The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

PRISONER B

AGED 36

IN MAGHABERRY PRISON

ON 8 MARCH 2009

27 October 2010

[Published: 15 November 2010]

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

22nd Floor, Windsor House, Bedford Street, Belfast BT2 7FT
T 028 9044 3982 F 028 9044 3993 www.niprisonerombudsman.gov.uk

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PREFACE

At the request of his family, the Prisoner to whom this report refers has, throughout this report, been called Prisoner B.

Prisoner B was born on 29 November 1972. He was 36 years old when he died by suicide in his cell in Lagan House, Maghaberry Prison, on the night of Sunday 8 March 2009.

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

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

My findings are presented in 10 sections:

- Section 1: Prisoner B's regime and Activities as a Chinese National Prisoner
- Section 2: Events between 15 August 2008 and 1 September 2008
- Section 3: Events between 2 September 2008 and 28 September 2008
- Section 4: Prisoner B's Admission to the In-Patient Healthcare Unit, 20 to 28 November 2008
- Section5: Events between 28 November 2008 and 24 February 2009

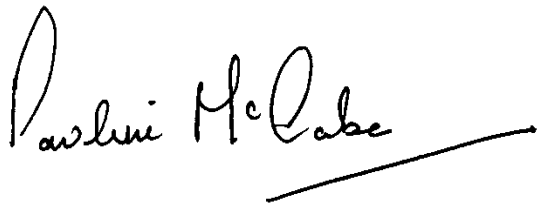
- Section 6: Events between 25 February 2009 and 7 March 2009
- Section 7: Events of 8 March 2009
- Section 8: Post Mortem Report
- Section 9: Events after Prisoner B's death
- Section 10: Independent Clinical review
- Section 11: Other Issues

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 my additions or changes.

As a result of my investigation, I make **nine 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.

I would also like to thank the Chinese Welfare Association for their assistance in liaising with Prisoner B's family.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
27 October 2010

SUMMARY

Prisoner B was remanded into the custody of Maghaberry Prison on 9 June 2008. Prisoner B had been in Northern Ireland for approximately six months.

On 10 June, as part of the normal committal process, Prisoner B underwent a healthcare assessment to identify any medical problems that would need to be addressed during his time in prison. As Prisoner B did not speak any English, the nurse who assessed him was assisted by an interpreter. Prisoner B was assessed as being fit and well. It was noted that he was calm and cooperative and had no thoughts of self harm.

Prisoner B was one of 48 Chinese prisoners taken into custody around the same time, on the back of a PSNI operation. The investigation found that the Prison Service had made efforts to be responsive to the particular needs of the Chinese and other foreign national prisoners. The action taken and the findings of an inspection in 2009 in respect of these are described in Section 11 of this report.

Up to 14 August 2008, Prisoner B appeared to be coping with prison life. He was attending some education classes and sport activities, using the library and attending Sunday Church services.

On 15 August 2008, it was brought to the attention of landing staff, by a fellow Chinese prisoner, that Prisoner B was not feeling well. A nurse officer assessed Prisoner B and found that he was tearful and appeared depressed. It is recorded that Prisoner B expressed concerns about his family in China and the fact that he never received

the money he was owed for the crimes he was alleged to have committed. Following the consultation, it is noted that Prisoner B was to be referred to the mental health team and the prison doctor.

On 22 August 2008, Prisoner B had his initial consultation with a mental health nurse officer, who became his primary mental health nurse. A full mental health assessment was carried out which resulted in a risk assessment and care plan being drawn up. During the assessment, Prisoner B said to the nurse that there was a history of mental health illness in his family which was never formally diagnosed, due to the families' financial situation. The mental health nurse noted that Prisoner B had experienced *"Low mood for two years which has become worse over the past two months while in prison," "States he feels emotionally blunt,"* and *"Being in company doesn't improve his mood."*

The mental health nurse also recorded that Prisoner B had told her that he had never self harmed before but that he *"had one thought of self harm a week ago but this scared him. He had thoughts of banging his head off the wall but stopped when he thought of his family."*

The nurse recorded her intention to consult with the prison doctor in order to start Prisoner B on anti-depressants. She also recorded that she planned to review Prisoner B again in two weeks time and that she had spoken to the landing staff, who had advised her that they would consider giving Prisoner B a job.

In his clinical review report, Dr Quinn said that the mental health assessment, risk assessment and care plan produced on 22 August 2009 were all appropriate and he noted that *"the risk assessment*

identified risk of self-harm, need for treatment with anti-depressant medication and a pragmatic approach to managing him on the wing through employment." Dr Quinn was impressed that Prisoner B's mental state was recognised to be disturbed and his needs were identified, at such an early stage.

Between 22 August and 1 September 2008, Prisoner B's mood did not improve. He was seen on four separate occasions by different nurse officers during this period. It is recorded that Prisoner B had been seen to be visibly upset and weeping and landing staff were concerned about his well being. During a mental health review on 1 September, Prisoner B told the nurse that he felt his life was *"meaningless while in prison."* Prisoner B had still not been prescribed anti-depressants and it was decided that he should see a prison doctor the next time a doctor was available. In the event, Prisoner B did not see a doctor but his anti-depressants were prescribed on 2 September 2008 and given to him on 4 September 2008.

On 3 September 2008, it was brought to the attention of a senior officer in Lagan House, by another Chinese prisoner, that Prisoner B was still tearful and had been rocking. As a result, a further review was carried out by Prisoner B's mental health nurse. The nurse recorded that Prisoner B was *"no worse since I saw him last, has thoughts of self harm."*

Concerned about this development, a Prisoner at Risk (PAR1) booklet[1] was opened to ensure regular staff observation of Prisoner B and increased engagement with him. To reduce the risk of him feeling

[1] PAR 1 Booklet definition – A **P**risoner **A**t **R**isk booklet is 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.

isolated, managers in Lagan House also agreed that staff would try and ensure that Prisoner B was kept with a cell mate.

Prisoner B's PAR1 booklet remained open until 28 September 2008, during which time he spent time in the REACH gardens[2] and was given small tasks such as making cups of tea and tidying up as part of his care plan. Two further mental health reviews took place and it is recorded that Prisoner B's mood had improved.

The decision to close Prisoner B's PAR1 booklet was, in line with Prison Service policy, taken at a multi-disciplinary case conference. It was agreed that the PAR1 would be closed on the basis that Prisoner B was *"much more settled and engaging in activities. He attends the REACH gardens and is interacting much more with some of the Chinese prisoners who are offering good support to him. He feels his medication is effective and claims he had no thoughts of self-harm. He continues to have issues in relation to his family, but is coping better and is happy to come off the PAR1. Has been reassured that support is still available to him and he was encouraged to come to staff if he feels down. He stated he would."*

Reviewing the decision to open the PAR1, Dr Quinn said that, not only were Prisoner B's health difficulties noted but the need for a cell mate was also identified. He concluded that there was a pragmatic, holistic approach and that both the decision to open the PAR1 and the decision to close it, were appropriate.

[2] REACH Gardens definition – REACH stands for **R**eaching out to prisoners through **E**ngagement, **A**ssessment, **C**ollaborative working **H**olistic approach. There is a landing and gardens dedicated for use in the management of vulnerable prisoners.

Following the closure of the PAR1, two further mental health reviews were carried out on 8 October and 7 November 2008. It was found that Prisoner B's mood had begun to deteriorate.

On 20 November, Prisoner B was again seen by his mental health nurse who recorded:

"Spoke with Prisoner B via an interpreter. Mental state has deteriorated. There has been a period of lock down in Lagan House. Prisoner B has been stopping and starting his anti-depressants, he's not eating properly, he's not sleeping and he feels guilty about the situation and missing his family. During the interview (he) was crying and rocking and he has a swollen right eye from crying. Denies any thoughts of harming himself but appears miserable. Plan to bring him in to healthcare for a period of assessment."

The reference to *"a period of lock down"* resulted from all prisoners in Lagan House being confined to cell for a number of days, following an attack on Chinese prisoners by other prisoners on 13 November 2008.

Later that day, on 20 November, Prisoner B was seen by a visiting psychiatrist[3]. This was the first time, since his committal to Maghaberry, that Prisoner B had been seen by a doctor.

Following the review on 20 November, the Psychiatrist noted:

".....Transferred for assessment of mental state following concerns. Describes difficulties in mood, sleep appetite from June 2008. Recently prescribed antidepressant medication, however describes issues with

[3] Visiting Psychiatrist – A psychiatrist who is not a full time employee of the Prison Service, but contracted to attended the prison on a part time basis.

receiving this on a regular basis. Denies a past psychiatric history, psychiatric admissions or deliberate self harm. Denies medical history. Currently on antidepressant medications……. On mental state examination pleasant and cooperative. Eye contact poor. Speech spontaneous, no English. Mood lowered, sleep reduced with initial insomnia, appetite reduced but no reduction in weight. Reduced interest and social interaction. Denies thoughts of self harm or suicidal ideation. Concerns regarding family and them not being provided for as he is currently not working. Denies hallucinations. Cognition and insight intact. Impression is one of depressive episode within the context of situational difficulties and intermittent treatment with medication. Plan- Admit to healthcare for a period of assessment. Review medications. Review arranged with the interpreter for Tuesday. Nursing staff to coordinate telephone call to family and visit from Chinese speaking friend if Prisoner B wishes and prison is agreeable. Allow to library for reading material and association at ward level."

The psychiatrist prescribed a different anti-depressant for Prisoner B and increased the dosage.

Prisoner B's nursing progress sheets record that while he was in the in-patient unit, he "*appeared to be settled", "used the telephone", "read book"* and *"slept well."*

Prisoner B was seen again by the visiting psychiatrist on 25 November 2008. The psychiatrist noted that Prisoner B's mood had improved and that he was keen to engage in orderly type work duties.

Having discussed arrangements for Prisoner B's return to Lagan House with a senior officer, the psychiatrist recommended that in view

of Prisoner B's current mental state and the "*propensity for social and cultural isolation within the healthcare setting*," Prisoner B would be discharged from the healthcare centre on 27 November 2008. It was also noted that it would be advantageous for Prisoner B to carry out light orderly type duties, as well as spending time in the REACH gardens with a member of the Chinese community.

The psychiatrist did not note any requirement for a further review of Prisoner B.

In his clinical review report, Dr Quinn expressed his concern about the level of input by doctors into Prisoner B's assessment and care plan. He said that it was a matter of concern that Prisoner B appeared to have contact on two occasions with the visiting psychiatrist and, beyond these contacts, he was not monitored by either a general practitioner or a psychiatrist. Dr Quinn said that *"the absence of frequent medical review of someone in whom there are concerns about their mental state would not in the author's view amount to the full use of multi-disciplinary involvement…..more specifically, this is usually at regular intervals when a prisoner is in receipt of treatment with psychotropic medication."*

Between 28 November 2008 and 5 February 2009, Prisoner B had a further four mental health reviews with nurses. At a review on 18 December 2008, the mental health nurse recorded that Prisoner B's mood had improved and attributed this to the new medication he had been taking since 20 November 2008. At a review on 31 December 2008, the same nurse recorded that Prisoner B *"appeared flat"* although he said that he was "*feeling fine and eating and sleeping well."* At a review on 9 January 2009, it is recorded that Prisoner B

"*looked gloomy*" and that he was sharing a cell with a Chinese prisoner, but was very homesick and keen to return to China and his family.

Prisoner B's last review before his death took place on 5 February 2009 and was not, as required, recorded on the healthcare EMIS[4] system. On 16 March 2009, after Prisoner B's death, the nurse who reviewed him on 5 February 2009 completed a staff communication sheet, giving an account of the consultation. The sheet was also signed by the interpreter who was present at the review. The nurse wrote that Prisoner B's mood was much the same, that he missed his family and that he had said that he was eating and sleeping fairly well and was continuing with his medication, which was helping. She also wrote that he was getting on well with his cell mate and getting out to the REACH gardens which he enjoyed. She said that Prisoner B denied any thoughts of harming himself and was looking forward to his trial, which he believed would be coming up soon and would mean that he would know when he could return to China.

The mental health nurse made a note in her diary on 5 February 2009 in respect of Prisoner B to "*carry forward*" and the investigation was advised that the nurse intended to review Prisoner B on 19 February 2009 and 25 February 2009. The South Eastern Health and Social Care Trust advised that the planned reviews did not take place because the nurse was unavailable because of other duties.

As stated, the nurse who saw Prisoner B on 5 February 2009 said that he was looking forward to his trial and to knowing when he might be likely to be able to go home. It is evident from Prisoner B's phone

[4] EMIS Definition – Egton Medical Information System which is an electronic database which stores a persons medical history.

calls home that he was missing his family very much. It is also evident from phone calls and interviews with Chinese prisoners who knew Prisoner B that he desperately wanted his case to be heard and was extremely worried about how long his sentence would be. It would appear to be the case that Prisoner B thought that he could receive a sentence of up to 12 years.

