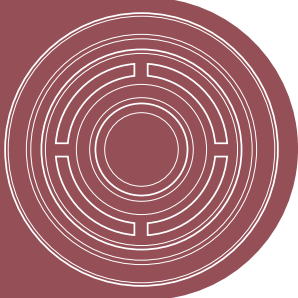


THE SAFETY OF PRISONERS HELD BY THE NORTHERN IRELAND PRISON SERVICE

A JOINT INSPECTION BY CRIMINAL
JUSTICE INSPECTION NORTHERN IRELAND
AND THE REGULATION AND QUALITY
IMPROVEMENT AUTHORITY

November 2019



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November 2019



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List of abbreviations

AD:EPT	Alcohol and Drugs: Empowering People through Therapy
ADHD	Attention Deficit Hyperactivity Disorder
ADP	Average Daily (Prisoner) Population
ASD	Autistic Spectrum Disorder
BIR	Bullying Incident Report
CAB	Challenging Anti-social Behaviour
CCTV	Closed Circuit Television
CJI	Criminal Justice Inspection Northern Ireland
COPD	Chronic Obstructive Pulmonary Disease
CRC	Camera Recording Cell
CSU	Care and Supervision Unit
DHSSPS	Department for Health, Social Services and Public Safety (now DoH)
DIC	Death in Custody
DoH	Department of Health
DoJ	Department of Justice
EMIS	Egton Medical Information System
ETI	Education and Training Inspectorate
GP	General Practitioner
HBW	Hydebank Wood
HMIP	Her Majesty's Inspectorate of Prisons in England and Wales
HMP	Her Majesty's Prison
HNA	Health Needs Assessment
HQ	Headquarters
HSCB	Health and Social Care Board
IMB	Independent Monitoring Board
MDT	Mandatory Drugs Test/Testing
MoJ	Ministry of Justice
NI	Northern Ireland
NIPS	Northern Ireland Prison Service
NPS	New Psychoactive Substances
OST	Opioid Substitution Treatment
PASRO	Prisoners Addressing Substance Related Offending
PDD	Passive Drug Dog
PDU	Prisoner Development Unit
PECCS	Prison Escort and Court Custody Service
PfG	Programme for Government

POA	Prison Officers' Association
PONI	Prisoner Ombudsman for Northern Ireland
PREPS	Progressive Regimes and Earned Privileges Scheme
PRT	Prison Review Team
PSNI	Police Service of Northern Ireland
PSST(s)	Prisoner Safety and Support Team(s)
RQIA	Regulation and Quality Improvement Authority
SAI(s)	Serious Adverse Incident(s)
SAM	Safer at Magilligan
SEHSCT	South Eastern Health and Social Care Trust
SPAR	Supporting Prisoners at Risk
SPAR Evolution	Revised Version of SPAR
UK	United Kingdom
YOC	Young Offender's Centre



Chief Inspector's Foreword

The punitive element of imprisonment is the loss of an individual's liberty. Their successful rehabilitation is often dependent on isolating them from the negative factors in their lives that contributed to their offending. Many arrive in prison with significant diagnosed and undiagnosed healthcare needs, addictions to drugs and alcohol, mental health issues and a number struggle with the rigours and restrictions of the prison regime and the bullying and intimidation that despite the efforts of staff to challenge, are synonymous with prison life. Some will self-harm or become suicidal and the challenges for prison and healthcare staff are real and omnipresent.

During 2018 I performed the role of Interim Prisoner Ombudsman for Northern Ireland and during that time I met the families of young men who had died in prison as a result of suicide or drug overdose. The death in custody investigations revealed that in many cases, their unmet needs in the community during their childhood and adolescence, their mental ill health, their addiction to drugs and alcohol had not been adequately dealt with and their descent into criminality became almost inevitable. I acknowledge the limited choices available to Judges who must of course, consider the safety of the public and the offender when sentencing.

In my view the most difficult issue facing the Northern Ireland Prison Service (NIPS) is the identification of those really vulnerable prisoners, as opposed to those who just seek isolation from the main prisoner population, or those prisoners who seek to avoid the more challenging elements of the prison regime designed for rehabilitation. I have often said that prison is not by nature a therapeutic environment and yet, that is exactly what the NIPS has to create to stabilise individuals at risk and enable them to manage their imprisonment more safely.

The NIPS and the South Eastern Health and Social Care Trust (SEHSCT) have improved the operational delivery of prison healthcare. However, this report highlights difficulties at a strategic level which have led to very slow progress in establishing the levels of partnership that are essential to embedding and improving the fundamental building blocks that will make prisons safe. I am frustrated at having to repeat recommendations from my 2014 report.

I am encouraged by the new approach to managing prisoners at risk; the efforts to extend the reach of the Prisoner Safety and Support Teams; and the embryonic willingness to involve families in trying to work more effectively with some difficult and demanding prisoners. The identification of vulnerability by prison and healthcare staff has improved and critical interventions have undoubtedly saved lives. The efforts to stem the availability of illicit drugs and the use of psychoactive substances are paying dividends, but as one supply route is blocked another will be attempted, such is the nature of demand and supply.

The report makes two strategic and 10 operational recommendations and identifies a number of areas for improvement which all flow from the findings. Sadly, I am not confident that on their own and at the current pace, that they will deliver the transformational change that is required.

I do believe the NIPS needs to become a more intelligent provider in partnership with the SEHSCT, when it comes to the levels of healthcare provision that it needs to keep prisoners safe. I believe there is a critical need for the creation and appointment of a Director of Healthcare, within the NIPS, an individual with the level of knowledge and expertise to drive forward the prison healthcare agenda.

This inspection was conducted by Dr Ian Cameron and Stevie Wilson from CJI jointly with colleagues in RQIA. My sincere thanks to all who supported this work.



Brendan McGuigan CBE
Chief Inspector of Criminal Justice
in Northern Ireland

November 2019

Criminal Justice Inspection
Northern Ireland
a better justice system for all





Executive Summary

The health profile of prisoners, the high levels of mental ill-health, personality disorder, learning difficulty, drug and alcohol addiction, the proportion of prisoners on medication, and in numerous cases a combination of these factors, together with other vulnerability factors, all created a concentration of need within the prison establishments.

It was therefore vital to have effective multi-disciplinary working between the Northern Ireland Prison Service (NIPS) and the South Eastern Health and Social Care Trust (SEHSCT) to address these issues and to deliver the appropriate levels of care, safety and healthcare provision to the prison population.

There had been a number of incidents where the prompt actions and interventions by staff in response to serious self-harm incidents had undoubtedly saved lives. Inspectors were aware of, and on many occasions witnessed, individual members of prison and healthcare staff demonstrating a very caring and compassionate approach to vulnerable prisoners, sometimes in extremely challenging circumstances.

Concerns remained that prison did not provide the therapeutic environment required for prisoners with complex needs and the Courts should be aware of these limitations when committing people to prison for mental health assessments.

In November 2016, the Ministers of Justice and Health announced a joint review of vulnerable people in custody. This followed five deaths in prison custody in Northern Ireland, four relating to mental health issues, and incidents of prisoners committing acts of serious self-harm. At the time of this inspection the work had not been completed. The Ministerial Forum for Safer Custody had not met for some time and there was no strategic drive at Northern Ireland Assembly level to address these wider issues.

Working relationships at local level between prison and health staff had improved since the previous CJI Safety of Prisoners inspection in 2014. There needed to be much closer working between the NIPS and the SEHSCT in the joint-delivery of the strategies on suicide and self-harm and the management of substance abuse which were crucial to the safety of prisoners; on the implementation of inspection and Death in Custody (DIC) report recommendations; and the delivery of safer custody at establishment level.

Inspectors have made a strategic recommendation that the NIPS and SEHSCT should immediately review and address the effectiveness of the joint-working and joint-governance arrangements between the two organisations.

There had been progress made in relation to the management of vulnerable prisoners and those in crisis with the piloting of SPAR Evolution. Inspectors viewed the new policy as positive, and if successfully implemented, should address many of the areas where concern had been expressed in the past. The SEHSCT however needed to be much more involved in the design and delivery of the policy, and further work needed to be undertaken before the roll-out of SPAR Evolution across all the prison sites.

The Safer Custody case-load meetings in the three prisons should be jointly-chaired by the NIPS and the SEHSCT to focus on identifying and addressing the clinical needs of the prisoners in crisis.

There was the need for the NIPS and the SEHSCT to examine the effects of purposeful activity on prisoners' self-harm and suicide, drug-taking and bullying behaviour and to address the findings as part of the wider approach to safer custody.

Inspectors had previously commented on the need for increased family support for vulnerable prisoners and those involved with SPAR, and family support needed to be more embedded within the safer custody arrangements.

The implementation of the recommendations from DIC investigations, and in particular joint recommendations to the NIPS and the SEHSCT, needed to be addressed to

provide corporate assurance to Prison Service and Health Trust senior management that recommendations were fully implemented in a timely manner, with learning properly shared and embedded in operational practice.

The quantity and availability of drugs within prisons continued to be a matter of significant concern. The publication of a Joint Strategy for the Management of Substance Misuse in Custody by the NIPS was a positive development. The prisons had demonstrated a degree of success in reducing the supply of drugs into the prisons, although there undoubtedly remained a serious problem of access to illegal drugs and diverted prescription medication in Northern Ireland prisons. Further work was needed to implement and embed the strategy by the NIPS and the SEHSCT.

There had been advances in search technology which the NIPS should examine as an element of its strategy to address substance misuse, bullying and violence.

Bullying was a significant issue in the prison setting. It could be exacerbated by a number of factors including the prison environment, drugs, or may be offence-related. Much of it was not reported and went unnoticed and unrecorded. It created some very negative outcomes for prisoners. Inspectors have again recommended that the NIPS should review its Violence Reduction and Anti-Bullying Strategy to take account of the issues raised in this report. We consider that this should be prioritised with the work completed to address the strategic recommendation within six months of the publication of this report.

The report makes comment about the prescribing and management of medicines. It found that policies and procedures in



relation to these areas were undergoing review. Challenges remained in relation to prisoners' in-possession medications; the control of medications to prevent diversion; the supervised swallow arrangements for benzodiazepine stabilisation or withdrawal; and the recording and use of the SEHSCT's management information.

The health needs of the prison population were complex. This inspection found that communication and joint working at landing level was good. However, further development was required in the formal governance structures and working relationship between the NIPS and the SEHSCT to ensure effective communication and improve joint working, which would lead to positive outcomes for prisoners in respect of their health.



Recommendations

Strategic recommendations

1

The NIPS and SEHSCT senior management teams should immediately review and address the effectiveness of the joint-working and joint-governance arrangements between the two organisations.

This should result in an agreed plan of action to include *inter alia*:

- the joint-governance arrangement for the NIPS/SEHSCT at operational and establishment level;
- the joint implementation of relevant inspection and DIC recommendations;
- corporate oversight of the implementation of the joint strategies on suicide and self-harm and for the management of substance abuse;
- the timely and effective exchange of information regarding Mandatory Drug Testing (MDT) results;
- the chairing arrangement for safer custody case management meetings; and
- measures to assess joint contribution towards improving outcomes for prisoners, with joint performance indicators to allow effective assessment and management (*paragraph 3.118*).

2

The NIPS should review its Violence Reduction and Anti-bullying strategy to take account of the issues raised in this report. The revised approach should be completed within six months of the publication of this report. This should include:

- an effective strategy to challenge bullying and anti-social behaviour;
- the management of violence reduction and bullying within the wider safer custody meeting structure;
- the management information and performance metrics relating to indicators of violence, anti-social behaviour and bullying;
- the particular needs of women and young offenders in Hydebank Wood in respect of violence, anti-social behaviour and bullying;
- the identification and investigation process for allegations of violence, anti-social behaviour and bullying, the management and quality assurance of the process and the training and guidance for officers;
- measures to reduce under-reporting and increase confidence in the reporting and investigation process;
- the use of the restorative approach to address prisoner conflicts, particularly with the limited scope to move prisoners in some areas; and
- the links between bullying, substance misuse and safer custody (*paragraph 4.57*).

Operational recommendations

1

The NIPS work under Prisons 2020 to ‘define the scope of purposeful activity and establish the baseline position at each establishment’ by December 2019 should include the areas recommended by CJI/RQIA in the 2014 Safety of Prisoners Inspection Report (*paragraph 2.18*).

2

The NIPS Family Strategy should provide for the necessary family support for vulnerable prisoners and those involved in the safer custody arrangements (*paragraph 2.19*).

3

Prior to the roll-out of SPAR Evolution to Maghaberry and Hydebank Wood, the NIPS and the SEHSCT should fully consider the findings of the evaluation of the work to introduce SPAR Evolution in Magilligan and Ash House, together with the issues raised in this report, and take full account of these in the planning and training of staff for a NIPS-wide SPAR Evolution (*paragraph 3.21*).

4

Within three months of the publication of this report the Safer Custody case-load meetings in the three prisons should change from NIPS-driven and directed meetings with a healthcare input, to meetings jointly-chaired by the NIPS and the SEHSCT, which can focus on identifying and addressing the clinical needs of the prisoners in question (*paragraph 3.24*).

5

The NIPS and the SEHSCT should review the way that DIC recommendations are implemented within six months of the publication of this report. This should include a mechanism to provide corporate assurance to the NIPS and the SEHSCT senior management that recommendations (including joint recommendations) were fully implemented in a timely manner, with learning properly shared and embedded in operational practice at local level (*paragraph 3.38*).

6

The NIPS should examine the introduction and implementation of body-scanning technology in prisons in England and Wales, with a view to introduction in Northern Ireland to reduce the supply of illicit and prescription drugs, New Psychoactive Substances (NPS) and other contraband into prisons, as an element of the strategy to address substance misuse, bullying and violence (*paragraph 3.44*).

7

Within 12 months of publication of this report the Health and Social Care Board / Public Health Agency, facilitated by the SEHSCT should complete a comprehensive population health needs assessment that includes the mental health and addiction needs of the Northern Ireland prison population (*paragraph 3.100*).

8

The SEHSCT should jointly agree with the NIPS to implement a robust procedure for monitoring the management of in-possession medicines by prisoner's i.e. spot checks. This will provide evidence that medicines are being managed appropriately and not misused or traded (*paragraph 3.107*).

9

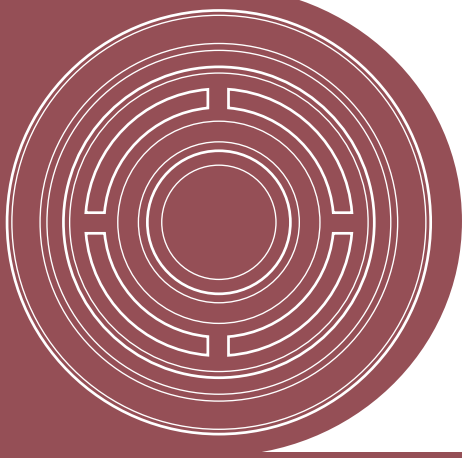
The NIPS and SEHSCT should put immediate procedures in place to ensure the Hydebank Wood Care and Supervision Unit (CSU) is maintained to an appropriate standard (*paragraph 3.114*).

10

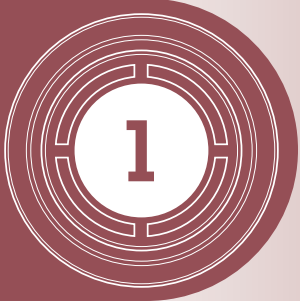
As part of the implementation of the Joint Strategy for the Management of Substance Misuse in Custody the NIPS, in consultation with the SEHSCT, should examine, within one year of the publication of this report, the following areas:

- the substance misuse meeting structure, including chairing arrangements, terms of reference, attendees etc;
- the management and performance information to deliver the strategy;
- a review of the role of the Security Department and the processes to support an intelligence-led approach to searching and testing;
- a review of the searching arrangements for prison officers and support staff, visitors, prisoners, contractors and suppliers to the three prison sites;
- the links between substance misuse, safer custody and violence reduction;
- a review of the operation of the mandatory drug testing programme and substance testing arrangements, including the potential to use saliva, hair or other sample testing; and
- the particular substance misuse needs of women and young offenders in Hydebank Wood (*paragraph 4.41*).

Areas for Improvement are highlighted in bold text throughout the report.



Inspection Report



Introduction

Context

- 1.1 In October 2014 Criminal Justice Inspection Northern Ireland (CJI) and the Regulation and Quality Improvement Authority (RQIA) published a joint report on the Safety of Prisoners held by the Northern Ireland Prison Service.¹ The Report made three strategic and a number of operational recommendations (see Appendix 2).
- 1.2 A Follow-up Review would normally take place 18 months to two years from the date of the original inspection, however at that time, the main strategic recommendations had not been implemented. In view of the importance of the inspection topic, it was decided to instead undertake a further full announced joint inspection in September 2018.
- 1.3 The NIPS had to deal with people committed to prison by the Courts either on remand or sentenced for a crime. These could be some of the most vulnerable individuals in society who present with a high level of complex needs and risk. Prisons have historically been built around the needs of security and detention. They were not designed to be a therapeutic environment for detaining people with serious mental health issues, addictions, personality disorder or other chronic or complicating conditions. Despite this there was a duty of care on the NIPS and the SEHSCT to provide a safe and humane environment for those people in their care.
- 1.4 CJI had previously expressed concerns that prison did not provide the therapeutic environment that was required for prisoners with complex needs and the Courts should be aware of these limitations when committing people to prison for mental health assessments.² At the time of writing these concerns remained.

1 *The Safety of Prisoners held by the Northern Ireland Prison Service*. A joint inspection by CJI and RQIA. October 2014. Available at <http://www.cjini.org/getattachment/677ac123-4a48-43c3-8170-c2c73d2282a4/picture.aspx>

2 *Report on an unannounced visit to Maghaberry Prison 3-4 April 2017*, to review progress against the nine inspection recommendations made in 2015. CJI, HMIP, RQIA and ETI, August 2017. Available at <http://www.cjini.org/getattachment/e93bc92d-262d-4d68-90e1-1362add7ef13/picture.aspx>

- 1.5 The core purpose of the NIPS was to improve public safety by reducing the risk of reoffending through the management and rehabilitation of offenders in custody. The delivery against this core purpose was supported by three strategic aims, the first of which ‘*Safe, secure and decent custody*’,³ was of direct relevance to this inspection. The safety of prisoners was therefore central to the work of the NIPS, and crucial to public confidence in the prison system.
- 1.6 There had been a number of deaths in custody and other incidents of serious self-harm over recent years, and a number of subsequent reports and death in custody investigations⁴ had been critical of the NIPS and the SEHSCT. This led to widespread media and political comment, which undoubtedly impacted on public confidence in the ability of the NIPS and SEHSCT to provide safe, secure and decent custody.
- 1.7 The SEHSCT assumed responsibility for healthcare in the three Northern Ireland prisons on 1 April 2008.⁵
- 1.8 The CJI 2014 inspection report highlighted that Northern Ireland’s prisons housed a complex mix of prisoners. The health profile of prisoners, the high levels of mental ill-health, personality disorder, learning difficulty, drug and alcohol addiction, the proportion of prisoners on medication, and in numerous cases a combination of these factors, together with other vulnerability factors which could surface while in prison custody, all created a concentration of need within the prison establishments. This level of complexity remained evident and is described in this report in more detail.
- 1.9 It was therefore vital to have effective multi-disciplinary working between the NIPS and the SEHSCT to address these issues and to deliver the appropriate levels of care, safety and healthcare provision to the prison population.
- 1.10 The inspection was set within the context of a continuing prison reform process, ‘*Prisons 2020. The Way Forward*’⁶ and following the *Prison Review Team (PRT)*’ Report recommendations.

3 Northern Ireland Prison Service Annual Report and Accounts 2017-18, NIPS. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/justice/nips-annual-report-and-accounts-2017-18.pdf>

4 <https://niprisonerombudsman.gov.uk/publications/death-in-custody>

5 The Partnership Agreement between the Department of Health, Social Services and Public Safety and the Northern Ireland Prison Service for the accountability and commissioning of health services for prisoners in Northern Ireland dated 20 February 2009 is available at <https://www.justice-ni.gov.uk/sites/default/files/publications/justice/FOI%2016%20255%20signed%20Healthcare%20partnership%20agreement%20between%20NIPS%20and%20DHSSPS.PDF>

6 *Prisons 2020. The Way Forward*. NIPS, July 2018. Available at <https://www.justice-ni.gov.uk/articles/prisons-2020-way-forward>

7 *Review of the Northern Ireland Prison Service. Conditions, management and oversight of all prisons*. Prison Review Team final report. October 2011. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/doj/owers-review-of-the-northern-ireland-prison-service.pdf>

Scope of the Inspection

- 1.11 The Terms of Reference for the inspection are included at Appendix 1.
- 1.12 The inspection examined the wider aspects of safety within the three prisons in Northern Ireland. The primary focus of the inspection was on safer custody, suicide and self-harm prevention; violence reduction and bullying; the use and misuse of prescription medication and illegal drugs; and the support within the NIPS and healthcare for prisoners who were struggling with these issues.
- 1.13 Whilst the inspection was not specifically about ‘vulnerable prisoners’, it was inevitable that reference will be made to this group, and the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007⁸ defined all persons lawfully detained in a prison or a young offender’s centre as vulnerable adults.

Background to the Prison Population in Northern Ireland

- 1.14 It was acknowledged that the prison population contained much higher concentrations of mental ill-health, learning disability and personality disorder, there was poorer general physical health, levels of literacy and numeracy, and the social and psychological profile of prisoners was poorer than that of the general population.
- 1.15 The Northern Ireland population had a 25% higher prevalence of mental ill-health than the rest of the United Kingdom (UK)⁹. The prevalence of mental ill-health and intellectual disability within the Northern Ireland prison population, however, was poorly understood.¹⁰ It was acknowledged that determining the true prevalence had been hampered by conflicting information and statistics.¹¹
- 1.16 The most recent Health Needs Assessment (HNA) (2016) of mental health in Northern Ireland Prisons found that 29% of newly committed prisoners reported experiencing depression in the past; 6% reported current anxiety symptoms and 6% reported psychosis.¹² Although the HNA found low rates of self-reported personality disorder (2%), high-quality studies had estimated the prevalence to be higher ranging from 7-10% to 65% depending on the clinical criteria used.¹³ Prescription rates in prison were higher than in the general population and prescribing data for Northern Ireland prisons indicated that 45% of prescriptions were for anti-depressant medication.

