



The
**Prisoner
Ombudsman**
for Northern Ireland

OFFICIAL - SENSITIVE

**INDEPENDENT INVESTIGATION REPORT
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF**

MR WALLACE FERGUSON

**AGED 55
AT MAGHABERRY PRISON
ON 12 FEBRUARY 2024**

CONTENTS**PAGE**

Section	Contents	Page Number
	Foreword from the Prisoner Ombudsman	3
	The Role of the Prisoner Ombudsman	5
1	Investigation Objectives	7
2	Methodology	8
3	Summary of Mr Ferguson's Case	10
4	Chronology of events leading up to Mr Ferguson's death	12
5	Hot and Cold Debriefs	16
6	Findings	17
7	Conclusions	21
8	Good Practice, Failings, Lessons Learned and Recommendations	22
Appendix 1	Glossary	23
Appendix 2	Reports • CJI • IMB	24
Appendix 3	Northern Ireland Prisons Background	26

Foreword from the Prisoner Ombudsman

The Office of the Prisoner Ombudsman holds a Standing Commission from the Director General of the Northern Ireland Prison Service to investigate deaths in custody (DiC) occurring within prisons.

This report details Mr Wallace Ferguson's time in custody and the circumstances surrounding his death. Mr Ferguson was 55 years old, he was remanded into the custody of Maghaberry Prison for the first time on 27 September 2023. Mr Ferguson died on 12 February 2024.

For the majority of his short time in custody, Mr Ferguson was housed in a specialised unit, Moyola, to best address his medical needs which included a history of diabetes, strokes and low mobility. Mr Ferguson was assessed by the Northern Ireland Prison Service and when, on three occasions, the assessment deemed him to be '*At Risk*', observation care plans were invoked under the Supporting People at Risk Evolution procedure. His last Supporting People at Risk Evolution care plan was closed on 7 February 2024. While he had additional risk factors for suicide and self-harm, there was little to indicate to staff caring for Mr Ferguson that he was at a heightened risk in the time immediately before his death.

On Monday 12 February 2024 at around 22:15 Mr Ferguson was found unresponsive in his cell. Despite attempts by Northern Ireland Prison Service and Healthcare in Prisons staff, he could not be resuscitated and his life was recognised as extinct by a Northern Ireland Ambulance Service paramedic at 23:17.

It is crucial any opportunities for learning are addressed and good practice is acknowledged and shared across the custodial environment. It is only through this process prisoners and their families can gain confidence in the prison system, the standard of medical care, the investigation itself and the operational independence of the Office of the Prisoner Ombudsman.

The responsibility for the care and wellbeing of prisoners lies with the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust. Both

organisations have cooperated fully in this investigation and have had the opportunity to review the report for factual accuracy and I would like to thank them for their co-operation throughout this investigation.

I offer my condolences to Mr Ferguson's family on their loss.

Darrin Jones
Prisoner Ombudsman for Northern Ireland

The Role of the Prisoner Ombudsman

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

The Prisoner Ombudsman (Ombudsman) is an independent appointment made by the Minister of Justice and his Investigating Officers are completely independent of the Northern Ireland Prison Service (NIPS).

The purpose of the Ombudsman's investigation is to find out, as far as possible, what happened and why; establish whether there are any lessons to be learned; assist the Coroner's investigative obligations under Article 2 of the European Convention on Human Rights (ECHR)¹ and make recommendations to the Northern Ireland Prison Service (NIPS) and the South Eastern Health and Social Care Trust (the Trust) for improvement where appropriate.

By highlighting learning to NIPS, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

The Trust was established on 1st April 2007 and is one of 5 Trusts in total within Northern Ireland. The South Eastern Trust has responsibility for providing healthcare to all prisoners in Northern Ireland. This is delivered on a day to day basis by the Healthcare in Prison (HiP) team. While they are based in the establishments, they are not part of NIPS.

¹ "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

- (a) in defence of any person from unlawful violence;
- (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

Investigation objectives are set out in the Ombudsman's Terms of Reference on our website at www.niprisonerombudsman.com/index.php/publications and are further tailored to each independent investigation into a death in custody to:

- establish the circumstances and events surrounding the death, including the care provided by NIPS;
- examine any relevant healthcare issues and assess the clinical care provided by the Trust;
- examine whether any changes in NIPS or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure the deceased's family has an opportunity to raise any concerns they may have and take these into account in the investigation;
- identify good practice and/or relevant failings;
- highlight lessons learned and make recommendations where applicable; and assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights.

