The Prisoner Ombudsman for Northern Ireland

SUMMARY INVESTIGATION REPORT

INTO A SERIOUS ADVERSE INCIDENT AT MAGHABERRY PRISON – MAY 2023

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The role of the Prisoner Ombudsman

On 15 May 2023 the Director of Prisons invited the Office of the Prisoner Ombudsman to conduct an investigation into the circumstances surrounding a serious adverse incident which occurred on 7 May 2023. This was in accordance with the NIPS Suicide and Self-Harm Prevention Policy 2011[1].

The Prisoner Ombudsman for Northern Ireland has discretion to respond to requests from the Northern Ireland Prison Service (NIPS) to investigate serious adverse incidents as per the Justice Act NI (2016) Part 2, para 39. This is the basis on which this investigation was conducted.

Serious Adverse Incident Investigation

On 7 May 2023 the prisoner attempted hanging in his cell at Maghaberry. He survived without serious long-term harm from the incident. At the time the investigation was initiated, the prisoner had returned to Maghaberry Prison having received care at hospital. The purpose of the Prisoner Ombudsman's investigation was to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to NIPS and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

[1] The Prison Service policy states: 'Generally, all cases involving serious self-harm and death in custody will be reviewed internally by NIPS or externally by the Prisoner Ombudsman, as appropriate. However, an investigation by an independent agency or agency may be required where a prisoner self-harms to the point where:
• without *immediate* intervention the prisoner would have died;
• as a result of the incident the prisoner has suffered permanent of long-term serious injury; and
• as a consequence of the long-term injuries sustained the individual's ability to know, investigate, assess and/or take action in relation to the circumstances of the incident has been significantly affected'.

Investigation Objectives

The objectives of this investigation were to:

- establish the circumstances which led to the prisoner being found unresponsive on 7 May 2023, including the care provided by NIPS, the Trust and any other relevant contributory factors;
- examine any relevant health and clinical issues; and
- examine whether any operational methods, policy, practice or management arrangements require improvement.

Committal history

The prisoner's committal on remand to Maghaberry Prison followed standard procedure. He arrived in the prison reception at 17:46 on 2 May 2023 and was taken through the full committal process including an initial health care assessment. He stated he had previously self-harmed but had no current thoughts of self–harm or suicide.

The Prisoner informed staff he had taken drugs prior to committal and expected to suffer withdrawal symptoms. Healthcare in Prison (HiP) completed withdrawal observations, the score indicated that no further treatment was needed at that time. There were no further withdrawal observations scheduled or completed to detect symptoms should they have become evident. Referrals to Mental Health and Addictions were recommended by HiP staff. The Prisoner advised he had had involvement with mental health services in the community prior to being remanded and was awaiting an appointment.

Upon completion of the committal process the prisoner went to accommodation in Bann Committal House. Other than the prisoner receiving medical treatment on 5 May 2023 for a head wound he sustained prior to entering prison, there were no issues with the prisoner's time in custody until the evening of 7 May 2023.

Overview of the incident

On Saturday 7 May 2023 at 19:32 the prisoner was found unresponsive during a cell check shortly after lock up. Prison staff observed the prisoner with a ligature around his neck and entered his cell. NIPS staff immediately cut the ligature and commenced first aid. At 19:36 NIPS staff issued an alert, requesting attendance of both NIPS Management and HiP staff, both of whom responded immediately. An emergency ambulance was requested at 19:38. The prisoner was breathing but was having seizures. HiP Nursing staff arrived on the scene and took over his medical care at 19:40. The ambulance arrived on the scene at 20:00. Upon arrival, the Northern Ireland Ambulance Service emergency response paramedics took over treatment of the prisoner. The prisoner remained unresponsive and he was moved to the ambulance and taken to Craigavon Area Hospital at 20:23.

NIPS held a SPAR Evo Care Plan[2] meeting following the incident on 7 May 2023 to devise a care plan for this prisoner. The prisoner returned to Maghaberry on 13 May 2023 with no lasting effects. On return, it was recorded in his SPAR Evo care plan notes he informed NIPS staff he was feeling better “now that his medication was sorted”. He was placed in an observation cell in Bann House on regular 15-minute observation checks until 15 May 2023 when observations were reduced to 30 minutes. On 18 May 2023 the care plan was closed. He was released from custody on 23 May 2023 without further incident.

A summary timeline of events and SPAR Evo care plan milestones is at Annex 1.

[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.

Clinical Review of the Incident

Given the reported comment in respect of his medication being "sorted", an independent Clinical Review was commissioned into the care provided to the prisoner.

Overall, the Clinical Reviewer found:

> "*The provision of healthcare to 'the prisoner' during the first five days following his committal and up to the incident on 7th May 2023 was prompt and broadly equivalent to what he could reasonably have expected in the community*."

The Clinical Reviewer was specifically asked to consider:

> "*The adequacy of [the prisoner's] healthcare concerning his medication before and after the incident on 7 May 2023, including whether, (considering his condition at the time) there was anything in, or lacking from, his medication that could have increased his likelihood of self-harm or suicidal intent*".

The Clinical Reviewer reported: "*there was a gap in recorded administration of Mirtazapine*" between the prisoner's committal on 2 May 2023 and the incident on 7 May – i.e. five evenings as it was to be administered once x 15mg each evening.

