The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF MR JOHN ANTHONY DEERY AGED 50

WHILST IN THE CUSTODY OF MAGHABERRY PRISON ON 28 AUGUST 2009

1 December 2010

[Published 8 December 2010]

Please note that where applicable, names have been removed to anonymise the following report

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PREFACE

Mr John Anthony Deery was born on 18 August 1959. He was 50 years old when he died by suicide whilst in the custody of Maghaberry Prison, on Friday 28 August 2009.

I offer my sincere condolences to Mr Deery's family for their sad loss. I have met with Mr Deery's family and shared the content of this report with them and responded to the questions and issues they raised.

This report contains this preface and a summary followed by my recommendations, an introduction and my findings.

The findings are presented in nine sections:

- Section 1: Early Investigation
- Section 2: The Prisoner Ombudsman Investigation - Mr Deery's Time in Lagan House from 22 - 25 August 2009
- Section 3: Mr Deery's Move to Healthcare on 25 August 2009
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- Section 5: Observations and Discovery of Mr Deery
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As part of the investigation into Mr Deery's death, Dr Seena Fazel, Consultant Forensic Psychiatrist and Clinical Senior Lecturer in Forensic Psychiatry at the University of Oxford, was commissioned to carry out a clinical review of Mr Deery's mental health needs and medical treatment whilst in prison.

Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, was commissioned to provide his expert opinion of the

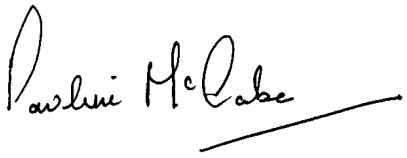
actions taken by the staff who found Mr Deery and the medical care he received after he was found.

The Prisoner Ombudsman is grateful to Dr Fazel and Mr Brackenbury for their assistance. Both clinical reviews have informed some of the findings and recommendations in this investigative report.

In the event that anything else comes to light in connection with the matters addressed in this investigation, I shall produce an addendum to this report and notify all concerned of the additions or changes.

As a result of the investigation, I make **12 recommendations** to the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust.

I would like to thank all those from the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and other agencies, who assisted with this investigation.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
1 December 2010

SUMMARY

Mr Deery died on 28 August 2009 whilst in the custody of Maghaberry Prison.

Immediately following Mr Deery's death the Prisoner Ombudsman, in line with normal practice, carried out a review of Mr Deery's prison records and of all relevant CCTV footage. This early investigation identified 148 instances of possible concern in connection with: staff recording that observations of Mr Deery had taken place when they had not; observations not being carried out at the required intervals; observations being recorded retrospectively; a lack of management action in response to gaps in the Prisoner at Risk booklet[1]; recorded observations which were inconsistent with actions observed on CCTV; staff on the telephone/computer at times when observations were not recorded and important information that could affect Mr Deery's future care plan, not being recorded. Concerns were also raised in connection with the quality of Mr Deery's regime and the extent of his interactions with staff. The concerns identified related to both Mr Deery's first three days in prison when he was located in an observation cell[2] in Lagan House, and to his last two days when he was moved to the Healthcare Centre.

The information relating to these instances of possible concern was presented to the Prison Service and South Eastern Health and Social Care Trust (SEHSCT), who then informed the Prisoner Ombudsman of their intention to conduct an internal disciplinary investigation into the matters raised. As a result of the internal investigation nine recommendations were made. These included recommendations that nine staff should be subject to disciplinary proceedings; that remedial action should be taken in respect of 25 staff who were found to have performance issues and that there should be a training needs analysis to address the shortfalls in leadership in the healthcare team. The investigation found that a number of the

[1] Prisoner at Risk booklet – Used when a prisoner shows low coping skill or has threatened to self harm. The prisoner is classed as vulnerable and extra measures are put in place to increase the number of observations carried out on the individual. Multi-Disciplinary case conferences are also held to agree the best care plan to manage the individual.

[2] Observation Cell – A cell designed to house vulnerable prisoners in imminent risk of self harm. This type of cell has reduced ligature points, an in cell CCTV camera which allows a prisoner to be monitored around the clock and an intercom which allows the occupant to directly speak with an officer in the POD or call the Samaritans.

areas of possible concern identified by the Prisoner Ombudsman resulted from a lack of clarity in respect of matters related to the implementation of prison service policy. A recommendation for a policy update was, therefore, also made.

The Prisoner Ombudsman early investigation also found evidence of good practice. There were numerous instances where officers and healthcare staff carried out the correct observations at the correct times and accurately recorded them. There were times when particular staff members had significant contact with Mr Deery, talking with him, bringing him drinks and providing him with cigarettes. There were also examples of individual staff members and a senior officer being particularly conscientious in carrying out their duties and checks.

A summary of the Prisoner Ombudsman early investigation and the action taken in response by the Prison Service and SEHSCT can be found at Section 1 of this report.

Following the presentation of the early findings to the Prison Service and SEHSCT, the Prisoner Ombudsman proceeded, in accordance with her Terms of Reference, to carry out a full investigation into Mr Deery's death.

The investigation established that Mr Deery was re-committed to Maghaberry Prison on 22 August 2009 following an alleged breach of a probation order. In his previous custodial period, Mr Deery spent most of his time located in Maghaberry's healthcare centre, because he was considered to be a vulnerable prisoner.

On 22 August 2009, Mr Deery was assessed by a committal nurse officer who established that he had thrown himself down the stairs of a courthouse earlier that day and had attempted to take an overdose earlier that week. The nurse officer recorded that Mr Deery told her that he had *"no reason for living (and) didn't wish to reach the age of 50."* Mr Deery's 50th birthday had been on 18 August 2009.

As a result of the discussion, the nurse officer opened a Prisoner at Risk booklet and Mr Deery was moved to an observation cell in Lagan House. In line with Prison

Service policy, Mr Deery was left in his own clothing, but his shoe laces were removed. It is recorded that Mr Deery was *"in good spirits but a little tearful."*

On 23 August, Mr Deery was visited by healthcare staff, governors, landing staff, a family officer and another prisoner as part of the listener scheme[3]. Mr Deery also spoke with the Samaritans[4] on two occasions. The first call lasted 40 minutes and the second 30 minutes. Mr Deery was seen on CCTV to be upset during the longer conversation. During the day when he wasn't speaking with staff members, Mr Deery spent most of his time lying on his bed and was also seen to sit rocking on the edge of his bed.

Prior to his committal, Mr Deery smoked approximately 30 cigarettes per day, and it is recorded in his Prisoner at Risk booklet that one of his triggers for heightened anxiety and risk is a lack of tobacco. On 23 August staff, and in particular one officer, provided numerous cigarettes for Mr Deery and engaged in conversation with him on every occasion.

Mr Deery was seen by a prison doctor who prescribed him with all of the medication that he had been taking prior to entering prison, with the exception of Zimovane (a strong sleeping tablet), Gamanil (an antidepressant) and Lansoprazole (to prohibit gastric fluid production). That night, when a nurse officer was giving Mr Deery his evening medication, Mr Deery banged his head 28 times off the cell wall, because he was upset that he was not provided with his other medication. During the evening he saw a listener[5] and a nurse officer, known to Mr Deery from his previous time in prison, who gave him a hug and talked with him for approximately 24 minutes.

During the course of the evening Mr Deery, when left alone was seen on CCTV to be crying, rocking and, on three occasions, banging the window.

[3] Listener Scheme – The Northern Ireland Prison Service and the Samaritans run a peer/listener support scheme, whereby prisoners can volunteer to be trained by the Samaritans so that they can support vulnerable prisoners by encouraging the flow of information whilst maintaining their confidentiality.

[4] Samaritans – The Samaritans provide a direct service for prisoners located in observation cells. Details of these conversations are confidential and as such are not requested as part of the investigation.

[5] Listener – The Northern Ireland Prison Service and Samaritans, run a peer/listener support scheme, whereby prisoners can volunteer to be trained by the Samaritans so that they can support vulnerable prisoners by encouraging the flow of information whilst maintaining their confidentiality.

Mr Deery was later changed into anti-suicide clothing[6]. The corresponding medical record entry notes that *"he (Mr Deery) has problems of bad dreams at night and he has present thoughts of DSH (deliberate self harm) namely hanging."*

On the morning of 24 August, Mr Deery was visited by the principal officer from Lagan House and a prison doctor. The prison doctor noted that Mr Deery had a *"History of not coping in prison and had been in hospital before. I think we should retain in obs cell until seen by MHT (mental health team). No beds in hospital at present. Habitual self harmer and ischemic heart disease."*

Mr Deery was also visited on 24 August by a prison chaplain, probation officer and a nurse officer who gave him his medication. The total time that staff spent with Mr Deery was, however, less than the previous day and he was offered far fewer cigarettes. In the morning, Mr Deery appeared to be emotional and very low, however in the afternoon his mood appeared to have improved. In the evening he looked restless and was fidgeting and rocking. During the day, his total time out of cell was one minute.

Mr Deery's family asked the Prisoner Ombudsman why he was moved from the observation cell in Lagan House.

It is Prison Service policy, in line with best practice, not to locate a prisoner in an observation cell for longer than is necessary for their safety and well being. A case conference is required to authorise a move out of an observation cell and on 25 August 2009, the principal officer for Lagan House arranged a multi-disciplinary case conference to review whether Mr Deery still needed to be located in an observation cell and to discuss Mr Deery's future care plan.

Prior to the case conference, a mental health nurse spent over half an hour talking with Mr Deery. At interview, the nurse said that prior to the case conference he felt that he was being "*pressured*" into moving Mr Deery from the observation cell because *"it was quite apparent that the staff wanted him out of Lagan. He'd been there four days and they felt it was too long."* The nurse said that he initially

[6] Anti Suicide Clothing – Clothing especially designed for inmates to reduce the likelihood of self harming.

disagreed with this but that once he had carried out a *"mini mental health assessment"* of Mr Deery, he did agree that Mr Deery needed to move.

At 15.00 on 25 August 2009, the case conference was held and a summary of the meeting was recorded as follows:

"John has had a long history of self harm and over the past couple of days in the obs cell has been very weepy….Probation have seen him and 2 doctors. (Mental health nurse) said that he presents as he always has in the past and should be moved to healthcare."

There is some disagreement between those attending the case conference about how the decision to relocate Mr Deery to healthcare was taken and the accuracy of the recorded note of the meeting. Notwithstanding this, Dr Fazel, one of the independent clinical reviewers, noted that the mental health nurse who saw Mr Deery believed that his risk of self harm was reduced and he said that, in his opinion, the decision to move Mr Deery to healthcare was not inappropriate in the circumstances.

Speaking about the case conference, the Maghaberry suicide prevention co-ordinator pointed out that it was acknowledged that "*Mr Deery was still at risk….And that's why the Prisoner at Risk booklet was not closed and that's why it was retained and he remained on the Prisoner at Risk booklet."*

At interview, the principal officer who had spoken with Mr Deery before the case conference said that when he was told that he might be moved to healthcare *"it cheered him up no end."*

It was apparent to staff that one of the factors making Mr Deery upset was his concern for the well being of one of his family members. Having made contact with Mr Deery's priest, staff were able to obtain an up to date contact number for the family member and, immediately after the case conference, Mr Deery was taken to the principal officer's office and permitted a five minute phone call to the family

member he was concerned about. A subsequent entry in the Prisoner at Risk booklet notes that following this phone call, Mr Deery was *"in good form."*

Prior to Mr Deery's move to healthcare, he was handed back his own clothing and his shoe laces. His family asked why his shoe laces were returned when he was on *"suicide watch."*

Prison Service policy specifies that the only time shoe laces and belts must be removed is when someone is placed in an observation cell because they are considered to be at immediate risk of self harm. Where a prisoner, who has an open Prisoner at Risk booklet, is being managed in a normal residential location, they will normally retain all of their clothing and personal belongings. This was found to be general practice throughout the UK.

It is, however, the case that no risk assessment was carried out when the decision was made to return Mr Deery's shoe laces and this was noted by Dr Fazel in his clinical review.

In August 2009, the main healthcare facility at Maghaberry was undergoing refurbishment and at 18.24 on 25 August, Mr Deery arrived at the temporary healthcare facility in Bush House. That evening it is recorded that Mr Deery told staff that he was happy to be back in healthcare. At 19.25 he was locked for the night but before this, nurse officers entered his cell on three further occasions to talk with him and to provide him with his medication and supper.

On the morning of 26 August, Mr Deery was still on 15 minute observations. Between 07.56 and 12.00, CCTV shows staff engaging with Mr Deery on seven occasions for periods of between 30 seconds and two minutes. He was not, however, observed at fifteen minute intervals as required.

Mr Deery's family asked why the frequency of his observations was at some point changed from 15 minutes to hourly, considering his vulnerable state. The investigation found that the manner in which the decision to change the frequency of Mr Deery's observations was made was not consistent with prison service policy.

The Prisoner at Risk staff information pack states that *"The level of observation a prisoner is on, can only be changed by holding a case conference. It is not acceptable for observation to be changed on the daily log."*

At 12.00, a mental health nurse recorded the following daily log entry in Mr Deery's Prisoner at Risk booklet:

"Follow up review from case conference yesterday. John has settled very well and very quickly back in the healthcare setting where he feels safe and secure. His threats and risks of self harm have also reduced. I recommend current observation level to be reviewed and made hourly at irregular intervals. This is subject to regular appraisal."

At interview, the mental health nurse said that he carried out a *"review/informal case conference"* with two other nurse officers. The mental health nurse said that carrying out a *"review"* was an agreed practice in healthcare as long as three healthcare staff were in agreement. The other two members of staff who were named as taking part in the review were unable to recall being involved in any discussion about changing the frequency of Mr Deery's observations. All three staff can be seen on CCTV talking, but it is not possible to say what they discussed.

The mental health nurse who carried out the review said that his contribution to the review was informed by entries in the Prisoner at Risk booklet and his previous experience with Mr Deery. It was however the case that Mr Deery's Prisoner at Risk booklet entries did not, as they should have, record any details of his mental state/demeanour that morning.

It is noted later in the day on 26 August that Mr Deery was *"more content since he moved to healthcare," "pleased to see staff that he remembered"* and *"well settled."*

Following the recorded recommendation that Mr Deery should move to hourly observations, the next three checks were recorded as having taken place at 12.30, 13.00 and 13.30. It was, however, subsequently established that none of the three checks had been carried out at the times stated. Mr Deery was actually observed

at 12.10 and the next time he was checked was 13.50. He was then checked at least hourly for the remainder of the day.

Considering the decision to change the frequency of observation of Mr Deery on 26 August, the clinical reviewer commented that *"It is my opinion that the decision to reduce his observation levels was not inappropriate. His last recorded self harming episode was on the 23 August, and staff perceived his risk of self harm and suicide to have reduced. However, the process by which the decision was made was unclear."*

Mr Deery's family also asked what mental health support he received and whether he had been seen by a psychiatrist.

On the morning of 27 August at 09.45, Mr Deery was seen by a visiting psychiatrist[7], who carried out a full mental health assessment.

At interview the psychiatrist said that it was usual for the mental health assessment for vulnerable persons, such as Mr Deery, to be carried out within *"one to two days"* of being identified as vulnerable. She did not know why there was a delay of five days in the case of Mr Deery.

In his clinical review report, Dr Fazel noted that Mr Deery "*was not seen by a psychiatrist until the 27 August, around five days after reception into custody. For someone with a complex mental history, who was on a range of psychotropic medication, and at increased risk of self harm and suicide, this is suboptimal in my opinion, and he should, in my view, have been assessed sooner."*

The psychiatrist said that at the consultation on 27 August "*Mr Deery maintained fair eye contact throughout the interview and was not agitated……His speech was spontaneous and coherent. His mood was subjectively lowered but his mood was reactive throughout the interview……He was orientated in time, person and place*

[7] Visiting Psychiatrist - Specialist medical professional contracted by the Trust to provide medical assistance/sessions on agreed days in the week.

and insight was present. He had thoughts of life not worth living but he had no active suicide ideation."

The psychiatrist also said at interview that from her experience, and from listening to comments from other staff who knew Mr Deery, she identified *"two main clinical predicators*" of self harm. The first, she said was that Mr Deery would tell staff that he wanted to self harm. She said he was *"very good at ventilating feelings of increased thoughts of self-harm"* if he was going to act upon his thoughts of self harm. The second was that Mr Deery would present an, *"increasing agitated and distressed state."*

The psychiatrist said that, during the consultation, Mr Deery informed her of concerns about his family and his apprehension about being moved to a normal prison setting outside of healthcare. The psychiatrist said that she reassured him, told him there were no plans for him to be moved and explained that he was in a supportive environment, where there were nursing staff and medical doctors whom he knew well. The psychiatrist also said that she *"encouraged"* Mr Deery to attend ward-based activities such as occupational therapy programs, which she said he agreed to do.

The recorded psychiatrist's diagnosis of Mr Deery was that of, *"dysthymia*[8] *and personality deficit and deficiencies related to a dissocial and emotionally unstable state."* The clinical reviewer, Dr Fazel, said that he felt that this was the correct diagnosis.

It was the psychiatrist's belief and understanding that the consultation was concluded satisfactorily and that Mr Deery had not raised or displayed any concern in respect of their discussion. However, following the consultation, it is recorded on his Prisoner at Risk booklet that he was seen by a nurse officer who noted that he, *"Spoke with myself re his anxiety and apprehension of moving out of healthcare. Reassurance given."*

[8] Dysthymia is considered a chronic mood disorder but with less severity than a major depressive disorder. Symptoms can include, feelings of hopelessness, insomnia or hypersomnia, poor concentration or difficulty making decisions, low energy or fatigue, low self esteem, poor appetite or overeating and irritability.

At interview the nurse said that Mr Deery had become "*a bit anxious*" following his conversation with the psychiatrist because he understood that he was going to be moved *"straight away"* to the REACH landing[9]. She said that she told Mr Deery that he wouldn't be moved straight away and said also that she checked with the psychiatrist that this was the case.

At interview, the psychiatrist said that she couldn't recall speaking with Mr Deery about a move to the REACH landing. She said that the only time that she recalled discussing the REACH landing was with the Maghaberry senior psychiatrist, following her assessment of Mr Deery. The psychiatrist also said that if she had mentioned moving Mr Deery to the REACH landing, then she would have reassured him that the move would not have been immediate.

The senior psychiatrist at Maghaberry said at interview that Mr Deery had chronic mental health problems that did not respond to known therapies. He said that Mr Deery was unable to engage coping strategies and tended to run with the emotion of the moment. He also said that Mr Deery "*would tend to select the worst aspects of what you said to him….He would take what he viewed as a negative thing and this would…remain in his mind."*

The senior psychiatrist did not speak directly with Mr Deery on the 27 August. It would, therefore, appear to be the case that it was Mr Deery's understanding or interpretation of his discussion with the psychiatrist that led to him telling the nursing officer that he was worried about a move to REACH.