In the interests of openness and transparency, investigation reports are published on the Ombudsman's website. Reports are also circulated to those who independently monitor services in prisons and the care and treatment of prisoners; these include:

- Criminal Justice Inspection Northern Ireland (CJI).
- the Regulation and Quality Improvement Authority (RQIA); and
- Independent Monitoring Board (IMB).

More information about published reports from these organisations can be found at Appendix 2.

SECTION 1: Investigation Objectives

The objectives of this investigation are to:

1.	establish the circumstances surrounding the death of Mr Ferguson, including a detailed timeline of his care during custody;
2.	examine the care provided by NIPS;
3.	examine the adequacy of the induction process and how Mr Ferguson was cared for based on his medical and mental health needs;
4.	examine the healthcare provided to Mr Ferguson by the Trust;
5.	examine the mental health assessments and support provided to Mr Ferguson, including Supporting People At Risk Evolution (SPAR Evo) ² being mindful this was his first time in custody;
6.	identify any relevant failings or learning and good practice for the future, highlighting any lessons learned from the death of Mr Ferguson; and
7.	assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights.

² Supporting People at Risk Evolution (SPAR Evo) was jointly developed by NIPS/SEHSCT in 2018 and was signed off by both organisations in April 2019. The approach is person-centred and aims to support people through a period of crisis or distress in a way that meets their needs.

SECTION 2: Methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of the case. This comprises interviews with relevant individuals/witnesses and examination of all prison records in relation to the deceased's life while in custody including (CCTV) footage, telephone calls and mail. This report is structured to detail the events and emergency response leading up to the death of Mr Ferguson on 12 February 2024. Notices of the Ombudsman's investigation into Mr Ferguson's death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and the IMB. This encourages anyone with information to come forward and speak to the Ombudsman's Investigators.

All the information gathered was carefully examined and the relevant matters underpinning this report's findings have been detailed. This includes the sharing of reports concerning Mr Ferguson's care from Healthcare in Prison (HiP).

2.1 Independent advice

After further consideration of the issues, independent professional advice from a Clinical Reviewer was obtained. The Clinical Reviewer is a registered Mental Health Nurse with over 20 years' experience, a fully accredited Advanced Nurse Practitioner and a registered Specialist Non-Medical Prescriber.

The Clinical Reviewer was previously employed as National Head of Nursing for the largest provider of prison healthcare services in England, overseeing Primary Care, Mental Health and Substance Misuse services in 48 English prisons encompassing prisoners in all categories.

The information and advice which informed the findings and conclusions are included at Section 7 of this report.

2.2 Family Liaison

The Office informed Mr Ferguson's family of this investigation and invited them to share any specific questions or concerns. No such inquiries have been received.

Section 3: Summary of Mr Ferguson's case

On 27 September 2023 Mr Ferguson was remanded into Maghaberry Prison. This was his first time in custody. On arrival at Prison Reception, NIPS staff interviewed Mr Ferguson to capture and assess his needs in prison in line with committal practice. He underwent committal nursing and Mental health face to face screening assessment by Healthcare in Prison staff.

On 29 September 2023 Mr Ferguson was relocated to Moyola specialist unit to better enable assessment and management of his complex medical history. In respect of his risk assessment, Mr Ferguson was adamant he had no thoughts of self-harm and his notes recorded he was at *No Apparent Risk*.

An incident of self-harm was recorded on 7 October 2023 and HiP initiated mental health and other referrals detailed in Section 4. Following a further incident of self-harm with *cuts to forearms* on 19 December 2023, a SPAR Evo care plan was initiated. Mr Ferguson was temporarily moved to an observation cell with anti-ligature clothing and placed on 15-minute observations. When assessed the next day, NIPS staff agreed Mr Ferguson should be returned to his cell in Moyola on 30-minute observations. On 24 December 2023 Mr Ferguson's SPAR Evo care plan was closed.

On 27 December 2023 a new SPAR Evo care plan was opened. The reason for concern which triggered this care plan was that another prisoner informed prison authorities that Mr Ferguson had told him he was having suicidal thoughts. Mr Ferguson was initially placed on 30 minutes observations, on 2 January 2024 observations were extended to 60 minutes until closure of the SPAR Evo care plan on 5 January 2024.

On 2 February 2024 a SPAR Evo care plan was triggered by a concern for Mr Ferguson when NIPS staff observed him as upset when receiving his insulin from a nurse; this plan advised 60-minute observations and daily reviews until it was closed on 7 February 2024.