8 https://www.legislation.gov.uk/nisi/2007/1351/pdfs/ukxi_20071351_en.pdf

9 *Mental Health in Northern Ireland: Fundamental Facts 2016*. Mental Health Foundation. Available at <https://www.mentalhealth.org.uk/publications/mental-health-northern-ireland-fundamental-facts>

10 *Prison Mental Health in Northern Ireland*. Royal College Psychiatrists 2018. Available at <https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr219.pdf>

11 Draft Review of Vulnerable People in Prison in Northern Ireland, Population Needs Assessment Statistics and Information. [Oriol Brown, James McAuley, Diana Gossrau-Breen. PHA/HSCB. February 2017.](#)

12 [Irvine, M. Health Needs Assessment in Northern Ireland Prisons – Mental Health and Addiction Needs. May 2016.](#)

13 Fazel et al. The mental health of prisoners: a review of prevalence, adverse outcomes and interventions. *Lancet Psychiatry*. 2016 Sep; 3(9): 871–88. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5008459/>

- 1.17 Of all newly committed prisoners, 31% were referred to mental health services. Of those referred, 41% reported previous alcohol misuse and 57% reported previous substance misuse. During their time in prison, 7% reported current alcohol misuse and 33% reported current substance misuse. Women in prison were found to have a higher incidence of mental ill-health, higher rates of referral to mental health services and higher rates of prescribed medication.¹⁴
- 1.18 Whilst 5% of newly committed prisoners reported self-harming behaviour, 49% of referrals to mental health services in Maghaberry Prison were due to self-harming behaviours. Of Supporting Prisoners at Risk (SPAR) case conferences, 45% were due to individuals reporting thoughts of suicide; 16% of conferences were due to suicide attempts or statements of intent to commit suicide. Of all Serious Adverse Incidents (SAIs) in Northern Ireland prisons in 2014, 25% (255) were related to self-harm or overdose. Out of 83 SAIs, 68 were due to self-harm including attempted or completed suicide.¹⁵
- 1.19 Numeracy and literacy levels are known to be lower in the prison population with 30% of Northern Ireland prisoners estimated to have either a learning disability or learning difficulty in comparison to 6.7% of the general population.¹⁶
- 1.20 The prevalence of acquired brain injury is known to be significantly higher in the prison population. O'Rourke et al found a 79% prevalence rate for previous traumatic brain injury amongst women prisoners in Northern Ireland with 38% of women reporting six or more previous injuries. The majority of injuries were sustained as result of either childhood or partner physical abuse.¹⁷
- 1.21 In terms of general physical health, 75% of prisoners were found to smoke tobacco in comparison with 22% of the general population. Consequently the prevalence of Chronic Obstructive Pulmonary Disease (COPD) was higher at a rate of 3.4% compared with 1.97% of the population. The proportion of prisoners reporting exercise activity on three or more occasions per week was noticeably lower at 34% compared with 53% of the general population.¹⁸

14 [Irvine, M. Health Needs Assessment in Northern Ireland Prisons – Mental Health Addiction Needs. May 2016.](#)

15 Ibid.

16 Ibid.

17 O'Rourke et al. Traumatic brain injury and abuse among female offenders compared to non-incarcerated controls. [Brain Injury](#) 32(13-14):1-8 October 2018. https://www.researchgate.net/publication/328608732_Traumatic_brain_injury_and_abuse_among_female_offenders_compared_to_non-incarcerated_controls

18 [Convery L. Health Needs Assessment in Northern Ireland Prisons. Chronic Disease. May 2017.](#)

1.22 In 2017-18 the characteristics of the Northern Ireland prison population was as follows:

- the average daily prison population was 1,439, down from a high of 1,826 in 2013;
- there was a high level of turnover with 3,986 people committed and 4,021 discharged in 2018-19;
- 25.6% of prisoners were on remand;
- 96% of the population was male;
- 0.5% were fine defaulters; and
- 32.9% were aged 21-29.
- There was a significant proportion of older prisoners:
 - 16% were 40-49;
 - 10% were 50-59; and
 - 6% were over 60.
- Sentence length was:
 - 19% under one year;
 - 41% one to five years;
 - 25% over five years and less than life; and
 - 15% life.
- Offence types were:
 - 35% violence against the person;
 - 16% public order;
 - 10% sexual crime;
 - 9% robbery; and
 - 9% drugs offences¹⁹.

1.23 At the time of the main inspection fieldwork at the end of September 2018, the prison population was made up of a total of 1,423²⁰ prisoners as follows:

Table 1 Prison population as at September 2018

	Maghaberry	Magilligan	HBW Male	HBW Female
Sentenced	497	414	33	43
Unsentenced (on Remand)	352	4	58	22
Total	849	418	91	65

19 *The Northern Ireland Prison Population 2017-18*. DoJ Analytical Services Group. Research and Statistical Bulletin 26/2018. September 2018. Available at https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

20 *Analysis of NI Prison Population from 1/7/17 to 30/9/18*. NIPS. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/justice/analysis-of-prison-population-010717-to-300918.pdf>

Risk Factors

- 1.24 MoJ research²¹ identified a number of empirically supported risk factors for men who self-harm in prison. These included the following, many of which were prevalent within the Northern Ireland prison population:
- 1.25 Socio-demographic factors:
- Age – younger men had a higher rate of self-harm, but older men (30+) who self-harmed tended to result in more serious injury;
 - Ethnicity – self-harm rates were higher among white men;
 - Educational background – increased risk of self-harm among those lacking in formal education;
 - Relationship status – increased risk of self-harm among those who were single and/or have experienced a recent relationship breakdown; and
 - Accommodation – increased risk of self-harm among those with no fixed abode.
- 1.26 Custodial/prison-related factors:
- People were at increased risk of self-harm in their early days in prison;
 - There were higher rates of self-harm in prisoners who are on remand and those serving a life sentence;
 - Higher rates of self-harm were seen in local prisons, high security prisons, and Young Offender Institutes; and
 - There were higher rates of self-harm in prisoners who have a high number of disciplinary infractions.
- 1.27 Psychological/psychiatric factors:
- History of self-harm – having a history of self-harm was a good predictor of future self-harming behaviour both prior to and in custody;
 - Depression/hopelessness;
 - Borderline personality disorder (BPD); and
 - Substance misuse.

21 *Self-harm by adult men in prison: A rapid evidence assessment (REA)*. Ministry of Justice Analytical Series 2018. Laura Pope Her Majesty's Prison and Probation Service. Available at <https://www.gov.uk/government/publications/self-harm-by-adult-men-in-prison-a-rapid-evidence-assessment>

Previous inspection reports

- 1.28 The periodic prison inspections provided an insight into the outcomes for prisoners in a number of the areas relevant to their safety.

Maghaberry

- 1.29 Maghaberry was a complex prison which held over 800 men. It received all adult male committals and had a high throughput of prisoners; this included remand prisoners, those serving short custodial sentences, long-term and indeterminate sentenced prisoners and separated paramilitary prisoners. As a Category 'A'²² prison, it held the highest risk prisoners in Northern Ireland. Large numbers of men arrived at the prison with problems related to substance misuse, physical and mental health and history of self-harm, and this had become more marked over recent years.²³
- 1.30 There was no SEHSCT in-patient facility; an on-site health centre provided primary healthcare services. Healthcare was delivered by primary and secondary care staff; mental health and addictions staff; a range of allied healthcare specialists; and, by a number of voluntary and community sector organisations.
- 1.31 Maghaberry was the most recently inspected prison (April 2018), and at that time the safety outcomes for prisoners were judged to be not sufficiently good against the healthy prison test.²⁴ Findings relevant to this inspection included:
- Levels of violence had reduced considerably with better supervision by staff and a more predictable regime. Efforts had been made to keep prisoners safe from anti-social and violent behaviour.

22 NIPS prisoner categories are as follows: Category A: prisoners whose escape would be highly dangerous to the public or the police or the security of the State, no matter how unlikely that escape might be, and for whom the aim of the NIPS must be to make escape impossible. Category B: prisoners for whom the very highest conditions of security are not necessary, but for who escape must be made very difficult. Category C: prisoners who cannot be trusted in open conditions, but who do not have the resources or the will to make a determined escape attempt. Category D: prisoners who can be reasonably trusted in open conditions. Category U: All remand, awaiting trial or awaiting sentence prisoners/inmates will be placed in Category U (unclassified). The only exception is those remand prisoners/inmates identified as Category A. All remand prisoners will be reviewed if and when sentenced and allocated to the appropriate Category A-D above. DOJ website. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/doj/14-62-prisoner-categories-maghaberry.pdf>

23 Report on an unannounced inspection of Maghaberry Prison 9-19 April 2018, CJI, HMIP, RQIA and ETI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

24 The Healthy Prison Test Criteria were:

- Outcomes for prisoners are good. There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.
- Outcomes for prisoners are reasonably good. There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.
- Outcomes for prisoners are not sufficiently good. There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.
- Outcomes for prisoners are poor. There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

- Effective action had been taken to reduce the supply of drugs and the benefits of this were evident across the prison. The random Mandatory Drug Test (MDT) positive rate, for example, had fallen to 9.34%, which was very positive. The search strategy afforded an appropriate response to deter and detect drugs and other prohibited items.
- At the time of the inspection (April 2018) there had been five self-inflicted deaths since the inspection in January 2016. While there had been some improvement in implementing DIC recommendations, some had not been completed and more robust monitoring was needed to ensure that they were embedded in operational practice.
- Completion of the SPAR documentation had improved but quality was still too variable. Care planning required improvement, not just to keep prisoners safe but to focus on helping them solve their problems. Families needed more involvement in this process.
- Medication management had improved but concerns remained about some aspects of tradeable medication being held in-possession.
- Learning from adverse incidents was shared with the wider health team. A number of serious incidents were investigated at too high a level which contributed to a significant backlog of investigations.
- At the time of the inspection (April 2018), 66% of prisoners said they had a mental health problem, but only 24% said they had been helped.
- Mental health provision was reasonably good, but some men waited too long to transfer to in-patient mental health services.
- Prisoners arriving with confirmed opiate substitute treatment (OST) prescriptions continued with their treatment. Those who were dependent on illicit opiates only received symptomatic prescribing and prisoners could no longer start OST during their sentence because there were no specialist prescribers and long national waiting lists for community treatment. Opportunities to engage these prisoners in treatment were therefore lost.
- Although prisoners with substance misuse issues had access to some good psychosocial provision, overall the clinical and psychosocial support remained too limited.²⁵

Magilligan

- 1.32 Magilligan was a medium security prison primarily holding sentenced prisoners. The population comprised low to medium-risk prisoners and the population was relatively stable. There were fewer prisoners with acute vulnerabilities, although the prison held a significant population of older men, many who could be considered vulnerable because of the nature of their offences.
- 1.33 There was a separate low-security semi-open facility for selected prisoners who were nearing the end of their sentences, many of whom worked outside the prison on a day-release basis.

25 Report on an unannounced inspection of Maghaberry Prison 9-19 April 2018, CJI, HMIP, RQIA and ETI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

- 1.34 There was no SEHSCT in-patient facility; an on-site health centre provided primary healthcare services. Healthcare was delivered by primary and secondary care staff; mental health and addictions staff; a range of allied healthcare specialists; and, by a number of voluntary and community sector organisations.
- 1.35 The last inspection of Magilligan took place in June 2017. Safety outcomes for prisoners were judged to be reasonably good against the healthy prison test. Findings relevant to this inspection included:
- Recorded levels of violence were very low. However, more prisoners than at the previous inspection said they did not feel safe, and more also reported victimisation. Governance and analysis of data on safer custody were weak. The 'Safer at Magilligan' (SAM) process was under-used and not embedded sufficiently, and we found evidence of under-reporting of bullying.
 - Levels of self-harm were low. SPAR case management needed to improve.
 - Not all recommendations from the DIC action plan had been fully implemented. Actions needed to be monitored and embedded.
 - There was proactive searching and testing for drugs, which was showing some good results. The positive MDT rate of 9.9% was within the target of 12%.
 - Aspects of the management and prescribing of medications needed to be improved.
 - Clinical addition services offered conventional treatments, although there was insufficient staff to ensure continuity of service during staff absences.²⁶

Hydebank Wood Secure College²⁷

- 1.36 Hydebank Wood held Northern Ireland's young offenders, aged 18-24, on a shared site with the Women's Prison. In April 2015 Hydebank Wood Young Offenders' Centre was renamed Hydebank Wood Secure College.
- 1.37 The population was made up of remand and sentenced offenders, some for very serious offences and the levels of need and vulnerability could be acute amongst this age group.
- 1.38 There was no SEHSCT in-patient facility; an on-site health centre provided primary healthcare services. Healthcare was delivered by primary and secondary care staff; mental health and addictions staff; a range of allied healthcare specialists; and, by a number of voluntary and community sector organisations.

26 *Report on an unannounced inspection of Magilligan Prison 12-22 June 2017.* CJI, HMIP, RQIA and ETI, December 2017. Available at <http://www.cjini.org/CMSPages/GetFile.aspx?guid=30135725-7a54-431e-85a0-d5ac80fe284c&chset=b3b8fc27-253c-418a-b263-309c2ba3bc2d>

27 The Hydebank Wood Young Offenders' Centre was renamed Hydebank Wood Secure College in April 2015.

1.39 At the last inspection in May 2016 outcomes for prisoners were not sufficiently good against the healthy prison test. Findings relevant to the safety of prisoners included:

- More young men reported feeling unsafe which was likely to have been related to an increase in the availability of illicit drugs and associated bullying. Recorded levels of violence were not excessive. A more strategic approach to bullying was needed to understand the nature of the challenge, and address poor behaviour.
- SPAR document completion had improved but issues remained about quality and completeness, and the availability of therapeutic interventions.
- There was still no 'Listener' scheme (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners for those in crisis).
- There had been one self-inflicted death since the last inspection. Mechanisms were not robust enough to address DIC recommendations and to ensure they were implemented and embedded.
- Initiatives to limit the drug supply were weak. Drugs, including synthetic cannabis and illicit medication, were easily available. MDT positive rates were not excessive but when refusals were included, it did point to significant concerns about the illicit use of drugs.
- The strategic approach to drugs was poor with psychosocial services good, but little intensity provision was available. Specialist clinical addiction services did not meet the needs of the population. The integration between clinical and psychosocial services remained weak.
- There had been some good initiatives in medicines management. However, inadequate supervision created a risk of bullying and diversion. Medication which should have been administered under supervision was being given in-possession at night, and monitoring checks were not taking place.
- Learning identified from serious adverse incidents was not actioned promptly.
- The brief mental health screening the young men received as part of their reception was inadequate.
- The waiting times for urgent mental health assessments were too long. The mental health service was not commissioned to meet the needs of young men with learning disabilities, autism spectrum, post-traumatic stress disorder or personality disorders.²⁸

Hydebank Wood Ash House Women's Prison

1.40 Ash House was Northern Ireland's Women's Prison, and had the disadvantage of being co-located with the Secure College for young offenders which restricted access to facilities and services. CJI had made clear on a number of occasions that Ash House was, and remained, an unsuitable environment for women prisoners.

1.41 Inspectors had previously commented that many of the women had serious social, health and emotional problems and that the small population and confined nature of the Ash House environment exacerbated these issues.

28 Report on an unannounced inspection of Hydebank Wood Secure College, 9-19 May 2016, CJI, October 2016. CJI, HMIP, RQIA and ETI. Available at <http://www.cjini.org/getattachment/deb7ee5a-50c8-4b01-8586-c0abf5a523a8/picture.aspx>

- 1.42 There was no SEHSCT in-patient facility; an on-site health centre provided primary healthcare services. Healthcare is delivered by primary and secondary care staff; mental health and addictions staff; a range of allied healthcare specialists; and, by a number of voluntary and community sector organisations.
- 1.43 At the last inspection in May 2016 outcomes for prisoners were reasonably good against the healthy prison test. Findings relevant to this inspection included:
- Over half of women said they had felt unsafe at some time. This was likely to have been because of the complexity of the population, perceived staff shortages, diverted medication, the increased availability of illicit drugs and associated bullying and victimisation. The work was particularly challenging in Ash House given the population, and creative responses, such as formal mediation, were under-used.
 - Case management interventions for those at risk of self-harm through SPAR had improved but quality needed to be improved.
 - There was still no 'Listener' scheme for those in crisis or on a SPAR.
 - Intelligence was not used well enough, and initiatives to limit the drug supply were weak. Women and staff said it was easy to obtain drugs, including synthetic cannabis and illicit medication. Random MDT rates were low, but when refusals were included, they did highlight significant concerns about the illicit use of drugs.
 - The strategic approach to drugs and alcohol remained poor; psychosocial services were good, but no high intensity provision was available. Specialist clinical addiction services did not meet the needs of the population.
 - We saw some good initiatives in medicines management however, inadequate supervision created a risk of bullying and diversion. Medication that should have been administered under supervision was being given in-possession at night without monitoring checks taking place.
 - Learning identified from serious adverse incidents was not actioned promptly.
 - The brief mental health screening that women received as part of their reception was inadequate.
 - The waiting times for urgent mental health assessments were too long. The mental health service was not commissioned to meet the needs of women with learning disabilities, autism spectrum, post-traumatic stress disorder or personality disorders.²⁹

Prison Review Team Report

- 1.44 In 2011 the Prison Review Team (PRT) produced a wide-ranging report on the conditions, oversight and management of all prisons in Northern Ireland. A section of the report focussed on suicide prevention and substance misuse and included commentary on the wider concerns about the efficacy of the SPAR procedures and support mechanisms for those at risk, and referred to previous investigations which revealed failings in both support and understanding for those at risk.

²⁹ Report on an unannounced inspection of Ash House Women's Prison 9-19 May 2016. Published October 2016. CJI, HMIP, RQIA and ETI. Available at <http://www.cjini.org/getattachment/efa315e4-3288-47e1-85f6-2de9186916fc/picture.aspx>

- 1.45 The Review Team was not reassured that the SPAR procedures were properly implemented, or that the causes of vulnerability were understood and engaged with.³⁰
- 1.46 The report also highlighted that many of those at risk of suicide and self-harm had long histories of prescription drug use and addiction. Prescribing policies in prisons have been neither consistent nor safe: with delays in obtaining prescriptions, and a too swift reduction in supply, resulting in significant levels of anxiety and increased vulnerability.³¹
- 1.47 The Report made a number of recommendations in relation to substance misuse, including the need for a cycle of annual needs assessments, service monitoring and planning for substance misuse services, supported by effective data collection. There was also a need for an increase in partnership working and integrated care amongst the three providers of substance misuse services (primary care, secondary care and Alcohol and Drugs: Empowering People through Therapy (AD:EPT)), with other departments and services in the prisons, supported by information-sharing protocols. Progress in relation to this recommendation will be addressed in this report.

Prisoner Ombudsman's Reports

- 1.48 Prisoner Ombudsman for Northern Ireland (PONI) reports and death in custody investigations (DIC) had highlighted issues around prisoner safety and the SPAR process, bullying and the use of drugs in prison, and these included a number of repeat and similar recommendations where common issues had recurred.

30 Concerns were expressed that:

- procedures for linking previous and current SPARs did not appear to be operating effectively;
- SPARs appeared to be closed very quickly, with no evidence of a proper closure review or assurances that issues of concern had been dealt with;
- many comments on the SPAR logs were purely observational with no evidence of insight or in-depth conversations, even when these were mandated in the care plan; and
- though-care plans existed, the aims were often unhelpfully vague.

Review of the Northern Ireland Prison Service. Conditions, management and oversight of all prisons. Prison Review Team final report. October 2011. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/doj/owers-review-of-the-northern-ireland-prison-service.pdf>

31 *Review of the Northern Ireland Prison Service. Conditions, management and oversight of all prisons.* Prison Review Team final report. October 2011. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/doj/owers-review-of-the-northern-ireland-prison-service.pdf>



Strategy and governance

Draft Programme for Government (PfG)

- 2.1 The Draft Programme for Government PfG³² outlined the major societal outcomes the Northern Ireland Executive sought to achieve, and the DoJ led on PfG Outcome 7 '*We have a safe community and we respect the law and each other*'. Underpinning this were three justice-related indicators, relevant to the issues in this report affecting the safety of prisoners held by the NIPS. They were:
- indicator 1 – reduce crime;
 - indicator 38 – increase the effectiveness of the Justice System; and
 - indicator 39 – reduce re-offending.
- 2.2 Other health related PfG outcomes were:
- indicator 2 - reduce health inequality;
 - indicator 3 - increase healthy life expectancy;
 - indicator 4 - reduce preventable deaths;
 - indicator 5 - improve the quality of the healthcare experience; and
 - indicator 6 - improve mental health.³³

Review of Vulnerable People in Custody

- 2.3 In November 2016 the Ministers of Justice and Health announced a joint review of vulnerable people in custody. This followed a number of deaths in custody and incidents of prisoners committing acts of serious self-harm.³⁴

32 *Draft Programme for Government Framework 2016-21*. Northern Ireland Executive, May 2016. Available at <https://www.northernireland.gov.uk/sites/default/files/consultations/newnigov/draft-pfg-framework-2016-21.pdf>

33 Inspectors were aware of the DoH/DoJ joint Health in Justice Strategy and Action Plan however this was published on 27 June 2019 which was after this report was written. Available at <https://www.justice-ni.gov.uk/publications/improving-health-within-criminal-justice>

34 *Investigation Report into serious self-harm incidents by Sean Lynch at Maghaberry Prison between 2 and 5 June 2016*. Prisoner Ombudsman, September 2016. Available at <https://niprisonerombudsman.gov.uk/publications/other-investigation-reports-om-will-detail-which-reports>

- 2.4 The Terms of Reference for the Review recognised that recent prison inspections and reports had highlighted the challenges of managing vulnerable people in a prison environment, and that the needs of those in prison were complex and multi-factorial and reflected societal trends. People were admitted to prison with physical and mental health issues, learning difficulties, substance misuse (including the use of new psychoactive substances) and experience of trauma which increased their vulnerability.³⁵
- 2.5 The Review was intended to focus on prisoners who were more vulnerable because of mental health concerns or are at risk of suicide or self-harm while in prison.
- 2.6 At the time of the inspection, there had been a number of meetings of a Review Steering Group involving the DoH, the SEHSCT, the Health and Social Care Board, the Public Health Agency and the NIPS. However it was not clear when the Review would be formally concluded, whether it would make recommendations, or what would happen to the finalised review in the continuing absence of a functioning Northern Ireland Assembly and Health and Justice Ministers.
- 2.7 In December 2018 the DoH commissioned the RQIA to assume responsibility for the Review of Vulnerable Prisoners. Inspectors understand that Terms of Reference drafted by the previous Review Team were to be revised and, at the time of writing, had not been established.

Ministerial Forum on Safer Custody

- 2.8 At strategic level, there had been a Ministerial Forum on Safer Custody,³⁶ chaired by the Justice Minister, which met on a tri-annual basis³⁷ and championed a shared-responsibility across all the custodial agencies for the care and well-being of vulnerable people at risk of self-harm or suicide within the criminal justice system.
- 2.9 There had not been a meeting of this forum for some time before and since the dissolution of the Northern Ireland Assembly in January 2017, and at the time of the inspection, its function was not being formally undertaken.
- 2.10 This was an important forum to exchange knowledge and drive improvements across the wider custody remit. In the continuing absence of a Minister and Northern Ireland Assembly, it would be the view of CJJ that the meeting should be recommenced with the Director General of the NIPS as Chair.

35 The terms of reference for the Review are attached at Appendix 3.

36 Membership includes the NIPS, the Police Service of Northern Ireland, the Northern Ireland Courts and Tribunals Service, the Probation Board for Northern Ireland, Healthcare, Academia, the Independent Monitoring Board, Voluntary and Community Sector, and the Prisoner Ombudsman.

37 There was a gap in meetings from May 2013 to May 2014.

Northern Ireland Prison Service

- 2.11 The key role of the NIPS, as defined by its Statement of Purpose, was improving public safety by reducing the risk of re-offending, through the management and rehabilitation of offenders in custody.
- 2.12 The NIPS had identified three strategic aims, which supported delivery against this core purpose. The first of which is particularly relevant to this inspection:
- safe, secure and decent custody;
 - reform and modernise to create an effective and efficient Service; and
 - reduce the risk of re-offending.³⁸

Prisons 2020

- 2.13 In July 2017 the NIPS published a discussion document which committed the Service to embedding the change delivered by the PRT reforms and focussed on driving continuous improvement both in the service the NIPS provided and the way it was provided.³⁹
- 2.14 Following consultation, the strategic commitments were published in the year-one annual delivery plan for 2018-19. Of relevance to this inspection area were the commitments under the key areas of Prisoner Safety and Wellbeing, Purposeful Activity, and Family Engagement.
- 2.15 The Prisoner Safety and Wellbeing commitments were to:
- work in conjunction with the SEHSCT to improve services to the people in NIPS care;⁴⁰
 - SPAR Evolution. Deliver a person-centred approach to supporting people at risk of suicide and/or self-harm; and
 - Review of Vulnerable People (see above). Deliver the joint review of current services provided to vulnerable people and implement recommendations.