Immediately following Mr Deery's consultation with the psychiatrist and his discussion with the nurse officer who reassured him, a nurse officer recorded on Mr Deery's Prisoner at Risk booklet that at "*11.45, Served lunch, refused, says he does not want any food at the minute."* A further entry at 12.28 records that Mr Deery, *"Refused lunch meal. Asleep (at) present"* He continued to refuse food and it is recorded at 15.50 that *"Refused offer of tea meal. Said he was not hungry."*

[9] REACH Landing – is a facility within Maghaberry Prison and outside the healthcare centre, which identifies prisoners with complex needs and provides assessment, support within a structured and therapeutic environment facilitated by multi-disciplinary working and person centred planning.

Refusing food is one of the behavioural indicators listed on the Prisoner at Risk booklet that may indicate a prisoner is considering self harm. At interview, a nurse officer said that it was not uncommon for a prisoner to refuse food but that, if this continued for over a day, staff would become concerned. The psychiatrist said that not eating was something Mr Deery would have done previously "*on an intermittent basis.*"

After his consultation with the psychiatrist on 27 August, Mr Deery went with a nurse officer to reception to get some telephone numbers which were stored in his mobile phone. The nurse recorded on the Prisoner at Risk booklet that Mr Deery was, *"Very tearful and very regretful that he has ended up in prison again. He had been seen by (the psychiatrist) this morning but remains very emotional. On return from reception he was upbeat and pleased to have got the numbers."*

Throughout the rest of the afternoon/early evening, entries in Mr Deery's Prisoner at Risk booklet record that he was watching the television in his cell or asleep in his bed.

At 18.04, Mr Deery's cell was unlocked for association and his door left open. At interview a nurse officer said that Mr Deery was offered evening association but he chose to remain in his cell. The nurse officer said that he thought Mr Deery may have been reluctant to leave his cell because of fears for his safety related to his crime. The nurse officer also said that normally, where an inmate refuses the offer of association, their cell would then be locked. On this occasion, however, Mr Deery's door was left open so, *"he (Mr Deery) didn't feel so closed in."*

During the association period, CCTV shows that an orderly briefly entered Mr Deery's cell and that he was seen by staff six times before being locked. One nurse remained with him for six minutes and, at interview, described Mr Deery's demeanour as, *"calm"* when she saw him in the evening. She said that he was, *"smiling and initiating the conversation and was telling me about (a family member)."*

At 19.33 Mr Deery was given a light for a cigarette and then locked for the night. At 20.00, it is recorded in Mr Deery's Prisoner at Risk booklet, *"Spent evening in cell with open door. Prefers to be alone at present."*

"Withdrawal of social contact" is also listed on the Prisoner at Risk booklet as a behaviour that should alert staff to the possibility that a prisoner may be considering self harm.

At 20.17 on 27 August, a nurse officer commencing her night shift duty checked all the cells on the wing, as part of a routine head count. This was the last time Mr Deery was seen alive.

At 20.27, the two nurse officers who were on night shift duty started to deal with a medical emergency only a few cells up from Mr Deery's cell. Both nurse officers were tied up dealing with this emergency until 21.28, when the prisoner concerned was taken to hospital. CCTV shows three prison officers, a senior officer and a dog handler on the landing, whilst the nurse officers were dealing with the emergency. At no stage during this period, did a member of staff check on the four prisoners in healthcare that had an open Prisoner at Risk booklet. This included Mr Deery.

At interview, one of the nurse officers said that she had become preoccupied with providing urgent medical assistance to another prisoner, which resulted in Mr Deery not being checked at the required time. The nurse officer said that she thought that in the future, in the event of a medical emergency, a principal officer or senior officer should ensure that all the prisoners are checked, particularly vulnerable prisoners who have an open Prisoner at Risk booklet.

After the medical emergency, both nurse officers tidied up the equipment used to deal with the incident. At 21.32 both nurse officers left the landing.

At interview, one of the nurse officers said that she and her colleague returned to the treatment room to replenish and restock the equipment used during the incident and to write up the medical records on the prisoner.

Eighteen minutes later, at 21.50, CCTV shows that one of the nurse officers arrived back on the landing. One minute later a senior officer arrived and shortly afterwards, commenced a check of all the prisoners with an open Prisoner at Risk booklet.

At 21.53, one hour and thirty six minutes after he was last observed, the senior officer looked through the observation flap of Mr Deery's cell. At interview, the senior officer said that he saw Mr Deery sitting in the dark at the back wall. He said that his, "*face was facing me*." The senior officer said that he did not speak to Mr Deery because it was a hospital landing and he finds that many patients with mental health difficulties are reluctant to engage with non healthcare staff. The senior officer did not have a torch with him when he was checking the cells.

At 21.55, the senior officer returned to the nurse's desk and asked the nurse officer to check on Mr Deery to ensure that he was okay. At 21.56 the nurse officer checked Mr Deery, as requested.

At interview, the nurse officer said that she looked into Mr Deery's cell and recalls seeing him in the dark. She said, *"He just looked like he was leaning against the bed."* The nurse officer said, she could not see his face and she called him, but got no response. She said that she was under the impression that Mr Deery was ignoring her and went to get a torch so that she could get a better look at him.

The nurse officer retrieved a torch from the desk whilst the senior officer re-checked Mr Deery. At 21.57, the nurse officer passed the torch to the senior officer and Mr Deery was checked again. Immediately the nurse officer ran off the landing to raise the alarm.

At 21.58, the senior officer entered Mr Deery's cell along with a night custody officer. There was no CCTV in Mr Deery's cell but after the incident and, in line with Prison Service policy, the senior officer completed a staff communication sheet. It is recorded on the communication sheet that Mr Deery had a ligature attached to the top bunk of his bed which was tied around his neck. It is further recorded that the senior officer lifted Mr Deery under his arms and the night

custody officer cut the ligature using a Hoffman knife. This account was confirmed at interview.

One of the questions asked by Mr Deery's family was whether he was brought back to life, to make it look like he didn't die in Prison.

At 21.59, CCTV shows that Mr Deery was lifted onto the landing by the senior officer and night custody officer. Both nurse officers immediately commenced Cardio Pulmonary Resuscitation (CPR) with the assistance of other staff. The medical staff attached the leads of a defibrillator to Mr Deery and an Ambu Bag[10] was used to provide him with oxygen. The nurse officer said at interview that at no stage did the defibrillator instruct them to administer a shock, which indicates that no heart rhythm was detected by the device.

The nurse officer said, *"I ascertained he had no pulse and he wasn't breathing……..He was dead, he had stopped breathing."* CPR continued and a nurse officer said that on each occasion that she checked, Mr Deery *"didn't have any cardiac output."*

At 22.18, the ambulance staff arrived on the landing. One of the clinical reviewers Mr Brackenbury said in his report that it is recorded in the paramedics notes that "*pulseless electrical activity was seen on the paramedic's heart monitor and accordingly adrenaline was administered. The heart monitor then showed a tachycardia."* A tachycardia is a rapid heart rate. Mr Deery began to make weak respiratory efforts, about 3-4 breaths per minute.

At 22.34, Mr Deery was wheeled off the landing on a stretcher. He was taken by emergency ambulance to the Royal Victoria Hospital, Belfast.

In his clinical review report, Mr Brackenbury stated that after Mr Deery was found, *"There is no evidence of clinical negligence from the prison staffs clinical management*

[10] Ambu Bag – a hand held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately.

of Mr Deery. A nurse officer worked hard to successfully maintain Mr Deery's circulation and respiration and should be commended for her efforts."

Mr Deery was first checked by the senior officer at 21.53. It was five minutes later, at 21.58, that his cell door was opened. He was lifted on to the landing at 21.59 and CPR commenced. The clinical reviewer, Mr Edward Brackenbury, was asked whether this delay impacted on Mr Deery's final outcome. Mr Brackenbury said *"on balance of probabilities, it is likely that Mr Deery took his own life sometime before the 21.53h check evidenced by the lack of pulse when found and there was therefore enough time to already have produced irreversible brain damage from which he could not be recovered despite rapidly restoring his circulation."*

A detailed summary of Mr Brackenbury's findings is at Section 28.

When staff re-entered Mr Deery's cell, a note was found addressed to two of his family members. The note said *"Sorry"* and told them that he loved them. It is not known when this letter was written.

On the afternoon of 28 August 2009, the Prison Service received confirmation that Mr Deery had passed away.

During the course of the investigation into the circumstances of Mr Deery's death, a number of concerns in connection with his care were identified that have been reported in previous Death in Custody investigations and recommendations made and accepted. A list of areas of concern previously identified in connection with the death of Colin Bell at Maghaberry Prison, are summarised in section nine of this report.

A number of areas were of particular concern.

Research has indicated that lower levels of self–inflicted death are associated with higher rates of purposeful activity and, in his review into Non-natural Deaths in Northern Ireland Prisons (November 2005), Professor Roy McClelland referred to the correlation between poor regimes and adverse effects on the mental well being

of offenders. Professor McClelland made a recommendation to the Northern Ireland Prison Service that more attention should go into the way that vulnerable prisoners spend their days. A further recommendation was made by the Prisoner Ombudsman following the death of Colin Bell.

The investigation found that Mr Deery spent 11 minutes or less out of his cell on the four days before his death and 44 minutes on the day of his death, including 21 minutes with a psychiatrist and 21 minutes being taken to reception to retrieve numbers from his mobile phone. Over the five days, the total time he spent having contact with staff or other prisoners during the fourteen or so hours he was awake each day, varied from 30 minutes to 102 minutes.

Mr Deery did not, as required by Prison Service policy, have a meaningful care plan and he was not assigned a care coordinator. In his review, Professor McClelland talked about the need for vulnerable prisoners to have a multi-disciplinary care plan and a care coordinator responsible for ensuring that the care plan elements are actioned. The Prisoner Ombudsman repeated these recommendations in her report into the death of Colin Bell. In the case of Mr Deery a care co-ordinator could, for example, have helped to ensure: appropriate observation and recording of information relevant to decision making; appropriate case conferencing arrangements; the development of a care plan; time out of cell; engagement in purposeful activity; early review by a psychiatrist and appropriate medicine management.

During Mr Deery's first two days in prison, most of the medicines he was taking before entering prison were prescribed. Two medicines, however, Zimovane (a strong sleeping tablet) and Gamanil (an antidepressant) were not prescribed until Mr Deery saw a psychiatrist on the day he died. This occurred even though Mr Deery's community psychiatric nurse had phoned the prison two days earlier to provide details of his medication. The clinical reviewer Dr Fazel said that a sudden withdrawal of Gamanil can lead to withdrawal symptoms, which generally begin within 24-48 hours of discontinuing the drug and peak on day five. The main symptoms are dizziness, headache, nausea and flu-like symptoms, as well as anxiety, confusion, irritability, excessive dreaming and insomnia.

On 22 August, during the night, Mr Deery was given two paracetamol tablets for an unspecified reason. On the 24 August, he was given paracetamol when he complained of a headache. It is not, however, possible to say whether or not these were connected with the withdrawal of Gamanil. It is, however, the case that the withdrawal of the drug could have contributed to Mr Deery's mood and demeanour at the time of his death.

These and other areas of concern are discussed fully at Section 7 of the report.

As a result of my investigation, I make 12 recommendations to the Northern Ireland Prison Service and South Eastern Health and Social Care Trust.

Where appropriate, I have tried to make recommendations more strategic and overarching in order that the responsibility for the detail lies with the Prison Service and the South Eastern Health and Social Care Trust, and recommendations can be effectively integrated into current service development initiatives.

RECOMMENDATIONS

As a result of my investigation I make 12 recommendations to the Northern Ireland Prison Service. A number of the recommendations relate to the provision of healthcare and are, therefore, made to the Prison Service and the South Eastern Health and Social Care Trust (SEHSCT).

I shall request updates on the implementation of these recommendations in line with the action plan provided by the Prison Service.

Recommendation 1

I recommend that the Governing Governor of each of Northern Ireland's prisons arranges for a robust audit of the implementation of the recommendations in the areas listed below, which were made and accepted after the death of Colin Bell (CB). The audit should be completed and reported by Friday 14 January 2011.

Areas to be audited

- Full compliance with Prison Service policy and guidelines for the carrying out and recording of observations of vulnerable prisoners. (CB Recommendations 1, 6 & 15)

- Requirement for checks to be conversational. (CB Recommendation 4)

- Requirement for checks to be carried out at unpredictable intervals. (CB Recommendation 5)

- Requirement for frequency of checks to be subject to individual risk assessment and recorded. (CB Recommendation 7)

- Requirement for appropriate briefing and training for staff working with vulnerable prisoners. (CB Recommendation 22)

- Requirement for an appropriate and recorded handover at shift changes. (CB Recommendation 25)

- Requirement for senior officers to routinely check landing and secure POD records and discuss monitoring and observations with staff. (CB Recommendation 30)

- Requirement to consistently deliver a purposeful regime for vulnerable prisoners. (CB Recommendation 32)

- Requirement for each vulnerable prisoner with a multi-disciplinary Care Plan to have a Care Co-ordinator. (CB Recommendation 33)

- Requirement for ongoing robust self audit to measure standards on all prisoner care issues. (CB Recommendation 42)

Recommendation 2

I further recommend that immediate action is taken to address any performance shortfalls highlighted by the audits

Recommendation 3

I recommend that the Prison Service and SEHSCT review the arrangements for the staffing, supervision, management and delivery of appropriate clinical and professional standards in the Maghaberry Healthcare Centre and implement the changes required.

Recommendation 4

I recommend that the Prison Service and SEHSCT ensure that for every shift, on every landing, it is agreed, for each vulnerable prisoner, which officer/nurse is responsible for carrying out required observations.

Recommendation 5

I recommend that the Prison Service and SEHSCT ensures that all staff who work with vulnerable prisoners record all information that may influence care plans and may be important to staff on future shifts.

Recommendation 6

I recommend that the SEHSCT carries out a review of medicine management. This should include: arrangements for contacting a prisoner's GP at the earliest possible opportunity following committal; prescribing arrangements; arrangements for giving out medicines in line with prescriptions and arrangements for recording all medicines given out on medical records. Appropriate action should be taken to address any performance shortfalls and to audit compliance with adjustments made.

Recommendation 7

I recommend that the Prison Service and SEHSCT review the Self Harm and Suicide Prevention policy and SPAR booklet (which replaced PAR) to ensure that they are fully up to date, consistent and appropriate and make any adjustments necessary. In carrying out this review, I further recommend that account is taken of the comments of the clinical reviewer Dr Fazel in respect of the treatment of risk factors.

(Dr Fazel's comments can be found at Section 8(5) of this Report.)

Recommendation 8

I recommend that the Prison Service Self Harm and Suicide Prevention policy is also amended to include guidance on the requirements to be satisfied when a decision to cease the use of anti-suicide clothing is made.

Recommendation 9

I recommend that attendance at multi-disciplinary case conferences should be as specified by Prison Service policy and that consideration should also be given to circumstances where the attendance of a doctor or psychiatrist would be appropriate.

Recommendation 10

I further recommend that the Prison Service and SEHSCT ensures, in line with Prison Service policy, that at or immediately following a case conference to discuss any vulnerable prisoners, a comprehensive and meaningful care plan is written/updated.

Recommendation 11

I recommend that the Prison Service reviews the role and responsibilities of the Safer Custody Co-ordinator at each prison to ensure that these are fit for purpose.

Recommendation 12

I recommend that the Prison Service and SEHSCT produce an action plan for the implementation of the recommendations made as a result of the internal disciplinary investigation.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. The Prisoner Ombudsman[11] for Northern Ireland has responsibility for investigating the death of Mr John Anthony Deery who died on the 28 August 2009 in the Royal Victoria Hospital, whilst in the custody of Maghaberry Prison. The Prisoner Ombudsman's Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Appendix 1.

2. The investigation provides enhanced transparency into the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. The Prisoner Ombudsman's office is independent of the Prison Service. As required by law, the Police Service of Northern Ireland continues to be notified of all deaths in custody.

Objectives

4. The objectives for the investigation into Mr Deery's death are:

- to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;

- to examine any relevant healthcare issues and assess the clinical care afforded by the Prison Service;

[11] The Prisoner Ombudsman became responsible for the investigation of deaths in prison custody in Northern Ireland from 1 September 2005.

- to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;

- to ensure that Mr Deery's family are given the opportunity to raise any concerns that they may have and that these are taken into account in the investigation; and

- to assist the Coroner's inquest.

Family Liaison

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the family.

6. The Prisoner Ombudsman first met with Mr Deery's family on 24 September 2009 and was grateful for the opportunity to keep in contact with them on further occasions, to update them on the progress of the investigation. In November 2010 the Ombudsman met the Deery family to explain and discuss the findings and recommendations within this report.

7. It was important for the investigation to learn more about Mr Deery and his life from his family. The Prisoner Ombudsman would like to thank Mr Deery's family for giving her the opportunity to talk with them about him and the circumstances of his death.

8. Although the report will inform many interested parties, it is written primarily with Mr Deery's family in mind. It is also written in the trust that it will inform policy or practice, which may make a contribution to the prevention of a similar death in future at Maghaberry Prison or any other Northern Ireland Prison Service establishment.

9. Mr Deery's family asked the following questions:

- Why did Mr Deery's observations change from 15 minute intervals to hourly intervals, given his medical history and how vulnerable he was?

- How did Mr Deery manage to use his shoe laces to commit suicide when he was on *"suicide watch"* and should his shoe laces have been removed?

- Why was Mr Deery moved from an observation cell to a normal cell considering his circumstances?

- What mental health support did Mr Deery receive and, was he seen by a psychiatrist?

- Did Mr Deery die in Maghaberry and was he brought back to life to make it look as though he didn't die in Prison?

INVESTIGATION METHODOLOGY

Notification

10. On 27 August 2009, the Prisoner Ombudsman's office was notified by the Prison Service that Mr Deery had been found hanging in his cell, but that staff and paramedics had managed to obtain a pulse.

11. A member of the Ombudsman's investigation team attended Maghaberry Prison on 27 August 2009 to be briefed about the series of events before and after staff found Mr Deery hanging in his cell.

12. On 28 August 2009, the Prisoner Ombudsman's office was notified by the Prison Service that Mr Deery had died.

13. The investigation into Mr Deery's death began on 28 August 2009. Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison, inviting anyone with information relevant to Mr Deery's death to contact the investigation team.

Notice to Prisoners

14. One prisoner came forward in response to the Notice to Prisoners.

Prison Records and Interviews

15. Maghaberry Prison was visited by the investigation team on numerous occasions and investigators met with prison management, staff and prisoners. All the prison records relating to Mr Deery's period of custody, including his medical records and the internal disciplinary investigation, were obtained.

16. Interviews were carried out with prison and health service management and staff in order to obtain information about the circumstances surrounding Mr Deery's death.

Telephone Calls and CCTV Footage

17. During Mr Deery's period of custody, he made no telephone calls using the main prisoner PinPhone[12] system. Any calls he did make were not, therefore, recorded.