On Monday 12 February 2024, during a routine check on Mr Ferguson around 22:15, the NIPS Night Guard observed Mr Ferguson suspended from the window of his cell. The Night Guard raised the alarm, entered the cell and lowered Mr Ferguson to the floor where he began cardiopulmonary resuscitation (CPR). He was promptly assisted by NIPS colleagues, HiP staff and Northern Ireland Ambulance Service (NIAS) paramedics. Despite their collective efforts, Mr Ferguson could not be saved, with recognition of life extinct recorded at 23:17 by a NIAS paramedic.

The Post Mortem Report stated the cause of Mr Ferguson's death was 'hanging'.

Section 4: Chronology of events leading up to Mr Ferguson's Death.

4.1 Committal to Prison, September 2023

Mr Ferguson was committed on remand to Maghaberry Prison on 27 September 2023. The committal process captured his health needs including Type1 Diabetes, history of strokes, low mobility and insulin dependency. It was also recorded Mr Ferguson had a history of mental health issues which had led to treatment at Antrim Area Hospital.

On committal, Mr Ferguson was placed in Bann House Landing 2 Cell 4. From 29 September 2023 (with the exception of one overnight when placed in an observation cell for enhanced observation) to address his medical and mobility needs Mr Ferguson was housed in the Moyola unit where the cells are larger than normal and have an ensuite to assist those with mobility needs; it is also beside the main prison healthcare building for greater proximity to medical resources.

4.2 Custody and *At Risk* Treatment, October 2023 – January 2024

Following an incident of self-harm resulting in cutting scratches to his arms on 7 October and presenting to staff in "*very low mood*", NIPS and HiP conducted a risk assessment which recorded Mr Ferguson to be "*No Apparent Risk*" with Referrals. Referrals were made to the Mental Health Team, Prisoner Safety and Support Team and Occupational Therapy. They also referred Mr Ferguson for an optician appointment. On 10 October 2023 Mr Ferguson was formally inducted by NIPS.

On 13 October 2023, Mr Ferguson who believed his insulin dosage was too low, tried personally to increase his dosage, however, a nurse administered the correct amount and informed Mr Ferguson he was no longer allowed to administer his own insulin. Concerns were raised by NIPS staff due to low mood but, while Mr Ferguson stated he was "*frustrated with being in prison*", he also provided assurance he "*could keep himself safe*" and a Risk Assessment outcome of "*No Apparent Risk*" was determined.

Mr Ferguson was seen by a mental health triage nurse on 15 October 2023. The nurse noted Mr Ferguson's diagnosis of depression managed by his GP and previous

outpatient contact with psychiatric services. Due to his intentional overdose of insulin in the days immediately prior to his admission to prison, the nurse referred Mr Ferguson for an urgent mental health assessment. This full mental health assessment was completed by way of face-to-face consultation on 17 October 2023. The nurse assessed his mood as low and captured Mr Ferguson's physical and mental health history, including his mental health referral made by his GP in July 2020 citing "*depression, suicidal ideation and psychological difficulties*"; the referral was closed in late July 2023. The nurse noted that Mr Ferguson "*denies any thoughts or plans to harm himself but does admit to feeling 'down, worried and isolated'*" and she described him as "*experiencing a situational crisis with distress and low mood*". The nurse noted a 7-point plan including crisis management "*by way of supportive SPAR process if required*" without the need for a key mental health worker to be assigned.

On 19 October 2023 during an Occupational Therapy assessment, the Occupational Therapist also noted Mr Ferguson's low mood which, in addition to arranging equipment to aid his mobility including a rollator, she reported to NIPS staff on the landing that day. Through the month of November, Mr Ferguson was attended to by HiP staff to address his various medical conditions.

On 19 December 2023 staff noted Mr Ferguson had made cuts to his forearms and it was recorded he had stated he "*just wants to die*". A Risk Assessment was undertaken which found Mr Ferguson to be "*At Risk*", he was temporarily relocated to an observation cell with anti-ligature clothing under 15-minute observations. During assessment the next morning, Mr Ferguson reported the observation cell "*was making him feel worse*" and he had "*no further plan to harm himself*". The NIPS staff managing his care plan agreed to reduce observations to 30 minutes and Mr Ferguson was returned to his cell in Moyola that day. On 24 December 2023 a Risk Assessment found Mr Ferguson to be at "*No Apparent Risk*" and the SPAR Evo care plan was closed with agreement of the HiP Senior Nurse.

