

Report on an unannounced visit to
MAGHABERRY PRISON

3-4 April 2017

to review progress against the nine inspection
recommendations made in 2015.

August 2017



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by the Chief Inspector of Criminal Justice in Northern Ireland; Her Majesty's Chief Inspector of Prisons; the Regulation and Quality Improvement Authority; and the Education and Training Inspectorate.

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List of abbreviations

CJI	Criminal Justice Inspection Northern Ireland
CSU	Care and Supervision Unit
ETI	Education and Training Inspectorate
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons in England and Wales
NIPS	Northern Ireland Prison Service
PREPs	Progressive Regime and Earned Privileges scheme
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
SPAR(s)	Supporting Prisoners at Risk



Chief Inspector's Foreword

When the last full inspection of Maghaberry was carried out in January 2016, the Inspection Team concluded that the prison had stabilised and that some progress had been made against the nine recommendations which we had made in May 2015.

To support the momentum and changes that were required at Maghaberry, I undertook to review progress against the recommendations through a series of low-impact visits to the prison. The second of these visits took place between 3 and 4 April 2017 and involved a small team of Inspectors from Criminal Justice Inspection Northern Ireland (CJI), Her Majesty's Inspectorate of Prisons in England and Wales (HMIP), the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI).

This report reviews the progress that the prison has made to date against the nine recommendations. Our intention was not to re-inspect all areas of the prison, nor to deal with the issues in the same level of detail that is associated with a full unannounced inspection. This was a light touch review of progress and should be seen as a partial picture of what was happening at the prison and the experience of the men being held there.

I welcome the drive, determination, innovation and creativity being shown by the leadership team and staff to stabilise the prison and improve the outcomes for those committed to their care. Healthcare and educational provision is improving and I welcome the commitment and actions of the South Eastern Health and Social Care Trust (SEHSCT) and the Belfast Met to raise standards. I am encouraged with the ongoing operations to stem the flow of illicit drugs into the prison, however the misuse of prescription medication and the tendency of some prisoners to experiment with any substance available to get a 'high' remains an issue.

The numbers of vulnerable prisoners remained high and their care and management presented a real challenge to the staff on the landings at Maghaberry.



I am concerned that despite the critical reports into deaths in custody and serious self-harm, some important lessons have not been learnt. This prison does not provide the therapeutic environment that is required for prisoners with complex needs and the courts should be aware of these limitations when committing people to prison for mental health assessments. The management and delivery of effective Northern Ireland Prison Service (NIPS) care plans for some men assessed to be at risk of suicide and self-harm remained unacceptable and requires urgent attention.

I believe there is a real desire to deal with the underlying issues that threaten the safety of both staff and prisoners at Maghaberry and I welcome the ongoing contributions being made by the many groups and individuals within the prison staff and outside bodies in support of that aim.

I would like to thank all those who supported the work of the Inspection Team.

Brendan McGuigan
Chief Inspector of Criminal Justice
in Northern Ireland

August 2017



**Maghaberry
unannounced
review visit
April 2017**



Background and format of the assessment

Background

In May 2015 Criminal Justice Inspection Northern Ireland (CJI), Her Majesty's Inspectorate of Prisons in England and Wales (HMIP), the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI) conducted a full, unannounced inspection of Maghaberry Prison.

Inspectors found the prison to be in crisis, with failures in leadership and culture compounding the inherent complexity of the institution to produce some poor and extremely concerning outcomes for the prisoners held there.

We made nine key high-level recommendations, aimed at assisting the Northern Ireland Prison Service (NIPS) to address our substantive concerns, and halt the obvious decline of Northern Ireland's most secure prison. We informed prison management and NIPS senior managers that we would return in January 2016 and expected to see significant progress to address the areas of poor performance and improved outcomes for prisoners.

Our announced re-inspection of Maghaberry in January 2016 found encouraging signs of improvement; leadership had improved, the prison was more stable and some important early signs of recovery were evident. However, Inspectors remained concerned about a number of issues, in particular a predominant staff culture which emphasised that prisoners were to be feared, and that little could be done to support efforts to rehabilitate the men held in the prison.

Prison managers had started the process of challenging these views, but cultural change is difficult to achieve and we considered it early days in this endeavour. Nevertheless, we reported a degree of optimism that if momentum was maintained, the prison could move towards becoming a modern 21st Century institution, which not only held prisoners safely and respectfully, but also effectively supported rehabilitation.