18. Copies of all CCTV coverage of Mr Deery's period of time in Lagan House and the temporary healthcare facility in Bush House were obtained and reviewed.

Maghaberry Prison, Prison Rules and Policies

19. Background information on Maghaberry Prison and a summary of Prison Rules and Procedures referred to in the report are attached as Appendix 2.

Early Investigative Findings

20. As a result of an initial review of Prison Service records and enquiries into Mr Deery's death by the investigation team, it was deemed appropriate to share a number of early observations with the Prison Service and South Eastern Health and Social Care Trust, in advance of this report.

21. It was the Prisoner Ombudsman's view that action in respect of these findings could impact upon the risk of a similar death occurring and, as such it would have been inappropriate to wait for the production of the final investigation report. Section 1 of this report provides further information in respect of the action taken.

[12] PinPhone – The payphone system prisoners have access to on the landings – all calls are recorded.

Autopsy & Toxicology Report

22. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy report.

Clinical Reviews

23. As part of the investigation into Mr Deery's death, Dr Seena Fazel, Consultant Forensic Psychiatrist and Clinical Senior Lecturer in Forensic Psychiatry at the University of Oxford, was commissioned to carry out a clinical review of Mr Deery's mental health needs and medical treatment whilst in prison.

24. Mr Edward Brackenbury, Consultant Cardiothoracic Surgeon at the Royal Infirmary of Edinburgh, was commissioned to provide his expert opinion of the actions taken by the staff who found Mr Deery and the medical care he received after he was found.

25. The Prisoner Ombudsman is grateful to Dr Fazel and Mr Brackenbury for their assistance. Both clinical reviews have informed some of the findings and recommendations in this investigative report.

Working together with interested parties

26. An integral part of any investigation is to work together with all the interested parties involved. To that end the investigation team liaised with the Police Service of Northern Ireland.

Previous Prisoner Ombudsman & Criminal Justice Inspectorate Reports/Recommendations

27. Previous recommendations made to the Northern Ireland Prison Service by the Prisoner Ombudsman and the Criminal Justice Inspectorate, which are

relevant to the circumstances surrounding Mr Deery's death, have been considered and are referred to within this report.

Factual Accuracy Check

28. The Prisoner Ombudsman submitted the draft investigation report to the Director of the Northern Ireland Prison Service and South Eastern Health and Social Care Trust for a factual accuracy check.

29. The Prison Service and Trust responded with a list of comments for the Prisoner Ombudsman's consideration. These have been fully considered and amendments have been made where appropriate.

FINDINGS

SECTION 1: EARLY INVESTIGATION

1. Overview of Findings of Initial Case Review

Immediately following Mr Deery's death, the Prisoner Ombudsman's investigation team carried out a complete review of Mr Deery's prison records and of all the relevant CCTV footage.

The early investigation identified the following possible areas of concern in connection with Mr Deery's care:

- Staff recording that observations required by Prison Service policy had taken place when checks had not been carried out.
- Observations not being carried out at the required intervals.
- Observations being completed retrospectively and, at times, a number of retrospective observations being recorded at the same time.
- No evidence of supervisory/management action to question or address gaps in the observation sheets of the Prisoner at Risk booklet[13].
- Recorded observations which were inconsistent with Mr Deery's actions observed on CCTV.

[13] Prisoner at Risk booklet – Used when a prisoner shows low coping skill or has threatened to self harm. The prisoner is classed as vulnerable and extra measures are put in place to increase the number of observations carried out on the individual. Multi-Disciplinary case conferences are also held to agree the best care plan to manage the individual.

- Staff on the telephone/computer at times when observations were not recorded.

- Important information about Mr Deery's behaviour, demeanour and interaction with staff which might affect his future care plan not being recorded.

- The quality and limited extent of Mr Deery's regime and interactions with staff.

It was considered appropriate to immediately share these concerns with Senior Management from the Prison Service and South Eastern Health and Social Care Trust (SEHSCT). The findings were presented at two separate meetings on 30 September 2009 and 19 October 2009.

The Senior Management of both organisations were also asked to urgently bring to the attention of their staff, the following key learning points:

1. Staff must complete the Prisoner at Risk booklet and POD observations[14] at the time intervals determined and record their findings immediately afterwards.

2. Staff must record observations at the time they are carried out. If an observation is missed for any reason it should be recorded accurately at the time the actual observation took place and the reason for the delay noted.

3. Staff should never make up information because an observation has been missed.

[14] POD Observations – Lagan House has a secure POD where an officer will be stationed 24/7. The officer in the secure POD monitors and controls access into and throughout the house. The POD officer has CCTV monitors which allow him/her to view all CCTV in the house. Lagan House has two observations cells with in-cell CCTV which the POD officers are required to monitor and record their observations, at the required intervals.

4. Staff should manage their telephone time/personal calls and avoid calls that interfere with the carrying out of required observations/record keeping.

5. Staff should manage their computer time/activity in order that it does not interfere with required observations/record keeping.

6. If a POD officer sees that a prisoner is unwell or agitated, he or she should inform landing staff and record that the conversation took place.

7. Staff must record all relevant care information: conversations, demeanour, food offered/taken, amount of sleeping, how time is spent in cell etc. This information may influence case conference decisions including the frequency of observations required and the prisoner's future care plan.

8. Staff should record whenever time out of cell is offered and refused with reasons and action taken.

9. Staff should, wherever the prisoner is awake, make observation checks conversational.

10. Staff should maximise engagement in purposeful activity and record all activity/time out of cell.

Following the initial meeting, the Prison Service and SEHSCT informed the Prisoner Ombudsman of their intention to conduct an urgent internal disciplinary investigation into all of the matters raised. Two governors and a personnel manager from the SEHSCT were appointed to carry out this investigation.

2. Prison Service/Trust Internal Disciplinary Investigation

On 5 October 2009, the internal disciplinary investigation team met with the Governor of Maghaberry Prison who provided them with their terms of reference.

The Prisoner Ombudsman's early findings highlighted 148 instances of possible concern, all of which were investigated by the internal disciplinary investigation team.

The internal disciplinary investigation team carried out interviews of all staff identified in the Prisoner Ombudsman's findings and, as a result, a number of systemic weaknesses were highlighted and reported to the governor at Maghaberry Prison on 8 February 2010.

These included:

- A lack of clarity in policy in relation to whether it is acceptable that recordings of observations are completed by third parties.
- A lack of clarity in policy in relation to the timing of entries recorded – should they be logged as the time of the observation or the time of entry?
- Insufficient rigour in the application of management /supervisory responsibilities.
- A lack of clarity in relation to who is responsible for the completion of the observations in the Prisoner at Risk booklet, on a shift by shift basis.
- Inconsistent handover procedures.
- A lack of therapeutic care being afforded to Mr Deery.

The internal investigation found that a number of areas of possible concern highlighted by the Prisoner Ombudsman were due to the lack of clarity in respect of the matters of policy application highlighted above.

Recommendations of the Internal Disciplinary Investigation Team

The internal disciplinary investigation made recommendations to the senior management team of Maghaberry as follows:

1. The NIPS Suicide and Self Harm Prevention policy should be updated, further to its January 2009 revision, to clarify the following:

    a. The current SPAR Process[15] and ASIST[16] training.
    b. The use of 3rd party reporting and whether this is permitted.
    c. How observation log entries are timed (at the time of entry or observation).
    d. How the frequency of prisoner observations can be changed.
    e. The difference between a "review" and a "case conference". It was found that these had been used interchangeably and had caused some confusion.

2. Each landing should have detailed on the shift rota duties, an individual staff member who will be responsible for any open Prisoner at Risk booklet on their landing, therefore, providing a clear line of accountability.

3. There should be improved handover procedures which are the responsibility of the house manager.

4. There should be improved page layout of the observational logs, to allow more space for detailed comments to be recorded.

5. There should be a training needs analysis to address the shortfalls in leadership of the healthcare team.

[15] SPAR Definition - **S**upporting **P**risoners **A**t **R**isk is a new policy/process which came into effect on 1 December 2009 and supersedes the previous PAR 1 policy/process.
[16] ASIST Training – **A**pplied **S**uicide **I**ntervention **S**kills training.

6. Disciplinary proceedings should be initiated for nine staff alleged to have carried out gross misconduct, gross neglect of duty and general misconduct.

7. Performance reviews should be organised for 25 staff identified as having performance issues and remedial action taken.

8. There should be a referral to the National Medical Counsel of nursing staff implicated in the disciplinary procedures.

9. Break times for night shift staff in healthcare should be clearly defined in policy and subject to regulation by the lead nurse in charge.

Disciplinary proceedings are ongoing.

Evidence of Good Practice

The findings of this investigation and the Prison Service's internal disciplinary investigation showed that a number of staff carried out their role in a consistently professional manner. There was also evidence of implementation of some previous recommendations made by the Prisoner Ombudsman.

The Prisoner Ombudsman found:

- Numerous instances where officers carried out the correct observations at the correct times and accurately recorded them.

- Times where particular officers and healthcare staff members had significant contact with Mr Deery, talking with him, bringing him drinks and providing him with cigarettes.

- Examples of individual staff members and senior officers being particularly conscientious in carrying out their duties and checks.

- Mr Deery being provided with a blanket throughout his period in the observation cell[17].

- POD staff changes taking place during the period of the night shift so that one officer is not confined to the POD and, therefore, not responsible for CCTV observations for a full shift.

[17] Observation Cell – A cell designed to house vulnerable prisoners in imminent risk of self harm. This type of cell has reduced ligature points, an in cell CCTV camera which allows a prisoner to be monitored around the clock and an intercom which allows the occupant to directly speak with an officer in the POD or call the Samaritan.

SECTION 2: THE PRISONER OMBUDSMAN INVESTIGATION - MR DEERY'S TIME IN LAGAN HOUSE FROM 22 AUGUST TO 25 AUGUST 2009

3. Mr Deery's move to an Observation Cell

On 22 August 2009, Mr Deery was assessed by a committal nurse officer on his arrival at Maghaberry Prison. During the committal interview, the nurse officer established that Mr Deery had thrown himself down the stairs of a courthouse earlier that day and had attempted an overdose earlier that week. The nurse officer recorded that Mr Deery told her that he had *"no reason for living (and) didn't wish to reach the age of 50."* Mr Deery's 50th birthday had been on 18 August 2009. As a result of the discussion, the nurse officer opened a Prisoner at Risk booklet.

A Prisoner at Risk booklet (now replaced by the SPAR booklet) is used when a prisoner shows low coping skills or has threatened to self harm. The prisoner is classed as vulnerable and extra measures are put in place to increase the number of observations carried out on the individual. The Prisoner at Risk booklet always moves with the prisoner and is intended to be a comprehensive record of information relevant to the care of the prisoner.

In line with Prison Service policy, Mr Deery was interviewed by the residential manager and authorisation was sought from the duty governor to move Mr Deery to an observation cell in Lagan House.

The residential manager recorded his decision to move Mr Deery to an observation cell as, *"Inmate has attempted self harm and maintains he intends to kill himself. Duty Governor has authorised move to safer (observation) cell in Lagan."*

Mr Deery signed a form agreeing that he had been informed of the reason for moving him to an observation cell.

4. Mr Deery's first night in Maghaberry Prison

At 16.54 on 22 August 2009, Mr Deery was taken to his observation cell by a senior officer and two other officers. It is recorded that Mr Deery was *"in good spirits but a little tearful."*

In line with Prison Service policy, which states, *"prisoners will be routinely placed in the observation cell with their own clothing, staff should ensure shoe laces and belts are removed,"* Mr Deery was left in his own clothing, but his shoe laces were taken. He did not have a belt.

During that evening, Mr Deery made contact with the Samaritans[18] on two occasions. The first call lasted for 13 minutes and the second call lasted for eight minutes. Mr Deery was also seen by a governor who recorded on the Prisoner at Risk booklet that he *"explained why he (Mr Deery) was placed in an obs cell."* A nurse officer also saw Mr Deery that evening and gave him Chlorpromazine Hydrochloride (antipsychotic drug) and Diazepam (a sedative) and an oral spray for his angina. During the course of the evening, CCTV shows that Mr Deery, at times, walked around his cell, looked out of the window and sat on the edge of his bed rocking.

Mr Deery went to bed at 19.55 and remained there for the rest of the night, except for a period in the early hours of the next morning when he requested two paracetamol tablets. Whilst Mr Deery was waiting for his tablets, he sat on the edge of his bed rocking. The paracetamol was provided by the duty nurse. It is not known what the paracetamol was for as this was not recorded in Mr Deery's medical records or Prisoner at Risk booklet.

[18] Samaritans – The Samaritans provide a direct telephone service for prisoners located in observation cells. Details of these conversations are confidential and as such are not requested as part of the investigation.

5. Key events of 23 August 2009

A review of Mr Deery's Prisoner at Risk booklet, medical records and CCTV shows that on the 23 August, he had significant interaction with staff and he spoke twice with the Samaritans. One of Mr Deery's conversations with the Samaritans lasted for approximately 30 minutes and the other approximately 40 minutes. Mr Deery was seen to be upset during the longer conversation.

Prior to his committal to prison, Mr Deery smoked approximately 30 cigarettes per day and it is recorded in his Prisoner at Risk booklet that one of his triggers of heightened anxiety and risk, is a lack of tobacco. It is evident from CCTV that staff, and in particular one officer, was extremely aware of Mr Deery's need for cigarettes and provided these for him throughout the day, engaging in conversation with him on every occasion.

At 09.00, Mr Deery refused breakfast and afterwards a governor went into his cell. It is recorded in the Prisoner at Risk booklet that, *"he (Mr Deery) was worried about (a family member). He became tearful for a while and said he wanted to end it all."* Soon after, Mr Deery was seen by another governor and it is recorded that Mr Deery was, *"still having thoughts of self harm."*

Between 11.35 and 11.44, Mr Deery was seen by a nurse and prison doctor. The nurse officer recorded in Mr Deery's Prisoner at Risk booklet *"spoke with me about his medication. I informed him that the Dr will be coming in to write up his medication today."* There is no entry in Mr Deery's medical records in relation to this consultation with the house nurse.

The doctor recorded on Mr Deery's medical records that he examined Mr Deery in relation to an injury he had received to his right wrist, when he fell down the stairs of the court house the previous day. The doctor also authorised all of Mr Deery's medication that he had been receiving prior to coming into prison, with the exception of the sleeping tablet Zimovane, the

antidepressant Gamanil and Lansoprazole, a tablet for managing gastric fluid.

Prison Service policy states, "*When a Prisoner at Risk booklet is opened, this **will** become the primary record of all interactions and events concerning the management of the prisoner."* One of the reasons for this policy is that, whilst medical staff should always complete medical records, prison service staff cannot access healthcare records for reasons of confidentiality. There is no entry in Mr Deery's Prisoner at Risk booklet to show that the consultation with the doctor on 23 August took place.

On his return from seeing the nurse and prison doctor, Mr Deery talked with an officer in his cell. An entry in the Prisoner at Risk booklet records *"talked about hunger strike form[19]. Rang medic. They are aware."* There is no entry on Mr Deery's medical records to note this phone call. Shortly after this, Mr Deery refused his lunch.

CCTV shows that when Mr Deery was not smoking or speaking with staff members that morning he mainly lay on his bed with a blanket over him.

On the afternoon of 23 August, a family officer visited Mr Deery in his cell. An entry in the Prisoner at Risk booklet records, *"spoke with John in observation cell, very concerned about (a family member) obtained phone number of priest who he is friends with. Will make contact and see if we can find out how his (family member) is. Spoke clearly, although quite shaky."*

CCTV shows that before the family officer visited Mr Deery, he was walking around his cell and sitting on the edge of his bed rocking. Soon after the family officer left his cell, Mr Deery was offered his tea meal. Mr Deery appeared to tell the officer that he didn't want the meal and the meal was left on the bench in the cell. Within a few minutes, Mr Deery ate his tea.

[19] Hunger Strike Form - A detailed form which is completed when an inmate deliberately refuses to consume food.

At 19.43, a nurse officer went into Mr Deery's cell to give him his medication. Mr Deery refused the medication and it is recorded in the Prisoner at Risk booklet that the reason for this was that, *"…(it was) not what he wanted"* and that the, *"medic calmed John and said (he) would check his medication."* Mr Deery then repeatedly banged his head off the wall 28 times. Shortly after this, the nurse office left and Mr Deery sat crying and rocking on the edge of his bed. On three occasions he punched the cell window. The nurse officer then returned with other medication which Mr Deery took.

At 21.35 a Listener[20] entered Mr Deery's cell and he and Mr Deery spoke for 25 minutes. A bump on Mr Deery's head was noted by the listener and afterwards a healthcare officer saw Mr Deery in relation to this injury. When the healthcare officer entered the cell, Mr Deery gave him a big hug, and talked with him for 24 minutes. After the healthcare officer left Mr Deery's cell he was upset and he sat on the edge of his bed crying and rocking.

At 23.03, three prison officers went into Mr Deery's cell and Mr Deery then changed into anti-suicide clothing[21]. It is recorded on the Prisoner at Risk booklet that Mr Deery *"changed into suicide clothing on medics request."* The corresponding entry on the medical records notes that *"he (Mr Deery) has problems of bad dreams at night and he has present thoughts of DSH (deliberate self harm) namely hanging."*

Prison Service policy states that the decision/authorisation to place an inmate into anti-suicide clothing, can only be granted by the governor. There is no evidence that the decision to place Mr Deery in anti-suicide clothing was authorised by a governor and it was not recorded as required by Prison Service policy on the CRC 1[22] form. It is, however, likely that the governor would have supported the healthcare officer's decision in this instance.

[20] Listener – The Northern Ireland Prison Service and Samaritans, run a peer/listener support scheme, whereby prisoners can volunteer to be trained by the Samaritans so that they can support vulnerable prisoners by encouraging the flow of information whilst maintaining their confidentiality.
[21] Anti Suicide Clothing – Clothing especially designed for inmates to reduce the likelihood of self harming.
[22] CRC 1 Definition – Confinement Restraint Clothing Form used to authorise use of a protected room/special accommodation/special clothing/mechanical restraint.

Mr Deery went to bed at 23.25, where he remained for the rest of the night.

The total time that Mr Deery spent talking/interacting with staff and another prisoner on 23 August 2009 between 09.00 and 23.25, was approximately 102 minutes.

Mr Deery left his cell twice during the day. Once for 11 minutes to see the nurse/doctor and once, for approx one minute, when he walked along the corridor with an officer.