38 Northern Ireland Prison Service Annual Report and Accounts 2017-18. NIPS, June 2018. Available at www.justice-ni.gov.uk/sites/default/files/publications/justice/nips-annual-report-and-accounts-2017-18.pdf

39 Prisons 2020. Driving continuous improvement in the Prison Service. A discussion document. July 2018. Available at <https://www.justice-ni.gov.uk/publications/prisons-2020-way-forward>

40 This was to include:

- Project Echo – deliver nine learning & network sessions to develop skills and knowledge on suicide and self-harm;
- QI Project – review and improving medicine management and communication with people coming into custody/our care;
- deliver a wellbeing landing at Maghaberry;
- deliver a mental health hub at Magilligan; and
- deliver a well-being and student development landing at Hydebank Wood.

- 2.16 There was also a commitment to ‘define the scope of purposeful activity and establish the baseline position at each establishment’ by December 2019,⁴¹ and this was welcomed by CJI in the context of the 2014 Safety of Prisoners inspection in which Inspectors said:

‘a further issue which should be addressed by the NIPS is the effect purposeful activity, including work, education, time out of cell, association, exercise and the number of lock-ups has on rates of self-harm and suicide. Death in custody reports have shown that there needs to be an increase in purposeful activity as bored prisoners are at risk of suicide and self-harm, and that being locked up for long periods affects sleep which increases the demand for illicit drugs⁴² and medication to alleviate boredom⁴³. For prisoners who have issues with mental health and personality disorder, lock-ups can be particularly problematic.

As a recommended area for improvement, the NIPS and the SEHSCT should examine the effects of purposeful activity on prisoners’ self-harm and suicide, drug-taking and bullying behaviour, and address the findings as part of strategic recommendations⁴⁴ 1, 2 and 3.⁴⁵

- 2.17 Whilst purposeful activity was important, equally the NIPS and SEHSCT should review and examine the effects of therapeutic activity on prisoner’s mental health and wellbeing.
- 2.18 It would remain the view of Inspectors that this was an important area. The Prisons 2020 work to define the scope of purposeful activity and establish the baseline position at each establishment should incorporate the areas raised in the 2014 recommendation.

Operational recommendation 1

The NIPS work under Prisons 2020 to ‘define the scope of purposeful activity and establish the baseline position at each establishment’ by December 2019 should include the areas recommended by CJI/RQIA in the 2014 Safety of Prisoners inspection report.

41 Prisons 2020. Driving continuous improvement in the Prison Service. The Way Forward. July 2018. Available at <https://www.justice-ni.gov.uk/publications/prisons-2020-way-forward>

42 See also Northern Ireland Prison Service. Prisoner Quality of life Survey 2012. Roisin Broderick Scottish Prison Service Research Branch. April 2013.

43 Ministerial Forum for Safer Custody. Minutes of meeting 31 July 2012.

44 See Appendix 2.

45 *The Safety of Prisoners held by the Northern Ireland Prison Service*. A joint inspection by CJI and RQIA. CJI, October 2014. Available at <http://www.cjini.org/getattachment/677ac123-4a48-43c3-8170-c2c73d2282a4/picture.aspx>

- 2.19 Inspectors would also welcome the Prisons 2020 commitment to introduce a NIPS Family Strategy which recognised the importance of positive family connections, and social support, for prisoners in NIPS care by March 2019.⁴⁶ The NIPS SEHSCT Joint Suicide and Self-harm Risk Management Strategy also provided for promoting the social dimensions of contact with family and visitors to develop protective measures for vulnerable prisoners. Inspectors have previously commented on the need for increased family support for vulnerable prisoners and those involved with SPAR and look forward to seeing family support more embedded within the safer custody arrangements.

Operational recommendation 2

The NIPS Family Strategy should provide for the necessary family support for vulnerable prisoners and those involved in the safer custody arrangements.

- 2.20 At NIPS level there were three main areas of strategy and governance relevant to the safety of prisoners: safer custody; bullying and anti-social behaviour; and substance misuse; together with a further area of NIPS/SEHSCT joint-working to provide care and support to address the needs of those prisoners who required it.

Safer Custody

- 2.21 In 2014 Inspectors expressed concern that the central coordinating role of a senior member of staff at NIPS HQ had disappeared. Whilst the NIPS Director of Operations retained responsibility for the overall policy area, issues relating to safer custody in general, and the SPAR process in particular, had been delegated to the establishments, which removed the corporate approach. In addition, the NIPS HQ Safer Custody Forum, which included the three prisons, no longer met.
- 2.22 Inspectors therefore welcomed the appointment of a NIPS Head of Prisoner Wellbeing, in post from November 2017, which afforded a more corporate and co-ordinated approach. The appointment also provided the opportunity for feedback, lessons-learned and good practice to be communicated between HQ and the establishments in relation to the wider safer custody issues. In addition, a Safer Custody Steering Group had been established chaired by the Director of Operations.

46 Prisons 2020. Driving continuous improvement in the Prison Service. The Way Forward. July 2018.

NIPS Meeting Structure

NIPS Management Board

2.23 The Service's Management Board was responsible for the strategic and business management of the Agency's operations. Its main role was to provide advice to the Director General; lead on the development and implementation of policy and strategy; and to provide overall assurance to the Director General on NIPS affairs.⁴⁷

Operational Management Board

2.24 The Operational Management Board provided the governance mechanism to ensure that the operational responsibilities of the NIPS were effectively delivered, and that implementation and delivery remained effectively aligned to the over-arching corporate vision, priorities, values and behaviours.⁴⁸ The minutes of the meetings showed that the meeting did not provide a corporate oversight of the performance data or management information in relation to safer custody, drug or levels of violence.

Security Management Steering Group

2.25 The Security Management Steering Group, chaired by the NIPS Director of Prisons, had the remit to co-ordinate security across the NIPS,⁴⁹ with a specific area as requiring determined action by the NIPS as a priority:

- To examine, develop and support policy, operational procedures and practice to restrict the supply of abusable substances into and within prison establishments.

2.26 Given the Group's remit, and in light of the Joint NIPS/SEHSCT Strategy for the Management of Substance Misuse in Custody, Inspectors were surprised that there was no SEHSCT involvement in this forum to provide input on the demand side and through care. With the stated remit to develop and support policy, procedures and practice to restrict the supply of abusable substances, Inspectors could not see how the Steering Group could be fully effective as a NIPS-only forum.

47 Northern Ireland Prison Service Annual Report and Accounts 2017-18. NIPS, June 2018. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/justice/nips-annual-report-and-accounts-2017-18.pdf>

48 Ibid

49 The remit of the Security Management Steering Group was to:

- give direction and policy advice on security to the Service, its senior staff and the Minister;
- commission, consider, approve and provide ongoing oversight for security policy and operational procedures;
- provide scrutiny, oversight, challenge and support for the delivery of the security functions at Maghaberry Prison, Magilligan Prison, Hydebank Wood College and PECCS;
- examine any incidents or issues arising which relate to security;
- provide a mechanism to address recommendations relating to security from HMIP/CJI inspections, Ombudsman Reports or other scrutiny bodies; and
- provide assurance, advice and information to the Operational Management Board and the Prison Service Management Board. NIPS internal document.

Safer Custody Steering Group

2.27 This group was constituted in late 2017, chaired by the NIPS Director of Prisons, with the remit⁵⁰ to co-ordinate safer custody issues across the Prison Service, and included two priority areas which had been identified as requiring determined action by the NIPS:

- completing the required actions to address the recommendations from CJI 'Safety of Prisoners' inspection 2014; and
- completing the required actions to address the 'Review of Services provided to Vulnerable Prisoners' commissioned by the Minister of Justice.

2.28 In view of the comments earlier regarding corporacy in the area of safer custody, Inspectors viewed this meeting as a very positive development and the forum had met regularly from late 2017.

2.29 The terms of reference clarified the membership of the Group which did not include any representation from the SEHSCT. In the minutes of the meetings supplied to Inspectors which went back to February 2018, there had been no attendance from the SEHSCT at any of the meetings. Inspectors were surprised that in the light of the Steering Group's remit, and in particular specific areas highlighted in the Terms of Reference regarding the implementation of recommendations of the 2014 CJI/RQIA inspection report, from DIC and other Reports, and the Review of Vulnerable People in Custody, that the SEHSCT was not involved in this key strategic meeting. Again it would be the view of Inspectors that a strategic meeting regarding safer custody could not be fully effective without the presence of the SEHSCT.

NIPS SEHSCT Joint Suicide and Self-harm Risk Management Strategy

2.30 The CJI 2014 inspection report recommended a joint strategy for suicide and self-harm (Appendix 2). In August 2017, the NIPS and SEHSCT published the joint strategy to provide the strategic direction and guidance in the management of people in custody who were at risk from suicide and self-harm, taking into consideration the complex and challenging issues facing individuals. The strategy recognised that *'partnership is the foundation of effective work to mitigate the risk of suicide and self-harm'*, and emphasised *'the need for a 'Whole Prison' approach, combined with a targeted 'person-centred' approach for those who are at high risk from suicide and self-harm behaviours'*.

50 The Remit of the Safer Custody Steering Group was to:

- give direction to the strategic development of the safer custody of people with vulnerabilities in our care;
- commission, consider, approve and provide ongoing oversight for safer custody policy and operational procedures;
- provide scrutiny, oversight, challenge and support for the delivery of the safer custody functions (including when deaths or near misses occur) at Maghaberry Prison, Magilligan Prison, Hydebank Wood College and PECCS;
- provide a mechanism to address recommendations relating to safer custody from HMIP/CJI inspections, Ombudsman Reports or other scrutiny bodies; and
- provide assurance, advice and information to the Operational Management Board and the Prison Service Management Board. NIPS internal document.

- 2.31 The joint strategy had six core objectives⁵¹ with a vision to recognise that the prevention of suicide and self-harm remained everyone's responsibility and all staff were committed to ensuring the best possible care for people in custody.
- 2.32 The stated outcome of the strategy was that individuals will experience an improved quality of life. The indicators of success were:
- the percentage of the prison population who are recorded as having completed suicide;
 - number of people in custody who have been assisted through the SPAR process; and
 - number of self-harm incidences in prisons.
- 2.33 It would be the view of Inspectors that the NIPS and the SEHSCT should revisit the indicators of success to more accurately reflect outcomes for prisoners. For example CJI/ RQIA would expect performance indicators to be outcome-based, and to look at not just the number of people on a SPAR, but what has been the outcome, i.e. change as a result of the intervention, whether the SPAR addressed the prisoner's underlying problems, whether the prisoner had a subsequent SPAR etc.
- 2.34 Inspectors viewed the publication of the joint strategy as a very positive development. To implement the strategy, the NIPS and SEHSCT would develop operational policies and delivery plans to support the implementation of this strategy within their respective organisations.⁵² At the time of the inspection implementation of the strategy was work in progress, and joint policies and delivery plans were not available for implementation at local establishment level. Work had been completed to progress this including workshops between the NIPS and SEHSCT, and a mapping exercise to inform implementation.

51 The Core Objectives were:

1. To ensure that a reasonable, proportionate and practicable response to the risk of suicide and self-harm is applied, taking into account the circumstances of each case.
2. Care and a person-centred approach will be the explicit aim of all services in mitigating the risk for people in custody at risk from suicide and self-harm behaviour.
3. A range of appropriate interventions is essential to ensure a person-centred approach to meeting the individual needs of people in custody.
4. Intervention services will be integrated effectively with a wide range of prison based services to address the needs of people in custody at risk from suicide and self-harm behaviours.
5. Access to information will take into consideration the increasing diversity of people in custody at risk from suicide and self-harm behaviours.
6. The principles of recovery will be reflected in training for staff and service providers to support the continuous development of our workforce.

NIPS SEHSCT Joint Suicide and Self-harm Risk Management Strategy. Version 1.0 August 2017.

52 NIPS SEHSCT Joint Suicide and Self-harm Risk Management Strategy. Version 1.0 August 2017.

The NIPS Suicide and Self-harm Prevention Policy

- 2.35 The NIPS Suicide and Self-harm Prevention Policy was first published in 2011 and was updated in October 2013. The policy stated that *'the NIPS will take all practical and reasonable steps to ensure that prisoners who identify as being at risk of self-harm or suicide are effectively managed through a process of multi-disciplinary assessment and care planning'*.⁵³
- 2.36 The aim of the policy was to identify vulnerable prisoners at risk of self-harm or suicide and provide the necessary support and care to minimise the harm an individual may cause to him/herself throughout their time in custody.
- 2.37 Reference has previously been made to the health profile of prisoners and throughout the Suicide and Self-harm Prevention Policy, there was emphasis on the need for a multi-disciplinary approach and ensuring that the appropriate clinical and psychological support was provided.
- 2.38 The Policy contained the SPAR process, designed to help staff identify, at an early stage, symptoms or behaviours that suggest a prisoner may be in a personal crisis and who may need additional and immediate support and care, through a three-section SPAR document:
- Section 1 – contains a risk matrix and keep-safe plan for a 48-hour period;
 - Section 2 – provided for an assessment interview with the prisoner to more accurately assess the triggers and reasons behind the crisis s/he was experiencing; and
 - Section 3 – ensured an on-going Care Plan, attention and continuous review until the risks were sufficiently mitigated.⁵⁴
- 2.39 Inspectors, and the PRT Report, had been critical of how the SPAR process has been delivered in the NIPS. Criticisms included the quality and completion of the SPAR documentation; the over-use of isolation cells and anti-ligature clothing; and in particular, the care planning aspects of SPAR which tended to be protective, and needed to be more proactive to identify and address the prisoner's underlying issues that led to the cause of concern.
- 2.40 To address these criticisms and to improve the process the NIPS had reviewed SPAR. At the time of the fieldwork for this inspection the NIPS had a revised process, SPAR Evolution, which had been introduced. Live testing of the new model was ongoing in Magilligan and for the women prisoners in Ash House at Hydebank Wood.

53 *NIPS Suicide and Self-harm Prevention Policy 2011*. NIPS, Updated October 2013. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/doj/april-2014-suicide-and-self-harm-prevention-policy.pdf>

54 Ibid.

- 2.41 SPAR Evolution differed from SPAR in a number of areas and was made up of two parts:
Part 1: Concern form and risk assessment; and
Part 2: Individual Care Plan, regime and monitoring.
- 2.42 Where there was concern that a prisoner was distressed or in personal crisis the first part of the SPAR Evolution approach was completed. Following a meeting and risk assessment between the NIPS Senior Officer, and the relevant healthcare or mental health staff, one of three outcomes would be agreed:
1. No Apparent Risk: where there were no needs or no or little risk identified.
 2. No Apparent Risk with Referral/Other Action: Where there was no or little risk of suicidal behaviour or serious self-harm identified but there were other needs identified.⁵⁵
 3. At Risk: where the person was assessed as at risk of suicide or serious self-harm, this should be recorded on the Concern Form as 'At Risk' and the full SPAR Evolution approach initiated.
- 2.43 When it had been determined that a prisoner was 'at risk', the Part Two booklet would be opened. This included putting in place an individual care plan for the prisoner and a monitoring regime.
- 2.44 Inspectors welcomed the care plan description in the operating procedures as being person-centred. If successfully implemented, this should address CJI concerns that the care planning process under SPAR was too protective and not sufficiently proactive to address the underlying issues that led the prisoner to the crisis that precipitated the opening of the SPAR.
- 2.45 Inspectors viewed as positive that the operational procedures for Care Planning and Reviews included *inter alia*:
- Have sufficient information available to staff considering the case to be able to outline what specifically led to the concern that the person was at risk.
 - Devise a person-centred care plan that addresses and reduces the risks and provides support to the prisoner. This should include details of the environment, support and interventions, referral for interventions or additional assessments, to the GP, mental health team or other providers. Where possible, access to usual activities and education should be maintained.

⁵⁵ The operational procedures state that when an individual has had an incident of self-harm the Concern Form must be completed. The Officer, in conjunction with input from healthcare, should determine if there was any intent to complete suicide or if the method used meant there was a risk of significant harm or death. Where the self-harm has been confirmed by healthcare staff as a method for coping or release, it may not be appropriate to progress the individual to the initiation stage. The individual may be better supported through referrals to appropriate services such as the Mental Health Team, addiction services or other forms of support available at the establishment. NIPS SPAR Evolution. Operating Procedures. NIPS Internal Document.

- The person must be accommodated in their usual location unless the risk of suicide or self-harm justifies a safer environment; the rationale for use of an Observation Cell must be clearly recorded on the Care Plan Review.
- When relocated to an Observation Cell the person at risk should be in their normal clothes and have their belongings in the Observation Cell unless the risk of suicide or self-harm requires restrictions to clothing and/or any items in use.⁵⁶

- 2.46 In the 2014 Safety of Prisoners report Inspectors highlighted the scope for increased use of family support for vulnerable prisoners, where this was appropriate.⁵⁷ It was very positive that the SPAR Evolution Operating Procedures included the provision for inviting family members to Care Plan Reviews and to give input to future Reviews where it may be beneficial.
- 2.47 The procedures however, also stated that the NIPS accepts that both time constraints and operational issues make it extremely difficult to have external people attend Care Plan Reviews. Whilst Inspectors acknowledge these are issues, this should not hamper progress. Technological solutions and adaptable ways of working should not prevent family support being made available in appropriate cases to individuals in crisis, and to inform the care planning process for the most vulnerable prisoners. It would be the view of Inspectors that the NIPS Family Strategy under Prisons 2020⁵⁸ (see paragraph 2.19) should address and embed in practice, the need for increased family support for vulnerable prisoners and those involved under the safer custody arrangements (see Operational recommendation 2).

Bullying and Anti-Social Behaviour

- 2.48 Bullying and anti-social behaviour were recognised as a significant issue in prisons, as it was in society more generally, and could be exacerbated by the confined prison environment, overcrowding, the lack of purposeful activity, the presence of illicit drugs and prescription medicines, the demographic profile of the prison population, and the nature of the offence for which the person was imprisoned.
- 2.49 In 2014 Inspectors made the recommendation that the NIPS should review its violence reduction and anti-bullying policy (see Appendix 2) and whilst the local policies at establishment level had been refreshed, there had not been a corporate strategy introduced to drive activity as was recommended.
- 2.50 Policy around anti-bullying remained fragmented across the NIPS and there were different local policies across the three prisons: Challenging Anti-social Behaviour (CAB) was used in Ash House; Bullying Incident Report (BIR) at Maghaberry Prison and the Hydebank Wood Secure College; and Safer at Magilligan (SAM).

⁵⁶ NIPS SPAR Evolution. Operating Procedures. NIPS Internal Document.

⁵⁷ See Strategic Recommendation 1. *The Safety of Prisoners held by the Northern Ireland Prison Service*. A joint inspection by CJI and RQIA. CJI, October 2014. Available at <http://www.cjini.org/getattachment/677ac123-4a48-43c3-8170-c2c73d2282a4/picture.aspx>. Also Appendix II.

⁵⁸ Prisons 2020. Driving continuous improvement in the Prison Service. The Way Forward. July 2018.

Substance Misuse

2.51 The misuse of substances, including alcohol, but in particular the misuse of illicit drugs, new psychoactive substances⁵⁹ (NPS) and prescription drugs continued to be a serious and significant issue for the NIPS. There had been a number of deaths in custody, and serious incidents as a result of the misuse of drugs, and inspection and IMB reports referred to the relative ease with which illicit drugs and prescription medication could be accessed and traded in prisons.

NIPS SEHSCT Joint Strategy for the Management of Substance Misuse in Custody

2.52 In August 2017 the NIPS and the SEHSCT published a joint strategy for the management of substance misuse in custody, which also recognised that partnership was the foundation of effective substance misuse prevention work in prisons. This followed the CJI/RQIA recommendation in 2014. The Strategy emphasised the need for a 'Whole-Prison Approach', combined with a targeted approach for those who have a dependency on substances or were at high risk of substance misuse.

2.53 The joint strategy had eight core objectives⁶⁰ to achieve the vision to reduce substance misuse, minimise substance-related harm and reduce re-offending by adopting the principles of recovery, supporting people who are dependent on substances and reducing the supply and demand for illicit substances (including the misuse and diversion of prescribed medication).

59 New psychoactive substances (NPS) were a range of drugs that had been designed to mimic established illicit drugs, such as cannabis, cocaine, ecstasy and LSD. Manufacturers of these drugs develop new chemicals to replace those that were banned, which meant that the chemical structures of the drugs were constantly changing to try to stay ahead of the law. Available at <https://adf.org.au/drug-facts/new-psychoactive-substances/>

60 Core objectives were:

1. To ensure that a comprehensive range of security measures are in place to reduce the availability and supply of drugs & alcohol and associated paraphernalia within and entering Northern Ireland's prisons.
2. Recovery will be the explicit aim of all services providing treatment and rehabilitation for people in custody with drug and alcohol difficulties.
3. A range of appropriate treatment and rehabilitation services is essential to ensure a person-centred approach to meeting the individual needs of people in custody.
4. Treatment and rehabilitation services will be integrated effectively with a wide range of prison based services to address the needs of people in custody with drug and alcohol issues.
5. Testing for substance misuse by will be deployed with clearly defined purposes to support clinical prescribing, people safety, risk management and progression/regression.
6. A range of blood borne virus prevention, treatment, care and support services will be available in each prison in Northern Ireland.
7. Access to information will take into consideration the increasing diversity of people in custody with substance misuse issues.
8. The principles of recovery will be reflected in training for staff and service providers to support the continuous development of our workforce. NIPS SEHSCT Joint Strategy for the Management of Substance Misuse in Custody. August 2017.

- 2.54 The stated outcome of the strategy was that individuals will experience an improved quality of life. Indicators of success were:
- the number of people in custody who have engaged with addiction services; and
 - the percentage of people who successfully complete an addiction programme against the prison population.
- 2.55 It was very positive that the strategy had now been published, and that it recognised the inter-dependency between the NIPS and the SEHSCT, as neither organisation could effectively address the issues of substance misuse in prisons without the full support of the other.
- 2.56 Inspectors would however, have concerns that the indicators of success were not sufficiently outcome-based, and the NIPS and SEHSCT should review these accordingly. Furthermore the indicators did not take account of the outcomes of the work the NIPS was undertaking to reduce the supply of illicit and prescription drugs into the prison; the levels and types of seizures, or whether or not there was evidence of reduced availability of drugs on the residential landings in the three prisons. Another potential indicator would be the levels of failed/passed/refused MDT and the number of people who were commenced on Opiate Substance Treatment (OST) since their committal. As the misuse of drugs was so closely associated with levels of bullying and violence in prisons, there would be merit in considering this as an indicator of success.
- 2.57 To implement the strategy, the NIPS and SEHSCT would develop operational delivery plans to support the implementation of this strategy, and at the time of the inspection, this had not been completed and implemented. Work had taken place which included workshops and a mapping exercise to inform implementation.