We advised NIPS senior managers that to support this process of change, the original nine recommendations made after the 2015 inspection remained valid. We informed them that to support the change process and to ensure the forward momentum was maintained, it was our intention to work with them to review progress against the recommendations through a series of low-impact visits to assess the prison.

The first visit was carried out in September 2016, with the second taking place between 3 and 4 April 2017.

Format of the assessment

The low-impact assessment of progress which has been conducted is not intended to replicate the full unannounced inspections normally carried out by CJI, HMIP, RQIA and ETI, nor does it mirror the format of CJI's inspection follow-up reviews.

The purpose of this approach was to provide Inspectors with a sense of how the prison was progressing the nine inspection recommendations made following the 2015 inspection; to maintain and build on the positive momentum to deliver change; and identify any emerging difficulties or slippage in progress at an early stage, so leadership within the prison can take prompt remedial action.

While Inspectors sought and reviewed information and data provided by the NIPS to assist them to make informed judgements around the progress being made, Inspectors did not access the full range of documentation and statistical information as would be the case in a full or follow-up inspection.

Our intention was not to re-inspect all areas of the prison, nor to deal with issues in huge detail, but to take a 'light-touch' view of progress in addressing the key barriers faced by the prison in delivering better outcomes for the prisoners held there.

The aim of this assessment is to ensure that focus is maintained on achieving the recommendations made in 2015 and where possible, provide a measure of reassurance around the key areas of concern identified.

A small joint team consisting of experienced Inspectors from CJI, HMIP, RQIA and ETI Inspectors undertook the unannounced visit over two days with the express aim of reviewing progress against the nine recommendations made in 2015. Unlike the first review in September 2016, this visit was unannounced. The summary review should be seen as only a partial picture of what was happening at the prison, and of the overall experience of the men held there.

We outline our main findings against each of our nine recommendations in Chapter Two.



Review findings against the May 2015 Inspection recommendations

Leadership and stability

Prison leaders had continued to focus on the key challenges faced and we saw progress being maintained and developed in a number of important areas. The push to empower staff and first-line managers was key to maintaining momentum. Nevertheless, a significant number of challenges remained if Maghaberry was to achieve consistently good outcomes for the men held there.

Similar to our last review visit, we found the prison calmer than when we visited in May 2015. Although there had been a few serious incidents, levels of violence and disorder were generally low, and dynamic security had improved. Walk-throughs of association areas had embedded, and the focus now needed to shift to staff and prisoners having more meaningful engagement with each other.

The prevalence of illegal and diverted prescribed drugs from inside and outside the prison remained a major challenge, and the ongoing absence of an overarching strategy to address these issues was a concern. Nevertheless, some good work was being done to interrupt the supply of illicit and illegal drugs entering the prison, with some early signs of success. Clinical substance misuse treatment for those who arrived on community prescribed opiate substitution treatment was satisfactory, but remained inadequate for the majority. Psychosocial support remained too limited, although advanced plans to introduce SMART (Self Management and Recovery Training)¹ recovery groups in the next few months was an excellent initiative. The Lagan project was set up in February 2017. This partnership project with the NIPS and SEHSCT to break the cycle of long-term dependence on pain medication was showing promise, and the proposed new support-based approach to a positive drug test was an excellent initiative.

Erne House fire

Our concerns about the serious fire at Erne House had been investigated and appropriate action taken in response.

¹ SMART is an approach aimed at helping people recover from addictive behaviour using motivational, behavioural and cognitive methods.

The prison had made good progress with the recommendations, including carrying out evacuation drills and updating the prisons contingency plan accordingly.

Separated prisoners

Managing the separated units in the middle of Maghaberry remained a significant challenge and inevitably impacted on other areas of the prison. However, maintaining the regimes on these units was continuing to have much less of an impact on other men at the prison than previously, and in the first quarter of this year, curtailments and lockdowns across the prison were much reduced (see p.14).

The staff rotation policy on the separated houses was continuing, as was providing individual personal development support to staff.

Men on Roe House complained to us about poor access to education and cultural activities.

Care of vulnerable prisoners

Reception and first night arrangements were reasonably good. Reception remained a decent environment, and privacy had improved. The 'buddy' system of peer support for new committals was well established and working well. First night/induction information had been revised and updated. First night cells we reviewed looked well prepared, and prisoners we spoke to were content with their treatment. Remanded and convicted men occasionally were required to share cells.

