mr Lynch's self-harm episodes were preventable. More active treatment of his psychotic symptoms may have helped, but this assumes that his condition would have responded to medication. Professor Fazel also said that, even if it was a partial response, he still could not be certain that the psychotic symptoms contributed to the risk of self-harm.

SECTION 21: SPAR MANAGEMENT

Numerous Prisoner Ombudsman Death in Custody reports, the Prison Review Team report and the Criminal Justice Inspectorate's *"The Safety of Prisoners Held by the Northern Ireland Prison Service"* report in October 2014 have identified failings of the SPAR process, which are once more highlighted in this investigation.

Assessment Interview

The purpose of the assessment interview is to accurately assess the underlying triggers or reasons behind a prisoner's crisis. The SPAR booklet provides clear guidance on the role and approach of the interviewer.

Mr Lynch's assessment interview did not reflect any of the suicidal concerns identified by the officer who initiated the SPAR, and Part 5 of the interview (designed to identify coping strategies and how the prison can minimise the severity of any self-harm actions) did not address the question(s) that should have been asked.

The senior officer chair believed Mr Lynch was being manipulative in order to achieve a location move. This opinion disproportionately affected future decisions regarding Mr Lynch's management as a vulnerable prisoner.

SPAR Case Reviews

The SPAR process was initiated on 26th May, one week before Mr Lynch's first self-harm episode. Between 26th May and 5th June he was reviewed five times. The following concerns were identified in relation to these reviews:

- While Healthcare personnel attended four of the five reviews, there was no recorded Healthcare input at any of them (EMIS reflects a nurse attended on three of the five reviews);
- Limited detail was recorded to support questionable decisions, such as returning Mr Lynch to share a cell with someone whom he alleged sexually assaulted him; or moving him out of an observation cell when he continued to exhibit irrational behaviour;
- It does not appear that SPAR observation logs were considered during reviews;
- Reasons for key participants non-attendance were not recorded;
- Mr Lynch's denials of self-harm or suicidal ideation went unchallenged, even after he self-harmed;
- There was no recognition that his ongoing psychotic illness may have compromised his ability to participate fully in SPAR reviews;
- The PSST was only represented at one review.

While Mr Lynch's mental illness deteriorated to a level that was beyond the capacity of the SPAR process to manage, in the absence of other interventions these failings meant it was of little benefit: the reviews were not truly multi-disciplinary, the plans they generated were not meaningful and the underpinning focus appeared to be on Mr Lynch's manipulative efforts to leave Erne House due to drug debts, rather than on understanding and addressing the risks and root cause of his bizarre behaviour.

Mr Lynch identified two NIPS staff, a senior officer in Quoile and a mental health nurse who he felt tried to help him during this period in Maghaberry.

Regardless of the cause of his vulnerability, Mr Lynch's safety needed to be accepted as an important issue. No actions were identified in his Care Plans to determine whether there was a risk of returning him to Erne House, and if so, what should be done about it. Nor were there any actions to address the suspicion that his behaviour was drugs-related: no Security Incident Reports were generated, nor was he tested for drugs. No enquiries were made to establish from whom he obtained any drugs, and no cell searches nor medication in-possession risk assessments were conducted.

This case generates a sense that there were a variety of personnel involved in SPAR reviews, mental and physical health assessments, and psychiatric reviews, with additional input from the Maghaberry Security Department and Duty Governors. Yet there was little coordination between them.

SPAR Care Plans also failed to identify simple, practical steps that could have helped Mr Lynch, such as additional cigarettes, access to fresh air or activity such as playing football – all of which could have had a positive effect on his mental state. Some of these were actually being done, but when not recorded in his Care Plan, they were not available for other staff to ensure he was consistently managed.

Even when there was evidence of Care Plan actions (e.g. a phone call or a visit) being "completed," their benefit was not assessed as no feedback was provided to, or sought by, the SPAR Case Manager. This is a classic example of the letter of the law being applied, but the spirit totally missed.

SPAR Observation Logs

The purpose of SPAR observation logs is to record an appropriate level of detail to assist staff in caring for a vulnerable prisoner.

While the majority of staff completed them in accordance with the policy, none of the DST interventions were recorded and a number of healthcare assessments were also omitted, and therefore not shared with those who required them.

For example, while Healthcare staff had more than 20 contacts with Mr Lynch between 27th May and 5th June, only two of these were recorded in his SPAR observation logs.

There was also evidence of misleading entries in logs, which highlighted only the positive aspects of engagements with Mr Lynch rather than providing the full picture; and staff did not explore some significant comments and requests that he made.

ECR SPAR Observation Logs

The night time senior officer is responsible for checking the CCTV observations log of prisoners who are accommodated in an observation cell. However an ECR night custody officer said this is seldom done.

Observation Cell / Anti-Ligature Clothing Usage

There were several deviations from NIPS policy in relation to Mr Lynch's time in observation cells:

- He was not provided with footwear for 20 hours while in an observation cell in Lagan House;
- A duvet was never provided, only anti-ligature bedding;
- While in a Lagan observation cell Mr Lynch was only provided with one item of anti-ligature bedding (a quilt), whereas in Quoile he was provided with a bottom sheet to avoid having to lie on the plastic mattress;
- Although anti-ligature clothing was authorised for use, there is no evidence of what risk assessment(s) took place each time it was used as required;
- Mr Lynch was placed in an observation cell in Lagan House which did not have in-cell television, when other observation cells were vacant in the prison.

Handovers

Maghaberry Governor's Orders 7-25 and 8-1, and the SSH Policy all contain detailed specifications and guidance which require thorough handovers between daytime and night staff and confirmation of equipment checks. They are particularly emphatic about the requirement for sharing information about prisoners who are subject to the SPAR process.

In this case the majority of Journal entries have "*handover complete.*" This is totally insufficient and far from policy-compliant. No officers who transferred Mr Lynch from one location to another confirmed they provided a handover.

On 5th June the night custody officers were not informed of any of his previous self-harm incidents or violent outbursts. Nor did the ECR officer receive a handover - she was only told about the frequency of observations to be undertaken.

Prisoner Safety & Support Team

In a Death in Custody investigation which was published in April 2014, the Prisoner Ombudsman recommended, and the NIPS accepted, that residential managers and staff should be informed when a prisoner on their landing has been referred to PSST; and a record should be retained of the information shared. Mr Lynch was referred to the PSST on 23rd May 2014. While this referral was made by a senior officer, other relevant NIPS staff were unaware of it, or of any mechanism to ensure they would know about it.

No actions were generated to address the concerns that were identified at Mr Lynch's PSST review on 4th June. Nor was there any reference to the blood test which had been requested by the PSST governor on 31st May. This seriously questions the purpose of such a multidisciplinary meeting which ought to have clear objectives with action plans to meet them.

Self-Injury Cause

NIPS staff recognise the SSH Policy requires them to enter a cell and retrieve an implement which a prisoner is using to harm themselves. Yet when self-harm is being caused in other ways - such as by the prisoners own hands or banging their head on the wall – as in Mr Lynch's case, they suggest this does not warrant immediate intervention. Consequently it is essential that policies and procedures are clarified to ensure all NIPS personnel fulfil their duty of care.

SPAR Audit Arrangements

The NIPS introduced quality assurance procedures in January 2014 for managers to audit completed SPAR booklets. However a review of the process shows that this has been a statistically-driven process that assessed basic levels of compliance and does not measure quality of Reviews, Care Plans or their implementation. A similar finding was made in October 2014 in the CJI and RQIA inspection report between *'The Safety of Prisoners held by the Northern Ireland Prison Service.'*