On 25 February 2009, Prisoner B attended a remand hearing via video link. It was evident from Prisoner B's telephone conversations with his family that he was expecting to hear when his trial date would be set. This was not, however, the case and a further remand hearing was scheduled to take place in four weeks.

Following this news, Prisoner B telephoned his wife and is heard to be upset and sobbing throughout most of the call.

During the call, Prisoner B tells his wife that the delay is because of the numbers that have been arrested. He tells her that only three people have yet to go to trial and that he is one of the last to get a trial date, because his case is slightly more complicated than others. Prisoner B's wife is upset to hear her husband sobbing and he tries to reassure her saying, *"it's nothing, it's nothing. I'm fine here with no other worries. It's just the waiting time is too long."*

At interview, Prisoner B's cell mate in the weeks before his death said that it was obvious that Prisoner B's frame of mind was a lot worse after the video link remand hearing on 25 February 2009. He said that Prisoner B would cry and shout into his blanket to muffle the sound. Prisoner B's cell mate stated that he never told the prison how

unhappy Prisoner B was and that this was because of the language barrier.

Prisoner B's cell mate said that Prisoner B couldn't understand why some prisoners had already been sentenced but that, nine months on, he still hadn't been.

In a further phone call home on 28 February 2009, Prisoner B was again very upset and can be heard sobbing from time to time, especially when he speaks to his children. His children tell him how much they miss him.

Prisoner B's cell mate had been sharing a cell with him since 6 January 2009 but, having achieved Enhanced status in accordance with the Prison Service PREPS[5] policy, he was entitled to a single cell as a privilege. There is usually a waiting list for single cells and, on 7 March 2009, when a cell became available, Prisoner B's cell mate was next on the list and took the opportunity to move.

At interview, Prisoner B's cell mate stated that Prisoner B helped him move his belongings across the landing into his new cell. He said that Prisoner B did not show any sign of being upset that he was moving.

A senior officer in Lagan House who knew Prisoner B well, said at interview that he was not aware of Prisoner B's distress at this time. He further said that at that time, following a recent death in Lagan House, staff were more sensitive to mood changes and he was, therefore, shocked to hear that Prisoner B's low mood, as reported by Prisoner B's cell mate and evidenced by his phone call, had not been

[5] PREPS Definition – Progressive regime and earned Privileges Scheme.

picked up. He said that staff had a good relationship with the Chinese prisoners and prisoners would often come to him or other staff if there were things that they needed to know, or that they thought staff should know. He also said that if staff had been aware that Prisoner B was at risk, then they would have delayed moving his cell mate. He stated that he wasn't *"on their radar"* as being currently at risk.

Whilst there was significant evidence of nurse led mental health reviews and a range of positive interventions in response to Prisoner B's mental state over his months in Maghaberry, as stated earlier, it was the case that Prisoner B's last health review was on 5 February 2009, 31 days before his death. It would appear, therefore, that healthcare staff were also unaware of Prisoner B's mental state in the weeks before his death.

At around 12.20 on 8 March 2009, Prisoner B went with other prisoners from his landing to the yard and recreation room for association time.

CCTV of the recreation room shows prisoners either playing pool or playing cards in groups in the corner of the recreation room. Prisoner B is seen to spend most of his time moving around between the recreation room, dining hall and yard. During the course of the association, Prisoner B has conversations with three different prisoners.

At interview two of the prisoners who spoke with Prisoner B said that he talked to them about his concerns about the length of the sentence he would receive. One of them also said that it had cost Prisoner B £18,000 to come to the UK and he was worried that there would be

serious consequences for him and his family if the debt was not repaid.

At 12.26, Prisoner B made a phone call home and spoke to his mother. During the call Prisoner B does not show any obvious signs of distress. He asks his mother where his wife is and is told that his wife is in Beijing and that she left two days ago.

Following association, Prisoner B returned to the landing at 15.35. The tea meal was served and the prisoners were locked for the night at 16.15.

At approximately 20.20 on 8 March 2009, a night custody officer carried out a headcount check by looking into each cell on landings 3, 4, 5 and 6 in Lagan House, which he was responsible for. All 92 prisoners, including Prisoner B, were checked and accounted for.

At approximately 21.30 on 8 March 2009, the night custody officer commenced a prisoner check, accompanied by a senior officer who was carrying out a supervised body check[6] of all 92 prisoners.

At interview, the night custody officer said that when he came to Prisoner B's cell and opened the observation flap, he observed Prisoner B hanging at the end of his bed. He said that he called over to the senior officer and told him *"I've got someone hanging"*.

[6] Supervised Body Check – A routine unannounced check of prisoners, carried out by a senior officer.

CCTV shows that at 21.50 the senior officer ran to the secure POD[7] on the ground floor of Lagan House, retrieved a set of keys from his bag and ran back to Prisoner B's cell.

Prisoner B was then cut free and placed on bedding on the ground. Officers commenced cardiopulmonary resuscitation (CPR).

CCTV shows a nurse officer arriving in Lagan House at 21.52, accompanied by another night custody officer. At interview, the nurse officer stated that when she entered the cell, she was able to establish, after a five second assessment, that there were no signs of life. She requested an emergency ambulance and the on call prison doctor to attend.

Prisoner B's vital signs were found to be negative as CPR continued. The nurse checked Prisoner B's central nervous system observations at five minute intervals, but there was no response.

When the paramedics arrived in Lagan House at 22.33, they also established that Prisoner B had no signs of life. The on-call prison doctor arrived on the scene and pronounced Prisoner B dead at 22.55.

A post mortem examination gave the cause of Prisoner B's death as *"hanging."*

The toxicological analysis of samples taken at the autopsy was negative for alcohol and common drugs, including mirtazapine, the anti-depressant Prisoner B was intended to be taking. A forensic

[7] Secure POD definition – A secure room located in each house which monitors and controls access to and from the area. It also it the central point of contact for the main emergency room when there are any incidents. CCTV monitors are also located in this room.

scientist advised the investigation that it is likely that Prisoner B had not taken mirtazapine within the previous one to two days.

Withdrawal symptoms associated with mirtazapine include anxiety, agitation, irritability and panic attacks.

Prisoner B received his medication on a weekly basis and it is not possible to say how many doses of mirtazapine Prisoner B may have missed and whether he was experiencing any withdrawal symptoms.

Prisoner B wrote two letters before he died. In a letter to his family Prisoner B expressed deep regret about his current circumstances and was very concerned that the police thought that he was more involved than he was. In a letter to the PSNI, Prisoner B made it clear that his death was nothing to do with anyone but himself.

Following Prisoner B's death the Prisoner Ombudsman received a joint letter from 11 Chinese prisoners in which they said that the time the police investigation was taking was a contributory factor to Prisoner B taking his own life. They said also that Prisoner B was tirelessly saying that his sentence would be 10 years.

Also following Prisoner B's death a teacher at Maghaberry reported that a prisoner had told her that Prisoner B believed that his sentence would be 7-10 years and that this was *"devastating"* for him and he had *"lost all hope."*

RECOMMENDATIONS TO THE PRISON SERVICE

I make **9 recommendations** to the Prison Service and its South Eastern Health and Social Care Trust partners. 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 to the Prison Service that, in line with Prison Service policy and staff notices, they remind all staff of the importance of logging all activities carried out by a prisoner on PRISM[8].

Recommendation 2

I recommend to the Prison Service that they review the current arrangements for carrying out hot and cold debriefs following a death in custody, giving particular consideration to:

(a) Ensuring that learning opportunities that may help to prevent other serious incidents or deaths receive appropriate scrutiny.
(b) The need to fully support and look after staff and other prisoners involved in responding to a death.

[8] PRISM – Prison Records and Information Systems Management.

Recommendation 3

I recommend to the Prison Service and the South Eastern Health and Social Care Trust (SEHSCT) that where interpreting or translation services are used, this is recorded in a prisoner's personal and/or medical file.

Recommendation 4

I recommend to the Prison Service that all staff who work in the Emergency Control Room (ECR) are instructed that ambulances requested by medical staff can only be cancelled with the agreement of the medical staff.

Recommendation 5

I recommend to the Prison Service and SEHSCT that they ensure that foreign national prisoners receive information in their own language, at the time of their committal, about how to re-order medication. This should be included in the committal information pack.

Recommendation 6

I recommend that the Prison Service and SEHSCT review the arrangements for prison doctors to prescribe or adjust medication, where this is recommended by a nurse.

Recommendation 7

I recommend that the Prison Service and SEHSCT remind healthcare staff that all mental health reviews and planned further reviews should be recorded on EMIS.

Recommendation 8

I recommend that the Prison Service and SEHSCT review arrangements for ensuring that planned mental health reviews are always carried out as intended.

Recommendation 9

I recommend that the Prison Service and SEHSCT review the arrangements for ensuring the appropriate use of General Practice expertise and visiting psychiatrists, in the management of prisoners with mental health problems.

I note and support the recommendations made by the Criminal Justice Inspectorate as detailed on page 104 of this report and fully accepted by the Prison Service. I am not, therefore, repeating them.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[9] for Northern Ireland, I have responsibility for investigating the death of Prisoner B in Maghaberry Prison on the night of 8 March 2009. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Appendix 1.

2. I am independent of the Prison Service and my investigation, as Prisoner Ombudsman, provides enhanced transparency to 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. As required by law the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives

4. The objectives for my investigation into Prisoner B'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;

[9] The Prisoner Ombudsman took over the investigations 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 Prisoner B's family are given the opportunity to raise any concerns that they may have and that these are taken into account in my investigation; and

- to assist the Coroner's inquest.

Investigation Methodology

5. Details of the investigation methodology used are included as Appendix 2.

Family Liaison

6. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the deceased's family.

7. It is important for my investigation to learn more about a prisoner who dies in prison custody from any family members and to listen to any concerns they may have.

8. I am grateful to Prisoner B's family for meeting with me on 30 April 2009 and for the insight they gave me into his personal circumstances before he died.

9. The following questions were raised by Prisoner B's family:

- What were the circumstances and events leading up to Prisoner B ending his life?

- Given that Prisoner B had been on remand for 9 months, why did it take so long for his trial to be heard?

- Having been notified of Prisoner B's death, a police officer contacted the family and told them that in December 2008 a doctor had asked Prisoner B if he had thoughts of killing himself. The family want to know why Prisoner B was asked this type of question.

- In telephone conversations Prisoner B had with his family around the end of January/beginning of February, he told them that he was being bullied, under a lot of emotional pressure and asked them to *"save him"*. The family wanted to know if Prisoner B was being bullied and, if so, what was done about this.

FINDINGS

SECTION 1: PRISONER B'S REGIME AND ACTIVITES AS A CHINESE NATIONAL PRISONER

1. Prisoner B's Committal to Maghaberry on 9 June 2008

On 9 June 2008, Prisoner B was committed and remanded into the custody of Maghaberry Prison. Every prisoner, as part of their committal process, is seen by a nurse officer to carry out a healthcare screen. A healthcare screen is intended to identify any problems which can then be addressed through immediate treatment or onward referral to the appropriate specialists.

As part of Prisoner B's committal on 10 June 2008, a nurse officer recorded, with the aid of an interpreter, that Prisoner B was a non smoker and teetotaller. It is also recorded that he was passed as fit to work and had no immediate health concerns. It was further noted that Prisoner B was calm, co-operative, alert and orientated with no thoughts of self harm.

Family Concern

One of the concerns raised by Prisoner B's family was why he had been asked whether he'd had any thoughts of self harm. This is an important question that prisoners are asked on committal to prison and any time afterwards where there are concerns about a prisoners well being. Their answer will influence the level and type of care and support provided to them.

1a. On 9 June 2008, when Prisoner B was committed on remand into the custody of Maghaberry Prison, no immediate health concerns were identified.

2. Prisoner B's Location History and Association Time

Following Prisoner B's committal period, he was located in Lagan House which mainly accommodates remand prisoners. Where possible, Maghaberry Prison ensures small groups of same national prisoners are located on a landing together, to reduce their feeling of socio-cultural isolation.

During association, prisoners have access to the recreation room which has two pool tables, a cross trainer, telephone booths and a television, as well an outdoor yard area.

Association is allocated on an alternating daily basis to groups of landings as follows:

Session	Day 1	Day 2
Morning (09.30-11.15)	Landings 1, 3 and 5	Landings 2, 4 and 6
Afternoon (14.20-15.45)	Landings 2,4, and 6	Landings 1, 3, and 5
Evening (17.30-19.30)	Landings 1, 3, and 5	Landings 2, 4 and 6

Prisoner B's Location History

A print out of Prisoner B's location/cell sharing history shows the following:

09/06/2008 to 16/06/2008 Committal's Landing, Roe House.

16/06/2008 to 30/07/2008 Lagan 6, cell 10, no cell mate.