NIPS/SEHSCT Joint Working

- 2.58 In April 2008 responsibility for delivering prison healthcare passed to the SEHSCT. A Partnership Agreement between the Department of Health, Social Services and Public Safety (DHSSPS now DoH) and the NIPS for the accountability and commissioning of health services for prisoners in Northern Ireland was signed and agreed on 20 February 2009.⁶¹
- 2.59 The agreement stated that from 1 April 2008, the SEHSCT had lead responsibility for providing or for securing the provision of a full range of health and social services for prisoners under Article 4 of the HPSS (Northern Ireland) Order 1972.⁶²

61 [Freedom of Information Request. Available at <https://www.justice-ni.gov.uk/sites/default/files/publications/justice/FOI%2016%20255%20signed%20Healthcare%20partnership%20agreement%20between%20NIPS%20and%20DHSSPS.PDF>](https://www.justice-ni.gov.uk/sites/default/files/publications/justice/FOI%2016%20255%20signed%20Healthcare%20partnership%20agreement%20between%20NIPS%20and%20DHSSPS.PDF)

62 Article 4 of the 1972 Order has since been repealed by Article 3 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 which is now the enabling provision under which the Department of Health may, as appropriate, delegate its duties in respect of the promotion of healthcare within Northern Ireland.

- 2.60 The health profile of prisoners was referred to earlier and, the high levels of mental ill-health, personality disorder, drug and alcohol addiction, the high proportion of prisoners on medication and in numerous cases a combination of these factors, all created a concentration of need within the prison establishments. This required a high degree of communication, co-ordination and joint-action between the NIPS and the SEHSCT.
- 2.61 The governance structure through which the SEHSCT and the NIPS planned and delivered a safe and effective prison healthcare service was a three-tiered model, introduced in August 2012. It replaced the previous Service Improvement Board, Partnership Board and local and regional governance meetings originally set up when the SEHSCT assumed responsibility for prison healthcare in 2008. The model was:
- The Prison Healthcare Strategic Forum attended by the NIPS Director General, the SEHSCT Chief Executive and representatives of the Health and Social Care Board (HSCB) and the DoH. It met every two months and its role was to make strategic decisions and provide strategic direction in relation to the provision of healthcare within the Northern Ireland prisons. It communicated decisions to the Operational Management Forum (see below) and considered issues referred to it as unresolved by the Operational Forum.
 - The Prison Healthcare Operational Management Forum was attended by the NIPS Director of Prisons; the three prison governors; and from SEHSCT, by the Director of Adult Services and Prison Healthcare together with a number of health specialist consultants and clinical leads. When available they were attended by the Head of Prisoner Wellbeing and the Assistant Director for Prison Healthcare. It was scheduled to meet every month and the Committee's role was to manage interface issues in relation to the delivery of healthcare in the prison setting. The formal mechanism for raising concerns was through the Strategic Partnership Forum. It also addressed any unresolved issues from the Local Forums (see below).
 - The Prison Healthcare Local Forums. These were held at each of the three prison establishments and on the NIPS side included the Governor of the prison and other nominated managers. Healthcare was represented by the Assistant Director Prison Healthcare, clinical leads and local staff. The role of the Local Forum was to discuss all local interface issues in relation to the delivery of healthcare. Senior managers would disseminate all relevant information to members of their respective teams where decisions would be translated into the delivery of care. The Forum should resolve to share all areas of good practice between each of the three sites⁶³.

63 South Eastern Health and Social Care Trust. Prison Healthcare Strategic Forum ToR August 2012. Prison Healthcare Operational Management Forum TOR August 2012. Prison Healthcare Local Forums TOR August 2012.

- 2.62 The Prison Healthcare Strategic Forum was functioning as described above, however Inspectors understand that neither the Operational nor the Local Forums had convened for some time. At Headquarters level, the main governance was through periodic meetings between the NIPS Director of Operations and the Director of Adult Services and Prison Health Care. At prison establishment level, there were monthly one-to-one meetings between the Prison Governor and the Assistant Director of Prison Health. Inspectors understand that these lower-level meetings did not operate under a formal process of agenda-setting and the meetings were not formally minuted. Whilst Inspectors were advised that the communication at this level was working to the satisfaction of both parties, Inspectors would have concerns that there was not proper recorded governance of the issues discussed and agreed in areas pertaining to the safety of prisoners, or a formal mechanism to record and raise areas of concern to a more senior level (see Strategic Recommendation 1).

Healthcare Provision

- 2.63 In April 2008 responsibility for commissioning and delivering prison healthcare passed to the Department of Health, Social Services and Public Safety (DHSSPS), now known as the Department of Health (DoH). It was commissioned by the Health and Social Care Board (HSCB) in conjunction with the Public Health Agency (PHA), and delivered by the SEHSCT.
- 2.64 At the time of this inspection, 53 prisoners were known to the prison's addiction service.⁶⁴ This number seemed low when cross referenced with information provided by the NIPS, SEHSCT staff, AD:EPT staff and 'prisoner Listeners' about the presenting needs of prisoners observed on the landings.
- 2.65 At the time of the inspection it was difficult to establish how many prisoners were known to the mental health service. There was no mechanism in place to identify prisoners presenting with severe mental illness, learning disability, post-traumatic stress disorder and personality disorder at any given point in time. Inspectors were concerned that the numbers of prisoners who were supported by the mental health team was low. There was no up to date population needs analysis available to determine this fact, however anecdotal evidence provided by prison and health care staff, AD:EPT and 'prisoner Listeners' suggests that the needs of prisoners in relation to mental health were significant.
- 2.66 The provision of the addiction service was recorded as a risk on the SEHSCT Directorate Risk Register in March 2017. The service had reduced staffing levels with no addiction consultant, one addictions keyworker working within three prisons (Hydebank Wood, Ash House and Maghaberry) and one addictions key worker working in Magilligan. Inspectors were unable to access up to date information regarding the number of prisoners who had substance misuse problems within each prison.

64 Prisoners receiving a health service from the SEHSCT were referred to as 'patients'. For the avoidance of confusion the term 'prisoner' has been used throughout the report.

- 2.67 The SEHSCT had a facility for data collection and monitoring. This information was used to produce a monthly performance report. The monthly report mostly detailed the waiting times for both primary and secondary health care services within the prison. From the July 2018 report Inspectors noted that all prisoners committed had an initial health screening and 100% of prisoners committed to Maghaberry had a further comprehensive health screening 72-hours after their committal. The report indicated that 97% of prisoners committed to Hydebank Wood had a further health screening, the reduction in this statistic was due to the release of prisoners prior to the 72 hours.



Delivery

- 3.1 Deaths in prison custody were tragic occurrences and could receive widespread media attention, however there were many times when the good work of prison staff went unnoticed by the wider public. Inspectors were acutely aware that there had been a number of incidents, across the three prisons, where prompt interventions by the NIPS and SEHSCT staff had saved the lives of prisoners who had attempted suicide or serious self-harm.
- 3.2 The delivery of policy in the NIPS was delegated to the prison Governor and was primarily at establishment level within the three prisons. Suicide and self-harm policy and procedures remained a corporate matter.

Suicide and Self-harm

Safer Custody Meeting Structure

- 3.3 At Headquarters level there was a Safer Custody Steering Group, to give '*direction to the strategic development of the safer custody of people with vulnerabilities*' within the NIPS care. However it was not evident from the minutes of the meeting how this forum drove the implementation of the Joint Suicide and Self-harm Strategy, and, although not recorded as members of the group, there had been no attendance by representatives of the SEHSCT recorded in the minutes at any of the meetings in 2018 which Inspectors reviewed. It would be the view of Inspectors that a strategic meeting of this nature could not effectively implement a joint strategy if one of the parties was not present.
- 3.4 It would be the view of CJI that the meeting would benefit from an increased focus on performance improvement and the use of performance management information to more effectively undertake its scrutiny, oversight and challenge functions for the three prisons.

Safer Custody and SPAR

- 3.5 The SPAR process was introduced in 2011 and had been the subject of adverse comment from various inspection bodies including the PRT, the Prisoner Ombudsman for Northern Ireland, Her Majesty's Inspectorate of Prisons in England and Wales (HMIP) and CJI (see above).

- 3.6 The SPAR process was designed to be a short-term crisis first-aid management tool and was not designed to provide long-term care, or to address the underlying issues such as poor mental health, addictions or historical trauma.
- 3.7 In furtherance of PRT Recommendation nine,⁶⁵ CJI examined SPAR documentation on a number of occasions, including as an integral element of prison inspections of the three prison establishments. The NIPS had subsequently introduced procedures for internally auditing the completion of SPAR booklets and for managers to quality assure their content, and this has resulted in an improvement. However Inspectors remained of the view that these needed to focus more on the qualitative aspects and outcomes for prisoners. Inspectors were in no doubt that there had been significant improvements, there was more comprehensive completion of the SPAR booklets, and much of this could be attributed to the staff on the Prisoner Safety and Support Teams (PSSTs) who had made strenuous efforts to make a difference, and the attendance at the multi-disciplinary reviews was well improved. Nevertheless there were still gaps in the care planning which remained mostly protective, as indicated by the continued high use of safer cells and anti-ligature clothing. It also needed to be much more proactive to identify and deal with problems and to effectively utilise the services available to support vulnerable prisoners.
- 3.8 The SPAR policy provided for family support as an element of care planning, and whilst Inspectors found that this was used on occasions, this was the exception, and there was significant potential for more use to be made of family support in appropriate cases. Families were not sufficiently involved and more needed to be done to deliver this support to the most vulnerable prisoners. Inspectors have long been of the view that families were not sufficiently involved in the care and treatment of vulnerable prisoners. Inspectors viewed it as positive that the NIPS had taken steps to address family involvement and would expect the Family Engagement work strand of Prisons 2020 to embed this in operational practice (see Operational recommendation 2).

SPAR Evolution

- 3.9 SPAR Evolution, as referred to earlier, had been designed to address the areas of concern outlined above. Inspectors fully recognised that SPAR Evolution was a new policy, and at the time of the fieldwork it was in the early stages of development and was undergoing live-testing in Magilligan and Ash House. There had been a long period of planning and a number of workshops involving a cross-section of NIPS and SEHSCT staff had taken place. Inspectors were also aware that the SPAR Evolution documentation that we examined during the inspection was not the final version and was subject to amendment and change.

⁶⁵ PRT recommendation nine states 'The Prisoner Ombudsman should be invited to carry out random reviews of SPAR documentation, and her findings should be reflected in training for managers and staff'; and following discussion with the Minister, the Prisoner Ombudsman and the Chief Inspector CJI, it was subsequently agreed that it would be more appropriate for CJI to undertake this role.

- 3.10 Inspectors would be very supportive of the principles of SPAR Evolution and in particular the key areas to provide:
- assessment of risk to balance protective and risk factors; and
 - person-centred care plans with care and support tailored to the individual's needs.
- 3.11 If successfully implemented these should address the long-held CJI concerns about the SPAR process not effectively addressing the underlying issues which prompted the prisoner's crisis.
- 3.12 There were a number of areas of SPAR Evolution which Inspectors examined during the fieldwork which were of potential concern, and the live testing provided a valuable opportunity for the NIPS to identify and address issues as they arose. Inspectors would recommend the NIPS take full account these matters before further rolling-out SPAR Evolution to the rest of the NIPS.
- 3.13 CJI, supported by the PRT Review, has always been of the view that the safety of prisoners was not something the NIPS as an organisation could undertake on its own. Prisoner safety was inextricably linked to the wider institutional issues around the nature of the prison population, regime and estate, the availability of drugs, and the wider levels of violence and bullying in prisons. It was also linked to the individual circumstances of prisoners in terms of their mental and physical health, addictions, childhood trauma, family, social and educational circumstances. Safety issues could only be effectively addressed by a joint approach with the SEHSCT.
- 3.14 Inspectors were concerned that the SPAR Evolution policy, operational procedures and documentation were mainly NIPS-orientated, and whilst they made some references to the role of the SEHSCT, were not assessed by Inspectors as being the joint approach that CJI/ RQIA would have expected. Inspectors would have significant concerns that the current policy did not incorporate the SEHSCT as a fully contributing collaborative partner, and did not sufficiently allow for the necessary joint NIPS/SEHSCT assessments and decision-making at the key stages of the process. A number of NIPS staff expressed concerns to Inspectors about the level of SEHSCT involvement. The overall Suicide and Self-harm Management Strategy was a joint document. It would be the strong view of Inspectors that SPAR Evolution, which gave effect to the Strategy, must also be a partnership approach.
- 3.15 Whilst acknowledging that SPAR Evolution was in its infancy, Inspectors also had concerns about the completion of the SPAR Evolution forms, and whilst many were to a good standard, others that we viewed were not. In some the 'Actions to address Concerns and Risk Factors' section and 'Individual Care Plans' were poorly completed, and did not take sufficient action to address the underlying reasons why the person was in crisis. Furthermore, Inspectors noted that in a number of cases, the language used in SPAR forms was limited to protective factors, for example, observations and conversation checks, rather than supporting the prisoner to address their problems. This was something Inspectors

would have seen, and been critical of, under the previous SPAR process. The NIPS and the SEHSCT needed to ensure that the training and implementation of SPAR Evolution delivered the underlying philosophy of the new approach to ensure that officers and staff culture did not revert to a 'SPAR approach' to SPAR Evolution. More needed to be done to provide the person-centred care plans with care and support tailored to the individual's needs as envisaged in the policy. These were areas which should be considered by the NIPS for future training of staff and before further roll-out to the remaining prisons.

- 3.16 In some cases the risk assessments were not made jointly with the SEHSCT, and as outlined earlier, the booklets were primarily NIPS-focussed with insufficient input from the SEHSCT. Inspectors were concerned that health care staff (nurse registrants) agreed and signed off on risk assessments without being fully involved in the process. It was RQIA's view that the risk assessment matrix tool and indicators to be used when assessing and determining risk were too complex for staff to use. This was raised as an area of concern with SEHSCT senior management, who agreed to review the process.
- 3.17 Inspectors would also have concerns that there was little evidence in the SPAR Evolution documentation that we examined of the involvement of families to support prisoners who were in crisis.
- 3.18 There had been internal NIPS consultation about the development and introduction of SPAR Evolution, but a number of the operational officers that Inspectors spoke to during the inspection said that they had not been consulted as part of the process. Inspectors understand that following the inspection fieldwork, there had been a further extension of SPAR Evolution to parts of Maghaberry prison. There would be merit in the NIPS engaging more fully with operation officers in the three prisons, and in particular the Senior Officers who will be primarily responsible for individual cases, before wider roll-out to Maghaberry and Hydebank Wood.

Women

- 3.19 In the CJI 2014 report and strategic recommendation (see Appendix 2) Inspectors made the recommendation that the NIPS self-harm and suicide prevention policy addressed the particular safer custody needs of women and young offenders. The subsequent NIPS/ SEHSCT Joint Suicide and Self-harm Risk Management Strategy did not make reference to the needs of women or young offenders in prison, nor did the SPAR Evolution Operating Procedures. The SPAR Evolution Part I booklet did however make reference to women and young people as part of the risk assessment⁶⁶ although this was not in detail.

⁶⁶ The SPAR Evolution booklet seen by Inspectors stated: Females may experience additional pressure such as separation from children or elderly relatives for whom they may have caring responsibilities; previous sexual abuse or violence and mental health issues. Young people tend to be more impulsive. They are less likely to be open about their feelings or willing to discuss with staff. They are more likely to be impacted by anti-social behaviour, more impressionable and therefore more susceptible to peer pressure. NIPS Suicide and self-harm risk management. SPAR Evolution. Part one: Concern Form and Risk Assessment. Version 2.0 July 2018.

- 3.20 In the 2016 Ash House inspection report, Inspectors said that a specific strategy was required to address the needs of the large number of women at Ash House with mental health problems and complex needs, including those at risk of self-harm and suicide.⁶⁷ Inspectors remain of the view that this is the case and SPAR Evolution needed to do more to address women-specific issues for its operation to be effective. Training for SPAR Evolution also needed to address women-specific issues and none of the staff Inspectors spoke to during the inspection had received properly tailored women-specific training prior to the introduction of SPAR Evolution into Ash House.
- 3.21 At the time of the inspection the formal evaluation of the introduction of SPAR Evolution at Magilligan and Ash House was not available, but Inspectors understand this was to be undertaken. It would be the view of Inspectors that the findings of this Report should be considered by the NIPS/SEHSCT, alongside the learning from work to introduce SPAR Evolution, and considered before the roll-out of SPAR Evolution to the remainder of the prison establishments.

Operational recommendation 3

Prior to the roll-out of SPAR Evolution to Maghaberry and Hydebank Wood, the NIPS and the SEHSCT should fully consider the findings of the evaluation of the work to introduce SPAR Evolution in Magilligan and Ash House, together with the issues raised in this report, and take full account of these in the planning and training of staff for a NIPS-wide SPAR Evolution.

- 3.22 There were Strategic Safer Custody Forums in the three prisons which were generally well attended by a wide cross-section of NIPS, SEHSCT and support organisations, including Samaritans, IMB, AD:EPT, Start 360, Cruse, and prisoner 'Listener' representatives. Although in Hydebank Wood the SEHSCT attendance was poor and representatives had only attended one meeting in the six months to June 2018. It was positive to see representatives from the Security Department at the Forums, and Inspectors were pleased that the relationship between the PSST and Security on safer custody matters was working much more effectively. The meetings provided a broad spread of information relating the prisoner safety issues, bullying and drug testing, but needed to be more outcome-focussed to drive operational activity and improved outcomes for prisoners.
- 3.23 It was a very positive development that the three prisons had a weekly multi-disciplinary meeting to discuss the individual safer custody prisoner caseload. At the time of the last inspection this only happened in Maghaberry. In 2014 the CJI/RQIA inspection report discussed this meeting in some depth and concluded that:

⁶⁷ Report on an unannounced inspection of Ash House Women's Prison 9-19 May 2016. CJI, October 2016. CJI, HMIP, RQIA and ETI. Available at <http://www.cjini.org/getattachment/efa315e4-3288-47e1-85f6-2de9186916fc/picture.aspx>

'the underlying vulnerabilities of many prisoners stem from broader health-related, social or addiction-based issues and it would be the view of Inspectors that the emphasis of the prisoner safety and support meeting should change from a NIPS-driven and directed meeting with a healthcare input, to one jointly-chaired by the NIPS and the SEHSCT which can focus on identifying and addressing the clinical needs of the prisoners in question'⁶⁸.

- 3.24 Inspectors remain strongly of the view that this still needed to happen and have repeated the recommendation.

Operational recommendation 4

Within three months of the publication of this report the Safer Custody case-load meetings in the three prisons should change from NIPS-driven and directed meetings with a healthcare input, to meetings jointly-chaired by the NIPS and the SEHSCT, which can focus on identifying and addressing the clinical needs of the prisoners in question.

- 3.25 Where there was serious concern about an individual prisoner who could not be dealt with through the prisoner safety and support meeting mechanism there was a referral to a multi-agency serious case review, chaired by the NIPS. These meetings were well attended by the relevant prison and support agencies including healthcare and psychiatry, but again Inspectors would argue that these should be jointly-chaired by the NIPS and the SEHSCT.

The Donard Centre

- 3.26 The Donard Centre in Maghaberry Prison was officially opened by the Justice and Employment and Learning Ministers in November 2011.
- 3.27 The Centre had changed function from a drop-in day centre for prisoners with vulnerabilities to a more structured remit where prisoners referred to the unit could undertake various classes and activities, including sessions for anxiety, social interaction, cooking and art. The centre was also being used for evening association for prisoners struggling to cope on the residential landings. A visit to Donard had been incorporated into the committal process and this was a very positive initiative.

68 *The Safety of Prisoners held by the Northern Ireland Prison Service*. A joint inspection by CJI and RQIA. CJI, October 2014. Available at <http://www.cjini.org/getattachment/677ac123-4a48-43c3-8170-c2c73d2282a4/picture.aspx>

- 3.28 Vulnerable prisoners considered suitable for Donard were identified by either PSST staff, who examined the committal lists to try to identify those prisoners who had vulnerabilities, or through the weekly multi-disciplinary meeting. It was positive to observe that multi-disciplinary working with AD:EPT, the mental health team and primary health care was good.
- 3.29 Inspectors were concerned that there was not a formal multi-disciplinary forum or pathway for prisoner referral, assessment, care planning and discharge from the Centre. The operational function of the Centre was the responsibility of the NIPS. It was the view of Inspectors that the purpose of the Centre needed to be clarified and the role and function of the Centre required to be reviewed. Inspectors observed that the Centre seemed to double-up as a social and drop-in centre as well as a therapeutic 'hub'. Accommodation in the Centre was very cramped and there was limited space for discrete group work. Good practice would suggest that the Centre should have a clear pathway, which should include robust admission criteria. The purpose of the centre should be to provide a facility for therapeutic interventions/activities that relate to the prisoner's assessed needs. The SEHSCT should have an integral role in developing this pathway.
- 3.30 A number of the NIPS staff attached to the Donard Centre had received mental health awareness training to help them understand the underlying issues affecting prisoners, and the rationale behind their actions. Some staff had completed training in Shannon Clinic but this was not recent. There were monthly learning lunches with the Mental Health team, and this was a very positive initiative, but was currently the only training the Donard NIPS staff had received. At the time of the inspection the Donard staff group was significantly under strength (five but should be 12) although the prison management assured Inspectors that arrangements were in hand to address this. This had impacted on the access to the Donard Centre, the gardens and the Men's Shed for vulnerable prisoners. Despite this, the staff group was motivated and felt well supported by their Senior Officer.
- 3.31 The PSST in Maghaberry had a good working relationship with the Care and Supervision Unit (CSU) to improve integration planning for those prisoners who had been in the CSU for a long period and this was a very positive initiative to support some of the most vulnerable men in the prison.

Death in Custody Report Recommendations

- 3.32 Following a death in custody or other serious event, the Prisoner Ombudsman undertook an investigation of the circumstances and may make recommendations to the NIPS, to the SEHSCT, or joint recommendations to both parties. In previous inspection reports CJI had been critical of the way in which the NIPS addressed and implemented these recommendations.

- 3.33 The SEHSCT also undertook a Serious Adverse Incident (SAI) investigation in accordance with the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents November 2016.⁶⁹ Inspectors were concerned that the SAI investigations were not completed within the agreed timeframe. At the time of the inspection there was a significant back log of investigations which had impacted on the timely completion of reports and identification of learning and recommendations. Some investigations in relation to incidents that had occurred as far back as 2017 were not complete. Therefore any learning or recommendations were not distributed effectively to influence change and service improvements.
- 3.34 Whilst there had been improvement at local level of the recording and implementing the recommendations, concerns still remained. Inspectors were aware that there was work continuing at the NIPS HQ to address this issue, but at the time of the inspection there was insufficient NIPS corporate strategic oversight of the DIC recommendations to ensure a consistent standard of implementation. The number of recommendations had built up over time, with some dating back to 2012, as a result the Action Plans could be unwieldy documents, which made the monitoring of progress, and the implementation and embedding of the recommendations difficult to manage.
- 3.35 The NIPS recommendations for an individual DIC Report were actioned by the prison where the incident happened. As a result the other prisons were not aware of the recommendations and learning which, in many cases, would be more widely applicable across the three prisons.
- 3.36 Many of the recommendations had been recorded as completed, some had not been, and some remained outstanding. Some elements of the action plans had been discussed at the safer custody meetings although it was not clear from the minutes what actions had been taken.⁷⁰ There was insufficient evidence available to Inspectors that would provide assurance that recommendations had been fully implemented, and importantly, were embedded by front line officers in current operational practice.
- 3.37 Of significant concern to Inspectors was the implementation of joint recommendations to the NIPS and SEHSCT. The two organisations had separate Action Plans and there was no joint working between the NIPS and the SEHSCT to discuss, implement or address joint recommendations. It was not clear to Inspectors what was being done to ensure that these recommendations were fully implemented and embedded in practice by the NIPS and the SEHSCT.

