



The
**Prisoner
Ombudsman**
for Northern Ireland

OFFICIAL - SENSITIVE

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

CHRISTOPHER MOULAND

**AGED 33
AT MAGHABERRY PRISON
ON 6 JULY 2022**

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Foreword from the Prisoner Ombudsman

Mr Christopher Mouland was a 33-year-old remand prisoner who had been in custody for 33 days from 3 June 2022. This was not his first time in a custodial setting. He died in prison on 6 July 2022.

This report details the outcome of the investigation into the treatment and care Mr Mouland received prior to his death and the circumstances leading up to it.

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 and both organisations have cooperated fully in this investigation.

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 be assured of confidence in the prison system, the standard of medical care, the investigation itself and the operational independence of the Office of the Prisoner Ombudsman.

I am conscious of the length of time Mr Mouland's family have had to wait for the completion of this investigative process and appreciate their patience.

This report provides as much detail as possible about Mr Mouland's time in custody and the circumstances surrounding his death. I hope this information will be helpful to his family as they piece together the last days of his life.

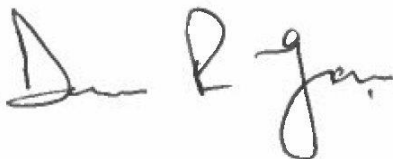
Mr Mouland was a new committal detained during the Covid 19 pandemic (pandemic). The process for new committals changed on 22 April 2022 and at this time the process was to complete a period of quarantine in Maghaberry Prison. A lateral flow test was completed on day 2 and if this was negative and a further negative test result was obtained on day 6/7 then they were relocated into the wider prison establishment. The new measures adopted during the reception process, which applied to Mr Mouland, were to ensure the safety of prisoners and staff during the pandemic. The procedures

put in place by NIPS to mitigate the limitations caused by the Covid-19 arrangements are documented in Appendix 2.

On Wednesday 6 July 2022 at 16:10 Mr Mouland was found unresponsive in his cell in Davis House, Landing A2, Cell 23 at Maghaberry Prison. Despite attempts, he could not be resuscitated, and his life was recognised as extinct at 17:01.

I would like to thank all those who contributed to the preparation of this report including the Northern Ireland Prison Service and Healthcare in Prison.

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

A handwritten signature in black ink, appearing to read 'Darrin Jones', written in a cursive style.

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) and the South Eastern Health and Social Care Trust.

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 Rights¹ and make recommendations to 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 Health and Social Care 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.

The generic investigation objectives are set out in the Ombudsman's Terms of Reference and are available [here](#).

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."

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

- Criminal Justice Inspection Northern Ireland (CJINI);
- 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 3.

SECTION 1 – Investigation Objectives

The specific objectives of this case are to:

1.	Establish the circumstances and events surrounding Mr Moulard's death on 6 July 2022, including the care provided by NIPS and relevant outside factors;
2.	Examine any relevant health care issues and assess clinical care and risk management;
3.	Examine how NIPS and the Trust cared for Mr Moulard in Bann House, Maghaberry Prison where he was in quarantine and what procedures were in place to support his committal into prison, investigating the application of Covid-19 risk control measures by NIPS and Trust and any possible implications for Mr Moulard;
4.	Ensure Mr Moulard's family has the opportunity to raise any concerns they may have and that these concerns are taken into account in the investigation and report;
5	To provide a timeline of events surrounding the death of Mr Moulard;
6.	Examine the care NIPS provided to Mr Moulard and consider whether any changes would help prevent a similar death in the future;
7.	Examine the adequacy of committal processes provided by HiP;
8.	Examine the mental health assessments, support and care planning provided to Mr Moulard through Supporting People at Risk Evolution (SPAR EVO) ² ;

² Supporting People at Risk Evolution (SPAR Evo) was jointly developed by NIPS/the Trust in 2018 and, following a proof of concept between April and July 2018, went through several iterations until it was finally 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.

9.	Identify any relevant failing or commendable practice and highlight any lessons learned from the death of Mr Mouland; and
10.	Assist the Coroner's investigative obligation under Article 2 of the ECHR, by ensuring as far as possible the full facts are brought to light.

SECTION 2 - Investigation methodology

The investigation methodology aims to thoroughly explore and analyse all aspects of each case. This comprises interviews with prison staff and prisoners and a meeting held with the family. Examination takes place of all prison records in relation to the deceased's life while in custody including Closed-Circuit Television (CCTV) footage and telephone calls. This report is structured to detail the events and emergency response leading up to the death of Mr Mouland on 6 July 2022.

Notices of the investigation into Mr Mouland's death were issued to relevant parties within Maghaberry Prison, including prisoners, NIPS and IMB. This encourages anyone with information to come forward and speak to the Ombudsman's Investigators.

All of the information gathered was carefully examined and the relevant matters that underpin this report's findings have been detailed.

2.1 Independent advice

After 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 within the body of this report. It should be noted the Clinical Reviewer provides advice and recommendations. It is then down to the discretion of the Ombudsman, based on

the overall context of the case, whether the advice or recommendations are included within the final recommendations for this report.