01/08/2008 to 20/11/2008	Lagan 6, cell 5. Prisoner B shared with three different Chinese prisoners.
20/11/2008 to 28/11/2008	Healthcare Ward.
28/11/2008 to 06/01/2009	Lagan 6, cell 5.
17/12/2008	Chinese cell mate moved to another location.
17/12/2008 to 29/12/2008	No cell mate
29/12/2008 to 02/01/2009	Sharing with a European Cell mate
02/01/2009 to 06/01/2009	No cell mate
06/01/2009 to 07/03/2009	Moved to cell 15 Lagan 4 to share with another Chinese prisoner.
07/03/2009 to 08/03/2009	No cell mate

2a. Prisoner B was located in Lagan House with other Chinese National prisoners, with whom he could interact during out of cell association.

2b. Of the 272 days Prisoner B spent in prison, he had a Chinese National cell mate for 191 days.

3. Prisoner B's contact with his family

Foreign national prisoners, who receive no visits and/or have little or no money, have difficulties contacting their family overseas, due to the cost of overseas phone calls. Foreign national prisoners may also feel more isolated due to language barriers and cultural differences. Maghaberry prison has, therefore, set up a system which allows foreign national prisoners, who have less than £20 in their IPC account[10], to call home once a week for ten minutes, free of charge.

Whilst it would be expected that all foreign national prisoners would partake in this scheme, there were difficulties in getting some of the Chinese prisoners to do so.

It was established this was because some prisoners were initially reluctant to provide their families contact details to prison staff, because they were fearful that the details would be passed on to other authorities.

Prisoner B was one of the prisoners who, initially, did not use the free phone call scheme.

At interview, a senior officer from Lagan House said that Prisoner B's need to talk to his family didn't become apparent until sometime around July 2008, when he was alongside someone reading a Chinese newspaper. The newspaper contained an article about the after tremors of the devastating earthquakes China had experienced on 12 May 2008, when

[10] IPC account - Inmates Personal Cash account

approximately 80,000 people died in the Sichuan Province of China, where Prisoner B was from. Although Prisoner B was not in prison at the time of the initial earthquakes, it would appear that he was not aware that this had occurred and understandably, became very concerned about the safety of his family.

Following this, contact details for Prisoner B's family were obtained and arrangements were made for him to be able to make weekly calls to his family back in China.

3a. Maghaberry prison set up a free phone system to allow foreign national prisoners with less than £20 in their IPC account to call their family once a week.

3b. Some Chinese prisoners were reluctant to provide contact details for their family in case the details were passed onto other authorities.

3c. Prisoner B started to use his free phone allowance and contacted his family in July 2008.

4. Translation Services

The Prison Service has access to interpreting and translation services, and regularly has interpreters visiting Maghaberry Prison.

Between 24 June 2008 and 8 March 2009 records show that Maghaberry had one or two Mandarin Interpreters in the prison on 76 days of the 257 days and on the majority of occasions, numerous Chinese Prisoners availed of this service.

As well as visiting interpreters, the Prison Service has access to Language Line, a telephone interpreting service available 24/7, which is accessible across all three prison establishments.

At interview, Prisoner B's mental health nurse officer said that on occasions, when an interpreter was not available, she used 'Babel Fish[11]' which is an online translating service. The Prison Services Notice to Staff - NS06/07 *"Management of Foreign National Prisoners – An Initial Guide for Staff"* issued 1 February 2007 states, *"the use of on-line translation services (as opposed to interpreting services) is not advisable nor recommended as we are not able to stand over the quality of the work provided."*

At interview, a governor stated that on occasions staff would ask one of the Chinese prisoners, who could speak some English, to interpret for them in situations where quick answers were needed. While this seemed a practical short term solution, it became apparent to staff that some of the English speaking

[11] Babel Fish - Babel Fish is an online translating service which can translate languages free of charge.

Chinese prisoners were higher up in organised Chinese criminal gangs and were, they feared, putting pressure on some of the prisoners who were lower down in the chain of command. The governor stated that once they became aware of this issue, any decision to ask another prisoner to translate was considered very carefully.

Prisoner B appears to have generally been seen with an interpreter for his medical reviews. Staff could not, however, recall and it was not recorded in Prisoner B's medical file, how he was communicated with at three of his consultations on 29 August 2008, 8 September 2008 and 7 November 2008.

When the Prisoner Ombudsman spoke to a group of Chinese Prisoners in Maghaberry Prison on 24 March 2009, some of the feedback received was in relation to concerns about limited access to interpreters and difficulties being experienced in communicating needs or concerns.

At interview, Prisoner B's cell mate said that he was aware interpreters could be requested, but that it sometimes took many days for one to arrive.

4a. During Prisoner B's time in Maghaberry prison, interpreters were available at Maghaberry on particular days.

4b. When interpreters were not available prison staff at times made use of Language Line for interpreting services.

4c. Some Chinese prisoners said that it was at times difficult to communicate needs or concerns.

5. Legal Visits, Consultations, Remand Hearings and Court Appearances

Whilst Prisoner B was in prison, he attended the following legal appointments:

4 Video Link Legal Consultations
9 Video Link Remand Hearings
2 Visits from his solicitor
1 Court appearance

At interview, a governor and a senior officer stated that a lack of information or/and incorrect information from legal representatives, the police and UK Border agency has been a big concern for staff and foreign national prisoners. Concerns relate to information in respect of the possible length of sentences, the progression of cases and reasons why prisoners were being held on immigration warrants. One possible reason offered for inaccuracies in information presented to prisoners was that interpreting services have not always been used by legal representatives at consultations and immigration paperwork has not always been translated for the prisoner.

Prisoner B's solicitor said that there was always an interpreter present during Prisoner B's remand hearings or consultations.

6. Education, Library, Church Services, Sports and Fitness

Education

The education department in Maghaberry Prison provides an ESOL (English Speaking as an Other Language) course for foreign national prisoners who want to learn, or improve, their English and learn more about cultural differences.

Prisoner B started to attend ESOL classes on 2 July 2008 and attended a further three times on 7 July 2008, 5 August 2008 and 12 August 2008.

Documentation provided by Prisoner B's ESOL teacher records that in August 2008, Prisoner B *"asked to be withdrawn from the class due to (his) court case."*

6a. On 2 July 2008, Prisoner B commenced ESOL classes but, at his request, he stopped attending after 12 August 2008.

Sport and Fitness

Prisoners in Maghaberry are given the opportunity to participate in a variety of indoor sports and fitness activities including tennis, badminton, and the use of the gym.

It is recorded on PRISM[12] that Prisoner B attended this type of activity on three occasions during his first five weeks in prison.

[12] PRISM – Prison Records and Information Systems Management.

There is no record of him attending sports activities after 14 August 2008.

6b. Prisoner B used the sports facility on three occasions during his early weeks in prison but did not participate in sport after 14 August 2008.

Church Services

There are a wide variety of religions and beliefs practiced in Maghaberry prison and in response to this, a "minister for all" visits the prison and conducts a weekly service in the Prison Chapel, for those prisoners who are not catered for by the other church services available.

Due to the number of Chinese prisoners who attended this weekly service, Maghaberry prison arranged for a Chinese speaking pastor to carry out a number of services. Since the number of Chinese prisoners in Maghaberry prison has now reduced, the current arrangement is that they attend one of the regular Sunday services[13].

It is recorded on PRISM[14] that Prisoner B's first attendance at a church service was on 29 June 2008. Prisoner B attended a further 16 church services up to 1 March 2009.

6c. Prisoner B attended the Sunday church service regularly.

[13] Sunday Church Services – For integrated prisoners, Maghaberry Prison holds a Free Presbyterian Service, a Roman Catholic Service and two Combined Services.
[14] PRISM – Prison Records and Information Systems Management.

Library

With the influx of Chinese prisoners in June 2008, Maghaberry prison invested in the purchase of Chinese books and other reading materials. Other books were donated to the prison.

PRISM records show that Prisoner B attended the prison's library on four occasions between 19 June 2008 and 26 November 2008. There are no records of Prisoner B attending the library after this time.

A senior officer said at interview that *"Prisoner B may have used the library on other occasions, as this is not always recorded."*

The senior officer also said that there are approximately 150 Chinese books in the library and that Chinese prisoners were allowed to retain their books for longer periods and to swap the books between the landings.

A handwritten copy of a play found in Prisoner B's cell appeared to suggest that he was copying this out from a book he had accessed in the library.

6d. Prisoner B had access to a selection of Chinese books.

SECTION 2: EVENTS BETWEEN 15 AUGUST 2008 AND 1 SEPTEMBER 2008

7. Initial Referral to the Mental Health Team

On 15 August 2008, it was brought to the attention of landing staff, by a fellow Chinese prisoner using hand signals and actions, that Prisoner B was not feeling well. As a result, a nurse officer assessed Prisoner B with the assistance of an interpreter, and the corresponding entry on EMIS[15] records that Prisoner B was very tearful and appeared depressed. It is further recorded that Prisoner B was given the opportunity to *"ventilate"* and express his concerns about his family in China and the fact that he never received the money he was owed for the crimes he was alleged to have committed. Following the consultation, it is recorded that Prisoner B was referred to the mental health team and the prison doctor.

Initial Mental Health Assessment

On 22 August 2008, Prisoner B had his initial consultation with a mental health nurse officer, who became his primary mental health nurse.

During this consultation, a full mental health assessment was carried out which resulted in a risk assessment and care plan being drawn up for Prisoner B.

[15] EMIS Definition – Egton Medical Information System which is an electronic database which stores a persons medical history.

On Prisoner B's assessment form, it is recorded that he has a feeling of heaviness on his back and a dry mouth and that he informed the mental health nurse officer that there is a history of mental health illness in his family which was never formally diagnosed, due to the families' financial situation.

At the time of this assessment, Prisoner B's mental health issues were recorded as:

- Low mood for two years which has become worse over the past two months while in prison.
- Mood feels worse in the morning.
- Appetite some days but others he doesn't.
- Wakes early in the morning but doesn't feel refreshed.
- States he feels emotionally blunt.
- Being in company doesn't improve his mood.
- Is pre-occupied with feeling under pressure and is worried that if he feels mentally unwell he won't be able to support his family.
- Had one thought of self harm a week ago but this scared him. He had thoughts of banging his head off the wall but stopped when he thought of his family.
- Never harmed himself before.
- No history of alcohol or drug abuse and doesn't smoke.

The mental health nurse also recorded that Prisoner B was physically well but worried about his family back in China and that he had been in Northern Ireland for six months, although he didn't really want to be here.

In respect of the management of Prisoner B's mental illness concerns, it is recorded that the mental health nurse was to consult with the prison doctor in order to start Prisoner B on anti-depressants. The nurse also recorded that she planned to review Prisoner B again in two weeks time and that she had spoken to the landing staff, who had advised her that they would consider giving Prisoner B a job.

7a. On 15 August 2008, concerns were raised by a fellow Chinese prisoner that Prisoner B was not well. As a result he was seen by a nurse and referred to the prison mental health team.

7b. On 22 August 2008, Prisoner B was assessed by a mental health nurse and it was recommended that he commence anti-depressants and be given a job on the landing.

8. Follow-up Mental Health Reviews

29 August 2008 – Mental Health Review

A week earlier than planned, on 29 August 2008, Prisoner B's mental health nurse carried out a review with him. The corresponding entry on EMIS records that Prisoner B's mood was still very low and worse in the morning, but that it slightly improved by the evening, even though he wasn't sure why. The entry also records that Prisoner B had not received his anti-depressant medication, and that a request had been made to the house nurse to liaise with the doctor, so that Prisoner B would receive his medication. The mental health nurse planned to review Prisoner B in a further two weeks, or sooner if required, noting that he *"felt the information I had given him was helpful"*.

The following day, Prisoner B was seen by a house nurse officer at the request of landing staff, as he had been weeping and was very upset that he didn't get to go to church that morning.

An entry on EMIS notes that the wrong name had been put on the list for church and as a result, Prisoner B was unable to attend the Sunday church service. The entry further records, *"misses his family but is helped by other prisoners who talk to him in the yard. Stated he had no thoughts of self harm. Staff have given him time out of his cell and this had appeared to help him … will request mental health team to review."*

8a. A mental health review, carried out on 29 August 2008, noted that Prisoner B's mood was still low and that he had not received his anti-depressant medication, the need for which had been identified on 22 August 2008.

8b. On 30 August 2008, Prisoner B was upset and weeping when he couldn't attend the Sunday church service and a further referral to the mental health team was made.

1 September 2008 – Mental Health Review

On 1 September 2008, a nurse officer recorded on EMIS that Prisoner B's mood was very low and that this had been brought to her attention by the senior officer on duty. It is further recorded that she spoke to Prisoner B through an interpreter and that he had not improved since his mental health review on 29 August 2008. He was still not receiving any anti-depressant medication and another request was made for a member of the mental health to review him.

A further EMIS entry, by the same nurse, records that she had spoken with a different mental health nurse to the one who usually saw Prisoner B and it was agreed that Prisoner B was to be seen by a doctor, on the next sick parade[16].

Later on that day, the same mental health nurse met with Prisoner B, in the company of an interpreter. The EMIS entry records that Prisoner B's mood remained low and that he *"feels his life is meaningless while in prison*". It is further noted that

[16] Sick Parades – When prison doctors are available to see patients. This could be the next day, or the next time a prison doctor is available.

he had no thoughts of life not worth living and that he became tearful during the consultation and mentioned again how much he was missing his family.