We continued to have significant concerns about the management and care for vulnerable men, particularly those who self-harm. Further work was needed by the wider criminal justice and healthcare system to provide alternatives to custody for highly vulnerable prisoners. The lack of a safer custody strategy was a major concern, and we again observed much variance in practice.

Some limited progress had been made. The NIPS now had a single over-arching death in custody action plan, and levels of self-harm and the number of men self-harming had decreased, although both remained high in relative terms. Quality assurance of Supporting Prisoners at Risk (SPARs) was being developed.

However, there were major shortcomings in the care and support provided to the most vulnerable men in the population of Maghaberry and we were not confident that lessons were being learned from previous self-inflicted deaths in custody. There had been 11 self-inflicted deaths at the prison since 2012 and three in 2016. The death in custody action plan was not being effectively reviewed to drive improvements; minutes of the strategic safer custody meeting did not reflect meaningful discussions about the issues it raised; it was not clear what action had been taken and when; some actions were blank, some contradictory and it was not clear that all the recommendations had been clearly understood. This was a very concerning picture.

The quality of some SPARs we saw remained poor and did not provide assurance that the men concerned had been adequately cared for. Staff still seemed more concerned with meeting the letter of the process, rather than its spirit and the response to self-harm or its threat. Care plans were often defensive rather than designed to support the man concerned. Whilst the use of observation cells and anti-ligature clothing had decreased somewhat, both were still far too high. Access to 'Listeners'² was still not good enough.

Inspectors were concerned that the SPAR care plans were insufficiently individualised and lacked sufficient healthcare information. A mental health practitioner also attended SPAR reviews when required.

Concerns were also expressed to us about how bad news was communicated to men and the delayed involvement of the Chaplaincy Team in this process.

Discipline and segregation

The governance of disciplinary processes had improved, although not enough use of the Progressive Regime and Earned Privileges scheme (PREPs) was being made to deal with lower level anti-social behaviour.

The segregation unit environment was much improved and better than we often see and staff appeared to adopt a humane approach to the men held. However, some men stayed in the observation cells for too long, and others had been living on the unit for prolonged periods with a poor regime that did not effectively address issues of wellbeing and psychological deterioration. Care and exit planning remained poor and links with the mental health team needed to be stronger to ensure the needs of the long-stay men were understood and met.

The prison regime impacts on the ability of healthcare staff to access prisoners within the Care and Supervision Unit (CSU) on a daily basis and access for healthcare requires to be addressed by the NIPS to ensure the needs of the men held in the Unit are assessed and met.

Use of force remained high but governance had improved.

Outcomes for Catholic prisoners and equalities work

The prison had started to carry out more analysis of outcomes for diverse groups, including dip-sampling. This data was discussed at the monthly diversity meeting, at which the Chaplaincy Team now attended. The monitoring was finding some clear poorer outcomes for Catholic men.

2 'Listeners' are prisoners who have been trained by the Samaritans to provide confidential, emotional support to fellow prisoners who are struggling to cope with the aim of reducing incidents of suicide and self harm.

There was a willingness amongst managers to address these disparities, and recognition that to do so would require external support to fully understand the underlying reasons for some of these issues. We were told that the Governor had initiated such external input and that there were advanced plans for this to happen.

More generally, forums were taking place consistently with foreign nationals and older prisoners. Plans to consult with disabled prisoners were progressing. There was a range of specific activities being developed for older prisoners and work ongoing to provide opportunities and reassurance to gay and bisexual men to disclose their sexuality. Diversity complaints were being identified, and discussed at the diversity meeting.

Healthcare

Healthcare was an improving picture overall. Leadership had improved and partnership work was now stronger. There was a clear commitment and drive to improve the provision and enhance outcomes for prisoners. Improvements were noted in networked links with a range of SEHSCT nurses who were available for advice, training and support. Additional resources had been secured to address the backlog of Serious Adverse Incidents from 2015-16. Dental waiting times had improved but a small number of breaches were evident in the Trust's 14-day target to see a General Practitioner (GP). A new GP clinical lead had been appointed and missed appointments were down from 50 per cent to 13 per cent. Some support for long-term conditions had been developed.