2.2 Family liaison

Liaison with the deceased's family is a very important aspect of the Ombudsman's role when investigating a death in custody. On 5 September 2022 Mr Mouland's family met with the then Ombudsman and asked the following areas to be included in the Ombudsman's investigation:

1.	Who found him, where did he get the ligature, who was in the cell when staff were working on Christopher and why protocol was not observed in contacting the next of kin?
2.	Prison Service Staff Resources - was the landing understaffed and what was the impact of recreational time on staff resources, did staff on duty remain on the landing at this time?
3.	Should Christopher have been on a 'watch' given he had tried to hang himself the previous day?
4.	Had it been reported that Christopher had suicidal thoughts?
5.	Was there any impact from Christopher's previous committal to Maghaberry Prison?
6.	Why did Christopher not go into the exercise yard?
7.	Did Christopher choose to share with his cellmate or were they together because they shared similar circumstances?

8. Were addiction services offered to Christopher and if not, why not? and

9. Was Christopher on any medication to help him including Methadone?

SECTION 3 – Summary of Mr Mouland’s case

On 3 June 2022 Mr Mouland was remanded into the custody of Maghaberry Prison. Mr Mouland was located in Bann House Landing 2 Cell 15. At that time Covid-19 pandemic (pandemic) restrictions were in place across all prison sites. The process for new committals changed on 22 April 2022 and at this time the process in Maghaberry Prison was to complete a period of quarantine. A lateral flow test was completed on day 2 and if this was negative and a further negative test result was obtained on day 6/7 then they were relocated into the wider prison establishment. However, due to additional pressures on all other residential units as a result of the increasing prison population Mr Mouland was “doubled”³ with another prisoner who was also committed on the same day. Mr Mouland remained doubled with the same individual during his period in custody. These measures were in response to the pandemic and adopted during the reception process to ensure the safety of prisoners and staff.

Prior to this detention Mr Mouland had 24 previous periods of custody between 2007 and 2022 ranging from 3 days to 216 days.

Mr Mouland had a history of substance misuse and self-disclosed an addiction to heroin on committal. Additionally, he suffered from depression and anxiety, for which he was on medication.

On 6 July 2022, Mr Mouland was found hanging from a ligature in his cell when his cellmate returned from being in the exercise yard. Prison Officer A looked through the cell door flap, he did not notice anything untoward so opened the door and stepped back to allow Prisoner A to enter the cell. Prisoner A stepped into the cell, then immediately exited the cell. Prison Officer A activated the alarm and alerted Prison Officer B to lock up all other prisoners on the landing. Prison Officer A entered the cell and cut the ligature from Mr Mouland and, with assistance from Prison Officer C, moved Mr Mouland to the middle of the cell where Cardiopulmonary Resuscitation (CPR) was commenced by Senior Officer A.

³ Quarantine cells previously had been singly occupied however due to pressures there was an increase in cells having 2 occupants. Both occupants were tested via LFT prior to being moved to another residential location.

Resuscitation efforts continued with the assistance of both HiP and NIPS staff, until the arrival of clinicians from the Helicopter Emergency Medical Service (HEMS) team, who then led advanced life support measures. Despite their efforts, Mr Mouland did not respond and was pronounced deceased by HEMS staff at 17:01 hours on 6 July 2022.

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

SECTION 4 – Timeline of Events leading up to Mr Mouland’s Death

4.1 Pre-committal Thursday 2 June 2022

On Thursday 2 June 2022 Mr Mouland was arrested at his home, taken to Antrim Police station, was detained, interviewed, charged and refused bail. Whilst in Antrim Police station Mr Mouland received three healthcare reviews which noted he was to be monitored for opiate withdrawal.

He was subsequently transferred to Maghaberry Prison on 3 June 2022 where he was held on remand awaiting trial.

4.2 Maghaberry Prison Friday 3 June 2022

Upon his arrival at Maghaberry Prison on 3 June 2022, Mr Mouland underwent an initial committal assessment with NIPS staff. During this assessment, he reported no history of self-harm or suicide attempts and stated he had no current thoughts of the same. Mr Mouland expressed confidence in his ability to keep himself safe while in custody and assured staff he would alert them if his mood changed. He disclosed an addiction to heroin and mentioned experiencing mild withdrawal symptoms. Additionally, he suffered from depression and anxiety, for which he was on medication. Mr Mouland was hopeful about applying for bail the following week.

At 14:32 Mr Mouland received an initial nursing assessment by HiP, Nurse A which was recorded on the Egton Medical Information System (EMIS). Mr Mouland reported he was on Diazepam, this was confirmed on Police and Criminal Evidence notes. As the day of committal was a Bank Holiday due to the Platinum Jubilee, Nurse A rang the out of hours service at Lagan Valley to arrange a prescription. Nurse A advised he was on Rivaroxaban, Diazepam and Mirtazapine and a prescription was generated to cover the weekend. When the pharmacy team reconciled the medications against the active Northern Ireland Electronic Care Record (NIECR) prescriptions on the following Monday morning, it was discovered that he had not actually been prescribed Rivaroxaban or Mirtazapine since March 2022. If medications have not been

prescribed for over a month prior to committal, then they are not automatically issued until a medication review is completed. As the Diazepam was still a live prescription it was continued. Mr Mouland had a Self-Administration Risk Assessment (SARA) completed and was assessed as direct administration which meant he would have any medications administered directly and would not be in possession of them. He was given a lateral flow test (LFT) for Covid 19 which was negative. He stated he was aware of the routines and procedures involved with being in custody.