The EMIS entry records that Prisoner B was given the opportunity of spending time in the in-patient healthcare unit but declined the offer. It is recorded that his reason for refusal was that he felt it would not be beneficial because he shares a cell with another Chinese prisoner and can communicate with him, which helps him to feel less isolated.

It is further recorded that the mental health nurse provided Prisoner B with a handwritten note saying *"could I see someone from the mental health team please"* and was advised to show this to a member of staff if he felt his mood changed or if he needed support. As noted, the landing staff were also informed of this.

Other Observations

It is to note that by 1 September 2008, Prisoner B had still not been seen by a prison doctor and was not receiving his anti-depressant medication, as recommended by his mental health nurse.

8c. On 1 September 2008, a senior officer was concerned that Prisoner B's mood had further deteriorated. The house nurse contacted the mental health team and a further review was carried out.

8d. On 1 September 2008, Prisoner B had still not been seen by a prison doctor and had not been prescribed his anti-depressant medication, as recommended by his mental health nurse on 22 August 2008.

SECTION 3: EVENTS BETWEEN 2 SEPTEMBER 2008 AND 28 SEPTEMBER 2008

9. Use of a Prisoner at Risk (PAR1) Booklet and Prisoner B's subsequent management.

On 3 September 2008, it was brought to the attention of a senior officer in Lagan House, by another Chinese prisoner that Prisoner B was still not coping well in prison. With the aid of an interpreter, Prisoner B was spoken to. At interview, the senior officer stated that it wasn't easy to get to the bottom of what was troubling Prisoner B, because it was difficult to get information from him. He stated that *"to err on the side of caution,"* Prisoner B's mental health nurse was requested to carry out a further review.

The corresponding entry on EMIS records that landing staff were concerned because Prisoner B was still tearful and had been rocking. Prisoner B's mental health nurse, carried out an assessment and recorded on EMIS that he was *"no worse since I saw him last, has thoughts of self harm."* It is also recorded that the mental health nurse tried to encourage Prisoner B to attend the in-patient healthcare unit but that he refused. Concerned about this development, a PAR1 booklet[17] was opened on 3 September 2008 to ensure regular staff observation of Prisoner B and increased engagement with him.

[17] PAR1 Booklet Definition – **P**risoner **A**t **R**isk Booklet which is used for vulnerable prisoners who require more frequent observations and support/engagement from staff. The booklet documents the decisions made in how to manage the individual and, the observations and engagement staff have with the individual.

At interview, a senior officer stated that he also had a meeting with another senior officer and the safer custody co-ordinator to discuss the management of Prisoner B. He stated that instead of trying to persuade Prisoner B to attend the in-patient unit, they decided to manage him on the landing where he would have the support of the other Chinese prisoners around him.

It was also agreed that, to reduce the risk of isolation, landing staff would try and ensure that Prisoner B continued to be kept with a cell mate. At interview, the senior officer stated that there was *"a sort of rota in place with Chinese prisoners to share a cell with Prisoner B."* He said that *"relationships are relationships, and not everyone got on well with him. They changed over quite frequently which we didn't mind....but we tried to keep him with somebody."*

The feedback staff received from the Chinese prisoners who shared with Prisoner B was that he was *"hard work"* to talk to.

A record of Prisoner B's location history shows that, in fact, between 1 August 2008 and 20 November 2008 Prisoner B's cell mate changed three times.

Other Observation

Prisoner B's prescription for anti-depressants was authorised on 2 September 2008 by a prison doctor, nearly two weeks after it was originally recommended by his mental health nurse, but Prisoner B was not seen by the doctor. He was given his medication, Citalopram on 4 September 2008.

9a. On 3 September 2008, Prisoner B's mental state deteriorated further and as a result a PAR1 Booklet was opened.

9b. Prisoner B started his anti-depressant medication on 4 September 2008, two weeks after the recommendation was made them to be prescribed.

8 September 2008 – Mental Health Review

On 8 September 2008, Prisoner B had a review with his mental health nurse. The corresponding entry on EMIS records that Prisoner B looked "*less perplexed. He had started a job and had been out in the REACH gardens.*" It is also recorded that he had commenced his anti-depressant medication and that he would be reviewed the following week.

18 September 2008 – Mental Health Review

On 18 September 2008, a further mental health review of Prisoner B was carried out by his mental health nurse. The corresponding entry on EMIS records that he was feeling much better but that he wasn't sure whether it was because of the medication or the fact that he was working. It is further recorded that Prisoner B was still worried about his family and his situation, but that he was coping better. A further mental health review was to be carried out in one month or sooner if required.

Prisoner B remained on an open PAR1 booklet until 28 September 2008. In line with Prison Service policy, a multi-disciplinary case conference was held on 28 September 2008, and it was agreed that Prisoner B's PAR1 would be closed on the basis that he was *"much more settled and engaging in activities. He attends the REACH gardens and is interacting much more with some of the Chinese prisoners who are offering good support to him. He feels his medication is effective and claims he had no thoughts of self-harm. He continues to have issues in relation to his family, but is coping better and is happy to come off the PAR1. Has been reassured that support is still available to him and he was encouraged to come to staff if he feels down. He stated he would."*

Prisoner B's job in the REACH gardens

Between 3 September 2008 and 28 September 2008, it is recorded on PRISM that Prisoner B attended the REACH gardens on 11 occasions where he carried out small jobs, such as helping to tidy up and make tea.

9c. A further two mental health reviews were carried out while Prisoner B was on an open PAR1 Booklet.

9d. Between 3 September 2008 and 28 September 2008, it is recorded on PRISM that on 11 occasions Prisoner B attended the REACH gardens where he carried out small jobs.

9e. On 28 September 2008, Prisoner B's PAR1 was closed as a result of a decision taken at a multidisciplinary case conference. It was felt that Prisoner B was much more settled.

SECTION 4: PRISONER B'S ADMISSION TO THE IN-PATIENT HEALTHCARE UNIT, 20 TO 28 NOVEMBER 2008.

10. Prisoner B's Admission to the Healthcare Wards 20 November 2008 to 28 November 2008

After Prisoner B's PAR1 booklet was closed on 28 September 2008, two further mental health reviews were carried out on 8 October and 7 November 2008, which showed Prisoner B's mood had begun to deteriorate.

On 20 November, Prisoner B was again seen by his mental health nurse who recorded:

"Spoke with Prisoner B via an interpreter. Mental state has deteriorated. There has been a period of lock down in Lagan House. Prisoner B has been stopping and starting his anti-depressants, he's not eating properly, he's not sleeping and he feels guilty about the situation and missing his family. During the interview (he) was crying and rocking and he has a swollen right eye from crying. Denies any thoughts of harming himself but appears miserable. Plan to bring him on to healthcare for a period of assessment."

The reference to *"a period of lock down"* resulted from all prisoners in Lagan House being confined to cell for a number of days, following an attack on Chinese prisoners by other prisoners on 13 November 2008. It is unclear from prison records for how long the prisoners in Lagan House were unable

to leave their cells for association. Chinese prisoners have said that the lock down lasted several days.

Later that day, on 20 November, Prisoner B was seen by a visiting psychiatrist[18]. This was the first time, since his committal to Maghaberry, that Prisoner B had been seen by a doctor.

Following the review on 20 November, the Psychiatrist noted:

".....Transferred for assessment of mental state following concerns. Describes difficulties in mood, sleep appetite from June 2008. Recently prescribed antidepressant medication, however describes issues with receiving this on a regular basis. Denies a past psychiatric history, psychiatric admissions or deliberate self harm. Denies medical history. Currently on antidepressant medications……. On mental state examination pleasant and cooperative. Eye contact poor. Speech spontaneous, no English. Mood lowered, sleep reduced with initial insomnia, appetite reduced but no reduction in weight. Reduced interest and social interaction. Denies thoughts of self harm or suicidal ideation. Concerns regarding family and them not being provided for as he is currently not working. Denies hallucinations. Cognition and insight intact. Impression is one of depressive episode within the context of situational difficulties and intermittent treatment with medication. Plan- Admit to healthcare for a period of assessment. Review medications. Review arranged with the interpreter for Tuesday. Nursing staff to coordinate telephone call to family and visit from Chinese speaking friend if Prisoner B wishes and

[18] Visiting Psychiatrist – A psychiatrist who is not a full time employee of the Prison Service, but contracted to attended the prison on a part time basis.

prison is agreeable. Allow to library for reading material and association at ward level."

Following the psychiatrists review of Prisoner B's medication, it is recorded on his medication administration chart that on 20 November 2008 his medication changed from Citalopram 20mg to Mirtazapine 15mg, another type of anti-depressant.

Prisoner B's nursing progress sheets record that while he was in the in-patient unit, he "*appeared to be settled", "used the telephone", "read book"* and *"slept well."*

The second occasion Prisoner B was seen by the visiting psychiatrist was on 25 November 2008. In the EMIS entry, the psychiatrist noted that Prisoner B's mood had improved and he was keen to engage in orderly type duties. His medication was to be increased and, having discussed arrangements for Prisoner B's return to Lagan House with a senior officer, the psychiatrist recommended that in view of his current mental state and the "*propensity for social and cultural isolation within the healthcare setting*," Prisoner B would be discharged from the healthcare wards on 27 November 2008. It was also recorded that it would be advantageous for Prisoner B to carry out light orderly type duties, as well as spending time in the REACH gardens with a member of the Chinese community.

It is recorded on Prisoner B's medical administration card that on 25 November 2008 his medication was increased from 15mg to 30mg per day.

As recommended by the psychiatrist, Prisoner B returned to his normal prison location in Lagan House a day later, on 28 November 2008.

At interview, a senior officer said that before he returned to Lagan House, Prisoner B had been very much involved in the discussions and wanted to return. He further said that *"there was a sort of reunion"* with the other Chinese prisoners because they had been concerned about Prisoner B's welfare.

10a. Between 20 and 28 November 2008, Prisoner B was admitted to the in-patient healthcare unit within Maghaberry prison because his mood had deteriorated.

10b. During this period, Prisoner B was assessed on two occasions by a visiting psychiatrist and his anti-depressant medication was adjusted.

10c. On 28 November 2008, on the recommendation of the psychiatrist and following discussion with him, Prisoner B returned to Lagan House. It was recommended that it would be helpful for Prisoner B to carry out light orderly type duties and to have visits to the REACH gardens.

SECTION 5: EVENTS BETWEEN 28 NOVEMBER 2008 AND 24 FEBRUARY 2009

11. Communication to landing staff of Prisoner B's future care plan

Following Prisoner B's return to Lagan House on 28 November 2008, there is no record on PRISM of Prisoner B attending the REACH gardens until 24 February 2009. It is unclear whether visits took place that were not recorded.

At interview a senior officer in Lagan House stated that there were no orderly job vacancies at that time. He said, however, that "*as an act of humanity"* senior staff in Lagan House created a job for Prisoner B, which included carrying out tasks such as making cups of tea and he was paid £6 per week. A record of Prisoner B's personal cash account shows that each week he received £6 wages.

11a. It is not clear whether Prisoner B visited the REACH gardens, as recommended by the psychiatrist, following his return to Lagan House.

11b. Prisoner B was given some work tasks to carry out and was paid £6 per week.

12. Mental Health Reviews

Prisoner B was seen by his mental health nurse on four occasions between 29 November 2008 and 5 February 2009.

18 December 2008 – Mental Health Review

On 18 December 2008, Prisoner B saw his mental health nurse with an interpreter and it is recorded on EMIS that his mood had improved with the new medication he was on. It is recorded that he was keen to share a cell with another person from the Chinese community and to go to the library. The EMIS entry also records that Prisoner B's mental health nurse spoke to landing staff in order to try and accommodate this. It was planned for the mental health nurse to carry out a further review in two weeks time.

31 December 2008 – Mental Health Review

On 31 December 2008, Prisoner B had a further mental health review with his nurse and an interpreter. The EMIS entry records that Prisoner B *"appeared flat,"* although he reported to the nurse that he was *"feeling fine, eating and sleeping well."* The only recorded concerns were that Prisoner B was still sharing a cell with someone who was not from the Chinese community and that he had not been to the library.

It was planned that a further review would take place in one to two weeks.

9 January 2009 – Mental Health Review

At his mental health review on 9 January 2009, it is recorded that Prisoner B looked gloomy. It is further recorded that he was now sharing a cell with a fellow Chinese prisoner and had been out to the library, but that he was still very homesick. It is further noted that when he had finished his sentence he was keen to return home to China to his family.

A further review was planned to take place in two weeks.

5 February 2009 – Mental Health Review

On 5 February 2009, almost one month after Prisoner B's last mental health review, he was seen again by his mental health nurse, but the review was not recorded by the nurse on EMIS.