6. Key Events of 24 August 2009

At 09.40 on 24 August 2009, the principal officer for Lagan House talked with Mr Deery for approximately 18 minutes in his cell. An entry in the Prisoner at Risk booklet records, *"Had long chat with John in Obs Cell. Has a long history of self harm. Before coming into prison he tried to hang himself and was committed to Gransha. He has also overdosed in the past few weeks.....he is very upset and weepy. Healthcare staff aware of him as he spent nearly 4yrs in the prison hospital during his last sentence."*

Later that morning at 11.12, Mr Deery was visited by a prison doctor. The doctor noted on Mr Deery's medical records:

"History of not coping in prison and had been in hospital before. I think we should retain in obs cell until seen by the MHT (mental health team). No beds in hospital at present. Habitual self harmer and ischaemic heart disease."

Shortly after being seen by the prison doctor, Mr Deery was visited by a prison chaplain, who talked with Mr Deery for approximately 14 minutes. It is recorded that Mr Deery was emotional but was *"able to have a good conversation."*

Over the lunchtime lockdown period, it is recorded that Mr Deery looked *"very down"* and *"very sad."*

During the afternoon, a nurse officer saw Mr Deery to give him his medication. He was also seen by a probation officer as part of the committal process. At 16.34, Mr Deery contacted the Samaritans and spoke with them for approximately 25 minutes. Throughout the afternoon/evening, Mr Deery's mood appeared to have improved and it is recorded that he seemed *"a lot happier"* and he seemed *"to be in good form."*

Later on that night, at 21.17, Mr Deery complained of a headache and, with the permission of a nurse officer, staff provided him with two paracetamol

tablets. For the next two hours, before Mr Deery went to bed, he looked restless and was fidgeting or rocking on his bed.

Overall engagement with Mr Deery, by staff and others, was noticeably less than the previous day. The total time spent interacting with staff between the time of getting up and going to bed was approximately 70 minutes. Mr Deery was also offered far fewer cigarettes and left his cell for just one minute on 24 August.

SECTION 3: MR DEERY'S MOVE TO HEALTHCARE ON 25 AUGUST 2009

7. Key Events of the Morning of 25 August 2009

Mr Deery woke at 08.34 on 25 August 2009 and shortly afterwards a principal officer spoke to him for approximately one minute. CCTV shows that Mr Deery was then rocking, before going back to bed. A Prisoner at Risk booklet entry states, *"08.35 Talked to John in (observation) cell. Complained his (medication was) wrong and he was not eating. I saw nurse – His (medication has) arrived and will be dispensed this morning."*

Sixteen minutes later, at 08.50 Mr Deery was given milk by two prison officers and then sat on the edge of his bed smoking and crying.

At 09.07 CCTV shows, the same principal officer returned to the cell and spoke to Mr Deery for six minutes. In the middle of the conversation Mr Deery shook the principal officer's hand. After the principal officer left, other prison officers entered the cell to give Mr Deery coffee/tea and a light for a cigarette. At 10.17, a nursing officer spoke to Mr Deery for seven minutes. None of this interaction is recorded in the Prisoner at Risk booklet.

Approximately 1 hour and 12 minutes later a nurse officer and a doctor saw Mr Deery, gave him medication and took his pulse. An entry in the Prisoner at Risk booklet states, *"Remain (in) observation until seen by mental health team."*

At 11.53 Mr Deery was given and ate his lunch.

8. Decision to move Mr Deery to Healthcare

One of the questions asked by Mr Deery's family was why, in view of his vulnerable state, Mr Deery had been moved from an observation cell to a normal cell in healthcare.

It is Prison Service policy, in line with best practice, not to locate a prisoner in an observation cell for longer than is necessary for their safety and well being.

The January 2009 addendum to the Self Harm and Suicide Prevention policy 2006, states, *"Prisoners should not continue to be accommodated in observation cells for more than 24 hours unless there are exceptional concerns or reasons identified at the case conference and outlined on the CRC 1 application.....If circumstances persist for more than 48 hours the case should be referred to the Suicide Prevention Co-ordinator, who will organise a multi-disciplinary case conference with key professionals to discuss issues which require to be addressed."*

A multi-disciplinary case conference was organised for 25 August 2009.

Plans for the Case Conference

A healthcare officer who was on duty in Lagan House on 25 August said at interview, that the Lagan House principal officer had approached him the morning of the case conference and told him that Mr Deery had spent too long in the observation cell and, therefore, *"he wanted him moved so that he (Mr Deery) would no longer be the responsibility of discipline staff."* The healthcare officer said that he told the principal officer *"he (Mr Deery) was in the safest place and should remain there, and should only be moved if mental health or a doctor recommended (this)."*

At interview, the Lagan House principal officer said that when he reviewed Mr Deery's Prisoner at Risk booklet *"it was (recorded) by a doctor that John*

Deery had to be seen by the Mental Health Team before he was moved." The principal officer said he requested a member of the mental health team to attend the case conference.

At interview, the mental health nurse said that *"One of the senior officers had asked for a volunteer to go and assist with a case conference, and the case conference was regarding John Deery. I knew Prisoner Deery fairly well from a previous time in jail, so I volunteered to attend the case conference."*

The mental health nurse also said that when he attended Lagan House he *"was being sort of pressured beforehand into moving him…it was quite apparent that the staff wanted him out of Lagan. He'd been in there four days and they felt it was too long. Now I sort of, I disagreed with that. Not verbally. I disagreed with that opinion because I felt that the staff were thinking more of the process of the Prisoner at Risk booklet and observation cell than the individual …. But after speaking to John I actually would agree (that he needed to move)."*

Prior to the case conference at 14.23, the mental health nurse spent approximately 32 minutes talking with Mr Deery. The mental health nurse said at interview that Mr Deery talked about the circumstances which lead to him being back in prison. The nurse said *"I wasn't there to do a full mental health assessment. I was there just to assist in the case conference but obviously I was giving him a mini mental health assessment…….I was getting enough information at that time to try and assist the healthcare aspect of the case conference."*

Return of Mr Deery's Clothing

At 14.55, prior to the case conference taking place, CCTV shows that, as the mental health nurse left Mr Deery's cell, the Lagan principal officer entered and handed a brown paper bag to Mr Deery containing his clothing and shoes. Mr Deery was then left to change out of the anti-suicide clothing he

was wearing and into his own clothes. Mr Deery was not given his shoe laces.

There is no record in the Prisoner at Risk booklet of this action taking place or the reason for it.

It is best practice that no one wears anti-suicide clothing for longer than is determined necessary for their own safety and well being. The investigation found, however, that there is no guidance in Prison Service policy as to what procedures or reviews should take place, prior to the decision being made to allow a prisoner to have their own clothing returned. The CRC 1 authorisation document, which requires a governor to provide reasons for a prisoner to remain in anti-suicide clothing, does not have a similar section requiring reasons for determining that anti-suicide clothing is no longer required.

9. Lagan House Case Conference

At 15.00 on 25 August 2009, a multi-disciplinary case conference was held to consider whether Mr Deery should remain in the observation cell and to look at his future care plan. The case conference was attended by the Lagan House principal officer, Maghaberry's suicide prevention co-ordinator, a probation officer and a mental health nurse.

The Northern Ireland Prison Service Revised Self Harm and Suicide Prevention policy states that *"those attending should include the originator of the prisoner at risk form, his/her manager, the residential governor who will chair the meeting, a member of healthcare and representatives from probation and psychology and where appropriate the prisoner concerned."*

More recently, the Prisoner Ombudsman has made a recommendation to the Northern Ireland Prison Service that consideration should be given as to whether the attendance of a doctor or psychiatrist at a case conference may be appropriate.

Mr Deery was seen at different times by three doctors prior to the case conference, but because the Prisoner at Risk booklet had not been filled in by the prison doctor who saw Mr Deery on 23 August, the members of the case conference were unaware of the consultation.

At interview, the mental health nurse said that at the case conference, *"the overall impression was that from when he (Mr Deery) first came into Lagan to this point, he had improved. You know, his situation had resolved, his self harm thoughts had decreased."*

A summary of the case conference was recorded as follows:

"John has a long history of self harm and over the past couple of days in the observation cell has been very weepy……Probation have seen him and 2

doctors. Mental health nurse said that he presents as he always has in the past and should be moved to healthcare."

At interview, the mental health nurse disagreed with the record of the case conference written by the principal officer. He said that he had not recommended that Mr Deery should be moved to healthcare, but that this was in fact an agreement by everyone present.

At interview, the principal officer said that his summary of the case conference was correct. He said that *"during this case conference it was decided to move him but it was on the decision... it was on the recommendation by (the mental health nurse) that he move to healthcare, and it was his clinical recommendation that he (Mr Deery) moved and we all agreed, because that's why I brought (the mental health nurse) into the case conference, to help us make this decision."*

At interview, the suicide prevention co-ordinator said, *"I don't have a right to admit him (Mr Deery), and neither does any discipline member of staff. It's a healthcare issue to admit someone in healthcare.... it was a suggestion from (the mental health nurse) shared with the rest of the case conference going... and obviously we are not (going to) go against a clinical decision."*

The suicide prevention co-ordinator further said that in relation to the decision to move Mr Deery to healthcare, it is *"a much better environment than being placed in an observation cell. Although he was engaging more with staff and so forth at that particular time..... it's not the same engagement that I would expect him to be getting in a healthcare environment, because it's more therapeutic, which has access to occupational therapists, which has access on a daily basis to psychiatrists, which has access on a daily basis to a doctor, which has access on a daily basis to a therapeutic environment managed appropriately by the nursing staff inside this establishment, who are mental health trained nurses."*

The suicide prevention co-ordinator also said that *"We acknowledged that Mr Deery was still at risk……And that's why the Prisoner at Risk booklet was not closed and that's why it was retained and he remained on the Prisoner at Risk booklet."*

Prison Service policy provides for a prisoner to attend a case conference where he is to be discussed. At interview the principal officer said that he talked with Mr Deery on the morning of the case conference to ask him if he wanted to attend and to discuss the possibility of him being moved to healthcare. The principal officer said that Mr Deery did not want to attend the case conference but the principal officer said that when Mr Deery heard that he might be moving to healthcare, *"it cheered him up no end."* The conversation was not noted on the Prisoner at Risk booklet.

Record of the Case Conference

Prison Service policy states that *"a comprehensive and meaningful Care Plan must be drawn up and documented by the residential manager at, or immediately following the case conference."*

A comprehensive and meaningful care plan was not recorded at or after the case conference on 25 August.

At interviews with the safer custody co-ordinator and probation officer, they said that other concerns and actions were also discussed at the case conference in the context of Mr Deery's future care plan, but were not recorded. These included:

- Making contact with Mr Deery's priest to ask him to come into prison.
- Involving Mr Deery in the family link service[23].

[23] Family Link Service – NIACRO (Northern Ireland Association for the Care and Rehabilitation of Offenders) provides a family link service to support prisoners by assisting with contacting families, assisting them with visits, leaving money in etc.

- Being aware that Mr Deery was anxious about being moved to another part of the prison (other than healthcare).

The mental health nurse recorded in the Prisoner at Risk booklet that Mr Deery, *"seems visibly more relaxed since learning that he will be housed in the hospital wing."* Another staff member recorded, *"John (was) told he was moving to Bush 4 (where the temporary healthcare centre was located), seems happy enough……"*

Clinical Reviewer's Opinion

In relation to the decision to move Mr Deery to healthcare, the clinical reviewer, Dr Fazel said *"I note that Mr Deery was reviewed before this decision was made by a mental health trained nursing officer, who had cared for Mr Deery previously in prison. I note that the decision to move Mr Deery was made at a case conference that was attended by two other members of staff including the principal officer. I note that as part of the mental health nurse's review, he concluded that Mr Deery's risk of self harm was reduced. I note from the mental health nurse's interview transcript that Mr Deery was apparently content with the move."*

Dr Fazel also stated, *"In my opinion, I do not believe this transfer was not appropriate in the circumstances. It would appear that an updated risk assessment was conducted and the move was discussed at the multi-disciplinary case conference."*

10. Events Following the Case Conference

Family Phone Call

It was apparent to staff that one of the factors making Mr Deery upset, was his concern for the well being of one of his family members. Having made contact with Mr Deery's priest, staff were able to obtain an up to date contact number for the family member and at 15.18, immediately after the case conference, Mr Deery was taken to the principal officer's office and permitted a five minute phone call to the family member he was concerned about.

A subsequent entry in the Prisoner at Risk booklet notes that following this phone call, Mr Deery was *"in good form."*

Samaritans Phone Call

At 16.22 Mr Deery talked to the Samaritans for approximately one minute.

Return of Shoe Laces

One of Mr Deery's family concerns was in relation to why he had shoe laces when he was on *"suicide watch."*

At 18.15, prior to his move to healthcare, Mr Deery was handed back his shoe laces. Mr Deery used his shoe laces to hang himself.

Prison Service policy specifies that the only time shoe laces and belts must be removed is when someone is placed in an observation cell.

The opening of a Prisoner at Risk booklet (or the SPAR booklet which replaced it), is not treated as an automatic reason for shoe laces and belts to be removed. When a prisoner with a Prisoner at Risk booklet (or SPAR) is being managed in a normal residential location it is the case that they

should have been risk assessed and deemed not to be at *"immediate risk"* of self harm. If a prisoner has been assessed as being at *"immediate risk"* of self harm, then they should be moved to an observation cell and will automatically have their shoe laces and/or belt removed.

In a previous Prisoner Ombudsman death in custody investigation, some comparative research of prison establishments throughout the UK was carried out to establish the circumstances in which prisoners had their shoe laces removed. It was found that the general practice is to only remove shoe laces from prisoners where it is deemed really necessary because a risk of serious self-harm or suicide has been identified.

In January 2009, the Prisoner Ombudsman also visited Holloway Prison where staff spoke of the de-humanising effect of removing normal clothing and placed greater emphasis instead on the need to provide a normal, purposeful regime and regular interactive checks on vulnerable prisoners.

It is the case, however, that no risk assessment was carried out when the decision was made to return Mr Deery's shoe laces and this was noted by Dr Fazel in his clinical review report. Dr Fazel said that Mr Deery had not self harmed with ligature clothing during his current period of custody, but had stated that he intended to hang himself. Dr Fazel pointed out that reducing ligature points has been an important component of some national suicide prevention policies and recent data from England and Wales suggests that it may have reduced the number of suicides. He notes that this is far from conclusive evidence as other aspects of the care of prisoners have also improved.

Dr Fazel further said that it is not possible to conclude that removing any potential clothing that could have been used for ligaturing would have prevented his suicide.

Transfer to Healthcare

The main healthcare facility at Maghaberry Prison was being refurbished in August 2009. At 18.24, Mr Deery arrived in the temporary healthcare facility in Bush House. Shortly afterwards he was taken to his cell by a nurse officer, who stayed with him for approximately six minutes.

An entry in Mr Deery's Prisoner at Risk booklet at 18.50 records that he was watching TV and told a senior nurse officer that he was *"happy with (the) location, chatted re situation and family, (family member) better and happy with this. Currently denies thoughts (of) self harm, describes form as good."*

At 19.25 Mr Deery was locked for the night but before this, nurse officers can be seen on CCTV entering Mr Deery's cell on three further occasions to talk with him and provide him with his medication and supper.

11. Observation of Mr Deery during his time in Lagan House 22 to 25 August 2009

Throughout his time in the observation cell in Lagan House, Prison Service policy required that Mr Deery should have been checked by landing staff at fifteen minute intervals and appropriate entries recorded on his Prisoner at Risk booklet. Prison Service policy also required that Mr Deery should be observed at fifteen minute intervals by the officer on duty in the Lagan House POD and appropriate entries recorded on the POD observation log.

Whilst there was evidence that appropriate checks were carried out on many occasions, an early investigation by the Prisoner Ombudsman identified significant concerns in respect of the carrying out and recording of the required observations in the case of Mr Deery. These are detailed in Section 1 of this report.

SECTION 4: MR DEERY'S PERIOD IN HEALTHCARE 26 TO 27 AUGUST 2009

12. Events on the morning of 26 August 2009

There is no in-cell CCTV in Bush House, but there is CCTV on the landing.

Following his transfer to healthcare, Mr Deery continued to be on fifteen minute observations. During the morning of 26 August 2009, Mr Deery carried out routine activities such as collecting milk at breakfast time, cleaning his cell and taking medication from staff, as part of the normal regime in the temporary healthcare facility.

Entries in Mr Deery's Prisoner at Risk booklet record that he spent most of his morning in his cell sitting or lying on his bed watching TV.

Between 07.56 and 12.00, landing CCTV shows that staff stood at Mr Deery's door or entered his cell on seven occasions for periods of between 30 seconds and two minutes. He was not, however, observed at fifteen minute intervals as required. There is nothing recorded on the Prisoner at Risk booklet to describe Mr Deery's state of well being that morning.

Lunch was served at 11.39 and Mr Deery collected his meal.

13. Change in Observation Levels

Mr Deery's family asked why *"considering his vulnerable state"* his observations were changed from 15 minutes to hourly. The investigation found that it was not entirely clear how this decision was reached and who took part in the decision making process.

The Prisoner at Risk staff information pack provides the following guidance in relation to changing observation levels:

"The level of observation a prisoner is on, can only be changed by holding a case conference. It is not acceptable for observation to be changed on the daily log."

At interview, the safer custody co-ordinator said that he would always hold a case conference before changing observation levels. This is in line with the instructions in the information pack, but is not recorded in the Prison Services Self Harm and Suicide Prevention policy.

At 12.00, a mental health nurse recorded the following entry in the Prisoner at Risk booklet:

"Follow up review from case conference yesterday. John has settled very well and very quickly back in the healthcare setting where he feels safe and secure. His threats and risks of self harm have also reduced. I recommend current observation level to be reviewed and made hourly at irregular intervals. This is subject to regular appraisal."

At interview, the mental health nurse, said that he carried out a *"review/informal case conference"* with two other nurse officers. The mental health nurse said that one of the nurse officers asked him if Mr Deery still needed to be on 15 minute observation intervals. The mental health nurse said that because it was mentioned at the case conference the day before that, if Mr Deery remained in Lagan House *"they were (going to) put him up to*

hourly observations," a review could be carried out. The mental health nurse said that carrying out a *"review"* was an agreed practice in healthcare when observation levels needed to be changed, as long as three members of healthcare staff were in agreement.

The mental health nurse said that all three staff members agreed that the frequency of Mr Deery's observations could be reviewed and changed to hourly intervals.

At interview, the principal officer who attended and wrote the notes of the case conference on 25 August, was asked whether the matter of putting Mr Deery on hourly observations was discussed. He said, *"I don't think so. I don't remember but I don't see why it would come up, (because) he's (Mr Deery) still in the observation cell while we were discussing this and we were talking about him going into Healthcare.* He further said, *"It was entirely up to Healthcare what they did after that."*

One of the nurse officers who is reported to have been involved in the informal case conference said at interview that *"I don't remember him (the mental health nurse) discussing prisoner Deery with me."* The nurse officer also said that he was unaware that a case review was carried out by the mental health nurse.

At interview, the other nurse officer reported to have participated in the informal case conference was unable to recall whether or not he was consulted about changing the frequency of observation of Mr Deery.