69 Health and Social Care Board Procedure and Follow up of Serious Adverse Incidents November 2016.

70 See also Report on *An unannounced inspection of Maghaberry Prison 9-19 April 2018* by CJI, HMIP, RQIA and ETI. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

- 3.38 There had been recognition of this at a local level and following the recent inspection, Maghaberry had an action on its 2018-19 Business Plan to *'put in place a robust system of scrutiny of all DIC reports to include multi-disciplinary meetings chaired by the Governor'*.

Operational recommendation 5

The NIPS and the SEHSCT should review the way that DIC recommendations are implemented within six months of the publication of this report. This should include a mechanism to provide corporate assurance to the NIPS and the SEHSCT senior management that recommendations (including joint recommendations) were fully implemented in a timely manner, with learning properly shared and embedded in operational practice at local level.

Drugs and Substance Misuse

- 3.39 The quantity and availability of drugs within prisons continued to be a matter of significant concern. Drugs of any description were a high-value currency in prisons and had been responsible for a number of deaths in custody and other serious incidents. They were also undoubtedly a cause of a significant proportion of the violence and bullying which took place in the prisons. This was true both for illicit and prescription drugs, and more recently from NPS. The abuse of prescription medication remained a problem and a number of inspection and DIC reports cited issues of concern in relation to therapeutic or prescription medication. It was clear that prescription drugs, whether issued or smuggled, were abused within the prison environment. It was positive to note that work has progressed by the SEHSCT to reduce the level of prescribing of medication that is at high risk of being misused/traded. It was noted that the pharmacy workforce has been developed to improve medicines management and reduce diversion.
- 3.40 The level of purposeful activity also directly impacted on the level of drug-taking and Inspectors commented on this in the 2014 inspection report⁷¹ (see Appendix 2 and Operational recommendation 1).
- 3.41 Inspectors did not underestimate the difficulty for the NIPS in its attempts to thwart supply. Until there was a development in search technology which would allow for the safe and effective detection of drugs which had been swallowed or secreted within a body cavity, it was impossible for the NIPS to totally prevent illicit and prescription drugs, NPS and other items of contraband, from getting into prisons.

⁷¹ Ministerial Forum on Safer Custody. Minutes of meeting 28 March 2012. See also Northern Ireland Prison Service. Prisoner Quality of life Survey 2012. Roisin Broderick Scottish Prison Service Research Branch. April 2013.

- 3.42 Technological solutions had advanced⁷² and scanning equipment was available, and in use in prisons in England and Wales, to support efforts to manage violence and drug use in prisons. The Ministry of Justice was installing scanners in 10 of the most challenging prisons to tackle drugs and violence.⁷³ HMP Belmarsh in London had introduced a body-scanner which would replace the need for full-body searching over time. Belmarsh Prison was trialling the new body-scanner in reception, which used low-level X-rays to identify prisoners concealing unauthorised articles. It had resulted in some finds of mobile phones, weapons and drugs, which would not have been identified during a full-body search. The initiative was encouraging, and promoted respect and decency. HMIP recommended this as an area of good practice as the body-scanner had produced some encouraging early results.⁷⁴
- 3.43 It would be the view of Inspectors that this body-scanning technology had significant potential to prevent the smuggling of drugs into the prisons in Northern Ireland, much of which was currently undetectable, as it was brought into the prison swallowed or secreted within a body cavity. In addition to the significant deterrent effect a body scanner would have on the wider prison population. It would also give relief to those prisoners who were smuggling drugs against their will, as a result of threats to them and their families by other prisoners and by people in the community, and to those prisoners who currently refused to apply for home leave for fear of being forced to smuggle drugs into the prison on their return.⁷⁵
- 3.44 It would be the view of CJI that the NIPS should seriously consider the introduction of scanning technology to reduce the supply of illicit and prescription drugs, NPS and other contraband into prisons as an element of the strategy to address substance misuse, bullying and violence.

Operational recommendation 6

The NIPS should examine the introduction and implementation of body-scanning technology in prisons in England and Wales, with a view to introduction in Northern Ireland to reduce the supply of illicit and prescription drugs, NPS and other contraband into prisons, as an element of the strategy to address substance misuse, bullying and violence.

72 CJI previously reported on PRT Recommendation 8 in May 2015.

73 10 prisons project gathers pace. Prisons Minister announces arrival of x-ray scanner at HMP Leeds. 4 January 2019. <https://www.gov.uk/government/news/10-prisons-project-gathers-pace>

74 *Report on an unannounced inspection of HMP Belmarsh*, by HM Chief Inspector of Prisons. 29 January–9 February 2018. Available at <https://www.justiceinspectorates.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2018/06/Belmarsh-Web-2018.pdf>

75 Individual prisoners have told IMB members that they have refused home leave rather than face being ‘persuaded’ to bring unauthorised articles back into the prison. *IMB Annual Report 2017-18 Maghaberry Prison*, IMB. Available at <http://www.imb-ni.org.uk/publications/oct-18/Maghaberry%20Annual%20Report%2017-18%20PDF.PDF>

- 3.45 However any sudden increase in the inability for prisoners to access illicit and illegal drugs at residential landing level potentially had a significant knock-on effect for the levels of bullying and violence (see later). Before the introduction of any such technology, the NIPS should ensure that its policies and procedures to deal with the likely upsurge in bullying and violence were robust and effective.

Drugs Strategy Meetings

- 3.46 It was not clear how the Joint Strategy was implemented through the established meeting structure at HQ and establishments.
- 3.47 At Headquarters level the Security Management Steering Group (see previous) which had the specific remit *'to examine, develop and support policy, operational procedures and practice to restrict the supply of abusable substances into and within prison establishments'* did not oversee and direct the implementation of the joint-strategy, and as referred to above, the SEHSCT was not a member of the Group.
- 3.48 It would be the view of Inspectors that the Security Management Steering Group meeting would benefit from an increased focus on performance improvement and the use of performance management information in relation to restricting the supply of drugs into and within the prisons, to more effectively undertake its scrutiny, oversight and challenge functions.
- 3.49 There were Drugs Strategy Meetings at local level and these needed to be more outcome-focussed. From the minutes of these meetings it was not clear how they drove the implementation of the Joint Strategy.
- 3.50 Maghaberry had local guidance for the management of Substance Misuse and a Substance Misuse Committee which was well attended by all the relevant parties. Detailed information was presented on MDT, finds etc. and the effectiveness of the meeting could have been improved by being more outcomes-based to focus resources on the emerging issues and risk areas.
- 3.51 The Magilligan local guidance for the management of Substance Misuse provided for a Substance Misuse Committee, but at the time of the inspection, there was no evidence that it had met. There had been a meeting in November 2017 and September 2018 to discuss drugs misuse and addictions but the minutes were not outcomes-focussed, and did not drive operational activity to identify and address the issues affecting the prison and improve outcomes for prisoners. The results of MDT were presented at the Safer Custody Forum but it was not clear how the information had been used to inform activity to reduce supply. It was a similar position in respect of the Security/Use of Force meeting.

- 3.52 Hydebank Wood did not have a Drugs Strategy Meeting although there was detailed information regarding the MDT results at the Safety and Support meeting. It was not clear from the meeting what was done with the information or how it had been used to inform activity or the operational response to reduce supply. The issues were also discussed at the Security meeting however this only involved the Deputy Governor, the Head of Security and the Residential Governor. It would be the view of Inspectors that for a proper discussion, planning and actioning emerging issues regarding substance misuse, this should also have involved the SEHSCT, addictions, PSST, the PDU, drug testing staff and residential management.

Supply Reduction

- 3.53 The first core objective of the Joint Strategy for the Management of Substance Misuse in Custody was *'to ensure that a comprehensive range of security measures were in place to reduce the availability and supply of drugs and alcohol and associated paraphernalia within and entering Northern Ireland Prisons'*⁷⁶
- 3.54 Illicit drugs supply remained a key risk for the three prisons, and at establishment level there were a number of measures to reduce the supply of drugs.

Staff Search

- 3.55 Maghaberry was a high security prison with a dedicated search facility for everyone entering the prison. This included prison and SEHSCT staff, and other associated staff and official visitors, although this was occasionally dropped due to resourcing issues outside peak times. The search involved outer clothing, belongings, bags and brief cases etc. being subject to an x-ray scan, with the person going through a metal detector followed by a rub-down search by a member of staff which could vary from thorough to cursory. The staff search was predominantly staffed by a male and female prison officer, but on occasions only one member of staff was present, when this happened people of the opposite gender were searched with a metal-detecting 'wand'.

76 This objective would be achieved by:

- Working with other law enforcement agencies to close down trafficking routes into prisons;
- Engaging in intelligence led searches of cells, prisoners, property, staff and visitors;
- Raising awareness amongst staff, service providers and others who work in prison, or with prisoners, to be competent to report drug related incidents;
- Maximising and targeting the use of drug dogs as a prevention and enforcement measure; and
- Benchmarking existing screening mechanisms.

- 3.56 Maghaberry had introduced a secondary search for staff and visitors which was used on a random and targeted basis inside the prison. Inspectors viewed this as a very positive initiative, in response to concerns about staff smuggling drugs into the prison. It also acted as a deterrent. It was an initiative that was overwhelmingly supported by staff that Inspectors spoke to. There had also been a recent detection and prosecution, in conjunction with the Police Service of Northern Ireland, of a prison officer for smuggling illegal and prescription drugs into the prison,⁷⁷ which demonstrated that the staff corruption-prevention arrangements had resulted in a successful outcome.
- 3.57 At Magilligan and Hydebank Wood the search of staff and official visitors was random. On occasions the staff search had been activated on an intelligence-led basis but this was very infrequent. Inspectors were advised that there were no occasional spot-checks of staff and visitors within the prison complexes. In the CJI 2014 report Inspectors expressed concerns that the lack of a structured search regime for staff, which was not proportionate to the potential threat of drugs entering the prison, could potentially leave staff and visitors vulnerable in the event of allegations of smuggling contraband, or to threats or pressure from prisoners. We remain of this view, and were not assured that the searching regimes at Magilligan and Hydebank Wood were sufficiently robust to address the potential threat.

Contractors and deliveries

- 3.58 There was a search regime for contractors and delivery vehicles to the three prison establishments although the effectiveness and thoroughness of the search varied. Inspectors saw some searches of commercial vehicles which were cursory. The Joint Strategy for the Management of Substance Misuse in Custody referred to maximising and targeting the use of drug dogs as a prevention and enforcement measure. Inspectors see potential for the NIPS to consider the use of dogs as a deterrent factor and to improve the effectiveness of the searching of contractors and deliveries.
- 3.59 In 2014 Inspectors recommended a review of the searching arrangements for prison officers and support staff, visitors, prisoners, contractors and suppliers to the three prison sites. Inspectors understand that no formal review has been undertaken. Inspectors would again recommend that a review should be undertaken to ensure that the physical searching arrangements are commensurate with the threat (see Operational recommendation 10).

⁷⁷ <https://www.belfasttelegraph.co.uk/news/northern-ireland/prison-officer-jailed-for-smuggling-drugs-into-maghaberry-jail-37533415.html>

Prison Visits

- 3.60 The smuggling of drugs into prison by visitors had long been identified and a main source of illegal and prescription medication. The NIPS Director General acknowledged that the smuggling of drugs by visitors was widespread.⁷⁸
- 3.61 Searching arrangements were in place for visitors at the three prisons involving a rub-down search and a passive drug dog (PDD) which had been trained to indicate to its handler if it detected the scent of certain drugs. If the PDD indicated about a visitor they were offered a closed visit. The visits rooms were covered by CCTV surveillance operators which was a specialised role and required a degree of skill to detect body-language and the subtle act of passing contraband between visitor and prisoner. Where there was information or suspicion about a particular prisoner, the Security Department would inform the CCTV operator.
- 3.62 There were occasions due to staff shortages, when the post monitoring the CCTV in visits in some prisons had been dropped. In addition, on occasions the available staffing could impact on the effectiveness of the patrol function in visits. Inspectors remain of the view that these were important roles, in particular the CCTV camera operator, which should be prioritised and undertaken by properly trained, skilled and fully-briefed officers.

Searching of prisoners

- 3.63 There was intelligence-led prisoner searching and routine searching of prisoners on committal to prison, on return to prison from home leave, compassionate temporary release, or if working outside the prison. There was also currently random and intelligence-led searching of prisoners on return from a visit.
- 3.64 Maghaberry had made use of the CSU to hold prisoners under Rule 32⁷⁹ who were returning to the prison from home leave or other temporary release who were suspected of having drugs swallowed or secreted in a body cavity and this had proved successful as a deterrent and in the recovery of smuggled items. This was in response to the identified threat and this, together with the other supply reduction measures, had a positive effect across the prison.⁸⁰

78 <https://www.belfasttelegraph.co.uk/news/northern-ireland/threat-to-prison-officers-from-dissident-killers-remains-severe-says-the-man-in-charge-of-northern-ireland-jails-37418698.html>

79 Restriction of association:
32. –(1) Where it is necessary for the maintenance of good order or discipline, or to ensure the safety of officers, prisoners or any other person or in his own interests that the association permitted to a prisoner should be restricted, either generally or for particular purposes, the governor may arrange for the restriction of his association.
(1A) Where a prisoner's association is restricted to ensure the safety of officers, prisoners or any other person, the prisoner may be accommodated in a cell equipped to aid the retrieval of any unauthorized or prohibited article which he may have in his possession. Prison Rules. Prisons and Young Offenders Centres. The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 <https://www.justice-ni.gov.uk/sites/default/files/publications/doj/prison-young-offender-centre-rules-feb-2010.pdf>

80 See also *Report on an unannounced inspection of Maghaberry Prison 9-19 April 2018* by CJI, HMIP, RQIA and ETC. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

Drug Testing

- 3.65 The NIPS SEHSCT Joint Strategy for the Management of Substance Misuse in Custody stated that *'testing for substance misuse will be deployed with clearly defined purposes to support clinical prescribing, people safety, risk management and progression/regression'*.⁸¹
- 3.66 A key element of MDT was also to provide, by means of the random testing programme, more accurate and objective information on the scale, trends and patterns of drug misuse, allowing prisons to manage and target more effectively their resources for tackling drug problems.⁸² It would be the view of Inspectors that this information was vital to allow the NIPS and the SEHSCT to effectively target need and reduced supply.
- 3.67 In the 2014 inspection report CJI referred to a 2008 NIPS Report⁸³ which looked strategically at the issue of substance misuse and assessed the extent of drug misuse in the prisons at that time. Inspectors were not aware of a current strategic assessment of the threat of substance misuse in prison and the extent, scale, trends and patterns of drug misuse, to allow the NIPS and the SEHSCT to focus resources, and how these link to the community to inform demand reduction and through-care strategies inside prison and on release into the community.
- 3.68 It was not clear to Inspectors how the development of the NIPS SEHSCT Joint Strategy for the Management of Substance Misuse in Custody was informed by the overall assessment of the risk. It was the view of Inspectors that a current assessment of the drug threat was needed to effectively inform the implementation of the strategy.

81 This was to be done by:

- The NIPS will carry out a range of mandatory and intelligence led testing for the prevention and identification of illicit substances, including notification to SEHSCT where a test is passed, but a prescribed substance should have produced a fail;
- Ensuring a process is agreed between SEHSCT and NIPS in regards to management of failed drug tests; and
- SEHSCT – health management testing for the purpose of clinical treatment in accordance with NI addiction healthcare standards.

82 The NIPS Guidance on the Mandatory Drug Testing of Prisoners outlines the specific objectives of mandatory drug testing in the NIPS as follows:

- to increase significantly the detection of those misusing drugs and to send a clear message to all prisoners that if they misuse drugs they have a greater chance of being caught and punished;
- to help prisoners to resist the peer pressure often placed on them to become involved in drug taking, due to increased possibility of detection;
- to help identify prisoners who may need assistance to combat their drug problems with assistance offered to those who want it;
- to provide, by means of the random testing programme, more accurate and objective information on the scale, trends and patterns of drug misuse, allowing prisons to manage and target more effectively their resources for tackling drug problems; and to enable the proportion of prisoners testing positive for different drug types on the random testing programme to be used as one performance indicator of drug misuse. NIPS Guidance on the Mandatory Drug Testing of Prisoners. Issues 15 September 2010.

83 Report on Minimising the Supply of Drugs in Northern Ireland Prisons. Internal Northern Ireland Prison Service paper. May 2008.

- 3.69 The current NIPS drug testing strategy covered a number of areas, in addition to random tests there were intelligence-led, suspicion testing and risk-assessment drug tests in relation to home leave applications, regime levels, testing for access to various privileged residential areas, and as key workers etc.

Failed Drugs Initiative

- 3.70 Maghaberry had introduced a very positive initiative for prisoners who failed a Mandatory Drug Test, and rather than adjudication, the prisoner had the opportunity to have motivational intervention with trained NIPS and AD:EPT staff to encourage him to engage in activities to help address his substance misuse issues. If the prisoner agreed to follow a programme of engagement designed specifically to his needs, then the adjudication relating to the failed test would be postponed to allow engagement to be monitored. If successful the adjudication was withdrawn.
- 3.71 At the time of the inspection the pilot scheme had shown positive results with the numbers engaging with AD:EPT and Inspectors would encourage the use of this more widely across the three prisons to allow a more comprehensive evaluation of the outcomes over the longer-term.

Bullying and Anti-social Behaviour

- 3.72 The approach to bullying and violence reduction varied across the three prisons.
- 3.73 The prisons had refreshed their local guidance on bullying and violence reduction. The Strategic Safer Custody forums discussed bullying, violence and anti-social behaviour but, as for safer custody issues, the meetings were not outcome-based and there remained scope for improvement in relation to a number of areas. These included the data on indicators of violence and management information available to the meeting; the security and intelligence available including phone monitoring; the links to substance misuse; and how these informed local strategies to allow proactive action to be taken to address issues of safety, violence and drugs to improve outcomes for prisoners.
- 3.74 In Maghaberry bullying was managed through the Bullying Incident Report (BIR) process, where following a report, a member of staff spoke to the victim, any witnesses and the alleged bully. The residential manager then directed what immediate actions were required.⁸⁴ If the alleged bully's behaviour was to be monitored a BIR booklet was opened, he was interviewed by the residential manager, and his behaviour monitored for up to 28 days. Completed forms were reviewed at the multi-agency PSST meeting.

84 These included: no further action; issue a formal written warning; or to commence a BIR monitoring process. There was also the option to direct interventions, for example victim provided support, adverse report under PREPS, or change the location of the victim or bully.

- 3.75 The Maghaberry PSST Team had focused on a campaign of awareness of violence and anti-social behaviour. Prisoners were more willing to report bullying to staff, and a concerted effort had been made to keep prisoners safe by identifying and managing prisoners involved in anti-social and violent behaviour, with prisoners challenged about their behaviour.⁸⁵
- 3.76 In Magilligan, SAM reports of bullying were passed to the anti-bullying co-ordinator who appointed two members of staff to investigate and interview the bully and the victim. The investigating officers could decide to pursue the matter further and refer to the Anti-bullying Management Board; resolve amicably between the parties; issue an informal warning; or take no further action. The Anti-bullying Management Board made recommendations to the Governor, for example to relocate the perpetrator or victim, issue warnings etc.
- 3.77 In Hydebank Wood allegations of bullying and anti-social behaviour among the young men was though BIR. In Ash House, CAB acknowledged that anti-social behaviour among women could be more discrete in nature and difficult to identify, and stressed the importance of holding women accountable for their behaviour. The unit manager investigated allegations and decided the course of action, for example through the CAB process or mediation/restorative practice; victim support booklet, informal warning, no further action etc. Where it was decided to proceed through CAB, a multi-disciplinary case conference convened and the woman was encouraged to address her inappropriate behaviour which was monitored over time.

Remand to Prison for a Mental Health Assessment: The Magistrates' Courts (Northern Ireland) Order 1981

- 3.78 Article 51 of the Magistrates' Courts (Northern Ireland) Order 1981⁸⁶ allowed a court to remand a person for such period as the court considered necessary to enable a report to be made on the person's physical or mental condition.
- 3.79 From January 2018 to the time of this inspection, there were 12 prisoners remanded to Maghaberry under Article 51. This figure has been steadily increasing since 2016.

85 See *Report on an unannounced inspection of Maghaberry Prison 9-19 April 2018* by CJI, HMIP, RQIA and ETI. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

86 51 (1) Without prejudice to the powers of the court under Article 50, where a person is charged before a Magistrates' court with an offence punishable on summary conviction with imprisonment or an indictable offence which is tried summarily, and the court is satisfied that the person charged did the act or made the omission charged but is of opinion that an inquiry ought to be made into his physical or mental condition, the court may remand him for such period as the court thinks necessary to enable a medical examination and report to be made so, however, that no single period shall, where the person remanded is on bail, exceed twenty-eight days commencing on the day after that on which the person is remanded or extend beyond the next sitting of the court whichever is the longer or, where the person remanded is in custody, exceed the period specified in paragraph (2) or, as the case may be, paragraph (3) of Article 47.

- 3.80 CJI had been clear that prison officers were not trained mental health professionals and the Chief Inspector of Criminal Justice said Maghaberry Prison did not provide a therapeutic environment and he was concerned to find the prison was being used as a safe place by the courts while mental health assessments took place.⁸⁷ This practice was continuing at the time of this inspection and our concerns remain extant.
- 3.81 The inspection of Maghaberry prison in 2017 made the following recommendation which remained extant:

'Whilst the pressing need for mental health assessment was a priority, the courts had other options to obtain urgent needs assessment into the physical and mental condition of potentially high risk individuals. Emergency referrals for mental health assessments would be through the relevant Trust processes. This is a new and emerging demand on prison mental health services therefore historic data was not available. It is clear that this new demand prioritises these assessments which impacts on others awaiting assessment.'

Recommendation: The Department of Justice and Department of Health should develop an agreed pathway to prevent individuals being admitted to prison for an emergency mental health assessment.⁸⁸

Healthcare Provision

Substance misuse service

- 3.82 The care and treatment of prisoners presenting with substance misuse problems involved a number of different teams within the four prisons. Primary care, secondary care and psycho-social interventions were available in each prison. The primary care team were significant providers of substance misuse services including: initial screening and assessment of prisoners; alcohol detoxification; and Benzodiazepine reduction regimes. The primary care team also facilitated the supervised dispensing of Opiate Substitute Treatment (OST), and provided on-going alcohol and drug support and advice to all prisoners receiving healthcare services.
- 3.83 Administration of OST was compliant with Trust Policy and Procedure. Interaction between staff and prisoners during this intervention was observed as patient-centered.