On 16 March 2009, after Prisoner B's death, the nurse who reviewed him on 5 February 2009 completed a staff communication sheet, giving an account of the consultation. The sheet was also signed by the interpreter who was present at the review. The nurse wrote that Prisoner B's mood was much the same, that he missed his family and that he had said that he was eating and sleeping fairly well and was continuing with his medication, which was helping. She also wrote that he was getting on well with his cell mate and getting out to the REACH gardens which he enjoyed. She said that Prisoner B denied any thoughts of harming himself and was looking forward to his trial, which he believed would be coming up soon and would mean that he would know when he could return to China.

The mental health nurse made a note in her diary on 5 February 2009 in respect of Prisoner B to "*carry forward*" and at interview the nurse officer said that she had planned to review him in two to four weeks time.

No further mental health reviews took place between 5 February 2009 and Prisoner B's death on 8 March 2009.

12a. At Prisoner B's mental health review on 18 December 2008, it was recorded that his mood had improved with his new medication.

12b. During Prisoner B's mental health review on 9 January 2009, he looked gloomy and was very homesick. He was keen to return to his family in China. A further review was planned to take place in two weeks time.

12c. The planned review took place nearly a month later on 5 February 2009. No notes of the review were recorded.

12d. On 16 March 2009, after Prisoner B's death, the nurse who reviewed Prisoner B on 5 February 2009 completed a staff communication sheet.

12e. The nurse noted that Prisoner B's mood was much the same and that he missed his family. She also noted that he said he was eating and sleeping well, was taking his medication and had no thoughts of self harm.

13. Telephone Calls 11 January 2009 to 21 February 2009

Between 11 January 2009 and 8 March 2009, the day of his death, Prisoner B made 15 telephone calls to his family. A number of times, he was unable to get through to the number dialled. The following are extracts from calls to 21 February 2009 and a summary of matters discussed.

11 January 2009

On 11 January 2009, Prisoner B had a telephone conversation with his wife. Prisoner B says to his wife:

"Well, the good news is that I'm fine. There isn't anything else about me apart from waiting.....Since I came inside in June, with so many other people, not a single one of us has been sentenced yet."

From the discussion that follows, it would appear that Prisoner B believed that one of the reasons for the delay in him being sentenced was because he thought that while people are in prison, the prison (and judicial system) were making money from them.

One of the concerns raised by Prisoner B's family was in relation to why, after nine months, he had not been on trial. The length of time that many prisoners are held on remand awaiting trial is a matter of general concern. In this instance it appeared to be the case that the scale of the police investigation into the matter for which Prisoner B was held as a remand prisoner, and the number of Chinese prisoners who were arrested within a similar time

frame, were causing delays in bringing Prisoner B's and other cases to trial.

17 January 2009

In a telephone conversation between Prisoner B and his mother on 17 January 2009, he discusses his children and checks that everyone is well. Prisoner B's mother is concerned for him and he tries to reassure her that he is okay. He tells her that it is just a matter of time, waiting for his trial. He goes on to explain that Maghaberry is not like the prisons in China. He tells her:

"I had two meals with chicken, two meals with beef, one meal with pork last week and there are also eggs. I get milk every morning."

Prisoner B's mother sounds pleasantly shocked on hearing this news and Prisoner B goes on to tell her:

"Yes, the food is fine. The management here is fine, they are just worried that you might (inaudible)…inside. As you can see, you don't have to do any work here. There are people doing the cleaning here. People come to you and you are allowed to play poker, table tennis and snooker. You can hear now that they are just playing outside here. It's not like China where you get beaten up…it's nothing…don't worry…don't worry."

Prisoner B's mother tells her son that she was worried that he was having a hard time in prison, because that was what she had been told. Prisoner B again tries to reassure her by saying, *"it's not hard inside here."*

Prisoner B tells his mother about two other prisoners who are from where Prisoner B's family live in China, and talks about the fact that *"everyone got conned"* and that they didn't know that it was going to be like this. Prisoner B tells his mother, *"There's no point regretting anything. Regret is useless."*

Telephone Call – 25 January 2009

(Note: Chinese New Year was 26 January 2009)

In a call on 25 January 2009, Prisoner B's family tell him what they have been doing for Chinese New Year and his son begs and pleads for him to return to China. This makes Prisoner B quite emotional, but he appears to try and hide this from his son. Prisoner B's wife asks if there is any news about his case. Prisoner B tells her that his case will be more or less ready in another two weeks, stating that *"they can't drag (it) on this time."*

Prisoner B then tells her that he has *"really been conned.....Who knew it was going to end like this?....I got conned by the boss. Who knew it was illegal to do that job? All I knew was to work and earn money."*

Prisoner B's wife asks him, when it is all over, to return to China as soon as possible and not to leave again.

Telephone Call – 9 February 2009

On 9 February 2009, Prisoner B speaks with his wife and quickly focuses on when his trial date is going to be.

Prisoner B says that he has to wait a further three weeks before he will find out when his trial will be. He also mentions that he has had a meeting with his solicitor and has found out that he is *"not in much trouble about this one. The fact is that I was just a worker, I didn't know anything. It was just like that."*

Telephone Call – 21 February 2009

Prisoner B discusses with his wife how the refurbishment is going in the shop and how much it has cost. The conversation then goes on to talk about Prisoner B's next court appearance which is scheduled for 25 February 2009.

Family Concern

Prisoner B's family said that they were concerned that he had been bullied whilst in prison and that in a telephone conversation, some time around the end of January/early February 2009, he had asked them to *"save him"*. As stated, the investigation obtained Prisoner B's telephone calls from 3 January to 8 March 2009 and found no evidence in the telephone calls that Prisoner B had told his family that he had been bullied or had asked them to *"save him"*.

In interviews with other Chinese prisoners no evidence was found that Prisoner B had been bullied.

13a. During his telephone conversation to his family over Chinese New Year, it was evident Prisoner B's children were missing him and Prisoner B became emotional.

13b. There is evidence that Prisoner B is troubled by the time he has spent on remand and is very anxious to find out his trial date and expected to do so at his next remand hearing scheduled for 25 February 2009.

SECTION 6: EVENTS BETWEEN 25 FEBRUARY 2009 AND 7 MARCH 2009

14. The Remand Hearing of 25 February 2009 and Subsequent Events

On 25 February 2009, Prisoner B attended a remand hearing via video link. From Prisoner B's telephone conversations with his family he was expecting to hear when his trial date would be set. This was not, however, the case and a further remand hearing was scheduled for a further four weeks.

Telephone Conversation – 25 February 2009

During a conversation with his wife, Prisoner B is upset and sobbing most of the time.

Prisoner B's wife asks if he has any news about his case. He tells her that he has no news and asks to speak with his children, but the children were not there.

Prisoner B goes on to tell his wife that he has to wait another four weeks until his next remand hearing to find out his trial date and says that the delay was because of the numbers that had been arrested. He then goes on to tell her that there is only three people left to go to trial, and that no one else is to be prosecuted. Prisoner B tries to explain to his wife that he is one of the last ones to get a trial date because his case is slightly more complicated, in that his finger prints were found in more than one location. While he is explaining the complication, his

wife cuts him off in mid sentence because she cannot hear what he is saying, due to her mobile phone not working properly. As a result, Prisoner B tells her he hasn't got much else to say other than that he has to wait a further four weeks.

Prisoner B is sobbing and when his wife asked him what is wrong, he tells her that *"it's nothing"* and repeats this three more times to her. Prisoner B's wife tries to reassure him and tells him not to get *"worked up as it is already like this now."*

Prisoner B's wife begins to get upset on hearing her husband sobbing and he tells her, *"it's nothing, it's nothing. I'm fine here with no other worries. It's just the waiting time is too long."*

Prisoner B tells his wife that he'll call her on Sunday and the call is finished.

At interview, Prisoner B's cell mate stated that it was obvious Prisoner B's frame of mind was a lot worse after the video link remand hearing on 25 February 2009, because he would cry and shout into his blanket to muffle the sound. Prisoner B's cell mate stated that he never told the prison how unhappy Prisoner B was, because of the language barrier.

Prisoner B's cell mate stated that Prisoner B couldn't understand why some prisoners had already been sentenced, but that nine months on he still hadn't been sentenced. The prisoner recalled a couple of occasions when Prisoner B had used his cue cards, with common requests written in English and Chinese, to ask the prison to contact his solicitor for him.

Prisoner B's cell mate didn't know whether or not Prisoner B had managed to see his solicitor.

It is unclear what contact Prisoner B had with his solicitor after December 2008. Prisoner B does make reference, in a phone call on 9 February, to a discussion with his solicitor. Attempts to clarify this with Prisoner B's solicitor were unsuccessful.

A senior officer in Lagan House, who knew Prisoner B well, said at interview that he was not aware of Prisoner B's distress at this time. He further stated that following a recent death in Lagan House, staff were more sensitive to mood changes, and therefore, it shocked him to hear that Prisoner B's low mood, as reported by Prisoner B's cell mate and evidenced by his phone call, had not been picked up. He said that no Chinese prisoners had raised any concerns about Prisoner B, as they had in the past when they were concerned.

As recorded earlier, Prisoner B's last mental health assessment took place on 5 February 2009. At that time, the mental health nurse said that she planned to review Prisoner B in a further two to four weeks. No further review did take place between 5 February and Prisoner B's death on 8 March 2009. It would appear, therefore, that healthcare staff were also unaware of Prisoner B's mental state in the weeks before his death.

Telephone Calls – 28 February 2009

Prisoner B attempted three phone calls on 28 February 2009, but was cut off soon after he had connected.

On his fourth attempt he called his younger brother and spoke with his own children. Throughout the phone call, Prisoner B was upset and was sobbing from time to time, especially when he was talking to his children. His children spoke to him about school and he told them how important it is that they both study hard. Both children told him how much they missed him, and Prisoner B said how much he looked forward to talking to them.

14a. Prisoner B's trial date was not, as hoped, set at his remand hearing on 25 February 2009.

14b. In a phone call with his wife, Prisoner B was very upset and distressed at the fact his case was delayed by a further four weeks.

14c. Following this remand hearing, Prisoner B's cell mate said that Prisoner B's mood deteriorated significantly and he would often cry and shout into his blanket at night.

14d. The senior officer and staff in Lagan House were unaware of Prisoner B's distress.

14e. Prisoner B was not reviewed by healthcare after 5 February 2009. Healthcare staff were, therefore, also unaware of his mental state in the weeks before his death.

14f. During a family telephone conversation on 28 February 2009, Prisoner B could be heard sobbing from time to time as he talked to his children. His children told him how

much they missed him.

15. Cell Mate's Cell Move - 7 March 2009

Up until 7 March 2009, Prisoner B had been sharing a cell with another Chinese prisoner, who it is reported he got on well with. They had been sharing a cell since 6 January 2009 but on 7 March 2009, Prisoner B's cell mate was moved to a single cell. He was entitled to a single cell as one of his privileges, because he had achieved Enhanced status in line with the Prison Service PREPS[19]. There is usually a waiting list for a single cell and, on 7 March 2009, when a single cell became available, Prisoner B's cell mate was next on the list and took the opportunity to move.

At interview, Prisoner B's cell mate stated that while he was moving his belongings across the landing into his new cell, Prisoner B helped him. He stated that at no point did Prisoner B show any signs of being upset that he was moving and, had he thought that Prisoner B was considering ending his life, he would never have moved into a single cell.

Prisoner B's cell mate said that he felt somewhat responsible for Prisoner B's death, in that he felt that if he had not moved cells, then Prisoner B would not have taken his life. Prisoner B's cell mate was, following Prisoner B's death, doubled up with another prisoner, whilst he was feeling vulnerable.

A senior officer said at interview that if they had been aware that Prisoner B was at risk, then staff would have delayed moving his cell mate. He stated that he wasn't *"on their radar"* as being currently at risk.

[19] PREPS Definition – Progressive regime and earned Privileges Scheme.

At interview, a number of Chinese prisoners, said that they were aware that Prisoner B suffered from depression, but that it came as a complete shock to them when he died by suicide.

15a. Staff in Lagan House said that they were not aware of Prisoner B's deterioration in mood following his remand hearing on 25 February 2009 and that it had not been brought to their attention by other prisoners.

15b. On 7 March 2009, Prisoner B's cell mate moved to a single cell.

15c. A senior officer in Lagan House said that if it was believed that Prisoner B was *"at risk"*, Prisoner B's cell mate's move would have been delayed.

SECTION 7: EVENTS OF 8 MARCH 2009

16. Chronology 09.15 to 16.15

On 8 March 2009, it is recorded in the landing journal that the prisoners on Prisoner B's landing were unlocked at 09.15 and breakfast was served.

It is also recorded that Prisoner B was on the list to attend one of the Sunday church services, however, both services were cancelled. Information received from a prison chaplain explained that the services were cancelled as a result of staff shortages.

At 11.25, lunch was served. It is not known whether Prisoner B went to get his lunch because there are no CCTV cameras on the landing and this information is not routinely recorded.

At 12.20, Prisoner B's landing went to the yard and recreation room for association time, returning at 15.20. Prisoner B did attend association.