The mental health nurse said that in order to make an informed contribution to the review, he drew information from other entries in the Prisoner at Risk booklet and his previous experience with Mr Deery. It was, however, the case that Mr Deery's Prisoner at Risk booklet entries, did not record any details of his mental state/demeanour for that morning.

CCTV shows that the mental health nurse came onto the healthcare landing at 11.52 and walked straight to the nurse's desk, where he spoke with one of the nurse officers named as participating in the review, for approximately three minutes. Following this, the other nurse officer named as participating in the review, approached the nurse's desk and talked to the mental heath nurse for less than one minute. At 11.58, the mental health nurse wrote on a document for approximately three minutes before leaving the wing at 12.09. At no time that morning did the mental health nurse visit Mr Deery.

At interview, the mental health nurse said that whilst he wrote the entry in the Prisoner at Risk booklet, it was not his sole decision to change Mr Deery's observation intervals to hourly. He said, *"I didn't change it to hourly, I had a discussion with those two members of staff. Let's not forget that, I only made a recommendation"* for the observation to be reviewed. He said also, "*A recommendation's not a decision."* He further said, *"I had information from the day before and the staff had information from that day as well. And they updated me and I updated them and they decided to... that was enough information to proceed to change the (observations) to hourly."*

One of the nurse officers who the mental health nurse said participated in the *"review/case conference"* said he only became aware of the change in observation times when he read the Prisoner at Risk booklet, after he returned from lunch. He also said in relation to the decision to change the observation times, *"It was his (the mental health nurse's) decision to change it."*

The Prisoner at Risk booklet has space for detailing a prisoner care plan. As part of the case conference held the day before, the care plan in Mr Deery's Prisoner at Risk booklet was updated as follows, *"Healthcare – Discussed at review. Observation level to be reviewed following change of location."* At interview the mental health nurse said that he added the entry approximately 20 minutes after the case conference and, without the knowledge of the other staff members who attended. He also said that he thought the chairperson had wanted him to add in the above comments. He

said that he had never done this before and the purpose was to inform healthcare staff of the *".....instruction, that it is to be reviewed."*

At interview the chairperson of the case conference said that no authority was given for additional information to be placed on the care plan which he signed off. He said also that after he wrote up the summary of the case conference he *"never saw it again."*

This matter is being considered as part of the internal disciplinary investigation.

Following the note made by the mental health nurse on the Prisoner at Risk booklet recommending that *"current observation level to be reviewed and made hourly, at irregular intervals"*, Mr Deery's next observations were recorded as having taken place at 12.30, 13.00 and 13.30. It was subsequently found that none of the three checks were carried out at the times stated. Mr Deery was seen by an officer at 12.10 and the next time he was checked was 13.50. He was then checked at least hourly for the remainder of the day and on two occasions it is recorded that Mr Deery was *"more content since he moved to healthcare"* and *"pleased to see staff that he remembered, well settled."*

Findings and concerns in connection with the carrying out and recording of observations are discussed in Section 1.

Clinical Reviewers Opinion

Considering the decision to change the frequency of observation of Mr Deery, the clinical reviewer said, *"It is my opinion that the decision to reduce his observation levels was not inappropriate. His last recorded self harming episode was on the 23 August, and staff perceived his risk of self harm and suicide to have reduced. However, the process by which the decision was made was unclear and guidelines clarifying how these decisions should be made would be helpful."*

The evidence examined by the investigation clearly showed that the decision to change Mr Deery's observation frequency was not compliant with Prison Service policy.

Other Observations – 26th August

CCTV shows that from 12.00 until 21.00 when he went to bed, Mr Deery remained in his cell other than when he collected his tea meal, medication and supper. Unlike in an observation cell, Mr Deery did not have an in-cell telephone to contact the Samaritans directly. He could, however, have asked to use the general telephone on the landing to do so.

At 17.58, Mr Deery was unlocked for association but he remained in his cell. At 18.42, CCTV shows that a nurse officer entered Mr Deery's cell and spent 12 minutes with him.

Throughout the remainder of the evening, discipline and medical staff are seen speaking with Mr Deery on three occasions for a total of approximately three minutes.

At 19.50 the landing was locked for the night and it is recorded on Mr Deery's Prisoner at Risk document that he *"Appears asleep"* from 21.00 through to the next morning.

Staff communication with Mr Deery on 26 August was for a total of approximately 31 minutes. Mr Deery was out of his cell for a total of five minutes. On one occasion only can it be seen on the landing CCTV that Mr Deery was given a light for a cigarette. There may have been other occasions that Mr Deery was given a light for a cigarette but, as there were no records made on his Prisoner at Risk booklet and there is no in-cell CCTV, it is not possible to say.

14. Mental Health Assessment – 27 August 2009

Mr Deery's family asked what mental health support he received and whether he had been seen by a psychiatrist.

On the morning of 27 August, CCTV shows that Mr Deery collected his breakfast and then some cleaning materials in order to clean his cell. He made a request to see a probation officer.

It was recorded in the Prisoner at Risk booklet that at 09.45 on 27 August, Mr Deery was seen by a visiting psychiatrist [24], who is contracted to work two days one week and three days the next at Maghaberry. On 27 August, the psychiatrist carried out a full mental health assessment of Mr Deery.

At interview the psychiatrist said that it was usual for the mental health assessment for vulnerable persons such as Mr Deery to be carried out within *"one to two days"* of being identified as vulnerable. She did not know why there was a delay of five days and said, *"I can't comment on this one because I'm not sure why there was a timing difference."*

The psychiatrist said that she had known Mr Deery from 2005 until his release in April 2007. She said that, she was aware of his previous medical history and the recent incident, where he had allegedly thrown himself down the stairs of a courthouse. The psychiatrist said that at the consultation on 27 August, Mr Deery was able to explain to her why he had been recommitted and told her that he denied the charges against him. She said that he appeared hopeful that he would be able to disprove them.

[24] Visiting Psychiatrist - Specialist medical professional contracted by the Trust to provide medical assistance/sessions on agreed days in the week.

The recorded psychiatrist's diagnosis of Mr Deery was that of, *"dysthymia*[25] *and personality deficit and deficiencies related to a dissocial and emotionally unstable state."*

At interview she said that other issues troubled Mr Deery and she noted "*that he had been consuming alcohol following his birthday."*

Speaking about the consultation, the psychiatrist said "*Mr Deery maintained fair eye contact throughout the interview and was not agitated. There was no evidence of alcohol withdrawal. His speech was spontaneous and coherent. His mood was subjectively lowered but his mood was reactive throughout the interview……There was no evidence of psychotic features of hallucinations. He was orientated in time, person and place and insight was present. He had thoughts of life not worth living but he had no active suicide ideation."*

The psychiatrist also said that from her experience, and from listening to comments from other staff who knew Mr Deery, she identified *"two main clinical predicators*" of self harm. The first, she said was that Mr Deery would tell staff that he wanted to self harm. She said he was *"very good at ventilating feelings of increased thoughts of self-harm*." The second was that Mr Deery would present an *"increasing agitated and distressed state."*

The psychiatrist said that, during the consultation, Mr Deery informed her of concerns about his family and his apprehension about moving to a normal prison setting outside of healthcare. The psychiatrist said that she reassured Mr Deery and told him there were no plans for him to be moved. She said that she explained that he was in a supportive environment where there were nursing staff and medical doctors whom he knew well. She also encouraged Mr Deery to attend to his personal hygiene and to attend ward-based activities such as occupational therapy programs, which she said he agreed to do.

[25] Dysthymia is considered a chronic mood disorder but with less severity than a major depressive disorder. Symptoms can include, feelings of hopelessness, insomnia or hypersomnia, poor concentration or difficulty making decisions, low energy or fatigue, low self esteem, poor appetite or overeating and irritability.

The psychiatrist prescribed the sleeping tablet Zopiclone and the antidepressant Gamanil for Mr Deery.

It was the psychiatrist's belief and understanding that the consultation was concluded satisfactorily and that Mr Deery had not raised or displayed any concern in respect of their discussion.

Input of Maghaberry's Senior Psychiatrist

Following Mr Deery's consultation with the visiting psychiatrist, the psychiatrist met with Maghaberry's senior psychiatrist to discuss Mr Deery's case. The senior psychiatrist, who had known Mr Deery for approximately eight years, recorded an untimed entry on Mr Deery's medical records identifying Mr Deery's core symptoms and trigger factors to inform all medical staff.

The entry, dated 27 August 2009, describes Mr Deery as having a current diagnosis of *"Dysthymia against a backdrop of long standing personality based deficits and deficiencies of the dissocial and emotionally unstable types.....which is complicated by the misuse of alcohol."*

At interview the senior psychiatrist said that Mr Deery had chronic mental health problems that did not respond to known therapies. He said that Mr Deery was unable to engage coping strategies and tended to run with the emotion of the moment. He also described Mr Deery as having a limited ability to appraise information and said that he found that he had a tendency to appraise situations negatively.

The senior psychiatrist described how Mr Deery's symptoms would manifest at two levels of emotional state. He stated that at the higher level Mr Deery would be in an extremely vulnerable state in respect of self harming. He recorded that in such a state, Mr Deery would display symptoms such as, *"lowering of mood, inattention, tremulousness, poor concentration and*

distractibility, periods of agitation, swings of mood and feelings of not being able to cope in stressful and demanding situations."

Clinical Reviewer's Opinion

In his clinical review report, Dr Fazel said the following in relation to the timing of Mr Deery's psychiatric assessment:

"He was not seen by a psychiatrist until the 27 August, around five days after reception into custody. For someone with a complex mental history, who was on a range of psychotropic medication, and at increased risk of self harm and suicide, this is suboptimal in my opinion, and he should, in my view, have been assessed sooner. Furthermore, the Revised Self Harm and Suicide Prevention policy (dated September 2006) states under Section 2.15 that medical staff should 'assess risk following reception'. Clarification of the timing of this assessment would be helpful to inform future policies".

Having considered the assessment of Mr Deery, Dr Fazel, supported the psychiatrist's diagnosis. He said *"I do not think that there is clear evidence that Mr Deery was suffering from a clinical depressive illness at the time of his death.....I do not believe that Mr Deery's treatment for dysthymia (rather than depression) was inappropriate."*

15. Mr Deery's Concern about Being Moved from Healthcare

On 27 August 2009, shortly after Mr Deery's mental health assessment, it is recorded on his Prisoner at Risk booklet that he was seen by a nurse officer who noted that he, *"Spoke with myself re his anxiety and apprehension of moving out of healthcare. Reassurance given."*

At interview, the nurse officer said that Mr Deery had become, "*a bit anxious"* following his consultation with the psychiatrist because Mr Deery understood from his conversation with her that he was going to move to the REACH landing[26] in Lagan House and was to be *"moved straight there."* The nurse officer said that she told Mr Deery that he wouldn't be moved off the ward, *"straight away"* and said also that she spoke separately with the psychiatrist to make sure that this was the case.

At interview, the psychiatrist said that Mr Deery had told her that he had concerns about being located outside of the healthcare setting and into the main prison. She said that she couldn't recall speaking with Mr Deery about a move to the REACH landing. She said that the only time that she recalled discussing the REACH landing was with the senior psychiatrist, following her assessment of Mr Deery. The psychiatrist also said that if she had mentioned moving Mr Deery to the REACH landing, then she would have reassured him that the move would not have been immediate.

At interview, the senior psychiatrist said that he was unaware as to whether or not the psychiatrist had discussed with Mr Deery the possibility of him moving to the REACH landing. He also said that Mr Deery *"would tend to select the worst aspects of what you were saying to him……He would take what he viewed as a negative thing and this would……remain in his mind."*

On the 27 August 2009, the senior psychiatrist recorded the following untimed entry in Mr Deery's medical records:

[26] REACH Landing – is a facility within Maghaberry Prison and outside the healthcare centre, which identifies prisoners with complex needs and provides assessment, support within a structured and therapeutic environment facilitated by multi-disciplinary working and person centred planning.

"In my opinion in the attempt to avoid further exacerbation of Mr Deery's long standing difficulties and to effectively lose the treatment gains made to date it would be important to place Mr Deery in a structured supported setting out with the Healthcare Unit – in for example REACH as it is highly probable that Mr Deery may be committed to prison for some time having regard to the nature of the current charges."

At interview, the senior psychiatrist said that he had discussed Mr Deery's exit strategy from healthcare with the visiting psychiatrist and said, *"It was my feeling that he should move from the healthcare centre to the REACH landing. Clearly, whenever his [Mr Deery's] situation had stabilized, any distressing symptoms had been ameliorated and it was clear how long he was going to serve in prison."*

He said that, if Mr Deery was moved to the REACH landing, it would have been, *"more stimulating and …given him a wider perspective, and, hopefully, a better sense of self-worth."*

Whilst it was not recorded in the medical records entry, the senior psychiatrist said that prior to such a move, which he said could have been up to 12 months away, it would have been ensured that "*if John had been alive, we would have got him up to the maximum level of functioning and the lowest level of psychic distress that we could manage…..and there would have been a negotiation, whether he wanted to go on computers, whether he wanted to do some braille, whether he... you know, there was a range of activities…some educational activities, practical gardening activities. Activities which he could have participated in on REACH."*

The senior psychiatrist also said that Mr Deery was very difficult to encourage to participate in many activities and could not be coerced into taking part.

The senior psychiatrist did not speak directly with Mr Deery on the 27 August. It would, therefore, appear to be the case that it was Mr Deery's

understanding or interpretation of his discussion with the visiting psychiatrist that led to him telling the nursing officer that he was worried about a move to REACH.

As explained earlier, the nurse who said that she did her best to reassure Mr Deery told him that he would not be moved *"straight away."*

16. Events after Mr Deery's Consultation on 27 August 2009

Immediately following Mr Deery's consultation with the psychiatrist and his subsequent discussion with the nurse officer, it is recorded on Mr Deery's Prisoner at Risk booklet that at "*11.45, Served lunch, refused, says he does not want any food at the minute.*" At 11.46, a prison officer spoke with Mr Deery and a minute later called a nurse into see him. The nurse was with Mr Deery for less than a minute and there is no record of why he was asked to see him. An entry on the Prisoner at Risk booklet at 12.28 records that Mr Deery, *"Refused lunch meal. Asleep (at) present."* He continued to refuse food and it is recorded at 15.50 that *"Refused offer of tea meal. Said he was not hungry."*

The *"Recognising Risk"* section of the Prisoner at Risk booklet provides a list of behavioural indicators that a person may exhibit when considering self harm. One of the indicators is, *"Self-neglect – e.g. not eating/ washing."*

At interview, a nurse officer said that it was not uncommon for a prisoner to refuse food but that, if this continued for over a day, staff would become concerned.

The visiting psychiatrist said at interview, *"The not eating is something that he (Mr Deery) previously would have done, on an intermittent basis."*

At interview the senior psychiatrist said, *"He would refuse food in the past as a way of sulking or he would refuse food really because he was preoccupied and he wasn't hungry and he was worried about something else.....there's a number of possibilities for him refusing food.....in the past he would have gone some days without food.....but it would not have been for very lengthy periods."*

Mr Deery's medical file shows a number of occasions where, in the past, he had refused food for periods of between one and 11 days.

Mr Deery was checked every half hour over the lunchtime lockdown on 27 August and it is recorded that he was asleep throughout.

At 15.30 on 27 August 2009, Mr Deery was escorted to reception to retrieve telephone numbers which were stored in his mobile phone. The phone had, in line with Prison Service policy, been taken from him when he entered prison. The corresponding entry in the Prisoner at Risk booklet by the healthcare officer who accompanied him notes that Mr Deery was *"very tearful and very regretful that he has ended up in prison again. He had been seen by (the psychiatrist) this morning but remains very emotional. On return from reception he was upbeat and pleased to have got the numbers."*

At interview, the healthcare officer said that he felt Mr Deery's emotional demeanour had remained the same throughout the day, but he noticed a, *"big positive impact on him (Mr Deery)"* when he had retrieved his family contact numbers from reception.

The healthcare officer said that at no stage did Mr Deery express concerns about the REACH landing or mention his earlier consultation with the psychiatrist.

Throughout the rest of the afternoon/early evening, entries in Mr Deery's Prisoner at Risk booklet record that he was watching the television in his cell or was asleep in his bed.

Observation of Mr Deery throughout the 27 August took place at least hourly.

CCTV shows that Mr Deery's cell was unlocked for association at 18.04 and his door left open. At interview, a healthcare officer said that Mr Deery was offered evening association, where he could go to the recreation room and interact with other prisoners and watch television, but he chose to remain in his cell. The healthcare officer said that he thought the reason Mr Deery was reluctant to leave his cell was because he was anxious about his own

safety. He said at interview that, *"I think he (Mr Deery) was a bit anxious about his safety with his history, with his crime. We did have one or two folk who were capable of possibly causing an incident who had to be kept an eye on. John would have been aware of that I think and just preferred to stay in his cell."*

The healthcare officer also said that normally, where an inmate refuses the offer of association, their cell would then be locked. On this occasion, however, Mr Deery's door was left open so *"he (Mr Deery) didn't feel so closed in."*

CCTV shows that an orderly entered Mr Deery's cell and cleaned it at 18.12 and then left. Mr Deery was then spoken to by a male nursing officer and given a light for a cigarette at 18.50. At 19.05, a female nursing officer spent six minutes with Mr Deery. A male nursing officer went into Mr Deery's cell at 19.20 and then returned at 19.23 for a minute.

At 19.24, Mr Deery was offered a cup of tea from the supper trolley which he refused.

At interview, a nurse officer, described Mr Deery's demeanour as, *"calm"* when she saw him in the evening and said that he was, *"smiling and initiating the conversation and was telling me about (a family member)."*

At 19.33, CCTV shows that a male nursing office checked the cells and stopped to give Mr Deery a light for a cigarette, before he was locked for the night.

At 20.00, it is recorded in Mr Deery's Prisoner at Risk booklet, *"Spent evening in cell with open door. Prefers to be alone at present."*

The *"Recognising Risk"* section of the Prisoner at Risk booklet states that one of the behavioural indicators that a person may exhibit when considering self harm is, *"Withdrawal from social contact."*

On 27 August, Mr Deery spent a total of approximately 44 minutes out of cell. This included 21 minutes when he visited the psychiatrist and 21 minutes when he went to reception to get his phone numbers. Over and above this, members of staff spoke with him for a total of 17 minutes.

Clinical Reviewer's Opinion

Commenting on Mr Deery's anxiety about a possible out of healthcare, Dr Fazel said *"I do not believe that Mr Deery's refusal of food on 27 August can, in of itself, constitute evidence of a significant change in his mental state. He apparently refused his lunch meal and teatime meal, and we do not know whether he simply did not like the food that he was offered. It is uncertain to what extent (the psychiatrist's) reported discussion with him about moving back to the main prison on 27 August did upset Mr Deery. The evidence in my opinion is inconsistent and nursing officers report that he was reassured with explanation at 1100 hours but at the same time, he remained 'tearful' and 'concerned' at 1530 hours but not apparently at 1900 hours."*

Shift Changeover

At 20.17, a nurse commencing her night shift duty checked all the cells on the wing, as part of a routine head count. This was the last time Mr Deery was seen alive. All prisoners were accounted for and the day staff finished their shift at 20.25.