87 Report on an unannounced visit to Maghaberry Prison 3-4 April 2017 to review progress against the nine inspection recommendations made in 2015. CJI, August 2017. Available at <http://www.cjini.org/getattachment/e93bc92d-262d-4d68-90e1-1362add7ef13/picture.aspx>

88 Ibid.

Addictions team

- 3.84 The addictions service was listed on the SEHSCT Directorate's Risk Register in March 2017. The risk assessment was completed in April 2017 and stated that *"Addiction services within Prison Healthcare are currently unable to provide prisoner access to an adequately safe service (comparable to a community service) due to depleted staffing levels, prescribing practices by clinicians not in line with clinical recommended guidelines and interface issues with Prison Service staff meaning prisoners on occasions not attending appointments which may result in patient harm"*.
- 3.85 Inspectors were concerned that the risk was assessed as "extreme", and there was no evidence of an up to date review of the risk. The risk remained the same at the time of this inspection. The governance arrangements in relation to completion and review of the risk assessment were unclear. Inspectors were also concerned that the existing control measures recorded on the risk assessment did not adequately mitigate the risk.
- 3.86 A copy of the SEHSCT Prescribing and Management Opioid Substitution Therapy (OST) Policy was available. The policy was up to date, appropriate and completed in accordance with national and regional policy and guidelines.
- 3.87 Since the last Safety of Prisoners inspection in October 2014, the staffing levels in the addictions team had been depleted. At the time of this inspection there was one addictions key worker covering three prisons, (Maghaberry, Hydebank and Ash House) and one addictions key worker who covered Magilligan. There was no addictions psychiatric consultant. However there was evidence that the team received good support from GP services. Inspectors were informed by SEHSCT senior management that recruitment was ongoing.
- 3.88 Inspectors were concerned that insufficient staffing levels were impacting on the availability of Opiate Substitute Treatment (OST) within each of the prisons. Prisoners already prescribed OST on committal had their treatment continued. However at the time of the inspection, the overall numbers of prisoners who had commenced OST was low. One prisoner had commenced OST in the previous eight months in Maghaberry. It was positive to note that 10 prisoners had been commenced on OST since January 2018 in Magilligan.
- 3.89 Stabilisation addiction treatment was not available, at the time of the inspection, to newly-presenting prisoners or to newly-committed prisoners.
- 3.90 The numbers of prisoners receiving OST at the time of inspection were as follows:
- Maghaberry – 19;
 - Magilligan – 31; and
 - Hydebank – 3.

- 3.91 Prisoners could access alcohol detox via the primary health care team. There were no concerns with access to this service.
- 3.92 Members of the multi-disciplinary team who met with Inspectors expressed concerns regarding drug use within the prisons and the changing complex needs of prisoners. Staff reported concerns in relation to the availability and increase of illicit substances and the impact this had on prisoners. Health staff were also concerned about the lack of an OST service.

AD:EPT

- 3.93 The Trust addictions pathway includes the psychosocial service commissioned by the Trust from AD:EPT Start 360. The AD:EPT service offered an open referral process with a single point of referral. The service, which was available in all four prisons, provided a number of interventions to prisoners seeking support with alcohol and/or drug problems. Prisoners were made aware of the service on committal and a referral was made if appropriate.
- 3.94 The service offered a range of psychotherapeutic interventions. The interventions provided included: counselling; one to one casework; pre-release sessions; and the Prisoners Addressing Substance Related Offending programme (PASRO). The PASRO programme is a cognitive behavioural therapy-based programme and works on the premise that a person can take control of their own choices and therefore change the behaviour or action. PASRO programmes run for 20 sessions. Inspectors were informed that the AD:EPT service would be replacing the PASRO programme with the Building Skills to Recovery programme. The service also provided Naloxone training to uniformed staff and acupuncture therapy to service users. Naloxone is a short acting opioid antagonist that reverses the effects of morphine and other opioid drugs.
- 3.95 AD:EPT staff who met with Inspectors detailed that the service was operating to its full capacity across the four prison sites.
- 3.96 Staff from AD:EPT said that there was good working relationships with the addiction multi-disciplinary team and prison staff. There were regular meetings with the addiction team to discuss cases and inform clinical decision making.

Mental Health

- 3.97 The mental health service was listed on the Directorate Risk Register. The risk assessment was completed in March 2018 and stated that *"there was a risk of being unable to provide full mental health service within Prisons resulting in potential serious harm or death of a person in custody and/or adverse publicity"*. The risk identified was due to reduced staffing levels and the lack of provision of a seven-day service. At the time of the inspection, the seven-day service was not available, although Inspectors were informed by Trust

senior managers that some progress had been made in developing the service. It was anticipated that the seven-day service will be implemented following a successful recruitment drive. Inspectors were concerned that the risk was assessed as “extreme”, however there was no evidence of an up-to-date review of the risk. The governance arrangements in relation to completion and review of the risk assessment were unclear. Inspectors were also concerned that the existing control measures recorded on the risk assessment do not adequately mitigate the risk. The risk level remained at an extreme level at the time of the inspection.

- 3.98 At the time of this inspection the multi-disciplinary team meetings were observed as a comprehensive review of prisoners, with actions arising and the meetings were well documented. The waiting list was reviewed, with the MDT agreeing who required an urgent assessment and who required a routine assessment.
- 3.99 There were good links between prison health care staff and community staff on committal and release from prison.
- 3.100 Inspectors were unable to establish the exact number of prisoners who accessed the mental health service. On reviewing the mental health caseloads, the number of prisoners known to the mental health team when contrasted with the number of the entire prison population was low. Inspectors were informed by prison staff, health staff and ‘prisoner Listeners’ that the needs of prisoners with mental health issues were significant. Inspectors were informed a comprehensive population health needs assessment has been agreed with the prison healthcare commissioning team for 2019/2020 to be led by the Health and Social Care Board / Public Health Agency and facilitated by the SEHSCT.

Operational recommendation 7

Within 12 months of publication of this report the Health and Social Care Board / Public Health Agency, facilitated by the SEHSCT should complete a comprehensive population health needs assessment that includes the mental health and addiction needs of the Northern Ireland prison population.

Medications and prescribing

- 3.101 It was positive to note that prisoners’ medication histories, including allergies, were recorded during the initial reception screening and full medicines reconciliation is completed within 72 hours of admission. In relation to Magilligan it was also positive to note that all prisoners were transferred with their medicine records, in-possession risk assessment and medicines. These are reviewed as part of the admission to Magilligan Prison. The review takes place in the health centre and any missing details are clarified by the nurse.

- 3.102 Any disruption in prescribing regimens was minimised and urgent/critical medicines could be accessed promptly. However Inspectors observed that several supervised swallow medicines had been allowed to run out-of-stock as they had not been re-ordered in a timely manner in Moyola House (Maghaberry). **Within one month of publication of this report supervised swallow medicines must be re-ordered by the SEHSCT in a timely manner in Moyola House (Maghaberry).**
- 3.103 In Hydebank Wood Inspectors were concerned that there was one registered nurse covering the entire site at night. The registered nurse was required to respond to all student and women's healthcare needs which had included episodes of self-harming. Inspectors noted that this had impacted on the timely administration of night time medicines.
- 3.104 No records were maintained for the disposal of medicines at risk of being misused/traded in all four prisons. In Magilligan there was no evidence of robust arrangements being in place for recording the receipt of the stock medicines Amitriptyline, Diazepam, Gabapentin, Pregabalin and Quetiapine or for the safe storage of the pharmacy delivery record sheets. This created an opportunity for the diversion of these medicines. **Within six months of publication of this report the SEHSCT should maintain a record of the disposal of medicines at high risk of being misused/traded.**
- 3.105 In Maghaberry the management of prescribed medicines for administration as supervised swallow continued to be challenging in the evenings, due to a combination of the impact of the prison regime and healthcare and discipline staffing levels. The majority of prisoners prescribed medicines for supervised swallow received their evening and night doses supplied in-possession. This practice created additional opportunities for misuse, overdose, diversion and bullying. Nurses stated that they risk assess the appropriateness of prisoners being given supervised swallow medicines in-possession.
- 3.106 Warfarin dosage instructions were not always received in accordance with policy and procedure. **Within one month of publication of this report Warfarin dosage regimens should be received in accordance with SEHSCT policy and procedure.**
- 3.107 The SEHSCT 'In-possession medication policy' stated that: *"The Northern Ireland Prison Service, in conjunction with the Police Service of Northern Ireland, will be responsible for addressing issues around bullying, misuse and trading of medications by prisoners. This includes intelligence led cell searches and spot checks."* There were no formal compliance checks on medicines held in-possession by prisoners.

Operational recommendation 8

The SEHSCT should jointly agree with the NIPS to implement a robust procedure for monitoring the management of in-possession medicines by prisoner's i.e. spot checks. This will provide evidence that medicines are being managed appropriately and not misused or traded.

- 3.108 Inspectors observed that all medicines were administered from a secure and respectful environment.
- 3.109 Healthcare staff who worked in Magilligan expressed concerns about the implementation of the new in-possession medicines policy (version 7). Staff said the current policy was working well and there were no issues with adhering to the policy in Magilligan.
- 3.110 The Trust policy and procedure in relation to Benzodiazepine withdrawal regimes was not always adhered to. The Trust Benzodiazepine Prescribing Policy (Prison Healthcare) had not been reviewed within the agreed timeframe (November 2017). **Within six months of publication of this report, the SEHSCT Benzodiazepine Prescribing Policy (Prison Healthcare) requires to be reviewed and updated.**

Hydebank Care and Supervision Unit

- 3.111 The standard of cleanliness and hygiene throughout the Care and Supervision Unit (CSU) had fallen well below acceptable standards.
- 3.112 Inspectors observed that it was evident that the CSU had not been cleaned for a considerable length of time. The accommodation was filthy and totally unacceptable. The entire CSU environment including cells, bathroom and room used by health care staff presented a health risk from infection to both students and staff and was not safe.
- 3.113 Our observations and identified infection health risks were escalated to the Deputy Governor.
- 3.114 Following the escalation, Inspectors returned to the CSU on two further occasions. Inspectors observed the environment and spoke to both the NIPS and SEHSCT. It was positive to note that improvements in relation to the cleanliness and hygiene of the environment had improved and mechanisms were put in place to continue to monitor the standard of the environment.

Operational recommendation 9

The NIPS and SEHSCT should put immediate procedures in place to ensure the Hydebank Wood CSU is maintained to an appropriate standard.

NIPS/SEHSCT Joint-working

- 3.115 Joint working around safer custody was key to providing improved outcomes for prisoners. Inspectors would have concerns that the joint working between the NIPS and the SEHSCT was not as effective as it could, and should, be.
- 3.116 Inspectors acknowledged that relationships at local level between prison and health staff had improved from 2014. Our concerns were more focussed at operational-level partnership working. These concerns include the partnership approach to implementing the strategic recommendations CJI/RQIA made in 2014.⁸⁹
- 3.117 Other concerns highlighted in this report included the SEHSCT involvement in the SPAR Evolution process; the lack of involvement of the SEHSCT in the strategic NIPS Steering Groups on Security Management and Safer Custody; the joint delivery of the strategies on suicide and self-harm and the management of substance abuse; the chairing arrangement for the Safer Custody Case Review meetings; the DIC Action Planning process; the lapsing of the Prison Healthcare Operational Management and Local Forums and the unstructured nature of the meetings between the NIPS and SEHSCT at prison establishment level which replaced them; and the effectiveness of the exchange of information regarding MDT (see Chapter 4).
- 3.118 All of these indicated to Inspectors that joint working relationships between the NIPS and the SEHSCT were not as effective as they should be, despite the declarations of partnership working and the need for a 'whole prison approach'. For example, in the joint strategies on suicide and self-harm and for the management of substance abuse, and in Prisons 2020 commitment to work with the SEHSCT to improve services to the people in NIPS care.⁹⁰

⁸⁹ The Report recommended a joint strategy on suicide self-harm be completed with nine months of the publication of the report (i.e. May 2015) it was published in August 2017. Similarly the strategic recommendation on substance misuse was also completed over two years late. In addition many of the areas where we made recommendations in 2014 were not fully completed and have had to be repeated in this report. *The Safety of Prisoners held by the Northern Ireland Prison Service. A joint inspection by CJI and RQIA.* CJI, October 2014. Available at <http://www.cjini.org/getattachment/677ac123-4a48-43c3-8170-c2c73d2282a4/picture.aspx>

⁹⁰ Prisons 2020. Driving continuous improvement in the Prison Service. The Way Forward. July 2018.

Strategic recommendation 1

The NIPS and SEHSCT senior management teams should immediately review and address the effectiveness of the joint-working and joint-governance arrangements between the two organisations.

This should result in an agreed plan of action to include *inter alia*:

- **the joint-governance arrangement for the NIPS/SEHSCT at operational and establishment level;**
- **the joint implementation of relevant inspection and DIC recommendations;**
- **corporate oversight of the implementation of the joint strategies on suicide and self-harm and for the management of substance abuse;**
- **the timely and effective exchange of information regarding Mandatory Drug Testing (MDT) results;**
- **the chairing arrangement for safer custody case management meetings; and**
- **measures to assess joint contribution towards improving outcomes for prisoners, with joint performance indicators to allow effective assessment and management.**

3.119 The NIPS had no staff at senior level who were medically qualified or with experience of delivering a healthcare service to a prison population where there was a high level of need. On occasions the NIPS had difficulty in negotiating its relationship with the SEHSCT, and specifying what was required from the healthcare provision, particularly in respect of the public health and healthcare aspects as they related to the needs of the prison population and its management. The success of the NIPS/SEHSCT relationship, the implementation of the joint strategies on suicide and self-harm and for the management of substance abuse, and the implementation of Strategic Recommendation 1 will involve the NIPS negotiating a joint-approach with the SEHSCT to deliver effective change and performance improvement. This could therefore prove challenging to the NIPS and a potential barrier to the delivery of Strategic recommendation 1. It would be the view of CJI that the NIPS should consider obtaining specialist healthcare advice to provide support and corporate assurance to navigate these areas.



Outcomes

- 4.1 Prison officers, staff from the SEHSCT and the various educational and voluntary and community sector organisations working in Northern Ireland's prisons had to deal with many extremely dangerous individuals, as well as some of the most damaged and vulnerable people in society. Many of these individuals had physical and mental health problems, addictions and other issues.
- 4.2 There had been a number of incidents where the prompt actions and interventions by staff in response to serious self-harm incidents had undoubtedly saved lives. Inspectors were aware of, and on many occasions witnessed, individual members of prison and healthcare staff demonstrating a very caring and compassionate approach to vulnerable prisoners, sometimes in extremely challenging circumstances. The majority of prisoners who were interviewed also confirmed that staff were compassionate and caring. Many of the landing staff, and in particular the PSST staff in the three prisons, had a comprehensive and detailed knowledge of the prisoners in their care and did their absolute best to help and support them during times of crisis.

Deaths and Self-harm in Custody

- 4.3 There was a considerably higher likelihood of self-inflicted death in prison in relation to the likelihood of suicide in the general population, for prisons in England and Wales it was 5.1 times greater.⁹¹ Some of the risk factors were outlined in Chapter 1.
- 4.4 There had been 20 deaths in Northern Ireland prisons since 2014, of these seven were due to natural causes⁹². Three of the deaths were drugs-related and 10 were as a result of suicide. Whilst these were all tragic occurrences the NIPS and SEHSCT needed to continue their efforts to prevent each and every unavoidable death, and to learn the lessons where things had gone wrong.

91 *Safety in Custody Statistics*, England and Wales: Deaths in Prison Custody to December 2017 Assaults and Self-harm to September 2017. Ministry of Justice. 25 January 2018. Available at <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2017>

92 In a number of these cases Inquests have not been held so the cause of death has not been confirmed.

- 4.5 In England and Wales in the 12 months to June 2018 there were 310 deaths in prison custody, of these 77 were self-inflicted deaths (0.9 instances per 1,000 prisoners).⁹³ By way of a comparator in 2018 there were three self-inflicted deaths in Northern Ireland (2.08 per 1,000 prisoners), which was more than twice the rate in England and Wales.
- 4.6 Caution should be taken with comparisons as the suicide rate in Northern Ireland was 18.5 per 100,000 population which was twice that of England, and significantly higher than Wales.⁹⁴
- 4.7 Self-harm in prison was also an area of concern. The figures are shown in Table 2 below. The rate of self-harm in Northern Ireland however, was significantly lower at 450 per 1,000 prisoners,⁹⁵ compared to England and Wales⁹⁶ where there had been 46,859 reported incidents of self-harm (a rate of 549 per 1,000 prisoners).
- 4.8 In England and Wales self-harm trends differed considerably by gender, with a rate of 467 incidents per 1,000 in male establishments, compared to a rate of 2,244 incidents per 1,000 in female establishments.⁹⁷ In Northern Ireland there was a similar differential, however the differences were less stark. The rate for females was 919 per 1,000 prisoners, for males it was 424 per 1,000 prisoners.

93 *Safety in Custody Statistics*, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018. Ministry of Justice. 26 July 2018. Available at <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2018>

94 In 2017 the suicide rate for NI was 18.5 per 100,000 population; England was 9.2; Wales was 13.2; Scotland was 13.9. Northern Ireland Assembly Research Matters. Available at <https://www.assemblyresearchmatters.org/2019/02/27/suicide-statistics-and-policy-in-northern-ireland/>

95 NIPS Statistics relate to an 11 month period from 1/9/17 to 31/7/18.

96 In the 12 months to March 2018. *Safety in Custody Statistics*, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018. Ministry of Justice. 26 July 2018. Available at <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2018>

97 *Safety in Custody Statistics*, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018. Ministry of Justice. 26 July 2018. Available at <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2018>

Safer Custody/SPAR and SPAR Evolution

4.9 There continued to be a high number of SPAR documents opened in the prisons.

Table 2⁹⁸ SPAR, self-harm and use of Camera Recording Cell (CRC) and special clothing

Location	Number of SPARs raised (number per prisoner against average daily Population ⁹⁹)	Number of self-harms (number per prisoner against average daily Population)	Number of CRC ¹⁰⁰ authorised (% of SPARs raised)	Special Clothing authorised (% of CRC authorisations)
Maghaberry	1011 (1.179)	433 (0.50)	373 (37%)	328 (88%)
Magilligan	70 (0.162)	29 (0.06)	29 (41%)	15 (52%)
Hydebank Wood (Male)	214 (2.25)	124 (1.30)	51 (58%)	34 (41%)
Hydebank Wood (Female)	133 (2.33)	62 (1.08)	28 (46%)	16 (57%)

4.10 The rates of SPARs raised and prisoner self-harms were much greater at Hydebank Wood.

4.11 Inspectors have commented in the past on the high levels of usage of observation cells and anti-ligature clothing as being too risk-averse. Observation cells and anti-ligature were inherently isolating and disrespectful, and as such, should only be used as a last resort with prisoners who were already exceptionally distressed and in a vulnerable state.¹⁰¹ The Governors in the prison establishments needed to take immediate steps to address this issue to reduce the use of observation cells and anti-ligature clothing, particularly in Maghaberry where it was used in 88% of cases where a Cell Recording Cell (CRC) had been authorised. Inspectors would hope that if our concerns about the implementation of SPAR Evolution were addressed, its ethos of assessment of risk to balance protective and risk factors, and person-centred care plans with care and support tailored to the individual's needs were successfully implemented, then it should do more to proactively provide support for the prisoner in crisis rather than having to use isolation cells as a mechanism of last resort.

98 All dates relate to the period 1 September 2017 – 31 July 2018.

99 Department of Justice. Analytical Services Group. The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. Available at https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

100 Camera Recording Cell.

101 See also *Report on an unannounced inspection of Maghaberry Prison 9-19 April 2018*, by CJI, HMIP, RQIA and ETI. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

- 4.12 Inspectors examined SPAR booklets during the inspection and found an improvement in the standard of completion, although some still required improvement. The PSST staff in the three prisons had made efforts to improve the quality of completion which had undoubtedly shown results. Concerns remained however, in relation to a number of areas including the procedures for linking previous and current SPAR forms, the quality and individuality of care planning, and families were not involved sufficiently in the care and treatment of vulnerable prisoners.

SPAR Evolution

- 4.13 SPAR Evolution had been operating in Magilligan for live testing for a number of months. It had been newly introduced in Ash House, Hydebank Wood two weeks before Inspectors visited. Inspectors recognised it was in developmental process and were supportive of its principles. It provided the NIPS and SEHSCT with a valuable opportunity to learn from the pilot before further roll-out. Inspectors had some concerns about the outcomes for prisoners from the new process and these are detailed in Chapter 3.
- 4.14 Inspectors acknowledge there had been some creative local initiatives to enhance safer custody. Therapy dogs had been used in Hydebank Wood and Magilligan had introduced one for safer custody,¹⁰² in addition to the introduction of Personal Officers for prisoners on the safer custody case-load, both of which were having extremely positive results.

Listeners

- 4.15 Listeners were prisoners who had volunteered, and been selected for the role, and had received training from the Samaritans. Listeners were available on request to help prisoners who were feeling in distress or contemplating suicide or self-harm, and they provided peer support on a confidential one-to-one service to talk through the issues and help to alleviate the distress.
- 4.16 There were established Listener schemes in Maghaberry which at the time of the inspection had six Listeners, and Magilligan which had two. These numbers were low and insufficient to provide an effective service to vulnerable and distressed prisoners on a 24/7 basis, although Inspectors understand that work was underway to recruit additional Listeners. Maghaberry had introduced a resident Listener in Bann House where new committals were allocated on arrival at the prison and Inspectors considered this good practice.

102 <https://www.belfasttelegraph.co.uk/news/northern-ireland/prison-dogs-providing-therapy-rather-than-guard-duties-37421846.html>

- 4.17 At the time of the inspection there were no Listener schemes operating in Hydebank Wood for either the women or the young men. Previous inspection reports had been critical of the absence of a Listeners service in Hydebank Wood for the young men and the women in Ash House,¹⁰³ although Inspectors acknowledge there were challenges of operating Listener schemes in this environment.
- 4.18 In Hydebank Wood there was the facility for both male and female prisoners to speak to the Samaritans through a dedicated portable phone, although the signal was poor.¹⁰⁴ On the day Inspectors visited the staff on duty were unable to get the phone and headset to work properly. Similarly in Magilligan the key for the Samaritans phone could not be located in Alpha House on the day Inspectors visited, and local management needed to ensure that those in crisis have quick and easy access to the Samaritans.
- 4.19 There were Insiders in Ash House who performed a valuable role mentoring and peer-supporting other women prisoners which was very positive¹⁰⁵ however the Insiders did not perform the role of a Listener. Similarly on the male side there were two 'Buddies' at the time of the inspection to provide peer-support to new committals, and whilst this was also a valuable initiative, it was not a substitute for the role of a Listener.
- 4.20 The Prisoner Surveys indicated that there was not a widespread knowledge of the Samaritans Listeners schemes. When asked about whether prisoners could speak to Listeners there was a high proportion of 'Don't know' responses (Maghaberry 43%; Magilligan 34%; HBW male 42% and HBW female 28%) and more needed to be done to raise awareness of the schemes and the Samaritans' phones.
- 4.21 The Joint Suicide and Self-harm Risk Management Strategy provided for meeting the needs of people in custody by maximising opportunities to involve people with lived-experience, and Inspectors would see this as extending to the Listener Scheme.

103 *Report on an announced inspection of Hydebank Wood Young Offender's Centre 18-22 February 2013.* CJI, HMIP, RQIA, ETI. CJI, 1 October 2013. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2013/October---December/Hydebank-Wood-Young-Offenders>

Report of unannounced inspection of Ash House, Hydebank Wood Women's Prison 18-22 February 2013. CJI, HMIP, RQIA, ETI. 1 October 2013. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2013/October---December/Ash-house>
Report on an unannounced inspection of Ash House Women's Prison 9-19 May 2016. CJI, HMIP, RQIA and ETI. CJI October 2016. Available at <http://www.cjini.org/getattachment/efa315e4-3288-47e1-85f6-2de9186916fc/picture.aspx>.