Prisoner B's actions (as seen on CCTV) during association

A number of Chinese prisoners were on association with Prisoner B. CCTV of the recreation room shows these prisoners generally remaining in groups, playing pool or cards, in the corner of the recreation room.

CCTV shows Prisoner B's actions as follows:

12.26 Prisoner B walks into the yard and over to a cell window where he stands and talks through the window to another prisoner. After 17 minutes Prisoner B returns to the recreation room.

12.49 Prisoner B returns to the yard and stands talking to someone through a different cell window for approximately 28 minutes before returning to the recreation room.

13.19 Prisoner B sits with a group of Chinese prisoners who were playing card games for approximately 25 minutes.

13.44 Prisoner B spends time milling around the recreation room or observing the card games which were being played.

14.07 Prisoner B walks through the dining hall towards the phone booths. A fellow Chinese prisoner leaves one of the phone booths and gives Prisoner B a friendly punch in the arm as he passes him. Prisoner B continues to walk towards the phone booth whilst the Chinese prisoner follows and embraces him by putting his arm around Prisoner B's shoulders. They both walk into one of the phone booths and talk to one another for approximately one minute before Prisoner B is left in the phone both on his own.

14.10 Prisoner B leaves the telephone booth and walks over to the same prisoner. They talk for seven minutes.

14.23 Prisoner B enters the yard and speaks to another prisoner through a cell window for three minutes before returning to the recreation room.

14.28 Prisoner B speaks with the same prisoner spoken to earlier, in the dining hall for 10 minutes.

14.38 Prisoner B moves around between the recreation room, dining hall and yard.

15.02 Prisoner B speaks with the same prisoner in the dining hall for six minutes. Prisoner B's hand movements become quite animated whilst talking to the prisoner.

15.08 Prisoner B sits with the group of Chinese prisoners who are playing cards for seven minutes.

15.15 Prisoner B gets up from the game and paces between the recreation room and dining hall continuously until 15.33 when association ends. He appears to be restless.

Interview with the prisoner, Prisoner B spoke to at 12.26

At interview, the Chinese prisoner that Prisoner B spoke to at 12.26 said that:

- He had only met Prisoner B in Maghaberry. He would often speak to Prisoner B through his cell window, having seen him walking around the yard on his own, or sometimes with another Chinese prisoner.

- Like himself, Prisoner B didn't want to play cards all the time like the other Chinese prisoners do.

- Prisoner B was concerned that the police thought that he was one of the "bosses", and might receive a longer prison sentence.

- He and the Chinese community in prison couldn't understand why Prisoner B died by suicide. He said that Prisoner B's behaviour was *"normal"* and *"he didn't show any signs of depression or mental health problems."*

- It had cost Prisoner B approximately £18,000 to come to the UK and he was concerned that there would be serious consequences for him and his family if that debt was not paid back.

- Prisoner B had made a phone call after speaking with him at his cell window and that *"possibly the phone call triggered it off."*

The prisoner said that when he was arrested he, like Prisoner B, was concerned about his sentence because in China, if you are caught with 150 grams or above of drugs, you will receive the

death penalty. The prisoner stated that he tried to reassure Prisoner B by telling him that Northern Ireland doesn't have the death penalty and that the police would not see him as a boss, because he could not speak English and he had only been in the country for six months. He further advised that he told Prisoner B that he shouldn't listen to what others had been telling him. He told Prisoner B that the next time he talked to his solicitor he should ask him what sentence he would get, if he was found guilty.

Telephone call at 14.09

At 14.09 on 8 March 2009, Prisoner B called his mother. During the telephone call, there are no obvious signs of distress. Prisoner B asked his mother where his wife was and she told her son that his wife was in Beijing and that she had left two days earlier. When Prisoner B finds out that he has woken his mother up, he tells her to go back to sleep and ends the call.

Interview with the prisoner, Prisoner B spoke to at 14.07, 14.10, 14.28 and 15.02

At interview, the prisoner who spoke a number of times with Prisoner B, said that Prisoner B had been banging his head against the wall, whilst they were in the telephone booth together. He said that this was because he was in despair because he thought his length of sentence would be around ten years. The prisoner said that he tried to reassure Prisoner B by telling him that his sentence would only be around two to three years, like the rest of them. The prisoner could not recall

anything else that was discussed.

CCTV does not show Prisoner B banging his head against the wall while he was in the telephone booth or at any time whilst he was on association.

Interview with the prisoner, Prisoner B spoke to at 14.23

At interview, the prisoner whom Prisoner B had spoken to at 14.23, said that he didn't know Prisoner B very well but said that Prisoner B had spoken to his wife on the phone and that she was demanding money be sent over to her.

As explained earlier, Prisoner B spoke with his mother on the phone and no demands for money were made.

On the return of the prisoners to the landing, the tea meal was served and the prisoners were locked for the night at 16.15.

16a. Between 12.20 and 15.20 on 8 March 2009, Prisoner B along with the rest of his landing, had association time in the yard and recreation room.

16b. CCTV shows Prisoner B walking between the recreation room, dining hall and yard frequently and only briefly settling into any of the games the other Chinese prisoners were playing.

16c. During association Prisoner B discussed his case and concerns about the possible length of his sentence with

other Chinese prisoners.

16d. At 14.10, Prisoner B telephoned China to speak to his wife but was informed that she had gone to Beijing two days earlier.

16e. Following this call Prisoner B appeared restless as he moved around the recreation room, dining hall and yard.

17. Interview with Prisoner B's closest companion in Maghaberry Prison

A fellow Chinese prisoner who had travelled with Prisoner B from China to London referred to himself as Prisoner B's closest friend in prison. At interview, he stated that Prisoner B was okay in himself, but would worry a lot about money. He stated that when Prisoner B came to Northern Ireland, he was never paid any money and just given food and somewhere to stay.

He further stated that Prisoner B was under great pressure because his family was poor and there were some difficulties with family relationships. Prisoner B's friend stated that Prisoner B owed approximately £20,000 to £24,000 to the people in China who brought him to the UK. He further stated that if Prisoner B was sentenced to seven or eight years, he wouldn't be able to pay the debt back and, therefore, it would fall back on his son to pay.

Prisoner B's friend stated that Prisoner B would be talkative and join in with jokes and never once gave any indication that he would die by suicide.

17a. Prisoner B's friend said that Prisoner B was under great pressure because his family was poor and he owed money.

18. The discovery of Prisoner B and subsequent actions

On 8 March 2009 at 20.20, one of the night custody officers commenced his shift in Lagan House.

At interview, the night custody officer said that as soon as he came on duty he carried out a headcount check, by opening the observation flap of every cell and observing that the prisoners were alive and accounted for.

There were a total of 92 prisoners on landings 3, 4, 5 and 6 which the night custody officer was responsible for. Prisoner B was located in cell 15 on Landing 4 and was seen alive during this check.

The night custody officer said that at 21.30 he commenced a PEG and PAR1 check of his landings. A PEG check is a routine hourly patrol of the landings, which is to ensure that there is nothing untoward occurring and does not require individual prisoner checks. A PAR1 requires officers to check vulnerable prisoners, identified as being at risk of self harm.

While carrying out his PEG and PAR1 check, the night custody officer stated that the senior officer arrived to carry out a supervised body check of all 92 prisoners. This is a routine unannounced check, which is carried out by a senior officer. On this occasion, the senior officer was accompanied by the night custody officer.

The night custody officer said that when he came to Prisoner B's

cell and opened the observation flap, he observed Prisoner B hanging at the end of his bed. He said that Prisoner B appeared to be still. The night custody officer said that he called over to the senior officer and told him *"I've got someone hanging"*. He said that the senior officer came straight over to Prisoner B's cell and on confirming what the night custody officer had seen, the senior officer ran to get the cell key, returning with the key in a matter of seconds.

CCTV located in the Lagan POD and circle[20] shows the senior officer running to the secure POD on the ground floor at 21.50, retrieving a set of keys from his bag and running back out of the POD and up the stairs to Prisoner B's cell.

In a statement written shortly after Prisoner B was found, the senior officer recorded that when he went to the secure pod to obtain the key, he also contacted the emergency control room, via his radio, to inform them of the situation. The senior officer also requested the assistance of a nurse at the same time. A recording of the transmission confirms the action taken.

At interview, the night custody officer said that when the senior officer opened the cell door, he (the night custody officer) went into Prisoner B's cell and tried to release the ligature with his hands. He said that, within a matter of seconds, he was handed an anti-ligature knife by one of the officers who arrived to assist him and he used this to release Prisoner B. Prisoner B was then placed on bedding on the ground, so that cardiopulmonary resuscitation (CPR) could be commenced.

[20] An area in the centre of the building where landings meet.

The night custody officer began to give mouth to mouth resuscitation, whilst another officer began chest compressions.

Mouth to mouth resuscitation continued until a nurse officer arrived a few minutes later with oxygen. It is recorded that the night custody officer then positioned himself at Prisoner B's head, where he elevated his chin in order to clear his airway and CPR continued.

CCTV shows the nurse officer arriving in Lagan House at 21.52, accompanied by another night custody officer.

At interview, the nurse officer said that when she entered the cell, she was able to establish, after a five second assessment, that there were no signs of life. She further stated that, having no response from Prisoner B, she requested an emergency ambulance and the on call prison doctor to attend.

In her statement, the nurse officer recorded that Prisoner B's vital signs were negative as CPR continued. At five minute intervals the nurse officer assessed Prisoner B's central nervous system observations, but there was no response from him.

At 22.00, CCTV shows a second nurse officer attended Lagan House to assist.

It is also to note that the first nurse officer on the scene made a further request for an ambulance to be tasked, because her initial request had been cancelled.

It is recorded on the emergency control room (ECR) occurrence log that at 22.05, on hearing that Prisoner B appeared to be dead, the principal officer in the ECR cancelled the ambulance. It would appear that this was cancelled without any consultation with those dealing with the incident because, at 22.11, there is a further entry on the log that notes the emergency ambulance was re-tasked.

When the paramedics arrived in Lagan House at 22.33, they too established that Prisoner B had no signs of life. The on-call prison doctor arrived on the scene and pronounced Prisoner B dead at 22.55.

Other Observation

Following the discovery of Prisoner B, the senior officer, in line with good practice, instructed one of the other night custody officers to carry out a check of all the prisoners in Lagan House and to *"keep a check on the PAR1's."*

18a. At 21.50, during a supervised body check, Prisoner B was found with a ligature around his neck.

18b. Prison and healthcare staff attempted to resuscitate Prisoner B.

18c. A doctor recorded Prisoner B's time of death as 22.55.

SECTION 8: POST MORTEM REPORT

19. Findings of the Post Mortem Report

A post mortem examination carried out on 9 March 2009 gave the cause of Prisoner B's death as:

I(a) Hanging

The pathologist noted that there was no evidence of pre-existing significant natural disease and nothing to suggest that Prisoner B has been a victim of assault.

The toxicological analysis of samples of blood and urine taken at autopsy was negative for alcohol and common drugs. The anti-depressant, Mirtazapine, that Prisoner B was intended to be taking was not detected.

19a. Prisoner B's cause of death was recorded as hanging.

20. Arrangements for the administration of Prisoner B's medication

Prisoner B was commenced on the anti-depressant Citalopram on 4 September 2008. Whilst prisoners can be prescribed medication on a daily basis, if there is a specific reason to do so, Prisoner B was given his medicine on a weekly basis, following an in-possession risk assessment. In line with normal practice, it was his responsibility to request a new prescription each week.

On 20 November 2008, it was noted by a nurse that Prisoner B was *"stopping and starting"* his medication. He was admitted to the Healthcare Centre from 20 November to 28 November, during which time his medication was administered by staff.

Following Prisoner B's discharge from the Healthcare Centre he continued to receive his medication on a weekly basis.

At a review by a mental health nurse on 18 December 2008 it is recorded that Prisoner B said that his mood had improved with the new medication.

A mental health nurse who reviewed Prisoner B on 5 February 2009, did not make contemporaneous notes of the consultation but completed a staff communication sheet, after his death. On the sheet she noted that Prisoner B *"was continuing his medication and he felt it was helping"*. No further review of Prisoner B took place before his death on 8 March 2009.

Observations

From 20 November 2008, Prisoner B was prescribed the anti-depressant Mirtazapine by a visiting psychiatrist. Initially he was prescribed 15mg at night. This was increased by the same visiting psychiatrist to 30mg at night, on 25 November 2008.

There was no evidence of mirtazapine in Prisoner B's toxicological analysis.

The investigation established that the mean elimination half-life of Mirtazapine after oral administration ranges from approximately 20 hours to 40 hours across age and gender subgroups, with females of all ages exhibiting significantly longer elimination half-lives than males. The mean half-life for males is 26 hours.

A forensic scientist was asked to comment on the significant of the fact that no mirtazapine was detected in Prisoner B's toxicology analysis. She said:

"Mirtazapine has a fairly long residual time in the body, and although I can't be specific, from the results obtained it is likely that Prisoner B had not taken mirtazapine within the previous 1-2 days. I understand that he was found at 22.10 hours, and he would almost certainly not have taken any mirtazapine that evening, unless a dose was taken immediately before death and had not had time to reach the bloodstream, and it is unlikely he had taken any the previous evening.