17. Incident involving another prisoner

At 20.27, CCTV shows that an in-cell call button on Mr Deery's landing illuminated. Within a couple of minutes, the two nurses on duty attended to the call. An elderly prisoner with a chronic respiratory disorder was found to be having difficulties breathing.

At 20.35, the prisoner's cell door was opened and both nurses entered the cell. The prisoner's chronic respiratory condition had deteriorated and as a result, a prison doctor was called and an ambulance was tasked to attend. The nurses continued to assist the prisoner.

At 21.21, the ambulance paramedics arrive on the landing and attend to the prisoner. Seven minutes later, at 21.28, the prisoner was wheeled out of the landing on a stretcher and taken to hospital.

SECTION 5: OBSERVATIONS AND DISCOVERY OF MR DEERY

18. Prisoner at Risk Observations during the Medical Emergency

The last check on Mr Deery, prior to the medical emergency, was at 20.17. As Mr Deery was on hourly observation, he was due to be checked at the latest at 21.17. At 21.17, the two nurses on duty were attending to the medical emergency.

CCTV shows that three prison officers, a senior officer and a dog handler stood on the landing, whilst the nurses assisted the prisoner who was unwell.

At no stage during this period, did any member of staff check on the four prisoners on the healthcare landing who had an open Prisoner at Risk booklet. This included Mr Deery.

At interview, one of the nurses said that she had become preoccupied with providing urgent medical assistance to another prisoner, which resulted in Mr Deery not being checked at the required time. The nurse said that she was of the opinion that, in the future, a principal officer or senior officer should ensure that all the prisoners are checked, particularly vulnerable prisoners who have an open Prisoner at Risk booklet, in the event of a medical emergency.

A review of the Prison Service's Self Harm and Suicide Prevention policy shows that there are no instructions to staff in relation to extra checks being carried out on prisoners at risk in the event of a potentially distressing incident or an incident where a prisoner is likely to think that staff are busy/distracted.

The senior officer who attended the earlier emergency medical unlock was the same officer who later discovered Mr Deery. At interview he said that,

with hindsight, *"probably Deery should have been checked up and the other three PAR 1s as well."* As a result of Mr Deery's death, the senior officer said that he would now ensure that all checks are completed whenever the medical staff are occupied and unable to attend to their normal observational checks of prisoners at risk.

19. Circumstances leading to the discovery of Mr Deery and the subsequent actions taken

After the earlier medical emergency, both nurses tidied up the equipment used to deal with the incident. At 21.32 both nurses left the landing.

At interview, one of the nurses said that she and her colleague returned to the treatment room to replenish and restock the equipment used at the time and also to write up the medical records and their notes on the prisoner.

Eighteen minutes later, at 21.50, CCTV shows that one of the nurses arrived back on the landing. One minute later a senior officer walked down the stairs from the landing above. Shortly after this, the senior officer commenced a check of all the prisoners with an open Prisoner at Risk booklet, starting with Mr Deery's side of the landing.

At 21.53, one hour and thirty six minutes after he was last observed, the senior officer looked through the observation flap of Mr Deery's cell for three seconds. At interview, the senior officer said that when he looked into Mr Deery's cell he saw Mr Deery sitting in the dark at the back wall. He said that his, "*face was facing me*." The senior officer said that he did not speak to Mr Deery because it was a hospital landing and he finds that many patients with mental health difficulties are reluctant to engage with non healthcare staff. The senior officer said that he recorded a note of the time that he checked the cell and continued to check the other prisoners.

At 21.55, the senior officer returned to the nurse's desk and spoke to one of the nurses. At interview, the senior officer said that he asked the nurse to check on Mr Deery to ensure that he was okay. The senior officer also said that it was not uncommon for prisoners to sit in the dark.

The senior officer did not have a torch with him when he was checking the cells.

At 21.56, the nurse checked on Mr Deery, as requested by the senior officer. At interview, the nurse said that the senior officer told her that he had noticed Mr Deery was sitting in the dark and he asked her whether Mr Deery had a television.

The nurse said that she then went and looked into Mr Deery's cell and recalls seeing him in the dark. She said, *"He just looked like he was leaning against the bed."* The nurse said, she could not see his face and she called him, but got no response. She said that she was under the impression that Mr Deery was ignoring her and went to get a torch so that she could get a better look at him.

The nurse fetched a torch from the desk whilst the senior officer rechecked Mr Deery. At 21.57, the nurse passed the torch to the senior officer and Mr Deery was checked again. CCTV shows that the nurse then immediately ran off the landing to raise the alarm.

At interview, the senior officer said that he knew something was wrong when he shone the torch into the cell and noticed that Mr Deery's eyes were open and his pallor was grey in colour.

At 21.58, the senior officer entered Mr Deery's cell along with a night custody officer. There was no CCTV in Mr Deery's cell but after the incident, in line with Prison Service policy, the senior officer completed a staff communication sheet and he recorded that Mr Deery had a ligature attached to the top bunk of his bed which was tied around his neck. It is further recorded that the senior officer lifted Mr Deery under his arms and the night custody officer cut the ligature using a Hoffman knife. This account was confirmed at interview.

One of the questions asked by Mr Deery's family was whether Mr Deery was brought back to life, to make it look as though he didn't die in Prison. At 21.59, CCTV shows that Mr Deery was lifted onto the landing by the senior

officer and night custody officer. Both nurses immediately commenced CPR (Cardio Pulmonary Resuscitation), with the assistance of other staff.

All healthcare staff are trained in CPR and basic life support and where a pulse is absent, it is normal practice that healthcare staff would immediately commence CPR until a pulse is regained or until an ambulance arrives. The only occasion where staff would not attempt CPR is where it was felt that such an attempt was futile or there was no medical benefit, for example where rigor mortis had occurred.

CCTV shows that the medical staff attached the leads of a defibrillator to Mr Deery and used an Ambu Bag[27] to provide him with oxygen.

At interview, one of the nurses said that a defibrillator was attached to Mr Deery which analyses the heart rhythm and, if appropriate, will instruct the users to stand back and shock the patient's heart back into a normal rhythm. The nurse said that at no stage did the device instruct them to administer a shock, which indicates that no heart rhythm was detected by the device.

The nurse also said, *"I ascertained he had no pulse and he wasn't breathing……..He was dead, he had stopped breathing."* CPR continued and the nurse said that on each occasion that she checked, Mr Deery *"didn't have any cardiac output."*

At 22.18, the ambulance staff arrived on the landing, and whilst they were setting up their equipment, CPR was maintained by the nurses. One of the nurses said that the ambulance staff placed a heart monitor on Mr Deery which confirmed that he had no cardiac output.

One of the clinical reviewers, Mr Brackenbury, said in his report that it is recorded in the paramedic's notes that, *"pulseless electricity activity was*

[27] Ambu Bag – a hand held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately.

seen on the paramedics heart monitor and accordingly adrenaline was administered. The heart monitor then showed a tachycardia." A tachycardia is a rapid heart rate. Following this, Mr Deery began to make weak respiratory efforts, about three to four breaths per minute.

At 22.34, Mr Deery was carried off the landing on a stretcher. He was then taken by emergency ambulance to the Royal Victoria Hospital, Belfast.

At interview, one of the nurses said that when she was carrying out CPR she asked other staff to check the other prisoners with open Prisoner at Risk booklets. She said, *"I was very conscious of the fact that while I was dealing with one incident, John Deery had taken that opportunity to hang himself."*

Clinical Reviewer's Opinion

In his clinical review report, Mr Brackenbury commenting on the action taken by staff when Mr Deery was found said, *"There is no evidence of clinical negligence from the prison staffs clinical management of Mr Deery. A nurse worked hard to successfully maintain Mr Deery's circulation and respiration and should be commended for her efforts."*

Delay in Opening Mr Deery's Cell Door

Mr Deery was first checked by the senior officer at 21.53. It was five minutes later, at 21.58, that his cell door was opened. He was lifted on to the landing at 21.59 and CPR commenced.

The clinical reviewer, Mr Edward Brackenbury, was asked whether this delay impacted on Mr Deery's death and whether his life could have been saved if staff had intervened sooner.

Mr Brackenbury said *"on balance of probabilities….it is likely that Mr Deery took his own life sometime before the 21.53h check evidenced by the lack of pulse when found and therefore enough time to already have produced*

irreversible brain damage from which he could not be recovered despite rapidly restoring his circulation."

A detailed summary of Mr Brackenbury's findings is at Section 28.

20. Note found in Mr Deery's Cell and Notification of Death

A note was found in Mr Deery's cell addressed to two of his family members. The note said *"Sorry"* and told them that he loved them. It is not known when this letter was written.

Notification of Mr Deery's Death

On the afternoon of 28 August 2009, the Prison Service received confirmation that Mr Deery had passed away.

SECTION 6: EVENTS AFTER MR DEERY'S DEATH

21. De-Brief Meetings

Hot De-Brief

The Prison Service's Revised Self Harm and Suicide Prevention policy issued in September 2006 states:

"A Hot De-Brief meeting is vital following the death of a prisoner as it enables all who took part to comment, while it is fresh in their minds, in respect of what went right or what could have been done better. Hot De-Brief meetings make a positive contribution to the implementation of better practice locally, and sometimes, across the Prison Service. It also gives staff the opportunity to discuss their feelings and reactions and calm down or seek help before going home."

The investigation established that a hot de-brief took place on the 28 August 2009 and a full record was made.

Cold De-Brief

Section 6.11 of the Self Harm and Suicide Prevention policy requires that *"a more comprehensive [cold] de-brief should take place within 14 days."*

In a previous death in custody report it was recommended that:

"The Prison Service ensures that a Cold De-brief takes place following any death in custody, in line with the timeframe outlined in its Self-harm and Suicide Prevention policy, which states that a more comprehensive Cold De-brief should take place within 14 days."

The prison service accepted this recommendation on 12 December 2008 and in July 2009 they further advised that, *"Steps to complete a comprehensive*

de-brief within 14 days after a death will be taken, to ensure staff have the opportunity to vent any concerns regarding current procedures and practice and to inform better practice in the future."

A cold de-brief took place on the 20 October 2009. The minutes of the meeting recorded that the reason for the delay was due to difficulty in finding a suitable date and time to accommodate all attendees.

SECTION 7: OTHER MATTERS RELATING TO MR DEERY'S CARE

22. Nursing Care Plans

Mr Deery did not have a care plan when he was located in an observation cell in Lagan House and no comprehensive care plan was completed, as required by Prison Service policy, when a case conference was held to discuss him on 25 August 2009.

It was also the case that Mr Deery did not have an appropriate care plan when located in healthcare.

The Prison Service's Self Harm and Suicide Prevention policy 2006 states that:

"Care Plans - Healthcare Centre

Where the prisoner is located in the Healthcare Centre, the formulation of a healthcare plan will be the responsibility of the appropriate healthcare staff. A document to record these plans will be drawn up following a multi-disciplinary case conference and will record relevant activities and observations which will be the subject of review at a multi-disciplinary case conference at agreed intervals. A copy of this document should be retained with the Prisoner at Risk booklet on the prisoner's healthcare record. Information regarding the healthcare assessment must be passed to the manager in charge of the prisoner's usual location for his information and that of the form's originator."

The healthcare manager said at interview that when prisoners are newly admitted to the healthcare ward, it is the responsibility of the ward co-ordinator[28] or senior nurse officer, to complete a healthcare plan for the

[28] Ward Co-ordinator – A nurse officer who had been given the responsibility to co-ordinate prisoners care activities whilst admitted on the healthcare ward.

individual during their admission. He said that, in practice, no multi-disciplinary case conference takes place prior to a plan being drawn up.

A healthcare plan documents the aims and objectives for addressing particular problems or needs and the nursing interventions which are required in order to achieve them.

There are three healthcare plan sheets in Mr Deery's medical file dated 26 August 2009. The plans are intended to address: ineffective coping skills; thoughts of self harm and / or suicide; and low mood.

None of the three healthcare plan sheets include information to identify who placed them in Mr Deery's file or what nursing interventions/objectives were planned for addressing the identified needs. Mr Deery's signature is also absent, so it is unclear what discussion took place with him.

In the absence of properly completed information, nurse officers on different shifts do not have documented guidance on the care plan to be delivered.

At interview, a nurse officer said that the nursing care plan is effective where it is completed and used as it assists in identifying and managing the specific needs of a patient.

Also at interview, the visiting psychiatrist said that as part of her role she would review all the information in her possession, including the care plans. She said, in relation to whether she saw Mr Deery's uncompleted care plan, *"I don't recall, I'm afraid."*

The senior psychiatrist said at interview, *"there's no point having a care plan that isn't implemented."*

23. Healthcare Handover Procedures

The Prisoner Ombudsman's report into the death in custody of Colin Bell in January 2009, stated that *"The Governing Governor and Deputy Governor of Maghaberry Prison advised at interview that there is a 15 minute period built into the shift to allow for handover between night and day staff and that they would expect a comprehensive briefing to take place."*

The Colin Bell investigation found that appropriate handovers were not taking place and the Prisoner Ombudsman made a recommendation that the Prison Service takes action to ensure that an appropriate and recorded handover takes place between day and night shift staff, including night shift staff allocated to Secure POD areas. The recommendation said that handover should draw the attention of all staff to information recorded on the Prisoner at Risk booklet and CRC 1 booklets.

This recommendation was accepted by the Prison Service.

During the investigation into the death of Mr Deery, a nurse officer explained the handover process in the temporary healthcare facility in Bush 4. The nurse officer said that handover takes place at the desk and, "*one of the Night Guards, as we call (the) Night Duty Nurse, will go through each patient prisoner, you know, on the board and they give us a run down of how they've been, if there's been any incidents."*

A white board located behind the nurse's desk lists all of the prisoners currently on the ward. The nurse officer said that if a Prisoner at Risk booklet is opened for a prisoner, the other information that will be provided is the current observation intervals.

CCTV shows that on 25, 26 and 27 August 2009, no handover, as described above, took place between day shift nurse officers and those coming on to night shifts.

At interview a nurse officer, who was on duty on 27 August said, *"I didn't get a handover that night, a specific handover. I had been on on the 26th and I was told nothing had changed."*

The nurse officer also said that if a colleague arrived into work before her, then the other nurse officer would get the handover and *"I'm not getting a handover and I do have an issue with that."*

This was also confirmed by another nurse officer, who said at interview, that the first person on the next shift to arrive for the start of their duty would receive the handover and would then, *"relay it to the rest of the team"* as they started duty.

24. Appointment of a Care Co-ordinator

In his review of Non-Natural Deaths in Northern-Ireland Prison Service Establishments (November 2005), Professor McClelland reported that *"each prisoner with a multi-disciplinary care plan will need to have an assigned care co-ordinator….The care co-ordinator, will be responsible for ensuring the care plan elements are actioned, arranging reviews and co-ordinating information sharing with other agencies both internal and external to the prison establishment."*

Mr Deery did not have a care co-ordinator who would have monitored and addressed gaps in the day to day delivery of different elements of his care.

A care co-ordinator would have helped to ensure:

- That observations were being carried out as needed.
- That important information was being recorded.
- That Mr Deery spent as much time as possible out of cell/engaging with others.
- Appropriate arrangements for purposeful and therapeutic activity.
- Effective management of medicines.
- An early review by a psychiatrist.
- The carrying out of appropriate case conferences and the recording of appropriate action plans.
- Continuity and oversight of the implementation of agreed care plans.

The Colin Bell investigation also found that no care co-ordinator was assigned. The Prisoner Ombudsman recommended that the Prison Service take action to ensure full implementation of a recommendation previously made by Professor McClelland, which stated that *"each prisoner with a multi-disciplinary Care Plan should have an assigned Care Co-ordinator."*

It is also to note that as well as not having an assigned care co-ordinator, there was no arrangement in place to ensure that on each shift in Lagan House or in healthcare, a designated officer or nurse was given responsibility for carrying out checks on Mr Deery or other prisoners with Prisoner at Risk booklets. The absence of such an arrangement was found to increase the potential for the required checks to be missed.

25. Purposeful Activity/Contact with others

As reported in the Prisoner Ombudsman's report into the death of Colin Bell, a review into Non-natural Deaths in Prison Service Establishments (November 2005) chaired by Professor Roy McClelland stated that:

"Regime content and activity levels were also examined as literature, points to a correlation between poor regimes and adverse effects on the mental well being of offenders. This can contribute to self-harm and an increase in suicidal ideation."

HM Prison Service Order 2700, which applies to prisons in England and Wales states:

"Independent research has indicated that at prison level, lower rates of self-inflicted death are associated with higher rates of purposeful activity, even when the type of prison is taken into account."

A summary of the amount of time Mr Deery had out of his cell is as follows:

22 August 2009	Committed to Maghaberry
23 August 2009	11 minutes (approx)
24 August 2009	1 minute (approx)
25 August 2009	11 minutes (approx)
26 August 2009	5 minutes (approx)
27 August 2009	44 minutes (approx)

The majority of Mr Deery's time out of cell was to attend medical appointments. On one occasion Mr Deery had a five minute phone call with a family member, and on another occasion he went to reception to retrieve contact numbers stored on his mobile phone.

In-cell CCTV in Lagan showed that staff/prisoners did spend time with Mr Deery on a number of occasions each day. Mr Deery was awake for around

13/14 hours each day. The longest time and total time that staff/other prisoners can be seen talking with Mr Deery, each day, is as follows:

- On 23 August a listener engaged with Mr Deery for approximately 25 minutes. The total amount of interaction Mr Deery had with different people over the day was approximately 102 minutes.

- On 24 August a staff member spent approximately 18 minutes with Mr Deery. The total amount of staff interaction was approximately 70 minutes.

- On 25 August Mr Deery spoke for approximately 32 minutes with a nursing officer, prior to the nurse attending a case conference. The total amount of staff interaction, including Mr Deery's transfer to healthcare (19 minutes), was approximately 99 minutes.

- On 26 August a staff member spent approximately 12 minutes in Mr Deery's cell. The total amount of staff interaction was approximately 30 minutes.

- On 27 August the total amount of staff interaction Mr Deery had was approximately 61 minutes. This included a 21 minute consultation with a psychiatrist and 21 minutes that it took for Mr Deery to go to Reception to obtain telephone numbers from his mobile.

In his report into Non-Natural Deaths in Custody in Northern Ireland Prisons, Professor McClelland made the following recommendation which was accepted by the Northern Ireland Prison Service:

"Improving activity levels, work placement, education for vulnerable prisoners and therapeutic day care regimes should be established as components of care for this group. More attention to detail should go into the way that vulnerable prisoners spend their days."

This was accepted by the Prison Service.