Report on an unannounced inspection of Hydebank Wood Secure College 9-19 May 2016. CJI, HMIP, RQIA and ETI. CJI, October 2016. <http://www.cjini.org/getattachment/deb7ee5a-50c8-4b01-8586-c0abf5a523a8/picture.aspx>

104 *Report on an unannounced inspection of Hydebank Wood Secure College 9-19 May 2016.* CJI, HMIP, RQIA and ETI. CJI, October 2016. Available at <http://www.cjini.org/getattachment/deb7ee5a-50c8-4b01-8586-c0abf5a523a8/picture.aspx>

105 CJI has previously commented on the need for the Insiders to be properly trained and supported. See report on *An unannounced inspection of Ash House Women's Prison 9-19 May 2016.* CJI, HMIP, RQIA and ETI. CJI October 2016. Available at <http://www.cjini.org/getattachment/efa315e4-3288-47e1-85f6-2de9186916fc/picture.aspx>

- 4.22 Listener schemes were widely considered to be successful and a valuable resource for prisoners in times of crisis, and should be built upon and further improved. Inspectors would repeat what we said in the 2014 inspection report and suggest that **the NIPS should review the operation of the Listener scheme in the three prisons, particularly in Hydebank Wood; the ratio¹⁰⁶ of Listeners to prisoners; the availability of Listeners; and the general awareness of the scheme throughout prison population, with a view to expanding the scheme and increasing its uptake. This work should be completed within nine months of the publication of this report.**

Entry to the Prison System

- 4.23 Inspectors have previously raised concerns about prisoners in Maghaberry and Magilligan who entered the prison system through Hydebank Wood. These prisoners were readily identifiable to the NIPS by the 'H' prefix to their prison number.
- 4.24 The CJI Resettlement inspection highlighted the high numbers of 'H' numbers in the adult estate which merited further analysis to explain these resettlement outcomes from Hydebank Wood, and to inform future service provision.¹⁰⁷
- 4.25 The most recent Maghaberry inspection found that prisoners who came to Maghaberry from Hydebank Wood comprised a very high proportion of repeat self-harms and SPARs and Inspectors said this needed further investigation.¹⁰⁸
- 4.26 This was reinforced in the fieldwork for this inspection where the data showed that of the prisoners in Maghaberry who had repeat SPARs opened, 18 of the top 22 (82%) had 'H' Numbers. Similarly in Magilligan it was seven of the top 10 prisoners who had repeat SPARs (70%) were 'H' numbers. It was a similar picture for prisoners involved in repeat self-harm incidents in Maghaberry and Magilligan.
- 4.27 Inspectors would again highlight this issue to the NIPS as needing further investigation to allow the NIPS and SEHSCT to take appropriate action and suggest **within nine months of the publication of this report the NIPS, in consultation with the SEHSCT, should investigate the reasons for the high proportion of repeat SPARs and repeat incidents of self-harm among prisoners in the adult prisons who had previously been in Hydebank Wood.**

106 A ratio of one listener per 50 prisoners is the aim for prisons with a rota to allow a 24 hour service. Samaritans web site <http://www.Samaritans.org/your-community/our-work-prisons/listener-scheme>.

107 *Resettlement: An inspection of Resettlement in the Northern Ireland Prison Service*. CJI, May 2018. Available at <http://www.cjini.org/getattachment/1ded7a6c-034e-4a62-bf02-96ee30584645/picture.aspx>

108 See Report on *An unannounced inspection of Maghaberry Prison 9-19 April 2018* by CJI, HMIP, RQIA and ETI. CJI 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

Drugs and Substance Misuse

- 4.28 In general there had been an overall improvement in the efforts to reduce the supply and availability of illegal and prescription drugs since the position in 2014, although it remained a significant concern. The number of drug finds by the NIPS had shown an increasing trajectory from 2009-10, indicating sustained demand, but also that the NIPS was having a degree of success in its attempts to reduce supply.¹⁰⁹
- 4.29 Corruption prevention arrangements were beginning to produce results and there had been a recent notable success in relation to an officer smuggling drugs into Maghaberry prison.

Table 3 Drug finds

Finds ¹¹⁰	Maghaberry (number per prisoner against average daily Population ¹¹¹)	Magilligan (number per prisoner against average daily Population)	HBW male (number per prisoner against average daily Population)	HBW female (number per prisoner against average daily Population)
Drugs	177 (.20)	65 (.15)	13 (.13)	nil
Unknown substance	58 (.06)	18 (.04)	10 (.10)	3 (.05)
Total	235 (.27)	83 (.19)	23 (.24)	3 (.05)

The outcomes of the MDT testing process were as follows:

109 NIPS FOI Case No 15:208. Prisoner assaults, drugs, control and restraint and adjudications 2009/2010 to 2014/2015. <https://www.justice-ni.gov.uk/publications/nips-foi-15208-prisoner-assaults-drugs-control-and-restraint-and-adjudications-20092010>

110 NIPS Statistics. 1 September 2017 to 31 July 2018. Note Unknown substances may subsequently be confirmed as drugs so there may be some double counting in the figures.

111 Department of Justice. Analytical Services Group. The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

Table 4 Overall MDT results

Location ¹¹²	Number of tests* (number per prisoner against average daily Population ¹¹³)	Pass (%)	Fail (%)	Refusal (%)	Fail and Refusal (%)
Maghaberry	2344 (2.73)	1748 (74.5%)	393 (16.7%)	195 (8.31%)	588 (25%)
Magilligan	1052 (2.44)	808 (76.8%)	157 (14.9%)	87 (8.26%)	244 (23.1%)
Hydebank Wood	536 (3.52)	414 (77.2%)	48 (8.9%)	41 (7.6%)	89 (16.6%)

4.30 A large proportion of the MDT was as part of the risk assessment process for home leave, regime levels etc., and in many of these cases the prisoners could expect to be tested. The combined failure and refusal rates would indicate that drug availability remained an issue in all three prisons, particularly in Maghaberry and Magilligan.

Table 5 Random MDT results

Location ¹¹⁴	Number of tests* (number per prisoner against average daily Population ¹¹⁵)	Pass (%)	Fail (%)	Refusal (%)	Fail and Refusal (%)
Maghaberry	520 (.60)	434 (83.4%)	46 (8.84%)	40 (7.69%)	86 (16.5%)
Magilligan	31 (.07)	23 (74.1%)	3 (9.6%)	5 (16.1%)	8 (25.8%)
Hydebank Wood	162 (1.06)	131 (80.8%)	10 (6.17%)	12 (7.4%)	22 (13.6%)

4.31 Random tests may show a more accurate picture of the scale of drug misuse as prisoners are less likely to be expecting a test. The number of random drug tests at Magilligan was very low and was a result of staff shortages and other prioritisation. The refusal rate was high, albeit based on a low sample, and when combined with failures, indicated potentially high levels of substance misuse. Local management should take the necessary steps to investigate this further.

112 NIPS Statistics. 1 September 2017 to 31 July 2018. The results may not equate to the number of tests as a small number of tests were awaiting results.

113 Department of Justice. Analytical Services Group The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

114 NIPS Statistics. 1 September 2017 to 31 July 2018. The results may not equate to the number of tests as a small number of tests were awaiting results.

115 Department of Justice. Analytical Services Group, The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

Table 6 Suspicion test results

Location ¹¹⁶	Number of tests* (number per prisoner against Average daily Population ¹¹⁷)	Pass (%)	Fail (%)	Refusal (%)	Fail and Refusal (%)
Maghaberry	438 (.51)	142 (32.4%)	198 (45.2%)	91 (20.7%)	289 (65.9%)
Magilligan	322 (.74)	191 (59.3%)	87(27%)	54 (16.7%)	141 (43.7%)
Hydebank Wood	158 (1.03)	112 (70.8%)	18 (11.3%)	17 (10.7%)	35 (22.1%)

- 4.32 The results of the suspicion testing showed high levels of passes in Magilligan and particularly in Hydebank Wood which would suggest that the intelligence and targeting of suspected offenders needed to improve, or alternatively the MDT was not testing for the drugs in circulation. Local management should take the necessary steps to investigate this further. The fact that Maghaberry was testing a much lower proportion of its Average Daily Population (ADP) and still having by far the highest fail and refusal levels, would suggest that the intelligence and targeting of suspected drug abusers was much more effective than was the case in Magilligan and Hydebank Wood. The other prisons should take immediate steps to learn from the approach taken at Maghaberry.
- 4.33 As was the case in the 2014 inspection, some officers expressed concerns to Inspectors that there were occasions when prisoners who appeared to be clearly under the influence of drugs had passed the MDT. These concerns had also been expressed to IMB Members in Hydebank Wood.¹¹⁸ This was something that the NIPS needed to investigate.
- 4.34 CJI previously found that random and suspicion drug testing had suffered in the past from being inconsistently delivered with testing officers frequently redeployed to other duties, and this was still the case in Magilligan.¹¹⁹ It was much less of an issue in Maghaberry where the MDT was prioritised and more consistently staffed.¹²⁰

116 NIPS Statistics. 1 September 2017 to 31 July 2018. The results may not equate to the number of tests as a small number of tests were awaiting results.

117 Department of Justice. Analytical Services Group, The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

118 Hydebank Wood IMB reported that officers had raised concerns with it regarding drugs on landings; drug tests not picking up 'legal highs'; no perceived deterrent to students bringing drugs into Hydebank (they are not being regularly tested, there are few random searches, their movement is not restricted) – drug problem in Hydebank not being acknowledged and dealt with.

Independent Monitoring Board Annual Report 2017-18 Hydebank Wood College & Women's Prison. IMB. Available at <http://www.imb-ni.org.uk/publications/oct-18/HBW%20Annual%20Report%201718;%20Final%20PDF.PDF>

119 Magilligan IMB reported that due to staffing shortages, drug tests may be delayed for some time, especially those scheduled for the morning, and prisoners awaiting a test may be required to wait an unacceptably long time. *Independent Monitoring Board Annual Report 2017-18 Magilligan Prison.* IMB. Available at <http://www.imb-ni.org.uk/publications/oct-18/Magilligan%20Annual%20Report%2017-18%20PDF.PDF>

120 See report on *An unannounced inspection of Maghaberry Prison 9-19 April 2018* by CJI, HMIP, RQIA and ETI. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

- 4.35 Drug testing was carried out on prisoners' urine samples which tested for a number of substances, it did not cover all types of illicit and prescription drugs, for example synthetic cannabis was not tested for.¹²¹ The IMB reported that there has been a dramatic increase in the use of these 'legal highs', or NPS.¹²²
- 4.36 MDT results, of positives, negatives and refusals should be shared with the SEHSCT to ensure that the MDT results correlated with the prisoner's prescribed medication regime. This would allow the MDT process to identify if a positive test was as a result of a prescribed substance, and if it was at the correct level. It would also allow the NIPS and the SEHSCT to identify people who should have a level of prescribed medication but did not, for example, if the prisoner had been bullied for his/her medication or had it stolen. Inspectors found that this exchange of information between the NIPS and the SEHSCT was not effective. On occasions the information was not appropriately shared, prescription records were not/accurate up-to-date and work needed to be done by the two organisations to address this issue (see Strategic recommendation 1).
- 4.37 Inspectors referred previously to the inefficiency of the testing process where prisoners undergoing drug testing were taken to a designated area within the respective prison and were permitted up to four hours, in controlled supervised conditions, to produce a sample. This was a very time-consuming and resource-intensive process for the NIPS. It remained the view of Inspectors that drug testing could be undertaken much more efficiently by hair, saliva or other sample testing¹²³ and in 2014, we recommended that the NIPS should consider this as part of Strategic recommendation 3 (see Appendix 2). The use of PDDs and range of drugs detected by PDDs, and tested for as part of the MDT programme, should also be reviewed as part of this work. This remains extant.
- 4.38 Maghaberry has had success in reducing the supply of drugs into the prison, although there undoubtedly remained a serious problem of access to illegal drugs and diverted prescription medication in the three prisons. This was further confirmed by the prisoner survey information.
- 4.39 The widespread availability of drugs across the prisons was confirmed to Inspectors by prisoners we spoke to. Inspectors were aware of instances where prisoners had chosen to spend time in the spartan conditions of the CSU to try and curb their drug-seeking behaviour, as it was perceived as easier to escape the temptations of drugs in the CSU rather than on the residential landings.

121 Ibid

122 *Independent Monitoring Board Annual Report 2017-18 Magilligan Prison*. IMB. Available at <http://www.imb-ni.org.uk/publications/oct-18/Magilligan%20Annual%20Report%2017-18%20PDF.PDF>

123 This was a recommendation in the Report on Minimising the Supply of Drugs in Northern Ireland Prisons. Internal Northern Ireland Prison Service paper. May 2008.

- 4.40 At establishment level, driven corporately through the Security Management Steering Group, more needed to be done to ensure that the operation of the drug testing programme was meeting the objectives of providing more accurate and objective information on the scale, trends and patterns of drug misuse. This would allow Governors to manage and target more effectively their resources for tackling the drug problem. There was a need to develop more corporacy and consistent standards across the three prisons to drive performance improvement.
- 4.41 It would be the view of Inspectors that the search arrangements for staff and visitors to Magilligan and Hydebank Wood Prisons did not sufficiently address the identified threat and did not offer an effective deterrent. These should be re-examined by the NIPS as part of the supply-reduction element of the Joint Strategy. This should include the quality and effectiveness of the staff search arrangements at the three prisons, together with the arrangements for the searching of contractors and delivery vehicles entering the main prison complexes.

Operational recommendation 10

As part of the implementation of the Joint Strategy for the Management of Substance Misuse in Custody the NIPS, in consultation with the SEHSCT, should examine, within one year of the publication of this report, the following areas:¹²⁴

- **the substance misuse meeting structure, including chairing arrangements, terms of reference, attendees etc;**
- **the management and performance information to deliver the strategy;**
- **a review of the role of the Security Department and the processes to support an intelligence-led approach to searching and testing;**
- **a review of the searching arrangements for prison officers and support staff, visitors, prisoners, contractors and suppliers to the three prison sites;**
- **the links between substance misuse, safer custody and violence reduction;**
- **a review of the operation of the mandatory drug testing programme and substance testing arrangements, including the potential to use saliva, hair or other sample testing; and**
- **the particular substance misuse needs of women and young offenders in Hydebank Wood.**

¹²⁴ Include repeat recommendations from the 2014 inspection report.

Bullying and Violence Reduction

Table 7 Bullying investigations recorded

Establishment ¹²⁵	Number	Number per prisoner against average daily population ¹²⁶
Maghaberry (BIR)	356	0.41
Magilligan (SAM)	18	0.04
Hydebank Wood Male (BIR)	62	0.65
Hydebank Wood Ash House (CAB)	63	1.1

- 4.42 The PSST in Maghaberry had focused on a campaign of awareness of violence and anti-social behaviour, and prisoners were more willing to report bullying to staff. A concerted effort had been made to keep prisoners safe by identifying and managing the perpetrators of anti-social and violent behaviour.¹²⁷ This was evident from the higher number of reports in Maghaberry, even in the light of the lack of confidence in the process and under-reporting. The proportions of recorded bullying and violence were highest amongst the women in Ash House and the young men in Hydebank Wood.
- 4.43 There were low levels of recorded prisoner-on-prisoner assaults. From September 2017 to end July 2018, Maghaberry Prison recorded 34 (.03), Magilligan 12 (.02), and Hydebank Wood male 25 (.26) and female 17 (.29).¹²⁸ Again the proportions of assault against the average daily population (in brackets) showed much higher levels of assault at Hydebank Wood.
- 4.44 Inspectors would consider the recorded figures to be lower than the true level as many prisoners were reluctant to report when they had been assaulted or bullied, (see Prisoner Survey page 84). The Northern Ireland rate of 61 per 1,000 prisoners¹²⁹ was low in comparison to England and Wales where there had been 22,374 prisoner-on-prisoner assaults in the 12 months to March 2018 (a rate of 262 per 1,000 prisoners).¹³⁰

125 NIPS Statistics. 1 September 2017 to 31 July 2018.

126 Department of Justice. Analytical Services Group, The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. Available at https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

127 Report on an unannounced inspection of Maghaberry Prison 9-19 April 2018, by CJI, HMIP, RQIA and ETI. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

128 Department of Justice. Analytical Services Group, The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. Available at https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

129 Against the Average Daily Population. Department of Justice. Analytical Services Group, The Northern Ireland Prison Population 2017/18. Research and Statistical Bulletin 26/2018. September 2018. Available at https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern%20Ireland%20Prison%20Population%202017_18.pdf

130 Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2018 Assaults and Self-harm to March 2018. Ministry of Justice. 26 July 2018. Available at <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2018>

- 4.45 Bullying was a significant issue in the prison setting and could be exacerbated by a number of factors including the prison environment, drugs, or may be offence-related. It was reasonable to assume that much violence, bullying and anti-social behaviour was not reported and went unnoticed and unrecorded.
- 4.46 Bullying and violence created some very negative outcomes for prisoners. The IMB reported that bullying and threats of violence as a result of prisoners failing to bring back illegal substances while on Home Leave or incurring drug debts, caused acute difficulties in relation to providing safe accommodation. Frequently such prisoners had to remain in the CSU for lengthy periods in order to ensure their own safety.¹³¹ Also individual prisoners advised IMB members that they refused Home Leave rather than face being 'persuaded' by other prisoners to bring unauthorised articles back into the prison.¹³²
- 4.47 Demands for drug debts to be repaid and prescription medication to be 'handed over', formed the two most frequent reasons for bullying. Despite there being encouragement for prisoners to report bullying, they remained unwilling to do so.¹³³
- 4.48 Prison officers and prisoners advised Inspectors that policy contributed to the level of under-reporting, because when an incident was reported, the alleged bully would be interviewed about the allegations at an early stage. In many cases this made life for the victim much more difficult.¹³⁴ Even though at this point the alleged bully was being monitored by prison staff in line with the policy, the perpetrator could refrain from any inappropriate behaviour during the formal monitoring period, or would use prisoner networks to exert pressure on the victim.
- 4.49 Bullying could be a subtle and unseen process and many cases of reported bullying would come down to one prisoner's word against another. It was difficult for the investigating prison officer to obtain objective evidence. Other prisoners were understandably reluctant to get involved and evidence from independent witnesses was therefore not usually available.
- 4.50 Prisoners lacked confidence in the NIPS response to allegations of bullying, and this further contributed to the level of under-reporting.
- 4.51 Inspectors examined a number of the bullying reports in the three prisons. A number of these lacked a sufficiently rigorous investigative approach, and a number did not proceed because the victim was fearful of the potential consequences.

131 *Independent Monitoring Board Annual Report 2017-18 Magilligan Prison*. IMB. Available at <http://www.imb-ni.org.uk/publications/oct-18/Magilligan%20Annual%20Report%2017-18%20PDF.PDF>

132 *Independent Monitoring Board Annual Report 2017-18 Maghaberry Prison*. IMB. Available at <http://www.imb-ni.org.uk/publications/oct-18/Maghaberry%20Annual%20Report%2017-18%20PDF.PDF>

133 *Independent Monitoring Board Annual Report 2017-18 Magilligan Prison*. IMB. Available at <http://www.imb-ni.org.uk/publications/oct-18/Magilligan%20Annual%20Report%2017-18%20PDF.PDF>

134 See also for example *Summary and Issues of concern of the investigation into the circumstances surrounding the death in Hydebank Wood of Samuel Carson*. Prisoner Ombudsman for Northern Ireland 20 November 2012. Available at <https://niprisonerombudsman.gov.uk/publications/download/54>

- 4.52 Following the investigation of a bullying incident one possible way to resolve the matter was to move either the victim or the perpetrator to another location within the prison. However, the NIPS had very limited scope for interventions of this type, for example in Hydebank Wood and Ash House. Inspectors had previously recommended the use of a restorative approach to address prisoner conflicts.
- 4.53 The NIPS was piloting a restorative project in Quoile House in Maghaberry to promote better relationships between prisoners in conflict, and staff had been proactive in identifying prisoners suited to this approach.¹³⁵ This was a very positive initiative, which had shown marked success in reducing the number of 'keep-aparts'¹³⁶ in Maghaberry. Inspectors look forward to seeing how it develops and how restorative practices can be used more widely across the NIPS to address prisoner conflicts and bullying.
- 4.54 The prisons had local guidance on anti-bullying and violence reduction but these were not based on a corporate strategy or a strategic assessment of the nature and extent of violence in the Northern Ireland Prisons. The local strategies contained comprehensive suites of indicators of bullying and violence which, if recorded and analysed, would provide an accurate indication of the scale and nature of the problem and allow more effective management action to target perpetrators and areas of concern. This data needed to be collected corporately or at establishment level, effectively analysed and linked to other relevant data, for example, in relation to drugs or MDT outcomes.
- 4.55 At the time of the inspection the NIPS was in the process of training a number of security staff as analysts.¹³⁷ This development would provide an opportunity for the NIPS to effectively use this data to improve resource allocation and outcomes for prisoners.
- 4.56 Bullying was discussed at the local Strategic Safer Custody forums and, as referred to above, the meetings were not outcome-based. There remained scope for improvement in relation to the data on indicators of violence and management information available to the meeting, the security and intelligence available, (including phone monitoring), the links to substance misuse and how these informed local strategies to allow proactive action to be taken to address issues of safety, violence and drugs to improve outcomes for prisoners.
- 4.57 Inspectors would repeat the recommendation from the 2014 inspection report. This recommendation should also be read in the context of Operational recommendation 6.

135 See also *Report on an unannounced inspection of Maghaberry Prison 9-19 April 2018* by CJI, HMIP, RQIA and ETI. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>

136 Keep-aparts were prisoners who are kept apart in prison by local management because they were enemies, had a history of violence with each other etc.

137 Previous inspection reports have recommended that intelligence analysts within the Security function should be provided with appropriate training. *Report on an unannounced inspection of Maghaberry Prison 19-23 March 2012*. CJI, HMIP, RQIA, ETI. CJI, 17 December 2012. Available at <http://www.cjini.org/getattachment/b561aa96-c6b8-417f-9c70-a736713315e8/picture.aspx>

Strategic recommendation 2

The NIPS should review its Violence Reduction and Anti-bullying strategy to take account of the issues raised in this report. The revised approach should be completed within six months of the publication of this report. This should include:

- **an effective strategy to challenge bullying and anti-social behaviour;**
- **the management of violence reduction and bullying within the wider safer custody meeting structure;**
- **the management information and performance metrics relating to indicators of violence, anti-social behaviour and bullying;**
- **the particular needs of women and young offenders in Hydebanks Wood in respect of violence, anti-social behaviour and bullying;**
- **the identification and investigation process for allegations of violence, anti-social behaviour and bullying, the management and quality assurance of the process and the training and guidance for officers;**
- **measures to reduce under-reporting and increase confidence in the reporting and investigation process;**
- **the use of the restorative approach to address prisoner conflicts, particularly with the limited scope to move prisoners in some areas; and**
- **the links between bullying, substance misuse and safer custody.**

Prisoners' Views

- 4.58 The NIPS had undertaken a Prisoner Quality of Life Survey in 2012¹³⁸ but this had not been repeated and Inspectors considered the findings too dated to use in this inspection. There would be merit in the NIPS undertaking further work to obtain prisoners' views on current safety issues.
- 4.59 There was some information available through local prisoner forums and local questionnaires seeking the views of prisoners, however prisoners could be reluctant to disclose information on for example, safety, drugs and violence in open fora or to prison officers.

138 NIPS. Prisoner Quality of Life Survey 2012. Roisin Broderick Scottish Prison Service Research Branch. April 2013.

- 4.60 A better source of information were the inspection surveys¹³⁹ undertaken by HMIP and CJI as part of the prison inspections. The information in respect of Maghaberry and Magilligan was recent, 2017 and 2018 respectively. For Hydebank Wood in 2016 the data was less recent but still indicative of prisoners views.
- 4.61 When asked about their safety, prisoners' views varied across the establishments with 63% of respondents having felt unsafe at some time in Maghaberry and 29% felt unsafe at the time of the inspection. In Magilligan fewer prisoners were concerned about their safety (46% and 21% respectively). In Hydebank Wood 61% of the male prisoners had felt unsafe with 27% feeling unsafe at the time of the inspection: for the women in Ash House it was 58% and 16% respectively.