In terms of withdrawal symptoms, because it has a fairly long residual time in the body, if one dose was missed I would expect there to still be a residual level of mirtazapine in the blood, although not necessarily at the therapeutic level. I would therefore not necessarily expect any significant withdrawal symptoms if one dose was missed. I note that the British National Formulary states that to prevent withdrawal symptoms dose should be reduced over several weeks."

Withdrawal symptoms associated with mirtazapine include anxiety, irritability, panic attacks and agitation.

It is not possible to say how many doses of mirtazapine Prisoner B may have missed and whether he was experiencing any withdrawal symptoms. Prisoner B's medicine records do show that he received his weekly supply of his medication every week from 25 November until the time of his death with one exception. Prisoner B was due his weekly prescription on 17 February 2009 and received it three days late on 20 February 2009.

In his clinical review, Dr Quinn commented that:

"The monitoring of the prisoner's mental state should be a multi-disciplinary approach to include medical staff … this is usually at regular intervals when a prisoner is in receipt of treatment with psychotropic medication." Dr Quinn raised concerns by the absence, in the case of Prisoner B, of monitoring by a doctor.

Prisoner B's medication was returned to healthcare following his

death and disposed of in line with normal practice. The Prisoner Ombudsman has made new arrangements that in the event of any death in prison, irrespective of the apparent cause of death, any prescription or non-prescription drugs in a prisoner's cell will be collected from the cell by the Prisoner Ombudsman, as soon as the cell has been released by the PSNI.

20a. From 4 September 2008 until his death on 8 March 2009, Prisoner B was prescribed anti-depressants.

20b. With the exception of a one week period when he was admitted to the Healthcare Centre, his medication was issued weekly.

20c. It was noted on 20 November that he was *"stopping and starting"* his medication and he was admitted to the Healthcare Centre.

20d. At reviews on 18 December 2008 and 5 February 2009 Prisoner B told nurses that he was taking his medication.

20e. At the time of his death, it would appear that Prisoner B had not taken his anti-depressant medication for the previous one to two days. It is not possible to say how many doses Prisoner B may have missed or whether or not he experienced any withdrawal symptoms.

20f. The Clinical Review said that patients on psychotropic medication should have regular reviews by a doctor.

20g. Prisoner B was not regularly reviewed by a doctor.

SECTION 9: EVENTS AFTER PRISONER B'S DEATH

21. Action to be taken Following a Death in Custody

The documents 'Contingency Plans Forty Four and Forty Five – Death of a Prisoner' clearly details the roles and responsibilities of all members of staff upon notification of a possible death.

Using the contingency plans, the Emergency Control Room, which controls and records all movements around the prison, immediately notified the appropriate personnel of the time and preliminary assessment of the cause of Prisoner B's death. Those notified included the Police, the Coroner's Service and the Prisoner Ombudsman. The Emergency Control Room incident log records this action.

21a. The Emergency Control Room immediately notified the appropriate personnel of the time and preliminary assessment of cause of death.

22. Suicide Notes

Prisoner B wrote two letters before he died. One was addressed to his family and the other was addressed to the police. It is not known when these letters were written.

Letter to his family

In his letter to his family, Prisoner B said that he deeply regretted his circumstance and was very concerned that the police believed he was more involved than he thought he was.

Prisoner B also said "*I will receive a twelve-year sentence, my solicitor has told me this.*"

Letter to Police

In his brief letter to the police, Prisoner B wrote that his death was nothing to do with anyone but himself and that he hoped *"the leadership did not demand responsibility."* It is believed that this refers to leaderships of a Chinese gang.

22a. Prisoner B wrote two suicide letters. One to his family and one to the Police.

22b. In his letter to his family, Prisoner B said that he feared he would be given a prison sentence of 12 years.

23. Prisoner B's Concerns about his length of sentence

In a letter dated 16 March 2009, from an ESOL (English Speaking Other Language) teacher to a governor, the teacher outlined concerns raised by one of the Chinese prisoners in her class. In the letter she wrote that the prisoner was *"concerned that Prisoner B had received information from his solicitor in the days before his death that he would be imprisoned for 7-10 years. According to (the prisoner) this information had been devastating for Prisoner B and as a result 'all hope had gone.' (The prisoner) feels that Chinese prisoners would like to be informed accurately about their outcomes as there is uncertainty and hopelessness for those on remand."*

In response to the Prisoner Ombudsman notices of investigation, written in Mandarin and posted on the landings in Maghaberry, a joint letter was received from 11 Chinese prisoners. The prisoners stated that the time the police investigation was taking was a contributing factor in Prisoner B taking his life. They said that Prisoner B was tirelessly saying that his sentence would be more than 10 years. They also said that when Prisoner B was transferred (from the police station) to Maghaberry Prison, the situation that he was likely to be in was not explained by the police, Prison Service or his solicitor.

In a telephone conversation with Prisoner B's solicitor, the solicitor advised the investigation that he had not informed Prisoner B that he would be receiving a 12 year sentence. He said that he had told Prisoner B it would be more like two years.

Prisoner B's solicitor stated there was always an interpreter present during his consultations with Prisoner B.

23a. A number of prisoners stated that Prisoner B's was very concerned about the length of sentence he may get.

23b. Prisoner B's solicitor stated that he had never informed Prisoner B that he could get a 12 year sentence.

24. 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, whilst the governing governor and duty governor attended the scene and asked if staff were okay, no hot de-brief meeting took place. Staff said that this was because PSNI interviews were taking place.

Page 20 of the Addendum to the September 2006 Self Harm and Suicide Prevention Policy issued in January 2009 states that *"a brief note should be taken of those attending, and matters raised."* This amendment resulted from a recommendation following earlier death in custody investigations, which was intended to ensure that the policy in respect of hot de-briefs was properly implemented.

On 16 March 2009, a note of a hot de-brief was recorded by the duty governor who attended the incident. This note records the

events that took place, but does not suggest that staff were given a proper opportunity to discuss their feelings and reactions and calm down or seek support before going home.

24a. Whilst a record of a hot de-brief was completed by the duty governor, it would appear from interviews with staff that a hot de-brief, in line with the requirements of prison service policy, did not take place.

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."*

At interview all of the staff present on the night that Prisoner B died and said that no cold de-brief had taken place.

On 21 August 2009, five months after Prisoner B's death, a cold de-brief meeting took place.

At the meeting, staff who found Prisoner B expressed their concerns that there had not been any support either immediately following, or in the days and weeks after Prisoner B's death, to talk through whether their response was appropriate or if there was anything else they could have done for Prisoner B.

24b. A cold de-brief, as required by Prison Service policy, did not take place within 14 days of Prisoner B's death. On 21 August 2009, when the cold de-brief did take place, staff raised concerns that there was no support for them after the incident.

SECTION 10: INDEPENDENT CLINICAL REVIEW

25. Findings of the Clinical Reviewer

The Clinical Reviewer, Dr Quinn, included the following information in the introduction to his report.

Background Information

The author's report into the death of Prisoner B is based on experience as a Visiting Forensic Psychiatrist to Her Majesty's Prisons and does not rely on research or any theoretical basis. As the Ombudsman will be aware, research applies to populations and does not transfer readily to individuals. The Prisoner Ombudsman's office will be aware that prison psychiatry is an extremely difficult field and in many respects, does not reflect or equate with that which is delivered in inpatient psychiatric hospital.....Deliberate self-harm, be it a minor or major act, is not unusual particularly in remand prisoners, those who are experiencing their first time in custody and young prisoners. Foreign nationals now appear more and more in psychiatric prison clinics, and the assessment of those individuals is complicated by reliance on interpreters, the prisoner's social isolation (particularly if they are away from their homeland and their family have not travelled with them) and socio-cultural issues.

It has been the author's (and other colleagues) experience that interpreters are not always immediately available and assessing psychiatrists, in the first instance, may have to rely on

observations of prison staff and mental health professionals working within prisons.

There is no doubt there are times when prison psychiatry is practised in what would simply be regarded as far from ideal conditions, where clinical governance, as exists in the NHS, does not necessarily translate itself to Her Majesty's Prisons.

The following is a summary of the comments made by Dr Quinn in respect of Prisoner B's care.

Primary Mental Health Review - 22 August 2008

The author would regard the primary mental health referral form completed as satisfactorily, outlining the prisoner's mental state disturbance and the health care plan, as addressing his immediate and medium term needs. It is not clear as to who prescribed anti-depressant medication, namely Citalopram or subsequently Mirtazapine.

(Note: EMIS records show that a prison doctor prescribed the Citalopram on 2 September 2008, and the visiting Psychiatrist prescribed the Mirtazapine on 20 November 2008)

Risk Assessment – 22 August 2008

The risk assessment identified risk of self-harm, need for treatment with anti-depressant medication and a pragmatic approach to managing Prisoner B on the wing through employment. In the author's experience of advising on the

health care of prisoners who are suffering from depression, then not only treatment with anti-depressant medication may be of benefit, but employment/occupation within the prison may also assist. The author regards the aforementioned mental health assessment, risk assessment and health care plan as appropriate to meet Prisoner B's needs at that time.

PAR1 – Opened 3 September 2008

This is the author's first experience of the PAR1, but similar documents exist, including ACCT (Assessment Care in Custody and Teamwork) which can be initiated by any member of staff. The initiating member of staff recognised Prisoner B was struggling in prison, isolated and also notes the following observation – "*attempts will be made to find another suitable mate. New cell mate found – will monitor."* Not only were Prisoner B's mental health difficulties recognised but the need for support through a cell mate was also identified. The author would regard this as a pragmatic holistic approach to his management at that time.

The author has read the daily log entries beginning 17 September 2008 and notes that Prisoner B was in contact with his family by telephone, was working for a time in the gardens, read on occasions, talked to his cell mate and on 28 September 2008 he notes the medication – "*is helping him and he had good support amongst his peers – works in the REACH gardens."*

Those entries not only observe biological events such as Prisoner B's sleeping habits but note he was often engaged in

conversation to ascertain his mental state and any improvement therein.

The author has no criticisms to make on the use of the PAR1 and its discontinuation on 28 September 2008. The entries note he was more settled and engaged with other Chinese prisoners.

Psychiatrists Review – 25 November 2008

From when Prisoner B was remanded to Maghaberry Prison until seen by the visiting psychiatrist, some months had passed. Concerns were expressed about his mental state shortly after his reception and it appears to the author he was supported and managed by staff before he was seen by the psychiatrist.

Mental health reviews continued and on 8 March 2009 at 2150 hours Prisoner B was found hanging in his cell. Attempts to resuscitate him were unsuccessful. In so far as the author is aware, Prisoner B was not seen again by the psychiatrist following her review of him on 25 November 2008.

At interview with Prisoner B on 25 November 2008, the psychiatrist increased the dosage of Mirtazapine to 30mg nocte (at night). The author has not seen any documentation that suggests the psychiatrist planned to see Prisoner B again. The author cannot comment as to why the psychiatrist did not arrange to see Prisoner B again and has not seen any correspondence where this matter may have been raised. From when the psychiatrist first saw Prisoner B on 20 November 2008

until he was reviewed on 25 November 2008, there appears to have been improvement in Prisoner B's mental state. The psychiatrist recommended an increase in dosage of anti-depressant medication. The author is not clear as to who was responsible for monitoring the medication, including any potential side effects or indeed response to treatment. As to whether this was agreed with the General Practitioner in the prison is unclear. The responsibility for monitoring response to treatment with medication and/or difficulties such as side effects with medication would not usually be the responsibility of non-medical staff.

Medical Review Arrangements

The author has read the transcript of the Prisoner Ombudsman's interview with Prisoner B's mental health nurse and notes there was, at that time, a psychiatric clinic twice weekly. It appears to the author Prisoner B was never seen by a visiting General Practitioner when concerns were expressed about his mental state.

Prisoner B was seen on two occasions by a medical doctor, namely the psychiatrist, against the backdrop of concerns expressed about his mental state. The psychiatrist concluded he had a depressive episode. Throughout his stay at Maghaberry Prison, Prisoner B was seen on two occasions and not seen by a General Practitioner about the concerns over his mental state.

The author's concern is this – the absence of frequent medical review of someone in whom there are concerns about their mental state would not in the author's view, amount to the full use of multi-disciplinary involvement. The monitoring of the prisoner's mental state should be a multi-disciplinary involvement. The monitoring of the prisoner's mental state should be a multi-disciplinary approach to include medical staff. More specifically, this is usually at regular intervals when a prisoner is in receipt of treatment with psychotropic medication. The responsibility for this would not usually fall to one member of staff, nurse, officer or otherwise and would involve medical staff. The visiting psychiatrist to prisons has a number of roles, but primarily they are advisory. Advice would include management of mental state, advice on risk, treatment with medication and regular review of treatment. The author cannot say with any certainty there was regular medical review. It is the author's experience that visiting General Practitioners to prisons also have valuable contributions to make in the assessment and management of mentally disordered prisoners. Their remit is (in the author's experience) not only for investigation, management and treatment of physical disorders alone. Often visiting General Practitioners are the first (medical) point of contact before referral to a visiting psychiatrist. It is not certain that this was the case in Prisoner B's case.