Every person who comes into an establishment on committal or transfer from another establishment must be assessed for risk of self-harm or suicide. During his committal interview Mr Mouland denied any self-harm issues or suicidal intent and stated he could keep himself safe. He was assessed by NIPS staff as “no apparent risk” at that time and was advised how to escalate for help if he required it.

Mr Mouland was a known drug user and during his committal assessment stated he had an addiction to Heroin and was starting to feel mild withdrawals. His Clinical Opiate Withdrawal Score (COWS)⁴ was 3.

Mr Mouland was initially located in Bann House, Landing 2, Cell 15 in a shared cell with another prisoner. As Mr Mouland knew the other prisoner from outside the custodial environment and stated he was happy to cell-share.

4.3 Maghaberry Prison Saturday 4 June 2022

Mr Mouland was seen by Nurse B who noted his COWS score as 5. His blood pressure was checked and it was noted he was restless and irritable.

⁴ The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale is used to reproducibly rate common signs and symptoms of opiate withdrawal and monitor over time.
Score: 5- 12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

4.4 Maghaberry Prison Sunday 5 June 2022

Nurse C carried out a Comprehensive Committal Assessment. This included height, weight, blood pressure and temperature readings alongside an overview of medical history. Mr Mouland was offered a blood borne screening and a Hepatitis B vaccine which he refused. He requested to be referred to AD:EPT⁵ for addiction to heroin and cocaine. His COWS score was noted as 4.

4.5 Maghaberry Prison Monday 6 June 2022

A referral for Mr Mouland was sent to AD:EPT. A medicine reconciliation was completed as per NIECR and a 3-month prescription for Diazepam was issued with a review planned. A committal notification letter was sent to Mr Mouland's General Practitioner.

Mr Mouland made a 3-minute telephone call to his solicitor.

4.6 Maghaberry Prison Tuesday 7 June 2022

Mr Mouland and his cellmate were moved to Landing 3, Cell 9 within Bann House due to operational requirements. The movement of cells/landings is usual as a prisoner progresses from committal to general population.

4.7 Maghaberry Prison Thursday 9 June 2022

Mr Mouland had his second LFT test, a negative result was indicated.

4.8 Maghaberry Prison Friday 10 June 2022

Mr Mouland and his cellmate were moved to Landing 6, Cell 17 again within Bann House due to operational requirements.

⁵ AD:EPT (Alcohol, Drugs: Empowering through Therapy) is a therapeutic service funded by the South Eastern Health & Social Care Trust. The service supports individuals in custody who have issues with drugs and/or alcohol.

4.9 Maghaberry Prison Monday 13 June 2022

Mr Mouland and his cellmate were moved to Davis House Landing A1, Cell 28 due to operational requirements.

4.10 Maghaberry Prison Tuesday 14 June 2022

EMIS records show Mr Mouland received a mental health triage⁶. Mr Mouland denied any diagnosis of severe mental illness or history of self-harm. When asked about taking an overdose when he attended the Emergency Department on 2 April 2022 he stated it was unintentional. He stated he injects heroin daily. From the information provided there was no clinical indication a mental health assessment was required. Mr Mouland had been referred to AD:EPT as per his request at committal assessment. Mr Mouland advised he had no current thoughts or plans to harm himself or end his life. He said he had good family support and was hopeful of getting bail.

4.11 Maghaberry Prison Wednesday 15 June 2022

Mr Mouland attended court by video link.

4.12 Maghaberry Prison Thursday 16 June 2022

Mr Mouland had activated his cell bell and told NIPS staff he was feeling suicidal and his 'head was away'. He asked to be placed in a safer cell due to feeling suicidal. When pressed further, he advised he had no plan of suicide or self-harm. When NIPS staff asked why he was feeling this way he stated he just wanted his Diazepam. Confirmation was sought from the nurse that Mr Mouland was due medication that night to which he seemed content. A SPAR Evolution form of concern was opened following this interaction with staff and a risk assessment meeting was held with 3

⁶ A Mental Health Triage is a preliminary patient assessment to offer support, provide signposting, onward referral and ascertain mental state and need for further Mental Health assessment. This is undertaken in partnership with the patient through a face to face consultation and joint planning. The Mental Health Triage should be completed within 7 working days as per National Institute of Health & Care Excellence (NICE) Guideline: Mental Health of Adults in Contact with the Criminal Justice System (NG66, 2017)

NIPS staff where he was assessed as 'no apparent risk' and the concern form was closed.