In her report into the death of Colin Bell, published on 9 January 2009, the Prisoner Ombudsman again referred to Professor McClelland's recommendation and further recommended *"that the Prison Service takes action, in line with its own policy to achieve improving activity levels, work placement and education for PAR 1 prisoners, including those in Safer/Observation Cells on a CRC 1, and to ensure that therapeutic day care regimes are consistently a component of care for this group."*

This recommendation was also accepted.

During the investigation into the death of Mr Deery, a number of staff made comments in connection with the need for purposeful activity.

The suicide prevention co-ordinator said in respect of the decision to move Mr Deery to healthcare, it is *"a much better environment than being placed in an observation cell. Although he was engaging more with staff and so forth at that particular time….. it's not the same engagement that I would expect him to be getting in a healthcare environment, because it's more therapeutic, which has access to occupational therapists, which has access on a daily basis to psychiatrists, which has access on a daily basis to a doctor, which has access on a daily basis to a therapeutic environment managed appropriately by the nursing staff inside this establishment, who are mental health trained nurses."*

At interview the visiting psychiatrist, said that during Mr Deery's previous custodial periods she had encouraged Mr Deery to participate in ward based activities which he had enjoyed (when in prison previously) and as a result he would have been aware of what was available to him. The psychiatrist said that during the consultation with him on 27 August she encouraged Mr Deery to take part in activities.

The senior psychiatrist, who knew Mr Deery over a period of approximately eight years said at interview, *"You can't boss him, you can't cajole... sort of coerce him into doing things."* He said that Mr Deery needed to be persuaded to participate over a number of days and weeks, explaining to him why you wanted him to take part. This would enhance his sense of well being and divert him from his ongoing worries. However, progress would have to be at a pace governed by Mr Deery.

The senior psychiatrist added that occupational therapy may have been available along with other activities in the running of the healthcare centre such as helping with, *"setting meal tables, handing out meals, bringing meals back and doing some cleaning and washing jobs."*

Occupational therapy which includes activities such as painting, drawing, craftwork, cooking and games was normally available three times a week in healthcare. Between 25 August and 28 August 2009, occupational therapy was only available on the 25 August 2009 as the occupational therapist was attending a training course.

Information provided by the healthcare manager stated that, *"healthcare patients are automatically offered occupational therapy"* which would then be recorded on their medical records. There is no record that Mr Deery was considered for or offered occupational therapy.

At interview, the visiting psychiatrist said that there was no referral system in place to refer a patient to occupational therapy. The patient would have been encouraged to attend and it would have been done verbally without any written record made.

There is no evidence from the record of the case conference held on 25 August, in Mr Deery's care plan, on his Prisoner at Risk booklet or on his medical records that there was any meaningful plan for engaging Mr Deery for purposeful activity such as occupational therapy or exercise. There is also no evidence that the need to ensure that Mr Deery spent time out of cell

and had increased human contact in cell was addressed, over and above the encouragement given by the psychiatrist at the consultation on 27 August.

It is to note that a healthcare officer said at interview that he believed that Mr Deery was reluctant to leave his cell because of fears for his safety related to his crime.

Cell Sharing

The NIPS Revised Self Harm and Suicide Prevention policy states in section 3.11 that where a prisoner is deemed likely to self harm, consideration should be given to interim measures that may include *"doubling up with another prisoner or placing the prisoner in safe and appropriate accommodation in a residential area."*

No evidence was found that consideration was given to arranging for Mr Deery to double up with another prisoner. In his clinical review, Dr Fazel commented that *"placing him in a shared cell may well have been appropriate."*

Dr Fazel does also point out that *"It is not possible, in my view to conclude that placing Mr Deery in a shared cell …. would have prevented his suicide."*

26. Medication Prior to Committal

Prior to committal, Mr Deery was taking the following medication:

- Zimovane, at night (strong sleeping tablet)
- Gamanil, at night (antidepressant)
- Chlorpromazine Hydrochloride, 3 times per day (antipsychotic drug)
- Diazepam, 3 times per day (sedative)
- Clopidogrel, morning only (inhibits blood clots)
- Atorvastatin, at night (for blood cholesterol)
- Bisoprolol Fumarate, morning only (treatment for angina)
- Nicorandil, twice a day (treatment for angina)
- Isosorbide Mononitrate, morning only (treatment for angina)
- Lansoprazole, morning only (prevents the stomach from producing gastric acid)

First night in Prison

On 22 August 2009, along with a Nitrolingual spray for immediate relief of an angina attack, Mr Deery received two of his six prescribed medications. These were Chlorpromazine Hydrochloride and Diazepam.

Lagan House-23 August 2009

On 23 August 2009 sometime between 11.35 and 11.44, Mr Deery was seen by a prison doctor in relation to an injury to his right wrist. Following the consultation, the prison doctor authorised the following prescriptions:

To be taken each morning –

Bisoprolol Fumarate Tablets 2.5mg
Clopidogrel Tablets 75mg
Isosorbide Mononitrate capsules 25mg

To be taken three times a day -

Chlorpromazine Hydrochloride Tablets 50mg

Diazepam Tablets 5mg

To be taken twice a day (with food) -

Nicorandil Tablets 10mg

To be taken at night -

Atorvastatin Tablets 10mg

This meant that all of the medicine that Mr Deery had been taking before entering prison was prescribed with the exception of the sleeping tablet Zimovane, antidepressant Gamanil and a tablet Lansoprazole, for managing gastric fluid.

With the exception of Nicorandil, Mr Deery was placed on supervised swallow[29] for the above medications.

Mr Deery's medicine administration record shows that he received four of his seven regular morning medications when he saw the nurse officer between 11.35 and 11.44 on 23 August 2009.

At 19.43 on 23 August 2009 CCTV shows that a nurse officer entered Mr Deery's cell to give him his evening medication. Mr Deery was unhappy with the medication provided and was seen to bang his head off the wall 28 times.

At 20.06, the same nurse officer returned to Mr Deery's cell with more medication, which Mr Deery took. Other than Diazepam, it is unknown what medication Mr Deery was given, as his medical administration card was not filled in and there is no corresponding entry on his medical records.

[29] Supervised Swallow – When prisoners are not permitted to retain and manage their own medication due to risk of abuse, healthcare staff supervise the prisoners taking their medication as directed.

At 22.00, a healthcare officer entered Mr Deery's cell to look at a bump on his head from the earlier head banging incident. Mr Deery was given more medication. The corresponding entry in medical records does not indicate what medication he was given and, again, his medical administration record was not completed.

Lagan House-24 August 2009

At 10.36 on 24 August, a nurse officer entered Mr Deery's cell to give him his morning medication. CCTV shows that Mr Deery was still questioning the medication he was given.

At 14.34, CCTV shows that Mr Deery was provided with his lunchtime medication. It is recorded in his medical administration record that he only received Diazepam which was one of the two medications he had been prescribed to take at that time. He did not receive Chlorpromazine Hydrochloride.

At 18.41, Mr Deery was given his night time medication. Mr Deery's medical administration record was completed and indicates that he was given all his medication as prescribed.

Lagan House – 25 August 2009

At 08.40, Mr Deery was visited by a principal officer. The corresponding entry in the Prisoner at Risk booklet, states that the principal officer *"talked to John in Obs Cell. Complains his meds were wrong and he was not eating. I saw nurse – his meds have arrived and will be on premises this morning."*

An untimed entry on medical records on 25 August 2009 records that a nurse officer was contacted by Mr Deery's community psychiatric nurse (CPN), who had been working with him since he was last released from prison. The record reads:

"His medication within the community prior to his arrest was as per our current prescription PLUS – ***Zimovane 15mg nocte*** *(at night);* ***Lansoprazole 15mg mane*** *(in the morning);* ***Gamanil 70mg nocte with the plan to increase this to 140mg nocte****. Incidentally he was on Diazepam 5mg only."*

At 10.17, a nurse officer gave Mr Deery his morning medication and at 11.36, Mr Deery was seen by a nurse and doctor. The nurse officer gave Mr Deery more medication. It is unknown which of his prescribed medications Mr Deery was given at 10.17 and 11.36, as no record was made on the medical administration record.

At 15.30, Mr Deery was provided with his "lunchtime" medication and at 18.50, having been relocated to the temporary healthcare facility, Mr Deery was given his night time medication.

No changes were made to Mr Deery's prescribed medication following the call received from his community psychiatric nurse.

Medication Administration - Temporary Healthcare Facility

26 August 2009

Records show that on 26 August Mr Deery's medicines were administered and recorded in line with his prescription with the exception of his night time diazepam and Nicorandil.

27 August 2009

Following Mr Deery's assessment by the psychiatrist, during which he complained to her that he was not receiving the correct medication, Mr Deery was prescribed and issued with Zopiclone (same as Zimovane) and Gamanil, but not Lansoprazole.

Clinical Reviewer's Opinion of Medicine Management

In his clinical review report, Dr Fazel said that Mr Deery's medication was not correctly prescribed on reception into prison, and noted that Mr Deery expressed concern about this on a number of occasions.

Dr Fazel noted a short letter in Mr Deery's medical file, dated 2006, referring him to the community mental health service on his release from prison and indicating that he was on an antidepressant Lofepramine (Gamanil) at the maximum recommended dose. Since that letter, it was the case that Mr Deery's medication had reduced to half of the maximum recommended dose of Lofepramine.

Dr Fazel said that, *"Nevertheless, any reduction in antidepressant may lead to a worsening of the symptoms of depression, and it is common practice that an individual would be clinically reviewed to determine whether there had been any such relapse in depressive symptoms. A sudden discontinuation of Lofepramine (Gamanil) can lead to a withdrawal syndrome. This generally begins within 24 to 48 hours after discontinuing the drug. Symptoms peak usually on day 5, and usually resolve within 2 to 3 weeks. "*

The main symptoms associated with Lofepramine withdrawal are dizziness, vertigo, headache, nausea and flu-like symptoms, as well as anxiety, confusion, irritability, excessive dreaming and insomnia.

On 22 August 2009, Mr Deery was given two paracetamol tablets. It is not recorded why these were required. On the 24 August 2009, he was again given two paracetamol and it is recorded that he was suffering from a headache.

It is not known whether or not these symptoms were linked to the withdrawal of Lofepramine.

Dr Fazel also said that without his night time sedation of Zopiclone, Mr Deery's insomnia is likely to have been worse.

Contact with Mr Deery's CPN or GP

Dr Fazel said that *"The fact that healthcare staff did not telephone Mr Deery's GP or his CPN to check his medication was suboptimal care in my opinion."*

Dr Fazel also noted that even after Mr Deery's CPN phoned to tell the healthcare centre about his medication on 25 August 2009, it was not altered on that day. Dr Fazel recommended that *"Due to the problems with sudden withdrawal of psychotropic medication, consideration could be given to making contact with a prisoner's CPN or GP by the end of the next working day."*

Previous Recommendations by the Prisoner Ombudsman relating to Medicine Management

Contact with General Practitioners

In March 2010, following the report of an investigation into another death in custody, the Prisoner Ombudsman recommended that the Prison Service and South Eastern Health and Social Care Trust (SEHSCT) review the arrangements for contacting prisoners' community General Practitioners. In response to this recommendation, the Prison Service and SEHSCT said that the current position is that, if on committal assessment a medical or mental health problem is identified by the committal nurse, the prisoner's GP will be contacted to ascertain all relevant clinical information. The Prison Service also said that the committal process was under review by a joint Prison Service/SEHSCT working group.

Record Keeping

Mr Deery's medicine record and medical records were found not to have been completed/updated in a number of instances. On 19-23 January 2009, the CJI carried out an unannounced follow-up inspection of Maghaberry Prison and found that implementation of a previous recommendation made as a result of the inspection of Maghaberry in October 2005, that all clinical records should be made contemporaneously, had not been achieved. The inspection found that clinical records were kept electronically, which meant that nurses in the houses had easy and ready access to patients' clinical records. It was found that there were some good clinical entries, but also some omissions. The inspection also found that medication was administered to patients without medication administration charts present and at other times records were filled in before the medication was handed out. The CJI again repeated this recommendation.

SECTION 8: THE EXPERT CLINICAL REVIEWS

Two medical experts were commissioned to carry out comprehensive clinical reviews of Mr Deery's healthcare whilst in prison. Dr Seena Fazel is a member of the Royal College of Psychiatrists and has extensive experience of research on the mental health of prisoners and suicide in prisons. Mr Edward Brackenbury is a consultant cardiothoracic surgeon at the Royal Infirmary of Edinburgh who was able to provide a professional opinion in relation to Mr Deery's death and the actions of the medical staff when Mr Deery was discovered.

References to the clinical reviews are made throughout this report. A summary of key areas covered is as follows:

27. Clinical Review Report - Dr Seena Fazel

Dr Fazel made the following assessment:

1. The decision to move Mr Deery from the observation cell to Bush 4 in healthcare

   In my opinion, I do not believe this transfer was not appropriate in the circumstances. It would appear that an updated risk assessment was conducted and the move of Mr Deery was discussed at a multidisciplinary case conference.

2. The decision to change Mr Deery's observation levels from 15 minutes to hourly

   It is my opinion that the decision to reduce the observation levels was not inappropriate. His last recorded self harming episode was on the 23 August and staff perceived his risk of self harm and suicide to have reduced. However, the process by which the decision was made was

unclear and guidelines clarifying how these decisions should be made would be helpful.

3. Consideration of cell sharing and use of own clothing

- *I note that no assessment of Mr Deery's risk was explicitly made in relation to being placed in a cell on his own, with or without his own clothing, and whether any particular items of clothing should be removed.*

- *It is difficult to know whether such an assessment would have altered the type of cell and the circumstances of Mr Deery's accommodation in Healthcare. I note that he had not self harmed with ligature clothing during his current period of custody, but had stated that he intended to hang himself. I note that the NIPS Revised Self Harm and Suicide Prevention policy states in section 3.11 that where a prisoner is deemed likely to self harm, consideration should be given to interim measures that may include 'doubling up with another prisoner or placing the prisoner in safe and appropriate accommodation in a residential area.' From the evidence available to me, there is no indication that this was considered on Mr Deery's transfer to Healthcare, and placing him in a shared cell may well have been appropriate.*

- *It is not possible, in my view to conclude that placing Mr Deery in a shared cell or without any potential clothing that could be used for ligaturing would have prevented his suicide. Reducing ligature points has been an important component of some national suicide prevention policies, and recent data from England and Wales suggests that it may have reduced the number of suicides. But this is far from conclusive evidence as other aspects of the care of prisoners have also improved.*

4. Mental Health Care/Interventions

- *Mr Deery's mental health needs were partially identified on reception. He was put onto a (Prisoner at Risk booklet) which was appropriate considering his background risk and recent apparent suicide attempt in court. However he was not seen by a psychiatrist until the 27 August, around five days after reception into custody. For someone with a complex mental health history, who was on a range of psychotropic medication, and at increased risk of self harm and suicide, this is suboptimal in my opinion, and he should, in my view, have been assessed sooner.*

- *I do not think that there is clear evidence that Mr Deery was suffering from a clinical depressive illness at the time of his death. I note that the psychiatrist found his mood to be reactive and that he discussed the future, both of which are not consistent with a depressive episode, and one Nursing Officer reports Mr Deery smiling and initiating conversation on 27 August, features that are also not usually associated with clinical depression.*

- *I do not believe that Deery's treatment for dysthymia was inappropriate.*

5. Medicine Management

- *Mr Deery's medication was not correctly prescribed on reception into prison and he expressed concern on a number of occasions about this. It was corrected on 27 August 2009 after being seen by the psychiatrist.*

- *A sudden discontinuation of Lofepramine can lead to a withdrawal syndrome. This generally begin within 24 to 48 hours after discontinuing the drug. Symptoms peak usually on day 5 and usually resolve within 2 to 3 weeks. The main symptoms are*

dizziness, vertigo, headache, nausea and flu like symptoms as well as anxiety, confusion, irritability, excessive dreaming and insomnia. These can be experienced by at least a third of patients, are usually mild in nature, but are more severe if the antidepressants had been taken for more than 8 weeks and if there is concurrent antipsychotic use (which there was in Mr Deery's case in the case of chlorpromazine).

- *The fact that healthcare staff did not telephone Mr Deery's GP or his community psychiatric nurse to check his medication was suboptimal care in his opinion. I note that even after his CPN phoned to tell the mental health nurse about Mr Deery's medication, it was not altered on that day.*

6. Mr Deery's anxiety about being moved out of healthcare

- *I do not believe that Mr Deery's refusal of food on 27 August can, in of itself, constitute evidence of a significant change in his mental state. He apparently refused his lunch meal and teatime meal, and we do not know whether he simply did not like the food that he was offered. It is uncertain to what extent the psychiatrist's reported discussion with him about moving back to the main prison on 27 August did upset Mr Deery. The evidence in my opinion is inconsistent and nursing officers report that he was reassured with explanation at 1100 hours but at the same time, he remained 'tearful' and 'concerned' at 1530 hours but not apparently at 1900 hours.*

7. Other Observations

- *The list of indicators in Section 3.4 in the Revised Self-Harm and Suicide Prevention policy has some areas where improvement could be considered in light of new evidence. First, it does not quantify what are the strongest risk factors. Therefore, it may appear that a*

history of self harm, which increases the suicide risk eight-fold according to a recent international review of evidence, is of similar importance in risk prediction to 'an excessively anxious appearance', which the NIPS policy identifies as a risk factor, although there is no replicated evidence to my knowledge that supports anxiety as a risk factor for suicide in custody.

- *Second, the policy identifies a risk indicator that research to date suggests is not associated with suicide – being convicted of a sexual offence.*

- *A final area that the policy could be improved is that some established risk factors for suicide and self harm in custody are not included. These include poor physical health, being on remand, being convicted of a violent offence, and having a life sentence. Furthermore a 2007 review of the literature on self harm in custody has suggested that a history of disciplinary infractions, physical or sexual abuse, and expressing hopelessness are associated with increasing the risk of self harm (Lohner, International Journal of Prisoner Health 2007).*

28. Clinical Review Report - Mr Edward Brackenbury

Mr Brackenbury was commissioned to provide his expert clinical opinion on whether or not the six minute delay, from the initial check on Mr Deery to when CPR commenced, impacted on Mr Deery's death and whether his life could have been saved if staff had intervened sooner.