<u>The clinical reviewer made the following final comments:</u>

1. It is not the author's intention to be unnecessarily critical of what is (as stated earlier) difficult to practice in settings (prison) that are far from ideal. The management of mentally disordered

prisoners is difficult and complicated. The author is impressed Prisoner B's needs were identified at an early stage, his mental state was recognised to be disturbed as he suffered from a depressive episode complicated by dislocation from his country of birth and family. Prisoner B's worries were understandable. He was treated with psychotropic medication and the author regards this treatment as appropriate. It appears his mental state improved and significant attempts were made at all times to involve him with other prisoners and monitored him appropriately.

2. The management of mentally disordered prisoners should always be multi-disciplinary and draw on the expertise of different professionals including nursing, prison officers and medical (General Practitioners/Psychiatrists). It is of concern to the author Prisoner B appeared to have contact on two occasions with the visiting psychiatrist and beyond these contacts he was not monitored by either a General Practitioner or psychiatrist. When learning lessons from such unfortunate events, the prison may wish to consider the appropriate use of General Practice expertise and the roles of visiting psychiatrist.

3. The author has also considered how earlier recommendations suggested Prisoner B should stay doubled up with another prisoner. It is difficult for the author to make definite comments as to what period of time would have been acceptable for the implementation of this recommendation. The author is not convinced that a delay in its implementation had a significant impact on his treatment and management.

(Note: Full details of cell sharing arrangements are included in sub section 2 and 15)

4. The author has not seen any records of medical/nursing observations of Prisoner B's mental state in the weeks before his death. The records available to the author do not suggest his mental state had significantly deteriorated. The last entry (as seen by the author) is that of 9 January 2009 prepared by Prisoner B's mental health nurse who noted the following – *"and although he looks gloomy he reports he's alright. He has been doubled up with a Chinese man and he's been out to the library and he reports he is still very homesick and is keen when he's finished his sentence to return home. He speaks to his wife weekly and he looks forward to this but he worried about the family, plan to review in two weeks."*

(Note: EMIS was not completed to show that a mental health review took place on 5 February 2009. It is recorded on PRISM and in the mental health nurses diary that at 09.00 on 5 February 2009, a mental health review took place with the assistance of an interpreter. After Prisoner B's death on 16 March 2009, the mental health nurse completed a staff communication sheet outlining the review.)

South Eastern Health and Social Care Trust's (SEHSCT) Response to the Clinical Review Report

In response to the clinical review report conducted by Dr Quinn, the SEHSCT accepted the factual accuracy of the report but wished to add the following comments:

As part of the discharge process from the Inpatient Unit, Prisoner B was referred to Mental Health and was on the active Mental Health case load of a mental health nurse, who would arrange his follow up appointments. It is further recorded that as a consequence, the psychiatric review was not organised with the psychiatrist, however, the capacity existed for the psychiatrist to review Prisoner B on a routine or urgent basis at the request of nursing staff.

The mental health nurse saw Prisoner B on the 9 January 2009 and again on the 5 February 2009. Whilst the appointment on the 5 February 2009 can be evidenced on PRISM, the EMIS system does not contain this review. The Trust stated that during the consultation on the 5 February 2009, with the aid of an interpreter, Prisoner B denied any thoughts of self harm. The Trust stated that further reviews were planned by his mental health nurse for 19 February 2009 and 25 February 2009, but neither took place as she was unavailable because of other duties.

In conclusion the SEHSCT further added:

"The Trust notes Dr Quinn's concerns regarding the multi disciplinary nature of Prisoner B's care and his comments regarding referral to a General Practitioner in Primary Care.

A Service Improvement Board has been established, focussing in particular on the standards of Primary Care and Mental Health Services."

SECTION 11: OTHER ISSUES

26. NIPS Draft Foreign National Strategy 2008-2010

There has been a marked increase in the number of foreign national prisoners in Northern Ireland since the figures were first collected in July 2006. At that point, 46 foreign nationals were held. This number increased steadily, month by month to a peak of 157 in October and November 2008, before falling back to 19 in August 2010.

On 23 April 2008, the Prison Service published a Draft Foreign National Strategy 2008-2010. This aims to ensure that foreign nationals in custody have the same access to all prison facilities as other prisoners and recognises that they have specific and distinct needs.

CJI – Unannounced full follow-up inspection of Maghaberry Prison 19-23 January 2009 (Published 21 July 2009)

An inspection of Maghaberry in January 2009 looked at the arrangements in place for foreign national prisoners.

The inspection found that whilst the draft foreign national policy had been introduced across all three Northern Ireland prisons, there was no local policy and no needs analysis of the population at Maghaberry prison on which to base services, although some efforts had been made to meet the needs of this expanding group of prisoners.

Positive findings were:

- Information provided in languages other than English in reception, on the first night wing and in some of the houses.
- Officers knew they could use a telephone interpreting service and foreign national prisoners said it has sometimes been used to communicate with them.
- Interpreters being brought into the prison, although some wing files clearly indicated a need for interpreting services to be used more regularly.
- English for speakers of other languages classes were provided in education.
- A good supply of books, magazines, and newspapers in languages other than English.

The following recommendations were made and accepted by the Prison Service:

- Staff should receive relevant training in cultural, racial and diversity issues.
- Foreign national co-ordinators should be appointed and a local foreign national policy and strategy introduced based on the assessed needs of prisoners at Maghaberry.
- Foreign national prisoner support and information groups should be held at least monthly and areas of concern fed back to senior managers.
- Interpreting services should be used whenever necessary and recorded.

- A diversity policy should be introduced that meets the requirements of anti-discrimination legislation and outlines how the needs of minority groups will be met.
- Monitoring by a multi-disciplinary team should be introduced to ensure that prisoners from minority groups are not victimised or excluded from activity.

27. Ongoing Challenges in respect of Foreign National Prisoners

At interview, a governor said that it has been challenging for the Prison Service to cope with the increasing number of foreign national prisoners being committed to Maghaberry prison.

He further said that the prison has had to try and react to a number of challenges including:

- The fact that the hierarchy within the Chinese community is difficult to identify and that related issues such as inter community bullying have to be addressed.

- A lack of uptake in the Chinese community to participate in the prisons 'listener scheme'. The listener scheme[21] is usually supported by prisoners who have long term sentences.

- The fact that the UK Border Agency is holding prisoners on immigration warrants for extended periods, resulting in prisoners who are time served continuing their stay in a category A prison, when they should be held in an immigration removal centre (IRC). No IRC is available in Northern Ireland and foreign nationals being held on immigration warrants have to transfer to Dungavel House IRC in Scotland.

[21] Listener Scheme – 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.

- Some solicitors not providing accurate/up to date information for the Chinese prisoners about likely sentence duration and the legal position in respect of immigration matters.

- Some solicitors being reluctant to bring their own interpreters because the interpreters require payment sooner than the solicitors receive their legal aid payments.

- The need for diversity training for all prison staff.

The investigation found that since September 2009, when diversity training commenced, 161 out of 903 (as of 24 June 2010) staff members, from operational support grades to governors, have received this training.

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR THE 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

INVESTIGATION METHODOLOGY

Notification

1. On Sunday 8 March 2009 at approximately 23.00 the Prisoner Ombudsman's Office was notified by the Prison Service about Prisoner B's death in Maghaberry Prison.

2. A member of the Prisoner Ombudsman investigation team attended Maghaberry Prison on 8 March 2009 to be briefed about the events leading up to and following Prisoner B's death. The investigator also visited the scene and met with staff working at the time of Prisoner B's death.

3. Prisoner B's family live in China and, with the aid of an interpreter, the prison service notified the family of Prisoner B's death.

Notices of Investigation

4. The investigation into Prisoner B's death began on the morning of the 9 March 2009 when Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison announcing the investigation. The Notices, which were also transcribed in Mandarin, invited anyone with information relevant to Prisoner B's death to contact the Prisoner Ombudsman's investigation team.

Prison Records

5. All the prison records relating to Prisoner B's period of custody, including his medical records, were retrieved and analysed.

CCTV and Prisoner Telephone Calls

6. The investigation team listened to 15 telephone calls made by Prisoner B from 3 January 2009 to 8 March 2009, in order to establish whether any information in the calls was relevant to the circumstances of Prisoner B's death.

The CCTV footage in Lagan House, specific to Prisoner B's movements were also retained, and reviewed, for the period of 7 March 2009 to 8 March 2009.

Staff Communication Sheets and Interviews

6. Staff Communication Sheets completed following Prisoner B's death were retrieved as part of the investigation and investigators interviewed relevant prison and healthcare staff.

Post Mortem Report

7. My investigation team liaised with the Coroners Service to retrieve the post mortem report in order to establish the exact cause of Prisoner B's death.

Clinical Review

8. As part of the investigation into Prisoner B's death, a clinical review was commissioned to examine his healthcare needs and medical treatment whilst he was in custody in Maghaberry. I am grateful to Dr Patrick Quinn, who carried out the clinical review.

9. Dr Quinn's clinical review report was forwarded to the Prison Service for comment. Prison Service healthcare staff responded and I have reflected these comments at the appropriate places in this report.

Working together with interested parties

10. An integral part of any investigation is to work together with all interested parties involved. My investigation team worked closely with the PSNI and the Coroner's Service for Northern Ireland.

Maghaberry Prison

11. Included at Appendix 3 is some background information describing Maghaberry Prison and the Prison Service policies and procedures relevant to this investigation.

Factual Accuracy Check

12. I submitted my draft report to the Director of the Northern Ireland Prison Service for a factual accuracy check. The Prison Service responded with a list of comments for my consideration. I have fully considered these comments and made amendments where appropriate. This is, therefore, my final report.

APPENDIX 3

BACKGROUND INFORMATION

Maghaberry Prison

Maghaberry Prison is a relatively modern high security Prison which accommodates male long-term sentenced and remand prisoners, in both separated[22] and integrated[23] conditions.

Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. The complex includes four Square Houses - Bann, Erne, Foyle and Lagan. Roe and Bush Houses were built in the late 1990's and were used for several years for 'ordinary' remand and sentenced prisoners, before half of each block was set aside for separated accommodation in 2004.

Roe House also has a separate wing dedicated to accommodating prisoners on committal where they undergo an induction programme before being transferred to an appropriate residential location within Maghaberry. Before prisoners are moved to the committal wing of Roe House, they are processed through the Prison Reception Area.

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

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

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

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[24] 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.

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 built to accommodate 682 prisoners, however, there were over 800 prisoners in Maghaberry on the day that Prisoner B died.

A recent joint inspection of Maghaberry Prison by the Criminal Justice Inspectorate Northern Ireland and the HM Inspectorate of Prisons England and Wales was carried out in January 2009. The report of this inspection was published on 21 July 2009.

Healthcare Centre – Maghaberry Prison

The Healthcare Centre has an inpatient unit and a primary care facility. The primary care unit comprises a pharmacy room, a large treatment room, various consulting rooms, an X-ray room, a dental surgery and offices.

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

There are 20 beds in the inpatient unit. This includes a six-bed bay, which is used for prisoners with mental health conditions, and a four-bed ward for prisoners with physical illnesses or disabilities.

PRISON RULES, POLICIES AND PROCEDURES

The following is a summary of Prison Service policies and procedures relevant to my investigation, some of which can be found on the Prison Service's website.

Prison Rules

Rule 24 of the Prison and Young Offenders Centres Rules (Northern Ireland) 1995 relates to foreign nationals.

24. (1) Foreign nationals shall be informed without delay that they may communicate with the appropriate diplomatic representatives of the state to which they belong and be given reasonable facilities to do so.
24. (2) refugees or stateless persons shall be given reasonable facilities to communicate with the diplomatic representative of the state which looks after their interests, or any national or international authority which serves the interests of such persons.
24. (3) Special arrangements shall be made to meet the needs of foreign national with linguistic difficulties.

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 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. By doing the check, this confirms that the prisoners in the cells are alive and there is no visible concern for their wellbeing or safety.

Self Harm and Suicide Prevention Policy

The Prison Service's Self Harm and Suicide Prevention Policy deals with prisoners at risk of suicide or self harm, but also provides guidance for management and staff on handling a natural death in custody.

Contingency Plan Forty Four – Death of a Prisoner

'Contingency Plan 44 – Death of a Prisoner' provides guidance to the Emergency Control Room on the actions to take immediately following a death in custody between the hours of 08.00 – 17.00.

Contingency Plan Forty Five – Death of a Prisoner

'Contingency Plan 45 – Death of a Prisoner' provides guidance to the Emergency Control Room on the actions to take immediately following a death in custody between the hours of 17.00 – 08.00.

Operational Performance Standards

This manual contains a set of Operational Performance Standards across all the operational areas of the Prison Service which staff are

required to maintain. Section F. 5 deals with the actions to take following a death in custody.