4.13 Maghaberry Prison Friday 17 June 2022

Mr Mouland met with a representative from Family Links⁷ who relayed a message from Mr Mouland's mother.

4.14 Maghaberry Prison Thursday 23 June 2022

Mr Mouland was due to attend a hearing at Ballymena Magistrates Court; however, he did not attend as a summons was not produced.

4.15 Maghaberry Prison Thursday 30 June 2022

Mr Mouland attended court by video link.

4.16 Maghaberry Prison Tuesday 5 July 2022

Mr Mouland's cellmate reported to NIPS staff Christopher had tried to self-harm through the night by placing a phone cable around his neck. Following this report, a concern form was opened as part of the SPAR EVO process. Following the opening of the concern form, a risk assessment meeting was held with 2 NIPS officers and House Nurse A during which he presented as tired, sluggish and not fully engaging and stated he was not sleeping well and wanted to go back to his cell to sleep. He said he could keep himself safe; however, due to his response and demeanour Mr Mouland was deemed "at risk" and a care plan was put in place with 30-minute observations. During the risk assessment meeting Mr Mouland stated he "*gets on well with cellmate and wants to remain doubled with him*". This would have been considered as a positive protective factor⁸.

⁷ Family Links is an independent service offered to the families of people in prison. They offer both practical and emotional support to help families cope.

⁸ a positive protective factor is a strength, resource, or positive influence that helps a person, family, or community avoid negative outcomes and bounce back from challenges.

Contact was made with the Mental Health Team so Mr Mouland could be reviewed by them. Following this contact, and while they were on the landing, Mental Health Practitioner A spoke to Mr Mouland who stated to that his mood had dipped a little and he just wanted his medications (Mirtazapine and Methadone) restarted. He was advised he would need to request a GP appointment in relation to these medications. A note was made on the care plan that staff were to search the cell; There is no evidence a search was carried out. On asking for clarification from NIPS whether the search took place they were not able to provide a definitive answer and stated “it is very likely the cell search did occur” but also added “recording is not universal unfortunately”. This raises issues around record keeping which I have addressed in the recommendations.

4.17 Events on the day of Mr Mouland’s death Wednesday 6 July 2022

At 07:17 Mr Mouland activated the cell bell and advised Prison Officer D he was feeling low. Prison Officer D advised him to talk to the Senior Officer. Mr Mouland was asked if he could keep himself safe, he replied he could.

At 08:25 within the handover received from night staff it stated Mr Mouland had said “*his heads away*”.

At 09:50 during a SPAR EVO check Prison Officer B asked Mr Mouland how he was feeling. Mr Mouland replied that he was still feeling low. When asked why he was feeling low he said it was to do with his medication. Mr Mouland confirmed he was not currently having any thoughts of self-harm or suicide, just low mood.

At 10:32 Mr Mouland arrived in the Donard Centre for a SPAR EVO review. This was conducted by Senior Officer B, Senior Officer C and Mental Health Practitioner B. During his review Mr Mouland engaged well. Mr Mouland said he “*feels much better today and has no current thoughts of harming himself*”. His main issue is with addiction, he had been using heroin prior to coming into custody and advised he had previously been prescribed Methadone which he would like to start again. “*He said he does not want to die and hopes to get bail soon*”. Due to his positive interactions and

having no current thoughts of harming himself the review team agreed to close the SPAR EVO.

11:04 – Mr Mouland was escorted back to Davis House.

14:10 – Time in the exercise yard was offered to the landing. Mr Mouland declined and was locked in his cell in line with procedure. As Mr Mouland was no longer under SPAR EVO observations there was no requirement for checks on him to be conducted at this time.

16:10 – All prisoners were returned from yards to the landing. Prison Officer A escorted Mr Mouland’s cellmate back to their cell. He looked through the flap but did not see anything unusual. He then opened the door, noting it would not fully open and stepped back to let Prisoner A into the cell. Prisoner A entered the cell followed by Prison Officer A; they both exited the cell due to finding Mr Mouland unconscious with a ligature made with a shoelace around his neck. Prison Officer A activated their blick alarm to alert other staff. Prisoner A was moved to another cell on the landing and a SPAR EVO was opened for him as a support mechanism.

16:10	Alarm Activated Davis A2. Reported code blue, matter of priority. HiP staff in attendance. ECR contacted ambulance control. Mr Mouland found unconscious with ligature around neck.
16:12	Prison Officer A and Prison Officer C enter cell. Prison Officer A cuts the ligature from Mr Mouland and with the help of Officer C move Mr Mouland to middle of the cell. Prison Officer A leaves the cell as they injured themselves while using Hoffman knife to cut ligature.
16:12	Senior Officer A enters cell and commences CPR on Mr Mouland with Prison Officer C. Senior Officer D enters the cell.
16:12	Prison Officer arrives with medical bag and passes it into the cell.
16:13	Governor A arrives on landing.
16:13	Nurse D arrives on landing with medical bag and oxygen.
16:17	Nurse A arrives on landing with Nurse E who has additional medical bag and oxygen.
16:21	Governor B onto landing.
16:22	Defibrillator onto landing and handed into cell.
16:23	Request by Nurse D to bring more oxygen to location.
16:24	More oxygen arrives.
16:28	8 Nurses now in attendance. CPR continuing.