In his assessment, Mr Brackenbury included the following points:

- *Mr Deery's blood circulation was maintained by the prison nursing staff performing CPR until the paramedics arrived and administered adrenaline to boost the heart rate and blood pressure.*

- *This enabled the circulation to be restored and cardiac massage could be discontinued. However, Mr Deery only took breaths occasionally once his circulation was restored suggesting that he may have already suffered significant brain damage to his respiratory centre located in the brainstem. He still required external respiratory support during transfer to Royal Victoria Hospital (RVH) where he could be formally intubated and artificially ventilated by an anaesthetist.*

- *The fixed, dilated pupils noted on arrival at RVH supported the diagnosis of severe brain injury. CT scanning confirmed that Mr Deery had sustained hypoxic brain injury.*

- *The restoration of the pulse and blood pressure does not necessarily mean that the suicidal act had occurred recently, this is evidenced by the fact that the heart continues to beat for some 20 minutes or so after judicial hangings. My own observation of diseased hearts removed during cardiac transplantation surgery demonstrates that even these diseased hearts can continue to beat intermittently for many minutes after removal from the body. Therefore, one could speculate that, if Mr Deery had hanged himself at 21.53, then the 6 minute delay in opening his cell, undoing the ligature, manhandling him into an appropriate*

area where resuscitation could be effectively performed and assessing his clinical status would be relevant to a condition where every passing minute without a circulation counts towards an increasing probability of severe brain damage. On balance of probabilities, however, it is likely that Mr Deery took his own life sometime before the 21.53h check evidenced by the lack of pulse when found and there was therefore enough time to already have produced irreversible brain damage from which he could not be recovered despite rapidly restoring his circulation. Indeed, it is entirely conceivable that Mr Deery took the opportunity to commence his suicidal plans during the disruption to routine caused by another prisoner's sudden illness.

- *The question arises whether the Senior Officer should have opened Mr Deery's cell at 21.53 rather than 21.59 and potentially abbreviating Mr Deery's ongoing brain damage by 6 minutes. If Mr Deery had shut down the circulation to his brain at 21.52 then a 6 minute delay before restoration of the cerebral circulation would be materially relevant to the outcome of resuscitative efforts. If Mr Deery had shut down the circulation to his brain at, say 21.49 then significant brain damage would have likely occurred and the 6 minute delay to open the cell would be materially irrelevant to the outcome.*

- *With respect to the prison staffs' clinical management of Mr Deery there is no evidence of any clinical negligence. The nurse worked hard to successfully maintain Mr Deery's circulation and respiration and should be commended for her efforts.*

- *I would also like to point out that, after reading the transcripts of interviews with the nurse and senior officer, I was impressed by the care and responsibility shown by these members of staff towards their incarcerated charges.*

- *The provision of torches with which to adequately visualise prisoners during checks and provision of knives to cut ligatures are already in*

place. I think it is important that prison officers, when checking prisoners at risk, seek a verbal response from those who appear awake.

South Eastern Health and Social Care Trust's Response to the Clinical Review's

A copy of the clinical review reports were provided to the South Eastern Health and Social Care Trust, to provide the Trust with the opportunity to respond to the reviewers comments.

The Trust made the following responses:

Dr Fazel's Clinical Review Report

"The report highlighted areas where Dr Fazel felt that the health care provided was suboptimal; namely that:

a. People with complex mental health needs should receive a mental health assessment sooner than was the case with Mr Deery.

b. Healthcare staff did not contact Mr Deery's GP to check his medication following reception.

The Trust would wish to provide reassurance that action has been taken to address the shortfalls addressed by Dr Fazel.

All prisoners identified on committal with mental health needs are now referred to the Mental Health Team. Routine referrals will be seen within one week. Urgent referrals will be seen by a health care professional within 48 hours. All prisoners identified on committal who are on prescribed medication will have medication prescribed the next working day following confirmation of medication prescribed by their GP."

Mr Brackenbury's clinical review report

"We note his commendation for the nurse who worked hard to successfully maintain Mr Deery's circulation and respiration. We also note that he was

impressed by the care and responsibility shown by the nurse and senior officer.

I wish to indicate one point of correction, in Mr Brackenbury's conclusion he raises the issue of the 6 minute delay in commencing CPR and possible resulting consequences, however he then goes on to say that in the balance of probabilities Mr Deery had already done irreversible damage before 21.53hrs."

(Prisoner Ombudsman Note: Mr Brackenbury assessed the impact of the six minute delay on the Mr Deery's final outcome. It is correct, as stated by the Trust that it was his opinion that in the case of Mr Deery, the greater likelihood was that Mr Deery had already done irreversible damage, by the time he was found. Mr Brackenbury's analysis demonstrates that, in other circumstances, six minutes could be materially relevant.)

SECTION 9: PREVIOUS PRISONER OMBUDSMAN RECOMMENDATIONS IN RESPECT OF THE DEATH IN CUSTODY OF MR COLIN BELL

On 9 January 2009, the Prisoner Ombudsman reported on the death in custody of Mr Colin Bell. Like Mr Deery, Mr Bell was a vulnerable prisoner who had a history of self harm and was on an open Prisoner at Risk booklet at the time of his death. The investigation into Mr Bell's death found that the observation and care of Mr Bell in the days before his death fell well short of acceptable standards. As a result of the investigation into Colin Bell's death, the Prisoner Ombudsman made 44 recommendations to the Prison Service and South Eastern Health and Social Care Trust (SEHSCT). 43 of the recommendations were accepted.

The following is a list of areas/arrangements where concerns were identified in the Colin Bell report, and recommendations were made and accepted, where evidence of the same concern was wholly or partially evidenced during the investigation into the death of Mr Deery:

- Carrying out of observational checks
- Carrying out and recording of conversational checks
- Carrying out of checks that are unpredictable
- Recording of information about observations
- Arrangements for the authorisation of anti suicide clothing
- Carrying out of appropriate and recorded staff handovers
- Carrying out of appropriate and recorded risk assessments to inform decisions
- Arrangements for time out of cell/purposeful activity
- Appointment of care co-ordinators to vulnerable prisoners
- Preparation and use of care plans
- Culture of care in respect of vulnerable prisoners
- Carrying out of robust self audit to measure standards of prisoner care

Pearson Review Report – June 2009

As part of the Pearson review team's terms of reference they were required to *"quality assure the effectiveness of the Maghaberry and NIPS action plans for implementing the Ombudsman's Recommendations."*

In doing so, the review recommended that implementation of recommendations 1 to 43 should be completed by December 2009.

The six month audit report to review progress made on the previous recommendations from the Pearson Report Team, was published on 25 March 2010. It stated that 31 of the Prisoner Ombudsman's recommendations were complete and 12 remained partially complete. Only one recommendation, the requirement for a job description for Night Custody Senior Officers, was considered to be an issue for concern.

CJI report on Vulnerable Prisoners - December 2009

In December 2009, the Criminal Justice Inspectorate (CJI) carried out an inspection of the treatment of vulnerable prisoners by the Northern Ireland Prison Service. The report sets out CJI's assessment of the extent to which the Prisoner Ombudsman's recommendations made in the death of Mr Bell had been delivered. It also provides a wider view on the treatment of vulnerable prisoners across the Prison Service.

In summary, the inspection found that much activity had taken place in response to the findings and recommendations of the report into the death of Mr Bell, and examples of good practice across the Northern Ireland Prison Service was seen.

However, the inspection found significant concerns over the regime for vulnerable prisoners at Maghaberry Prison. The report said that little appeared to have changed in the day to day regime for vulnerable prisoners, which was not adequate for their ongoing care and improvement. The

inspection also found that prisoners continued to spend too long in their cells, have inadequate multi-disciplinary care and limited access to out-of-cell activities. The assessment and monitoring of prisoners at risk was also found to be inconsistent.

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

   - **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

   - Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
   - Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
   - In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.

- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require

immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to

criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Secretary of State for Northern Ireland (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

16. Annex 'A' contains a more detailed description of the usual reporting procedure.

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

3. The Service responds within 28 days. The response:

   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of

the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman

will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

APPENDIX 2

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a modern high security prison which holds adult male long-term sentenced and remand prisoners, in both separated[30] and integrated[31] conditions.

Maghaberry Prison was built to accommodate 682 prisoners, however, there were 789 prisoners in Maghaberry on the day Mr Deery died.

Maghaberry Prison is one of three Prison establishments managed by the Northern Ireland Prison Service, the others being Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. Four Square Houses - Bann, Erne, Foyle and Lagan, along with purpose built separated accommodation houses of Roe and Bush, make up the present residential house accommodation.

There are three lower risk houses within the Mourne Complex of Maghaberry Prison, called Braid, Wilson and Martin Houses. These are used specifically to house life sentence prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU) located at Crumlin Road, Belfast.

There is also a Landing called Glen House which is used to accommodate vulnerable prisoners and a further Landing in Lagan House, called the REACH[32]

[30] Separated – accommodation dedicated to facilitate the separation of prisoners affiliated to Republican and Loyalist groupings.

[31] Integrated – general residential accommodation houses accommodating all prisoners

[32] REACH Landing definition – **R**eaching out to prisoners through **E**ngagement, **A**ssessment, **C**ollaborative working **H**olistic approach.

Landing. The REACH Landing is a service which identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working.

The REACH Landing is a facility which the Prison Service states *"identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working and person centred planning."*

There is also a Special Supervision Unit[33] (SSU) and a Healthcare Centre in Maghaberry Prison, which incorporates the prison hospital.

The regime in Maghaberry Prison is intended to focus on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and resettlement of which addressing offending behaviour is an element.

Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme[34] (PREPS).

Maghaberry Prison was last inspected by HM Chief Inspectorate of Prisons and the Chief Inspector of Criminal Justice[35] in Northern Ireland in October 2005.

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[33] Special Supervision Unit (SSU) – cells which house prisoners who have been found guilty of disobeying prison rules, and also prisoners in their own interest, for their own safety or for the maintenance of good order under Rule 32 conditions.

[34] Progressive Regimes and Earned Privileges (PREPS) - There are three levels of regime. Basic - for those prisoners who, through their behaviour and attitude, demonstrate their refusal to comply with prison rules generally and/or co-operate with staff. Standard - for those prisoners whose behaviour is generally acceptable but who may have difficulty in adapting their attitude or who may not be actively participating in a sentence management plan. Enhanced - for those prisoners whose behaviour is continuously of a very high standard and who co-operate fully with staff and other professionals in managing their time in custody. Eligibility to this level also depends on full participation in Sentence Management Planning.

[35] Website link - http://inspectorates.homeoffice.gov.uk/hmiprisons/inspect_reports/547939/551446/maghaberry.pdf?view=Binary

As well as taking into account the clinical review carried out by Professor McClelland mentioned earlier, I also draw references in my report to a publication called: *"A review of Non–natural Deaths in Northern Ireland Prison Service Establishments (June 2002–March 2004)"* which was chaired by Professor McClelland.

The REACH Landing

The REACH Landing in Lagan House was established in April 2007. This is a facility which the Prison Service states *"identifies prisoners with complex needs, and provides assessment and support within a structured and therapeutic environment, facilitated by multi-disciplinary working and person centred planning."*

The original ethos and expectation for the REACH Landing was to manage the needs of prisoners and staff within a supported environment to help improve prisoners' mental well-being and social functioning, reduce staff distress, improve relationships and reduce the use of Rule 32[36]. The average length of time a prisoner is located on the landing is 10 weeks.

The REACH Landing provides accommodation for between 16-20 prisoners who are referred and assessed by staff for suitability. Prisoners are reviewed after 4 weeks on the Landing to ascertain if they are suitable to be located back into the general prison population.

The staff working on the REACH Landing undertake mental health awareness training. The programme includes learning how to deal with psychiatric illnesses, learning therapeutic communication skills, motivational interviewing and dealing with personality disorders.

[36] Prison Rule 32 – where it is necessary for the maintenance of good order or discipline, or in his own interests that the association permitted to a prisoner should be restricted, either generally or for particular purposes, the governor may arrange for the restriction of his association by placement in the Special Supervision Unit (SSU).

Observation Cell Accommodation

The other unique function of the REACH Landing in Lagan House within Maghaberry Prison is the Safer Custody suite.

The Safer Custody suite consists of two observation Cells, Cell 15 and 16, and a double Listener cell at Cell 17/18 which is two cells joined together.

All observation Cells have CCTV camera, built in television in a panel which also incorporates panel buttons for access to an intercom/telephone to the Samaritans, as well as an emergency call bell and intercom to the Secure POD.

The Secure POD is located at the entrance to each residential house and is the key control point within each house where all prisoner and staff movement is managed and logged.

During the day, the Secure POD is staffed by two Main Grade Officers and in the evening by one Night Custody Officer.

The Secure POD is locked and access is restricted. If a member of staff requires entry to the Secure POD, the keys should be passed out through a key window and the door is opened from the outside.

In Lagan House, the Secure POD is also responsible for monitoring the observation cells located on the REACH Landing.

There are CCTV cameras in all the observation cells and the Secure POD Officers on duty are responsible for monitoring the occupants of those observation cells at 15 minute intervals using observation logs.

All observation cells are fitted with anti-ligature furniture and fittings which include:

- *"A high security window with polycarbonate glazing*

- *24 hour CCTV observation facility*
- *Cast synthetic resin wash hand basin and WC Pan with push button water controls*
- *Audible cell call system and intercom facility directly linked to staff*
- *Direct help line to Samaritans*
- *Fixed resin cell furniture and bed*
- *Cornice light fitting and TV recessed into protective metal casing."*

POLICIES AND PRISON RULES

Prison Rules

Rule 47 of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 gives the authority under which a person can be confined in a special cell or protected room. This Rule is replicated below:

"Temporary confinement

***47.** –(1) For the purpose of preventing disturbance, damage or injury, a refractory or violent prisoner may be temporarily confined in a special cell or protected room approved for the purpose by the Secretary of State; but a prisoner shall not be confined in such a cell as a punishment or after he has ceased to be refractory or violent.*

(2) The governor shall inform the medical officer of the intended removal of any prisoner to a special cell or protected room, but where this is not possible the medical officer shall be informed as soon as possible thereafter.

(3) Notwithstanding the provisions of paragraph (1) and (2) the medical officer may, for the purpose of preventing a prisoner from causing injury to himself or to others, order that he may be temporarily confined in a protected room and to be confined there for as long as the medical officer considers necessary.

(4) The governor, the Secretary of State and a member of the board of visitors (now called independent monitoring board) shall be informed of any prisoner who is so confined.

(5) Every prisoner who is temporarily confined in a special cell or protected room shall be visited at least once a day by the governor and by the medical officer.

(6) Every prisoner so confined shall be observed at least once every 15 minutes by an officer and a record shall be kept of such observations."

Standard Operating Procedures

The policy for the use of the observation cell in Maghaberry Prison is reflected in its Standard Operating Procedures Document SOP/01, issued on 27 May 2008.

The Standard Operating Procedures Document SOP/01 for the Use of the Observation Cell in Maghaberry Prison is further reflected, service-wide, in the CRC 1 Use of Observation Cell (Special Accommodation) Authorisation booklet.

Death in Custody Contingency Plan

The Death in Custody Contingency Plan provides step by step guidance for all staff in how to deal with and manage the death of a prisoner in custody.

Governor's Orders

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners.

Governor's Order 1-12 'Self Harm and Suicide Prevention': Provides information on the Prison Service's Self Harm and Suicide Prevention policy. It describes a number of preventative measures, including the use of the protected room in healthcare. It also sets out the procedures to follow when a prisoner has attempted suicide, action taken in cases of hanging, suspected drug overdoses, swallowed corrosive substances and severe external bleeding.

Governor's Order 2-29 'Observation Cells': provides the specification of an observation cell and sets out the procedures to follow when the use of one is required.

Governor's Order 3-12 'Preservation of Evidence': sets out the procedures to be followed on discovery of a serious incident, what considerations need to be

addressed to ensure evidence is preserved and the avoidance of contamination and overall scene management.

Governor's Order 7-19 'Body Checks/Roll Checks: provides information and instructions to staff on how prisoners should be checked at specific times of the day and night and to ensure there are no defects in the fabric of the establishment.

Self-Harm and Suicide Prevention Policy

In a desire to improve its arrangements for dealing with vulnerable prisoners, the Prison Service revised its Self-Harm and Suicide Prevention policy in September 2006.

The revised policy states that it:

"aims to identify prisoners at risk of suicide or self harm and provide the necessary support and care to minimise the harm an individual may cause to him or herself. The Service recognises that this is an important priority and one that demands a holistic approach."

Following investigations into a number of deaths in custody where recommendations were made by the Prisoner Ombudsman and Professor McClelland in his review into non-natural deaths in NIPS, in January 2009, an addendum to the September 2006 Self Harm and Suicide Prevention policy was introduced, in particular, to provide additional information to reflect the NIPS response to the Colin Bell recommendations.

Prisoner at Risk' Booklet

A Prisoner at Risk (PAR 1) booklet is an authorisation and observation booklet which is opened when a prisoner is put under closer observation, usually in his own cell, for his own protection and safety.

The Prison Service's Self-Harm and Suicide policy states that *"a multi-disciplinary case conference must be held at least every 14 days*" for a prisoner with an open PAR 1.

PREPS – Progressive Regime and Earned Privileges

PREPS hinges on motivating prisoners to engage with the constructive activities outlined on their agreed resettlement plan. Constructive activities include any form of training, education, work or other activity, as specified on the plan. PREPS works towards these objectives of allocating privileges according to different regime levels. Privilege and regime levels are based on a three tier system: Basic, Standard and Enhanced.

CRC 1 'Use of Observation Cell' Authorisation Booklet

The policy reflecting the Use of the Observation Cell in Maghaberry Prison is laid out in the Standard Operating Procedures Document SOP/01 mentioned earlier in paragraph 57 and 58 and replicated in Annex 3.

In line with the policy, if a prisoner has shown, or has demonstrated, a greater risk of self-harm, an authorisation for the prisoner to be placed in a Observation Cell can be initiated using a CRC 1 Use of Observation Cell (Special Accommodation) Authorisation booklet. The CRC 1 booklet also states:

"Extension -
Authority to extend the use of Special Accommodation (Observation Cell), anti-ligature clothing or mechanical restraints should only be granted following full consideration of all the relevant information. Authorisation for the use of special accommodation, anti-suicide clothing or mechanical restraints for any period in excess of 24 hours may only be granted by the Secretary of State through the Deputy Director, Head of Operations at Prison Service Headquarters. The reasons for an extension must be fully documented."

[Note: Although the CRC 1 sets the authorisation level for the extended use of the Observation Cell for any period in excess of 24 hours at Deputy Director level, this is not fully reflected in the Standard Operating Procedures Document SOP 0/1]

However, in line with those Standard Operating Procedures, the CRC 1 instructions, as quoted above, contain the necessary instructions for the authorisation for the use of anti-suicide clothing or mechanical constraints, including the requirements to be adhered to, at Deputy Director level, if these measures are to be used for any period of extension in excess of 24 hours.

Samaritans Listener Scheme

The Samaritans' Listener Scheme was launched at Maghaberry Prison on 11 December 2006. The scheme is controlled by the Samaritans. A Principal Officer acts as a Co-ordinator on behalf of the Prison Service.

The agreement for provision of the scheme is laid out in a Service Level Agreement between the Governor of Maghaberry Prison and the Samaritans Belfast Branch. Guidance on the scheme is set out in Governor's Order 7-22, Notices to Staff 124, 125, 126/06, and Notice to Prisoners 69/06.