On 27 December 2023 Mr Ferguson was seen to be in "*low mood*" during a Risk Assessment Meeting in his cell. It was reported he had told another prisoner he was having "*suicidal thoughts*" as he was having relationship and money issues outside

the prison environment. A new SPAR Evo care plan was opened with 60-minute observations. On 5 January 2024 this SPAR Evo care plan was closed.

4.3 Custody and At Risk Treatment February 2024

On 2 February 2024 NIPS records note Mr Ferguson was *“tearful”* and *“reluctant to say he could keep himself safe”* as his relationship with his partner had broken down. A SPAR EVO care plan was opened and Mr Ferguson was placed on hourly observations. On 7 February 2024 the multidisciplinary team were *“all in agreement SPAR can be closed”*. A care plan review of Mr Ferguson recorded the outcome as *“NAR”* noting *“his money issues are now sorted”*, he was seen to be *“feeling much better”* and stated he had *“no thoughts of suicide or self-harm”*.

Between his last prison visit (4 February 2024) and his final attempted phone call on the morning of his death, recorded telephone calls listened to in the course of this investigation identified a downturn in Mr Ferguson’s key external relationships. Phone calls are not routinely monitored in prison and these conversations were not listened to ‘live time’ and, therefore, were not risk assessed.

On the evening of Monday 12 February 2024 Mr Ferguson was observed in his cell during routine checks at 19:30 and again at 20:40 by Nightguard Officer, Prison Officer A, who saw nothing to indicate concern.

Later, at around 22:15 during a routine check, Officer A observed Mr Ferguson suspended from the window of his cell by a ligature. Officer A raised the alarm via his radio and entered the cell where he found Mr Ferguson with a power cord from his bed around his neck. Prison Officer A lowered Mr Ferguson to the floor and immediately commenced CPR.

The scene was promptly attended by Officer B and Officer C who rotated CPR duties and Senior Officer A. Senior Officer A managed the incident scene and landing with support from HiP staff who applied a defibrillator to assist resuscitation. Two NIAS ambulances arrived at the prison (at 22:40 and 22:51). Despite their collective

efforts, Mr Ferguson could not be saved. A NIAS paramedic recognised life extinct at 23:17.

SECTION 5: Hot and Cold Debrief Meetings

In all cases involving a serious incident of self harm or death in custody, hot de-briefing will take place and will involve all staff (where possible) who were closely involved with the incident.

The hot de-brief will be held by the Duty Governor or the most senior manager at the time (depending on the circumstances of the case) and will take place as soon after the incident has been brought under control as possible. During the hot de-brief staff should have the opportunity to express their views in relation to how the situation was discovered, managed and any additional support or learning that could have assisted. In addition, the hot de-brief is an opportunity to identify if staff themselves require specific support.

At 06:40 on 13 February 2024 Governor A held the hot debrief with all key staff who provided emergency response to Mr Ferguson present. The events surrounding the incident were recorded and all staff involved were asked how they were and signposted to support services. Contact details for the Duty Governor were also supplied to all those present.

The cold debrief was held on 01 March 2024 and prompted an action for NIPS to issue reminder to all staff about the importance of having the proper uniform and equipment when on duty as the Senior Officer pointed out that one officer had no belt on whilst on duty and had to leave the cell during the incident for equipment which would have been on his belt.

SECTION 6: Findings

This section outlines the findings of this report in relation to its objectives.

In respect of the care provided to Mr Ferguson by NIPS.

6.1 To establish the circumstances surrounding the death of Mr Ferguson, including a detailed timeline of his care during custody.

The circumstances and chronology of Mr Ferguson's death have been established by this investigation and recorded in Section 3 by way of summary, with a more detailed timeline in Section 4.

6.2 To examine the care provided by NIPS.

The care afforded to Mr Ferguson by NIPS while in custody was considered to be professional and in line with policy, including the management of the SPAR Evo care plans in conjunction with HiP. The investigation found the emergency response on the night of his death was handled with particular care and respect for Mr Ferguson's dignity.

6.3 To examine the adequacy of the induction process and how Mr Ferguson was cared for based on his medical and mental health needs.

Based on Mr Ferguson's complex medical needs and mental health history, the housing of Mr Ferguson in the Moyola unit was appropriate and sensitive. Considering his mobility needs, Mr Ferguson had more room in a larger cell with greater proximity to healthcare resources.

6.4 This investigation commissioned an independent Clinical Review which examined the care provided by the Trust in respect of Mr Ferguson’s medical and mental health concerns in support of the following objectives.