16:29	10 Nurses now in attendance. CPR continuing.
16:30	More oxygen arrives
16:35	Governor C on landing. Air Ambulance crew arrived at prison, escorted to Davis House.
16:38	Air Ambulance staff x2 arrive at Davis House and take over management of Mr Mouland.
16:39	Mr Mouland moved from cell out onto the landing to allow more room to continue CPR.
16:42	Automatic chest compressor now in operation.
16:44	Ambulance crew x2 arrive.
16:59	Air Ambulance Paramedics continue with treatment.
17:01	Paramedic A advised that Christopher Mouland is deceased.

4.18 Social interaction

Mr Mouland had limited social interactions during his period in custody. He had no domestic visits and made no telephone calls other than one call to his solicitor. His cellmate Prisoner A stated *“he only really left his cell to collect his food. Other than that he mostly lay in his bed”*. During his period in custody, he was encouraged by other prisoners and by Prison staff to attend the exercise yard as was noted in Prison Service records and a statement given by Prisoner A.

4.19 Hot and Cold Debrief Meetings

Standard 25 of NIPS Suicide and Self-Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody. In all cases hot de-briefing will take place and will involve all of the 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.

During the hot debrief staff raised a concern regarding the grill system. The grill system allows access to areas in the house, it appeared overwhelmed with staff experiencing difficulty identifying priority staff (oxygen, healthcare professionals).

Staff were thanked for their efforts and reminded of the various care and support mechanisms available

The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning. Records evidence all in attendance at the cold debrief on 19 July 2022 were thanked for their efforts to resuscitate Mr Mouland and were advised of the support services available. It was stated there were a lot of people present at the scene, some unnecessarily.

Governor E said privacy screens were being considered. NIPS have confirmed Privacy screens have been purchased and are available in all areas.

Section 5 - Findings.

This section outlines the findings of this report in relation to its objectives and concerns raised by the family.

	<p>Investigation Objectives</p>
<p>1.</p>	<p>Establish the circumstances and events surrounding Mr Mouland's death on 6 July 2022, including the care provided by NIPS and relevant outside factors;</p>
	<p>The circumstances and chronology of Mr Mouland'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.</p>
<p>2.</p>	<p>Examine any relevant health care issues and assess clinical care and risk management;</p>
	<p>The Clinical Reviewer stated: <i>“Throughout his time in custody, Mr Mouland engaged with a range of healthcare professionals, including mental health nurses, assessments by the Clinical Addictions Team (CAT), consultations with a dietitian and speech and language services.”</i></p> <p>The Clinical Reviewer concluded <i>“overall, Mr Mouland’s engagement with different healthcare services during his periods in custody was at least equivalent to the access and provision of healthcare he would have expected within the community*”</i>.</p>
<p>3.</p>	<p>Examine how NIPS and the Trust cared for Mr Mouland in Bann House, Maghaberry Prison where he was in quarantine and what procedures were in place to support his committal into prison, investigating the application of Covid-19 risk control measures by NIPS and Trust and any possible implications for Mr Mouland.</p>

	<p>Mr Mouland had been in the custody of Maghaberry Prison in 2021, and he was aware of the need for quarantining. He was doubled in a cell with another prisoner who he knew from outside the custodial environment</p> <p>Primary and Mental Health Assessments were carried out and do not indicate Mr Mouland was prevented from accessing services based on restrictions imposed due to the pandemic.</p>
4.	<p>Ensure Mr Mouland’s family has the opportunity to raise any concerns they may have and that these concerns are taken into account in the investigation and report;</p>
	<p>Concerns raised by the family of Mr Mouland are detailed in Section 2.2.</p>
5	<p>To provide a timeline of events surrounding the death of Mr Mouland;</p>
	<p>The timeline of events surrounding Mr Mouland’s death are recorded in Section 4.</p>
6.	<p>Examine the care NIPS provided to Mr Mouland and consider whether any changes would help prevent a similar death in the future;</p>
	<p>The care afforded to Mr Mouland 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 Mouland’s dignity.</p>
7.	<p>Examine the adequacy of induction and committal processes provided by HiP;</p>
	<p>The Clinical Reviewer indicated:</p> <p><i>“the recording of Mr Mouland’s committal assessment, both initial and comprehensive, was sufficiently documented. The initial assessment</i></p>