This investigation also reviewed CCTV footage which suggests the prisoner was not in receipt of evening medications during the rounds of medical unlocks supporting the Clinical Reviewer's observation of this gap.

However, the Clinical Reviewer noted nothing in any records "*indicate that he raised any concerns about prescription medications during interactions with healthcare and NIPS staff*" and "*there is no indication from records that [the prisoner] was acutely concerned about this at the time*".

The prisoner was on the lowest possible dosage and the omission of this one medicine was not found to be a matter of substantive concern.

The Clinical Reviewer identified the following areas of Good Practice:

> "*Despite lower survival rates typically associated with out-of-hospital resuscitation, the coordinated response by NIPS and healthcare stabilising [the prisoner] and arranging an urgent emergency ambulance transfer to an acute*

hospital, likely contributed directly to his favourable outcome and is commendable."

and;

"*Effective communication between NIPS and prison healthcare staff ensured that sufficient information was shared during ICU admission and supported planning for [the prisoner's] discharge back to Maghaberry Prison. This continuity of care reflects established community practice and contributed to a well-coordinated transition*."

Conclusion

Having thoroughly examined the circumstances of this incident, this investigation did not find any action or lack of action by NIPS or the Trust which directly contributed to this prisoner self-harming.

As there were no indications that the prisoner was at imminent risk of self-harm, I am content that Prison Service and Trust staff provided the prisoner with appropriate care during the Committal process and the remainder of his short time in custody on this occasion. Moreover, I would like to thank NIPS and Trust staff for the response taken in relation to this incident which resulted in a prisoner's life being saved.

I note the Trust conducted an internal review of this serious adverse incident which has been shared with the individual concerned. The Trust identified areas of learning including on the continuation of withdrawal monitoring and has updated its policies to embed best practice within prisons.

I would like to thank all those who contributed to the preparation of this report.

Darrin Jones
Prisoner Ombudsman for Northern Ireland
24 September 2025

Annex 1

May 2023 Timeline	
2 May	The prisoner was remanded to HMP Maghaberry, Bann 1, Cell 5.
4 May	The prisoner was moved to Bann 3, Cell 5.
5 May	The prisoner's head wound sustained prior to custody was checked by a HiP nurse.
7 May 19:32	Prison Officer arrives at the prisoner's cell for check and attempts to get a response. With no initial reaction, the Officer persists with kicking the door and shining his torch into the cell to try to elicit a response.
19:34	The Officer leaves the scene briefly for assistance to gain entry to the cell.
19:35	NIPS staff unlocked the cell and found the prisoner on his cell floor with clothing tied in a ligature around his neck. They initiated emergency treatment.
19:36	NIPS Staff made an emergency call for attendance of NIPS Managers and HIP staff.
19:37	Additional NIPS staff attended the scene.
19:38	Ambulance called.
19:39	HiP Nurse arrives at the scene and the prisoner was moved to the corridor for assessment and continued treatment.
19:40	Additional HiP staff arrived at the scene. The prisoner was breathing but having seizures, a defibrillator was used. HiP Staff continued treatment until the arrival of the Ambulance Crew at 20:00.
20:12	The prisoner was moved to an ambulance, cell locked and sealed.
20:23	The prisoner was taken by ambulance to Craigavon Area Hospital and treated in Intensive Care Unit.
20:58	SPAR Evo care plan initiated for the prisoner with 15-minute observations to commence on his return from outside hospital.

8 May 10:15	Call to the prisoner's Next of Kin (NOK) (Mother) to advise of incident of self-harm. NOK advised she should contact the hospital for update, visiting times etc.
9 May	The prisoner was extubated at hospital.
10 May	NIPS bedwatch staff reported the prisoner was breathing on his own.
11 May	The prisoner was stepped down to ward level care.
13 May	The prisoner returned from Craigavon Area Hospital to an observation cell in Bann 5, Cell 16.
15 May	The prisoner moved to Bann 5, Cell 13 under 30-minute observations.
18 May	Closure of the SPAR Evo care plan.
19 May	The prisoner spoke to a Prison Officer regarding medication issues, was informed this is a matter for HiP.
20 May	HiP informed a GP appointment has been arranged. The prisoner stated he will be refusing all medication.
21 May	The prisoner was observed by an officer concealing an item in his left shoe whilst standing outside the Medic's Office in Foyle House. Issued a verbal warning that unauthorised passing is not permitted.
22 May	The prisoner issued with a phone card.
23 May 09:43 10:30	The prisoner moved to Bann1, Cell 10. The prisoner moved to Bann 5, Cell16. Prisoner discharged.

SPAR Evo Milestones	
2 May	Committal Risk Assessment outcome: “No Apparent Risk with Referrals”.
7 May	Following the Serious Adverse Incident, Risk Assessment changed to: “At Risk” SPAR Evo initiated and care plan meeting held.
9 May	Care plan Review Meeting held: “At Risk” Care plan – 15 min checks on return from hospital.
13 May	Care plan observations commenced on prisoner return to Maghaberry.
14 May	Care plan Review Meeting held – remained on 15 min checks.
15 May	Care plan Review Meeting held – checks extended to 30 min.
18 May	Care plan Review Meeting held. SPAR Evo closed from 13:51.