The Clinical Reviewer considered multiple elements of healthcare including:

- Primary Care Services (inclusive of Risk Assessment)
- Asthma/COPD
- Diabetes
- Hypertension
- Medicines Management (inclusive of Risk Assessment)
- Mobility

6.4.1 Primary Care Services (inclusive of Risk Assessment)

The Clinical Reviewer concluded from Mr Ferguson’s comprehensive nursing care assessment on 30th September 2023 to evaluate his health and associated risks:

“The approach demonstrated that Mr Ferguson’s medical and risk-related needs were documented and addressed promptly upon his entry into custody.”

6.4.2 Asthma/COPD

Regarding Mr Ferguson’s asthma care the Clinic Reviewer observed:

“Regular monitoring of his respiratory condition was conducted, ensuring ongoing support and compliance.”

Further, Mr Ferguson’s respiratory health was reviewed on 19th January 2024, he was diagnosed with COPD. The Clinical Reviewer noted that while care plans for other long-term conditions were in place:

“Mr Ferguson did not have a care plan in place relating to his asthma/COPD.”

6.4.3 Diabetes

On Mr Ferguson’s diabetes treatment, the Clinical Reviewer commented:

“Healthcare’s management of Mr Ferguson’s insulin treatment was consistent with good clinical practice. They demonstrated a good level of collaboration with

external specialists, ensuring his prescriptions and doses were appropriate and well-documented. Interventions such as liaising with the diabetic specialist nurse, managing supply issues, and maintaining accurate medical records highlight the adequacy of his healthcare. These practices ensured continuity and safety in his insulin management, aligning closely with standards expected in community-based care settings, recognising some difference due to custodial constraints.”

6.4.4 Hypertension

The Clinical Reviewer noted that Mr Ferguson was seen frequently, his:

“Past medical history of hypertension and continuation of drugs following committal was appropriately identified and documented.”

6.4.5 Medicines Management (inclusive of Risk Assessment)

The Clinical Reviewer commented that:

“The prescription and administration records were well-maintained, with all relevant sections e.g. batch numbers, appropriately completed and reflected in the scanned documents reviewed.”

6.4.6 Mobility

The Clinical Reviewer commented on Mr Ferguson’s assessments, including by occupational therapists and physiotherapists, to evaluate his mobility and safety stating that:

“Equipment needs were identified in a timely manner and provided to maintain Mr Ferguson’s functional independence.”

6.4.7 Clinical Review Conclusion

Overall, the Clinical Reviewer found:

“The healthcare services provided to Mr Ferguson demonstrated thorough assessments, targeted interventions, and risk management strategies. Despite the constraints of his setting, his healthcare appears to be equivalent to what he might have received in the community.”

6.5 To examine the mental health assessments and support provided to Mr Ferguson, including SPAR Evo and being mindful this was his first time in custody.

The Clinical Reviewer noted:

“The healthcare provided to Mr Ferguson during his committal including mental health assessments, appeared responsive to his needs. Assessments were conducted in a timely manner, identifying risks and conditions. Mental health reviews documented his engagement and progress, with decisions made collaboratively and in alignment with his reported feelings of improvement. SPAR EVO care was implemented to monitor and support Mr Ferguson during periods when his risk of self-harm was heightened. The records indicate that healthcare staff engaged throughout these periods, addressing both his physical and mental health needs. Specific health and wellbeing concerns were documented, with agreed actions noted and carried out.”

SECTION 7: Conclusions

7.1 Upon investigation, I am satisfied the care provided to Mr Ferguson by NIPS and HiP was appropriate and in line with the relevant policies.

7.2 NIPS

The investigation findings show there were no relevant failings by NIPS, with one area of good practice recognised in Section 8.1.1.

7.3 HiP

The investigation findings show there were no relevant failings by The Trust and four areas of good practice by HiP are identified at Section 8.1.2.

SECTION 8: Good Practice, Failings, Lessons Learned and Recommendations

8.1. Good Practice

8.1.1 NIPS

The investigation highlighted the prompt and sensitive management of the incident by NIPS during the emergency response under the leadership of Senior Officer A.