	<p><i>appropriately identified issues that could affect Mr Mouland's immediate health and safety, prior to the comprehensive (second-stage) health assessment. This documentation is consistent with the best practice guidance outlined in NG66 'First-stage health assessment at reception into prison'. The onward referral for a triage was also appropriately completed, as per the actions required in the NICE guidelines.</i></p> <p><i>Mr Mouland had access to a comprehensive committal assessment on 29th June 2022, which further documented his polysubstance misuse and past medical history relating to deep vein thrombosis (DVT) and associated therapies. Clinical observations were taken, and Blood-borne virus screening was offered. Although Mr Mouland initially declined this, it was followed up for a later appointment. Referrals to AD:EPT and a dietitian were also completed”.</i></p>
8.	<p>Examine the mental health assessments, support and care planning provided to Mr Mouland through Supporting People at Risk Evolution (SPAR EVO);</p>
	<p>The Clinical Reviewer stated:</p> <p><i>“following this committal, a SPAR EVO (Supporting People at Risk) process was initiated, during which Mr Mouland indicated that he felt able to keep himself safe in his cell. A possession risk assessment was completed, identifying that it was not suitable for him to have medications in his possession, which was deemed an appropriate outcome.</i></p> <p><i>Overall, Mr Mouland's engagement with different healthcare services during his periods in custody was at least equivalent to the access and provision of healthcare he would have expected within the community*.</i></p>
9.	<p>Identify any relevant failing or commendable practice and highlight any lessons learned from the death of Mr Mouland; and</p>
	<p>the management of the incident was very clear and calm with good teamwork.</p>

10.	Assist the Coroner's investigative obligation under Article 2 of the ECHR, by ensuring as far as possible the full facts are brought to light.
	A copy of this report and underlying materials will be provided to the Coroner as part of the usual process.

The Mouland family raised several questions during their meeting with the then Ombudsman. These are detailed in section 2.2 and findings recorded below:

	Family Concerns
1.	Who found him, where did he get the ligature, who was in the cell when staff were working on Christopher and why protocol was not observed in contacting the next of kin.
	<p>Who found Christopher: Mr Mouland was found by his cellmate in his cell when he returned from the exercise yard. During yard time, when a prisoner does not attend, they are locked in their cell in line with protocol.</p> <p>Where did Christopher get the ligature: Mr Mouland had used a shoelace as a ligature. It is unclear from records whether this belonged to Christopher or his cellmate as there were no shoelaces in Christophers' shoes, this is addressed in the recommendations.</p> <p>Who was in the cell when staff were working on Christopher: The family were concerned that Prisoner A was in the cell while staff were carrying out CPR. It is confirmed this was not the case. Prisoner A was moved to another cell on the landing while the resuscitation efforts were ongoing.</p> <p>Why was protocol not observed in contacting next of kin: Prisoner A had access to a phone which he used to contact a member of his family to alert them of the ongoing situation, who then passed this information on to a member of Mr Mouland's</p>

	<p>family. In Davis House, all cells have in-cell phones, which enabled Prisoner A to make the call. The former Governor of Maghaberry Prison stated they would be reticent to isolate phones during such an incident as many prisoners use them as a support mechanism. Mr Mouland's mother telephoned the Prison at 17:27 and spoke to the Duty Governor (Governor D) who was then able to provide her with an update. It is unfortunate the family were informed in this manner; however, it was outside of NIPS control and prevented them from following the usual protocol.</p>
<p>2.</p>	<p>Prison Service Staff Resources - was the landing understaffed and what was the impact of recreational time on staff resources, did staff on duty remain on the landing at this time.</p>
	<p>Investigators are satisfied the levels of staff on duty in Davis House while Mr Mouland was detained were appropriate and in line with Governor's instructions.</p>
<p>3.</p>	<p>Should Christopher have been on a 'watch' given he had tried to hang himself the previous day?</p>
	<p>When notified of the attempt to take his life the previous day, a SPAR EVO concern form was opened and following an interview with Mr Mouland he was deemed 'at risk' and was placed on 30-minute observations. He remained under observations until the following day when a SPAR EVO review was conducted. During his review he engaged openly with staff, was positive about the future and stated he had no intention of self-harming. He indicated he wanted to keep sharing his cell with Prisoner A as they got on well. Based on all this information, the SPAR EVO was closed, and Mr Mouland was no longer kept under detailed observation. The only issue he raised during his review was he wanted to restart his Opioid Substitution Therapy⁹ (OST). A referral was made to AD:EPT clinical addictions team at Mr Mouland's request.</p>
<p>4.</p>	<p>Had it been reported that Christopher had suicidal thoughts?</p>

⁹ Opioid substitute treatment (OST) is the term used to describe the prescribing of an opioid medication to assist patients who are seeking treatment for dependent use of heroin or other opioids.