The surveys provided the following information about drugs from respondents:

Table 8 Prisoners' views regarding drugs

Question	Maghaberry	Magilligan	HBW M	HBW F
Did you have a drug problem when you came into the prison?	56%	25%	58%	41%
Have you developed a problem with illicit drugs since you have been in the prison?	30%	16%	16%	24%
Have you developed a problem taking medication not prescribed to you since you have been in the prison?	27%	21%	18%	32%
Is it easy to get illicit drugs in this prison? (easy or very easy)	45%	41%	33%	50%
Is it difficult to get illicit drugs in this prison? (difficult or very difficult)	18%	10%	4%	5%

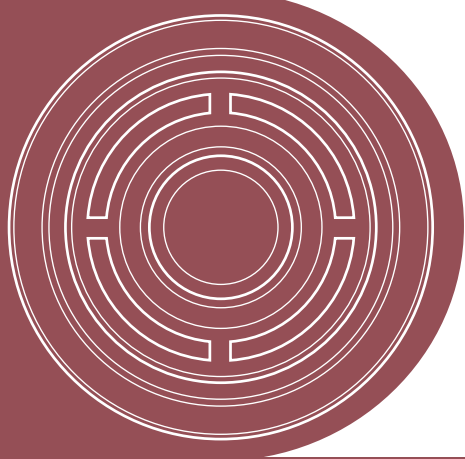
139 See Report on *An unannounced inspection of Maghaberry Prison 9-19 April 2018* by CJI, HMIP, RQIA and ETI. CJI, 27 November 2018. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2018/October-December/Maghaberry>.
 Report on *An unannounced inspection of Magilligan Prison 12-22 June 2017* by CJI, HMIP, RQIA and ETI. CJI, December 2017. Available at <http://www.cjini.org/CMSPages/GetFile.aspx?guid=30135725-7a54-431e-85a0-d5ac80fe284c&chset=b3b8fc27-253c-418a-b263-309c2ba3bc2d>.
 Report on *An unannounced inspection of Hydebank Wood Secure College 9-19 May 2016*. CJI, HMIP, RQIA and ETI. CJI, October 2016. Available at <http://www.cjini.org/getattachment/deb7ee5a-50c8-4b01-8586-c0abf5a523a8/picture.aspx>.
 Report of *An unannounced inspection of Ash House, Hydebank Wood Women's Prison 18-22 February 2013*. CJI, HMIP, RQIA, ETI. CJI, 1 October 2013. Available at <http://www.cjini.org/TheInspections/Inspection-Reports/2013/October---December/Ash-house>.
 Report on *An unannounced inspection of Ash House Women's Prison 9-19 May 2016*. CJI, HMIP, RQIA and ETI. CJI, October 2016. Available at <http://www.cjini.org/getattachment/efa315e4-3288-47e1-85f6-2de9186916fc/picture.aspx>.

- 4.62 The prisoner survey information indicated that there were high levels of people entering the prisons with existing drug problems, which was an issue the NIPS and the SEHSCT needed to deal with on their arrival.
- 4.63 Despite the efforts of the NIPS to reduce the supply of drugs into prison, Inspectors were concerned that the surveys indicated prisoners considered that there was a relative ease to obtaining drugs in prison. This was also relevant to the concerning findings that significant numbers of prisoners were developing problems with drugs and diverted medication whilst in prison.
- 4.64 The findings from respondents in the prisoner surveys showed significant levels of violence and bullying. Prisoners in Maghaberry had experienced bullying/victimisation from other prisoners, and this included verbal abuse (40%), threats or intimidation (31%), theft of property (25%), and assault (24%). In Magilligan 25% of prisoners had been victimised by other prisoners and included threats or intimidation (20%), verbal abuse (19%), offence-related (14%) and assault (12%). In Hydebank Wood male 38% reported they had been victimised, mainly by way of verbal abuse (25%), and threats or intimidation (21%). Ash House had the highest proportion of prisoners (50%) who had been victimised by other prisoners, for threats or intimidation (37%), verbal abuse (29%), for their medication (24%).
- 4.65 Of concern to Inspectors was the prisoners' confidence to report that they were being bullied, and it was particularly concerning in Maghaberry and amongst the young offenders in Hydebank Wood.

Table 9 Prisoners' views about reporting bullying

	Maghaberry	Magilligan	HBW Male	HBW Female
Prisoners who would not report being bullied/victimised by other prisoners	70%	22%	36%	16%

- 4.66 Inspectors welcomed the steps taken by the SEHSCT to engage with prisoners and utilise the feedback within service improvement. The Welcome Project/10,000 voices survey, the employment of a healthcare staff member with lived experience of the justice system, and the establishment of a dedicated engagement officer within prison healthcare were all evidence of a co-production approach with seeking the views of those with the lived experience. This provided real time feedback and was used to produce animation videos developed jointly with prisoners and healthcare staff and information leaflets designed by prisoners.



Appendices



Appendix 1: Terms of Reference

An inspection of the Safety of Prisoners held by the Northern Ireland Prison Service (NIPS)

Terms of Reference

Introduction

Criminal Justice Inspection Northern Ireland (CJI) and the Regulation and Quality Improvement Authority (RQIA) propose to undertake a joint inspection of the safety of prisoners held by the Northern Ireland Prison Service (NIPS).

Context

The core purpose of the NIPS is to improve public safety by reducing the risk of reoffending through the management and rehabilitation of offenders in custody.

The delivery against this core purpose is supported by the strategic aims of the NIPS, the first of which is 'Safe, secure and decent custody'.¹⁴⁰ The safety of prisoners is therefore central to the work of the NIPS, and crucial for public confidence in the Prison Service.

The South Eastern Health and Social Care Trust (SEHSCT) assumed responsibility for healthcare in the three Northern Ireland prisons on April 2008. Many prisoners have mental health and personality disorder issues, many have drugs and alcohol addiction and, in addition, other vulnerability factors can surface while in prison custody. Women in prison have specific requirements. There is a need therefore, for effective multi-disciplinary working between the NIPS and the SEHSCT to address these issues to provide safe, secure and decent custody.

The Prison Review Team (PRT) Report expressed concern about the operation of the SPAR (Supporting Prisoners at Risk) process, and previous Criminal Justice Inspection, Her Majesty's Inspectorate of Prisons, and the Prisoner Ombudsman death in custody reports have highlighted issues in respect of the safety of prisoners.

This inspection is set within the context of the wider prison reform process, the implementation of the PRT recommendations, and the previous inspection on the same subject published in October 2014¹⁴¹.

140 Northern Ireland Prison Service Annual Report and Accounts 2016-2017.

141 *The Safety of Prisoners held by The Northern Ireland Prison Service. A joint inspection by Criminal Justice Inspection Northern Ireland and the Regulation and Quality Improvement Authority.* CJI, October 2014. Available at <http://www.cjini.org/getattachment/677ac123-4a48-43c3-8170-c2c73d2282a4/picture.aspx>

Aims of the Inspection

The broad aims of the inspection are to examine the effectiveness of:

- the safety of prisoners held by the NIPS;
- the support available for, and the understanding of, vulnerable prisoners;
- the policies and procedures for prisoner safety, including the operation of the SPAR process;
- the governance issues around vulnerable prisoners, the meeting structures and reporting mechanisms;
- the communication and inter-disciplinary working between the NIPS and SEHSCT in respect of prisoner safety;
- the services provided within prisons to vulnerable prisoners and those with suicide and self-harm issues;
- the joint comprehensive assessment of prisoners, on committal and during the custodial period, to identify vulnerability; and
- issues around assessment for, and provision of, prescription medication.

Methodology

The inspection will be based on the CJI Inspection Framework for each inspection that it conducts. The three main elements of the inspection framework are:

- Strategy and governance;
- Delivery; and
- Outcomes.

Constants in each of the three framework elements and throughout each inspection are equality and fairness, together with standards and best practice. CJI inspection methodology can be found on the CJI website – www.cjini.org

Research and Review

Collection and review of relevant documentation such as previous inspection and other reports, the NIPS and SEHSCT policies and procedures, management information, minutes of meetings, SPAR and other prisoner safety-related documentation.



Fieldwork

- Terms of reference will be prepared and shared with the NIPS and SEHSCT prior to the initiation of the inspection. Liaison officers from the NIPS and SEHSCT should be nominated for the purposes of this inspection;
- The NIPS and SEHSCT will be given the opportunity to complete a self-assessment of the safety of prisoners and to provide Inspectors with any management information deemed relevant;
- Interviews and focus groups will be conducted with the NIPS and SEHSCT management and staff, relevant stakeholders, and prisoners, to give an insight into the issues affecting prisoner safety;
- Progress in the development of management information and performance management data will be examined;
- Evidence of planning and decision-making leading to performance improvement and recognition of future development will be gathered; and
- Where appropriate benchmarking and identification of best practice within and outside Northern Ireland.

CJI Inspectors carried out a series of engagements with stakeholders and criminal justice agencies. These included:

May 2018

Meeting with Samaritans.

Meeting with AD:EPT.

June 2018

Meeting with Prisoner Ombudsman's Office.

Meeting with Assistant Director Prisons and Head of Psychology Probation Board for Northern Ireland.

Meeting with Assistant Director Prison Health, Adult Services, SEHSC Trust.

Meeting with Quakers.

July 2018

Meeting with NIACRO.

Meeting with Extern.

Meeting with T/Chief Inspector, Safer Detention and Custody, PSNI.

September 2018

Meeting Governor and D/Governor Magilligan.
Meeting Safer Custody Co-ordinators Magilligan.
Meeting Governor Security Magilligan.
Meeting Security Senior Officer Magilligan.
Focus group residential officers Magilligan.
Focus group Listener prisoners Magilligan.
Focus group Residential Senior Officers Magilligan.
Focus group short-term prisoners Magilligan.
Meeting Visits Senior Officer Magilligan.
Focus group long-term prisoners Magilligan.
Focus group foreign national prisoners Magilligan.
Meeting Chaplains Magilligan.
Meeting IMB Magilligan.
Meeting POA Magilligan.
Meeting PBNI Manager Magilligan.
Meeting safer custody personal officers Magilligan.
Meeting Residential Governor Magilligan.
Meeting CSU Senior Officer Magilligan.
Meeting Security Senior Officers Magilligan.
Meeting Residential Governor Maghaberry.
Meeting Security Governor Maghaberry.
Meeting Visits Senior Officer Maghaberry.
Meeting Governor Reception Maghaberry.
Focus group Senior Officers Maghaberry.
Focus group Listener Prisoners Maghaberry.
Meeting Governor Maghaberry.
Meeting Deputy Governor Maghaberry.
Focus group foreign national prisoners Maghaberry.
Meeting Governor Quoile House Maghaberry.
Focus group Residential officers Maghaberry.
Meeting Drug Testing Officer Maghaberry.
Meeting CSU Senior Officer Maghaberry.
Focus group long-term prisoners Maghaberry.
Focus group short-term prisoners Maghaberry.
Meeting Chaplains Maghaberry.
Meeting IMB Maghaberry.
Meeting POA Maghaberry.
Meeting PBNI Manager Maghaberry.
Meeting Senior Officers Safer Custody Co-ordinators Maghaberry.
Focus group Donard Officers Maghaberry.
Meeting PECCS Governor Maghaberry.
Meeting Governor Safer Custody Co-ordinator Hydebank Wood.



Meeting Deputy Governor Hydebank Wood.
Meeting Security Manager Hydebank Wood.
Meeting Safer Custody Officers Hydebank Wood.
Focus group Residential Senior Officers Hydebank Wood.
Meeting PDU Governor and Senior Officer Hydebank Wood.
Focus group Ash House foreign national prisoners.
Focus group Ash House short-term prisoners.
Focus group Ash House long-term prisoners.
Focus group Ash House residential officers.
Focus group residential Senior Officers Hydebank Wood.
Meeting Governor Head of Security NIPS HQ.
Meeting Governor Residential male Hydebank Wood.
Focus group residential officers Hydebank Wood.
Focus Group long-term Students Hydebank Wood.
Focus group short-term students Hydebank Wood.
Focus group foreign national students Hydebank Wood.
Meeting Chaplaincy Hydebank Wood.
Meeting IMB Hydebank Wood.
Meeting Senior Officer CSU Hydebank Wood.
Meeting PBNI Manager Hydebank Wood.
Meeting Head of Prisoner Wellbeing NIPS Headquarters.
Director of Operations NIPS Headquarters.
Director General of NIPS and Director of Reducing Offending.
Meeting Governor Ash House.
Meeting staff and visits to CSU Maghaberry, Magilligan and Hydebank Wood.
Meeting staff and visits to Prison Visits Maghaberry, Magilligan and Hydebank Wood.
Meeting of staff and visits to residential areas in Maghaberry, Magilligan and Hydebank Wood.

Feedback and writing

Following completion of the fieldwork and analysis of data a draft report will be shared with the NIPS and SEHSCT for factual accuracy check. The Chief Inspector will invite the NIPS and SEHSCT to complete an action plan within six weeks to address the recommendations and if the plan has been agreed and is available it will be published as part of the final inspection report. The inspection report will be shared, under embargo, in advance of the publication date with the NIPS and SEHSCT.

Inspection Publication and Closure

- The final report is scheduled for completion by March 2019;
- A report will be sent to the Minister of Justice for permission to publish;
- When permission is received the report will be finalised for publication;
- Any CJI press release will be shared with the NIPS and SEHSCT prior to publication and release; and
- A suitable publication date will be agreed and the report will be issued.

Appendix 2

Strategic and Operational recommendations from the 2014 CJI/RQIA joint inspection report.

Strategic recommendations

1. The NIPS, in conjunction with the SEHSCT, should review its Suicide and Self-harm Prevention Policy to take account of the issues raised in this report. The revised approach should be a joint strategy between the NIPS and the SEHSCT to address issues of safer custody in the three prisons and should be completed within nine months of the publication of this report (paragraph 4.21). (NIPS and SEHSCT)

It would be the view of Inspectors that the review should address:

- the SPAR procedures, documentation, management and quality assurance of the process;
 - the wider safer custody and SPAR meeting structure, including the chairing arrangements, terms of reference, attendees etc;
 - the management information and performance metrics relating to safer custody;
 - procedures to address the issues of prisoners on repeated or long-term SPARs;
 - the particular safer custody needs of women and young offenders in the YOC¹⁴²;
 - an increased focus on case management and whether there is a need for a care-coordinator role to address underlying issues, treating the prisoner and provision of therapeutic interventions;
 - the use of family support for vulnerable prisoners, where appropriate;
 - the role and structure of Donard and how it can be further improved to increase capacity/programmes for the most vulnerable prisoners; and
 - the links between safer custody, violence reduction and substance misuse.
2. The NIPS should review its Violence Reduction and Anti-bullying policy to take account of the issues raised in this report. The revised approach should be completed within six months of the publication of this report (paragraph 4.34). (NIPS)

It would be the view of Inspectors that this should include:

- an effective strategy to challenge bullying and anti-social behaviour;
- the management of violence reduction and bullying within the wider safer custody meeting structure;
- the management information and performance metrics relating to indicators of violence, anti-social behaviour and bullying;
- the particular needs of women and young offenders in Hydebank Wood in respect of violence, anti-social behaviour and bullying;

142 See also footnote 57.



- the identification and investigation process for allegations of violence, anti-social behaviour and bullying, the management and quality assurance of the process and the training and guidance for officers;
 - measures to reduce under-reporting and increase confidence in the reporting and investigation process;
 - the use of the restorative approach to address prisoner conflicts, particularly with the limited scope to move prisoners in some areas; and
 - the links between bullying, substance misuse and safer custody.
3. There should be a comprehensive substance misuse strategy, based on a detailed strategic assessment of the scale and nature of the drugs problem, to address the key areas of supply reduction, demand reduction and throughcare. It should be a joint strategy with the SEHSCT and should be implemented within nine months of the publication of this report (paragraph 4.50). (NIPS and SEHSCT)

It would be the view of Inspectors that the strategy should address:

- the substance misuse meeting structure, including chairing arrangements, terms of reference, attendees etc;
- the management and performance information to deliver the strategy;
- a review of the role of the Security Department and the processes to support an intelligence-led approach to searching and testing;
- a review of the searching arrangements for prison officers and support staff, visitors, prisoners, contractors and suppliers to the three prison sites;
- the links between substance misuse, safer custody and violence reduction;
- a review of the operation on the mandatory drug testing programme and testing arrangements, including the potential to use saliva and hair sample testing; and
- the particular substance misuse needs of women and young offenders in Hydebank Wood.

Operational recommendations

4. The NIPS and the SEHSCT should introduce Memoranda of Understanding at the three prison establishments to clarify the respective roles and responsibilities, particularly in relation to the needs of prisoners in relation to safer custody, anti-bullying and drugs issues (paragraph 4.61). (NIPS and SEHSCT)
5. Inspectors recommend that the opiate substitute treatment programme is recommenced (paragraph 3.80). (SEHSCT)
6. Inspectors recommend that the Opiate Dependency Policy is updated (paragraph 3.80). (SEHSCT)
7. In Hydebank Wood YOC and Maghaberry Prison, the IP supply of medicines at high risk from misuse/trading should be reviewed to ensure the appropriate control of medication diversion (paragraph 4.85). (SEHSCT)
8. In Maghaberry Prison, if a prisoner is undergoing benzodiazepine stabilisation or withdrawal these medicines should be given as supervised swallow in accordance with Trust policy (paragraph 4.85). (SEHSCT)
9. The IP risk assessments should be accurately completed and monitoring checks increased and audited to ensure compliance with Trust policy (paragraph 4.85). (SEHSCT)
10. The actual practice for recording on to the Egton Medical Information System (EMIS) should be reviewed to ensure consistency and appropriate read codes used on the EMIS so that figures can be collated (paragraph 4.85). (SEHSCT)
11. The IP medication policy should be reviewed to reflect actual practice (paragraph 4.85). (SEHSCT)

Areas for Improvement

1. The NIPS and the SEHSCT should examine the effects of purposeful activity on prisoners' self-harm and suicide, drug-taking and bullying behaviour, and address the findings as part of strategic recommendations 1, 2 and 3 (paragraph 3.9). (NIPS and SEHSCT)
2. The NIPS should review the operation of the Listener scheme in the three prisons, particularly in Hydebank Wood, the ratio of Listeners to prisoners, the availability of Listeners and the general awareness of the scheme throughout the prison population, with a view to expanding the scheme and increasing its uptake (paragraph 4.17). (NIPS)



Appendix 3

Terms of Reference

Review of services provided to vulnerable prisoners

The Review will be led by DoH and DoJ and undertaken in partnership with the Northern Ireland Prison Service (NIPS), and the South Eastern Health and Social Care Trust (SEHSCT).

Background/Context

On the 1st April 2008 the responsibility for Prison Health transferred from Northern Ireland Prison Service (NIPS) to the Department of Health, Social Services & Public Safety (now Department of Health); SEHSCT was commissioned by the HSCB/PHA to provide healthcare to all prisoners in Northern Ireland. In January 2017 the prison population in Northern Ireland was 1428 individuals in custody across three sites at Hydebank Wood, Maghaberry and Magilligan. There are approximately 6441 committals to prisons in Northern Ireland each year.

Recent prison inspections and reports have highlighted the challenges of managing vulnerable people in a prison environment and have suggested that the current model of healthcare delivery be reviewed in the context of the changing needs of the population in prison.

The Departments of Health and Justice acknowledge that the needs of those in prison are complex and multi-factorial and reflect societal trends. People are admitted to prison with physical and mental health issues, learning difficulties, substance misuse (including the use of new psychoactive substances) and experience of trauma which increases their vulnerability when engaging with the Justice system.

Prison services have undergone significant change since the transfer of responsibility for healthcare in 2008 and as a result of the Prison Reform Team programme more recently. The Prisons 2020 approach will embed the change delivered and focus on driving continuous development into the future.

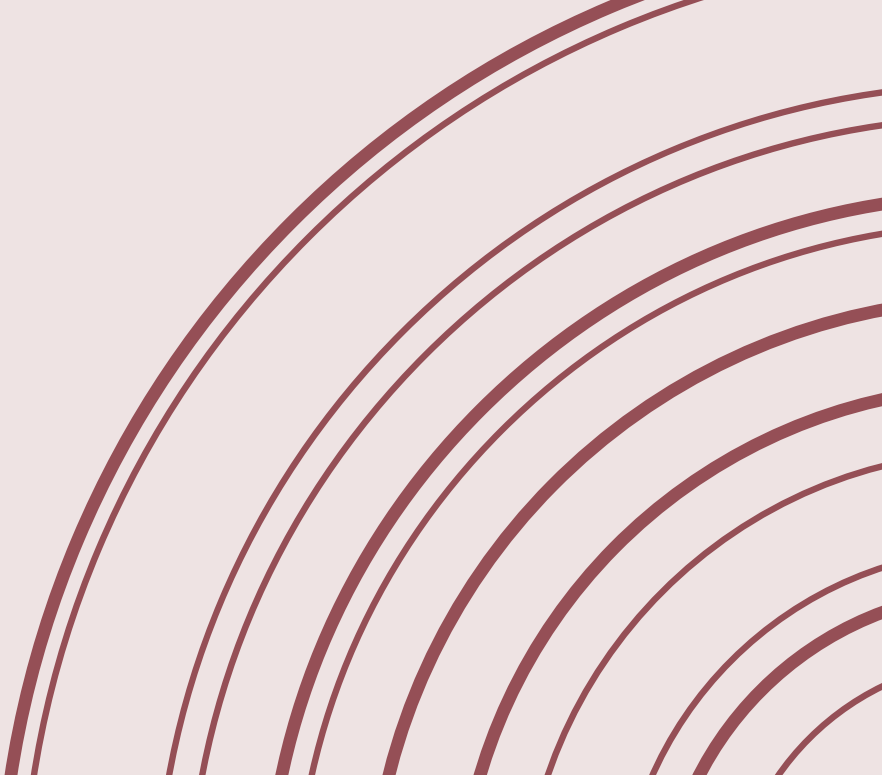
Following the announcement in November 2016 of a joint review of vulnerable people in custody, the planned review should focus on prisoners who are more vulnerable because of mental health concerns or are at risk of suicide or self-harm across the prison estate.

This review should form an action under the draft Joint Healthcare and Criminal Justice Strategy – “Improving Health within Criminal Justice” (Priority 5 – Health promotion and Ill Health Prevention) which is scheduled for publication once the approval process can be facilitated.

The Review will consider:

1. The health and social care needs profile of people in custody.
2. The current provision of services within the physical locations of the Prison environment:
 - a. The use of existing healthcare resources;
 - b. The potential for enhanced support for those who are vulnerable;
 - c. Existing pathways to support people in custody; and
 - d. How the custodial environment can be adapted to enable healthcare delivery and ill-health prevention activity.
3. A Learning Needs Analysis related to the care and management of people in custody.
4. Support for prisoners with specialist need such as ASD, ADHD, intellectual disability, neurology, clinical psychology, and brain injury.
5. Existing Supporting Prisoners structures and communication flows about vulnerable prisoners, including how information is shared.
6. The potential to introduce clinically appropriate alternatives to hospital assessment, treatment and review (for example, diversion from pain medication through alternative therapies and activities).

The review will also consider and agree the joint actions that should be taken by a range of partners including those in the Health and Social Care system, the Prison Service and Probation services, together with other Departments and Voluntary and Community sector to deliver improved health and well-being outcomes for people in custody.



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CRIMINAL JUSTICE INSPECTION NORTHERN IRELAND
Block 1, Knockview Buildings
Belfast BT4 3SJ
www.cjini.org