8.1.2 The Trust

The Clinical Reviewer highlighted the following good practice:

i. *Comprehensive Assessment Following Committal*

“A robust and holistic assessment was completed after Mr Ferguson’s committal. This considered his multi-morbidities, addressing both physical health and wellbeing factors. The inclusion of risk assessments, such as those for mobility and diabetes, allowed healthcare staff to tailor Mr Ferguson’s plan effectively. This approach reflects best practice in managing patients with multiple long-term health conditions.”

ii. *Collaborative Approach Through MDT Discussions*

“Mr Ferguson’s care involved discussions within a multidisciplinary team (MDT). This collaborative approach ensured comprehensive management of his complex healthcare needs, alongside the support provided via the SPAR EVO process.”

iii. *Preventative Healthcare*

“Preventative measures were proactively offered and accepted by Mr Ferguson, such as screenings for HCV and HIV. This reflects adherence to public health guidelines and preventative care within the custodial environment.”

iv. *Medication Reconciliation and Screening*

“Comprehensive medication reconciliation was undertaken to ensure the continuity of Mr Ferguson’s care following committal. This process supported the accurate and safe administration of his treatments.”

8.2 Failings

No failings by NIPS or HiP were identified.

Appendix 1**GLOSSARY**

CCTV	Closed-Circuit Television
CPR	Cardiopulmonary Resuscitation
HiP	Healthcare in Prison
IMB	Independent Monitoring Board
NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
SPAR Evo	Supporting People At Risk Evolution (procedure)
The Trust	The South Eastern Health and Social Care Trust

Appendix 2

Criminal Justice Inspection Northern Ireland (CJI)

CJI is a United Kingdom National Preventive Mechanism (NPM) member body that independently monitors places of detention to prevent the ill treatment of prisoners. CJI inspects Northern Ireland prisons in partnership with His Majesty's Inspectorate of Prisons (HMIP), the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate. HMIP and the RQIA are also NPM members.

At the time of Mr Ferguson's death the most recent inspection report on Maghaberry Prison was published in June 2023 followed by an Independent Review of Progress (IRP) published in February 2024.

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

Against one of the Inspectors Key Concerns – Oversight and management of prisoners on Supporting People AT Risk plans were weak, the IRP Noted "*the oversight and management of prisoners on SPAR Evo plans had improved and were now reasonably good*" due to "*reasonable progress in this area*".

CJI reports are available at [Maghaberry Prison inspection report June 2023](#), [CJINI Independent Review Progress Report 2024](#) and [CJINI Full Inspection May 2015](#)

Independent Monitoring Board (IMB)

Maghaberry Prison has IMB volunteers whose role is to independently monitor the care and treatment of prisoners. In its most recent Annual Report on Maghaberry for the period of Mr Ferguson's custody 2023-2024, IMB recognised "*the efforts of the*

Prison Service and Healthcare in trying to prevent loss of life or serious self-harm within the prison population” and that: “The numbers of prisoners being given support in relation to potential suicide or self-harm risk has also decreased in this reporting year.” IMB reported *“It is still high at 611, but the work being carried out by prison officers, the Mental Healthcare team, and the work carried out in Prisoner Safety and Support function (PSS) will hopefully continue to reduce the numbers of those held in custody requiring such intervention”.*

IMB Annual Reports can be viewed at [Independent Monitoring Board \(imb-ni.org.uk\)](http://imb-ni.org.uk)

Appendix 3

Maghaberry Prison

Maghaberry Prison was established in 1986 and serves as a high-security prison in Northern Ireland. It was designed to replace the aging Long Kesh/Maze Prison and provides a secure environment for the detention and rehabilitation of individuals involved in serious criminal activities.

Maghaberry Prison is classified as a high-security prison. It houses individuals who have been convicted of serious offenses and pose a significant risk to public safety. The prison employs stringent security measures to ensure the safety of staff, visitors, and the wider community.

Magilligan Prison

Magilligan Prison, established in 1972, is a medium-security prison for male inmates. Located in Limavady, County Londonderry, it primarily accommodates offenders serving shorter sentences. Over the years, it has evolved to include various rehabilitation programs aimed at reducing reoffending rates.

The prison's infrastructure includes modernized facilities that support educational and vocational training, ensuring that inmates have opportunities to improve their skills and reintegrate into society post-release. The prison also emphasizes mental health support and substance abuse programs, crucial for the well-being and rehabilitation of its inmates.

Hydebank Wood College and Women's Prison

The campus of Hydebank Wood College and Ash House Women's Prison, (HBW) situated on the outskirts of Belfast, is a prison, which houses young male students from age 18-24, and women prisoners from 18 upwards. There is a combination of those who are sentenced and those who are on remand.

HBW is the only location for adult women prisoners in Northern Ireland and although they are housed separately, it is a shared campus with the young men.