At our review in September 2016 we recommended a review be carried out by the Health and Social Care Board (HSCB) into the service model at the prison to ensure the needs of prisoners with complex health issues were met. A project had been set up and was working on this issue. However, this work has been superseded by a Joint Review of Vulnerable Prisoners by the Department of Health and Department of Justice. The scope of this review will address the service model, expectations and prisoner pathways across both justice and health. Following the completion of this review, consideration will be given to the development of a Memorandum of Understanding (MoU) that will make explicit what healthcare will deliver.

However, some significant concerns still remained. Staffing levels had improved but permanent staffing was still inadequate with continued reliance on agency staff. There were still some gaps in long-term conditions provision. Significant concerns remain about several aspects of medicines management, particularly the fact that medicines prescribed to be administered to prisoners, as supervised swallow, continued to be administered in-possession for evening doses, which was contrary to professional guidance on medicines administration and created additional opportunities for misuse, overdose, diversion and bullying. There was no formalised process for performing regular spot checks of in-possession medicines to check if prisoners were taking their in-possession medicines correctly, which might identify and reduce misuse. A more collaborative approach to the management of prescribed medicines is still required between the NIPS and the SEHSCT to address, positively, these ongoing challenging issues. Prison healthcare achieving Investors in People (IIP) accreditation in February 2017 provides assurance of progress across a number of workforce standards.

Overall mental health support was meeting the considerable needs of men at Maghaberry reasonably well, although staffing shortages were impeding the further development of the service. The Wellbeing Centre (previously called the Donard Centre) was providing excellent support and this provision had improved markedly since our last review visit.

A third healthcare needs assessment 2016-17 focusing on chronic diseases, Asthma, Diabetes, Coronary Artery Disease and Chronic Obstructive Pulmonary Disease has been completed and the final report will be available in May 2017.

We were concerned to see that the prison was being used as a safe place by the courts whilst mental health assessments took place. In our view this was inappropriate (see recommendation p.15).

Whilst the pressing need for mental health assessment was a priority, the courts had other options to obtain urgent needs assessment into the physical and mental condition of potentially high risk individuals. Emergency referrals for mental health assessments would be through the relevant Trust processes. This is a new and emerging demand on prison mental health services therefore historic data was not available. It is clear that this new demand prioritises these assessments which impacts on others awaiting assessment.

RQIA identified a number of ongoing issues in relation to various aspects of healthcare provision. Three particular recommendations continue to be identified for improvement. It is acknowledged these are complex and require collaboration with the NIPS to implement. The RQIA have written separately to the SEHSCT regarding these matters.

The regime and purposeful activities

The regime was far more stable and reliable than previously; curtailments happened less often, and more predictably. Nevertheless, we still found significant numbers of men locked [in their cells] at various points during the core day.

The Belfast Met provision was now well established, and the picture was again one of improvement overall. The range of courses had increased, more men engaged in activities and outcomes were improving. Managers were focussed on improving attendance, and we saw a general step forward in both the quality of what was being offered, and the motivation of the men in activities.

Nevertheless, some further improvements still needed to be made to sustain and build upon the progress made to date. Strategic planning between the Belfast Met, other external providers and the NIPS needed to be better to provide coherent progression and development opportunities for men. Real-time performance data should be available and used more effectively to drive improvements and inform future planning. There were some challenging issues to address, including extending the provision beyond Level 2, and enhancing what was offered for separated prisoners.

Resettlement

We did not inspect any significant aspects of resettlement support during this review as a separate CJI Inspection of Resettlement had commenced, but feedback re-assured us that this remained a relatively strong area for Maghaberry. We were told that resources were sufficient to undertake all aspects of work. Communication with partners, in particular the Probation Board for Northern Ireland was excellent.

Wilson and Burren Houses had been brought under the remit of the Head of the Prisoner Development Unit (PDU). This was an excellent initiative aimed at providing smoother progression routes for men who had served long sentences.

However concerns were highlighted with regards to prisoners known to the Mental Health Team (MHT) who were bailed without the MHT being informed. In these cases no post-discharge support arrangements were in place to provide follow-up support in the community.

We were re-assured that the erroneous release of a prisoner remanded for serious offences which took place before the visit was subject to a NIPS investigation.

Recommendation

The Department of Justice and Department of Health should develop an agreed pathway to prevent individuals being admitted to prison for an emergency mental health assessment.



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