	All thoughts of life not worth living were documented and acted upon appropriately through the SPAR EVO process.
5	Was there any impact from Christopher's previous committal to Maghaberry Prison?
	There is no evidence to suggest there was any impact on Christopher.
6.	Why did Christopher not go into the exercise yard?
	It is evident from records that Mr Mouland rarely left his cell apart from collecting his meals, though he was encouraged by officers and other prisoners to attend yards.
7.	Did Christopher choose to share with his cellmate or were they together because they shared similar circumstances?
	Christopher and his cellmate were committed on the same day and were happy to share as they knew each other from the community environment.
8.	Were addiction services offered to Christopher and if not, why not?
	<p><i>The Clinical Reviewer stated:</i></p> <p><i>"Upon Mr Mouland's return to Maghaberry prison on 3 June 2022, a medicines reconciliation was completed, with Diazepam being the only active prescription. A three-month prescription for Diazepam was arranged, with a review planned thereafter. On 6th July 2022, Mr Mouland expressed to mental health staff his desire to restart mirtazapine and methadone, both of which he had previously taken but were not current at the time of his committal. He had disclosed that he had been free from heroin for approximately one month at the time of his committal.</i></p>

A plan was agreed for Mr Mouland to seek a GP appointment to discuss his medications, and a referral to AD:EPT was noted, which would be required for any initiation of OST. The steps taken to refer Mr Mouland to AD:EPT as part of his request for OST were appropriate”.

9. Was Christopher on any medication to help him including Methadone?

A medicine review was carried out as part of the committal process. Mr Mouland was not being prescribed Methadone at that time. The only active prescription at the time of his committal was Diazepam. A three-month prescription for Diazepam was arranged, with a review planned thereafter. Mr Mouland expressed to mental health staff his desire to restart Mirtazapine and Methadone, both of which he had previously taken but were not current at the time of his committal. He was advised he would need to speak to the GP to arrange this.

SECTION 6 – Conclusions

Pandemic restrictions significantly impacted daily activities. Procedures to manage prisoner interaction, mitigating measures including meaningful contact opportunities were in place.

The emergency response to Mr Mouland was prompt and adhered to best practices.

The decision to commence CPR and the resuscitation were conducted in accordance with best practices and national guidelines.

Mr Mouland received healthcare at least equivalent to that available within the community.

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

The Clinical Reviewer raised the following issue:

The review has noted initial issues documented by healthcare staff responding including the “*oxygen cylinder not working and the ambu bag would not fully inflate*”. Both items referenced here is essential equipment as part of the airway management, in the event of a medical emergency and/or resuscitation.

To ensure the highest standards of patient safety and emergency preparedness, it is necessary that robust systems for the checking, maintenance, and availability of oxygen cylinders be established and maintained. If not already included, these systems should be integrated into existing resuscitation audits as part of a robust clinical governance approach. This will ensure that all staff continuously have access to fully functioning emergency resuscitation equipment.

The Trust completed a Local Significant Incident Review (LSIR) following the death of Mr Mouland which found an oxygen cylinder was noted to be not functioning correctly – this had no impact as further supply was obtained.

My Investigator confirmed detailed checks have always been in place for review and inspection of the emergency equipment used by HiP staff. These are to be conducted weekly and following every incident. On 20 February 2024 these procedures were formalised. This clearly documents the checks required, the frequency of the checks and audit arrangements for these. I am satisfied these are robust and fit for purpose and no further actions is required. I have included it to highlight measures were in place at the time and have since been reviewed and formalised.

The investigation findings show there were no relevant failings by NIPS or the Trust, with areas of good practice recognised in Section 7.

SECTION 7: Areas of good practice or areas for improvement.

Good Practice

7.1 NIPS

It was noted some staff felt the management of the incident was very clear and calmly managed with one person taking control of the incident and directing staff as required. However, others reported there were many people there who did not need to be there. When reviewing the CCTV footage this was also noted.

An Inspire session was arranged for staff which was reported to be very useful.

7.2 NIPS and the Trust

Staff involved directly in the incident felt there had been good teamwork with all involved remaining professional and calm throughout.

Areas for improvement

The Clinical Reviewer noted the following area for improvement for the Trust:

- 1. It is recommended that all incidents of self-harm, such as the ligature attempt, be thoroughly documented in the SPAR EVO and referenced in subsequent reviews. There was no mention of the high-risk rating or clear documentation regarding the decision to close the case. While the Nurse present recorded evidence in the medical records, it is crucial that risk assessments remain dynamic, but that comprehensive documentation is maintained in all records related to SPAR EVO reviews. This ensures evidence of informed and defensible decision-making.*

The Trust completed a Local Significant Incident Review following the death of Mr Mouland which has addressed the issue and identified the following recommendation:

A learning line is to be issued to advise staff to consider carefully regarding closing a SPAR Evo process when there has been a recent significant self-harm gesture yet the patient denies having thoughts of self-harm. Closure is not recommended within 24 hours of the significant incident.

This recommendation was implemented on 28 October 2024.

The investigation findings show there were no relevant failings by NIPS or the Trust.

SECTION 8: Recommendations

I have made one recommendation to NIPS.

1. It is unclear from NIPS records whether the cell search noted in the care plan was conducted. NIPS stated it is very likely this did occur, however there is no record of whether this did in fact take place which raises the issue of poor record keeping. Therefore, staff should ensure good record keeping at all times showing all actions taken/not taken and the reason given. A reminder should be issued to all staff in this regard.

NIPS has accepted this recommendation.

GLOSSARY**Appendix 1**

AED	Automated External Defibrillator
BBV	Blood Borne Virus
CCTV	Closed Circuit Television
CJINI	Criminal Justice Inspection Northern Ireland
COWS	Clinical Opiate Withdrawal Scale
CPR	Cardiopulmonary Resuscitation
DSH	Deliberate Self Harm
ECHR	European Convention on Human Rights
EMIS	Egton Medical Information System
HBW	Hydebank Wood College and Ash House Women's Prison
HEMS	Helicopter Emergency Medical Service
HiP	Healthcare in Prisons
HMIP	His Majesty's Inspectorate of Prisons
HSCB	Health and Social Care Board
IMB	Independent Monitoring Board
IRP	Independent review of Progress
LFT	Lateral Flow test
MHT	Mental Health Team
NIAS	Northern Ireland Ambulance Service
NIECR	Northern Ireland Electronic Care Register
NIPS	Northern Ireland Prison Service
NPM	National Preventive Mechanism
OST	Opioid Substitution Therapy
PHA	Public Health Authority
PSST	Prisoner Safety and Support Team
RQIA	Regulation and Quality Improvement Authority
SARA	Self Administration Risk Assessment
SPAR EVO	Supporting People at Risk Evolution
The Trust	South Eastern Health and Social Care Trust
WHO	World Health Organisation

Guidance during the Covid-19 pandemic

Appendix 2

NIPS worked with SEHSCT Infection control specialists from February 2020 in preparation for the pandemic and was informed by PHA and the HSCB from April 2020. NIPS and SEHSCT colleagues were also representatives on the 5 Nations Covid-19 Health and Justice group that proved a valuable forum in learning from other jurisdictions.

NIPS recognised that the general prisoner population did not present a risk; it was people coming into prison (staff and new committals) that posed a risk of transmission of the Covid-19 virus to general population. NIPS restricted staff access early on to essential staff (NIPS and SEHSCT) and introduced committal quarantine to protect the general prisoner population.

Committal quarantine was initially implemented for 14 days, based on PHA advice and quarantined prisoners were held in specific accommodation, with largely the same staff group in place. Committal quarantine was reduced to 10 days from 12 November 2021 subject to the individual agreeing to be tested for the virus (again, informed by PHA advice). Committal quarantine was again varied on the 22 April 2022 to facilitate the relocation of prisoners into the general population following a negative test on day 2 and on day 6/7, in line with PHA advice.

Prisoners held in quarantine landings had a TV in their cell, distraction packs and access to in-cell exercise equipment (procedure through funding provided by HSCN). All prisoners were facilitated to have regular showers and phone calls and, apart from check-ins with NIPS staff, quarantined prisoners were seen by Healthcare in Prison staff daily. In addition, the HiP Prisoner Engagement staff also visited with each prisoner.

Criminal Justice Inspection Northern Ireland (CJINI)**Appendix 3**

CJINI is a United Kingdom National Preventive Mechanism (NPM) member body that independently monitors places of detention to prevent the ill treatment of prisoners. CJINI 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. In November 2019 CJINI and RQIA reported on the Safety of Prisoners held by NIPS and made two strategic and ten operational recommendations for improvement including better joint-working between NIPS and the Trust to increase the safety of prisoners. This is available at [CJINI - Criminal Justice Inspection Northern Ireland - The Safety of Prisoners](#)

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. Inspectors reported the prison had settled considerably since the last full inspection in May 2015 and was now a much safer place.

A priority concern in the 2023 report was when a prisoner died at Maghaberry Prison leaders waited for the Ombudsman's and 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 reasonable progress against this priority concern.

The overall picture of safety has progressed hugely and levels of violence and disorder had reduced; however, Inspectors remained concerned that work to support the most

vulnerable men at Maghaberry Prison had not developed to the same level as other aspects of safety.

CJINI reports are available at <https://www.cjini.org/report-category/prisons/>

Regulation and Quality Improvement Authority (RQIA) Review of Services for Vulnerable Persons detained in Northern Ireland Prisons

Following a report of an accident of serious self-harm from the Prisoner Ombudsman's Office in 2016 and the number of recorded suicides in prisons, the Departments of Health and Justice jointly commissioned a review to consider provision for particularly vulnerable prisoners. The RQIA Review, published in October 2021, goes some way to addressing concerns. Recommendations made by the RQIA specifically address mental healthcare. The Ombudsman works with the RQIA and others to raise matters of concern and improve the delivery of support to prisoners.

The RQIA reports are available [here](#).

Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB of volunteers whose role is to independently monitor the care and treatment of prisoners. From the 2021-2022 Maghaberry Prison IMB annual report the IMB state there has been clear evidence of prison staff intervention in relation to prisoners who may attempt suicide or inflict self-harm which has improved the safety and wellbeing of prisoners. The IMB would acknowledge the excellent work carried out by staff in this regard to ensure the safety of prisoners, especially those who have been identified as being vulnerable. The IMB did however, continue to have some concerns regarding the standard of accommodation within Foyle during this year particularly around lack of furniture and non-working showers, and the impacts on prisoners due to Covid-19 restrictions particularly 23-hour lock ups.

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

Appendix 4

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.